MEDICAL STAFF
OF
COMMUNITY MEDICAL CENTER

RULES AND REGULATIONS

ARTICLE I. PURPOSE

The purpose of these General Rules and Regulations of the Medical Staff of Community Medical Center, which may also be referred to as Supplemental Medical Staff Governance Documents, from time to time is to promote high standards of medical and surgical care of patients of Community Medical Center. Furthermore, these General Rules and Regulations shall serve as a guide for accomplishing this purpose as well as to provide certain protections for the patient, the hospital and its personnel and the providers. Each Medical Staff member shall be required to abide by the Bylaws and these General Rules and Regulations of Community Medical Center and to assist in achieving the standards set forth by The Joint Commission and other state and federal regulatory bodies.

ARTICLE II. GENERAL RULES AND REGULATIONS OF THE MEDICAL STAFF

In accordance with the Bylaws of the Medical Staff, the following General Rules and Regulations of the Medical Staff of Community Medical Center are adopted. These General Rules and Regulations may also be referred to as Supplemental Medical Staff Governance Documents. General Rules and Regulations adopted by the Medical Staff in accordance with the Bylaws of the Medical Staff are binding to all members of the Medical Staff. The collective functions of the Medical Staff and the independent functions of its individual members shall be accomplished in accordance with applicable state law.

ARTICLE III. ADMISSION OF PATIENTS

1. Only a member of the Medical Staff assigned to a category of the Medical Staff that permits admission may admit a patient to Community Medical Center. The official admitting policy of the hospital shall govern all practitioners.

2. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible or within twenty-four (24) hours after said admission. Standard nomenclature shall be used.

Practitioners admitting emergency cases shall be prepared to justify to the Executive Committee of the Medical Staff and the Administration of the Hospital that said emergency admission were a bona fide emergency. The history and physical must clearly justify the patient

being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

3. Any patient who does not have a physician on the Community Medical Center Medical Staff will be referred to the physician that is on service.

4. All service patients shall be attended by duly appointed members of the Active and Interim Medical Staff and shall be assigned to the service concerned in the treatment of the disease which necessitated admission under the Bylaws, General Rules and Regulations, and Departmental Rules and Regulations of the Medical Staff of Community Medical Center.

5. A complete history and physical examination shall be done no more than thirty (30) days before or (24) twenty-four hours after admission of the patient to the hospital. For a medical history and physical examination that was completed within thirty (30) days prior to registration or inpatient admission, an update documenting of any changes in the patient's condition shall be completed within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

(a) The only exception shall be the patient re-admitted within thirty (30) days with the same diagnosis. In this case, an interim history and physical examination shall suffice. This interim history and physical examination shall be accompanied by the original history and physical examination and the discharge summary from the previous admission and shall include all additions to the history and any subsequent changes in the physical findings.

(b) The history and physical must include the chief patient complaint; details of the present illness or condition including, when appropriate, assessment of the patient's emotional, behavioral, and social status; relevant past social and family histories appropriate to the patient's age; inventory of body systems; physical examination; and diagnosis or problem list with a plan of care. For children and adolescents, the history should also include an evaluation of the patient's developmental age; consideration of educational needs and daily activities, as appropriate; the parent or guardian's report or other documentation of the patient's immunization status; and the family/guardian expectations for, and involvement in, the assessment, treatment and continuous care of the patient.

(c) A short form version of the history and physical examination can be utilized for Observation patients, Interventional Radiology, Minor Room, Same Day Surgery, or any other invasive procedure performed as an outpatient. However, if the patient is converted to an inpatient, then a full H&P must be dictated / documented within 24 hours of the conversion documenting the event that led to the patient's admission from an outpatient setting.
The minimum content a Short Form History and Physical must contain is the: Chief Complaint / Contemplated Procedure / Past Medical History / Past Surgical History / Social and Family History / Current Vital Signs /Allergies / Brief Physical Review (Heart – Lungs – Abdomen-body area being effected by surgery) / Mental Status / Medications / Lab Results.

6. Patients admitted by dentists, except for Oral Maxillofacial surgeons, shall have a complete history and physical examination by a physician of the Active Medical Staff of Community Medical Center. Said physician shall be designated as the primary physician in patient care in this hospital and the patient should be so advised by the dentist.

A complete written history and physical by a member of the Medical Staff shall be done and available on each patient before oral surgery. Oral and Maxillofacial surgeons, who have been credentialed to do so, may do the history and physical on ASA Class I and II patients. These privileges would apply only to Oral and Maxillofacial surgeons who are Board eligible, Board certified or have completed a qualified training program and possess a New Jersey Specialty License in Oral and Maxillofacial Surgery.

7. A podiatrist member of the Medical Staff may co-admit patients to the hospital with an appropriate physician member of the Medical Staff. A complete written history and physical shall be done and available on each patient before podiatric surgery. Podiatrists, who have been credentialed to do so, may complete the history and physical on ASA Class I and Class II patients. The history and physical cannot supplement the pre-anesthesia assessment and evaluation to be performed by appropriate personnel.

8. All patients pregnant to eighteen (18) weeks or more shall be admitted to the Obstetrics Unit for bleeding episodes or threatened labor.

9. The Community Medical Center shall admit patients suffering from diseases commonly admitted to a general hospital under modern accepted medical/dental practices. The Nursing Department must be notified immediately by the attending physician or dentist of all known or suspected contagious diseases as well as provide such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause.

10. Laboratory tests, which are considered to be routine, will be determined by the OR Advisory Committee. Laboratory, radiology, EKG, pathology and other essential reports must be incorporated into the medical records within twenty-four (24) hours, as appropriate to the nature of the test.

11. The attending physician will be responsible for notifying the family of a patient's status at all times.

12. COBRA/EMTALA (Consolidated Omnibus Budget Reconciliation Act/Emergency Medical Treatment and Active Labor Act.)

(a) If any hospital employee or Medical Staff member has reason to believe that the hospital may have received an individual from another hospital who has been transferred in an unstable emergency medical condition, the Medical Staff member or hospital employee must notify Nursing Administration or the administrator on call, who will notify the New Jersey Department of Health as agents for the Center for Medicare Services ("CMS").

(b) All notifications must take place within seventy-two (72) hours of the time that the Medical Staff or hospital employee becomes aware that a patient may have been

inappropriately transferred. The telephone number for CMS is 1-212-264-3942 or 9043. The telephone number for the New Jersey Department of Health is 1-800-792-9770.

(c) The hospital may not penalize or take adverse action against any physician or qualified medical person because the physicians or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized. Furthermore, the hospital may not penalize or take adverse action against any hospital employee or physician because the employee or physician reports a violation of federal regulations governing the special responsibilities of Medicare hospitals in emergency cases.

(d) On-call physicians must respond to the Emergency Department within twenty (20) minutes. If an on-call specialist does not respond within twenty (20) minutes, cannot come into the hospital within one hour (or such earlier period of time as set forth in the Policies, Procedures, Standards and/or Departmental/Divisional Rules and Regulations) or refuses to come in to see the patient, the treating physician shall contact the department chair of the specialist or transfer the patient. This decision needs to be made by the treating physician and must be based on the patient's condition and the risks and benefits of the transfer. Note: If there is a disagreement between the treating physician attending to the patient and an off-site physician as to whether an *Emergency Medical Condition* exists or whether a patient has been stabilized, the medical judgment of the treating physician takes precedence over the judgment of the off-site physician.

(e) For the purpose of a "*medical screening examination" a "qualified medical person"* is a credentialed physician on staff at Community Medical Center, physician assistant or nurse practitioner in the Emergency Department of the Hospital, in each case operating within his/her scope of practice and may include patient's physician providing such examination within the scope of such physician's specialty. In the case of maternal patients, a credentialed Certified Nurse Midwife utilizing the EMTALA Algorithm will also be considered a qualified medical person.

13. All entries or telephone orders given by the House Physician must be signed by said physician.

(f) All patients presenting to Community Medical Center will be screened and stabilized within the capabilities of Community Medical Center by a qualified medical person as defined in these Rules and Regulations.

(g) For the purpose of signing a physician certification authorizing transfer to another medical facility, in the absence of a physician, a Certified Nurse Midwife or a Registered Nurse shall be deemed as "qualified medical persons" authorized to sign the certification in consultation with the physician providing that the physician countersigns the certification within 24 hours.

ARTICLE IV. DISCHARGE OF PATIENTS

1. Patients shall be discharged only by order of the attending (added 1/2008) physicians, dentist, or surgeon in charge, or designee. The attending practitioner shall be responsible for the dictation of the death or discharge summary and completion of the patient's medical records. The

discharge summary should include diagnosis, treatment discharge medications and diet and instruction for follow-up care.

2. Should a patient leave the hospital against the advice of the attending practitioner, without proper discharge, a notation of the incident shall be made in the patient's medical record. The appropriate staff shall be notified promptly for completion of administrative details. If for some reason, the attending staff professional desires not to discharge the patient AMA under the latter circumstances, a notation of this should be made on the clinical record.

3. Plans should be made to discharge patients before noon if at all possible.

4. The Attending Practitioner is required to document the need for continued hospitalization. The statement must contain:

- ❖ An adequate written record of the reason for continued hospitalization; a simple reconfirmation of the patient's diagnosis is not sufficient.
- ❖ The estimated period of time the patient will need to remain in the hospital.
- ❖ Plans for post-hospital care.

ARTICLE V. DEATH OF PATIENTS

1. The provider shall be responsible for signing the death certificate within twenty-four (24) of the demise. A copy of the death certificate shall be made a part of the final hospital record of the patient.

2. Every member of the Medical Staff shall be actively interested in securing autopsies, whenever possible. No autopsy shall be performed without the written consent of the person having the legal custody of the body. All autopsies shall be performed by the hospital pathologist or by a physician to whom he may delegate the duty. When appropriate, the provider shall report those cases to the Medical Examiner's office.

3. All deaths involving violence or suspicious circumstances, and death which occur within twenty-four (24) hours of admission, and have not been under provider's care are considered Medical Examiner's cases and must be so reported by the hospital and the practitioner.

4. Any deaths that occur in the emergency room that were not DOA's and/or admitted should be reviewed by the Emergency Room Department on a monthly basis.

5. Refer to the Administrative Policy and Procedure Manual, "Expirations: Autopsy/Medical Examiners Cases/Post Mortem Care" Policy #: A-06

ARTICLE VI. SURGICAL PROCEDURES

1. A complete history and physical examination and preoperative diagnosis must be recorded before the time stated for the operation or the operation shall be cancelled. The only exception to this rule shall be a written statement by the treating provider that any delay would constitute a life-threatening hazard to the patient.

2. All surgical procedures performed shall be recorded by the operating surgeon or designee promptly following the procedure, with a detailed operative report including the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis dictated within twenty-four (24) hours following the procedure. Dictated operative notes shall be signed within fifteen (15) days after discharge.

3. Prior to any surgical procedure there will be for identification purposes a "time out" when both the surgeon and the nurse will assess the patient and the proposed surgical site as the correctly determined site prior to initiating the surgery. This "time out" period is to prevent any confusion related to patient identification, proposed surgical procedure and the surgical site.

4. All tissue specimens removed surgically shall be sent to the Department of Pathology for examination with the exception of specimens specifically designated below. These may be sent for examination at the discretion of the attending surgeon.

(a) Cataracts

(b) Orthopedic implants

(c) Foreign bodies

(d) Ribs or portions of ribs removed to enhance operative exposure

(e) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary.

(f) Foreskins from infants

(g) Placentas that are grossly normal

(h) Teeth, including fragments

(i) Scar tissue from previous surgery

(j) Tonsils and adenoids

(k) Skin and subcutaneous tissues removed during plastic surgery procedures in which no pathologic change is suspected clinically (such as tissue from blepharoplasty)

(l) Abdominal aortic aneurysms

(m) Femoral heads

It will be the physician's responsibility to document the disposition of such specimens in the patient's medical record.

All bullets will be sent to the laboratory for proper identification and disposition by the Pathologist.

5. For patients having any surgical intervention it shall be mandatory that the skin of the surgical site be marked after discussion with the patient and prior to the administration of anesthesia and surgery. Refer to Clinical Policy and Procedure Manual "Verification of Correct Site for Invasive Procedures" Policy #: 0-4.

ARTICLE VII. GENERAL

1. Any recommended change of established procedures, initiated by the Medical Staff throughout the hospital, must be approved by the President/CEO of the Hospital with the advice and consent of the Executive Committee of the Medical Staff and the Board of Trustees.

2. Standing orders shall be formulated by conference between the Medical Staff and the President/CEO of the Hospital. They may be changed by the Hospital President/CEO of the Hospital after appropriate conferences with the Medical Staff. These orders shall be followed insofar as proper treatment of the patient will allow, and when specific orders are not written by the treating provider, they shall constitute the orders for treatment. Standing orders shall not, however, replace or cancel those written orders for the specific patient by the responsible provider. Standing orders should be signed by the responsible provider at the time of the next visit of said provider.

3. All orders for treatment shall be in writing or placed in the computer. All previous orders are cancelled when patients go to surgery. Patients undergoing major surgery shall be on the surgical service to be co-managed by other providers at the discretion of the surgeon or dentist.

4. A physician, advanced practice provider, registered nurse, registered/certified respiratory therapist/technician, licensed physical therapist, speech pathologist, or registered dietician may accept telephone or verbal physician orders for evaluation and/or treatment relative to their respective discipline and enter orders via appropriate method, i.e. in writing or placed in the computer.

5. The registered dietician may accept verbal or telephone orders for diet changes and tube feeding changes only. A registered pharmacist may clarify orders with physician by telephone or verbally. Orders dictated over the telephone shall be signed by the appropriately authorized person to who dictated with the name of the physician, surgeon, or dentist per his or her own name. The responsible physician, surgeon, or dentist shall sign such orders within thirty (30) days. Covering physicians shall sign verbal orders if the original ordering physician is unavailable to sign the verbal order within the thirty (30) days period.

6. As far as possible, the use of proprietary remedies shall be avoided. When such are ordered for private patients by the treating physician, surgeon or dentist, they shall be secured by the pharmacy.

7. The treating provider be held responsible for the accurate, timely and legible completion of a medical record for each patient

8. It is the duty of all members of the Medical Staff to complete their medical records in a timely manner so that their charts do not become delinquent. Delinquency is herein defined as thirty (30) days post discharge. If a medical record has not been completed fourteen (14) days after a patient's discharge, the Chief Medical Officer or designee shall notify the responsible

Medical Staff member in writing that the medical record must be completed prior to the expiration of the thirty (30) day period which commenced on the date of the patient's discharge. The letter shall also specify that the Medical Staff member shall be suspended if the medical record is not completed within said thirty (30) day period. If the medical record has not been completed twenty-five (25) days after the patient's discharge, the Health Information Management Department shall notify the responsible Medical Staff member by telephone. Practitioners who are chronically suspended for medical records completion will be notified by telephone, facsimile, email and/or regular mail that they must complete medical records. If suspended three (3) times in one year, the Practitioner will be invited to meet with the President to discuss issues or problems in timely medical records completion. Practitioners who are suspended for delinquent medical records after meeting with the President shall be fined and shall pay the sum of Five Hundred ($500) Dollars to be removed from the suspension. Practitioners shall be fined and shall pay the sum of One Thousand ($1,000) Dollars for each additional suspension in order that such suspension is removed.

9. In the event that such noticed members do not complete their delinquent medical records as set forth in 8 above, the clinical and consulting privileges of the practitioner shall be automatically suspended without further notice. Notwithstanding this suspension, the practitioner shall be responsible for fulfilling all Emergency Department call obligations and may admit emergency patients. During the period of a suspension due to medical record delinquency, the Medical Staff member shall not be permitted to admit patients to the Hospital except under the following circumstances: (i) the patient has been admitted to the Hospital from the Emergency Department after being seen by the suspended Medical Staff member while they are on Emergency Department call; or (ii) a patient who identifies the suspended Medical Staff member as their attending physician is admitted to the Hospital through the Emergency Department. In addition, the suspended Medical Staff member shall be permitted to treat their patients who were admitted to the Hospital prior to the imposition of the suspension. Privileges suspended shall be automatically reinstated after completion of all outstanding medical records and payment of all assessed fines, if any.

10. All records are the property of the Hospital and original records shall not be removed except by court order. X-ray film copies may be released with the permission of the Department of Radiology and Nuclear Medicine. In case of re-admission of a patient, all previous records of the admitted patient shall be available for the use of the present treating physician, surgeon, or dentist.

11. (a) Except in an emergency, consultations with a member of the Consulting, Attending, or Associate Attending Medical Staff or other qualified physician shall be required in all major surgical cases in which the patient represents a risk and in accordance with the Rules and Regulations of the departments concerned.

(b) When deemed necessary by the treating physician, a satisfactory consultation shall include an examination of the patient and the hospital records and the preparation of a written opinion of the findings and recommendations which shall be made a part of the medical record. Except in an emergency, when operative procedures are involved, a consultation note shall be recorded prior to surgery.

(c) It shall be the duty of the Medical Staff, its department Chairs, or designees, to see that members of the Medical Staff do not fail in the matter of calling consults needed. Consults will be classified as Routine and STAT. Routine must be completed within a 24 hour period of being called. STAT consultations require physician to physician communication and the consulted physician should have a telephone response time of 20 minutes after consult is called.

(d) It shall be the duty of Administration to assure the Medical Staff that the hospital records are signed by the patient and/or family to assure treatment and hospitalization of said patients.

12. An automatic stop order on dangerous or toxic drugs as defined by the Pharmacy and Therapeutics Committee shall be in force after seventy-two (72) hours. Such other medication, drug permitted in the treatment of a patient shall be formulated by a current, dated, schedule by the Pharmacy and Therapeutics Committee of the Medical Staff; including sedatives, tranquilizers, antibiotics, etc., as well as stop order on specific drugs.

All medication orders including intravenous orders must specify the name and strength of drug and instructions for administration. Telephone orders must be signed within twenty-four (24) hours by the responsible physician.

13. All aerosolized medication therapies, metered dose inhalers, and equipment have an automatic three-day stop order.

14. Patients in any section of the hospital who become mentally disturbed and who continue to be so disturbed to the extent that they interfere with the rest or safety of other patients shall be transferred to an appropriate section of the hospital by the President/CEO of the Hospital, or designee, after consultation with the treating physician, surgeon, or dentist. Administration shall also have the right to request the treating physician, surgeon, or dentist to obtain a psychiatric consultation and/or to transfer the patient to an appropriate facility. In the event of difficulty in obtaining the said request by Administration, the President/CEO of the Hospital may obtain an opinion for the transfer of said patient by the President of the Medical Staff, Department Chairs, or designees.

15. Designated members of the Medical Staff must be in attendance at and will be responsible for all department outpatient clinics. No clinic shall commence without the assigned member or substitute in attendance. Any deviation from this procedure will be reported to the President/CEO of the Hospital and to the Chair of the responsible department for appropriate action. Hospital indemnification policies and procedures are specifically understood to include a physician attending in the clinics.

16. The Executive Committee of the Medical Staff shall have the authority to recommend to the Board of Trustees the suspension of any member of the Medical Staff who persistently violates the Bylaws, the General Rules and Regulations of the Medical Staff, the Rules and Regulations of the Department as well as those of the governing body.

17. Members of the Medical Staff, regardless of excuse, who do not attend at least fifty percent (50%) of their committee meeting obligations, may be subject to disciplinary action by the Executive Committee of the Medical Staff.

18. Members of the Medical Staff shall abide by and be subject to the Rules and Regulations of the Department and Section in which they serve, any special Rules and Regulations delineated by the Medical Staff or the Board of Trustees, the Bylaws of the Medical Staff and these General Rules and Regulations.

19. Any observers permitted into the hospital shall be given an ID stating that they are observers and are not to participate in any official or medical capacity. All members of the medical staff will be provided with IDs which they must have on their person while in the hospital premises.

20. Physicians, who bring into and leave their own equipment in the hospital, do so at their own risk. Their respective department Chairs must approve the equipment brought in by individual physicians and the hospital's safety engineer must check all new electrical equipment.

21. MIU-Physician Liability: PL 1973, Chapter 229, Senate Bill 2135 "No physician or nurse as defined herein who in good faith gives emergency instructions to a paramedic at the scene of an emergency, and no mobile intensive care paramedic who in good faith performs any service authorized by this act, shall be liable for civil damages as a result of such instruction or service."

"No hospital corporation or first aid, rescue or ambulance squad participating in any project authorized by this act shall be liable for any civil damages as a result of such participation."

An attending physician's liability begins with the treatment of the patient. The attending physician is not liable for acts that occur prior to the commencement of treatment.

22. Moderate Sedation: Practitioners must be qualified to administer moderate sedation and be able to rescue patients who fall into a level of deep sedation.

To administer moderate sedation, practitioners must:

(a) Hold a current ACLS course completion card. Members of the Department of Emergency Medicine who are Board Certified in Emergency Medicine are exempt from ACLS. Board Eligible physicians are not exempt.

(b) Pass a test developed by the Chair of Anesthesiology with a score of 100%.

(c) Sedation privileges will be granted by the Department Chairperson. Adverse outcomes will be reviewed by Quality Assurance.

(d) The New Jersey Department of Health & Senior Services Hospital Licensing Standards now mandate that all anesthesia providers maintain current training in Advanced Cardiac Life Support. Steps 1 and 2 are required for biennial re-appointment. Deep sedation/anesthesia is reserved for Anesthesiologists only.

23. In accordance with RWJBH Corporate Care policy, all members must have appropriate TB screening and testing completed at initial appointment and for the following:

a. Medical Staff with low TB exposure risk do not require annual screening or testing at any interval after baseline/initial appointment

b. Medical Staff exposed to TB; Exposure Risk Guidelines/RWJBH Corporate Care policy must be followed as to what will be required from the applicants/Medical Staff members

24. These General Rules and Regulations including the sections herein relating to Appointment and Reappointment, Corrective Action and Hearing and Review Procedures and Committee Structure may be amended at any regular or special meeting of the Active Medical Staff by a majority vote of the Active Medical Staff, a quorum being present, and such amendment shall become effective when approved by the Board of Trustees.

The General Rules and Regulations and policies of the Medical Staff and the Bylaws of the governing body shall not conflict. Neither body may unilaterally amend the General Rules and Regulations of the Medical Staff. In the event of a conflict between the General Rules and Regulations and the Bylaws of the Medical Staff, the Bylaws of the Medical Staff shall govern.

25. Individual in training, such as medical/dental residents and students, participate in the care of patients only under the supervision of a responsible staff member with relevant clinical privileges, and subject to protocol designed by the department/program and approved by the Graduate Medical Education Council Subcommittee (GMECS). In addition, the Resident Housestaff Manual is available on the Intranet.

26. In all cases, a patient shall receive a visit by a practitioner at least once every two days. All prescriptions and orders issued by registered first year residents in the inpatient setting must be countersigned by a licensed physician or permit holder (a person authorized in the State of New Jersey to engage in the practice of medicine in the second year of graduate medical education program or beyond). If orders are not countersigned by a licensed resident or permit holder, the Attending Physician will become responsible for the countersignature.

ARTICLE VIII. APPOINTMENT AND RE-APPOINTMENT OF THE MEDICAL STAFF

Section 1. Application for Appointment

(a) All applications for appointment to the Medical Staff shall be submitted on a form prescribed by the Executive Committee after consultation with the governing body. The application shall detail the applicant's professional qualifications, and include at least three (3) persons who provide adequate references about the applicant's current professional competence, medical/clinical knowledge, clinical judgment, technical and clinical skills, for each specific privilege applied for, as well as the applicant's health and moral and ethical character interpersonal skills, communication skills, professionalism, and ability to work with others. Peer

recommendations from peers in the same professional discipline as the applicant shall be used as part of the basis for the initial grant of privileges. The application shall include information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or institution, and as to whether membership in local, state, or national medical societies, or license to practice any profession in any jurisdiction, has ever been suspended or terminated and reasons therefore and shall require applicant to demonstrate professional liability insurance as herein provided. The application for appointment and accompanying documentation such as these Rules and Regulations shall describe the mechanism for appointment or reappointment and initial granting and renewal of Clinical Privileges.

All applications for appointment or reappointment to the Medical Staff shall include any previously successful or currently pending challenges to any licensure or registration; Medicare, Medicaid or other federal program participation; voluntary or involuntary relinquishment of any licensure or registration; involvement in professional liability actions, including, at a minimum, final judgments or settlement; and denial, voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction or loss of Clinical Privileges at the Hospital and/or at another organization. If any of the above had occurred, it is the responsibility of the staff member to notify the Chairperson of the Credentials Committee.

(b) The applicant shall have the burden of producing adequate information for a proper evaluation of competence, character, health including a statement that no health problems exist that could affect the applicant's ability to perform the privileges requested, ethics and other qualifications and for resolving any doubts about such qualifications. In order to "verify" his or her identity, after submission of a completed application, the applicant will personally appear in the Medical Staff office and shall present either (1) a current picture hospital identification card, or (2) a valid picture identification issued by a state or federal agency such as a driver's license or passport. The applicant shall also provide his facsimile number and an email address that is regularly checked.

(c) The completed application shall be submitted to the Hospital President/CEO or designee. After collecting the references and other materials deemed pertinent, the completed application and all supporting materials shall be transmitted to the Credentials Committee for evaluation. After initial review and acceptance by the department in which applicant will be associated, consultation should be obtained as required by the department and/or Credentials Committee to resolve any questions concerning the applicant's competence, ethics or morals. Consultations may be independently retained to consider the applicant's physical and moral condition.

(d) By applying for appointment to the Medical Staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to this application. He/she authorizes the hospital to consult with members of Medical Staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character and ethical qualifications, consents to the hospital's inspection of all records and documents that may be material to an evaluation of professional qualifications and competence to carry out the privileges requested including licensure, specific training, experience, current competence, ability to perform the Clinical Privileges requested, health status

and questions of moral and ethical qualifications for staff membership, releases from any liability all representatives of the hospital and its Medical Staff for acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials, and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and privileges, including otherwise privileged or confidential information. The Applicant shall also agree that if an adverse ruling is made with respect to his appointment or reappointment to the Medical Staff, he will exhaust the administrative remedies afforded in these Bylaws before resorting to formal legal action.

(e) Requests by Medical Staff members for a transfer from one Department to another shall be processed through and accepted by the Credentials Committee on a case by case basis.

(f) Compliance with all the requirements of the Bylaws and these General Rules and Regulations shall be required by applicants.

Section 2. Appointment Process

(a) Within ninety (90) days after receipt of the completed application for membership, including all required reference materials, the Credentials Committee shall make a written report of its investigation to the Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence, review and analyze all relevant information regarding each applicant's character, current licensure status, professional competence, qualifications, training, experience, ability to perform the requested Clinical Privileges and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the Committee, including an appraisal from the department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the category of the staff membership and the privileges requested by him/her. The Credentials Committee shall consider additional information from other sources including the Federation of State Medical Boards Physician Disciplinary Data Bank in order to determine new information and to flag inconsistencies when compared to the Applicant's application. The Credentials Committee shall also gather essential information such as resources, equipment and personnel then currently available or available within a specified timeframe necessary to support the requested privilege. Each department Chairperson in which the applicant seeks privileges shall provide the Credentials Committee with specific, written recommendations for delineating the privileges, and these recommendations shall be made a part of the report and applicant's record. Together with its report and applicant's report, the Credentials Committee shall transmit to the Executive Committee the completed applications and a recommendation that the applicant be either given an Interim appointment to the Medical Staff or be rejected for Medical Staff membership, or that the application be deferred for further consideration. Should the Credentials Committee recommend Interim appointment, it shall simultaneously recommend the delineation of privileges.

(b) All Applicants must complete computer training under the auspices of the Hospital's MIS Department prior to being interviewed by the Credentials Committee.

Documentation of completion of training may be provided at the interview or subsequently by MIS and filed with the Credentials Committee before Membership is effective.

(c) The application form shall include a statement that the applicant has received and read the Bylaws of the hospital and the Bylaws and General Rules and Regulations of the Medical Staff and Rules and Regulations of the department in which he/she will serve and agrees to be bound by the terms thereof if he/she is granted membership and/or privileges and to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or privileges in all matters relating to consideration of his/her application.

(d) At its next regular meeting after receipt of the applications and the report and recommendation of the Credentials Committee, the Executive Committee shall determine whether to recommend to the governing body that the applicant be given an Interim appointment to the Medical Staff; that he/she be rejected for Medical Staff membership, or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the department to which such Practitioner has been assigned, privileges to be granted, which may be qualified by Interim conditions relating to such privileges. Gender, race, creed or national original shall not be used in making decisions regarding the granting or denial of Medical Staff membership or Clinical Privileges.

(e) When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within one hundred (100) days with a subsequent recommendation for an Interim appointment with specified privileges, or for rejection for staff membership.

(f) When the recommendation of the Executive Committee is favorable to the applicant, the Hospital President/CEO shall promptly forward it, together with all supporting documentation, to the governing body.

(g) The Board may elect to delegate the authority to render initial appointments, reappointments and renewals or modifications of Clinical Privileges decisions to the Board's Credentials Subcommittee.

(h) When the recommendation of the Executive Committee is adverse to the applicant whether in respect to appointment or privileges, the Hospital President/CEO shall promptly so notify the applicant by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the governing body until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in the Hearing and Appellate Review Procedures of these General Rules and Regulations.

(i) If, after the Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, the Executive Committee's reconsidered recommendation is favorable to the applicant, it shall be processed in accordance with sub-paragraph (f) of this Section 2. If such recommendation continues to be adverse, the Hospital President/CEO shall promptly so notify the applicant, by certified mail, return receipt requested. The Hospital President/CEO also shall forward such recommendation and

documentation to the governing body, but the governing body shall not take any action thereon until after the applicant has exercised or has been deemed to have waived his/her right to an appellate review as provided in the Hearing and Appellate Review Procedures of these General Rules and Regulations.

(j) At its next regular meeting after receipt of a favorable recommendation, the governing body shall act on the matter. If the governing body's decision is adverse to the applicant in respect to either appointment or privileges, the Hospital President/CEO shall promptly notify the Medical Staff and the applicant of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived his/her rights under Hearing and Appellate Review Procedures of these General Rules and Regulations. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

(k) At its next regular meeting after all of the applicant's rights under in the Hearing and Appellate Review Procedures of these General Rules and Regulations has been exhausted or waived, the governing body shall act in the matter. The governing body's decision shall be conclusive, except that the governing body may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the governing body shall be made and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the governing body shall make a decision either to give the applicant an Interim appointment to the staff or to reject him/her for staff membership. All decisions to appoint shall include a delineation of the privileges that the practitioner may exercise.

(l) Notice of the Board of Trustees' final decision shall be sent within ten (10) days following such decision. The Hospital, through the Hospital President/CEO, shall comply with reporting requirements imposed by state or federal law, to the extent applicable to such decision. (added 4/2008)

(m) Reapplication after Denial. An applicant who is denied appointment or whose Medical Staff membership is terminated shall not be eligible to reapply for a period of two (2) years from the final determination of the governing body. Any reapplication thereafter shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or governing body may require to be satisfied that the basis for the prior denial no longer exists.

Section 3. <u>Reappointment Process</u>

(a) Ninety (90) days prior to the final scheduled governing body meeting in the Medical Staff year, each member of the Medical Staff shall submit such pertinent information as required by the Bylaws of the Medical Staff, on a form approved by the Medical Staff to the department in which such member has privileges in order to evaluate Medical Staff members for their continued ability to provide quality care, treatment and services for the privileges requested. All fines previously imposed upon a Medical Staff member which are past due shall accompany

the reappointment application and such reappointment application shall not be complete until such fines are paid. In order to verify his or her identity, after submission of a completed application, the applicant will personally appear in the Medical Staff Office and shall present either (1) a current picture hospital identification card, or (2) a valid picture identification issued by a state or federal agency such as a driver's license or passport. (added 4/2008) The Chairperson of the Department shall review such form within ten (10) days of receipt and forward it to the Credentials Committee for its review and recommendations. At least sixty (60) days prior to the final scheduled governing body meeting in the Medical Staff year, the Credentials Committee shall review all pertinent information available on each practitioner scheduled for biennial appraisal, for the purpose of determining its recommendations for re-appointments to the Medical Staff and for the granting of privileges for the ensuing period, and shall transmit its recommendations, in writing, to the Executive Committee. Where non-re-appointment or a change in privileges is recommended, the reason for such recommendation shall be stated and documented. Data for re-appointments is to be initiated by each department and sent to the Credentials Committee according to a table of organization set by the department.

(b) Each recommendation concerning the re-appointment of a Medical Staff member and the privileges to be granted upon reappointment shall be based upon such member's professional competence and clinical judgment in the treatment of patients, health status, clinical or technical skills, ethics and conduct, attendance at Medical Staff meetings and participation in staff affairs, compliance with hospital Bylaws and the Medical Staff Bylaws, department and General Rules and Regulations, cooperation with hospital personnel, use of hospital's facilities for his/her patients, relations with others and general attitude toward patients, the hospital, other practitioners and the public. Re-appointment policies and appraisal shall include professional, physical, and mental capabilities with a written periodic record to be made part of the permanent file of the hospital. Consultation may be independently obtained to consider the practitioner's physical and mental condition. Peer recommendations shall be used to recommend individuals for the renewal of clinical privileges when insufficient peer review date is available.

(c) At least thirty (30) days prior to the final scheduled governing body meeting in the Medical Staff year, the Executive Committee shall make written recommendations to the governing body, through the Hospital President/CEO, concerning the re-appointment, non-re-appointment and/or privileges of each practitioner then scheduled for periodic appraisal. Where non-reappointment or a change in privileges is recommended, the reasons for such recommendations shall be stated and documented.

(d) Thereafter, the procedure provided in Section 2 of the Appointment and reappointment section of these General Rules and Regulations relating to recommendations on applications for initial appointment shall be followed, including professional liability insurance. Practitioners shall annually, by the first day in October, advice the Credentials Committee and Administration of practitioner's mal-practice experience, setting forth the information required of an applicant upon initial application.

(e) Where a member has performed fewer than six (6) procedures or consultations or emergency room treatments or admitted fewer than six (6) patients during the staff year, the Department Chairperson may recommend re-appointment under supervision. Nothing in

this provision shall relieve a low volume member from payment of all dues and fees charged to members of the Active Staff.

(f) Except for those persons granted provisional status, applicants to the Medical Staff with no procedures, treatments or admissions during the previous period of appointment or reappointment shall be assigned to the Affiliate Staff.

(g) Conditional reappointment is a time-limited reappointment, trial period, lasting up to one year. During this time the medical staff member has agreed to fully comply with the requirements of the CMC Medical Staff Bylaws, General Rules and Regulations, and Department Rules and Regulations. This category assignment would be based on a history of non-compliance with these rules and a request by a Department Chairman, or the Credentials Committee, and/or the MEC in order to be assigned to this category. MEC approval is required for this assignment to take effect. Failure by the medical staff member to comply during this conditional reappointment period would be considered as a voluntary resignation from the Medical Staff.

Section 4. New Procedure Credentialing

The Medical Staff member must direct a request to perform a new procedure to the Chairperson of his/her Department as well as the Credentials Committee. The Chairperson of the Department will decide if the procedure is:

(a) A new procedure,

(b) Within the scope of the Physician or Independent Limited Professional specialty,

(c) Develops necessary credentialing criteria,

(d) Requires the supervision by a proctor and if so,

(e) Will approve the selection of the proctor.

(f) Will decide on the need for additional equipment and/or staff and training that may be required. If a proctor is required, the cost incurred shall be underwritten by the Hospital. The proctor shall supervise the Physician or Independent Limited Health Professional for the number of procedures necessary to determine current clinical competency, document his/her competency and certify as to his/her proficiency to the Chairperson of the Department and the Credentials Committee. Upon receipt of certification from the proctor and approval for performance of requested procedure from the Chairperson of the Department, the Credentials Committee shall revise the Physician or Independent Limited Health Professional's Briggs form and take all other appropriate action.

Section 5. Economic Credentialing

This hospital will not in any manner use economic criteria for the termination or granting of privileges unrelated to clinical qualifications, professional responsibilities or quality of care.

Furthermore, the Medical Staff physician privileges should not be tied to payer mix or diagnosis. If any economic data is collected, it should be used for educational purposes only.

Section 6. Leave of Absence

(a) A Practitioner requesting a Leave of Absence must do so in writing to the respective Chairperson of the department with copies furnished to the Chairperson of the Credentials Committee, Chief Medical Officer, and President of the Medical Staff. Any elective Leave of Absence should be requested no less than thirty (30) days in advance of the proposed commencement of such Leave so as to allow for coverage of the Practitioner's responsibilities except that leaves of absence due to termination of contracts or restrictive covenants may be requested on an immediate basis.

(b) A member of the Medical Staff may apply for a Leave of Absence not to exceed one (1) year with a separate application for another one (1) year extension. Upon return the member must furnish, for reinstatement, the following:

(i) A letter accounting for all professional activities, if any, during the LOA.

(ii) If in training, a letter from the institution and/or supervising physician.

(iii) If on a Medical LOA, a letter from the treating physician clearing the member to go back to work at Community Medical Center.

(iv) If in practice elsewhere, a letter from the institution and/or supervising physician stating that the member is in good standing.

(c) A Practitioner requesting a Leave of Absence must complete all delinquent charts and must be signed off by the respective department Chairperson before being granted a Leave of Absence. The Practitioner must continue to provide coverage for his/her practice until his/her application is approved by the Executive Committee. The request for a Leave shall also be accompanied by a statement that the Practitioner is not under any investigation for patient care or other issues.

(d) The granting of a Leave of Absence is discretionary. In the event the application for a Leave of Absence is denied, the Practitioner shall have the right to address the Executive Committee, which decision is final and shall not entitle the Practitioner to a Hearing.

(e) No dues are to be paid during the pendency of the Leave and the Practitioner may not hold office, vote or serve on Committees during the Leave.

(f) Time on leave shall not be counted towards advancement.

(g) A Practitioner on Leave is subject to reappointment during the regular reappointment cycle and must complete the reappointment application and fulfill all reappointment obligations even though on Leave.

(h) Practitioner's returning from an extended approved Leave of Absence, if such Leave of Absence exceeds one (1) year, must fulfill all the requirements for reappointment except the payment of an application fee, with privileges to be delineated by the governing body.

(i) Absence for longer than two (2) years shall constitute voluntary resignation of Medical Staff appointment and clinical privileges unless an exception is made by the Medical Executive Committee.

(j) A leave of absence shall not impact or interfere with any corrective action or adverse recommendation made with respect to the Practitioner requesting the leave.

(k) Practitioner's granted leaves of absence may be subject to Focused Professional Practice Evaluation upon their return depending upon the circumstances.

ARTICLE IX. PEER REVIEW AND CORRECTIVE ACTION

Section 1. Collegial Intervention.

(a) These General Rules and Regulations encourage the use of progressive steps by Medical Staff leadership, beginning with collegial and educational efforts to address issues relating to a practitioner's professional conduct and/or activities including clinical conduct.

(b) Collegial efforts shall include, but not be limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

(c) All collegial intervention efforts by Medical Staff leadership are part of the hospital's performance improvement and professional and peer review activities.

(d) The President of the Medical Staff or his designee(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in a practitioner's confidential file. If documentation of collegial efforts is included in a practitioner's file, the practitioner will have the opportunity to review the information and respond in writing. The response will be maintained in the practitioner's file along with the original documentation.

(e) While collegial intervention is encouraged, it is not mandatory and shall be within the discretion of Medical Staff leadership.

Section 2. Procedure for Corrective Action

(a) Whenever the activities or professional conduct of any practitioner with privileges are considered to be lower than the standards of the Medical Staff, or to be disruptive to the operations of the hospital, or where a physician remains on automatic suspension over ninety (90) days and fails to resume an active status, or fails to maintain a current patient record, or if the physician removes any medical, hospital records, report or x-ray from the hospital without permission of the Hospital President/CEO, or if the physician fails to appear at a scheduled review meeting at which he/she has been required to appear and from which he/she has not been excluded, or if a physician is placed on probation by the State Board of Medical Examiners, or if a physician is subject to sanctions by Medicare, Medicaid or any governmental payor or is convicted of a crime relating to the practice of medicine including reimbursement crimes, or if a Practitioner fails to maintain the qualification of his/her appointment or reappointment as set forth in Article VIII of these General Rules and Regulations, or if any of the other requirements of this Article IX are met, corrective action against that practitioner may be requested by any officer of the Medical Staff, by the Chairperson of any department, by the Chairperson of any standing committee of the Medical Staff, by the Hospital President/CEO, or by the governing body or the Executive Committee may direct the matter to be handled pursuant to the Impaired Practitioner Policy and Procedure set forth in these General Rules and Regulations. All requests for corrective action shall be in writing, shall be made to the Executive Committee and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request. The Executive Committee may elect to obtain an external peer review of the matter(s) which form the basis of the request and may elect to delay the initiation of corrective action pending receipt of such external peer review. In making its determination to pursue corrective action and/or to refer the matter for handling pursuant to the Impaired Practitioner Policy and Procedure, the Executive Committee may, but is not obligated to, discuss the matter with the practitioner.

(b) Whenever the corrective action could be a reduction or suspension of clinical privileges, the Executive Committee shall forward such request to the Chairperson of the department wherein the practitioner has such privileges. Upon receipt of such request, the Chairperson of the department shall immediately appoint an Ad Hoc Committee to investigate the matter consisting of practitioners who may be members of other Departments and may include individuals not on the Medical Staff. The Executive Committee shall inform the practitioner that an investigation has begun and shall include the general nature of the charges against the Practitioner. Notification may be delayed if, in the Executive Committee's judgment, informing the practitioner immediately would compromise the investigation or disrupt the operation of the hospital or the Medical Staff.

(c) Within thirty (30) days after the department's receipt of the request for corrective action, the department shall make a report of its investigation to the Executive Committee. The Ad Hoc Investigative Committee shall consult with the Chief Medical Officer and the Medical Staff office to obtain relevant information that such offices may have. Prior to the making of such report, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the departmental Ad Hoc Investigation Committee. At such interview, the practitioner shall be informed of the general nature of the charges against him/her and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws

with respect to hearings shall apply thereto. A memorandum of such interview shall be made by the department and included with its report to the Executive Committee. A practitioner shall be entitled, but not obligated to be accompanied by legal counsel, who may advise the practitioner, but shall not be entitled to examine or cross-examine witnesses or otherwise participate in the interview process or participate in the discussion. The Ad Hoc Investigation Committee may, but is not obligated to, have legal counsel present for the purposes of advising the Ad Hoc Investigation Committee during the interview process. The failure of a Practitioner to participate in the interview shall be documented in the report, but no presumption shall attach to this fact.

(d) The Ad Hoc Investigation Committee shall have available the full resources of the Medical Staff and the hospital, as well as the authority to use outside consultants as needed. The Committee may also require a physical and/or mental examination of the practitioner being investigated by a physician or physicians satisfactory to the Committee, and shall require that the results of such examination be made available for the Committee's consideration. The Ad Hoc Investigation Committee may request that the Practitioner supply office or other medical records of a patient that such Practitioner may have access to with respect to a review of a particular case involving such patient.

(e) The Executive Committee shall take action upon the report of the investigation, if any: (i) as soon as feasible after the conclusion of the investigative process but in any event within ninety (90) days following the receipt of a request for corrective action, or (ii) following receipt of a report from a department following the department's investigation of a request for corrective action involving reduction or suspension of privileges,. If the corrective action could involve a reduction or suspension of privileges, or a suspension or expulsion from the Medical Staff, the Executive Committee may, but is not obligated to, permit the affected practitioner to make an appearance before it prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. The Executive Committee shall make a record of such appearance. In connection with its evaluation, the Executive Committee may examine the Practitioner's Credentials file, peer review and quality files and physician profiles.

(f) The Executive Committee may accept, reject, or modify the basis for the request for corrective action. If accepted, in whole or in part, the Medical Staff Executive Committee shall recommend a specific sanction or sanctions which may include but is not limited to the following:

(i) A written warning, admonition or reprimand;

(ii) Time limited periods of probation, which shall require monitoring of the Practitioner's actions with additional episodes of the basis for corrective action necessitating further sanction or penalty;

(iii) Requirement for remedial activity including additional or training education;

(iv) Referral to the NJ Professional Assistance Program;

(v) Placement on probation or other conditional status;

(vi) Appointment or reappointment for less than two (2) years;

(vii) Fail to place a Practitioner on any on-call or interpretation roster or removal of any Practitioner from any such roster or denial of appointment to requested Department or Section;

(viii) Continuation of Interim appointment or Medical Staff reduction in rank to the extent permitted in such other sections of these Bylaws;

(ix) Suspension of Clinical Privileges for less than thirty (30) days;

(x) Suspension pending medical consultation;

(xi) Involuntary reduction, suspension for more than thirty (30) days or revocation of Clinical Privileges;

(xii) Sustaining, terminating, expanding or otherwise modifying already imposed corrective action, including summary suspension of Clinical Privileges;

(xiii) Requirement for clinical supervision of care, consultation on categories of care, or co-privileges with another Practitioner;

(xiv) Suspension or revocation of Staff Membership; and/or

(xv) Other specific sanctions as appropriate to the circumstances.

(g) Any recommendation by the Executive Committee which, if ratified by decision of the governing body, will adversely affect a practitioner's appointment to or status as a member of the Medical Staff or the scope of his/her exercise of clinical privilege pursuant to Article IX, Section 2(f) (x - xiv), or any combination of such actions, shall entitle the practitioner to the procedural rights as provided in these Rules and Regulations.

(h) The Chairperson of the Executive Committee shall promptly notify the Hospital President/CEO, or designee, in writing of all requests for corrective action received by the Executive Committee and shall continue to keep the Hospital President/CEO, or designee, fully informed of all action taken in connection therewith. After the Executive Committee has made its recommendation in this matter, the procedure to be followed shall be as provided in Appellate Review Procedures these General Rules and Regulations.

(i) To the extent required, any action as a result of the process must be reported to the National Data Bank in compliance with the Healthcare Quality Improvement Act of 1986 and the Medical Conduct Reform Act of 1989 and/or the New Jersey Practitioner Review Panel.

(j) All Practitioners agree as a condition of their membership to respect the independence and objectivity of the processes provided in these Rules and Regulations. Consequently, any attempt to lobby, intimidate, or otherwise unduly influence the corrective action, investigation, fair hearing and/or appellate review and/or any witness in a manner under review shall itself be an independent grounds for corrective action.

Section 3. Precautionary Suspension

(a) Any one of the following: the President of the Medical Staff, the Chairperson of a department, the Executive Committee, the Hospital President/CEO with the consent of a member of the Executive Committee of the Medical Staff shall each have the authority, to precautionary suspend or place under supervision all or any portion of the privileges of a practitioner, whenever action must be taken immediately in the best interest of patient care in the hospital, to protect the life of any patient, or to reduce the substantial likelihood of injury or damage to the health or safety of any patient, employee or other person or if the practitioner refuses to submit to previously required evaluation or testing and such precautionary suspension shall become effective immediately upon imposition. The practitioner may, but is not required to, be provided with an opportunity to refrain voluntarily from exercising privileges pending an investigation. Direct verbal notification is appropriate in the interests of time but shall be subsequently documented by written notice.

(b) As soon as feasible, but no longer than fourteen (14) days after such precautionary suspension, a meeting of the Medical Executive Committee shall be convened to review and consider the action taken. The affected Practitioner may but is not obligated to meet with the Medical Executive Committee to provide information as to why the suspension should not continue. The Practitioner shall have access to copies of applicable records and documents. Any copies of material provided to the Practitioner shall be at the Practitioner's expense. The appearance of the affected Practitioner before the Medical Staff Executive Committee shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules set forth in these Bylaws with respect to hearings shall apply to such an appearance. The Medical Executive Committee shall determine whether to continue, remove or modify the suspension. The Committee may remove the suspension only if it concludes, based on its review, that the suspension is no longer necessary in the best interests of patient care, for example, it is not necessary to protect the life of any patient(s) or to reduce the substantial likelihood of injury or damage to the health or safety of any patient, employee or other person or if the practitioner submits to the previously refused evaluation or testing.

(c) The decision of the Medical Executive Committee to continue, remove, or modify the suspension shall continue in effect unless and until reversed by the Board, and shall entitle the affected Practitioner to the due process hearing and appeal rights set forth elsewhere in these Rules and Regulations to the extent set forth in Article IX, Section 2(f) (x - xiv) of these Rules and Regulations.

(d) Immediately upon the imposition of a precautionary suspension, the President of the Medical Staff, or designee, or responsible department Chairperson, or designee, shall have authority to provide for alternative medical coverage for the patients of the suspended

practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of a substitute practitioner who has appropriate privileges.

Section 4. Automatic Suspension and Termination of Privileges

The clinical privileges of any member of the Medical Staff shall be automatically suspended under the following circumstances:

(a) If the hospital chart of a patient is not completed by the treating practitioner within fourteen (14) days after discharge of the patient, or if a current chart is not maintained as hereafter defined the practitioner will be notified of such chart deficiency by telephone and written notice by FAX, email, or placement in the practitioner's hospital mail box. If the chart or charts listed in the notice are not completed or brought to a current status within thirty (30) days after the patient's discharge, the clinical privileges of the treating practitioner shall be automatically suspended until such time as the chart or charts set forth in the notice are completed or brought to a current status, unless the practitioner has made satisfactory progress towards completion of the deficient chart(s) in the discretion of the President. In a group practice, the practitioner writing the initial order and treatment is considered the treating and responsible practitioner. An exception to this provision for automatic suspension shall pertain in the case of illness or absence from the community, in either of which instance a practitioner will be allowed a period of seventy-two (72) hours, after recovery from the illness or return from an absence from the community within which to complete or bring to a current basis any charts which would occasion the entry of the practitioner's name on the delinquent list for the reason of incomplete charts. The above exception shall be applicable only if the practitioner gives timely written notice to members of the Medical Records library of illness or planned absence from the community. The following chart entries are deemed to be critical to the maintenance of a current patient record: The admitting diagnosis shall be recorded within (24) twenty-four hours after the admission of the patient to the hospital. A full history and physical examination shall be done no more than (7) seven days before or (24) twenty-four hours after admission of the patient to the hospital with a unique note including a planned course of treatment for the patient, are to be entered on a daily basis. All notes should commensurate with the daily patient visitations by the treating practitioner, or designee. Such visitations must be performed and documented by the treating physician on a daily basis while the patient is undergoing treatment in the hospital. Notes must comply with the RWJBH "Cloning of Clinical Documentation in EHR Policy". Clinical documentation, including cloned documentation within or incorporated into a medical record must represent services actually performed and with accurate clinical data on the indicated date of service by the identified author.

(b) In group practice, the discharge summary is the responsibility of the practitioner writing the discharge order.

(c) Medical Staff Department and/or Committee leadership shall notify Medical Staff members in the following manner when requesting information: A first letter to be faxed to the physician, with copy to be placed in the physician mailbox in the hospital. If a response is required and is not received within thirty (30) days from the receipt of the faxed letter, a second letter will be sent Certified Mail, Return Receipt Requested to the physician. A copy will be sent to the appropriate Department Chairperson. If a response is not received within thirty (30)

days of certified receipt date, a list of "no response received to date" will be forwarded to the President of the Medical Staff and the Executive Committee. The Executive Committee will take appropriate corrective action.

(d) Action by the State Board of Medical Examiners revoking or suspending a practitioner's license shall result in the automatic revocation or suspension of staff membership and privileges without a hearing. Should the State Board of Medical Examiners revocation or suspension be reversed in a court of law or reversed by the State Board of Medical Examiners, then the practitioner shall be required to submit a request for reinstatement that shall include all the information required of a new applicant. Action by the State Board of Medical Examiners suspending a practitioner's license shall result in the automatic suspension of staff privileges co-extensive with the suspension of his/her license. Upon the expiration of the suspension, the practitioner shall submit an application to the Medical Staff for reinstatement that shall include all the information required of a new applicant. Action by the State Board of Medical Examiners placing a practitioner upon probation shall automatically suspend all hospital privileges. The Credentials Committee shall meet within seventy-two (72) hours of notice of such suspension to determine whether to continue the suspension pending a hearing or to place the practitioner under supervision pending a hearing. In addition, the Credentials Committee shall review the rank of the practitioner and reduce such rank for the period of probation in accordance with the nature of the reason for probation and the terms of the probation.

(e) The suspension or debarment of a Practitioner from participating in Medicare or Medicaid or another federally funded health care program shall result in an automatic suspension of the Practitioner's hospital privileges without a hearing. Upon the expiration of the suspension or debarment, the Practitioner shall submit an application to the Medical Staff for reinstatement that shall include all the information required of a new applicant.

(f) An automatic suspension shall occur whenever a Practitioner does not meet the malpractice insurance requirements contained in the Bylaws and/or Rules and Regulations.

(g) The conviction of a practitioner of a crime shall result in an automatic suspension of the practitioner's hospital privileges. The Credentials Committee shall meet within seventy-two (72) hours of notice of such suspension to determine whether to continue the suspension or to place the practitioner under supervision pending a hearing or to determine that the conviction is not related to the practitioner's ability to practice medicine or to receive reimbursement for medical services rendered. The incarceration of a practitioner for a period in excess of sixty (60) days shall result in the automatic revocation of membership and privileges without a hearing. Upon release from incarceration, the practitioner may re-apply for staff membership. The incarceration of a practitioner for a period less than sixty (60) days shall result in automatic suspension from staff privileges. Upon release from incarceration, the Credentials Committee shall review the reasons for incarceration and determine whether to continue the suspension or to place him/her under supervision pending a hearing or to take such other action required by the reasons for the incarceration.

(h) Final action by the Board of Trustees of another hospital within the Barnabas Health System imposing a restriction, limitation, suspension or revocation of a practitioner's Medical Staff appointment and/or Clinical Privileges shall automatically result in

the limitation, restriction, suspension or revocation of the Practitioner's Clinical Privileges in the Hospital commensurate with such final action of the other hospital.

The provisions of this Section shall apply only if the action taken by the other hospitals within the Barnabas Health System was reportable to the Medical Practitioner Review Panel of the State Board of Medical Examiners.

(i) Issues Common to Automatic Suspensions

(i) The Practitioner shall be notified of the basis of any automatic suspension by certified and regular mail as promptly as possible after the automatic suspension.

(ii) The Practitioner shall be provided with thirty (30) days to produce clear and convincing evidence to the MEC that the facts relied upon in imposing an automatic suspension are not correct.

(iii) If such evidence is not received within thirty (30) days, the Practitioner's Membership and Clinical Privileges shall automatically terminate unless the time is extended by the President and the individual shall not be entitled to a hearing as set forth elsewhere in these Bylaws.

(iv) In the event the Practitioner does produce evidence with thirty (30) days which disputes the facts relied upon in automatically suspending the Practitioner, the Practitioner shall be entitled to a Fair Hearing and Appellate Review unless the automatic suspension is terminated and the Practitioner is reinstated.

(v) If any action is taken which does not entitle a Practitioner to a hearing, the Practitioner shall be offered the opportunity to submit a written statement or any information which the Practitioner wishes to be included in the Practitioner's internal peer review file along with documentation regarding the action taken.

ARTICLE X. HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Right to Hearing and to Appellate Review

(a) When any practitioner receives notice of a recommendation pursuant to these Bylaws that, if ratified by decision of the governing body, will adversely affect his/her appointment to or status as a member of the Medical Staff or the scope of his/her exercise of clinical privileges pursuant to Article IX, Section 2(f) (J-N), the practitioner shall be entitled to a hearing before an Ad Hoc Committee of the Medical Staff. If the recommendation(s) of the Ad Hoc Committee, following such hearing, are adverse to the affected practitioner, then he/she will be entitled to appellate review conducted by the Appellate Review Committee of the governing body before the governing body renders a final decision on the matter.

(b) All hearings and appellate review procedures shall be in accordance with the procedural safeguards set forth in these General Rules and Regulations to assure that the affected practitioner is afforded all due process rights to which he/she is entitled.

(c) The notice of adverse recommendation shall:

(i) Advise the applicant of his/her rights to a hearing and/or appellate review pursuant to Article X of these General Rules and Regulations;

(ii) Specify that he/she shall have thirty (30) days following the date of receipt of such notice in which to request in writing a hearing and/or appellate review;

(iii) State that the failure to so request within the specified time period shall constitute a waiver of his/her rights to a hearing and an appellate review;

(iv) State the ground or grounds upon which the adverse action is based, the acts or admissions with which the practitioner is charged, a list of specific or representative charges being questioned, and/or the other reasons or subject matter that is considered in making the adverse recommendation or decision;

(v) State that upon the receipt of his/her request, the practitioner will be notified of the date, time and place of the hearing; and,

(vi) Advise the practitioner of his/her right to review the hearing record and report, if any, and to submit a written statement in his/her behalf as part of the appellate procedure.

Section 2. Request for Hearing

(a) The Hospital President/CEO, or designee, shall be responsible for giving prompt written notice of an adverse recommendation or decision to an affected practitioner who is entitled to a hearing or an appellate review, by certified mail, return receipt requested.

(b) The failure of the practitioner to request a hearing to which he/she is entitled by these Rules within the time and in the manner provided shall be deemed a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled on the matter. The failure of the practitioner to request an appellate review to which he/she is entitled by these Rules within the time and in the manner herein provided shall be deemed a waiver of his/her rights to such appellate review on the matter. The Practitioner's request for a hearing shall be in writing delivered to the President with a copy to the Hospital President/CEO and shall include the name and address of any attorney or other representative for the Practitioner along with a list of witnesses expected to testify at the hearing on behalf of the Petitioner.

(c) An adverse recommendation or decision, if the hearing or appellate review relating to such adverse recommendation or decision is waived by the practitioner, shall thereupon become and remain effective against the practitioner, pending the governing body's decision on the matter. In either event, whereby the practitioner has waived further review, the Hospital

President/CEO, or designee, shall promptly notify the affected practitioner of his/her status by certified mail, return receipt requested.

(d) A waiver by the practitioner of either a hearing and/or appellate review to which he/she might otherwise have been entitled by these Rules shall constitute acceptance of the adverse recommendation or decision.

(e) The request for a hearing or an appellate review shall be in writing, setting forth:

(i) The specific grounds and defenses for the request addressing each issue set forth in the notice,

(ii) The records, documents, treatise and authorities which will be relied upon by the practitioner, and

(iii) A list of witnesses whom the practitioner intends to call.

Section 3. Notice of Hearing

Within thirty (30) days after receipt of a request for hearing from a practitioner entitled to the same, the Chairperson of the Ad Hoc Committee shall schedule and arrange for such hearing and shall, through the Hospital President/CEO or designee, notify the practitioner of the time, place and date of the scheduled hearing by certified mail, return receipt requested. The hearing date shall be not less than thirty (30) days or not more than sixty (60) days from the date of receipt of request for a hearing; provided, however, that a hearing for a practitioner who is under suspension which is then in effect shall, upon requests of the Practitioner, be held as soon as arrangements therefore may be reasonably made, but not later than fourteen (14) days from the date of receipt of such practitioner's request for hearing. Such notice shall also include the list of witnesses expected to testify at the hearing on behalf of the Medical Staff.

Section 4. Composition of Hearing Committee

(a) The hearing shall be conducted by an Ad Hoc Hearing Committee of not less than five (5) non-hospital employed physician Attending members of the Active Medical Staff, one of whom shall be designated as Chairperson by the President of the Medical Staff.

(b) The President of the Medical Staff, or designee, within five (5) days after the receipt of a request for a hearing from a practitioner entitled to same, shall draw by lot from a list of Attending members five (5) Attending members who shall then be subject to challenges for cause addressed to the President of the Medical Staff. All such challenges shall be submitted in writing within five (5) days after receipt of the list of Committee members. The decision of the President, or designee, excusing a member challenged shall be conclusive upon such member and the parties, but not as to his/her decision to permit such member to remain, which is reviewable after completion of the hearing to determine if it is arbitrary, capricious or unreasonable. In those cases where there are not at least five (5) remaining members, the President of the Medical Staff

shall draw by lot, substitute Attending members who may be challenged for cause. Such challenges may be verbal and shall be made within one (1) day after notice of such an appointment.

(c) If five (5) qualified full Attendings are not available, the President of the Medical Staff shall draw by lot non-hospital employed physicians from the Associate Attendings in rank and thereafter proceed to Assistant Attending in rank. If five (5) Active Staff members to serve on the Ad Hoc Hearing committee who meet these requirements cannot be identified, then one or more members of the Ad Hoc Hearing committee may be appointed from New Jersey licensed physicians or retired New Jersey physicians not currently having Medical Staff privileges or membership at this Hospital, but qualified to serve by training, experience, and similar considerations.

(d) No person who initiated or participated in the adverse recommendation or decision which is the basis of the hearing affecting the practitioner, or who is designated by the parties as a potential witness, shall serve as a member of the Ad Hoc Committee for this hearing. Knowledge of the underlying matter, in and of itself, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Ad Hoc Committee. Notwithstanding the foregoing, nothing in these Rules and Regulations shall prohibit the Ad Hoc Committee from being comprised of one or more persons who previously served as a panelist in a hearing on the same underlying facts. Solely as means of example, a panelist who served on an Ad Hoc Committee to consider a member's appeal of a precautionary suspension shall not be prohibited from serving as a member of an Ad Hoc Committee or Appellate Panel with respect to a member's subsequent appeal of an adverse recommendation to terminate or permanently suspend privileges arising from the action that was the basis of the precautionary suspension.

Section 5. Conduct of Hearing

(a) All members of the Ad Hoc Committee shall be present when the hearing takes place and no member may vote by proxy. If extraordinary circumstances preclude a member's attendance at a session, the session may proceed if a majority of the committee members are present. The missing member shall be required to read the transcript and review all exhibits of the missed session prior to voting on the Ad Hoc Committee's recommendation.

(b) A stenographic record of hearing must be kept.

(c) The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in the Hearing and Appellate Review Procedures of these General Rules and Regulations, Section 2 and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 2 subject to the final decision of the Board of Trustees.

(d) The postponement of the hearing beyond the time set forth in these Bylaws shall be made only with the majority approval of the Ad Hoc Hearing Committee. Granting of

such postponement shall be only for good cause shown in the sole discretion of the Ad Hoc Hearing Committee.

(e) The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing or by a member of his/her local professional society, or by an attorney-at-law, admitted to practice in the State of New Jersey. The Medical Staff shall be entitled to be represented by an attorney-at-law, admitted to practice in the State of New Jersey.

(f) The governing body shall provide the Ad Hoc Committee, after consultation with the Executive Committee, with a hearing officer, who shall be an attorney-at-law of the State of New Jersey. The attorney to the hospital may serve as the hearing officer, and may further serve as counsel to the Appellate Review Committee and Board of Trustees if so requested by the Board of Trustees. The hearing officer shall not participate in the decision of the Ad Hoc Committee and may be challenged by any party for prejudice. Any such challenge shall be made in writing to the President within five (5) days of receipt of notice of the appointment of the hearing officer. The decision of the President or designee removing and replacing the hearing officer shall be conclusive upon the hearing officer and the parties, but not as to his/her decision to permit the hearing officer to remain, which is reviewable after completing of the hearing to determine if it was "arbitrary, capricious or unreasonable".

(g) The hearing officer of the Ad Hoc Committee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant, oral and documentary evidence, to maintain the decorum, and to provide legal advice to the Ad Hoc Committee both during the hearing and deliberations. The hearing officer shall require a representative (who may be counsel) for the practitioner and for the Medical Staff to participate in a pre-hearing conference. At the pre-hearing conference, the hearing officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness' testimony and cross examination.

(h) The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which reasonable persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule that might make evidence inadmissible over objection in similar civil or criminal proceedings. The practitioner for whom the hearing is being held and the representative of the Medical Staff shall, prior to or during the hearing, and at the close of the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become part of the hearing records.

(i) Judicial notice may be taken by the Ad Hoc Hearing Committee either before or after submission of the matter for decision, of a generally accepted technical or scientific matter relating to issues under consideration at the hearing and of any facts which may be judicially noticed by the Courts of the State of New Jersey. The Ad Hoc Hearing Committee shall also be entitled to consider any pertinent material contained on file in the Community Medical Center and all other information, which can be considered in connection with applications for appointments or re-appointments to or status on the Medical Staff and for clinical privileges pursuant to these

Bylaws. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or by oral presentation of authority, the matter of such refutation to be determined by the Ad Hoc Committee. The parties and counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimonies is reasonably required.

(j) The Medical Staff shall appoint a member of the Medical Staff and/or an attorney at law of the State of New Jersey, to present all of the relevant facts, and to examine and cross-examine witnesses who appear thereat. Said counsel shall be competent in the field of hospital law and prior to commencement of the hearing shall reach a reasonable fee arrangement with representative of the governing body.

(k) It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or decision, and bears the burden of proof, by proving through clear and convincing evidence, that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

(l) Each party and/or its or his legal representative shall have the following rights: To call and examine witnesses, to introduce written evidence, to cross-examine any witness and to rebut any evidence. If the practitioner does not testify on his own behalf, he may be called and examined as if under cross-examination. Notice is hereby given to the participants that no party has the legal power of subpoena. To the extent permitted by the Ad Hoc Committee, each party may supplement its witness and evidence list.

(m) If the affected practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination. The hearing provided for in these Bylaws is a fact-finding, non-adversarial proceeding for the purpose of resolving matters bearing on professional competence and conduct. Accordingly, the practitioner, by requesting a hearing or appellate review, authorizes any and all medical and/or dental societies, associations, examining boards of the various states in which he/she has been licensed, members of such examining boards, hospitals in which he/she has been trained and/or worked, members of the Medical Staff, other employees of such hospitals, including Community Medical Center, to furnish any and all information in their possession and to render an opinion which might have a bearing upon the adverse recommendation or decision; and further authorizes any of the above enumerated to furnish any and all copies of transcripts, records, transcripts of any court reported proceedings and any other documents which they may have in their possession to Community Medical Center for use in the proceedings conducted pursuant to these Bylaws including the results of physical and mental examinations to the extent they have previously been provided to the Ad Hoc Investigative Committee. The practitioner at the request of the President/CEO, or designee, will sign any and all forms authorizing release of the above information. A practitioner who fails to sign a requested release shall be deemed to have waived his/her rights in the same manner as provided in Section 2 of this Hearing and Appellate Review Procedure of these General Rules and Regulations, and have

accepted to adverse recommendation or decision involved, and the same shall thereupon become and remain in effect pending the final decision of the Board as provided in Section 2. The practitioner, by requesting a hearing or appellate review, releases any and all of the above enumerated as well as any other person, corporation or association from any and all liabilities they may have to him/her arising from (1) testimony they provide in good faith during the proceedings; (2) release of the above enumerated information; (3) good faith participation in any capacity at such hearing, appellate review or final action.

(n) The Ad Hoc Hearing Committee may, without special notice, recess hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may thereupon at the time convenient to itself conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

(o) Within thirty (30) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendations setting forth the basis for its decision and shall forward the same together with the hearing record and all other documentation to the Executive Committee with a copy to the Hospital President/CEO. The report may recommend confirmation, modification, or rejection of the original adverse recommendation. A copy of the written report and recommendation shall be forwarded to the Practitioner by certified mail, return receipt requested. Negative votes shall be recorded setting forth the basis for such vote. Thereafter, the procedure to be followed shall be as provided in the Hearing and Appellate Review Procedures of these General Rules and Regulations.

(p) At its next meeting after receipt of the report of the Ad Hoc Hearing Committee, the Executive Committee or the board, as appropriate, shall act to affirm, modify or reverse the original adverse recommendation.

(q) If the Executive Committee's action on the report is adverse to the practitioner, the Hospital President/CEO or designee shall within ten (10) days notify the practitioner of his right to an appellate review pursuant to section 6, below. If the Executive Committee's action on the report is favorable to the practitioner, the Hospital President/CEO or designee shall transmit the result to the Board for final action. At its next regularly scheduled meeting, the Board shall act. If the Board takes action favorable to the practitioner it shall be final action and the matter shall be closed. The Hospital President/CEO shall give the practitioner written notice of the Board's decision within ten (10) days. If the Board takes action which is adverse to the Practitioner, the Hospital President/CEO or designee shall within ten (10) days notify the practitioner of his right to appellate review pursuant to Section 6, below.

(r) If the Board decides to remand the matter to the Executive Committee for either review of the matter in total, or consideration of specific issues, the Hospital President/CEO or designee shall notify the practitioner and the Executive Committee within ten (10) days and shall state the matter to be determined and the deadline for a decision which shall not exceed forty-five (45) days from the date of the notice.

Section 6. Appeal to the Governing Body

(a) Within five (5) days after receipt of notice of an adverse recommendation or decision made or adhered to after a hearing as above provided, the affected practitioner may, by written notice to the governing body, delivered through the Hospital President/CEO or designee, by certified mail, return receipt requested, request an appellate review pursuant to these Bylaws by the governing body. Such appellate review shall be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below.

(b) If such appellate review is not requested within five (5) days, the affected practitioner shall be deemed to have waived his/her rights to the same, and to have accepted such adverse recommendation or decision, and the same shall be forwarded to the Board for a final decision as provided in Section 2 of the Hearing and Appellate Review Procedures of these General Rules and Regulations. The Hospital President/CEO, or designee, shall promptly notify the affected practitioner of his/her status by certified mail, return receipt requested.

(c) Within five (5) days after receipt of such notice of request for appellate review, the Chairman of the governing body shall appoint an Appellate Review Committee consisting of not less than seven (7) members of the governing body. The Chairman of the governing body shall further designate the presiding officer of the Appellate Review Committee. The representative of the Medical Staff and the affected practitioner shall each be entitled to challenge for cause any member of the Appellate Review Committee. All such challenges shall be submitted in writing within five (5) days' notice of receipt of the composition of the appellate review panel. The challenges shall be made to the Chairman of the governing body whose decision excusing such member challenged for cause shall be conclusive upon such member and the parties, but not as to his/her decision to permit such member to remain which shall be reviewable after completion of appellate review to determine if it was arbitrary, capricious or unreasonable. The Appellate Review Committee will be duly constituted if at least five (5) members are remaining after challenges. Otherwise the Chairman of the governing body shall substitute members who must be challenged within one (1) day for cause, until a committee is composed of five (5) members.

(d) Within twenty (20) days after receipt of such notice of request for appellate review, the Chairperson of the Appellate Review Committee shall schedule a date for such review, and shall, through the Hospital President/CEO, or designee, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be less than twenty (20) days nor more than forty-five (45) days from the receipt of notice of request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may be reasonably made, but not more than thirty (30) days from the receipt of such notice. The time limit herein may be extended by such time as it is required to secure transcripts of the testimony and to enable the parties and the Committee a reasonable opportunity to review same.

(e) The affected practitioner and the representative of the Medical Staff shall have access to the report and records of the Ad Hoc Hearing Committee and all of the material, favorable or unfavorable, that was considered in making the adverse recommendation or decision. The parties shall submit a written statement in which those factual and procedural matters with which they disagree and the reasons for such disagreement shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Appellate Review Committee through the Hospital President/CEO, or designee, by certified mail, return receipt requested, at least five (5) days prior to the scheduled date for the appellate review. The Hospital President/CEO shall provide copies thereof to the other party immediately upon receipt.

(f) The Appellate Review Committee shall be on the record of the proceedings and shall consider the written statement submitted for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified, and was not arbitrary, capricious or unreasonable.

(g) New or additional matters not raised in the original hearing or in the Ad Hoc Hearing Committee hearing report, not otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Appellate Review Committee shall in its sole discretion determine whether such new matters shall be accepted.

(h) The Appellate Review Committee may recommend to the governing body that the decision be affirmed, modified or reversed or in its discretion it may refer the matter back to the Ad Hoc Hearing Committee for further review and recommendation within fourteen (14) days. Such referral may include a request for the Ad Hoc Hearing Committee to arrange for a further hearing to resolve specified disputed issue.

(i) The Appellate Review Committee may be assisted by the hospital counsel in performing its duties hereunder.

(j) The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 shall have been completed or waived.

Section 7. Final Decision by the Governing Body

Within thirty (30) days after the conclusion of the appellate review, the governing body shall make a decision in the matter and shall send notice thereof to the Executive Committee and Ad Hoc Hearing Committee, and through the Hospital President/CEO to the affected practitioner (and his/her attorney) by certified mail, return receipt requested. Such notice shall be sent within ten (10) days of the Board of Trustees' decision. The Hospital, through the Hospital President/CEO, shall comply with reporting requirements imposed by state and federal law, to the extent applicable to such decision. If this decision is not in accordance with the Executive Committee's last recommendation, the governing body shall refer the matter to the Joint Conference Committee for further review and recommendation within twenty (20) days, and shall include in such notice of its decision, a statement that its final decision will not be made until the

Joint Conference Committee's recommendation has been received. Within twenty (20) days after receipt of the Joint Conference Committee's recommendation, the governing body shall make its final decision with like effect and notice as first above provided in this Section 7, the Hearing and Appellate Review Procedures of these General Rules and Regulations. A decision by the governing body postponing or delaying the effective date of the commencement of any suspension or termination of privileges shall not be deemed to be contrary to the decision of the Ad Hoc Hearing Committee.

Section 8. Miscellaneous

The cost of the certified court reporter employed by the Ad Hoc Hearing Committee, the fees of counsel employed by the Ad Hoc Hearing Committee and the Medical Staff, and the expert or other witness fees for experts and/or witnesses called by the Medical Staff are to be paid by the hospital. The hospital agrees to indemnify all parties for their good faith participation in the hearing or appellate review, which indemnification shall cover the cost of defense as well as judgment or settlement.

Section 9. No More than One Hearing

(a) No applicant or Practitioner shall be entitled as a matter of right to more than one hearing and one appellate review on any matter which has been the subject of an action by the Medical Executive Committee, the Hospital Board or a duly authorized committee of either the Medical Staff, Hospital Board or both. For purposes of this provision, the matter shall be defined as the underlying action of the applicant or the Medical Staff member which was the basis of the corrective action recommended. Solely as means of example, the termination of a member's clinical privileges after a precautionary suspension which has been appealed by the Practitioner and ultimately approved by the Board shall entitle the Practitioner to an appeal as to the propriety of the termination only and not the underlying facts that gave rise to the adverse recommendation to precautionary suspend.

(b) If the Board denies a practitioner initial Medical Staff appointment or reappointment or revokes such practitioner's medical staff membership or clinical privileges and the practitioner has exhausted his rights under this Article X, such practitioner may not apply for appointment or reappointment to the Medical Staff or for the affected Clinical Privileges for a period of two (2) years following the final decision of the Board, unless set forth to the contrary by the Board in its final decision.

ARTICLE XI. MEDICAL STAFF MEETINGS

Section 1. Regular Meetings

The Annual Meeting of the Medical Staff shall be held following the last Quarterly Staff Meeting of the calendar year. The agenda of the Annual Meeting shall include reports of review

and evaluation of the work done in the departments and the performance of the required Medical Staff functions or committees standing or otherwise. No less than two (2) meetings of the Medical Staff shall be held during the calendar year. A Quarterly Staff or Annual Meeting may be rescheduled at the discretion of the President of the Medical Staff.

Section 2. Special Meetings

(a) The President of the Medical Staff or the Executive Committee may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within fourteen (14) days after receipt by him or her of a written request for same signed by not less than ten (10%) percent of the Active Staff and stating the purpose for such meeting. The 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 Medical Staff shall be delivered, either personally or by mail, to each member of the Active staff not less than three (3) nor more than seven (7) 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 staff member at his/her address as it appears on the records of the hospital or placed in such Active member's mailbox at Community Medical Center. Notice may also be sent to such other members of the Medical Staff who have previously so requested that such notice be sent by the Secretary of the Medical Staff. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that in the notice calling the meeting.

Section 3. Quorum

The presence of forty percent (40%) of the total membership of the Active, Interim and Adjunct Medical Staff at any regular or special meeting shall constitute a quorum for the purposes of these Bylaws and the Rules and Regulations, and all except if specifically set forth to the contrary in such documents.

Section 4. Attendance Requirements

Each member of the Active, Interim and Adjunct Medical Staff shall be required to attend at least fifty percent (50%) of all regular Medical Staff meetings in each year. A member who is compelled to be absent from any regular staff meeting shall promptly notify the President or Secretary of the Medical Staff beforehand the reason for such absence. Unless excused for cause by the Executive Committee, the failure to meet the foregoing annual attendance requirements may be grounds for corrective action leading to revocation of medical membership. Reinstatement of staff members whose membership has been revoked because of absence from staff meetings shall be made only upon application, and all such applications shall be processed in the same manner as applications for original appointment.

Section 5. Agenda

(a) The agenda at any regular Quarterly Medical Staff meetings shall be:

(i) Call to order

(ii) Opening remarks

(iii) Acceptance of the minutes of the last regular meeting and all special meetings

(iv) Report from the Hospital President/CEO of the hospital

(v) Special Reports

(vi) Treasurer's Report

(vii) Correspondence, if any

(viii) Unfinished business

(ix) Reports of departments

(x) Reports of committees

(xi) New Business (including elections when appropriate)

(xii) Review and analysis of the clinical work of the Hospital including discussion and recommendations for improvement of the professional work of the Hospital

(xiii) Adjournment

(xiv) Reading of the notice calling the meeting

(xv) Transaction of business for which the meeting was called

(xvi) Adjournment

(b) The title of any committee report with a brief description of such report shall be provided to the President of the Medical Staff by close of business on the third Monday of the month in which the Quarterly Staff meeting is to be held. Any motions to be proposed at the Quarterly Staff meeting shall be provided to the President of the Medical Staff by close of business on the Friday prior to the Medical Staff meeting, shall have been posted on the Medical Staff bulletin board, an agenda setting forth the reports and motions to be considered at the Quarterly Staff meeting. If an item is not on the agenda, it can only be considered at the Quarterly Staff meeting by a two-thirds (2/3) of the voting members present.

(c) Each member shall be limited to speaking once on each motion for a maximum of three (3) minutes unless two-thirds (2/3) of the voting members present or the President of the Medical Staff authorizes a different rule for the particular motion.

ARTICLE XII. COMMITTEE AND DEPARTMENT MEETINGS

Section 1. Regular Department Meetings

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings at least (4) times per calendar year to review and evaluate work of the practitioners with privileges in the department. At the regular department meetings, emphasis must be placed on morbidity and mortality analysis with detailed consideration of all deaths, and infections, complications, errors in diagnosis and treatment.

Section 2. Special Meetings

A special meeting of any committee or department may be called by or at the request of the Chairperson, or by the President of the Medical Staff, or by one-third (1/3) of the department's or committee's Active staff members.

Section 3. Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or department not less than ten (10) days before the time of such meeting, by the person or persons calling the meeting, or by the President of the Medical Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his/her address as it appears on the records of the hospital with postage thereon prepaid, or by placing notice in the practitioner's hospital mail box. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 4. Quorum

Forty percent (40%) of the Active Medical Staff members of a committee or department shall constitute a quorum at any meeting except if otherwise set forth herein.

Section 5. Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote thereat. All voting members of the Medical Staff are entitled to one (1) vote on matters to be voted on by the members.

Section 6. Rights of Ex-Officio Members

Persons serving under these Bylaws as ex-officio members of a committee or department shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum and shall not be entitled to a vote.

Section 7. Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer or secretary and copies thereof shall be promptly submitted to the attendees for approval, and after such approval is obtained, forwarded to the Executive Committee and then to the Board. Minutes of peer review/clinical activities shall be first submitted to the Medical Staff Quality Committee for analysis and submission to the Executive Committee and to the Board in a summarized fashion. Each committee and department shall maintain a permanent file of the minutes of each meeting. The attendance of members at a meeting shall constitute a waiver of notice of approval of such minutes.

Section 8. Attendance Requirements

(a) Each member of the Active, Interim and Adjunct Medical Staff shall be required to attend at least fifty percent (50%) of all regular Medical Staff meetings in each year. A member who is compelled to be absent from any regular staff meeting shall promptly notify the President or Secretary of the Medical Staff beforehand the reason for such absence. Technology may be used to conduct meetings and satisfy meeting attendance. Unless excused for cause by the Executive Committee, the failure to meet the foregoing annual attendance requirements may be grounds for corrective action leading to revocation of medical membership. Reinstatement of staff members whose membership has been revoked because of absence from staff meetings shall be made only upon application, and all such applications shall be processed in the same manner as applications for original appointment.

(b) A practitioner whose patient's clinical course is scheduled for discussion at a regular departmental meeting or clinico-pathological conference shall be so notified and shall be expected to attend such meeting. If such practitioner is not otherwise required to attend the regular monthly administration departmental meeting, the President of the Medical Staff shall, through the Hospital President/CEO, give the practitioner advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the practitioner shall so state and shall be given by certified mail, return receipt requested, and shall include a statement that his/her attendance at the meeting at which the alleged deviation is to be discussed is mandatory.

(c) Failure by a practitioner to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused beforehand by the Executive Committee or Chairperson of the department or committee, upon showing of good cause, may result in an automatic suspension of all or such portion of the practitioner's privileges as the Executive Committee may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all cases, if the practitioner shall make a timely beforehand request for postponement supported

by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the Chairperson of the department, or by the Executive Committee if the Chairperson is the practitioner involved, until not later than the next regular departmental meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled

ARTICLE XIII. MEDICAL STAFF COMMITTEES

All Medical Staff committees shall have the right to meet in a consensus forum upon motion and approval in order to permit free discussion of staff activities while maintaining confidentiality. Only voting members of the Medical Staff shall be present during the Consensus Forum, and no committee action shall be taken.

Section 1. Credentials Committee

(a) Composition: The Credentials Committee shall consist of members of the Active staff selected on a basis that will insure representation of the major clinical specialties, the hospital-based specialties and the Medical Staff at large. No more than one (1) member of a family or group practice shall serve on this Committee at the same time. The Vice President shall serve as the Committee Chairperson. The Immediate Past President of the Medical Staff shall serve on the Committee with vote. The Chief Medical Officer shall serve ex-officio without vote. The Chairperson of a department, or designee, may attend without vote when that department is to be affected by an applicant. No member shall serve more than two (2) consecutive terms and shall be eligible for re-appointment after a two (2) year lapse. The Secretary shall be chosen by the Chairperson of the Committee.

(b) Duties: the duties of the Credentials Committee shall be:

(i) To review the credentials of all applicants and to make recommendations for membership and delineation of privileges in compliance with these General Rules and Regulations. The Committee shall consult with representatives of the governing body in making its investigation. It shall seek such counseling and advice as may be required to enable it to make a thorough, impartial, and objective investigation of the qualifications and competence of each applicant. Each clinical department Chairperson, or designee, shall first evaluate, verify, and accumulate data to be presented to the Credentials Committee for each applicant, including a recommendation of privileges to be delineated as well as manner of supervision of each applicant as to time and the procedures. This shall include Leaves of Absence.

(ii) To make a report to the Executive Committee on each applicant for Medical Staff membership or privileges, including specific consideration of the recommendations from the departments in which such applicant requests privileges;

(iii) To review periodically and whenever requested pursuant to these Bylaws and at least biannually all information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of privileges, re-appointments, and the assignment of practitioners to the various departments or services as provided in Appointments and reappointments of these General Rules and Regulations.

(iv) To review reports that are referred by the Executive, Medical Records, Medical Evaluation, and Utilization Review Committees and the President of the Medical Staff;

(v) To maintain a separate record for each Applicant.

(vi) To recommend the clinical services to be provided by telemedicine.

Section 2. Joint Conference Committee

(a) Composition: The Joint Conference Committee shall consist of thirteen (13) members:

(i) Six (6) members of the Board of Trustees consisting of four officers and two other trustees.

(ii) Six (6) members of the Medical Staff consisting of the President, the Vice President, the Secretary, and Treasurer. Two (2) additional members of the Medical Staff shall be elected at large to serve a (2) two-year term. Member of the Medical Staff in good standing may petition, with required signatures, to have his/her name placed on the election ballot.

(iii) The Hospital President/CEO shall serve ex-officio with vote. No more than one (1) member of a family or group practice shall serve on this Committee simultaneously.

(b) Duties: The Joint Conference Committee shall conduct itself as a forum for the discussion of matters of Hospital policy and practice, especially those pertaining to efficient and effective patient care within the resources available at the Hospital. It shall also provide medical, administrative liaison with the governing body and the Hospital President/CEO, or designee. The Joint Conference Committee shall also consider matters referred to it by the Board and render a decision as set forth in Section 7 of the Hearing and Appellate Review Procedure set forth in these Rules and Regulations.

(c) Meetings: Meetings shall be called to session as needed by the President of the Medical Staff, the Hospital President/CEO of the Hospital, or the Chairperson of the Board of Trustees.

Section 3. Medical Staff Quality Committee

(a) Scope: The Medical Executive Committee shall administer and coordinate the Quality Assessment and Improvement activities of the Medical Staff primarily through the Medical Staff Quality Committee.

(b) Membership shall consist of the Secretary of the Medical Staff, who will act as Chairperson; Physician Advisor, who will act as Co-Chairperson; Treasurer of the Medical

Staff; the Vice Chairpersons of the Medical Staff departments or such Vice Chairperson's permanent alternate designee approved by the Chair of the Department and the President; the Chief Medical Officer; Vice President of Patient Care Services; Director of Quality Resource Services; and the Director of Risk Management.

(c) Meetings will be held at least six times per calendar year and at other times subject to the call of the Chairperson.

(d) Purpose and Functions:

(i) Facilitate continuous quality improvement in patient care by ongoing monitoring to determine the implementation and effectiveness of recommended actions.

(ii) Facilitate continuous quality improvement in patient care by participation of the Patient Care Management Council and referral of quality and risk issues to appropriate committees and individuals for appropriate follow-up.

(iii) Monitor Medical Staff compliance with published standards of the New Jersey State Department of Health, The Joint Commission and other regulatory or external review organizations.

(iv) Administer the peer review process as defined and approved by the Medical Staff. (Refer to the Performance Improvement Plan, "Medical Staff Peer Review Process.")

(v) Evaluate the Medical Staff component of the Quality Assessment and Improvement Program on an annual basis.

Section 4. Utilization Review Committee

(a) Composition: The Utilization Review Committee is a standing committee of the Medical Staff and holds at least six (6) monthly meetings during the year and shall consist of at least five (5) practitioners from the Active Medical Staff. The Director of Quality Resource Services and representatives from Administration, Nursing Services, Case Management and discharge planning shall serve without vote.

(b) The responsibilities, duties and authority of the Utilization Review Committee shall be to:

(i) Comply with all requirements of the utilization review plan approved by the Medical Staff and governing body.

(ii) Require documentation that utilization review is applied regardless of payment source.

(iii) Require that focused reviews be emphasized.

(iv) Determine whether under-utilization and, when appropriate, over-utilization practices impact adversely on the quality of patient care and recommend the appropriate action to be taken.

Section 5. Pharmacy and Therapeutics Committee

(a) Composition: Shall be a standing committee of the Medical Staff consisting of at least six (6) Active staff members, the Chairperson of the Pharmacy Department shall have a vote and act as Secretary and one (1) member each from nursing service and hospital administration (ex-officio without vote).

(b) Duties: This Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital. It shall also perform the following specific functions:

(i) Serve as an advisory group to the hospital, Medical Staff and the pharmacist on matters pertaining to the choice of available drugs;

(ii) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(iii) Develop and review periodically a formulary or drug list for use in the hospital, as well as updating or canceling drugs;

(iv) Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

(v) Evaluate clinical data concerning new drugs or preparations requested for use in the hospital; and

(vi) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(vii) Perform objective ongoing evaluation of the clinical use of all antibiotics in the hospital, whether the drugs are prescribed prophylactically, empirically, or therapeutically and

(viii) Whether administered to inpatients, outpatients, emergency room patients, or hospital-sponsored home care patients. The Committee shall recommend action for any required practice change to the Executive Committee and shall follow up through the Medical Staff Quality Committee to be sure the approved change has occurred. The Committee shall recommend and/or approve criteria for use in all facets of antibiotics use evaluation.

(ix) Ensure hospital compliance with all of The Joint Commission standards related to medication use.

(c) Meetings: This committee should meet at least ten (10) times per year. It should remit reports of each meeting to the Executive Committee of the Medical Staff and governing body regarding its activities.

Section 6. Infection Control Committee

(a) Composition: The Infection Control Committee shall be a standing Medical Staff committee consisting of at least six (6) practitioners to include one from the Department of Pathology and Laboratories, a specialist physician in Infectious Diseases, and one from the Section of Pulmonary Disease/Critical Care, Emergency Medicine, Internal Medicine and a pharmacist. Members available on a consulting basis without vote are Pediatrics, OB/GYN, and Hematology/Oncology. The infection control nurse, the nursing director and the operating room supervisor shall serve without a vote. A representative from hospital administration shall serve ex-officio without vote. Other individuals representing, housekeeping, laundry, dietary, etc., shall participate as consultants on an as-needed basis. Non physicians should not have a vote on the Medical Staff Committees.

(b) Duties: The Infection Control Committee will serve on an advisory basis. The Infection Control Committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the hospital's activities including:

(i) Operating rooms, delivery rooms, recovery rooms, emergency rooms, special care units and all hospital areas;

(ii) Sterilization procedures by heat, gas, chemicals or otherwise;

(iii) All isolation procedures;

(iv) Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;

(v) Testing of hospital personnel for carrier status;

(vi) Disposal of infectious material; and

(vii) All other situations as requested by the Executive Committee.

(c) Meetings: This committee shall meet at least every two (2) months and shall report thereon to the Executive Committees of the Medical Staff and governing body.

Section 7. Blood Utilization Committee

(a) Composition: The Pathologist serving as a Chairperson of the Blood Bank will serve as Chairperson. Members will include at least five (5) other practitioners from the Medical Staff including a representative specializing in Hematology\Oncology who will serve as Vice Chairperson. The physician members of the Committee will be appointed by, and serve a term concurrent with, the President of the Medical Staff. In addition, the Chairperson of the Committee may appoint non-physician hospital associates as members of the Committee (without vote) for designated periods of time to provide a multi-disciplinary resource of expertise as

appropriate to Committee activities. Forty (40%) per cent of the voting members shall constitute a quorum.

(b) Activities: The Committee will review activities related to use of blood and blood components by the Medical Staff including: (1) ordering, (2) distribution, handling and dispensing, (3) administration, and (4) monitoring the blood and blood components' effects on patients. Use of blood and blood components will be monitored in both the inpatient and outpatient setting. The Committee will regularly review the scope of Blood Bank services available at the hospital and make such recommendations for change as are appropriate for continuous improvement of medical care. The Committee will have a written Quality Improvement Plan documenting the procedures for accomplishing the above duties. The results of the Committee's evaluations will be communicated to the individual departments of the Medical Staff and the Medical Staff Quality Committee on a regular basis. The Committee will meet a minimum of four (4) times each calendar year.

Section 8. Operative and Other Invasive Procedures – **On February 7, 2017 the Medical Executive Committee dissolved the Operative and Other Invasive Procedures Committee.**

Section 9. Health Information Management Committee

(a) Composition: The Medical Records Committee is a standing committee of the Medical Staff and consisting of six (6) members of the Active staff. A representative from administration, nursing service, and the Director of Medical Records serve without vote. The Committee shall meet at least (4) four times per calendar year.

(b) Duties: The responsibilities, duties and authority of the Medical Records Committee shall be to:

(i) Review and evaluate medical records objectively, using prescribed work sheets, to help assure that records are adequate for: (a) continuity of care purposes (b) use in quality assurance activities, and (c) assisting in protecting the legal interest of the patient, the hospital, and the responsible practitioner. The physician representatives on the Committee shall evaluate whether or not the records reflect an accurate and adequate documentation of medical events.

(ii) Address issues of medical record delinquency and deficiency, and recommend needed actions to the Executive Committee and to the Quality Assurance Committee.

(iii) Establish the format of the medical record in concept with the Director of the Medical Record Department and review and advise the Administration and Executive Committee regarding all forms to be used in the medical record.

(iv) Review and recommend approval or not, of all policies, rules and regulations relating to medical records.

(v) Recommend any need for and the interval for micro-filming medical records, and participates in decisions for computerization of medical record data.

(vi) Develop or cause to be developed and implement a record review system that, over a reasonable period of time, causes a representative sampling of the records of **all** practitioners to be evaluated.

Section 10. Critical Care Committee

(a) Composition: The Critical Care Committee (CCU, PCU MICU, SICU, and SPCU) shall consist of at least six (6) members of the Active staff with representatives from the specialties using the critical care areas. Five (5) members of the nursing staff who are trained in the special techniques of CCU, PCU MICU, SICU and SPCU shall serve without vote

(b) Duties: The functions and duties of the Critical Care Committee shall be:

(i) To develop policies and procedures regarding the operation of the CCU, PCU MICU, SICU, and SPCU units.

1. To develop criteria for patient selection to ensure optimal utilization of these units.

2. To conduct screening procedures to ensure proper utilization.

3. To ensure compliance with The Joint Commission standards regarding critical care units.

4. To provide periodic instructional courses in appropriate fields to the nursing staff in conjunction with the Medical Education Committee.

5. To provide monitoring and review of Quality and Performance in these units.

(c) Meetings: The Committee shall meet at least (4) four times per calendar year. Minutes of each meeting will be sent to the Executive Committee outlining its activities.

Section 11. Medical Education Committee

(a) Composition: The Medical Education Committee shall consist of a Chairperson appointed by the President of the Medical Staff. In addition, the members should represent each clinical department.

(b) Duties: The functions and duties of this Committee shall be to plan professional educational programs at Community Medical Center and to encourage the participation of the Medical Staff and the professional staff in the programs established for the good of the patients, hospital, and community. This Committee shall keep an ongoing review of

continuing medical education courses of all the members of the Medical Staff. The functions and duties of this Committee shall be to oversee the planning, conduct, and evaluation of continuing medical education at Community Medical Center. The Medical Education Committee shall ensure that continuing medical education meets the needs identified by licensed physicians. Composition of this Committee shall be determined by the complexity of the services provided and assure compliance with the essentials of the Medical Society of New Jersey. The Committee shall meet at least (4) four times per calendar year and on call and furnish reports to the Executive Committee of the Medical Staff and the governing body.

Section 12. Radiation Safety Committee

(a) Composition: The Radiation Safety Committee shall be composed of at least six (6) Active staff members to include one or more radiologists, the Chairperson (or designee) of Radiation Therapy and a representative from the Department of Pathology & Laboratories. Ex-officio members shall include the administrative director of Radiology, a radiation physicist (when available), medical/surgical, and a representative from nursing services and Administration. The physician Chairperson of Radiology shall be the Chairperson.

(b) Duties: The responsibilities, duties and authority of the Radiation Safety Committee shall be to:

(i) Develop or cause to be developed rules, regulations, policies, and procedures to help protect all patients, personnel, and visitors wherever radiation sources (fixed or mobile) are present in the hospital;

(ii) Monitor that all individuals providing services in which radiation sources are used have approved privileges to do so;

(iii) Determine and recommend the means of compliance with all federal and state requirements for the use, storage, handling, transport, and disposal of radioactive materials and equipment;

(iv) Evaluate the need for, and the impact on the hospital (space, construction, safety, etc.) from proposed new services, equipment, and diagnostic/therapeutic agents concerned with radioactivity.

(c) Meetings: The Radiation Safety Committee shall meet “on call” but not less than (4) four times per calendar year.

Section 13. OR Advisory Committee

(a) Composition: The OR Advisory Committee shall be a standing committee of the Medical Staff consisting of at least eight (8) Active staff members to include the Chairpersons of the various departments and sections utilizing the operating room, recovery room, Same Day Surgery, as well as a representative from Administration, shall serve without vote. The Committee shall meet at least (6) six times per calendar year.

(b) Duties: The OR Advisory Committee shall:

(i) Review policies and procedures for the surgical department.

(ii) Discuss equipment needs – both operational and capital.

(iv) Participate in product evaluation.

(v) Discuss operational problems and develop possible solutions.

(vi) Review physician, staff and patient complaints.

(vii) Review and make recommendations for current and future services. Appoint and maintain a Laser Subcommittee to review and regulate all hospital laser use, and to provide laser Quality Assurance review.

Section 14. Patient Care Incident Review Committee

(a) Composition: The Patient Care Incident Review Committee is a standing committee of the Medical Staff consisting of not more than six (6) members of the active Medical Staff appointed by the President of the Medical Staff. The President shall appoint one of the Medical Staff members of the Committee as Chairperson. The Chief Medical Officer, a representative of Nursing Administration, and the Director of Quality Resource Services and the Director of Patient Relations shall serve without vote. The Committee shall meet at least quarterly during the calendar year.

(b) Duties: The responsibilities, duties and authority of the Committee shall be to review physician incident reports in order to make recommendations for improvement of quality and processes. It shall serve to address all issues pertaining to patient care. It shall assist in the formulation of broad professional policies pertaining to the patient's quality of care during the course of their hospitalization. It shall also serve to implement effective communication between the Medical Staff, nursing and patient representatives. Consultants from any hospital department may be called when necessary. It shall promote the principle and practice of patient advocacy. The Committee shall forward minutes to the Executive Committee meetings.

Section 15. Bylaws Committee

(a) Composition: The Bylaws Committee shall consist of five (5) members of the Medical Staff. The Chairperson shall be the Treasurer of the Medical Staff. The remaining four (4) members shall be appointed by the President of the Medical Staff.

(b) Duties: The functions and duties of the Committee shall be to formulate necessary amendments and revisions to the Bylaws and General Rules and Regulations of the Medical Staff and to assist all of the departments to formulate their rules and regulations according to the Bylaws of the Medical Staff for the good of the hospital and all members of the Medical Staff. The Bylaws Committee shall ensure that the Medical Staff Bylaws, rules and regulations

and the Governing Body's Bylaws do not conflict. This Committee is advised to consult with the Medical Staff attorney in its deliberations.

Section 16. Peripheral Vascular Interventional Committee

(a) Composition: Four (4) Active staff members to include the Chairperson of the Department of Radiology; Senior Interventional Radiologist; Sub-Section Chairperson of Vascular Surgery; Sub-Section Chairperson of Interventional Cardiology. Include additional members per the Chairperson's discretion. The Committee shall meet four (4) times per calendar year of at the call of the Chairperson.

(b) Duties: The functions and the duties of this Committee shall be to

(i) Oversee catheter based interventional peripheral vascular procedures
(ii) Perform Quality Peer Review and report actions to Medical Staff Quality Committee
(iii) Create policy and guidelines as indicated for the practice of catheter based Interventional peripheral vascular surgery

Section 17. Ethics Committee

(a) Composition: The hospital shall, under those circumstances set forth in the memorandum of the Board of Medical Examiners, convene an Ethics Committee whose membership shall be pursuant to that memorandum or other regulations issued either by the Board of Medical Examiners or the Department of Health.

Section 18. Cancer Committee

(a) The purpose of the Cancer Committee is to ensure comprehensive cancer care to the community. The Committee shall function in accordance with the requirements of the American College of Surgeons.

(b) The Cancer Committee shall assess all cancer-related activities in this institution. It ascertains that educational programs, conferences and other clinical activities are based on the major sites of cancer seen at this institution. The Committee functions as a multidisciplinary team and recognizes each patient as an individual and strives to improve the quality of life by providing state-of-the-art medical care, supportive care and education. The Cancer Committee monitors and verifies that patients have access to consultative services in all major medical disciplines. It monitors and evaluates patient care by review of audit data such as oncology-related indicators.

(c) The Cancer Committee shall oversee the Oncology Data Center.

(d) The Cancer Committee shall meet at least four times in a calendar year. Membership of the Committee shall consist of at the least the following departments or disciplines: Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, Pathology, Cancer Liaison Program, Administration, Nursing, Social Services, Cancer Registry, Quality Assurance and. Dietitian/Nutrition Specialist.

(e) Quality issues are reported to the Section of Oncology, the Chairperson of the Department of Medicine and reflected in minutes that go to the Medical Staff Quality Committee.

(f) Cancer Conference activities are reported by the Cancer Conference Coordinator to the Cancer Committee at least annually.

Section 19. Appointment of Committee Members

Where the Bylaws calls for the appointment of committee members, only members of the Active Medical Staff shall be appointed, unless otherwise specified in these Rules and Regulations or unless the appointment of a non-active member is approved by the Executive Committee for the good of the hospital by virtue of the individual's specific training. Unless otherwise set forth in these Bylaws, all standing committee members shall be appointed by the President of the Medical Staff and shall service at the pleasure of the President for such duration as he/she determines.

Section 20. Quorum

Unless otherwise set forth in these Bylaws, a quorum of a Committee shall be forty (40%) percent of its members.

ARTICLE XIV. PATIENTS' RIGHTS

Respect for human rights shall be a basic tenet of Community Medical Center and its Medical Staff. All programs will support and protect the fundamental human, civil, constitutional and statutory rights of each individual patient.

The care, treatment and rehabilitation services will be modified to meet the patient's needs taking into account disease severity and disabilities. Patients and/or their family members and/or designated representatives have the right to:

Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire.

Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care;

Considerate and respectful care provided in a safe environment, free from all forms of abuse or harassment;

Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff;

Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her;

Receive information from his/her physician about his/her illness; his/her course of treatment and his/her prospects for recovery in terms that he/she can understand;

Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment;

Participate in the development and implementation of his or her plan of care, and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment;

Formulate advance directives regarding his/her healthcare and have hospital staff and practitioners who provide care in the hospital comply with these directives (to the extent provided by state laws and regulations);

Have a family member or representative of his/her choice notified promptly of his/her admission to the hospital;

Have his/her personal physician notified promptly of his/her admission to the hospital;

Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual involved in his/her healthcare;

Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the hospital. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care;

Access information contained in his/her medical record within a reasonable time frame (usually within 48 hours of request);

Reasonable responses to any reasonable request he/she may make for service;

Leave the hospital even against the advice of his/her physician;

Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care;

Be advised of the hospital grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels determined discharge date is premature. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the hospital contact person, the steps taken on his/her behalf to investigate the grievance, the results of the grievance and the grievance completion date;

Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the hospital;

Know which hospital rules and policies apply to his/her conduct while a patient;

Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient;

Receive any information regarding human experimentation or research or education projects affecting their healthcare, and to refuse to participate in experimental or research protocols, if he/she chooses, without jeopardizing his/her care.

Organ/Tissue Donation:

Patients or their legal next-of-kin have a right to donate organs/tissue, if they choose to do so. All deaths in the hospital should be considered for possible organ/tissue donations according to the established criteria

Human Research:

Patients have the right to agree to participate in research and, at the same time, they have the right to know that research requirements have been followed. The hospital is responsible for the protection of subjects from undue risk and from deprivation of personal rights and dignity. This protection is best ensured by consideration of two issues which are the touchstone of ethical research:

That voluntary participation by the subjects, indicated by free and documented informed consent.

That an appropriate balance exists between potential benefits of the research to the subject or to society and the risks assumed by the subject.

Therefore, Community Medical Center and its Medical Staff will adhere to the guidelines of the Committee on Human Research and the Institutional Review Board of Community Medical Center.

Under certain circumstances, the transmission of photographs of patients by cell phone, from one physician to another, on an unsecured line, will be permissible. If a photograph does not show a patient's face then, in and by itself, the photograph is not Protected Health Information (PHI) under the HIPAA Privacy Rules. If the photograph does show the patient's face, then it is PHI, and may not be disclosed in by a physician except in the same manner as medical records, and therefore may not be sent without patient permission, and may not be sent on an unsecured line. A portion of the face, such as a close up of a laceration where the patient cannot be identified, might not be considered PHI, and would therefore may be transmissible, depending upon the photo.

A non-facial photograph that does not identify the patient is not by itself PHI. If you combine that non-facial photograph with other information about that patient, such as date of surgery, location of surgery, etc., then the totality of the information may make that photograph linkable back to a particular patient. This combination of information would be PHI, and therefore may not be sent without patient permission, and may not be sent on an unsecured line.

ARTICLE XV. IMPAIRED PRACTITIONER POLICY AND PROCEDURE

Section 1. Policy

It is the policy of Community Medical Center ("Hospital") and its Medical Staff to provide support and assistance to members of the Medical Staff and Adjunct Medical Staff (collectively "Practitioners") who are or may be impaired. In doing so, it is important to maintain a balance between individual rights and the Hospital's responsibility to provide quality patient care and to safeguard public health.

Section 2. Purpose

The purpose of this policy is to set forth the procedures applicable to instances in which the performance of Practitioners may be compromised as a possible result of impairment and, in furtherance of such purpose, to set forth the responsibility for, identification of and referral for treatment of Practitioners who are perceived to be impaired with the intention to treat illnesses and return the Practitioner to active staff/work status.

Section 3. Definitions

Definition of Impairment: A Practitioner 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 upon professional performance. Impairment also implies a decreased ability and/or willingness on the part of the affected Practitioner to acknowledge the problem or to seek help to recover.

Physicians Health Team ("PHT"): The PHT shall consist of the Chief Medical Officer and two senior respected members in good standing of the Medical Staff appointed by the

President of the Medical Staff. The President of the Medical Staff may serve as one of the members of the PHT at his election.

Physician's Health Program ("PHP"): The PHP of the Medical Society of New Jersey is the fully staffed group of professionals dedicated to promoting the personal and professional well-being of all New Jersey physicians and which is endorsed by the New Jersey Association of Osteopathic Physicians and Surgeons and the New Jersey Podiatric Society.

Section 4. Procedure

(a) Self-Referral. A Practitioner who is impaired or who is concerned about possible impairment may seek advice directly from the Chief Medical Officer of the PHT.

(b) Other Referrals

(i) If a Practitioner observes indications of potential impairment or has reason to suspect impairment of a fellow Practitioner, then he shall report same, in confidence, directly to a member of the PHT or, if unavailable, to the President of the Medical Staff or Chief Medical Officer as soon as is possible under the circumstances.

(ii) If a practitioner is approached by any individual who has observed or suspects impairment of another Practitioner, the individual shall be encouraged to discuss the matter directly with a member of the PHT or, if unavailable, with the President of the Medical Staff or Vice President for Medical Affairs. If the individual refuses to directly transmit this information, then the practitioner shall report the information to a PHT member. The PHT member will then determine what course of action is appropriate in pursuing the matter.

(c) Confidentiality. All individuals involved in the Referral, deliberation, monitoring or treatment of impairment shall at all times maintain the confidentiality of the names of all persons involved and the facts of the matter. All meetings or discussions pertaining to the matter shall be closed and shall be attended only by those who are directly involved. All records, correspondence, notes, reports and/or other documents relating to the matter, from whatever source, shall be kept in a locked, confidential file (the "Confidential File") accessible only to PHT members, President of the Medical Staff, Chief Medical Officer, and otherwise as may be required by law.

(d) Records by the PHT. Following each phase of the inquiry process, the PHT shall prepare written reports known as "Determinations", which state the facts of the Referral, the details of any discussions or meetings pertaining thereto, recommendations or decisions made, and any actions taken (or not taken) and the reasons therefore. Determinations shall be stored in the Confidential File.

(e) Deliberation and Investigation by PHT. Upon the receipt of a Referral concerning possible impairment from a Practitioner or other individual, the PHT member receiving the Referral shall promptly contact the other PHT members and convene a meeting to discuss, in confidence, the details of the Referral. On the basis of the Referral and the

discussion pertaining thereto, the PHT shall determine whether further investigation into the facts of the Referral is warranted. If the PHT determines that:

(i) An investigation is not necessary, and then the Determination shall be completed, stating the facts of the Referral and the reason why no further action was deemed necessary. The Determination shall then be stored in the Confidential File.

(ii) An investigation is warranted, and then the PHT shall conduct such investigation on a confidential basis. As part of such investigation, the PHT shall, within 10 working days or as soon thereafter as is reasonably possible, after it determines that an investigation is warranted, summon the Practitioner who is the subject of the Referral ("Subject Practitioner") to a confidential meeting with the PHT to discuss the allegations contained in the Referral. The Subject Practitioner shall be given at least 48 hours advance personal or telephone notice of the time and place of the PHT meeting. The source(s) of the referral will not be disclosed to the Practitioner. Investigation may include a request by the PHT for drug and/or alcohol testing by a Hospital designated laboratory. Additional steps which may be taken by the PHT as part of such investigation may include, but are not limited to, direct observation of the Subject Practitioner by PHT members, confidential inquiries by PHT members of persons in a position to observe the Subject Practitioner, and reviews of relevant patient medical records. The Department Chairperson will meet with the Practitioner to facilitate patient care coverage arrangements for the Practitioner, as necessary, while the investigation is ongoing.

(iii) If the PHT believes that there is sufficient reason to think that impairment exists, then the PHT shall notify the President of the Medical Staff. The Chief Medical Officer shall also notify the PHP of the case and may forward all relevant information to the PHP. After input from the PHP, if, and to the extent deemed necessary by the PHT, the PHT shall devise an appropriate rehabilitation and treatment program ("Program") for the Subject Practitioner, and determine how and to what extent the Subject Practitioner's privileges and professional activities will be affected by the finding of impairment. Under such circumstances, the Practitioner is entitled to the general protections of the Medical Staff Physician Bylaws, if he wishes to invoke them. The Reviewers and the PHT shall issue to the Subject Practitioner a written directive advising him or her of the details of the Program and any other information, which will affect the Subject Practitioner's practice and/or privileges.

1. The Practitioner may request a Leave of Absence ("LOA") in writing per the Medical Staff Bylaws. The reason for the LOA will remain confidential so long as the Practitioner remains in compliance with PHT and PHP recommendations.

2. The PHT will inform the Department Chairperson if the Practitioner has entered into a recovery agreement with the PHP and/or PHT.

(iv) In situations involving failure by an impaired Subject Practitioner to undergo rehabilitation and treatment, or otherwise cooperate with the directives of the PHT and/or PHP, and participants in the Program, precautionary suspension of the Subject Practitioner's Medical Staff status or all or any portion of his clinical privileges may be implemented, in the

manner specified in the Medical Staff Bylaws. Under such circumstances, 0000the Practitioner is entitled to the general protection of the Medical Staff Bylaws, if he wishes to invoke them.

(f) Objections to PHT findings or actions. If a Subject Practitioner disagrees with the findings or actions taken by the PHT, he may present additional reports, documents or statements not previously considered by the PHT for expeditious review by the PHT. The Chief Medical Officer shall also contact the Medical Director of the PHP, who shall participate in the deliberations.

(i) If the added data provides sufficient evidence to reverse the PHT's determination about impairment, then the PHT shall take either the action set forth in Section 5. A or B above.

(ii) If the added data does not provide sufficient evidence to reverse the PHT's determination about impairment, then the PHT shall take either the action set forth in Section 5. C or D above.

(g) Monitoring and follow-up. Whenever it is determined by the PHT that monitoring and follow-up of a Subject Practitioner is necessary to ensure continued quality professional performance, the PHT shall work with the President of the Medical Staff and the Chief Medical Officer in devising a schedule of supervision.

Monitoring of treatment in instances of impairment shall be reviewed on a regular basis by the PHT with the Medical Director of the PHP. Reports will be requested by and sent to the Chief Medical Officer who will inform the PHT, the President of the Medical Staff and the Department Chairperson of compliance. The frequency of reports will be at least quarterly for two years. Should the Subject Practitioner have taken a LOA or had a curtailment or suspension of privileges, or had his Medical Staff, Adjunct Staff or Allied Health privileges revoked, the PHT will make appropriate recommendations about return from leave and reactivation of privileges to the President of the Medical Staff and the Chief Medical Officer in accordance with Medical Staff Bylaws. Prior to any Practitioner returning to active status after a LOA, the PHT and the applicable Department Chairperson will meet with the individual to affirm continued participation in recovery.

The Hospital and the PHT are committed to the rehabilitation of all impaired Practitioners wherever possible. Should attempts at rehabilitation fail, there shall be full deliberation and review to assure that all good faith efforts for rehabilitation have been made. Subsequently, disciplinary actions

regarding clinical privileges and licensure may be necessary, as specified in the Medical Staff Bylaws, in which event, should any such action be recommended or taken, the Practitioner shall be entitled to a fair hearing under the Medical Staff Bylaws.

(h) Reporting requirements. The Chief Medical Officer shall take responsibility for any reporting obligations under the New Jersey Professional Medical Conduct Reform Act and the Federal Health Care Quality Improvement Act when required in connection with the matters set forth in this Policy.9.

(i) Privileges of new practitioners. New Practitioners to the Medical Staff with a history of or concurrent participation in a recovery program will be required to meet with the PHT upon appointment for monitoring requirements during the Practitioner's interim appointment period.

(j) Violation of Laws. If in the course of its deliberation and investigation, the PHT finds instances of possible violation of state or federal law, it shall consult the President of the Medical Staff and the Chief Medical Officer about obtaining legal counsel for further advice.

(k) Education. The PHT shall educate the Medical Staff and other organized staff about illness and impairment recognition issues specific to physician health and prevention of physical, psychiatric or emotional illnesses. Such education shall include publication and dissemination to the Medical Staff and other organized staff information regarding these processes along with education regarding the same in new physician orientation.

ARTICLE XVI. FINANCIAL RELATIONSHIP DISCLOSURE

1. Physicians nominated for elective office (including officers of the Medical Staff Executive Committee, Department and Section chairs and all officers of Departments must disclose the existence of a financial relationship and any other perceived conflicts of interest with Community Medical Center and its subsidiaries and all other hospitals (including Barnabas Health and any other New Jersey Hospital or Health Care System) and their subsidiaries no later than 30 days prior to the election. Perceived conflicts include but are not limited to employment by the physician or immediate family members by Community Medical Center, Barnabas Health and/or its affiliates, any other New Jersey hospital or health care system, or ownership of any level in a healthcare entity that competes with any service offered by Community Medical Center, Barnabas Health and/or its affiliates. It shall be the responsibility of the physician declaring the conflict or perceived conflict to describe said conflict in reasonable detail, including the type of employment (e.g., title, whether it is full time, part time or per diem [including percentage of total work hour], name of employer, etc.) and/or the percent of ownership in the facility or competing facility.

2. A list of all physicians who have any financial affiliation with Community Medical Center will be available in the Medical Staff Office and for the purposes of the elections be available at the medical staff office to all members of the medical staff.

3. Disclosure will not be required of full time employees (e.g. Chairs of the Departments of Pathology, Radiology and Nuclear Medicine, Emergency and Outpatient Medicine and the Chief Medical Officer) because they are contractual physicians.

4. Disclosure will consist of a list by physicians who are compensated in any capacity by a hospital included in or affiliated with the Saint Barnabas Health Care System and will include their title and tenure. Physicians who hold privileges at more than one hospital are required of disclose their financial relationship with that institution. Disclosure information will be submitted to the Medical Staff Office and shall be available for review by the Executive Committee of the Medical Staff, the Chief Medical Officer and the Hospital President/CEO.

5. Disclosure will include any relationship with this or other hospitals including its parent board and subsidiaries.

6. Candidates for department and section chairs shall be nominated (30) thirty days prior to election to facilitate financial disclosure.

7. All members of the Medical Staff holding elective office shall supplement their written disclosure as necessary.

ARTICLE XVII. PHYSICIAN ORIENTATION/EDUCATION

1. Education in a formal classroom environment and clinical information systems will be a prerequisite to maintaining Medical-Dental Staff privileges. Those members of the Medical-Dental staff who do not complete an introductory educational course concerning the basics of safe electronic order entry will not be issued passwords to utilize the clinical informational system, and therefore will not be able to participate in patient care.

2. Medical Staff members will be expected to comply with HIPAA regulations. They will not share passwords, and they will be held accountable for inappropriately accessing electronic charts where they have no professional relationship.

3. Individual medical staff members will be expected to enter their own orders when they are onsite, except in an emergency. These requirements do not apply to disabled physicians who will receive special accommodations.

4. CPOE and the electronic medical charts are considered part of the routine practice of medicine and, as such, will be a condition of securing clinical privileges and re-credentialing-.

5. Verbal orders are defined as orders that are verbalized because the physician is unable to access a computer workstation.

6. Telephone orders are defined as orders given over the telephone when the physician is not physically present and accessing a computer workstation is not possible. Medical Staff members are expected to remain on the phone for read back and verify, and to provide responses to clinical alerts that may occur during the ordering process. Texting or emailing orders to the Hospital floors is prohibited.

7. All verbal and telephone orders, and co-signatures for mid-level providers' orders, should be authenticated in 48 hours.

Adopted at a regular meeting of the Active Medical Staff of Community Medical Center.
Adopted: 05/28/81
Amended: 05/24/82
Amended: 01/10/90
Amended: 09/15/90

Amended:	11/24/91		
Amended:	04/27/92		
Amended:	02/11/93		
Amended:	09/27/93		
Amended:	11/29/93		
Amended:	06/06/96		
Amended:	04/27/98		
Amended:	09/28/98		
Amended:	04/26/99		
Amended:	09/27/99	Approved:	11/04/99
Amended:	11/19/01	Approved:	01/29/02
Amended	09/24/07	Approved	11/01/07
Amended	04/28/08	Approved	06/05/08
Amended	04/27/09 & 9/26/09	Approved	01/26/10
Amended	4/26/10, 7/29/10, 1/24/11	Approved	03/03/11
Amended		Approved	06/29/11
Amended		Approved	11/26/12
Amended	11/26/12	Approved	01/15/13
Amended	2014/2015	Approved	03/02/15
Amended	02/07/17		
Amended	10/30/18	Approved	11/29/18
Amended	01/06/19	Approved	01/31/19
Amended	11/07/19		
Amended	02/11/20		
Amended	06/06/23	Approved	06/06/23
Amended	11/06/24	Approved	11/06/24