MEDICAL STAFF BYLAWS

SUMMIT SURGICAL CENTER

Approved:

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Chairman, Management Board
Summit Surgical Center, LLC

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Revised September 2010
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PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of the medical care and the best interest of the patients, through concerted effort, subject to the ultimate authority of the Management Board, the Medical Staff practicing at Summit Surgical Center hereby organizes itself in conformity with its Bylaws, Rules and Regulations.

These Medical Staff Bylaws are adopted and made effective upon the recommendation of the Medical Staff and approval of the Management Board superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges at Summit Surgical Center shall be taken under and pursuant to the requirements of these Bylaws.

ARTICLE I - NAMES AND DEFINITIONS

1.1 Name

1.1.1 The name of this organization shall be the "Medical Staff of the Summit Surgical Center".

1.2 Definitions

1.2.1 SUMMIT SURGICAL CENTER means the Summit Surgical Center located on Bowman Drive, Voorhees, New Jersey.

1.2.2 MANAGEMENT BOARD means the governing board of Summit Surgical Center, LLC

1.2.3 ADMINISTRATOR means the Chief Executive Officer of the Summit Surgical Center.

1.2.4 DIRECTOR OF QUALITY MANAGEMENT means the person appointed by the Administrator to oversee and supervise the quality/risk management and clinical services provided at Summit Surgical Center.

1.2.5 MEDICAL DIRECTOR means the physician appointed by the Administrator as confirmed by the Management Board to act in directing the medical affairs and maintaining medical services at the Summit Surgical Center.

1.2.6 MEDICAL STAFF YEAR means the period from January 1 to December 31.

1.2.7 MEMBER or PRACTITIONER means the physician, dentist or podiatrist who is applying for or exercising clinical privileges in the Summit Surgical Center.

1.2.8 ORAL SURGEON shall be interpreted to refer to licensed dentists who have successfully completed a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.

1.2.9 VIRTUA HEALTH shall mean those acute care hospitals located in Voorhees, Marlton and Mt. Holly whose corporate office address is 303 Lippincott Drive, 4th Floor, Marlton, New Jersey.

1.2.10 AHP credentialed by the Management Board are CRNA’s, CRNFA, PAs.

ARTICLE II - PURPOSE

2.1 The purpose/mission of this Organization shall be

2.1.1 The Summit Surgical Center, LLC provides cost effective, outpatient services by a highly skilled and compassionate team using state of the art technology.
Supporting Statement:

2.1.2 To establish a high level of professional performance of all members of the Medical Staff through the appropriate delineation of privileges to practice in Summit Surgical Center and the continuous review and evaluation of the activities of all individuals granted clinical privileges in the Summit Surgical Center.

2.2 **Purpose: Medical Staff**

2.2 The purposes of this Medical Staff are to:

2.2.1 Bring the professionals who practice at the Center together into a cohesive body to promote good patient care.

2.2.2 Screen and recommend applicants for Medical Staff membership.

2.2.3 Review privileges of Members and Allied Health Professionals (AHP).

2.2.4 Evaluate and assist to improve the work done by the Medical Staff through participation in the peer review process.

2.2.5 Provide education.

2.2.6 Provide advice to the Management Board.

2.2.7 Participate in the development and review of Center Policies.

2.2.8 To maintain and recruit qualified physicians as identified by the existing Medical Staff, Virtua Health System and other entities within the healthcare community.

ARTICLE III - MEDICAL STAFF MEMBERSHIP

3.1 Qualifications

3.1.1 Consideration for Medical Staff membership shall be based upon the qualifications of the applicant, recommendation of their peers, the needs of the community and economic (resource) limitations of the facility. Membership on the staff of the Summit Surgical Center is a privilege.

3.1.2 Only practitioners licensed to practice in the State of New Jersey who can document their backgrounds, experience, training and demonstrated competence, their ability to work with others, their adherence to the ethics of their profession and their good reputation with sufficient adequacy to assure the Medical Staff and the Management Board that any patient treated by them will be given high quality medical care, shall be qualified for membership on the Medical Staff.

3.1.3 Board certification or active candidacy for board certification in a practitioner's area of requested privileges is required at time of application for medical staff appointment and reappointment. Active candidates who do not become board certified within five years from the date they become eligible to take the examination will be deemed to have voluntarily relinquished staff appointment and privileges. With the exception of Podiatry who is allowed a seven (7) year grace period to become Board certified. This is as per American Board of Podiatric Surgery.

3.1.4. Proof of current professional liability insurance of not less than $1,000,000.00 per occurrence or an amount as determined by resolution of the Management Board.

3.1.5. Proof of current Drug Enforcement Administration (DEA) registration and Controlled Dangerous Substance (CDS), if applicable, is required at time of application for Medical Staff appointment and reappointment.

3.1.6. Proof of serologic Rubella and Rubeola immunity as well as a current TST (within the last six months) is required at time of application for Medical Staff appointment. For reappointment, evidence of TST testing within the previous 12 months is required. As an alternative to TST testing, Quantiferon test results are also accepted or other appropriate New Jersey Department of Health or CDC Guideline approved tests for Mycobacterium Tuberculosis.

- Individuals with a history of BCG vaccine administration more than 2 years prior to evaluation may be evaluated using the two step, Mantoux method with initial testing of one (1) TU and if negative five (5) TU one to three weeks later. *TU = Tuberculin Units (or other appropriate New Jersey Department of Health or CD Guideline approved test for Mycobacterium Tuberculosis.
- Physicians will be exempt from testing if:
    1) there is a history of previous positive PPD

2) previous treatment for tuberculosis
3) BCG vaccine administration in the last 2 years
4) TST tested within the last 12 months
5) Rubeola- if date of birth is prior to 1957
6) Rubella- if date of birth is prior to 1957 and not able to become pregnant

Note* Documentation of MMR vaccination following a non-immune titer reading for Rubella and/or Rubeola shall be counted as evidence of immunity.

Note*Evidence of influenza vaccination, contraindication or declination during the influenza season of October 1 through March 31 annually is required.

Physicians meeting any of the above criteria for TST exemption must report this to the Virtua - Occupational Health Department. The reporting will be through the Tuberculosis Surveillance Questionnaire available through the Virtua Medical Affairs Office. Physicians will provide documentation of a History and Physical minimally every five years. Physicians will provide evidence of influenza vaccination or attestation annually during the peak influenza season of October 1st through March 31st. A physician who does not perform a single case during the peak influenza season is exempt.

Physicians will provide annually documentation of any mandatory education.

Physicians who fail to comply at the time of their biennial reappointment will be suspended and, if the physician is not in compliance at the time privileges would expire; medical staff membership shall terminate at that time.

3.1.7 No individual shall be denied appointment to the medical staff or the exercise of clinical privileges on the basis of age, race, color, sex, creed, religion, national origin, disability, sexual orientation, gender identification, marital status, or veteran status.

3.1.8. All credentialing criteria shall be those that are established by the Management Board.

3.1.9. Practitioner shall comply with State Regulations

3.2 Terms of Medical Staff Appointment

3.2.1 Appointments or reappointments to the Medical Staff shall be made by the Management Board. The Management Board shall act on appointments, reappointments or revocation of appointments only after there has been a recommendation from the Credentialing Committee, provided that in the event of unwarranted delay on the part of the Clinical Operations Committee, the Management Board may act without such recommendation.

*Note: The Credentialing Committee is a sub-committee of the COC consisting of the Medical Director (or covering Assistant Medical Director) as well as physicians on the COC

Committee. The COC members eligible to vote or take action on matters involving credentials includes the Medical Director (or covering Assistant Medical Director), COC physician members

3.2.2 Initial appointments and Reappointments shall be for a period of not more than two (2) years.

3.2.3 Appointment to the Medical Staff shall confer on the appointee only such privileges as may hereinafter be designated or limited and approved by the Management Board. The applicant has the burden of producing adequate information.

3.2.4 By applying for appointment or reappointment to Medical Staff, each applicant agrees to abide by the Medical Staff Bylaws, Rules and Regulations, and policies of the Summit Surgical Center and authorizes representatives of the Summit Surgical Center and its Medical Staff to consult with peers concerning information bearing on competence and qualifications of the applicant as well as to inspect all records and materials with respect to professional qualification and competency. In doing so, each applicant consents to the disclosure of all relevant information and releases from liability all representatives for acts performed with due care, without malice and in good faith in connection with evaluating the applicant or informing the Medical Staff about the Practitioner.

3.2.5 Interim Privileges

3.2.5.1 Interim privileges may be granted to a practitioner by the Medical Director after the application has been approved by the Credentials Committee and while awaiting Clinical Operations Committee and Management Board approval. Interim privileges may not exceed 60 days. An additional 60 days may be allowed in the event that the Credentialing Committee and Management Board approval process has encountered a delay. Interim privileges may not exceed 120 days in total

3.2.5.1The Committee also recommend the granting of clinical privileges to qualified Allied Health Professionals (provided that category of AHP has been approved for practice in the Center by the COC and Management Board).

3.2.5.2 The Credentialing Committee may recommend the discipline of Medical Staff members and AHPs for violation of these bylaws, federal or state laws, and any policy of the Center within the limitation of the authority delegated by the Management Board.

3.2.5.3. Allied Health Professionals are subject to the requirements of these Bylaws; however, they are *not* deemed members of the Medical Staff, and are not afforded the procedural rights set forth in these Bylaws with respect to Fair Hearings.

3.2.6. Provisional Status

3.2.6.1 Except as otherwise determined by the Management Board, all initial appointments to the Medical Staff shall be provisional until first request for reappointment. Each provisional appointee shall be observed by the Medical Director or such Medical Director's designee, which may include observation by a Credentials Committee member appointed by the Medical Director, for a minimum of two (2) surgical cases to determine eligibility for regular Medical Staff membership in the staff category to which the practitioner was provisionally appointed and for exercising the clinical privileges provisionally granted. At the Medical Director's discretion, additional cases may be observed.

3.2.6.2 An initial appointment once approved by the Management Board, shall remain provisional for two years. Within, or soon after, the one-year period the practitioner shall furnish to the Credentials Committee a certification signed by the Medical Director or his designee, that either has observed the practitioner in his/her professional practice at Summit, that the appointee meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogative of the staff category to which he/she was previously appointed. If, upon completion of the provisional period, the Medical Director and the Credentials Committee report no adverse recommendations, the practitioner will be recommended to the Management Board for full Medical Staff privileges.

3.2.6.3. If the provisional appointee fails within the provisional period to furnish the certification required in Section 3.2.6.2, meet all of the qualifications, or discharge all of the responsibilities, or has exceeded or abused the prerogative of the staff category to which he/she was appointed, his staff appointment shall automatically terminate. The appointee so affected shall be given special notice of such termination and shall be entitled to procedural rights in accordance with Article VI of these Bylaws. The Practitioner affected by this automatic termination shall not be eligible to reapply for Medical Staff privileges for a period of ten (10) months.

3.2.6.4 At the discretion of the Medical Director, the provisional period can be extended for two-year period which shall include observation by the Medical Director or his designee (as per 3.2.6.1) of a minimum of two (2) surgical cases, to determine eligibility.

3.2.6.5 Consulting Privileges shall be granted to those Practitioners meeting the requirements set forth in Section 3.3 of these bylaws, however these shall only be used for consultation services such as Radiology interpretation or assistance with a procedure as outlined in the individual consultant's delineation of privileges.

3.2.7 Activity Threshold

3.2.7.1 An activity threshold has been established at five (5) cases per year or ten (10) per reappointment period, must be performed at Summit Surgical Center.

3.2.7.2 Any practitioner not meeting this threshold will be considered to be voluntarily relinquishing his/her privileges, but may re-apply at any time.

3.2.7.3 All medical staff are expected to participate in peer review and may take part in a committee.

3.2.8 Peer Review by the Credentialing Committee

3.2.8 The Credentialing Committee shall review the performance of each member requesting reappointment at the next regularly scheduled meeting. The following criteria are used to gauge the current member's competency (details of criteria used shall be determined by the COC and Management Board), include but not limited to:

3.2.8.1 Performance.

3.2.8.2 Judgment, including but not limited to, the individual's physical and mental capacity to render care for privileges granted.

3.2.8.3 Technical skill

3.2.8.4 Frequency of procedures at the Center. In order to provide adequate medical records for peer review and quality assurance, each surgeon is required to perform a number of procedures at the center.

3.2.8.5 Other information pertaining to various Peer Review indicators that involve important aspects of care such as indications for surgery, appropriateness of care, infection control, transfers, etc., may be considered. Any information obtained through the peer review process is confidential and shall be treated as such. The member shall be required to provide documentation of physical and/or mental health status and to submit to such health examinations (urine drug screening and/or blood alcohol testing) as deemed necessary by the COC and/or Management Board.

3.2.8.6 Proctoring may be recommended on the results of Peer Review.

3.2.8.7 Recommendation of the Credentialing Committee: Upon making a recommendation to re-appoint a member, the Credentialing Committee shall also recommend the clinical privileges to be granted.

3.2.8.8 When Reappointment is Effective: Any reappointment, category of membership, or clinical privileges granted with reappointment shall be effective immediately upon approval of the Management Board so that there will not be interruption of privileges.

3.2.8.9 Failure to Renew Membership: If a Practitioner does not renew his/her membership and is removed from Active Staff status, he/she must complete and follow the procedure for initial application for appointment as set forth in Section 3.3 of the Bylaws in order to regain staff membership.

3.3 Procedure for application

3.3.1 The application for membership to the Medical Staff shall be submitted to the Medical Director who shall then transmit the same to the Credentials Committee. The Credentials Committee and Medical Director shall be responsible for investigating and verifying the applicant's professional qualifications. The Credentials Committee shall then submit a report through the Medical Director to the Clinical Operations Committee for their action. Credentials Committee Medical Staff represent a sub-committee of the Clinical Operations Committee.

3.3.2 The COC/Credentialing Committees shall communicate to the Management Board through the Medical Director, its recommendations on each applicant.

3.3.2.1 If the application has COC/Credentialing Committees recommendation and the Management Board approves, the applicant shall be appointed for a period not to exceed two (2) years.

3.3.2.2 If the Management Board does not approve the COC/Credentialing Committee's recommendation, action on the application will be deferred and the Credentials Committee and COC shall reconsider such application and make further investigations and inquiries and resubmit a report to the Management Board. In any event, the Medical Director shall promptly notify the applicant of any action taken by the Management Board.

3.3.2.3 If the Credentialing Committee's recommendation is adverse to the applicant and if the Management Board concurs, the applicant shall be entitled to the fair hearing rights as provided in Article VI of these Bylaws. The failure of the applicant to request such fair hearing rights within thirty (30) days after receiving any adverse determination by the Management Board shall constitute and be construed as a waiver of said right.

3.3.3 An applicant who has received a final adverse determination regarding appointment shall not be eligible to make reapplication for a period of one (1) year. Any such reapplication shall be processed as an initial application.

3.4 Procedure for Reappointment

3.4.1 The Medical Director shall, at least sixty (60) days prior to the expiration date of the existing staff appointment of each medical staff member, provide such staff member with an application for reappointment. Failure on the part of the staff member to return

the form within thirty (30) days of receipt shall be deemed a voluntary resignation from the staff and shall result in automatic expiration of appointment and clinical privileges without fair hearing rights.

3.4.2 Upon receipt of the reappointment application, the Medical Director shall transmit the form to the Credentials Committee and thereafter the procedure provided in Section 3.3 shall be followed.

3.5 Leave of Absence

3.5.1 A staff member may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the Medical Director stating the exact period of time of the leave, which may not exceed one (1) calendar years for reasons related to illness, continuing and/or further formal education. During such period of absence, the staff member's privileges shall be suspended.

3.5.2 At least thirty (30) days prior to the termination of leave, or at any earlier time, the staff member may request reinstatement of privileges by submitting a written notice to the Medical Director. The staff member shall submit a summary of his/her relevant activities during the leave.

3.6 Retired and Resigning Members

Members retiring or resigning their privileges should notify the Medical Director in writing (written or via electronic means) The Medical Director will notify the Credentialing Committee, The member will be notified of the status by letter or electronic mail. Retired and Resigned members are not eligible to admit or care for patients at Summit Surgical Center.

ARTICLE IV - DETERMINATION OF PRIVILEGES

4.1 Exercise of Privilege

4.1.1 All practitioners entitled to Medical Staff membership shall have specifically delineated clinical privileges. Each Medical Staff member shall be entitled to exercise only those privileges specifically granted.

4.2 Determination of Privileges

4.2.1 Determination of privileges shall be based upon the applicant's education, training, licensure, experience, demonstrated competence, ability to get along and work with others, peer recommendations and any other information deemed relevant by the COC/Credentialing Committees or the Management Board. All requests for privileges shall be processed in accordance with the procedures and policies of the Summit Surgical Center.

4.2.2 Applications for increased privileges will be processed in the same manner as an initial request for privileges. Primary source verifications and other regulatory requirements will apply and the request for increased privileges must be approved through the existing committee structures and approval processes.

4.2.2 (a) Requests for clinical privileges to perform either a significant procedure not currently being performed at Summit Surgical Center or a significant new technique to perform an existing ("new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by Summit Surgical Center and (2) criteria to be eligible to request those clinical privileges have been established.

4.2.2 (b) The Credentials Committee and the Clinical Operations Committee will make a preliminary recommendation as to whether the new procedure should be offered. Factors to be considered include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is Centers for Medicare and Medicaid Services approved, and whether the surgical center has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

4.2.2 (c) If it is recommended that the new procedure be offered, the Credentials Committee will conduct research and consult with experts, including those on the Medical Staff and those outside Summit Surgical Center, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee will forward its recommendations to the Clinical

Operations Committee, which will review the matter and forward its recommendations to the Board for final action.

4.2.2 (d) **Emergent Care.** In the case of an emergency, any Member, to the degree permitted by his/her license, regardless of staff status or clinical privileges, is permitted to do everything possible to save the life of a patient or save a patient from serious harm. For the purpose of this Section, an emergency is defined as a condition in which serious or permanent harm would result to a patient or in which the life of the patient is in immediate danger and any delay in administering treatment would add to that danger.

4.2.2 (e) **Credentialing Physicians in the Event of Disaster:** The purpose of this section is to provide a process to credential practitioners who are not members of the Medical Staff at Summit Surgical Center and do not possess medical staff privileges who may provide patient care services during a disaster (defined as an officially declared emergency, whether it is local, state, or national).

Note: Any practitioner providing patient care must be granted privileges prior to providing patient care, even in a disaster situation. Safeguards must be in place to verify that practitioners are competent to provide safe and adequate care.

Process: Disaster privileges are granted on a case-by-case basis after certification of identity and licensure. The following information must be presented by the physician in order to be granted disaster privileges:

(1) Application for Disaster Credentialing;
(2) Valid professional license to practice in the State of New Jersey;
(3) A valid photo ID issued by a state, federal, or regulatory agency;
(4) Current Malpractice Insurance
(5) In addition to the above, at a minimum, at least **one** of the following must also be presented;
    i. Hospital identification that clearly identifies the professional designation of the volunteer
    ii. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, the American Red Cross, or other recognized state or federal organizations.
    iii. Primary source verification of license.
    iv. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstance (such authority having been granted by a federal, state, or municipal entity).
    v. Presentation by a current hospital or medical staff member(s) who possess personal knowledge regarding the practitioner's professional ability to act as a licensed independent practitioner during a disaster.

Note: The following information must be provided as soon as possible:

(1) Certificate of malpractice insurance.

(2) List of current hospital affiliations where the practitioner holds active staff privileges.

(3) After viewing the documents presented, Credentialing will record the date and time of the request for the disaster privilege; the state license number and expiration date and any other pertinent information.

(4) If possible, copies will be made of all documents.

(5) Credentialing will immediately do the following and complete within 72 hours from the time the volunteer practitioner presents to the Surgical Center:

(i) Attempt to verify the state license

(ii) Attempt to contact the facility at which the physician has recently practiced to verify that s/he is in good standing

(6) In the event these calls cannot be completed, disaster privileges may still be issued pending verification of good standing.

(7) All physicians who currently have privileges or who receive disaster privileges will work under the direction of the Medical Director under the **Incident Command System.** The Medical Director, as defined above, will be responsible to oversee the professional practice of the volunteer practitioner. This can be done through direct observation, mentoring, and/or clinical record review.

(8) The privileges granted to the volunteer practitioner must be re-evaluated every 72 hours, to see if there is still a need to continue the granted privileges.

(9) A physician's privileges, granted under this disaster situation, may be terminated at any time without any reason or cause. Termination of these privileges will not give rise to a hearing or review.

(10) **The ranking Administrator on-site will grant privileges upon recommendation of the appropriate physician member of the Management Board**

(11) When the disaster situation no longer exists, these temporary disaster privileges will terminate.

(12) Any licensed independent practitioner presenting to Summit Surgical Center during a disaster as a spontaneous volunteer; not meeting these requirements, will be referred to the appropriate state or federally recognized organization for processing and registration.

4.2.3 Clinical Privileges for Dentists:

4.2.3.1 The scope and extent of surgical procedures that a dentist may perform at Summit shall be delineated and recommended in the same manner as other clinical privileges.

4.2.3.2 The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. A medical history and physical examination of each patient shall be performed before dental surgery shall be performed. H & P needs to be completed by an M.D., or collaborating APN or D.O.

Dentists may write orders within the scope of their license and consistent with the medical staff rules and regulations, and in compliance with medical staff bylaws and Summit policies.

4.2.3.3 Oral surgeons may perform a history and physical examination on and assess the medical risks of the procedure on ASA Class I and Class II patients. All patients not fitting into this category must have a medical consultation pre-operatively.

4.2.4 Clinical Privileges for Podiatrists:

4.2.4.1 The Scope and extent of surgical procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges within the scope of their license, consistent with the medical staff rules and regulations.

4.2.4.2 Podiatrists may perform a history and physical examination on and assess the medical risks of the procedure on ASA Class I. ASA Class II or higher patients must have an H & P exam performed by an M.D. or D.O. or collaborating APN prior to surgery. The podiatrist shall be responsible for the podiatry care of the patient, including the podiatry history and podiatry physical examination as well as all appropriate elements of the patient's record. A medical history and physical examination of each patient shall be performed by a physician before podiatry surgery shall be performed.

4.2.4.3 Podiatrists may write orders which are within the scope of their license, consistent with the medical staff rules and regulations, and in compliance with medical staff bylaws and Summit policies.

4.2.5 Clinical Privileges for Allied Health Personnel (AHP):

4.2.5.1 The COC may promulgate policies and procedures setting forth minimum qualifications, sponsorship and supervision requirements, delineation of privileges and/or scope of practice, and applicable performance standards for those categories of AHPs who are allowed to perform clinical procedures at the Center. In the absence of formal policies and procedures, the COC shall be authorized to exercise reasonable discretion in granting AHP privileges, setting forth sponsorship and supervision requirements, and establishing scope of practice and applicable performance standards in this Center. In no event shall an AHP be allowed to provide patient care services without confirmation of such licenses and permits as may be required by law, or without being covered by acceptable levels of malpractice liability insurance as determined by the Management Board.

4.2.6 Clinical Privileges for Anesthesiologist:

4.2.6.1 Anesthesiologist shall meet the above stated qualifications for Physician Membership; however the following exceptions or additional requirements apply.

4.2.6.2 Anesthesia Services will be provided by competent and qualified Anesthesiologists.

4.2.6.3 Anesthesiologist shall abide by the American Society of Anesthesia Standards of Care and shall abide by the following, but not by way of limitation, the anesthesia policies and procedure of the Center.

4.2.6.4 Current ACLS and PALS certification for Anesthesia health providers.

4.3 Special Condition for Post Graduate Residents

4.3.1 Post Graduate Residents who are introduced to the Summit Surgical Center by members of the Medical Staff for the purpose of teaching must be identified to the Medical Director or designee. The member of the Medical Staff who introduces a resident or medical student must bear full responsibility for their conduct as it applies to these Bylaws and applicable rules and regulations and policies and procedures of the Virtua Office of Graduate Medical Education.

4.3.2 Post Graduate Residents Adequate proof of such resident affiliation and insurance coverage, license and current PPD Rubella and Rubeola must be documented in the Summit residents file. Residents must be credentialed as Post Graduate Resident Staff at Summit Surgery Center.

4.3.3 Post Graduate residents need to apply for Resident Staff privileges from the Summit Management Board.

4.3.4 The Management Board shall approve affiliation agreements. The applicable program directors shall be responsible for verifying and evaluating the qualifications of each physician in training.

4.4 Physicians and Family Members

Members of the Medical Staff may not act as physician to their family members who are treated at Summit Surgical Center. The complexities of acting as physician for family members are clearly expressed in AMA policy #E-8.19 entitled, “Self Treatment or Treatment of Immediate Family Members.”

4.4.2 AMA Guidelines

E-8.19 Self-Treatment or Treatment of Immediate Family Members

Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care. It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV)

Issued June 1993.

Last updated: Aug 26, 2005

4.4.3 Medical staff members, Summit employees or contracted staff who desire consultation with or treatment for any medical staff are required to follow normal practice of office appointment & scheduled procedures. Except in life threatening emergencies it is not acceptable for any member of the medical staff to treat a Summit employee at Summit or write prescriptions for the employee, immediate family or contracted staff at Summit.

ARTICLE V - REMEDIAL ACTION, SUMMARY AND AUTOMATIC SUSPENSION

5.1 Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff, detrimental to patient safety or disruptive to the operations of the Summit Surgical Center, corrective action against such practitioner may be requested by the Medical Director, or by the Administrator. All requests shall be made to the Medical Director, and shall be specific as to the grounds for corrective action. Reports of remedial action or suspension will be made to the Board of Medical examiners as required by law.

5.2 The Medical Director shall make an initial investigation of the complaint and forward a report to the Clinical Operations Committee who shall within thirty (30) days subsequent to the receipt of such, consider such a complaint and report. Prior to a report being sent to the Management Board by the Clinical Operations Committee, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the Clinical Operations Committee. At such interview, the practitioner (and only the practitioner) shall be invited to discuss, explain or refute charges made against him. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules pertaining to hearings, or the right to have representation shall apply thereto.

5.3 The Management Board shall, at its next regular meeting, review the recommendations of the Clinical Operations Committee and may either affirm, modify, ratify, amend or reverse said recommendations. Upon an adverse Management Board's determination, the affected staff member shall be entitled to the procedural and hearing rights as provided in these Bylaws.

5.4 Upon termination or expiration of staff membership at other facilities; adverse determination by a peer review organization concerning quality of care; commencement of formal investigation or filing of charges by any law enforcement agency or regulatory body of the United States or any state; the member or applicant will immediately notify the Administrator. The Administrator upon notification will notify the Management Board to determine actions to be taken at Summit Surgical Center.

5.5 All forms of discrimination and harassment are contrary to the high standards of conduct expected of all Medical Staff Members. . No Medical Staff Member shall unlawfully discriminate against any patient, visitor; employee, Medical Staff Member or others, based upon age, race, color, sex, creed, religion, national origin, disability, sexual orientation, marital status, or veteran status.

Allegations of discrimination or harassment of employees, patients, visitors, other Members of the Medical Staff or others, including sexual harassment, a particularly intolerable form of disruptive behavior, shall be investigated and if substantiated, the practitioner will be suspended from practice. The appropriate regulatory and law enforcement agencies will be notified as indicated.

5.6 Summary Suspension

5.6.1 Any one of the following - the Medical Director or the Administrator, shall each have

the authority, whenever action must be taken immediately in the best interest of patient care, to summarily and immediately suspend all or any portion of the clinical privileges of a practitioner.

5.6.2 A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Clinical Operations Committee review the matter within such reasonable time thereafter. The affected practitioner shall be afforded an interview in accordance with Section 5.2.

5.6.3 The Management Board shall, at its next regular meeting, review the recommendations of the Clinical Operations Committee and may either affirm, modify or reverse said recommendations. Upon an adverse Board determination, the affected staff member shall be entitled to the procedural and hearing rights as provided in these Bylaws.

5.7 Automatic Suspension

5.7.1 A Member or applicant whose license to practice in this state is either revoked or suspended, or whose active clinical privileges at any hospital have been revoked or suspended for clinical or ethical reasons, or whose CDS, DEA, or malpractice insurance has expired, or who is convicted of a felony, or imposition of terms of probation or limitation of practice by any licensing agency of any state or jurisdiction or is excluded from participation Medicare, Medicaid or CHAMPUS reimbursement programs shall notify the Administrator in writing on the next business day of same. This shall be completed whether the event(s) were enacted voluntarily or involuntarily. The member or applicant shall immediately and automatically, without hearing, review or appeal, be suspended from practicing at the Summit Surgical Center.

5.7.2 An automatic suspension shall, after warning of delinquency, be imposed for failure to complete medical records per Summit Surgical policy and no new cases will be scheduled for the practitioner. Such suspension shall be in effect until medical records are completed in accordance with Summit Surgical Center policy.

5.7.3 A practitioner under automatic suspension by operation of this section shall not be entitled to the procedural rights provided in these Bylaws.

5.8 Voluntary Relinquishment of Clinical Privileges or Medical Staff Appointment

5.8.1 A medical staff appointee may voluntarily relinquish any or all of his or her clinical privileges at any time, so long as that relinquishment is not found by the Clinical Operations Committee to be for the purpose of avoiding a suspension of Clinical staff privileges.

5.8.2. Any voluntary relinquishment of clinical privileges that extends beyond ninety

(90) days, will require the practitioner, should he/she wish clinical privileges in the future, to reapply for medical staff membership and clinical privileges through the initial appointment process.

ARTICLE VI - FAIR HEARING PLAN

6.1 General

6.1.1 When any practitioner receives special notice of an adverse decision by the Management Board, such practitioner shall be entitled to a hearing before an Ad Hoc Committee consisting of three members, one (1) of whom shall be a member of the Management Board, one (1) of whom shall be a member of the Clinical Operations Committee (as elected by the Clinical Operations Committee), and one (1) member at large of the Medical Staff as chosen by the first two members. The Administrator shall appoint the chairman of the committee but may appoint a hearing officer to conduct such hearing. Recognizing that all members on staff at the Summit Surgical Center are and do perform surgery, every effort shall be made to choose individuals who are not in direct economic competition with the physician being reviewed.

As an alternative to the above procedure, upon determination by the Management Board, the conduct of the fair hearing and the taking of evidence shall be conducted by a single arbiter chosen in accordance with the rules then prevailing pursuant to the American Arbitration Association whose record transcript shall then be forwarded to the Ad Hoc committee for their determination. The Ad Hoc committee shall thereafter, based solely on the record developed by the arbiter, make its decision in accordance with these bylaws.

6.1.2 The practitioner affected shall receive reasonable written notice of any adverse determination including a precise factual statement sufficient to inform the practitioner of the nature of the adverse decision along with a list of witnesses expected to testify on behalf of Summit. The practitioner so affected shall file a written request with the Medical Director for a hearing within (30) days of receiving the notice of adverse determination. If the practitioner desires to be represented by an attorney at the hearing, the request for the hearing must so state. A practitioner who fails to request a hearing within the time and manner so specified above waives any right to such hearing. Such waiver in connection with an adverse determination shall constitute acceptance of the Board's action, which shall thereupon become effective as a final decision.

6.2 Hearing Prerequisites

6.2.1 Upon timely receipt of a request for a hearing the Administrator shall schedule a time and place for the hearing. The personal presence of the practitioner is required. Any practitioner who fails, without good cause, to appear and proceed at the hearing waives his rights in the same manner and the same consequence as provided in Section 6.1.2.

6.3 Hearing Procedure

6.3.1 The Chairman of the Ad Hoc Committee shall be the presiding officer unless a hearing officer is appointed or the alternative hearing procedure is adopted pursuant to Section 6.1.1. The presiding officer, hearing officer or arbiter shall make certain that all participants have a reasonable opportunity to present witnesses, relevant oral and documentary evidence and shall make all rulings on matters of law, procedures, and the admissibility of evidence. Notwithstanding this, the presiding officer or hearing officer may limit the number of character witnesses, pre-approved exhibits and set reasonable time frames for the examination and cross examination of any witnesses.

6.3.2 The practitioner shall be entitled to be accompanied and represented at the hearing either by a member of the Medical Staff in good standing, by a member of a local professional society or may be represented by an attorney at the hearing, provided his request for the hearing indicated the intent to be so represented. If, and only if, the practitioner is represented by an attorney at the hearing may the Management Board be allowed equal representation.

6.3.3 The hearing shall not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence, and shall not necessarily be in accordance with rules of evidence and procedure of the American Arbitration Association. Any relevant matter, written or oral, to the proceeding may be considered, regardless of the admissibility of such evidence in a court of law or arbitration proceeding; this may include, but not be limited to, letters, affidavits, reports, etc., or any evidence deemed to have some probative value. During the hearing, subject to Section 6.3.1, each of the parties shall have the right to call and examine witnesses, introduce exhibits, cross-examine any witnesses; challenge the practitioner or any witness, or rebut any testimony or evidence offered. The parties shall also be allowed to submit a written statement at the end of the hearing.

6.3.4 The Ad Hoc Committee shall review all of the evidence on which the adverse decision was based. The affected practitioner shall have the burden of proving that the adverse decision lacks any factual basis or that the conclusions drawn there from are arbitrary, capricious or unreasonable.

6.3.5 The expense of the transcript shall be born equally between the Summit Surgical Center and the practitioner being reviewed.

6.4 Ad Hoc Committee Report

6.4.1 Within twenty (20) days after the hearing, the Committee shall make a written report of its findings and make a recommendation, and the Medical Director shall forward the same, together with the transcript of the hearing and any documentary evidence presented, to the Management Board.

6.4.2 The practitioner being reviewed has the right to receive copies of the record of the hearing and the written recommendation of the Ad Hoc Committee including a

statement of the basis of the body's decision.

6.5 Management Board's Action

6.5.1 The Management Board shall review the matter at its next regular meeting; the scope of said review shall be limited to the transcript, the written findings of the Ad Hoc Committee and any evidence introduced at the hearing. The Management Board shall affirm, reverse or modify the Ad Hoc Committee's recommendations by a majority of members present. The decision of the Management Board shall set forth findings of fact, conclusions and sanctions, if any.

6.6 Reporting Requirements

6.6.1 Summit Surgical Center shall conform to all notice and reporting requirements pursuant to Federal and State law now or herein after enacted, including but not limited to those imposed by the Health Care Quality Improvement Act of 1986 and the Professional Conduct Reform Act of 1989.

ARTICLE VII - MEDICAL DIRECTOR

7.1 The Medical Director is appointed by the Management Board. The Medical Director shall be responsible for the direction, provision and quality of medical services provided to patients.

7.2 Duties of the Medical Director include, but are not limited to:

7.2.1 Responsibility for the overall professional activities of the Medical Staff in collaboration with the Medical Staff and the Clinical Operations Committee.

7.2.2 Serving as an ex-officio member of all committees of the Medical Staff.

7.2.3 Responsibility for developing, implementing, and reviewing medical policies, including Medical Staff bylaws, in cooperation with the Medical Staff and the Clinical Operations Committee. These shall be approved by the Management Board.

7.2.4 Responsibility for the enforcement of the Medical Staff Bylaws, and policies.

7.2.5 Receiving and communicating the policies of the Management Board to the Medical Staff and reporting to the Management Board through the Administrator on the performance and maintenance of quality with respect to the Medical Staff's responsibility to provide medical care.

7.2.6. Appointing all standing and special Medical Staff Committees not otherwise provided for in these Bylaws.

7.2.7 Other duties and responsibilities as assigned from time to time by the Administrator and Management Board.

7.2.8 Acts as Chairperson of the COC.

ARTICLE VIII - COMMITTEES

8.1 There shall be a Clinical Operations Committee, a Credentials Committee and other committees as approved by the Management Board.

8.2 Quorum

8.2.1 A quorum for all committees shall consist of the presence of at least fifty (50) percent of voting members. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than quorum exists at a later time in the meeting.

8.3 Clinical Operations Committee

8.3.1 Voting Membership for appointments/reappointments. Appointment and Reappointment of credentialed staff will be voted on by Physician staff members of the Credentialing Committee, which is a sub-committee of the Clinical Operations Committee. Non-physician members of the Credentials Committee may share pertinent feedback as appropriate regarding appointment/reappointment for the voting physicians' consideration.

8.3.2 Voting membership for matters not involving appointment/reappointment extends to all members of the COC.

8.3.3 Duties and responsibilities

8.3.3.1 The Management Board delegates to the Clinical Operations Committee with the authority to oversee; direct and control the following matters, in addition to other matters which may be delegated to it form time to time.

(a) Medical staff matters, including credentialing and peer review, subject to appellate review by the Management Board;

(b) development of quality assurance and utilization management policies for Management Board approval and implementation;

(c) development of budget recommendations to the Management Board;

(d) determining supply needs and selection of supplies within Management Board approved budgets;

(e) surgery scheduling policies and guidelines, including assignment of surgical blocks; and

(f) oversight; review, training and education of clinical support staff and employees.

8.3.3.2 Receive and act upon reports as provided in these Bylaws and relevant Summit policies and procedures and to make recommendations concerning them to the Credentials Committee, the Medical Director, the Administrator and the Management Board, as appropriate.

8.3.3.3 Coordinate the activities of the polices adopted by the Management Board, the Medical Staff and various other committees.

8.3.3.4 Account to the Management Board for the overall quality and efficiency of Care rendered to patients at Summit Surgical Center. This function shall, in all respects be in accordance with the standards promulgated by the New Jersey Department of Health and the Accreditation Association for Ambulatory Health Care and CMS

8.3.3.5 Provide liaison between the Medical Staff and The Management Board.

8.3.3.6 Enforce Summit and Medical Staff rules in the best interest of patient care with regard to all persons who hold appointment to the Medical Staff.

8.3.3.7 Refer questions involving the clinical competence, patient care and treatment, or inappropriate behavior of any Medical Staff appointee to the Medical Director for appropriate action.

8.3.3.8 Conduct a review of the Bylaws, Rules and Regulations annually and as Needed, and recommend revisions in accordance with Article XIII.

8.4 Credentials Committee

8.4.1 Membership

8.4.1.1 Medical Director, Chairperson.

8.4.1.2 Physician members of the COC

Only two members of the Credentialing Committee, in addition to the Medical Director, are required to review and evaluate the qualifications of a practitioner.

The Credentials Committee is a sub-committee of the COC and is represented by the physician members of the COC as well as the Medical Director.

8.4.2 Duties

8.4.2.1 Review and evaluate the qualifications of each practitioner based on measurable indicators to include, but not limited to: infection rate, complications, admissions to the hospital, noted incidents reported and patient complaints.

8.5 Patient Care Committee *

8.5.1 Composition: The Patient Care Committee (PCC) may be composed of one or more representatives from Center departments, such as: Administration, Business Office, Pre-op and Admitting, OR nursing staff, scrub technician, Recovery Room nursing staff, Medical Director, etc. Members (other than *ex-officio* members) will serve for one year and may be re-appointed.

8.5.2 Meetings: The PCC will generally meet regularly and subject to call of such special meetings as may be necessary to review particular problems or issues that may arise during the period between scheduled meetings.

8.5.3 Responsibilities: The purpose of the PCC is to monitor important aspects of care and to encourage communication about Center operations, which will provide maximum opportunities to implement continuous quality improvement and to aid in quality assurance and risk management. The committee will review at least the following at each meeting:

1. All incident/occurrence reports related to patient, visitor, employee and medical staff member safety.

2. All patient evaluation cards and surveys.

3. All direct Center admissions and transfers.

4. All complication data generated by chart review.

5. Medical chart audit studies (at least one per quarter).

8.5.4 Minutes: A permanent record will be kept of each meeting and these minutes will be submitted to the Clinical Operations Committee.

ARTICLE IX - MEETINGS

9.1 Special Meetings

9.1.1 Special meetings of the Medical Staff may be called on at least ten (10) days written notice and shall be called when requested by either the Medical Director, or the Administrator. No business shall be transacted at any special meeting except that which has been stated in the notice.

9.2 Conduct of Meetings

9.2.1 All meetings shall be conducted in accordance with these Bylaws and, in matters not covered herein, the Sturgis Standard Code of Parliamentary Procedures.

ARTICLE X - IMMUNITY FROM LIABILITY

10.1 The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at the Summit Surgical Center.

10.1.1 Any act, communication, report, recommendations, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility or governmental or quasi-governmental agency, for the purpose of achieving or maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent of the law. In addition, there shall, to the fullest extent permitted by law, be absolute immunity from civil liability. Such privilege and immunity shall extend to members of the Summit Surgical Center's Medical Staff and its Governing Body and representatives.

10.2 Peer Review Protection

10.2.1 All minutes, reports, recommendations, communications, and actions made or taken pursuant to these Bylaws are intended to be covered by the provisions of N.J. Stat. Ann. 2A:84A-22.8; 22.9 and 22.10 or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to these Bylaws shall be considered to be acting on behalf of Summit Surgical Center and its Management Board when engaged in such professional review activities and thus are "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

ARTICLE XI – POLICY AND PROCEDURES

11.1 Policy and Procedures which are approved by the Clinical Operations Committee shall set standards of practice that are to be required of each Member, and shall act as an aid to evaluating performance under, and compliance with, these standards. All Members shall cooperate with such rules, regulations and policies, and adhere to all laws, and such approved rules, regulations and policies applicable to their activities at Summit Surgical Center, the practice of their profession, and their participation in any federal health program as a condition of their continued appointment to the Medical Staff. In the event that any Member knows that s/he or any director, officer, employee or other Member has violated applicable laws or regulations, s/he immediately shall report the same to the Administrator. In the event that any Member suspects that s/he or any director, officer, employee or other Member has materially violated an applicable law or regulation, s/he should report same to the Administrator.

ARTICLE XII - ADOPTION AND AMENDMENT OF BYLAWS

12.1 These Bylaws shall become operative upon approval by the Summit Surgical Center, LLC Management Board.

12.2 The Medical Staff Bylaws may then be modified or amended as follows:

12.2.1 Any member of the Medical Staff may recommend modification or amendment by directing such recommendations to the Medical Director.

12.2.2 Upon receipt, the Medical Director shall present the recommended modification or amendment to the Clinical Operations Committee at its next regularly scheduled meeting.

12.2.3 Within one hundred twenty (120) days of its receipt, the recommendation or revision will be mailed to all members of the Medical Staff for vote.

12.2.4 Upon the affirmative vote of the majority of those members who responded within thirty (30) days, the proposed revision will be recommended to the Management Board for its approval at its next regularly scheduled meeting.

12.2.5 In the event that the Medical Staff shall fail to exercise its responsibility, the non response will be considered approval or if fewer than 50% of the Medical Staff members respond. The Management Board may resort to its own initiative in formulating, amending, or modifying these Medical Staff Bylaws.

ARTICLE XIII – CORPORATE COMPLIANCE

13.1 All medical staff appointees shall cooperate fully with the Corporate Compliance Policy of Virtua Health and adhere to all laws, regulations and standards of conduct applicable to their activities at Summit Surgical Center the practice of their profession, and their participation in any federal health program as a condition of their continued appointment to the medical staff. In the event that any medical staff appointee knows or suspects that he or she or any director, officer, employee or other medical staff appointee has violated applicable laws or regulations, he or she shall immediately report the same to the Medical Director or the Virtua Health Corporate Compliance Officer.