Stony Brook University Hospital
Medical Staff Bylaws

July 2006

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ARTICLE I

Mission and Purpose

A. MISSION STATEMENT

The Stony Brook University Hospital, an academic and regional medical center, has a mission to provide excellence in patient care, education, community service and research. Our mission is achieved through commitment to the core values of Integrity, Honesty, Excellence, Accountability, and Respect.

B. RESPONSIBILITIES

The medical staff of Stony Brook University Hospital is responsible for the quality of medical care in the hospital, and must accept and discharge this responsibility, subject to the ultimate authority of the hospital governing body. The cooperative efforts of the medical staff, the Chief Executive Officer, the dean, School of Medicine (revised 3/06) and the governing body are necessary to fulfill the hospital's obligations to its patients and to the Health Sciences Center. The medical staff recognizes that these goals can best be achieved by providing a means of self-regulation and a channel for communication with the Chief Executive Officer, the Dean, School of Medicine (revised 3/06) and with the governing body.

C. NEED FOR MEDICAL STAFF ORGANIZATION

In order to insure adequate and proper care of patients and to fulfill the teaching and p research obligations stipulated by the Board of Trustees, the physicians and dentists working in Stony Brook University Hospital, acting by the authority delegated to them by the Dean, School of Medicine (revised 3/06) and subject to the approval of the President of the State University of New York at Stony Brook, and ultimately of the Chancellor and Board of Trustees of the State University of New York, hereby organize themselves into an organization called the Medical Staff of Stony Brook University Hospital, and adopt these Bylaws.

D. STANDARDS

Standards for patient care, education, community service and research at Stony Brook University Hospital shall be no less than those established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Council for Graduate Medical Education (ACGME), the Department of Health of the State of New York (DOH), and the Office of Mental Hygiene of the State of New York (OMH), and other relevant and appropriate Rules and Regulations.

ARTICLE II

Medical Staff Membership

SECTION 1. ELIGIBILITY

Membership on the medical staff of Stony Brook University Hospital is a privilege which shall be extended only to professionally competent physicians and dentists, who continuously meet the qualifications, standards and requirements set forth in these bylaws.

A. QUALIFICATIONS.

1. Licensure.

Only physicians and dentists who possess a full, unrestricted license to practice in the State of New York may be members of the medical staff.

2. Malpractice Insurance.

Practitioners of the medical/dental staff are required to carry sufficient malpractice insurance, the level to be determined by the Medical Board from time to time.

A lapse in coverage for any reason must be reported in writing to the medical staff services department. A current "certificate of insurance" must be on file at all times in the doctor's credentials file. Members shall be given the opportunity to participate in a Malpractice Prevention Program.

3. Continuing Education.

All members of the medical/dental staff, except Honorary, must provide evidence of obtaining 50 hours of continuing medical/dental educational credits (at least 30 Category 1 in the two years prior to their reappointment. At least some of the CME will be related to the privileges requested.

4. Infection Control.

All members of the medical/dental staff must possess a current and valid certificate of infection control training as authorized by the State of New York.

5. Faculty Appointment.

Every applicant seeking appointment to the medical staff of Stony Brook University Hospital shall hold a faculty appointment in the School of Medicine or Dental Medicine. A faculty appointment does not confer or imply membership on the medical staff of the hospital.

6. Annual Health Assessment.

An annual health assessment is required for all members of the medical/dental staff, except Honorary. All elements of the NYS Health Code 405.3(b) [10] must be met.

B. DISCRIMINATIONPROHIBITED.

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

C. ETHICAL BEHAVIOR STANDARDS.

All members of the medical staff shall conduct their professional activities in accordance with the ethical code of their organized professional associations, in accordance with the education law covering professional practice, and in accordance with the Rules and Regulations of the Board of Trustees.

D. AGREEMENT TO LIVE BY THE BYLAWS.

Acceptance of membership on the medical staff shall constitute the staff member's agreement to abide by and be governed by these bylaws, rules and regulations, and all relevant hospital policies, as they now exist or as they may be amended after due process.

E. ANNUAL DUES.

1. All members of the medical staff shall be assessed annual dues.
2. They are payable as billed each medical staff year (July 1 to June 30).
3. Payment will be a condition of appointment and reappointment.
4. The amount of the dues will be reviewed on an annual basis by the medical board.
5. Dues of members joining the medical staff during the designated staff year shall be prorated for the appropriate fraction of that staff year.
6. Non-payment of dues. Unless extenuating circumstances are presented to, and accepted by the medical board, non-payment of dues [90 days after the billing date] shall be grounds for suspension or termination of medical staff membership.

SECTION 2. CONDITION AND DURATION OF APPOINTMENT

A. GOVERNING BODY ROLE.

The governing body shall make appointments, reappointments, or revocation of appointments and the granting of clinical privileges to the medical staff. The governing body shall act only after there has been a recommendation from the medical board as provided in these Bylaws.

B. DURATION.

1. Initial appointments to any category of the medical staff shall be provisional for a period of one (1) calendar year.
2. Members on provisional status are accorded all rights of the category to which they have been assigned.
3. New appointees to the medical staff are subject to regular review, and the review mechanism will be described in the initial appointment letter.
4. After the initial first year of provisional appointment, the chief of service of the appropriate clinical service, in conjunction with the faculty review process, will also review information concerning the practitioner's professional performance, judgment and clinical and technical skills over the past year. If the practitioner has met the expected standards of

patient care, clinical education and obligations of the department and the hospital, the provisional appointment will be converted to a regular appointment of the medical staff.

5. Reappointments, thereafter, shall be for a period of not more than two years.

SECTION 3. APPOINTMENT

A. APPLICATION REQUIREMENTS.

1. Responsibilities of Applicant.

The applicant shall have the burden of producing adequate information on a signed application form for a proper evaluation of education, training, experience and clinical competency. They must also provide other qualifications and be able to resolve any doubts about such qualifications [*i.e*., challenges to licensure] including the reporting of impending, past or present liability actions. The applicant must signify a willingness to appear for interviews. They shall also be obligated to provide continuous care and supervision of their patients.

2. Verification of Information.

The Medical Staff Services Dept. will conduct primary source verification to assure evidence of current licensure, relevant training or experience, current competence and the ability to perform the privileges requested. At a minimum, the following items will be verified: licensure, challenges to licensure, education, relevant post graduate education training (residency, fellowship), board status, malpractice, affiliations at health care institutions [i.e. regarding the voluntary or involuntary relinquishment of medical staff membership or limitation, reduction, suspension of or loss of clinical privileges] Clinical competence, as well as the ability to perform the privileges requested, will be determined by professional reference [e.g. chief of service, chief of staff at another hospital at which the applicant holds privileges or by a peer]. They will also query the National Practitioner Data Bank (NPDB) pursuant to the Health Care Quality Improvement Act of 1986 and the Medicare/Medicaid Cumulative Sanctions Report published by the Office of Inspector General [OIG]. To ensure the practitioner requesting privileges is the same practitioner identified in the credentialing documents, each practitioner will be required to submit original photo identification in person. {JCAHO 4.10 EP 3} (6/05)

Once information is completely verified, the appointment process will be completed in 90 days.

3. Release of Information Consent.

Each applicant shall authorize the Hospital and its duly authorized representatives, including any independent contractors engaged for such purpose, to make inquiry of any person who, or organization that, may have information which, in the Hospital's reasonable judgment, is necessary, relevant and material to evaluate the applicant's application for medical staff membership/privileges. Such inquiry may include information regarding (a) the applicant's (i) background; (ii) qualifications; (iii) credentials; (iv) clinical competence and performance, and (vi) professional behavior; (b) any pending or prior actions or proceedings regarding the applicant's practice of his/her profession, or (c) any matter reasonably related to any of the foregoing. Each applicant shall execute and deliver, an Authorization and Release whereby the applicant (a) authorizes the Hospital to make the foregoing inquiries and (b) releases from any claims or liability any person who, or organization that, provides any information in good faith in connection with any such inquiry (9/03).

4. Release from Liability.

The applicant releases from liability all representatives of the hospital and of its medical staff for their acts performed (in good faith and without malice) in connection with evaluating the applicant. This may include a review of otherwise privileged or confidential information.

5. Obligation to Bylaws.

The application form shall include a statement that the applicant has received and read the Bylaws, Rules and Regulations of the medical staff, and that they will be bound by the terms thereof if granted membership and/or clinical privileges.

B. LEVELS OF REVIEW.

1. Credentials Committee.

The chief of service shall convene a credentials committee consisting of at least three (3) members of the medical staff within the service. The credentials committee shall consider the completed application and supporting materials, make such investigations as it deems proper and necessary, and shall make a report of its investigations and determinations, including specific recommendations for delineating the applicant's clinical privileges to the chief of service.

2. Chief of Service.

Only a completed and verified application for membership on the medical staff shall be submitted to the appropriate chief of service who shall collect the references and other materials that are deemed pertinent to the review. After review and recommendation by the chief of service, the application shall be forwarded to the MEC.

The Medical Director or designee shall recommend and sign the completed appointment application of the clinical chiefs of service if the appointment criteria are consistent with the Bylaws, Rules and Regulations of the Medical Staff. (6/05)

3. MEC.

The completed application package will be submitted to the MEC. The MEC will review the appointment and submit their recommendations to the medical board.

4. Medical Board.

The medical board will review the appointments and submit their recommendations to the governing body for final approval.

5. Governing Body.

Recommendations from these review bodies will be forwarded to the governing body for final approval. Whatever recommendation is made at any level of review, the ultimate approval will be granted by the governing body.

C. TIME FRAME.

The above process shall be completed, where practicable, within 60 (Revised 3/06) days after receipt of the chief of service's recommendation.

D. RESULTS OF RECOMMENDATIONS.

1. Recommend Appointment.

If the recommendation at every level of review is for appointment, the application shall be forwarded promptly to the governing body for final action. The applicant shall then be notified by letter from the Chief Executive Officer within 60 days, (Revised 3/06) indicating the rank of membership and clinical privileges granted.

2. Defer Appointment.

If the recommendation at any level of review is to defer the application for further consideration, action on the application must be taken up with the medical board's credentials committee and returned to the committee or person that sought advice before any action is taken.

3. Deny Appointment.

a) Reasons.

If the recommendation of the medical board is for non-appointment, either with respect to membership or clinical privileges, such recommendation shall state the reasons. They shall be related to standards of patient care, objectives of the institution, or the character, competency, and/or qualifications of the applicant.

b) Process.

The Chief Executive Officer shall promptly notify the applicant by certified mail, return receipt requested.

c) Rights of Practitioner.

No such adverse recommendations coming from any level of review shall be for warded to the governing body for action until after the applicant has exercised or has been deemed to have waived their rights to a Professional Review Procedure, as provided in Article III of these Bylaws.

d) Status of Faculty Appointment.

Any recommendation not to appoint to the medical staff which is based upon the applicant's failure to obtain a faculty appointment in the School of Medicine or Dental Medicine shall not be subject to the hearing and appellate review procedures.

E. FINAL ACTION.

In all instances, the final action of the governing body shall be communicated to the applicant in writing.

SECTION 4. REAPPOINTMENT

A. REAPPOINTMENT REQUIREMENTS.

1. Responsibilities of Practitioners.

The practitioner shall submit a completed and signed reappointment application, and in doing so, agrees to provide updated information on hospital appointment(s), voluntary or involuntary relinquishment of medical staff membership, or licensure status, voluntary or involuntary limitation, reduction, suspension or loss of clinical privileges at another hospital, involvement in liability claims, voluntary or involuntary cancellation of professional liability insurance or license/Drug Enforcement Administration/Medicare/Medicaid sanctions, including both current and pending investigations and challenges, and any removal from a managed care organization panel for quality of care reasons or unprofessional conduct. The practitioner will pledge to provide for the continuous care of his or her patients.

2. Verification of Information.

The Medical Staff Services Dept. will conduct primary source verification to assure evidence of current licensure, relevant training or experience, current competence and the ability to perform the privileges requested. At a minimum, the following items will be verified: licensure, challenges to licensure, education, relevant post graduate education training (residency, fellowship), board status, malpractice, affiliations at health care institutions [i.e. regarding the voluntary or involuntary relinquishment of medical staff membership or limitation, reduction, suspension of or loss of clinical privileges.

Once information is completely verified, the reappointment process will be completed in 90 days.

3. Responsibilities of Medical Staff Leadership.

Current competence will be determined by the results of performance improvement activities, and recommendations from the credentials committee and division/department. This recommendation will be based on the ongoing monitoring of the practitioner's professional performance, judgment and clinical/technical skills. The ability to perform the privileges requested (health status) will be confirmed by professional reference(s) and the chief of service in the reappraisal form. In addition, the practitioner must have a current (within one year) physical examination at the time of reappointment.

B. LEVELS OF REVIEW.

1. Credentials Committee.

The chief of service shall convene a credentials committee consisting of at least three (3) members of the medical staff within the service. The credentials committee shall consider and review the reappointment application and supporting materials, including meeting attendance, documented evidence of continuing education, results of quality assurance activities, and make such investigations as it deems proper and necessary. The credentials committee shall recommend to the chief of service, reappointment unless two-thirds (2/3) of its members vote to defer or deny. The credentials committee report shall not be binding but must be forwarded along with the chief's recommendation to the MEC and medical board.

2. Chief of Service.

Only a completed and verified reappointment application shall be submitted to the appropriate chief of service. After review and recommendation by the chief of service the reappointment application shall be forwarded to the MEC. A chief who is considering not reappointing a member of their clinical service shall inform that person of his/her intention in writing or in a personal interview.

The Medical Director or designee shall recommend and sign the completed reappointment application of the clinical chiefs of service if the reappointment criteria are consistent with the Bylaws, Rules and Regulations of the Medical Staff (6/05).

3. MEC.

The completed reappointment application will be submitted to the MEC. The MEC will review the reappointment and submit their recommendation to the medical board.

4. Medical Board.

The medical board will review the reappointments and submit their recommendations to the governing body.

5. Governing Body.

Recommendations from these review bodies will be forwarded to the governing body for final action. Whatever recommendation is made at any level of review, the ultimate approval will be granted by the governing body.

C. TIME FRAME.

1. Schedule.

A fraction of the medical staff will be reviewed alphabetically on a quarterly basis. A schedule will be posted in the medical staff services department.

2. Frequency.

This review process occurs every two years.

3. Voluntary Resignation.

Failure to return the necessary reappointment paperwork by the date designated in the reappointment letter will be considered a voluntary resignation.

D. RESULTS OF RECOMMENDATIONS.

1. Recommend Reappointment.

If the recommendation at every level of review is for reappointment, the reappointment application shall be forwarded promptly to the governing body for final action. The practitioner shall then be notified by letter from the Chief Executive Officer indicating category of membership and privileges granted.

2. Defer Reappointment.

If the recommendation at any level of review is to defer the application for further consideration, action on the application must be taken up with the medical board's credentials committee and returned to the committee or person that sought advice before any action is taken.

3. Deny Reappointment.

a) Reasons.

If the recommendation of the medical board is for non-reappointment, either in respect to membership or clinical privileges, such recommendation shall state the reasons. They shall be related to standards of patient care, objectives of the institution, or the character, competency, and/or qualifications of the staff member.

b) Process. -

The Chief Executive Officer shall promptly notify the staff member by certified mail, return receipt requested.

c) Rights of Practitioner.

No adverse recommendation, at any level of review, shall be forwarded to the governing body until after the applicant has exercised or has been deemed to have waived their rights to a Professional Review Procedure, as provided in Article III of these Bylaws.

d) Status of Faculty Appointment.

Any recommendation not to reappoint based upon termination or voluntary relinquishment the applicant's appointment to the faculty of the School of Medicine/Dental Medicine shall not be subject to the hearing and appellate review procedures of Article III.

E. FINAL ACTION.

In all instances, the final action of the governing body shall be communicated to the staff member in writing.

SECTION 5. PRIVILEGES

A. CLINICAL PRIVILEGES.

1. Criteria and Process.

All members of the medical staff shall be eligible for clinical privileges as demonstrated by their individual education, training, experience and competence, and as recommended by the credentials committee, the chief of service, the MEC, the medical board, and approved by the governing body. These privileges must be consistent with the objectives and programmatic needs of the medical center.

2. Specific.

No member of the medical staff shall be permitted to perform any diagnostic or therapeutic procedure which does not fall clearly under the commonly accepted and established guidelines of their specialty and has not been specified in the delineation of privileges, except in an emergency.

3. Applicant's Responsibility.

Each applicant shall have the burden of establishing their qualifications and competency for the clinical privileges desired or requested.

4. Renewal of Privileges.

Clinical privileges will be renewed every two years at the time of the medical staff reappointment. Renewal every two years will follow the same process as renewal at appointment. Increase of privileges will require a review by the respective department chief and credentials committee**.** Renewal of clinical privileges, and the increase or curtailment of those privileges, shall be based upon direct observation of care provided and the review of patient records. Other reviews should include any records, which can document the member's participation in the delivery of medical care and consistency with the objectives and programmatic needs of the medical center. {MS4.20 EP 4) (6/05)

B. ADMINISTRATIVE PRIVILEGES.

1. Justification.

There shall be two categories of administrative appointments described as:

a) ***Administrative privileges pending MEC, Medical Board and governing body approval*** - for those applicants whose appointment packages are complete and have been recommended for appointment by the departmental credentials committee and the chief of service.

b) ***Administrative privileges for special needs*** - such appointment may be granted to meet educational needs (such as visiting professor), extraordinary clinical needs or continuity of patient care (limited to current inpatients and subsequent planned admissions within 6 weeks for current inpatients) subject to the recommendation and approval of the Chief of Service.

2. Time Limitations.

a) *Administrative privileges pending MEC, Medical Board and governing body approval* shall be for a period of 90 days.

b) *Administrative privileges for special needs* shall be limited to 90 days for educational needs or extraordinary clinical needs or until the time of discharge for continuity of patient care.

c) The medical director shall be responsible for interpreting the provisions of this section.

3. Process.

Acting upon the recommendation of the chief of service, the President of the medical board (or his designee) may confer administrative privileges through the Chief Executive Officer (or his

designee) of the hospital. Any patient care procedure or admission must be delineated in scope and time and be carried out under the direction of the chief of service.

4. Verification.

Primary source verification of licensure, current competence, Office of Professional Conduct (OPMC), Office of Inspector General (OIG) and National Practitioner Data Bank query must be completed and a response received before administrative privileges are granted.

5. Rules.

Any individual acting under administrative privileges must abide by the Bylaws, Rules and Regulations of the medical staff, the requirements of the New York State Education Law covering professional practice, and the Rules and Regulations of the Board of Trustees of the State University of New York.

6. Fair Hearing/Appeal Process.

A process exists for individuals who have been awarded administrative privileges for a limited period of time to have a fair hearing and appeal process to address adverse decisions, even though they are not members of the medical staff. (Refer to Article III-Professional Review Procedure).

C. EMERGENCY PRIVILEGES.

1. Definition.

An "emergency" is defined as a condition, in which serious permanent harm would result to a patient, or in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that danger.

2. Expectation.

In case of an emergency, any physician or dental member of the medical staff, house staff or licensed health practitioner, limited only by the qualifications of their license and regardless of service or staff status, shall be permitted to render emergency care. They will be expected to do everything possible to save the life of a patient, utilizing all resources of the hospital as necessary, including the calling of any consultations necessary or desirable.

D. DISASTER PRIVILEGES IN THE EVENT OF AN OFFICIALLY DECLARED EMERGENCY/DISASTER.

1. Definition.

“Disaster privileges" may be granted when the emergency management plan has been activated and the hospital is unable to meet the immediate patient needs and there is a need for additional licensed health practitioners at Stony Brook University Hospital. (7/06)

2. Expectation

The Medical Director, CEO or appropriate Chief of Service or their designee will review and grant temporary disaster privileges. The individual granting privileges is not required to grant privileges

to any individual and is expected to make such decisions promptly, to the extent practicable, on a case-by-case basis at his or her discretion. (7/06)

All physicians requesting temporary disaster privileges are to be referred to the Medical Staff Services Office. If the Medical Staff Office is not open, the physician shall be referred to the Medical Director. (7/06)

Volunteers considered eligible to act as licensed independent practitioners must at a minimum present a valid government issued photo identification issued by a state or federal agency (i.e., driver's license or passport) and at least ONE of the following before disaster privileges may be granted. (7/06)

Any **one** of the following five items must be presented before disaster privileges may be granted (7/06)

- Current license to practice medicine.
- A current picture hospital ID card that identifies professional designation
- Primary source verification of the license
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organizations or group.
- Identification indicating that the individual has been granted authority to render patient care, treatment, services in disaster circumstances (such authority having been granted by a federal, state or municipal entity)
- Identification by current hospital or medical staff member who possesses personal knowledge regarding volunteer's ability to act as a licensed practitioner during a disaster. (7/06)

The name of the practitioner's primary hospital affiliation shall also be ascertained.

Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary circumstance that primary source verification cannot be completed within 72 hours (e.g., no means of communication or a lack of resources) verification will be done as soon as possible. In this extraordinary circumstance, the following will be documented: why primary source verification could not be performed in the required timeframe; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. In the even that the volunteer practitioner does not provide care, treatment or services under the disaster privileges, primary source verification of license is not required. As soon as possible, the Medical Staff Office will also query the National Practitioner Data Bank, State licensing agency *OPMC, OIG,* and hospital where current privileges are held by the volunteer. Records of these queries will be retained. (7/06)

The hospital will make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours, related to the continuation of the disaster privileges initially granted. (7/06)

Any information gathered that is not consistent with that provided by the physician must be referred to the Medical Director immediately who will determine any additional necessary action including but not limited to revocation of emergency temporary privileges.

Once temporary disaster privileges are granted, a record of the practitioner's actions shall be maintained. The record shall indicate that the practitioner exercising the "disaster privileges" does so at the request of an attending physician currently on Stony Brook University Hospital medical

staff. Practitioners granted temporary disaster privileges must practice under the direction of an attending physician currently on the medical staff at Stony Brook University Hospital.

The practitioner who is granted disaster privileges will be issued an Identification badge identifying them as having temporary disaster privileges.

The conclusion of the emergency will be determined by hospital CEO, Medical Director or designee who determines the emergency has concluded and therefore the need for licensed health practitioners granted emergency/disaster temporary privileges has simultaneously concluded.

E. VISITING FACULTY PRIVILEGES.

1. Definition.

There are occasions when physicians from other institutions may visit Stony Brook University Hospital. Such visiting faculty may be asked to participate in the academic programs of the institution, and may be asked to engage in clinical teaching, consultation or the review of academic and patient care programs. On those occasions when an individual holding such appointment supervises and/or engages in patient care activities in that capacity, no charges or billing for such professional services may be rendered.

2. Academic Appointment.

The sponsoring academic unit should provide an academic appointment as a visiting faculty member at the appropriate rank for a period of time limited to the individual's involvement at Stony Brook.

3. Hospital Privileges.

Arrangements for hospital privileges for the duration of the academic appointment should be made through the existing privilege process.

SECTION 6. DISCIPLINARY PROCEDURES

A. CORRECTIVE ACTION.

1. Any person may provide information to the medical board, medical director, chief of service or the Chief Executive Officer about the conduct, performance, or competence of a staff member. All such complaints shall be forwarded to the medical director for review unless the medical director himself is the subject of the complaint in which case the information shall be forwarded to the Chair of the MEC for disposition in any manner provided for in this section.

2. When reliable information indicates that a staff member may have exhibited acts, demeanor or conduct reasonably likely to be:

a) detrimental to a patient's or anyone's safety or to the delivery of patient care within the hospital or disruptive to the operations of the hospital in a manner affecting patient care;

b) contrary to the Medical Staff Bylaws or Rules and/or Regulations or policies and procedures of the hospital; or below applicable professional standards, a request for an investigation or action against such practitioner may be initiated by the chief of service, the Chief Executive Officer, the president of the medical board, or the medical director or his designee.* [*References to the

medical director, chief of service, Chief Executive Officer and president of the medical board throughout this section may be interpreted to include their designees.]

3. The medical director shall have the discretion to attempt to resolve issues arising under this section with the practitioner or other involved individuals or to refer them to the appropriate Quality Assurance liaison or other entity if appropriate, if, in his/her judgment, the complaint does not meet the criteria in Section 6, A.2. of this Article, or is not as serious as deemed to be by the complainant. In such instances where a request for corrective action has been initiated, a report shall be submitted in writing by the medical director to the MEC for approval.

4. If, however, the medical director concludes that an investigation is warranted, he/she shall recommend that an investigation be undertaken, with notice to the chief executive officer, the chief of service and the affected practitioner. The notice shall include a summary of the conduct being considered.

5. A recommendation for an investigation must be submitted to the MEC. The MEC shall assign the task to an ad-hoc committee of the MEC composed of five (5) members of the active attending staff who can serve in such a capacity without a conflict of interest. [In the event of a conflict of interest, the committee member shall be excused and the president of the medical board shall appoint a member of the medical staff to serve on the committee.] The committee shall proceed with its investigation in a prompt manner but in no event, more than ten (10) days following receipt of this recommendation. The practitioner shall be given an opportunity to provide information to the investigating committee in a manner and upon such terms, as the committee deems appropriate. The committee may, but is not obligated to, conduct interviews with persons involved. All members of the medical staff must cooperate with the investigation unless excused by the investigating committee.

6. The committee shall forward a written report of the investigation to the medical director and MEC as soon as practicable but no later than thirty (30) days following the assignment of the investigation to the standing committee of the medical board, unless an extension is granted by the MEC. The report may include a statement of facts, brief description of the investigation, recommendations for appropriate corrective action and a statement of the agreement or dissent of the affected practitioner. This investigation shall not constitute a "hearing" as that term is used in Article III nor shall the procedural rules with respect to hearings apply.

7. Despite the status of any investigation, the MEC shall at all times retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process or other action.

B. MEC ACTION.

As soon as practicable after the conclusion of the investigation, the MEC, based upon the recommendation of the standing committee shall, with notice to the Chief Executive Officer and chief of service, take action which may include, without limitation:

a. determining no corrective action be taken.
b. deferring action for a reasonable time where circumstances warrant.
c. issuing letters of admonition, warning, reprimand or censure. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file in the medical staff services department.
d. directing the medical staff member to undergo a medical and/or psychiatric examination by a physician chosen by the MEC.
e. levy fines.

f. recommending the imposition of terms of probation or limitation upon continued medical staff membership or the exercise of clinical privileges including, without limitation, requirements for co-admission, mandatory consultation or monitoring.
g. recommending reduction, modification, suspension or revocation of clinical privileges.
h. recommending reduction or limitation of any prerogatives directly related to membership on the medical staff.
i. recommending suspension, modification, probation or revocation of medical staff membership.

C. SUBSEQUENT ACTION.

1. If a corrective action as set forth in (f) through (i) of the above section, is recommended by the MEC, that recommendation shall be transmitted in writing to the practitioner with copies to the chief of service, Chief Executive Officer and medical director, and, in these cases only, the practitioner shall then be entitled to his or her rights as set forth in Article III.
2. If the staff member does not exercise his or her rights under Article III, the MEC shall forward its recommendation to the medical board, which, in turn, shall forward its recommendation to the governing body within thirty (30) days.
3. The decision of the governing body shall be deemed final action.
4. Notwithstanding the foregoing, the MEC may, in the alternative, and with notice to the Chief Executive Officer, enter into a remedial agreement with the affected practitioner to resolve the problem. If the affected practitioner fails to abide by the terms of the remedial agreement, the practitioner will be subject to the standard corrective action procedures of this article.

D. SUMMARY RESTRICTION OR SUSPENSION.

1. Whenever a staff member's conduct appears to require that immediate action be taken to protect the life or well-being of a patient or wherever the staff member's conduct presents a danger of immediate and serious harm to the life, health, safety of any patient, prospective patient or other person, the medical director, MEC, Chief Executive Officer or their designee(s), may summarily restrict or suspend the medical staff membership or clinical privileges of such staff members. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the MEC, the applicable chief of service, office of University Counsel and the Chief Executive Officer; verbal notice shall be given as soon as possible to units and personnel who have a need to know of this decision.
2. The summary restriction or suspension shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the staff member's patients shall be promptly assigned to another practitioner by the chief of service or by the MEC considering, where feasible, the wishes of the patient in the choice of a substitute staff member.
3. As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action. When necessary, the MEC shall direct the committee to further investigate the issues and hold such interviews as may be appropriate with respect to the affected staff member, followed by a report with recommendations to the MEC. The MEC shall complete its review and make its decision within ten (10) days after the restriction or suspension. The suspended staff member may attend and make a statement concerning the issues under investigation on such terms and conditions as the MEC or the investigating committee may impose. In no event shall any meeting of the practice panel with or without the member, constitute a "hearing" within the meaning of Article III. The MEC may modify, continue or terminate the summary restriction or suspension, but in any event, it shall

promptly furnish the staff member, the Chief Executive Officer and the medical director with notice of its decision.

4. Unless the medical director or *MEC* terminates the summary restriction or suspension within fourteen (14) days of its effective date, the member shall be entitled to his or her rights as set forth in Article III, but not otherwise.

E. AUTOMATIC SUSPENSION OR LIMITATION.

In the following instances, the staff member's privileges or membership may be suspended or limited as described. This action shall be final without a right to hearing under Article III or further appellate review.

1. Licensure.

a) Revocation and Suspension.

Whenever a member's license or other legal credential authorizing practice in this state is limited, suspended, revoked, or has lapsed, the member shall immediately notify the Chief Executive Officer or medical director and their medical staff membership and clinical privileges shall be automatically limited, suspended or revoked as of the date such action becomes effective.

b) Restriction.

Whenever a member's license or other legal credential authorizing practice in this state is limited, suspended or revoked by the applicable licensing or certifying authority, the member shall immediately notify the Chief Executive Officer or medical director and any membership or clinical privileges which the member bas been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c) Probation.

Whenever a member is placed on probation by the applicable licensing or certifying authority, the member shall immediately notify the Chief Executive Officer, medical director and their membership and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

2. Controlled Substances.

a) Restriction.

Whenever a member's DEA certificate is revoked, limited, suspended, or has lapsed the member shall immediately notify the Chief Executive Officer or medical director and the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b) Probation.

Whenever a member's DEA certificate or prescribing authority is subject to probation, the member shall immediately notify the Chief Executive Officer or medical director and the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3. Professional Liability Insurance.

A member who fails to maintain the level and type of professional liability insurance coverage as required by the hospital shall automatically be suspended from exercising all clinical privileges at the hospital, until the situation is remedied to the satisfaction of the medical director or further action is taken under these Medical Staff Bylaws.

4. Loss of Medicare or Medicaid Provider Status.

A member who loses his or her status as a Medicare or Medicaid provider shall automatically be suspended from exercising all clinical privileges at the hospital, until the situation is remedied to the satisfaction of the Chief Executive Officer or further action is taken under these Medical Staff Bylaws or by the governing body.

5. Loss of Faculty Appointment.

A member who loses a faculty appointment in either the School of Medicine or Dental Medicine will result in automatic revocation of medical staff membership and clinical privileges and such automatic revocation shall not be subject to the hearing and appellate procedures of Article III.

F. MEDICAL BOARD DELIBERATION.

As soon as practicable after action is taken or warranted as described in these sections A, B, C, D, or E, of Section 6, the MEC shall convene to review and consider the facts, and may recommend such further disciplinary action as it may deem appropriate following the procedures generally set forth in this Article II and M hereof.

G. TEMPORARY SUSPENSION.

The medical director or Chief Executive Officer shall have the authority to suspend a member, after written notice to the affected staff member, for failure to comply with the Rules and Regulations regarding completion on of medical records.

6. Failure to Comply with Department of Health (DOH) Mandated Requirements

Failure to comply with DOH mandated requirements (i.e., annual medical assessment) following notice will result in a thirty day suspension from the medical staff. Failure to correct the deficiency within the 30 day suspension period will result in termination from the medical staff.

ARTICLE III

Professional Review Procedure

SECTION 1. RIGHT TO HEARING

Except as otherwise provided for herein, any practitioner who is a member of the medical staff in good standing as well as other individuals holding clinical privileges and whose reappointment to the medical staff has been denied, or any practitioner whose clinical privileges have been curtailed, suspended, revoked or denied, or any practitioner who has received an adverse recommendation (under Article II, Section 6B, subsections (f) through (i) (adverse action) shall have a right to a hearing before a panel of individuals appointed by the President of the medical board in consultation with the officers of the medical board. No member of the panel shall be in direct economic competition with the affected practitioner or have any material conflict of interest, which would prevent him/her from discharging his/her duties in an unbiased manner. Such panel shall consist of an odd number of members.

SECTION 2. HEARING REQUIREMENTS

A. A practitioner, who is entitled to a hearing as set forth in Section 1 above, shall receive written notice from the Chief Executive Officer containing the following information: (1) a statement that an adverse action is proposed or taken against the practitioner; (2) the reason for such adverse action; (3) the time limits within which to request a hearing; and (4) a summary of his/her rights in the hearing.

B. The practitioner requesting a hearing must do so in writing, delivered in person or by certified mail to the Chief Executive Officer within thirty (30) days following receipt of any notice that an action affecting his/her medical staff status has been recommended. If a hearing is not requested within thirty (30) days, the practitioner shall be deemed to have accepted the recommended action. It shall become effective immediately and the practitioner shall have waived all rights due under the provisions of this Article.

C. The chair of the panel shall arrange for the hearing and shall give written notice to the requesting practitioner of the time, place and date of the hearing which shall take place within thirty (30) days after the date of the hearing request or as soon as possible, if the practitioner is under summary suspension. The hospital shall provide the practitioner and the chair of the panel with a list of the witnesses expected to testify at the hearing on behalf of the Hospital. This list of witnesses shall be provided at least seven (7) days prior to the commencement of the hearing, unless the hearing is held within seven (7) days of the request and then, as soon as possible in advance of the hearing.

D. The practitioner requesting the hearing shall be entitled to be accompanied by an attorney or any other person of the practitioner's choice. The attorney or other person representing the practitioner shall not be permitted to participate in the hearing other than advising his/her client. The practitioner shall provide a list of witnesses to the chair of the panel at least seven (7) days prior to the commencement of the hearing, unless the hearing is held within seven (7) days of the request and then, as soon as possible in advance of the hearing.

E. After the panel is appointed, it shall select a chair to preside over the hearing, if one has not been designated by the MEC or President of the medical board or its designee. The chair shall act to provide that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, that decorum is maintained and that the proceeding be completed in as expeditious manner as is possible under the circumstances. The chair shall be entitled to determine the order or procedure during the hearing. The hearing shall not be

conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. The chair and members of the hearing panel may directly question any of the participants in the hearing, including witnesses. A quorum is sufficient to proceed.

F. The practitioner and the hospital shall have the following rights:

1. A record shall be made of the proceedings, copies of which shall be available to the practitioner upon payment to the Hospital of any reasonable costs or charges associated with their preparation;
2. To call, examine and cross-examine witnesses;
3. To introduce evidence determined to be relevant by the panel regardless of its admissibility in a court of law;
4. To impeach any witness;
5. To rebut any evidence;
6. To submit a written statement at the dose of the hearing; and
7. The assistance of counsel or other representative subject to the limitation set forth in Section 2 D above in this Article.

G. The chair may recess the hearing and reconvene the same within fifteen (15) days for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, all without special notice. Upon conclusion of the presentation of evidence, the hearing shall be closed. The panel may, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

H. Within fifteen (15) days of the final adjournment of the hearing, the panel shall make a written report and recommendation to the President of the medical board. Such report and recommendation shall include a statement of the basis for the recommendation. The report may recommend confirmation, modification, or rejection of the adverse action. A copy of that report and recommendation shall be sent to the practitioner on the same day it is forwarded to the President of the medical board.

I. Within thirty (30) days after receipt of the hearing panel's report and recommendation, the MEC shall render a written decision in the matter, including a statement of the basis for the Board's decision, and shall forward a copy of its decision to the medical board for transmittal to the practitioner for whom the hearing was held. The medical board shall transmit a copy of the decision and supporting materials to the governing body for review and approval. The decision of the governing body is final.

ARTICLE IV

Categories and Duties of the Medical Staff

SECTION 1. CATEGORIES

There are three (3) categories of medical staff membership: Active Attending, Affiliate/Referring, and Interim. Physicians and dentists with emeritus status, those who have retired from hospital practice as attending physicians at Stony Brook University Hospital and other practitioners who have attained notable career achievements, may be given the designation of Honorary.

SECTION 2. ACTIVE ATTENDING

A. RIGHTS.

Appointees to this category may:

1. admit patients, without limitations, except at otherwise proscribed by their clinical privileges or the objectives of the institution;
2. vote on all matters presented at general and special meetings of the medical staff, and of the department, division, service or committees to which the practitioner is appointed;
3. hold office and sit on or be the chair of any committee;
4. exercise such Stony Brook University Hospital clinical inpatient and outpatient privileges as are granted to the practitioner;
5. have fair hearing rights as specified in Article Ill of these bylaws

B. RESPONSIBILITIES.

Appointees to this category must:

1. contribute to the organizational and administrative affairs of the medical staff.
2. contribute to the organizational and administrative affairs of the clinical service to which they are appointed and participate in recognized functions of staff appointment including administrative responsibilities, quality improvement and monitoring activities, committee service, and attend departmental, divisional and service meetings, supervise initial appointees during their provisional period, and discharge other staff and special purpose functions as may be required from time to time.
3. pay all dues and assessments promptly;
4. comply with all provisions of these Bylaws, Rules and Regulations and the policies and procedures of the hospital and;
5. notify the medical staff services department, in writing, within thirty (30) days, when staff status changes at any hospital where membership is held. These changes include, but are not limited to, appointments, licensure, registrations or other factors, which limit the practitioner’s rights of practice.
6. provide continuous quality care to their patients and not delegate the responsibility or care of their patients to any practitioner not qualified to undertake the responsibility (revised 3/06)

SECTION 3. AFFILIATE/REFERRING

A. RIGHTS.

Appointees of this category shall:

1. relate to the hospital primarily through the direct referral of patients to the attending medical staff for admission and/or evaluation;
2. be permitted to visit patients, review medical records, but shall have no admitting privileges nor be permitted to write inpatient orders, progress notes or participate actively in the direct provision of inpatient care;
3. be eligible for Stony Brook University Hospital outpatient clinical privileges at the discretion of the chief of service at Stony Brook University Hospital;
4. be eligible to serve special purpose functions, serve on medical staff committees and attend staff and continuing education meetings at the discretion of the appointing medical department at Stony Brook University Hospital; and
5. have fair hearing rights as specified in Article III of these bylaws.

B. RESPONSIBILITIES.

Appointees to this category shall:

1. contribute to the organizational and administrative affairs of the clinical service to which they are appointed and contribute to the medical staff organization*by fulfilling assignments and attending meetings as requested and;
2. pay all dues and assessments promptly
3. not be permitted to hold office or vote;
4. comply with all provisions of these Bylaws, Rules and Regulations of the medical staff and the policies and procedures of the hospital and;
5. notify the medical staff services department, in writing, within thirty (30) days, when staff status changes at any hospital where membership is held. These changes include, but are not limited to, appointments, licensure, registrations or other factors, which limit the practitioner*s rights of practice.

SECTION 4. HONORARY

A. DEFINITION.

Physicians and dentists who are honored by emeritus status, those who have retired from hospital practice as attending physicians at Stony Brook University Hospital and other practitioners who have attained notable career achievements. Honorary members of the medical staff do not have any patient care responsibilities and therefore are not reappointed.

B. RIGHTS.

Appointees to this designation shall:

1. be eligible to teach and attend all medical staff meetings and continuing education programs;
2. accept special purpose and committee responsibilities assigned by and at the discretion of the appointing department;
3. not be required to pay dues or assessments;
4. not be permitted to admit patients, hold office or vote and;
5. not have fair hearing rights as specified in Article III of these bylaws.

SECTION 5. INTERIM

A. DEFINITION

An interim appointment may be granted to an individual proposed for a faculty appointment, whose faculty appointment is in process, but not complete, once the medical staff appointment is completed, approved by the MEC, the Medical Board, and the governing body. Interim appointments can be granted for a period of no longer than 120 days. Interim appointments will not be granted to practitioners who are appointed with privileges in the Ambulatory Surgery Center only. (revised 3/06)

B. RIGHTS

The rights and responsibilities of an applicant with an interim appointment will be dependent upon the category to which he will be appointed once the faculty appointment is complete (i.e., Active Attending or Affiliate Referring).

ARTICLE V

Medical Staff Organization

SECTION 1. MEDICAL BOARD.

A. FUNCTION OF THE MEDICAL BOARD AND RELATIONSHIP TO THE GOVERNING BODY.

The governing body of the medical staff shall be called the medical board. The medical board shall be responsible for the self-regulation of the medical staff, and serve as a channel of communication between the MEC, the medical staff and the Chief Executive Officer of Stony Brook University Hospital and/or the Governing body. The Medical Board is empowered to act on behalf of the organized medical staff in between medical staff meetings. {JCAHO 1.20 EP11} The Medical Board, through the Medical Executive Committee, reports monthly to the Governing Body. The Governing Body approves the scheduling of reports of selected medical staff committees, departments and other activity groups {JCAHO 1.40 EP 12} (6/05)

B. COMPOSITION (revised 3/06).

The medical board shall be composed of:

Voting Members:

1. Officers: President, Vice-President, Secretary/Treasurer
2. All clinical Chiefs of Service
3. Three (3) members-at-large from the full-time faculty; three (3) from the voluntary faculty
4. Non-chair Heart Center and Cancer Center directors [one vote per center]
5. Medical Director
6. Associate Medical Director for Quality Management
7. Designated Institutional Officer (DIO)/Associate Dean for Medical Education {Revised 12/04}
8. Dean, School of Medicine

The President, Vice President, Secretary/Treasurer and the Members-at-Large must be members of the active attending category of the medical staff.

Ex-Officio. Non-Voting Members:

1. Chief Executive Officer, Stony Brook University Hospital
2. Chief Operating Officer, Stony Brook University Hospital
3. Chief Nursing Officer, Stony Brook University Hospital
4. Chief Financial Officer, Stony Brook University Hospital
5. Chief Resident, elected by Graduate Medical Education Committee, 1-year term

C. ALTERNATES.

Each chief of service shall designate a single alternate to represent him or her in the event of that person's absence and to vote on their behalf. That person must be designated, in writing, at the beginning of each medical staff year and reported to the Secretary of the medical board.

SECTION 2. BOARD ELECTIONS

A. NOMINATIONS.

Any member of the medical staff may make nominations for the elected positions on the Medical Board. Nominees shall be solicited by communication through e-mail, in a written publication, or by announcement at departmental meetings by the chief of service. The Dean, School of Medicine shall select the nominating committee. The nominating committee will make their selections from the proposed list of nominees. A minimum of two (2) candidates for each position will be submitted to the medical board by the nominating committee for approval prior to the election.

B. ELECTION RULES.

Officers and members-at-large of the medical board will be elected by secret ballot at the annual meeting of the medical staff. The nominees in each category with the largest tally of votes shall be considered elected. Only medical staff members whose category is active attending may vote.

C. TERMS OF OFFICE.

The President, Vice-President, Secretary/Treasurer and members-at-large shall serve for two (2) years provided they remain in good standing on the medical staff during their elected terms. They may be re-elected to a second term, but may not serve more than two consecutive terms in the same position.

SECTION 3. DUTIES OF OFFICERS

A. PRESIDENT (revised 3/06).

The President of the medical board shall simultaneously serve as President of the medical staff. He shall call and preside at all meetings of the medical board, medical executive committee and medical staff and may be a member of all its committees. He shall appoint the committee chairs and members of all committees of the medical board unless otherwise indicated in these bylaws. The President shall represent the medical staff (through attendance and voice) at the governing body meetings.

B. VICE PRESIDENT.

The Vice President shall assume all the functions and responsibilities of the President of the medical board in the absence of the President.

C. SECRETARY/TREASURER.

The Secretary/Treasurer shall simultaneously serve as Secretary/Treasurer of the medical board and the medical staff. S/he shall act on behalf of the Vice President in his/her absence.

SECTION 4. REMOVAL OF OFFICERS AND MEMBERS OF THE BOARD (revised 3/06).

Failure to attend 50% of the meetings during the academic year (July 1st – June 30th) without an excused absence, shall result in replacement on the board. The President of the medical board will determine on an individual basis if non attendance at a medical board meeting constitutes an excused absence.

The members and officers of the medical board can also be removed, for cause, including but not limited to: serious violation of the Bylaws, Rules and Regulations, DOH regulations, State or Federal law, breach of ethics or significant impairment of professional activities or failure to perform the duties of the position by a 2/3 vote of the medical board (revised 6/05).

Members in ex-officio positions will be removed in the event they terminate their position. {JCAHO).

SECTION 5. VACANCIES (revised 3/06)

If the office of President of the medical board/staff is vacated for any reason, the Vice-President shall succeed to that office until the position is filled by vote at a Special Election of the medical staff (revised 3/06). If the office of the Vice-President of the medical board/staff is vacated for any reason, the Secretary/Treasurer shall succeed to that office until the position is filled by a Special Election of the medical staff. If the office of the Secretary/Treasurer becomes vacant, the position will be filled by vote at the next annual meeting.

If a Member-at-Large position is vacated for any reason, the position will be filled by a Special Election of the medical staff.

If non-elected members are removed, for any reason, they will be replaced by the Dean, School of Medicine or his/her designee.

Special Elections may be held via mail and/or email.

SECTION 6. MEDICAL EXECUTIVE COMMITTEE (MEC)

A. COMPOSITION.

The MEC shall be drawn from among the members of the medical board and composed of:

Voting Members (revised 3/06):

1. Officers: President of the Medical Board, Vice-President of the Medical Board, Secretary/Treasurer of the Medical Board
2. Non-chair Heart Center and Cancer Center directors (one vote per center)
3. Two (2) members at-large elected by the medical board from those members at large serving on the medical board. The term of office will be the remainder of their term on the medical board. One will be from the full-time staff and one from the voluntary staff. In the case of vacancy, the medical board will have a special election by mail or email.
4. Four (4) clinical chiefs of service, elected by the other clinical chiefs of service to serve a two-year term.
5. Associate Medical Director for Quality Management
6. Medical Director
7. Designated Institutional Officer (DIO)/Associate Dean of Medical Education
8. Dean, School of Medicine

Ex-officio Non-Voting Members:

1. Chief Executive Officer, Stony Brook University Hospital
2. Chief Operating Officer, Stony Brook University Hospital
3. Chief Nursing Officer, Stony Brook University Hospital
4. Chief Resident Member of the Medical Board {Revised 12/04}

B. ATTENDANCE/REMOVAL OF MEMBERS (revised 3/06).

Failure to attend either 50% of the meetings or 3 consecutive meetings during the academic year (July 1st – June 30th) without an excused absence, shall result in replacement on the committee. Elected members will be replaced by a Special Election of the Medical Board. Non-elected members will be replaced by the Dean, School of Medicine, or his/her designee. (revised 3/06) Excused absences from MEC meetings will be determined by the Chair of the MEC. Attendance by a designated alternate shall constitute attendance by the Chief of Service provided the absence of the Chief is deemed an excused absence by the MEC Chair. (6/05)

Loss of membership on the Medical Board shall result in loss of membership on the Medical Executive committee. Replacements will occur as delineated above.

C. ALTERNATES

Each chief of service (4) on the MEC shall designate a single alternate to represent him or her in the event of that person's absence and to vote on their behalf. That person must be designated, in writing and reported to the Secretary of the medical board. (6/05)

SECTION 7. MEDICAL DIRECTOR

A. QUALIFICATIONS.

S/he shall be a senior, clinically active full time physician of the medical staff of Stony Brook University Hospital, State University of New York at Stony Brook. S/he shall have demonstrated training and experience in medical/administrative matters. (Revised 3/06)

B. DUTIES.

1. Direct the medical staff organization in accordance with New York State Health Department regulations.
2. Be a voting member of the Medical Quality Assurance committee of the medical board.
3. Coordinate the clinical programs of the medical staff of Stony Brook University Hospital.
4. Assist the medical staff in establishing goals/objectives and mediate conflicts that arise.
5. Participate in medical school/hospital planning as a member of the joint planning committee.
6. Assist with the regulatory requirements in relation to graduate and postgraduate medical education programs.

C. APPOINTMENT PROCESS (revised 3/06).

The Governing Body shall appoint, with the concurrence of the Chief Executive Officer of Stony Brook University Hospital, the Dean, School of Medicine and the President of the Medical Board, a member of the faculty who is a full time active member of the medical staff to serve as medical director.

D. RESPONSIBILITY TO THE GOVERNING BODY.

The medical director shall be responsible to the governing body through the organization of the State University of New York for directing the medical staff organization in accordance with provisions of Section 405.4 of NYCRR.

ARTICLE VI

Standing Committees of the Medical Board

SECTION 1. STRUCTURE

A. COMPOSITION.

Each committee of the medical board shall have a Chair and members appointed by the President of the medical board. The Chief Executive Officer, (or his designee) and the President of the medical board (or his designee) shall be members of each standing committee, ex-officio. Quality assurance issues shall be reported directly to the Medical Quality Assurance Committee.

B. QUORUM and ATTENDANCE.

A quorum shall be a majority of the medical staff members appointed to the committee. A minimum of 50% attendance at scheduled meetings .will be required by all members on an annual basis.

C. VOTING PRIVILEGES.

All members of committees shall have voice and vote unless otherwise specified.

D. COMMITTEE PROCESS AND PURPOSE.

All committees, whether charged by the Bylaws or ad-hoc, shall be governed and guided by a separate committee manual. A designated Chair will oversee each committee. Committee members will be assigned to committees by areas of expertise. For specific committee information, refer to the Committee Manual.

E. COMMITTEES REPORTING TO MEDICAL BOARD

The following standing committees of the medical board are established and charged: Bylaws, Cancer, Credentials, Graduate Medical Education, Medical Executive and Medical Quality Assurance.

SECTION 2. BYLAWS

A. CHARGE

It shall be the function of this committee to consider, draft, and recommend to the medical board proposed amendments to the Bylaws and Rules and Regulations of the medical staff.

B. COMPOSITION.

The Bylaws Committee shall consist of at least three (3) chiefs of service or division chiefs; one of who shall be designated Chair, and 1 or more member(s) of the hospital administrative staff. Legal counsel to the hospital may sit with this committee to render legal advice.

C. MEETING/REPORTING.

This committee shall meet as required, and report at least annually to the medical board.

SECTION 3. CANCER

A. CHARGE.

The charge of the committee is to provide leadership to plan, initiate, stimulate and assess the institution's cancer related activities, in accordance with the Commission on Cancer requirements for cancer program accreditation.

B. COMPOSITION.

The Cancer Committee shall consist of multi-disciplinary representation from members of the diagnostic and therapeutic medical staff services involved in the care of cancer patients and related allied health professionals. Its composition must include a board-certified physician from surgery, medical oncology, radiation oncology, diagnostic radiology, pathology and must include the cancer liaison physician. Non-physician membership must include administration, nursing social services, cancer registry and quality assurance.

C. MEETING/REPORTING.

The committee shall meet at least quarterly, and report at least annually to the medical board.

SECTION 4. CREDENTIALS

A. CHARGE.

The charge of this committee shall be to review the credentials of health care practitioners applying for appointment or reappointment to the medical staff and/or requesting clinical privileges when there is a need to address questions or issues that cannot be resolved at any other level of the review process. This charge shall also include review and comment on proposed revisions for clinical privileging by departments.

B. COMPOSITION.

The Credentials Committee shall consist of one representative from the departments of: anesthesiology, medicine, obstetrics and gynecology, pathology, radiology, surgery, and the medical director. The chair shall be a physician appointed by the president of the medical board.

C. MEETING/REPORTING.

The committee shall meet as needed and shall report at least annually to the medical board. Confidentiality of peer review activities will be maintained.

SECTION 5. GRADUATE MEDICAL EDUCATION

A. CHARGE.

The committee shall be responsible for advising and monitoring all aspects of our graduate medical education teaching programs. Details of the standards can be found in the General Requirements of the Essentials of Accredited Residencies in Graduate Medical Education as established by the Accreditation Council for Graduate Medical Education.

1. establishment and implementation of policies that effect all residency programs regarding the quality of education and the work environment for the residents in each program;
2. establishment and maintenance of appropriate oversight of and liaison with program directors and assurance that program directors establish and maintain proper oversight of and liaison with appropriate personnel of other institutions participating in programs sponsored by the institution;
3. regular review of all residency programs to assess their compliance with both the Institutional Requirements and Program Requirements of the relevant ACGME RRCs;
4. assurance that each residency program establishes and implements formal written criteria and processes for the selection, evaluation, promotion and
5. dismissal of residents in compliance with both the Institutional and Relevant Program Requirements;
6. assurance of an educational environment in which residents may raise and resolve issues without fear of intimidation or retaliation;
7. collecting of intra-institutional information and making recommendations on the appropriate funding for resident positions, including benefits and support services;
8. monitoring of the programs in establishing an appropriate work environment and the duty hours of residents
9. assurance that the resident's curriculum provides a regular review of ethical, socioeconomic, medical/legal, and cost-containment issues that effect GME and medical practice. The curriculum must also provide an appropriate introduction to communication skills and to research design, statistics, and critical review of the literature necessary for acquiring skills for lifelong learning. There must be appropriate resident participation in department scholarly activity, as set forth in the applicable Program Requirements.
10. Confidentiality of peer review activities will be maintained. All members of the committee shall keep in confidence all papers, reports and information obtained by virtue of membership on the committee.

B. COMPOSITION.

The Graduate Medical Education committee shall consist of the program director of each core residency program, three members or more of the house staff, two representatives from hospital administration, and others as appropriate.

C. MEETING/REPORTING.

The committee shall meet at least monthly and report to the medical board quarterly and to the Governing Body annually. Graduate Medical Education activities are also reported to the Governing Body quarterly by the President of the Medical Board in his report of the medical staff. {Revised 12/04} Minutes will be maintained and made available for inspection by accreditation personnel.

SECTION 6. MEDICAL QUALITY ASSURANCE

A. CHARGE.

The committee shall serve as an interdisciplinary forum for the peer review of individual events related to patient care. The committee will assist in setting standards across disciplines. Such events may be brought to the committee by its membership or by referral from relevant others. The committee will also receive and review the periodic required reports of the following committees: blood utilization, infection control, medical records, nutrition, pharmacy and therapeutics, and surgical review. Confidentiality of peer review activities will be maintained. All members of the committee shall keep in confidence all papers, reports and information obtained by virtue of membership on the committee.

B. COMPOSITION

The Medical Quality Assurance Committee shall consist of the QA physician liaisons from each clinical department, a nursing QA liaison as well as representatives from other professional services, including but not limited to social service, nutritional service, risk management, patient relations, medical care review and the medical staff services department. Ex-officio members shall include the chief operating officer and the medical director. The associate medical director for quality management shall chair the committee.

C. MEETING/REPORTING.

The committee shall meet at least every other month, maintain a permanent record of its proceedings and activities and report at least annually to both the MEC and the medical board. The committee chair will report as necessary, but no less often than every other month, to the governing body.

ARTICLE VII

Meetings

SECTION 1. MEDICAL STAFF

A. FREQUENCY.

The medical staff shall meet during June in each calendar year.

B. QUORUM.

A quorum shall be a majority of those present at these meetings for the conduct of business.

SECTION 2. REGULAR MEETINGS OF THE MEDICAL BOARD

A. FREQUENCY.

The Medical Board shall meet quarterly.

B. QUORUM.

A quorum shall be the majority of the voting members.

C. ATTENDANCE.

Members of the medical board (or alternates) are expected to attend all regular and all special meetings.

D. DUTIES.

1. Approving/modifying recommendations for appointments/reappointments
2. Acknowledging resignations
3. Acting on all action items submitted by the MEC within two (2) weeks
4. Approving minutes by the MEC
5. Submitting items to the governing body for approval

a) No objection to an issue: goes to governing body within two weeks

b) Objection to an issue: held over until next meeting of the medical board

E. AGENDA.

The order of business at any regular meeting shall include but not be limited to:

1. Call to order
2. Approval of minutes of the last regular and all intervening special meetings;
3. Report from the President of the medical board ;
4. Report from the Chief Executive Officer of Stony Brook University Hospital (or designee)
5. Report from the medical director (or designee);
6. Report from the DIO

7. Any item requested by the medical board by majority vote of its members;
8. Approval of changes in the medical staff bylaws;
9. New business;
10. Adjournment

SECTION 3. REGULAR MEETINGS OF THE MEC

A. FREQUENCY.

The MEC shall meet as often as necessary, but not less often than once per month. The MEC Chair or a majority of its membership may call additional meetings with a written request to the Chair.

B. DUTIES.

Duties of the MEC shall include, but not be limited to:

1. acting on behalf of the medical board between its quarterly meetings except for those actions requiring approval of the medical board as delineated in these bylaws;
2. coordinating and implementing the professional and organizational activities and policies of the medical staff;
3. receiving and acting upon reports/recommendations from: medical staff departments, divisions, committees and assigned activity groups;
4. recommending actions to the medical board on matters of a medical-administrative nature;
5. establishing the structure of the medical staff;
6. recommending to medical board appointments/reappointments and clinical privileges;
7. acknowledging terminations;
8. recognizing fair hearing and corrective actions;
9. monitoring the organization of quality assurance/improvement activities of the medical staff;
10. evaluating the medical care rendered to patients in the hospital;
11. participating in the development of all medical staff/hospital policy, practice and planning;
12. taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of or the participation in medical staff corrective or review measures when warranted;
13. designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff;
14. assisting in the obtaining and maintenance of accreditation;
15. appointing such special or ad hoc committees as may seem necessary or appropriate to assist the MEC in carrying out its functions and those of the medical staff;
16. receiving formal verbal reports from each MEC member at each meeting as deemed necessary;
17. maintaining a record of its proceedings and;
18. reporting to the medical board through its Chair.
19. Confidentiality of peer review activities will be maintained. All members of the committee shall keep in confidence all papers, reports and information obtained by virtue of membership on the committee.

C. QUORUM.

A quorum shall be a majority of the voting members.

D. ATTENDANCE.

Members are expected to attend 50% of all regular meetings and special meetings.

SECTION 4. SPECIAL MEETINGS

A. FREQUENCY.

Special meetings of the MEC or medical board may be called at any time by the President of the medical board or the Chair of the MEC, respectively, or at the request of the governing body or any five (5) members of the MEC or medical board.

Notification of a special meeting shall be communicated via fax, e-mail or phone call; at least 24 hours in advance of the time set for the meeting.

B. QUORUM.

MEC: A quorum shall be a majority of the voting members.

Medical Board: A quorum shall be 1/3 of the voting members.

C. AGENDA.

No business shall be transacted except that stated in the notice calling the meeting.

ARTICLE VIII

Bylaws Amendments and Adoption

SECTION 1. RULES FOR AMENDMENTS – BYLAWS and RULES and REGULATIONS

Revision of the Bylaws shall become effective and shall replace any previous Bylaws after they have been adopted by the organized medical staff and approved by the governing body. Neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations. (7/06)

A. VOTING.

Voting may be accomplished electronically or by whatever means is determined to be practical under the circumstances. A majority of the votes cast is required for approval. Once approved by the medical staff, the bylaws are submitted to the governing body for approval. (7/06)

B. NOTICE.

Proposed amendments to the Bylaws shall be submitted to the medical staff electronically or otherwise for a vote by a certain date. (7/06)

Amendments to the Rules and Regulations will follow the same procedure as amendment of the Bylaws. (JCAHO MS 1.20) (6/05)

C. EFFECTIVE DATE.

Amendments shall become effective when approved by the governing body.

D. FREQUENCY OF REVIEW.

The Bylaws shall be reviewed periodically by the Bylaws Committee and revised whenever necessary.

SECTION 2. RULES FOR ADOPTION

A. REQUIREMENTS.

The Initial adoption of these Bylaws shall require the following procedure:

1. Approval by 2/3 of the voting members of the ad-hoc MEC formed by the Vice President of the Health Sciences Center, State University of New York at Stony Brook.
2. Approval by the governing body.

ARTICLE IX

Definitions

For the purposes of these Bylaws, Rules and Regulations, the following terms are defined:

1.“CHIEF EXECUTIVE OFFICER”

the Chief Executive Officer of Stony Brook Stony Brook University Hospital.

2. “CHIEF MEDICAL OFFICER”

The Medical Director of Stony Brook University Hospital.

3. “GOVERNING BODY” - “Board of Trustees”

The Board of Trustees officially designates the President of the State University of New York at Stony Brook with respect to the approval of amendments and revisions of these bylaws.

4. “HOSPITAL”

Stony Brook University Hospital of the Health Sciences Center of the State University of New York at Stony Brook, New York.

5. “MEDICAL BOARD”

The governing body of the medical staff, responsible for the staff’s self-regulation and serving as a channel of communication between the medical staff, the Chief Executive Officer of the hospital, the Dean, School of Medicine and/or the Board of Trustees.

6. “MEDICAL EXECUTIVE COMMITTEE”

The policy making body of the medical board (MEC).

7. “MEDICAL STAFF”

“medical” and “physician” shall be interpreted to include the corresponding terms “dental staff*****, “dental”, and “dentist.”

8. “PEER REVIEW”

An individual in the same professional discipline with essentially equivalent qualifications and/or training. It may also include recommendations from a practitioner in a related specialty or a supervising physician, provided they address the individual’s training or experience, clinical competence, fulfillment of obligations, and the ability to perform the privileges requested [physical/mental health status.]

9. “SCHOOL OF MEDICINE”

The School of Medicine (SOM) of the Health Sciences Center (HSC) of the State University of New York at Stony Brook, New York.

10. “UNIVERSITY*”

The State University of New York at Stony Brook, New York.

SUBJECT INDEX

D (top of index)

E (top of index)

F (top of index)

G (top of index)

H (top of index)

I (top of index)

J (top of index)

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