Stony Brook University Hospital
Medical Staff
Bylaws

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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. DISCRIMINATION PROHIBITED.

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

5. 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.
6. 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 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 and reviewed once the disaster has ended. 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 (CEO) about the conduct, performance, or competence of a staff member (the “practitioner”). 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 president of the medical board for disposition in any manner provided for in this section.

2. A request for an investigation of or action against the practitioner may be initiated by the chief of service, the CEO, the president of the medical board, or the medical director when reliable information indicates that a practitioner 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 SUNY or hospital policies and procedures or;

c) below applicable professional standards

[References to the medical director, chief of service, CEO 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, who will be required to meet with the medical director, if asked, or other involved individuals, or to refer them, if appropriate, to a quality assurance liaison or other entity, if, in his/her judgment, the complaint can be resolved without a medical executive committee (MEC) investigation. If the medical director has taken action to resolve an issue, 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 to the MEC that an investigation be undertaken.

5. The MEC shall determine whether an investigation is warranted, and if so, assign the task to an ad-hoc committee of at least three (3) 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.

Ad hoc Investigative Committee.

a) The committee conducting the investigation shall have the authority to review documents it considers relevant, interview individuals, consider appropriate clinical literature and practice guidelines, and use the resources of an external consultant if deemed necessary and such action is approved by the MEC. The investigating body shall notify the practitioner in question that the investigation is being conducted and give the practitioner an opportunity to provide information in a manner the investigating body deems appropriate. All members of the medical staff must cooperate with the investigation unless excused by the investigating committee.

b) The investigative committee shall forward a written report of the investigation to the medical director and MEC, with a copy to the medical staff department, as soon as practicable but no later than thirty (30) business days following the assignment of the investigation, unless an extension is granted by the MEC. The report shall include a statement of facts, brief description of the investigation, recommendations for appropriate corrective action, a statement of the agreement or dissent of the practitioner and recommendations for corrective action that may include any items listed in B below.

c) 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. . The individual being investigated shall have neither the right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation.

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, shall, with notice to the CEO, chief of service and medical staff department, review the report and/or 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 to be placed in the practitioner's credentials file in the medical staff department. In the event such letters are issued, the practitioner may make a written response that shall be placed in his/her file in the medical staff department

d) requiring professional education or other training

e) requiring the practitioner to undergo a medical and/or psychiatric examination and/or to obtain professional counseling by a physician chosen by the MEC

f) retrospective or prospective review of records

g) setting fines

h) entering into a binding remedial agreement from which no appeal is permitted but reporting may be required

i) 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 or supervision.

j) recommending reduction, modification, suspension, or revocation of clinical privileges

k) application of a mandatory concurring consultation requirement or increase in the stringency of a pre-existing mandatory consultation requirement when such applies only to an individual medical staff member and is imposed for more than 14 days.

l) recommending reduction or limitation of any prerogatives directly related to membership on the medical staff

m) recommending suspension, modification, probation, or revocation of medical staff membership

n) recommending termination of medical staff appointment or denial of reappointment

o) any other appropriate corrective action

C. SUBSEQUENT ACTION.

1. If a corrective action as set forth in (j) through (n) of the above section is recommended by the MEC, that recommendation shall be transmitted in writing to the practitioner by certified mail, return receipt requested, or overnight courier, with copies to the chief of service, CEO, medical director, and medical staff department. In these cases only, the practitioner shall then be entitled to his or her rights as set forth in Article III.

2. If the practitioner does not exercise his or her rights under Article III within the allowable timeframe, the MEC shall forward its recommendation to the medical board for action. Within 30 business days the medical board shall forward its recommendation to the Governing Body.

3. The decision of the Governing Body shall be deemed final action.

D. SUMMARY RESTRICTION OR SUSPENSION.

1. Whenever there are reasonable grounds to believe that action must be taken immediately based on the professional competence or conduct of the practitioner that adversely affects (1) the welfare of a patient(2) the provision of patient care or; (3) to prevent imminent disruption of or harm to hospital operations, the chief of service, president of the medical board, medical director, or CEO each shall have the authority to summarily suspend all or any portion of the clinical privileges granted by the hospital to a member of the medical staff.

2. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person responsible shall promptly give verbal, followed by written notice to the practitioner (by certified mail, return receipt requested, or overnight courier) and to the MEC, the applicable chief of service, office of university counsel, the CEO and the medical staff department. The person or body imposing the summary restriction or suspension shall also give verbal notice as soon as possible to units and personnel who have a need to know of this decision.

3. The summary restriction or suspension shall remain in effect for the period stated or, if none, until finally resolved. Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner'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 practitioner on the medical staff.

4. 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. If necessary, the MEC shall direct an investigative committee of three active attending members of the medical staff who can serve in such capacity without a conflict of interest to further investigate the basis for the summary suspension and/or the conduct in question. The investigative committee shall hold such interviews as may be appropriate with respect to the practitioner. The investigative committee shall submit a report with recommendations to the MEC within 10 calendar days of the imposition of the suspension or restriction.

The practitioner shall, at the discretion of the MEC attend the meeting of the MEC and make a statement concerning the issues under investigation on such terms and conditions as the MEC or may impose. The MEC shall complete its review and make its decision within fourteen (14) calendar days after the restriction or suspension is imposed. In no event shall any meeting of the MEC or the investigating committee with or without the practitioner, constitute a "hearing" within the meaning of Article III.

The MEC may modify, continue, or terminate the summary restriction or suspension. It shall promptly furnish the practitioner (by certified mail, return receipt requested, or overnight courier), the CEO, the respective chief of service, the medical director and the medical staff office with notice of its decision. The practitioner shall then be entitled to his or her rights as set forth in Article III.

If the affected practitioner 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) calendar days. The decision of the Governing Body shall be deemed final action.

E. AUTOMATIC SUSPENSION OR LIMITATION.
In the following instances, a medical 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. Actions which are the result of license, DEA and/or malpractice insurance expiration and/or loss of faculty appointment are not reportable actions.

1. Licensure.

a) Revocation and Suspension.

Whenever a practitioner's license or other legal credential authorizing practice in this state is limited, suspended, revoked, or has lapsed, the practitioner shall immediately notify the CEO or medical director, and his/her 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 practitioner's license or other legal credential authorizing practice in this state is limited, suspended, or revoked by the applicable licensing or certifying authority, the practitioner shall immediately notify the CEO or medical director, and any membership or clinical privileges that the member has been granted at the hospital 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 practitioner is placed on probation by the applicable licensing or certifying authority, the practitioner shall immediately notify the CEO, or medical director, and his/her 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 practitioner's DEA certificate is revoked, limited, suspended, or has lapsed, the practitioner shall immediately notify the CEO or medical director, and the practitioner 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 practitioner's DEA certificate or prescribing authority is subject to probation, the practitioner shall immediately notify the CEO or medical director, and the practitioner '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 practitioner 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.

The medical staff membership and clinical privileges of a practitioner who is sanctioned or barred from Medicare, Medicaid Tricare or other federal programs shall automatically be relinquished as of the date the action becomes effective, of exercising all clinical privileges at the hospital, until the situation is remedied to the satisfaction of the CEO or further action is taken under these Medical Staff Bylaws or by the governing body.

5. Loss of Faculty Appointment.

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

6. Failure to Execute Release and/or Provide Documents.

A practitioner who fails to execute a general or specific release and/or provide documents when requested by the president of the medical board or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within 30 calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

F.TEMPORARY ADMINISTRATIVE LEAVE.

The medical director or CEO shall have the authority to place a practitioner on administrative leave, upon written notice to the practitioner by certified mail, return receipt requested, or overnight courier, for:

a) failure to comply with the Rules and Regulations regarding completion of medical records or;

b) failure to comply with DOH mandated requirements (i.e., annual medical assessment; infection control training).

The leave may be for a period of thirty calendar days. Failure to correct the deficiency within the 30 day suspension period will result in automatic termination from the medical staff. Administrative leaves are not reportable actions or subject to Article III or a professional review. Terminations which occur thirty calendar days after the administrative leave are not reportable actions or subject to Article III or a professional review.

ARTICLE III
Professional Review Procedure

SECTION 1. RIGHT TO HEARING

Any practitioner who has received notice of a proposed corrective action as set forth in Article II, Section 6.B (j) through (n), is entitled to a hearing before a hearing panel pursuant to the procedures set forth in this Article III.

In addition, any practitioner who has received notice in accordance with Article II of these Bylaws of an adverse recommendation with respect to his/her appointment to the medical staff, or to reappointment to the medical staff or to a restriction and/or reduction of the practitioner's clinical privileges is entitled to a hearing in accordance with the procedures set forth in this Article.

The notice, provided to the practitioner by the president of the medical board or his/her designee shall state:

1. the particular action taken or proposed to be taken against the practitioner
2. the reasons for the action
3. notification that the practitioner has the right to request a hearing on the action
4. the time limit within which the practitioner may request the hearing
5. a summary of the practitioner's rights at the hearing under this Article.

In the event the practitioner elects not to have a hearing or does not respond in the time frame required in the notice, the practitioner waives his or her right to a hearing or appeal. In this instance, the recommendation of the medical board shall be forwarded to the Governing Body for final action.

SECTION 2. REQUEST FOR A HEARING.

A request for a hearing before a hearing panel shall be made by the practitioner in writing and sent to the president of the medical board by certified mail, return receipt requested, or overnight courier within thirty five (35) calendar days of receipt by the practitioner of notice of the proposed corrective action or adverse recommendation. If the practitioner fails to request a hearing within such time limitation, or fails to appear at the time set for the hearing, he or she shall be deemed to have waived the right to a hearing as set forth in Section 5 of this Article III.

SECTION 3. SCHEDULING AND NOTICE OF HEARING.

The hearing panel chair (or designee) shall schedule the hearing and shall notify the practitioner, as soon as practicable, by certified mail, return receipt requested, or overnight courier, and shall include:

1.The time, place and date of the hearing

2. A list of proposed witnesses (known at that time, but which may be modified) who will give testimony or evidence in support of the MEC or medical board at the hearing.

3. The names of the hearing panel members and presiding officer or hearing officer, if known.

4. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient records numbers and other information, may be amended or added to at any time, even during the hearing, so long as the additional material is relevant to the continued appointment or clinical privileges of the practitioner requesting the hearing, and both the practitioner and the practitioner's counsel have sufficient time to study this additional information and rebut it.

Except as set forth below, the date of the hearing shall be no less than thirty (30) and no more than sixty (60) calendar days from the date of receipt by the practitioner of the notice of the scheduling of the hearing, unless the practitioner makes a written request to the hearing panel chair to schedule the hearing for a later date, and then subject to approval by the hearing panel chair.

REQUEST FOR EXPEDITED HEARING.

If a request for a hearing is received from a practitioner who has been summarily suspended in accordance with these Bylaws, the hearing may, upon the written request by the practitioner to the hearing panel chair, be scheduled for a date earlier than 30 calendar days from the date of receipt by the practitioner of such notice. However, the hearing shall not be scheduled for a date earlier than fifteen (15) calendar days from the receipt by the hearing panel chair of the practitioner's request for an expedited hearing. Postponement of the hearing beyond the hearing date shall be granted only with the approval of the hearing panel chair

The practitioner shall provide a list of witnesses and the name and address of the practitioner's legal counsel or representative (if any) accompanying him or her to the hearing to the hearing panel chair at least seven (7) calendar days prior to the commencement of the hearing, The hospital shall provide to the hearing panel chair and to the practitioner the name(s) of any legal counsel who will be appearing at the hearing.

SECTION 4. COMPOSITION AND SELECTION OF THE HEARING PANEL

The hearing shall be conducted by a hearing panel, consisting of no fewer than three (3) members of the active attending staff, all selected by the president of the medical board. One member of the hearing panel shall be designated as its chair by the president of the medical board. Knowledge of the matter involved shall not preclude any person from serving as a member of the hearing committee so long as that person did not take part in any process leading to the request for corrective action or adverse recommendation. Members of the medical board or active staff who are direct economic competitors of the practitioner shall not sit on the hearing panel. Any challenge by the practitioner to any member of the hearing panel shall be made in writing to the hearing panel chair. The practitioner must make any challenge regarding the members of the hearing panel within seven (7) calendar days of the receipt of names of the hearing panel. If the challenge is regarding the hearing panel chair, it shall be made by the practitioner to the president of the medical board.

SECTION 5. DUTIES OF THE CHAIR OF THE HEARING PANEL.

The hearing panel chair shall do the following:
1. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

2. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than 15 hours.

3. Maintain decorum throughout the hearing.

4. Determine the order of procedure throughout the hearing

5. Have the authority and discretion, in accordance with these bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.

6. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the practitioner requesting the hearing is considered by the hearing panel when formulating its recommendations.

7. Require the presence of any medical staff member including the practitioner.

8. Seek legal counsel when he or she feels it is appropriate. Legal counsel to, or retained by the hospital may advise the presiding officer or panel chair.

9. Rule on disputes involving evidence and witness.

SECTION 6. CONDUCT OF THE HEARING.

A. Rights of the Parties at the Hearing

Both sides shall have the following rights, subject to reasonable limits determined by the hearing panel chair:

1. To call and examine witnesses to the extent available

2. To introduce exhibits

3. To cross examine any witness on any matter relevant to the issues and to rebut any evidence.

4. To have representation by counsel who may be present at the hearing, advise his or her client, but not actively participate in the hearing. Attorneys may call, examine and cross examine witnesses and present the case. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the hearing.

5. To submit a written statement at the close of the hearing.
Any individuals requesting a hearing who do not testify on their own behalf maybe called and examined as if under cross examination. The hearing panel may question the witnesses, call additional witnesses, or request additional documentary evidence.

B. Hearing Rules

1. Record. A record of the hearing shall be made by such method determined by the hearing panel chair. The practitioner may obtain a copy of record upon payment of reasonable charges associated with preparation of the transcript.

2. Not a Public Hearing. The hearing is not open to the public nor to observers who are not part of the process. Documents and testimony are strictly confidential under state and federal law and shall be treated as such by all participants and witnesses.

3. No Discovery. There shall be no right to prehearing discovery including but not limited to discovery or information regarding other physicians and/or their clinical activities.

4. Rules of Evidence Do Not Apply. The hearing shall not be subject to formal rules of evidence and procedure. The hearing panel chair has discretion with respect to the evidence as set forth in Section 5 above.

5. Representation of Legal Counsel. The practitioner and the hospital may elect to be represented at the hearing by legal counsel or other representative. At its option, the hearing panel also may be advised by legal counsel, provided that the attorney appointed to advise the hearing panel is not the same attorney as the attorney representing the hospital before the hearing panel. Legal counsel shall not be permitted to participate in the hearing other than advising his/her client.

6. Order of Presentation. It shall be the obligation of the hospital to present, in the first instance, the corrective action or adverse recommendation and the reasons supporting the corrective action.

7. Standard of Proof. In order to reverse the recommendation, the practitioner shall have the obligation to persuade the hearing panel, by clear and convincing evidence, that the reasons supporting the corrective action lack any factual basis or that such basis, or any action based thereon, is either arbitrary, unreasonable or not in compliance with applicable law.

8. Appearance at the Hearing. Failure of the practitioner to appear at the hearing without good cause as determined by the hearing panel shall constitute a waiver of his/her rights under these bylaws.

SECTION 7. DECISION OF THE HEARING COMMITTEE AND APPROVAL BY MEDICAL BOARD

Within fifteen (l5) business days of the completion of the hearing, the hearing panel shall issue a decision, by simple majority vote of the hearing panel, either upholding the corrective action or terminating or modifying the corrective action. Such recommendations shall then be submitted to the medical board for its approval. Upon its approval, the medical board or designee shall forward copies of its decision to the practitioner by certified mail, return receipt requested, or overnight courier, and to counsel for the hospital who appeared at the hearing.

In the event the medical board does not approve the hearing panel's decision, the medical board can issue its own decision, request clarification of the hearing panel's decision, or re-review the hearing record. Any vote by the medical board to reject or modify a hearing panel's decision shall require a simple majority of the medical board and notification to the practitioner as described in the paragraph above.

If an appellate review is not requested, or if an appellate review is not requested on a timely basis, the medical board will send its decision to the governing body that shall make the final decision. The final decision shall be sent to the practitioner by certified mail, return receipt requested, or overnight courier, and to the CEO, medical director respective chief of service and medical staff department.

SECTION 8. RIGHT OF APPELLATE REVIEW.

Any party can appeal to a hearing may request an appellate review from an adverse decision.

a) Request for Appeal: If a practitioner receives notice of an adverse recommendation or adverse decision by the medical board after the hearing, the practitioner may, within ten (10) business days after receipt of such notice, submit to the president of the medical board a formal written request for an appellate review. The request must include a complete statement of the basis for the appeal. The president of the medical board to the governing body shall forward the record and appellate request, containing the basis for the appeal, within five (5) business days of receipt.

b) Waiver of Appeal: Failure by the practitioner to request an appeal within the allotted ten (10) business day period shall be deemed to be a waiver of the right to further appeal.

c) Appellate Review: Appeal to the Governing Body: The governing body acts as the appellate review body. The governing body shall review the record created in the proceedings, and shall consider any the letter of appeal for the purpose of determining whether the decision against the affected practitioner was justified.

d) Appellate Review Procedure: The appellate review shall be conducted in accordance with the following guidelines:

1. Review of the Hearing Record: The governing body shall review the report and record of the hearing panel and any other written statement or materials that were submitted by the practitioner and or hospital and was considered in making the adverse recommendation/decision. The governing body shall include in its review, the request for appeal with the complete statement of the basis for the appeal, unless the basis contains new or additional matters that will be treated as provided in Section D2.

2. Permissible Evidence: New or additional matters not raised during the original hearing or in the hearing panel report, nor otherwise reflected in the record, may not be introduced in the appellate review except under unusual circumstances, and the governing body shall in his/her sole discretion determine whether new matters shall be accepted.

3. Action Taken: The governing body may affirm, modify or reverse the adverse result or action taken after the hearing or, in his/her discretion, may refer the matter back to the medical board for further review and recommendation with respect to a particular factual matter. The medical board shall respond to the governing body within 30 business days. The president shall complete his/her deliberations and conclude the appeal within fifteen (15) business days after receipt of the report of the medical board.

The Appellate Review Shall be the Final Action.

Notice of the final determination of the Appellate Review will be promptly sent by certified mail, return receipt, or overnight courier, from the governing body to the practitioner and to the medical board, medical director, respective chief of service and medical staff office.

No practitioner shall be entitled to more than one Article III evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

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 III 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. (revised 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. (revised 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, a clinical research data manager or nurse, and pain control/palliative care physician or specialist. Non-physician membership must include administration, nursing, social services, cancer registry and quality assurance. (revised 2/09) The Cancer Committee shall establish an interdisciplinary steering sub-committee known as the Breast Program Leadership which is responsible and accountable for providing breast center services (revised 3/09).

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 voted on 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.