STONY BROOK

STATE UNIVERSITY OF NEW YORK

MEDICAL STAFF BYLAWS

STONY BROOK UNIVERSITY HOSPITAL

STONY BROOK, NEW YORK

(REVISED September 2003)

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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 the 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, 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 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 the University Hospital, acting by the authority delegated to them by the VicePresident of the Health Sciences Center, 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 the University Hospital, and adopt these Bylaws.

D. STANDARDS

Standards for patient care, education, community service and research at the 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 the 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 to qualify for excess malpractice insurance, with the following exceptions:

1. General practice dentists

2. Proof of other indemnification that meets the satisfaction of the medical board.

General practice dentists must carry at least $1/$3 primary malpractice coverage. 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 the University Hospital shall hold a faculty appointment in the School of Medicine or Dental Medicine. A faculty appointment does not confer or imply membership on the medical staff of the hospital.

6. Annual Health Assessment.

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

B. DISCRIMINATIONPROHIBITED.

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

reasonable accommodation, of performing the essential functions of the medical staff appointment.

C. ETHICAL BEHAVIOR STANDARDS.

All members of the medical staff shall conduct their professional activities in accordance with the ethical code of their organized professional associations, in accordance with the Education Law covering professional practice, and in accordance with the Rules and Regulations of the Board of Trustees. In case of conflict, the law of the State of New York and the Rules and Regulations of the Board of Trustees shall have precedence.

D. AGREEMENT TO LIVE BY THE BYLAWS.

Acceptance of membership on the medical staff shall constitute the staff member'sagreement to abide and be governed by these Bylaws as they now exist or as they may be amended after due process.

E. ANNUAL DUES.

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

SECTION 2. CONDITION AND DURATION OF APPOINTMENT

A. GOVERNING BODY ROLE.

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

B. DURATION.

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

the medical staff.

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

SECTION 3. APPOINTMENT

A. APPLICATION REQUIREMENTS.

1. Responsibilities of Applicant.

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

2. Verification of Information.

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

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

3. Release of Information Consent.

The applicant authorizes the hospital to consult with members of medical staffs of other health care institutions with which the applicant has been associated and with others that may have information bearing on their competence, character, and ethical qualifications. Furthermore, they consent to the hospital's inspection of all records and documents that may be material to an evaluation of the professional qualifications and competence to carry out the clinical privileges requested as well as moral and ethical qualifications for staff membership.

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.

3. MEC.

The completed application package will be submitted to the MEC. The NEC 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 90 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 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 non•appointment recommendation based upon the applicant's failure to have 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 verify current status of licensure, challenges to licensure, malpractice insurance, infection control training, and board certifications. All health care affiliations will be queried regarding the voluntary or involuntary relinquishment of medical staff membership or limitation, reduction, suspension or loss of clinical privileges. 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] will be queried.

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.

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 non•reappointment recommendation based upon revocation of 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.

Periodic 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.

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

1. Definition.

"Emergency/disaster privileges" is defined as privileges granted at the time of an officially declared emergency whether it is state, local or national when the hospital CEO, Medical Director or designee determines there is a need for additional licensed health practitioners who do not have privileges at University Hospital.

2. Expectation.
The granting of such privileges shall be prompt and require documentation as follows.

All physicians requesting temporary emergency/disaster privileges are to be referred to the Medical Staff Services Office 444-2754, Monday - Friday, 9:00 AM - 5:00 PM. At any other time, the physician shall be referred to the Medical Director.

The following information must be available in order to be granted emergency privileges:
Evidence of a valid professional license to practice medicine in the USA.
Photo identification.
List of current hospital affiliations where the practitioner holds active staff privileges. The practitioner must currently hold privileges at another accredited institution.

The Medical Director, CEO and appropriate Chief of Service or their designee will review and approve temporary emergency/disaster privileges.

Verification of the above information will be done as soon as possible by the medical staff office. A query to the National Practitioner Data Bank, State licensing agency and hospital where current privileges are held will be processed by the Medical Staff Services Office. Records of this verified information must be retained.

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 the emergency situation begins, SBUH will keep a record of the practitioner's actions. The record shall indicate that the practitioner exercising the "emergency privileges" does so at the request of an attending physician currently on SBUH medical staff. Emergency designees must practice under the direction of an attending physician currently on the medical staff at SBUH.

Emergency privileges may, at the discretion of the CEO, Medical Director and Chief of Service, become effective prior to receiving responses to queries.

E. VISITING FACULTY PRIVILEGES.

1. Definition.

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

2. Academic Appointment.

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

3. Hospital Privileges.

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

SECTION 6. DISCIPLINARY PROCEDURES

A. CORRECTIVE ACTION.

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

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

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

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

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

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

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

6. The committee shall forward a written report of the investigation to the medical director and MEC as soon as practicable but no later than thirty (30) days following the assignment of the investigation to the standing committee of the medical board, unless an extension is granted by the MEC. The report may include a statement of facts, brief description of the investigation, recommendations for appropriate corrective action and a statement of the agreement or dissent of the affected practitioner. This investigation shall not constitute a

"hearing" as that term is used in Article III nor shall the procedural rules with respect to hearings apply.

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

B. MEC ACTION.

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

a. determining no corrective action be taken.

b. deferring action for a reasonable time where circumstances warrant.

c. issuing letters of admonition, warning, reprimand or censure. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file in the medical staff services department.

d. directing the medical staff member to undergo a medical and/or psychiatric examination by a physician chosen by the MEC.

e. levy fines.

f. recommending the imposition of terms of probation or limitation upon continued medical staff membership or the exercise of clinical privileges including, without limitation, requirements for co •admission, mandatory consultation or monitoring.

g. recommending reduction, modification, suspension or revocation of clinical privileges.

h. recommending reduction or limitation of any prerogatives directly related to membership on the medical staff.

i. recommending suspension, modification, probation or revocation of medical staff membership.

C. SUBSEQUENT ACTION.

1. If a corrective action as set forth in (f) through (i) of the above section, is recommended by the MEC, that recommendation shall be transmitted in writing to the practitioner with copies to the chief of service, Chief Executive Officer and medical director, and, in these cases only, the practitioner shall then be entitled to his or her rights as set forth in Article III.

2. If the staff member does not exercise his or her rights under Article III, the MEC shall forward its recommendation to the medical board, which, in turn, shall forward its recommendation to the governing body within thirty (30) days.

3. The decision of the governing body shall be deemed final action.

4. Notwithstanding the foregoing, the MEC may, in the alternative, and with notice to the Chief Executive Officer, enter into a remedial agreement with the affected practitioner to resolve the problem. If the affected practitioner fails to abide by the terms of the remedial agreement, the practitioner will be subject to the standard corrective action procedures of this article.

D. SUMMARY RESTRICTION OR SUSPENSION.

1. Whenever a staff member's conduct appears to require that immediate action be taken to protect the life or well•being of a patient or wherever the staff member's conduct presents a danger of immediate and serious harm to the life, health, safety of any patient, prospective patient or other person, the medical director, MEC, Chief Executive Officer or their designee(s), may summarily restrict or suspend the medical staff membership or clinical privileges of such staff members. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the MEC, the applicable chief of service, office of University Counsel and the Chief Executive Officer; verbal notice shall be given as soon as possible to units and personnel who have a need to know of this decision.

2. The summary restriction or suspension shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the staff member's patients shall be promptly assigned to another practitioner by the chief of service or by the NEC considering, where feasible, the wishes of the patient in the choice of a substitute staff member.

3. As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the NEC shall be convened to review and consider the action. When necessary, the MEC shall direct the committee to further investigate the issues and hold such interviews as may be appropriate with respect to the affected staff member, followed by a report with recommendations to the MEC. The MEC shall complete its review and make its decision within ten (10) days after the restriction or suspension. The suspended staff member may attend and make a statement concerning the issues under investigation on such terms and conditions as the MEC or the investigating committee may impose. In no event shall any meeting of the practice panel with or without the member, constitute a "hearing" within the meaning of Article III. The MEC may modify, continue or terminate the summary restriction or suspension, but in any event, it shall promptly furnish the staff member, the Chief Executive Officer and the medical director with notice of its decision.

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

E. AUTOMATIC SUSPENSION OR LIMITATION.

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

1. Licensure.

a) Revocation and Suspension.

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

b) Restriction.

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

c) Probation.

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

2. Controlled Substances.

a) Restriction.

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

b) Probation.

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

3. Professional Liability Insurance.

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

4. Loss of Medicare or Medicaid Provider Status.

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

5. Loss of Faculty Appointment.

A member who loses a faculty appointment in either the School of Medicine or Dental Medicine will result in automatic revocation of medical staff membership and clinical privileges and such automatic revocation shall not be subject to the hearing and appellate procedures of Article 1111.

F. MEDICAL BOARD DELIBERATION.

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

G. TEMPORARY SUSPENSION.

The medical director or Chief Executive Officer shall have the authority to suspend a member, after written notice to the affected staff member, for failure to comply with the Rules and Regulations regarding completion of medical records or any other mandated activities by the Department of Health within a reasonable period.

ARTICLE III

Professional Review Procedure

SECTION 1. RIGHT TO HEARING

Except as otherwise provided for herein, any practitioner who is a member of the medical staff in good standing as well as other individuals holding clinical privileges and whose reappointment to the medical staff has been denied, or any practitioner whose clinical privileges have been curtailed, suspended, revoked or denied, or any practitioner who has received an adverse recommendation (under Article II, Section 6B (1), subsections (I) through (i) (adverse action) shall have a right to a hearing before a panel of individuals appointed by the President of the medical board in consultation with the officers of the medical board. No member of the panel shall be in direct economic competition with the affected practitioner or have any material conflict of interest, which would prevent him/her from discharging his/her duties in an unbiased manner. Such panel shall consist of an odd number of members.

SECTION 2. HEARING REQUIREMENTS

A. A practitioner, who is entitled to a hearing as set forth in Section 1 above, shall receive written notice from the Chief Executive Officer containing the following information: (1)a statement that an adverse action is

proposed or taken against the practitioner; (2) the reason for such adverse action; (3) the time limits within which to request a hearing; and (4) a summary of his/her rights in the hearing.

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

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

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

E. After the panel is appointed, it shall select a chair to preside over the hearing, if one has not been designated by the MEC or President of the medical board or its designee. The chair shall act to provide that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, that decorum is maintained and that the proceeding be completed in as expeditious manner as is possible under the circumstances. The chair shall be entitled to determine the order or procedure during the hearing. The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. The chair and members of the hearing panel may directly question any of the participants in the hearing, including witnesses. A quorum is sufficient to proceed.

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

1. A record shall be made of the proceedings, copies of which shall be available to the practitioner upon payment to the Hospital of any reasonable costs or charges associated with their preparation;

2. To call, examine and cross-examine witnesses;

3. To introduce evidence determined to be relevant by the panel regardless of its admissibility in a court of law;

4. To impeach any witness;

5. To rebut any evidence;

6. To submit a written statement at the dose of the hearing; and

7. The assistance of counsel or other representative subject to the limitation set forth in Section 2 D above in this Article.

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

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

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

ARTICLE IV

Categories and Duties of the Medical Staff

SECTION 1. CATEGORIES

There are three (3) categories of medical staff membership: Active Attending, Affiliate/Referring, and Interim. Physicians and dentists with emeritus status, those who have retired from hospital practice as attending physicians at 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 University Hospital clinical inpatient and outpatient privileges as are granted to the practitioner;

5. have fair hearing rights as specified in Article Ill of these bylaws.

B. RESPONSIBILITIES.

Appointees to this category must:

1. contribute to the organizational and administrative affairs of the medical staff.

2. contribute to the organizational and administrative affairs of the clinical service to which they are appointed and participate in recognized functions of staff appointment including administrative responsibilities, quality improvement and monitoring activities, committee service, and attend departmental, divisional and service meetings, supervise initial appointees during their provisional period, and discharge other staff and special purpose functions as may be required from time to time.

3. pay all dues and assessments promptly;

4. comply with all provisions of these Bylaws, Rules and Regulations and the policies and procedures of the hospital and;

5. notify the medical staff services department, in writing, within thirty (30) days, when staff status changes at any hospital where membership is held. These changes include, but are not limited to, appointments, licensure, registrations or other factors, which limit the practitioner’s rights of practice.

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 University Hospital outpatient clinical privileges at the discretion of the chief of service at 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 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 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 once the medical staff appointment is completed, approved by the MEC, the Medical Board, and the governing body, and when the only remaining part of the application is the completion of the faculty appointment, which is currently in process. Interim appointments can be granted for a period of no longer than 120 days.

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. 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 University Hospital and/or the Governing body.

B. COMPOSITION.

The medical board shall be composed of:

Voting Members:

1. Officers: President[Dean, School of Medicine]; 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

The Vice President and Secretary/Treasurer shall be elected from a slate of nominees who do not serve on the board in an ex-officio capacity.

Ex-Officio. Non-Voting Members:

1. Chief Executive Officer, University Hospital
2. Chief Operating Officer, University Hospital

3. Chief Nursing Officer, University Hospital
4. Chief Financial Officer, 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.

D. MEMBERS-AT-LARGE.

The nominating committee shall solicit nominations for at-large membership in March of each year. The first March, two of the three at-large members from both categories (with the greatest number of votes) will be elected for two (2) years, while the third member will serve one (1) year. Thereafter elected members will serve two (2) years. Unexpected vacancies will be filled by special election of the medical staff via mail or email.

SECTION 2. BOARD ELECTIONS

A. NOMINATIONS.

Any member of the medical staff may make nominations. Nominees shall be solicited by communication through e-mail, in a written publication, and by announcement at departmental meetings by the chief of service. At-large positions may be filled by any member of the medical staff. The nominating committee will make their selections from the proposed list of nominees. The President of the medical board shall name the chair of the nominating committee.

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 slates for officers and full-time and voluntary staff shall be presented separately and the nominees in each list with the largest tally of votes shall be considered elected. 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.

C. TERMS OF OFFICE.

The 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.

SECTION 3. DUTIES OF OFFICERS

A. PRESIDENT.

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 and staff and shall be ex-officio, a member of all its

committees. He shall appoint the Chairs and members of all committees.

B. VICE PRESIDENT.

The Vice-President shall be the chair of the MEC while simultaneously serving as Vice-President of the medical board and the medical staff. S/he shall assume all of 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. VACANCIES

If the office of President of the medical board/staff is vacated for any reason, the Vice-President shall succeed to that office until such time as a replacement is named. 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 vote at the next annual staff meeting. If the Secretary/Treasurer position becomes vacant, the position will be filled by vote at the next annual meeting.

SECTION 5. REMOVAL OF OFFICERS

The Vice-President and/or Secretary/Treasurer of the medical board can be removed, for cause, including but not limited to: failure to perform the duties of the position, serious violation of the Bylaws, Rules and Regulations, DOH regulations, State or Federal law, breach of ethics or significant impairment of professional activities, by a 2/3 vote of the medical board. The President can only be removed by action of the governing body.

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:

1. Officers:President of the Medical Board; Vice-President of the Medical Board [Chair, MEC]; 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) elected 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

Ex-officio. Non-Voting Members:

1. Chief Executive Officer, University Hospital
2. Chief Operating Officer, University Hospital
3. Chief Nursing Officer, University Hospital

B. ATTENDANCE.

Failure to attend 50% of meetings held will result in replacement on the committee by a member chosen by the President of the medical board.

SECTION 7. MEDICAL DIRECTOR

A. QUALIFICATIONS.

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

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 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.

The President of the medical board shall appoint, with the concurrence of the Chief Executive Officer of University Hospital, a member of the faculty who is an 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 Committeesof the Medical Board

SECTION 1. STRUCTURE

A. COMPOSITION.

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

B. QUORUM and ATTENDANCE.

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

C. VOTING PRIVILEGES.

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

D. COMMITTEE PROCESS AND PURPOSE.

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

E. COMMITTEES REPORTING TO MEDICAL BOARD

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

SECTION 2. BYLAWS

A. CHARGE

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

B. COMPOSITION.

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

C. MEETING/REPORTING.

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

SECTION 3. CANCER

A. CHARGE.

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

B. COMPOSITION.

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

C. MEETING/REPORTING.

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

SECTION 4. CREDENTIALS

A. CHARGE.

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

B. COMPOSITION.

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

C. MEETING/REPORTING.

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

SECTION 5. GRADUATE MEDICAL EDUCATION

A. CHARGE.

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

1. establishment and implementation of policies that effect all residency programs regarding the quality of education and the work environment for the residents in each program;
2. establishment and maintenance of appropriate oversight of and liaison with program directors and assurance that program directors establish and maintain proper oversight of and liaison with appropriate personnel of other institutions participating in programs sponsored by the institution;
3. regular review of all residency programs to assess their compliance with both the Institutional Requirements and Program Requirements of the relevant ACGME RRCs;
4. assurance that each residency program establishes and implements formal written criteria and processes for the selection, evaluation, promotion and
5. dismissal of residents in compliance with both the Institutional and Relevant Program Requirements;
6. assurance of an educational environment in which residents may raise and resolve issues without fear of intimidation or retaliation;
7. collecting of intra-institutional information and making recommendations on the appropriate funding for resident positions, including benefits and support services;
8. monitoring of the programs in establishing an appropriate work environment and the duty hours of residents
9. assurance that the residents* 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.

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 quarterly and report to the medical board at least annually. Minutes will be maintained and made available for inspection by accreditation personnel. The President of the Medical Board will transmit the report of the Graduate Medcial Education committee to the governing body.

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.

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 at each meeting and annually;
4. Report from the Chief Executive Officer of University Hospital (or designee) at each meeting;
5. Report from the Chair of the MEC (or designee) at each meeting;
6. Report from the medical director (or designee) at each meeting;
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 and;
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.

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

Revision of the Bylaws, thereafter shall become effective and shall replace any previous Bylaws after they have been adopted at a regular meeting of the medical board and approved by the governing body.

A. VOTING.

These Bylaws may be amended by a vote of 3/4 of the members of the medical board.

B. NOTICE.

Proposed amendments to the Bylaws shall not be voted upon at any meeting of the medical board until they have been presented to the medical board at a prior meeting or via email or mail. The board shall have two weeks from the date of notice of proposed changes to respond with their recommendations/comments. The proposed revision will then be presented at the next meeting or alternatively, may be emailed or mailed to the board for vote. Members will cast their vote at the next meeting or via email. If there are any recommendations to the proposed changes, action may be deferred to the next scheduled meeting or a special meeting may be convened at which time suggested revisions will be discussed and voted on.

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 the University Hospital.

2. “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.

3.“HOSPITAL”

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

4.“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 and the Chief Executive Officer of the hospital and/or the Board of Trustees.

5.“MEDICAL EXECUTIVE COMMITTEE”

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

6.“MEDICAL STAFF”

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

7. “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.]

8.“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.

9.“UNIVERSITY*”

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

SUBJECT INDEX

ABCDEFGHIJKLMNOPQRSTUVWXYZ

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