Stony Brook University Hospital
Medical Staff Bylaws

JANUARY 26, 2022

MEDICAL STAFF BYLAWS

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Stony Brook University Hospital

GOVERNING BODY APPROVAL

MEDICAL STAFF BYLAWS

REVISIONS JANUARY 26, 2022

The revisions to the Medical Staff Bylaws have been reviewed and are approved as presented January 26, 2022

Signature: Governing Body

Maurie McInnis, President, SUNY @ Stony Brook

1/26/2022
Date

Medical Staff Services Dept, Stony Brook, NY 11794-7097 · Telephone (631)444-2754 · Fax (631)706-3329

ARTICLE I

Mission and Purpose

A. MISSION STATEMENT

The Stony Brook University Hospital, an academic and regional medical center with hospital campuses in Stony Brook (the “Stony Brook Campus”), Southampton (the “Southampton Campus”), and Greenport (the “Eastern Long Island” campus) 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 (CEO), the Dean, School of Medicine 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 CEO, the Dean, School of Medicine 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 research obligations stipulated by the Board of Trustees, the physicians,dentists and midwives working in Stony Brook University Hospital, acting by the authority delegated to them by the Dean, School of Medicine 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 (JC), the Accreditation Council for Graduate Medical Education (ACGME), the Department of Health of the State of New York (DOH), and the Office of Mental Health and Hygiene of the State of New York (OMH),Office of Alcoholism and Substance Abuse Services (OASAS) and other relevant and appropriate Rules and Regulations. (11/18)

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, dentists and midwives, who continuously meet the qualifications, standards and requirements set forth in these bylaws.

A. QUALIFICATIONS.

1. Licensure.

Only physicians, dentists and midwives who possess a full, unrestricted license or a restricted dental faculty license to practice in the State of New York may be members of the medical staff (rev 4/18).

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 practitioner’s credentials file. Members shall be given the opportunity to participate in a Malpractice Prevention Program

3. Continuing Education.

All members of the medical staff, except Honorary, must provide evidence of obtaining 50 hours of continuing medical/dental educational credits (at least 30 Category 1) in the 2 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 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. Health Assessment.

An initial and, thereafter, annual health assessment is required for all members of the medical staff, except those in the Honorary category. All elements of the NYS Health Code 405.3(b) [10] and Stony Brook University Hospital policies 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.

The initial appointment shall not be longer than a period of 2 years and may occur in less than 2 years dependent on the reappointment cycle. Reappointments thereafter shall be for a period of not more than 2 years.

For those granted clinical privileges, a Focused Professional Practice Evaluation/FPPE will be conducted (refer to section on clinical privileges and Stony Brook University Hospital FPPE policy).

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. The applicant shall also be obligated to provide continuous care and supervision of their patients.

Each applicant shall submit a statement that no health problems exist that could affect the applicant's ability to perform the privileges requested. An evaluation by an internal or external source may be required in instances where there is doubt about an applicant's ability to perform the privileges requested. Each applicant shall submit a complete physical and history which is reviewed by employee health services.

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 or registration
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]. Peer recommendations will include information regarding the practitioner's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills and professionalism.

At a minimum, 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. Additionally, any other agencies which are required to be queried by state and/or federal regulations at the time the practitioner's application is being processed will be queried.

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.

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 the applicant's:

- background
- qualifications
- credentials
- clinical competence and performance
- professional behavior
- pending or prior actions or proceedings with regard to their profession or 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.

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 Department Chair/chief of service shall convene a credentials committee consisting of at least 3 physician or dentist members of the medical staff within the service (the "department credentials committee"). The Department Chair/chief of service shall not be one of the three members, but may be an additional member of the committee. The department 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.

For those applicants who express an intention to practice solely on the Southampton Campus, or Eastern Long Island Campus before their applications reach the department credentials committee as described above, they shall be reviewed by a local credentials committee (the "Southampton credentials committee" or "Eastern Long Island credentials committee"), which shall provide an advisory report and recommendation to the department credentials committee.

The Southampton credentials committee, appointed by Department Chairs/chiefs of service with the approval of the Dean, shall be comprised of one physician or dentist medical staff member from each department who practices primarily at the Southampton Campus, the Medical Director of the Southampton Campus, and two of the vice chairs/service chiefs of the Southampton Campus. The Southampton credentials committee shall consider the completed applications and supporting materials of those applicants who will be solely exercising privileges on the Southampton Campus, make such investigations as it deems proper and necessary, and shall make a report of its investigations and determinations, including specific recommendations for delineating an applicant's clinical privileges, to the department credentials committee.

The Eastern Long Island credentials committee, appointed by Department Chairs/chiefs of service with the approval of the Dean, shall be comprised of one physician or dentist medical staff member from each department who practices primarily at the Eastern Long Island Campus, the Medical Director of the Eastern Long Island Campus, and two of the vice chairs/service chiefs of the Eastern Long Island Campus. The Eastern Long Island credentials committee shall consider the completed applications and supporting materials of those applicants who will be solely exercising privileges on the Eastern Long Island Campus, make such investigations as it deems proper and necessary, and shall make a report of its investigations and determinations, including specific recommendations for delineating an applicant's clinical privileges, to the department credentials committee.

2. Department/Chair/Chief of Service.

Only a completed and verified application for membership on the medical staff shall be submitted to the appropriate Department Chair/chief of service. After review and recommendation by the Department Chair/chief of service, the application shall be forwarded to the Medical Executive Committee (MEC). If the recommendation of the Department Chair/chief of service is inconsistent with the recommendation of the department credentials committee, such appointment application shall be referred to the Hospital Credentials Committee for further guidance.

The chief medical officer (CMO) 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.

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 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 CEO within 60 days, indicating the rank of membership and clinical privileges granted.

2. Defer Appointment.

If the recommendation at the level of the department credentials committee or chief of service is to defer the application for further consideration, the hospital's credentials committee shall review the application and make a recommendation to the medical board or MEC. If the recommendation by the medical board or MEC is to defer the application for further consideration, the application will be returned to the chief of service for additional information.

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 (CEO) 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 forwarded 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 evoke the right to the hearing and appellate review procedures described in Article III.

e) Administrative Denial

An administrative denial (not reportable to any agency) due to lack of documentation or failure to produce evidence of fulfilling criteria for appointment or privileges, shall not evoke the right to the hearing and appellate review procedures described in Article III.

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
any removal from a managed care organization panel for quality of care reasons or unprofessional conduct.

Each applicant shall submit a statement that no health problems exist that could affect the applicant's ability to perform the privileges requested. An evaluation by an internal or external source may be required in instances where there is doubt about an applicant's ability to perform the privileges requested. All practitioners must have a current (within one year) physical assessment on file at the time of reappointment.

The practitioner will pledge to provide for the continuous care of their patients.

2. Verification of Information.

The Medical Staff Services Department will conduct primary source verification of the following:

current licensure/registration
challenges to licensure
additional education/training (e.g. residency, fellowship, if applicable)
board status
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].

At a minimum, 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. Additionally, any other agencies which are required to be queried by state and/or federal regulations, when the practitioner's application is being processed, will be queried.

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

3. Determination of Competence.

It is the responsibility of medical staff leadership to determine the practitioner's professional performance, judgment and clinical/technical skills. This will be determined by:

data collected through Ongoing Professional Practice Evaluation/OPPE (refer to Stony Brook University Hospital OPPE policy)
results of performance improvement activities
recommendations from the respective credentials committee and division/department.

The ability to perform the privileges requested (health status) will be confirmed by the chief of service in the reappraisal form.

For those practitioners with limited clinical activity at Stony Brook University Hospital, the ability to perform the privileges requested and current competence may be determined by professional references.

B. LEVELS OF REVIEW.

1. Credentials Committee.

The Department Chair /chief of service shall convene a credentials committee consisting of at least 3 physician or dentist members of the medical staff within the service (the “department credentials committee”). The Department Chair /chief of service shall not be one of the three members, but may be an additional member of the committee. The department 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 department credentials committee shall recommend to the Department Chair/chief of service, reappointment unless a majority of its members vote to defer or deny.

The department credentials committee report shall not be binding but must be forwarded along with the Department Chair’s recommendation to the MEC and medical board.

Prior to review by the department credentials committee, the Southampton or Eastern Long Island credentials committee shall consider and review the reappointment application and supporting materials of those seeking reappointment who solely exercise privileges on the Southampton or Eastern Long Island Campus, including meeting attendance, documented evidence of continuing education, results of quality assurance activities, and make such investigations as it deems proper and necessary. The Southampton or Eastern Long Island credentials committee shall provide an advisory report and recommendation to the department credentials committee.

2. Department Chair/Chief of Service.

Only a completed and verified reappointment application shall be submitted to the appropriate Department Chair/chief of service. After review and recommendation by the Department Chair/chief of service the reappointment application shall be forwarded to the MEC. If the recommendation of the Department Chair/chief of service is inconsistent with the recommendation of the department credentials committee, such reappointment application shall be referred to the Hospital Credentials Committee for further guidance.

The CMO 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.

3. 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 at least every 2 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 recommendation of the medical board shall be forwarded promptly to the governing body for final action. The practitioner shall then be notified by letter from the CEO indicating category of membership and privileges granted.

2. Defer Reappointment.

If the recommendation at the level of the department credentials committee or chief of service is to defer the application for further consideration, the hospital's credentials committee shall review the application and make a recommendation to the medical board or MEC. If the recommendation by the medical board or MEC is to defer the application for further consideration, the application will be returned to the chief of service for additional information.

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 CEO 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) Administrative Denial.

Any recommendation not to reappoint to the medical staff which is based upon an administrative denial (not reportable to any agency) due to lack of documentation or failure to produce evidence of fulfilling criteria for reappointment or privileges, shall not evoke the right to the hearing and appellate review procedures described in 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. ALLIED HEALTH CARE PRACTITIONERS - LICENSED INDEPENDENT PRACTITIONERS and REGISTERED DEPENDENT PRACTIONERS.

A. PROCESS.

Applications made by any licensed independent allied health practitioner, defined as psychologists, neuropsychologists, acupuncturists, podiatrists, speech and language therapists, audiologists, optometrists, nurse practitioners and licensed clinical social workers with “R” psychotherapy privileges or licensed dependent allied health practitioners, defined as physician assistants, specialist assistants, first assistants and nurse anesthetists for clinical privileges at Stony Brook University Hospital shall be forwarded to the appropriate clinical service for processing in accordance with the Bylaws, Rules and Regulations of the Medical Staff and those of the service (rev 4/18).

The process for appointment, reappointment and privileging shall follow the medical staff process, with the exception of the following:

allied health practitioners are not required to pay dues
psychologists, neuropsychologists, speech and language therapists, audiologists and licensed clinical social workers with “R” psychotherapy privileges are exempt from the NYS Infection Control Training Course
Nurse anesthetists, physician assistants, specialist assistants and first assistants are not required to have a faculty appointment in the School of Medicine/Dental Medicine

B. CONTINUING EDUCATION.

Allied health practitioners are required to provide evidence of obtaining 50 hours of continuing education (CE) credits or an amount to be determined by the medical board, in the 2 years prior to their reappointment. At least some of the CE will be related to the privileges requested.

C. AGREEMENTS/COLLABORATION

All allied health practitioners must have a collaborative or supervising physician, as required by law, who is a member of the medical staff. No physician shall be designated to supervise and direct more than 6 physician assistants/specialist assistants or a combination thereof.

Nurse practitioners shall have written practice agreements and written practice protocols on file as required by law.

D. RIGHTS

Allied health practitioners, holding clinical privileges are entitled to the same fair hearing and appeal process for renewal, revocation or revision of clinical privileges as the medical staff.

Allied health practitioners are not members of the medical staff. They are not permitted to hold office on the medical staff or have voting privileges.

Allied health practitioners duly qualified and approved for clinical privileges in the Hospital may, in accordance with the terms of their appointment and subject to the law governing their scope of practice:

Provide specifically designated patient care services under the supervision or direction of a member of the Medical Staff, as appropriate;

Write orders only to the extent specified in the Medical Staff Rules and Regulations or the applicable position description, but not beyond the scope of the allied health practitioner's license, certificate or other legal credentials;

Be invited by the President of the Medical Board or a department chair to serve with or without vote on Medical Staff and department committees and can also chair committees;

Attend Medical Staff and department education programs and clinical meetings related to their discipline;

Exercise such other prerogatives as the Medical Board may accord allied health practitioners in general or specific categories of allied health practitioners in particular.

SECTION 6. 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.

Before recommending privileges, at a minimum, the following will be evaluated:

voluntary and involuntary relinquishment of any license or registration
voluntary and involuntary termination of medical staff membership
voluntary and involuntary limitation, reduction or loss of clinical privileges
any evidence of an unusual pattern, or an excessive pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
documentation as to the applicant's health
relevant practitioner-specific data as compared to aggregate data when available
morbidity and mortality data when available
peer recommendations

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. Granting of Privileges.

A Focused Professional Practice Evaluation/FPPE, as delineated in the Stony Brook University Hospital FPPE policy, will be conducted for practitioners who are initially granted clinical privileges.

Any requests for new privileges by practitioners currently on staff will require a review by the respective division chief (if applicable), credentials committee and chief of service. Any new privileges granted, will require a Focused Professional Practice Evaluation/FPPE as defined in the Stony Brook University Hospital FPPE policy.

5. Renewal of Privileges.

Clinical privileges will be considered for renewal at the time of the medical staff reappointment and will follow the same review process as at appointment.

Renewal of clinical privileges, and or a change in privileges, shall be based upon current competence determined by any or all of the following;

direct observation of care provided
results of the data collected through Ongoing Professional Practice Evaluation/OPPE
results of performance improvement activities
review of patient records
recommendations from the respective division chief (if applicable), the department credentials committee and chief of service

Other reviews may 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.

The ability to perform the privileges requested (health status) will be confirmed by the chief of service in the reappraisal form. All practitioners must have a current (within one year) physical assessment at the time of reappointment.

For those practitioners with limited clinical activity at Stony Brook University Hospital, the ability to perform the privileges requested and current competence may be determined by professional references.

B. ADMINISTRATIVE/TEMPORARY PRIVILEGES.

1. Categories.

There shall be 2 categories of administrative appointments described as:

a. Administrative/temporary privileges pending MEC, medical board and governing body approval may be granted for a practitioner who has a complete appointment application. A complete appointment application has been processed by the Medical Staff Services Department and the practitioner does not have:

unverified gaps of more than 3 months in the prior 10 years
current or previously successful challenges to license or registration
any involuntary suspensions of medical staff membership at any other institution

The application has been reviewed by the division chief (if applicable), department credentials committee and chief of service and has been recommended for appointment.

Administrative/temporary privileges may also be granted for a member of the medical staff currently holding privileges who is requesting additional privileges, provided the request has been reviewed and recommended by the division chief (if applicable), the department credentials committee and the chief of service.

b. Administrative/temporary privileges for special needs 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/temporary privileges pending MEC, medical board and governing body approval shall be for a period of 90 days.

b. Administrative/temporary 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. Any patient care procedure or admission must be delineated in scope and time and be carried out under the direction of the respective chief of service.

3. Process.

a) Administrative/temporary privileges pending MEC, Medical Board and Governing body approval:

Acting upon the recommendation of the respective departmental credentials committee and chief of service, the President of the medical board (or designee) may recommend administrative/temporary privileges to the CEO (or designee) of the hospital. The Governing Body is responsible for final approval of administrative privileges.

b) Administrative/temporary privileges for special needs.

Acting upon the recommendation of the chief of service, the President of the medical board (or designee) may recommend administrative/temporary privileges to the CEO (or designee) of the hospital. The Governing Body is responsible for final approval of administrative privileges.

4. Verification.

a) Administrative/temporary privileges pending MEC, medical board and governing body approval – Primary source verification will be conducted as required for appointment process. All verifications must be completed prior to review by the division chief (if applicable), department credentials committee and chief of service.

b) Administrative/temporary privileges for special needs - Primary source verification of licensure, current competence, Office of Professional Conduct (OPMC), Office of Inspector General (OIG), National Practitioner Data Bank and all other regulatory bodies as required by regulation, must be completed/queried 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).

The CMO shall be responsible for interpreting the provisions of this section.

C. PRIVILEGES IN THE CASE OF AN EMERGENCY.

In an emergency any member of the medical staff, house staff or allied health practitioner staff is permitted to provide any type of patient care, treatment and services necessary as a life-saving measure or to prevent harm, regardless of medical staff status or clinical privileges, provided that the care, treatment and service provided is within the scope of the individual’s license.

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

1. Definitions.

“Disaster privileges" may be granted when the hospital’s 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.

Disaster ” is an emergency that, due to its complexity, scope or duration, threatens Stony Brook University Hospital’s capabilities and requires outside assistance to sustain patient care, safety or security functions.

2. Expectation

The CMO, 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 their discretion.

All licensed health practitioners requesting temporary disaster privileges are to be referred to the Medical Staff Services Department. If the Medical Staff Services Department is not open, the practitioner shall be referred to the Chief Medical Officer.

Volunteers considered eligible to act as licensed 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.

Any **one** of the following five items must be presented before disaster privileges may be granted:

- Current license, certification or registration to practice.
- 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.

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 or within 72 hours from the time the volunteer practitioner presents to the organization, whichever occurs first. 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 by the licensed practitioner to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. In the event 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 Services Department 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.

The medical staff will oversee the performance, including the care, treatment and services provided, of the licensed practitioners who are granted disaster privileges by one or more of the following methods (a) direct observation, (b) mentoring, (c) medical record review. The method(s) of oversight will be determined by the grantor at the time privileges are granted. The hospital will make a decision (based on information obtained regarding the professional practice of the volunteer as well as actual oversight of the practitioner) within 72 hours, related to the continuation of the disaster privileges initially granted.

Any information gathered that is not consistent with that provided by the practitioner must be referred to the CMO 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 and oversight 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, CMO 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 or dentists 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 7. DISCIPLINARY PROCEDURES

A. CORRECTIVE ACTION.

1.Any person may provide information to the medical board, CMO, chief of service or the CEO, about the conduct, performance, or competence of a staff member (the “practitioner”). All such complaints shall be forwarded to the CMO for review unless the CMO 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, CEO, president of the medical board, or CMO 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 CMO, chief of service, CEO and president of the medical board throughout this section may be interpreted to include their designees.]

3. The CMO shall have the discretion to attempt to resolve issues arising under this section with the practitioner, who will be required to meet with the CMO, if asked, or other involved individuals, or to refer them, if appropriate, to a quality assurance liaison or other entity, if, in the CMO's judgement, the complaint can be resolved without a MEC investigation. If the CMO has taken action to resolve an issue, a report shall be submitted in writing by the CMO to the MEC for approval.

4. If, however, the CMO concludes that an investigation is warranted, the CMO 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 3 physician or dentist 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 physician or dentist 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 investigative committee 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 investigative committee deems appropriate. All members of the medical staff must cooperate with the investigation unless excused by the investigative committee.

b) The investigative committee shall forward a written report of the investigation to the CMO and MEC, with a copy to the medical staff department, as soon as practicable but no later than 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, summary of the information provided by 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 Services Department. In the event such letters are issued, the practitioner may make a written response that shall be placed in their file in the medical staff services 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) recommending the imposition of terms of probation that includes a limitation upon the exercise of clinical privileges including, without limitation, requirements for co-admission, mandatory consultation and/or approval prior to a procedure or monitoring or supervision during a procedure or patient encounter.

i) recommending reduction, restriction, modification, suspension, denial or revocation of clinical privileges.

j) recommending suspension, modification, probation, termination or denial of medical staff membership

k) any other appropriate corrective action

C. SUBSEQUENT ACTION.

1. If a corrective action as set forth in (h) through (j) 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, CMO, and Medical Staff Services Department. In these cases only, the practitioner shall then be entitled to their rights as set forth in Article III.

2. If the practitioner does not exercise their 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, CMO, 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 Services 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 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 ad hoc summary suspension committee of three physician or dentist members of the active attending medical staff who can serve in such capacity without a conflict of interest to further review the basis for the summary suspension and provide a report to the MEC. The ad hoc summary suspension committee shall hold such interviews as may be appropriate and shall extend an invitation to meet with 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 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. Unless the MEC terminates the summary restriction or suspension, it shall also make a recommendation for further corrective action (i.e., corrective action that must be completed in order for the suspended/restricted privilege(s) to be restored or permanent revocation of the suspended/restricted privilege(s). It shall promptly furnish the practitioner (by certified mail, return receipt requested, or overnight courier), the CEO, the respective chief of service, the CMO and the medical staff services department with notice of its decision. The practitioner shall then be entitled to their rights as set forth in Article III.

If the affected practitioner does not exercise their 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 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 CMO, and the practitioner’s 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 CMO, 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 CMO, and the practitioner’s 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 CMO, 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 CMO, 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 CMO 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, 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 SUSPENSION.

The CMO or CEO shall have the authority to place a practitioner on administrative suspension, 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 physical assessment; infection control training).

The suspension may be for a period of 30 calendar days. Failure to correct the deficiency within the 30 day suspension period will result in automatic termination from the medical staff. Administrative suspensions are not reportable actions or subject to Article III or a professional review. Terminations which occur 30 calendar days after the administrative suspension 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 7.B (h) through (j), 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 their 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 their 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 their right to a hearing and 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 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, the practitioner 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 president of the medical board shall schedule the hearing and shall notify the practitioner, as soon as practicable, by certified mail, return receipt requested, or overnight courier, of the following:

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, if known.

4. A statement of the specific reasons for the recommendation as well as the list of patient records (if applicable) 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 review this additional information and rebut it.

Except as set forth below, the date of the hearing shall be no less than 30 and no more than 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 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 the practitioner to the hearing to the hearing panel chair, with a copy to the president of the medical board on behalf of the Hospital, at least 10 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 at the same time.

SECTION 4. COMPOSITION AND SELECTION OF THE HEARING PANEL

The hearing shall be conducted by a hearing panel, consisting of no fewer than 3 physician or dentist members of the active attending staff, all selected by the president of the medical board. To the extent that the practitioner solely practices at a particular campus of the hospital, the president of the medical board should attempt to select at least one hearing panel member who primarily practices at the same campus, if possible. 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 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.

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 the hearing panel chair feels it is appropriate. Legal counsel to, or retained by, the hospital may advise the hearing panel.

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 and advise their client. The extent to which the parties' counsel may actively participate in the hearing will be determined by the hearing panel chair.

5. To submit a written statement at the close of the hearing on a date determined by the hearing panel chair. The hearing shall be considered complete on the date that the parties' post-hearing statements are due. .

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; Exhibit Exchange. There shall be no right to prehearing discovery including but not limited to discovery or information regarding other practitioners and/or their clinical activities. Subject to the practitioner's execution of a confidentiality agreement acceptable to the hospital, no later than 7 calendar days prior to the scheduled date of the hearing the practitioner and the hospital shall exchange copies of all documents each party plans to introduce at the hearing, including expert reports as well as updated witness lists. Additional witnesses and documentary evidence shall be permitted at the hearing in the discretion of the hearing panel for good cause shown.

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. The extent to which the parties' counsel may actively participate in the hearing will be determined by the hearing panel chair.

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 the practitioner's rights under these bylaws.

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

Within 30 calendar 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, including a statement of the basis of its decision. Such recommendations shall then be submitted to the medical board for its review, with a copy sent to the practitioner by certified mail, return receipt requested, or overnight carrier. Following its review, 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, CMO respective chief of service and medical staff department.

SECTION 8. RIGHT OF APPELLATE REVIEW.

a) Right to Appeal: Following a hearing, the recommendation of the Medical Board may be appealed to the governing body by the practitioner or the hospital.

b) Request for Appeal: A request for appellate review shall be submitted in writing to the president of the medical board within 10 business days after receipt of the medical board's recommendation. The president of the medical board shall forward the appellate request, and the hearing record, including the hearing transcript, copies of the parties' hearing exhibits, post-hearing written statements, and the decision of the hearing committee, to the governing body within 5 business days of receipt of the request.

c) Waiver of Appeal: Failure of either party to request an appeal within the allotted 10 business day period shall be deemed to be a waiver of the right to further appeal.

d) Appellate Review: Appeal to the governing body: The governing body acts as the appellate review body.

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

1. Review of the Hearing Record and Statements: The governing body shall include in its review the hearing record and the written statements of the parties submitted pursuant to Section 8.e.2 of this Article.

2. Written Statements: Within 30 calendar days of receipt of a request for appellate review, the governing body shall inform the parties of the schedule for submitting the appellant's written statement and the appellee's written response. The appellant shall have no less than 30 calendar days from the receipt of such schedule to submit its statement to the governing body and appellee. The appellee shall have no less than 30 calendar days from the receipt of appellant's statement to submit its responsive written statement to the governing body and appellant. No additional statements will be accepted, unless explicitly requested by the governing body.

3. 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 for good cause shown as to why the matters could not have been raised earlier. The governing body shall in their sole discretion determine whether new matters shall be accepted.

4. Action Taken: Within 30 business days of the receipt of all written statements, the governing body shall affirm, modify or reverse the adverse recommendation or action taken after the hearing or, in their 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 governing body shall complete their deliberations and conclude the appeal within 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, CMO, 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 3 categories of medical staff membership: Active Attending, Affiliate/Referring, and Honorary. Physicians and dentists with emeritus status, those who have retired from hospital practice as attending physicians/ or dentists at Stony Brook University Hospital and other practitioners who have attained notable career achievements, may be given the designation of Honorary.

A. ACTIVE ATTENDING

1. RIGHTS.

Appointees to this category may:

a. admit patients, without limitations, except as otherwise proscribed by their clinical privileges or the objectives of the institution;
b. 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;
c. exercise such Stony Brook University Hospital clinical inpatient and outpatient privileges as are granted to the practitioner;
d. have fair hearing rights as specified in Article Ill of these bylaws

2. RESPONSIBILITIES.

Appointees to this category must:

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

b. 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.

c. pay all dues and assessments promptly;

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

e. notify the medical staff services department, in writing, within 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.

f. 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.

B. AFFILIATE/REFERRING

1. RIGHTS.

Appointees of this category shall:

a. relate to the hospital primarily through the direct referral of patients to the attending medical staff for admission and/or evaluation;

b. 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;

c. be eligible for Stony Brook University Hospital outpatient clinical privileges at the discretion of the chief of service at Stony Brook University Hospital;

d. 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

e. have fair hearing rights as specified in Article III of these bylaws.

2. RESPONSIBILITIES.

Appointees to this category shall:

a. 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;

b. pay all dues and assessments promptly

c. not be permitted to hold office or vote;

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

e. notify the medical staff services department, in writing, within 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.

C. HONORARY

1. DEFINITION.

Physicians and dentists who are honored by emeritus status, those who have retired from hospital practice as attending physician or dentists 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.

2. RIGHTS.

Appointees to this designation shall:

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

SECTION 2. INTERIM APPOINTMENTS.

A. DEFINITION

A faculty appointment in the School of Medicine or Dental Medicine is a requirement for medical staff appointment. 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.

B. RIGHTS

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

ARTICLE V

Clinical Services

SECTION 1. ORGANIZATION OF A CLINICAL SERVICE, DIVISION AND SECTION

A. DEPARTMENTS AND CLINICAL SERVICES

1. School of Medicine

The medical staff of the hospital shall be organized into clinical services which correspond to the clinical departments of the School of Medicine. The creation of a clinical department in the School of Medicine automatically shall result in the creation of such a clinical service in the hospital.

2. School of Dental Medicine

In addition to the foregoing, there shall be 1 additional clinical service in the hospital: the Department of Dentistry (School of Dental Medicine).

B. ORGANIZATIONAL RELATIONSHIPS

1. REPORTING MECHANISMS

Each service shall have a chief of service as the operational head who shall report directly to the CMO or the Dean, School of Medicine depending upon the function they are fulfilling relating to specific issues. Problems that cannot be decided by chiefs of service are referred to the MEC and Medical Board of the hospital by the CMO and/or CEO.

a. SCHOOL OF MEDICINE APPOINTMENTS.

For departments with School of Medicine accountability, the chief of service in the hospital shall be the chair of the corresponding clinical department in the School of Medicine unless otherwise designated by the Dean, School of Medicine.

b. SCHOOL OF DENTAL MEDICINE APPOINTMENTS.

In Dentistry, the chief of service shall be appointed by the Dean of the School of Dental Medicine. The person shall be selected from School of Dental Medicine faculty who are members of the medical staff of the hospital.

2. IN ABSENTIA

Delegation Process.

During the authorized absence of any chief of service, their duties shall be discharged by the associate chief of service or vice chair, if there be one. In the absence of an associate chief of service or vice chair, a physician designated by the chief of service shall discharge duties, and the CEO shall be so notified. In the absence of the chief of service for longer than one month, the individual serving in the chief of service's stead must have the approval of the Dean, School of Medicine.

3. QUALIFICATIONS

Each chief of service shall be certified by an appropriate specialty board or have comparable competence, established through the credentialing process.

4. FUNCTIONS/RESPONSIBILITIES OF A CHIEF OF SERVICE

Department Chairs/chiefs of service shall be responsible for all activities on all Hospital campuses (Stony Brook University, Southampton and Eastern Long Island) within their service, as defined and delegated by the governing body. The chief of service of each department is responsible for the ongoing, effective operation of the department and for assessing and improving its activities. Such responsibilities encompass not only the internal functioning, but also the integration of each department into the overall functioning of the organization. Fulfilling these responsibilities enables the integration of the department into the overall functioning of the organization, the coordination of its services with those of other departments, and the improvement of the services it provides. To carry out this responsibility, they shall do at least the following

1. All clinically related activities of the clinical services;
2. All administratively related activities of the clinical services, unless provided for by the hospital;
3. Continuing surveillance of the professional performance of all individuals in the clinical service who have delineated clinical privileges;
4. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the clinical service;
5. Recommending clinical privileges for each member of the clinical service;
6. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization ;
7. Integrating the department or clinical service into the primary functions of the organization;
8. Coordinating and integrating of inter and intradepartmental services;
9. Developing and implementing policies and procedures that guide and support the provision of care, treatment and services;
10. Recommending a sufficient number of qualified and competent persons to provide care, treatment and ~~or~~ services;
11. Determining the qualifications and competencies of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;
12. Continually assessing and improving the quality of care, treatment and services provided;
13. Maintaining quality control and patient safety programs, as appropriate;
14. Providing orientation and continuing education for all persons in the department or clinical service;
15. Recommending space and other resources needed by the department or clinical service;
16. Communicating to members of the department or service regarding the medical staff Bylaws, Rules and Regulations, hospital regulations and any actions taken by the medical board.

5. VICE CHAIRS/SERVICE CHIEFS AT SOUTHAMPTON CAMPUS

For each clinical department with a presence at the Southampton Campus, there will be a Southampton vice chair/service chief collaborating with, assisting, and reporting to the department chair/chief of service. The Southampton vice chair/service chief must, at the time of nomination and election, and throughout their term, be a physician or dentist member of the medical staff in good standing who practices at the Southampton Campus.

Nominations will be sought from the members of the Department practicing at Southampton by the department chair/chief of service and the vice chair/service chief at the Southampton Campus. The vice chair/service chief will be elected biennially by a plurality vote of the members of the department who practice at the Southampton Campus via secret ballot. In the event there is no member of the Medical Staff of the relevant Department at the Southampton Campus who is both eligible and willing to serve as vice chair/service chief, the department chair/chief of service may appoint a member of the Medical Staff to this role, subject to approval of the Dean, School of Medicine and the MEC. Each vice chair/service chief so elected shall also be subject to approval by the department chair/chief of service and the Dean, School of Medicine. A vice chair/service chief may be removed by the Department Chair/chief of service with the approval of the Dean.

The vice chairs/service chiefs of the Southampton Campus shall have the following duties:

1. Serve as the representative of the department chair/chief of service for the applicable department at the Southampton Campus and be responsible for monitoring the professional and administrative activities within the department/service at the Southampton Campus;

2. Serve as liaison between the department chair/chief of service and the members of the Medical Staff who practice at the Southampton Campus;

3. Provide input on certain administrative decisions which may be of legitimate concern to members of the Medical Staff who primarily practice at the Southampton Campus;

4. Participate in QA and QI activities with the department/service, and serve as liaison between the department chair/chief of service and the members of the Medical Staff who primarily practice at the Southampton Campus when concerns arise;

5. Participate in the development of those department/service rules and regulations which are of legitimate concern to members of the Medical Staff who primarily practice at the Southampton Campus;

6. When revisions in privileging criteria for the department/service are presented at Credentials Committee, present concerns that members of the Medical Staff who primarily practice at the Southampton Campus may have;

7. Represent members of the Medical Staff who primarily practice at the Southampton Campus at meetings of the Southampton Campus Leadership Coordinating Council, the department, the Medical Board and Medical Executive Committee, and other relevant meetings of the Medical Staff; and

8. Assume other duties and responsibilities in support of, and with approval of, the department chair/chief of service for the department at the Southampton Campus as requested.

The Department chair/chief of service and vice chair/service chief may, at their option at any time, choose a member of the Medical Staff who primarily practices at the Southampton Campus within the relevant department to serve as associate vice chair/service chief who may assist the vice chair/service chief in carrying out their duties.

Call Responsibilities

The Department Chairs/chiefs of service, in collaboration with the vice chairs/service chiefs at the Southampton Campus, as applicable, shall establish and administer call coverage responsibilities for their departments at each campus, as applicable

6. VICE CHAIRS/SERVICE CHIEFS AT EASTERN LONG ISLAND CAMPUS

For each clinical department with a presence at the Eastern Long Island Campus, there will be a Eastern Long Island vice chair/service chief collaborating with, assisting, and reporting to the department chair/chief of service. The Eastern Long Island vice chair/service chief must, at the time of nomination and election, and throughout their term, be a physician or dentist member of the medical staff in good standing who practices at the Eastern Long Island Campus.

Nominations will be sought from the members of the Department practicing at Eastern Long Island by the department chair/chief of service and the vice chair/service chief at the Eastern Long Island Campus. The vice chair/service chief will be elected biennially by a plurality vote of the members of the department who practice at the Eastern Long Island Campus via secret ballot. In the event there is no member of the Medical Staff of the relevant Department at the Eastern Long Island Campus who is both eligible and willing to serve as vice chair/service chief, the department chair/chief of service may appoint a member of the Medical Staff to this role, subject to approval of the Dean, School of Medicine and the MEC. Each vice chair/service chief so elected shall also be subject to approval by the department chair/chief of service and the Dean, School of Medicine. A vice chair/service chief may be removed by the Department Chair/chief of service with the approval of the Dean.

The vice chairs/service chiefs of the Eastern Long Island Campus shall have the following duties:

1. Serve as the representative of the department chair/chief of service for the applicable department at the Eastern Long Island Campus and be responsible for monitoring the professional and administrative activities within the department/service at the Southampton Campus;

2. Serve as liaison between the department chair/chief of service and the members of the Medical Staff who practice at the Eastern Long Island Campus;

3. Provide input on certain administrative decisions which may be of legitimate concern to members of the Medical Staff who primarily practice at the Eastern Long Island Campus;

4. Participate in QA and QI activities with the department/service, and serve as liaison between the department chair/chief of service and the members of the Medical Staff who primarily practice at the Eastern Long Island Campus; when concerns arise;

5. Participate in the development of those department/service rules and regulations which are of legitimate concern to members of the Medical Staff who primarily practice at the Eastern Long Island Campus;;

6. When revisions in privileging criteria for the department/service are presented at Credentials Committee, present concerns that members of the Medical Staff who primarily practice at the Eastern Long Island Campus; may have;

7. Represent members of the Medical Staff who primarily practice at the Eastern Long Island Campus; at meetings of the Eastern Long Island Campus Leadership Coordinating Council, the department, the Medical Board and Medical Executive Committee, and other relevant meetings of the Medical Staff; and

8. Assume other duties and responsibilities in support of, and with approval of, the department chair/chief of service for the department at the Eastern Long Island Campus as requested.

The Department chair/chief of service and vice chair/service chief may, at their option at any time, choose a member of the Medical Staff who primarily practices at the Eastern Long Island Campus within the relevant department to serve as associate vice chair/service chief who may assist the vice chair/service chief in carrying out their duties.

Call Responsibilities

The Department Chairs/chiefs of service, in collaboration with the vice chairs/service chiefs at the Eastern Long Island Campus, as applicable, shall establish and administer call coverage responsibilities for their departments at each campus, as applicable

ARTICLE VI

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 CEO 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, within the scope of its responsibilities as defined by the medical staff. The responsibility for the adoption of medical staff policies and for the communication of these policies to the medical staff by any means deemed effective is delegated to the Medical Board by the medical staff.

The Medical Board, through the MEC, reports monthly to the governing body. The governing body approves the scheduling of reports of selected medical staff committees, departments and other activity groups.

B. COMPOSITION

The medical board shall be composed of:

Voting Members:

1. Officers: President, Vice-President, Secretary/Treasurer
2. All clinical Department Chairs/chiefs of service
3. Seven members-at-large from the full-time faculty; Seven from the voluntary faculty, at least two of the seven voluntary faculty must practice solely at the Southampton Campus and be nominated by the Southampton Leadership Council and two of the seven voluntary faculty must practice solely at the Eastern Long Island Campus and be nominated by the Eastern Long Island Leadership Council.
4. Director of the Heart Center
5. Director of the Cancer Center
6. Chair of the Southampton Leadership Council
7. Chair of the Eastern Long Island Leadership Council
8. Medical Director of the Southampton Campus
9. Medical Director of the Eastern Long Island Campus
10. CMO
11. Associate Medical Director for Quality Management
12. Designated Institutional Officer (DIO)/Associate Dean for Medical Education {Revised 12/04}
13. Dean, School of Medicine

The President, Vice President, Secretary/Treasurer and the Members-at-Large must be a physician or dentist member of the active attending category of the medical staff. The President and Vice President must also be full time faculty members at the Stony Brook campus.

Non-Voting Members:

1. CEO, Stony Brook University Hospital (ex-officio)
2. Chief Operating Officer, Stony Brook University Hospital (ex-officio)
3. Chief Nursing Officer, Stony Brook University Hospital (ex-officio)
4. Chief Financial Officer, Stony Brook University Hospital (ex-officio)
5. Chief Administrative Officer of the Southampton Campus (ex-officio)

6. Chief Administrative Officer of the Eastern Long Island Campus (ex-officio)
7. Vice Dean for Faculty Affairs
8. Trauma Service Director
9. Chair of the Hospital Credentials Committee (only if CMO is not serving as Chair of Committee)
10. Chief Resident, elected by Graduate Medical Education Committee, 1-year term
11. Nurse Practitioner representative from the Nursing Council

C. ALTERNATES.

Each chief of service shall designate a single physician or dentist alternate to represent them 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. Nominees for president, vice president and secretary/treasurer of the Medical Board must be full time physician or dentist members of the Stony Brook faculty. A minimum 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.

Voting will be done annually in a secure manner by secret ballot either in person, or electronically if determined to be feasible (rev 4/18). 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 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 2 consecutive terms in the same position.

SECTION 3. DUTIES OF OFFICERS

A. PRESIDENT

The President of the medical board shall simultaneously serve as President of the medical staff. The President shall call and preside at all meetings of the medical board, MEC and medical staff and may be a member of all its committees. The President 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. To be eligible, Presidential and Vice Presidential candidates must have served on the medical board within the previous five years, and be physician or dentist members of the full time faculty at the Stony Brook Campus.

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 and shall act on behalf of the Vice President in the absence of the Vice President.

SECTION 4. REMOVAL OF OFFICERS AND MEMBERS OF THE BOARD

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.

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

SECTION 5. 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 the position is filled by vote at a Special Election of the medical staff. 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 election (rev 4/18).

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 the Dean's designee.

Special Elections may be held via mail and/or electronically (rev 4/18).

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, Secretary/Treasurer of the Medical Board
2. Chair of the Southampton Local Leadership Council
3. Chair of the Eastern Long Island Local Leadership Council
4. Non-chair Heart Center and Cancer Center directors (one vote per center)
5. Six 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. Three will be from the full-time staff and three from the voluntary staff, at least one of whom shall practice solely at the Southampton Campus and at least one of whom shall practice solely at the Eastern Long Island campus. In the case of vacancy, the medical board will have a special election by mail or email.
6. Six clinical chiefs of service, elected by the other clinical chiefs of service to serve a 2 year term.

7. Associate Medical Director for Quality Management.
8. CMO
9. Medical Director of the Southampton Campus
10. Medical Director of the Eastern Long Island Campus
11. Designated Institutional Officer (DIO)/Associate Dean of Medical Education
12. Dean, School of Medicine

Non-Voting Members:

1. CEO, Stony Brook University Hospital, (ex-officio)
2. Chief Operating Officer, Stony Brook University Hospital, (ex-officio)
3. Chief Nursing Officer, Stony Brook University Hospital, (ex-officio)
4. Chief Resident Member of the Medical Board
5. Nurse Practitioner representative from the Nursing Council

B. ATTENDANCE/REMOVAL OF MEMBERS

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 the Dean's designee. 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 of service is deemed an excused absence by the MEC chair.

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

C. ALTERNATES

Each chief of service on the MEC shall designate a single physician or dentist alternate to represent them 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.

D. SOUTHAMPTON CAMPUS LEADERSHIP COORDINATING COUNCIL (SHLCC)

1. Composition.

The SHLCC shall consist of the following members:

The Southampton Campus Medical Director
The Southampton Campus vice chairs/service chiefs
The Chief Administrative Officer of the Southampton Campus
The Nurse Executive of the Southampton Campus
Three physician or dentist medical staff members who have evidenced a commitment to the activities of the Southampton Campus. Such individuals are to be nominated by the SHLCC and approved by the Medical Board.

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Effective upon the closing of the transaction making Southampton Hospital a campus of Stony Brook University Hospital, and for the rest of 2017, one of these individuals shall be the Secretary/Treasurer of the Southampton Medical Staff immediately prior to closing.

The SHLCC shall also include the following individuals, without vote:

Chief Operating Officer, Stony Brook University Hospital
CMO or designee, Stony Brook University Hospital
Associate Director of Quality Management, Stony Brook University Hospital

2. Chair and Vice Chair.

The SHLCC shall be chaired by one of the voting members of the SHLCC through an annual election by the voting members of the SHLCC. Effective upon the closing of the transaction making Southampton Hospital a campus of Stony Brook University Hospital, and for the rest of 2017, this person shall be the individual serving as President of the Southampton Hospital Medical Staff immediately prior to closing.
The SHLCC shall have a vice chair who will be chosen by the SHLCC Chair from all members of the SHLCC. Effective upon the closing of the transaction making Southampton Hospital a campus of Stony Brook University Hospital, and for the rest of 2017, this person shall be the individual serving as Vice President of the Southampton Hospital Medical Staff immediately prior to closing.

3. Function.

The SHLCC shall work collaboratively with, assist, and report to the Medical Executive Committee, regarding the conduct of the medical affairs at the Southampton Campus and the relations with those Medical Staff members who solely exercise their clinical privileges at the Southampton Campus. The SHLCC's authority shall be limited to providing advisory recommendations and input to the MEC only.

THE SHLCC SHALL

a. Receive and review committee minutes and department reports for those divisions and committees and sub-committees based at the Southampton Campus;
b. Review and provide input on all performance improvement, quality management, risk management and utilization review activities of the Southampton Campus;
c. Provide liaison with, consider and recommend action to the Chief Administrative Officer of the Southampton Campus and the SBUH Medical Executive Committee on matters of a medico-administrative nature arising out of the operations of the Southampton Campus, and implement and monitor action based on approved recommendations;
d. Review the effectiveness and coordination of all general policies and clinical activities of the Medical Staff at the Southampton Campus and its various departments, divisions and sections.
e. Monitor professional and ethical conduct on the part of all members of the Medical Staff in their practice at the Southampton Campus and, if appropriate, recommend to the Medical Executive Committee potential corrective action for members of the Medical Staff solely practicing the Southampton Campus, provided nothing herein shall preclude the Medical Executive Committee from acting without such recommendations.
f. Other functions that may be assigned from time to time by the MEC.

MEETINGS

SHLCC shall meet at least 6 times per year
Special meetings can be called at any time by the Chair of the SHLCC or upon request from the Medical Executive Committee.
Minutes of all meetings will be maintained and approved at the next SHLCC meeting
The SHLCC will submit minutes of its proceedings to the Medical Executive Committee

E. EASTERN LONG ISLAND CAMPUS LEADERSHIP COORDINATING COUNCIL (ELILCC)

1. Composition.

The ELICC shall consist of the following members:

The Eastern Long Island Campus Medical Director
The Eastern Long Island vice chairs/service chiefs
The Chief Administrative Officer of the Eastern Long Island Campus
Nurse Executive of the Eastern Long Island Campus
Three physician or dentist medical staff members who have evidenced a commitment to the activities of the Eastern Long Island Campus. Such individuals shall be nominated by the ELILCC and approved by the Medical Board. Effective upon the closing of the transaction making Eastern Long Island Hospital a campus of Stony Brook University Hospital, one of these individuals shall be the Secretary/Treasurer of the Eastern Long Island Medical Staff immediately prior to closing.

The ELILCC shall also include the following individuals, without vote:

Chief Operating Officer, Stony Brook University CMO or designee,
Stony Brook University Hospital
Associate Director of Quality Management, Stony Brook University Hospital

2. Chair and Vice Chair.

The ELILCC shall be chaired by one of the voting members of the ELILCC through an annual election by the voting members of the Eastern Long Island Campus medical staff. Effective upon the closing of the transaction making Eastern Long Island Hospital a campus of Stony Brook University Hospital, this person shall be the individual serving as President of the Eastern Long Island Hospital Medical Staff.

The ELILCC shall have a vice chair who will be chosen by the ELILCC Chair from all members of the ELILCC. Effective upon the closing of the transaction making Eastern Long Island Hospital a campus of Stony Brook University Hospital, this person shall be the individual serving as Vice President of the Eastern Long Island Hospital Medical Staff immediately prior to closing.

3. Function.

The ELICC shall work collaboratively with, assist, and report to the Medical Executive Committee, regarding the conduct of the medical affairs at the Eastern Long Island Campus and the relations with those Medical Staff members who solely exercise their clinical privileges at the Eastern Long Island Campus. The ELICC's authority shall be limited to providing advisory recommendations and input to the MEC only.

THE ELICC SHALL

a. Receive and review committee minutes and department reports for those divisions and committees and sub-committees based at the Eastern Long Island Campus;
b. Review and provide input on all performance improvement, quality management, risk management and utilization review activities of the Eastern Long Island Campus;
c. Provide liaison with, consider and recommend action to the Chief Administrative Officer of the Eastern Long Island Campus and the SBUH Medical Executive Committee on matters of a medico-administrative nature arising out of the operations of the Eastern Long Island Campus, and implement and monitor action based on approved recommendations;
d. Review the effectiveness and coordination of all general policies and clinical activities of the Medical Staff at the Eastern Long Island Campus and its various departments, divisions and sections.
e. Monitor professional and ethical conduct on the part of all members of the Medical Staff in their practice at the Eastern Long Island Campus and, if appropriate, recommend to the Medical Executive Committee potential corrective action for members of the Medical Staff solely practicing the Eastern Long Island Campus, provided nothing herein shall preclude the Medical Executive Committee from acting without such recommendations.
f. Other functions that may be assigned from time to time by the MEC.

MEETINGS

ELILCC shall meet at least 6 times per year

Special meetings can be called at any time by the Chair of the ELILCC or upon request from the Medical Executive Committee.

Minutes of all meetings will be maintained and approved at the next ELILCC meeting

The ELILCC will submit minutes of its proceedings to the Medical Executive Committee

SECTION 7. CHIEF MEDICAL OFFICER (CMO)

A. QUALIFICATIONS.

The CMO 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 and shall have demonstrated training and experience in medical/administrative matters.

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.

B. APPOINTMENT PROCESS

The governing body shall appoint, with the concurrence of the CEO 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 CMO.

C. RESPONSIBILITY TO THE GOVERNING BODY.

The CMO 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.

D. MEDICAL DIRECTOR OF THE SOUTHAMPTON CAMPUS

The governing body shall also appoint, with the concurrence of the CEO of Stony Brook University Hospital, the Dean, School of Medicine, and the President of the Medical Board, a physician or dentist member of the faculty who is a full time active member of the medical staff practicing solely at the Southampton Campus to serve as Medical Director of the campus. The Medical Director shall meet the CMO qualifications set forth above and shall work collaboratively with the CMO, as requested, to fulfill the duties set forth above. The Medical Director shall report to the CMO.

E. MEDICAL DIRECTOR OF THE EASTERN LONG ISLAND CAMPUS

The governing body shall also appoint, with the concurrence of the CEO of Stony Brook University Hospital, the Dean, School of Medicine, and the President of the Medical Board, a physician or dentist member of the faculty who is a full time active member of the medical staff practicing solely at the Eastern Long Island Campus to serve as Medical Director of the campus. The Medical Director shall meet the CMO qualifications set forth above and shall work collaboratively with the CMO, as requested, to fulfill the duties set forth above. The Medical Director shall report to the CMO.

ARTICLE VII

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 CEO, (or designee) and the President of the medical board (or 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 physician or dentist 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 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. 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.

C. MEETING/REPORTING.

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

SECTION 4. HOSPITAL 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, including the department credentials committee. 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 physician or dentist representative from the departments of: anesthesiology, medicine, obstetrics and gynecology, pathology, radiology, surgery, and the CMO. 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 affect 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 dismissal of residents in compliance with both the Institutional and Relevant Program Requirements;

5 assurance of an educational environment in which residents may raise and resolve issues without fear of intimidation or retaliation;

6. collecting of intra-institutional information and making recommendations on the appropriate funding for resident positions, including benefits and support services;

7. monitoring of the programs in establishing an appropriate work environment and the duty hours of residents

8. 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.

9. 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 representative program directors, residents nominated by their peers, 2 representatives from hospital administration (ex-officio), a program coordinator elected by the coordinators 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 the report of the medical staff. 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, and medical care review. Ex-officio members shall include the chief operating officer and the CMO. The CMO or designee 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.

D. SOUTHAMPTON CAMPUS MEDICAL QUALTIY ASSURANCE SUBCOMMITTEE (SHMQAC)

1. Membership.

The SHMQAC will be comprised of QA physician liaisons designated by the vice chairs/service chiefs of those clinical departments at the Southampton Campus and approved by the Department Chair/chief of service, as well as a nursing QA representative, and QA representatives from other professional services, including but not limited to social service, nutritional service, risk management, patient relations, medical care review and medical staff services department at the Southampton Campus as well as the President of the Southampton Campus and the Medical Director of the Southampton Campus.

2. Functions.

The SHMQAC shall collaborate with, assist, provide input to, and report to the Medical Quality Assurance Committee. All quality events reported to the SHMQAC by its members, medical or clinical staff or by others shall be immediately reported to the Medical Quality Assurance Committee for review and disposition. At the direction of the Medical Quality Assurance Committee, the SHMQAC may serve as an interdisciplinary forum for review of individual events related to patient care occurring at the Southampton Campus, with findings and recommendations reported to the Medical Quality Assurance Committee as advisory only.

The SHMQAC will assist the medical quality assurance committee in monitoring the standards of care across disciplines in the Southampton Campus

The SHMQAC shall receive and review the periodic required reports of the following committees at the Southampton Campus:

- Blood Utilization
- Infection Control
- Medical Records
- Nutrition
- Pharmacy and Therapeutics
- Surgery

The proceedings of the committee shall be reported to the Medical Quality Assurance Committee and shall be considered confidential peer review activities. All members of the SHMQAC shall keep in confidence all papers, report, and information obtained by virtue of membership on the committee.

3. Meetings

The SHMQAC shall meet monthly. Committee minutes will be maintained and provided to the Medical Quality Assurance committee upon approval of the SHMQAC.

EASTERN LONG ISLAND CAMPUS MEDICAL QUALITY ASSURANCE SUBCOMMITTEE (ELIMQAC)

1. Membership.

The ELIMQAC will be comprised of QA physician liaisons designated by the vice chairs/service chiefs of those clinical departments at the Eastern Long Island Campus and approved by the Department Chair/chief of service, as well as a nursing QA representative, and QA representatives from other professional services, including but not limited to social service, nutritional service, risk management, patient relations, medical care review and medical staff services department at the Eastern Long Island Campus as well as the President of the Eastern Long Island Campus and the Medical Director of the Eastern Long Island Campus.

2. Functions.

The ELIMQAC shall collaborate with, assist, provide input to, and report to the Medical Quality Assurance Committee. All quality events reported to the ELIMQAC by its members, medical or clinical staff or by others shall be immediately reported to the Medical Quality Assurance Committee for review and disposition. At the direction of the Medical Quality Assurance Committee, the ELIMQAC may serve as an interdisciplinary forum for review of individual events related to patient care occurring at the Eastern Long Island Campus, with findings and recommendations reported to the Medical Quality Assurance Committee as advisory only.

The ELIMQAC will assist the medical quality assurance committee in monitoring the standards of care across disciplines in the Eastern Long Island Campus. The ELIMQAC shall receive and review the periodic required reports including but not limited to the following committees at the Eastern Long Island Campus:

Behavioral Health
Blood Utilization
Infection Control
Medical Records
Medicine
Nutrition
Patient Safety
Pharmacy and Therapeutics
Surgery

The proceedings of the committee shall be reported to the Medical Quality Assurance Committee and shall be considered confidential peer review activities. All members of the ELIMQAC shall keep in confidence all papers, report, and information obtained by virtue of membership on the committee.

3. Meetings

The ELIMQAC shall meet monthly. Committee minutes will be maintained and provided to the Medical Quality Assurance committee upon approval of the ELIMQAC.

ARTICLE VIII

Meetings

SECTION 1. MEDICAL STAFF

A. FREQUENCY.

The medical staff shall meet annually.

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 2 weeks
4. Submitting items to the governing body for approval
5. Adoption and communication of medical staff policies as delegated by the medical staff.

    a) No objection to an issue: goes to governing body within 2 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. Report from the President of the Medical Board ;
2. Report from the CEO of Stony Brook University Hospital (or designee)

3. Report from the CMO (or designee)
4. Report from the DIO
5. Quality and Regulatory Report
6. Report of the Medical Staff Services Department
7. Any item requested by the Medical Board by majority vote of its members
8. New business

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 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.

SECTION 5. IN ATTENDANCE OR PRESENT AT A MEETING

For purposes of these Bylaws, in addition to being physically present at a meeting, participation via telephone or teleconference or other electronic methods shall constitute attendance or presence at a meeting of the Medical Staff, Medical Board, MEC or committees of the Medical Board.

ARTICLE IX

HISTORY AND PHYSICAL EXAM

A physician, or other qualified individual* in accordance with State law and hospital policy, must examine an admitted patient and document this examination in the medical record within 24 hours of admission. If recorded in the patient's medical record by an individual other than the attending practitioner, the history and physical examination shall be reviewed and countersigned by the attending practitioner.

If an operative procedure (or procedure requiring moderate or deep sedation) is to occur within 24 hours of admission then the history and physical must be documented in the medical record prior to the procedure. If a history and physical was done within 30 days prior to admission then an update to that history and physical can be done provided it is done and entered in the medical record within 24 hours of admission, but in all cases prior to any surgery or procedure requiring anesthesia, and the update includes documentation of changes in the patient. The medical record shall document a current, thorough physical examination prior to the performance of surgery.

The history and physical examination shall include a chief complaint, history of the present illness, medication and allergy history and a prior medical and surgical history as well as an assessment of the vital signs, lungs, heart and level of consciousness. The examination of any other body system shall be as deemed appropriate by the respective service. The report shall include all pertinent findings resulting from this assessment. A history and physical is required, as described above, for all outpatients undergoing surgery or those requiring moderate or deep sedation for a procedure.

The history must include the reason for the procedure, a history of the organ system affected as well as a cardiac and respiratory history, history of allergies and medications, vital signs and an examination of the heart, lungs and organ(s) affected by the procedure. The examination of any other body system shall be as deemed appropriate by the respective service.

All entries in the medical record of history and physical examinations must be signed, dated, and timed.

* Physician is defined as an MD, DO, or doctor of dental surgery or dental medicine, an oral maxillofacial surgeon, privileged at Stony Brook University Hospital, or other qualified licensed individual in accordance with State law and hospital policy. Other qualified licensed individuals "are those licensed practitioners who are authorized in accordance with their State scope of practice laws or regulations to perform a history and physical and who are also formally authorized by the hospital to conduct a history and physical." (refer to Admin P&P PC:0026) (CMS regs; [482.24 (c) (2)] (JCAHO 2.10;6/05; 07/06)) [482.22(c) (5); 405.10 (b)(2)(i); 405.9 (b) (12) (405 more restrictive than CMS); PC 2.120]

ARTICLE X

Bylaws Amendments and Adoption

SECTION 1. AMENDMENTS TO THE BYLAWS

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.

Proposed amendments to these bylaws may be originated by either the Medical Board or by a petition signed by a majority (>50%) of the voting members of the medical staff.

Amendments proposed by either the medical staff or the medical board, shall first be submitted to the Bylaws committee for consideration.

The bylaws committee will review all proposed amendments and submit their recommendation to the Medical Board.

Any Medical Board recommendation shall be communicated to the voting members of the medical staff, via mail, fax or electronically at least ten days before the date of the vote.

Proposed amendments shall be voted on only by those voting members of the medical staff as described in Article IV. 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.

If the medical staff does not approve any amendment to the bylaws proposed by the Medical Board, or if the medical board does not submit for vote an amendment proposed by the majority of the voting medical staff, a meeting between representatives of the Medical Board and a representative group of the medical staff, as determined by the President of the medical board, shall be scheduled.

If resolution can be achieved, the resolution shall be submitted to the voting members of the medical staff. If the voting members vote to approve the revised amendment(s), the recommended amendment will be forwarded to the governing body for its review and consideration. The governing body has final approval.

Should the parties fail to reach a resolution, the proposed amendment and any concerns of the medical staff shall be submitted to the governing body for review and consideration. If the voting members of the medical staff do not approve the revised amendment, the revised amendment shall be submitted to the governing body for review and consideration. The decision of the governing body shall be final.

SECTION 2. AMENDMENTS TO THE RULES AND REGULATIONS

Revisions to the Rules and Regulations will follow the same procedure as amendment of the Bylaws.

SECTION 3. URGENT AMENDMENT TO THE RULES AND REGULATIONS

In the event that an amendment to the rules and regulations is required in order to comply with any law or regulation, the medical staff delegates to the medical board, the authority to provisionally adopt and the governing body may provisionally approve an amendment to a rule or regulation, without any prior approval of the medical staff. In such cases, the entire medical staff will be immediately notified by the medical board. Copies of any notice or materials requiring the urgent amendment, if not deemed confidential, will be submitted along with the written notice. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the medical staff and the medical board, the provisional amendment will remain in effect. If there is conflict over the provisional amendment, the process for resolving conflict between the medical staff and the medical board is implemented. If necessary, a revised amendment will be submitted to the governing body for its review and consideration. The bylaws, rules and regulations shall be reviewed periodically by the Bylaws Committee and revised whenever necessary.

SECTION 4. ADOPTION

These bylaws were initially adopted by approval of 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 and approval of the governing body.

ARTICLE XI

Conflict Management

If a majority (>50%) of the voting members of the medical staff sign a petition challenging any rule or policy established by the medical board, the following conflict management process shall commence.

The petition should clearly state the basis of the disagreement and may include any additional relevant information for medical staff members. The petitioner must acknowledge reading the petition and all attachments, if any, in order for their signature to be considered valid. Once a majority of the medical staff has signed the petition, the petition and any attachments as well as a list of petitioners shall be forwarded to the medical board.

Within 30 days of the medical board's receipt of the petition, a meeting between representatives of both the medical board, as determined by the President of the medical board, and a representative group of the petitioners shall be scheduled. The parties shall act in good faith and shall take reasonable steps to resolve the conflict in question.

If the medical board and the petitioners are able to resolve the conflict, the resolution shall be submitted to the voting members. If the voting members approve the proposed resolution, the proposal will be forwarded to the governing body for its review and consideration. If approved by the governing body, the decision shall be final.

Should the parties fail to reach a resolution, or if the voting members of the medical staff do not approve the proposed solution agreed to by the petitioners and medical board, the petition and all accompanying materials will be forwarded to the governing body for its review and consideration. The decision of the governing body shall be final.

At any point in the process of addressing a disagreement between the medical staff and the medical board, each have the right to recommend utilization of an outside resource to assist in resolving the dispute. The final decision regarding whether or not to utilize an outside resource, and the process that will be followed in so doing, is the responsibility of the governing body.

ARTICLE XII

Definitions

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

1. "CHIEF EXECUTIVE OFFICER (CEO)"

The Chief Executive Officer (CEO) of Stony Brook Stony Brook University Hospital.

2. "CHIEF MEDICAL OFFICER (CMO)"

The Chief Medical Officer (CMO) 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, which includes the Stony Brook, Southampton and Eastern Long Island Campuses.

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 CEO 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. "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.