

**SIERRA VISTA REGIONAL HEALTH CENTER  
MEDICAL STAFF BYLAWS**

**DEFINITIONS**

The following definitions shall apply to terms used in these Bylaws:

1. **Board:** The Board of Trustees of Sierra Vista Regional Health Center, who have the overall responsibility for the conduct of the Hospital.
2. **Chief Executive Officer or CEO:** The individual appointed by the Board of Trustees to act on its behalf in the overall management of the Hospital.
3. **Clinical Department:** A grouping of practitioners according to clinical activities and interests.
4. **Clinical Privileges:** Permission granted by the Board, acting on the Medical Executive Committee's recommendations, to render specific types of care to patients in Sierra Vista Regional Health Center.
5. **Ex Officio:** By virtue of an office or position held, without voting right unless otherwise specified.
6. **Health Care Quality Improvement Act of 1986:** It is the intent of the provisions of these Bylaws to be in compliance with the Health Care Quality Improvement Act of 1986.
7. **Hospital:** Unless the context suggests otherwise, the Board of Trustees, plus administrative/executive staff, plus medical staff, and refers to Sierra Vista Regional Health Center.
8. **Medical Executive Committee or MEC:** The elected and appointed representatives of the Medical Staff, authorized to act on behalf of the Medical Staff except when otherwise specified.
9. **Medical Staff:** The physicians (MD and DO), dentists (DDS and D.M.D.) and podiatrists (DPM) providing health care services in Sierra Vista Regional Health Center, subject to the relevant provisions of the Medical Staff and Hospital Bylaws.
10. **Practitioners:** Clinicians, including physicians, dentists and podiatrists, and allied health professionals who provide services to patients in Sierra Vista Regional Health Center.
11. Words used in this policy shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for

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convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

**ARTICLE I. NAME**

The name of this organization shall be the "Sierra Vista Regional Health Center Medical Staff."

**ARTICLE II. PURPOSES AND RESPONSIBILITIES**

**Section 2.1 Purposes**

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Sierra Vista Regional Health Center and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care. These responsibilities include the Medical Staff judging the appropriateness of professional performance and ethical conduct of practitioners authorized to practice in the Hospital.

**Section 2.2 Responsibilities**

The responsibilities of the Medical Staff are as follows:

- A. To account for the quality and appropriateness of patient care rendered by its members and allied health professionals through the appropriate programs for credentialing, continuing education, utilization review, quality improvement, peer review, and quality and cost appraisal;
- B. To assist in identifying community health needs and setting appropriate institutional goals and implementing programs to meet those needs; and
- C. To exercise the authority granted by these Bylaws, as necessary, to fulfill the foregoing responsibilities.

**ARTICLE III. CREDENTIALING**

**Section 3.1 Credentialing Policy**

Credentialing of Medical Staff members are governed by the Credentialing Policy of SVRHC, appended to these Bylaws as Appendix C.

**Section 3.2 Determination of Clinical Privileges**

**Section 3.2-1 Exercise of Privileges**

The physicians (MD and DO), dentists (DDS and DMD) and podiatrists (DPM), providing direct

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clinical services at Sierra Vista Regional Health Center by virtue of Medical Staff membership shall, in connection with such practice and except as otherwise provided, be entitled to exercise only those clinical privileges or services specifically granted to him by the Board. Only Staff members may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic. All clinical privileges granted shall initially be provisional in nature. Each individual granted privileges shall be assigned to a clinical department, and his performance shall be observed.

**Section 3.2-2 Delineation of Privileges**

Clinical privileges shall be delineated on an individual basis. The delineation of an individual's privileges shall include the limitations, if any, on the individual's privileges to admit and treat patients or direct the course of treatment for which patients are admitted. Each application for appointment and reappointment to the Medical Staff must contain a request for specific clinical privileges desired by the applicant. A request by a staff member for a modification of privileges must be supported by documentation of training and/or experience supporting this request.

**Section 3.2-3 Bases for Privilege Determinations**

An applicant for specific clinical privileges must demonstrate relevant training and experience and ability to perform the privileges requested, before specific clinical privileges are granted. Current privilege determinations to be made in connection with periodic reappointment, or otherwise, shall include observed clinical performance and documented results of the quality improvement activities required by these and the Hospital Bylaws. Privilege determinations shall also be based upon pertinent information concerning clinical performance obtained from other sources, especially other institutions and healthcare settings where a practitioner exercised clinical privileges. This information shall be added to, and maintained in, the Medical Staff file established for the staff member.

**Section 3.2-4 Procedure**

All requests for clinical privileges shall be processed pursuant to these Bylaws and the Credentialing Policy, appended to these Bylaws as Appendix C.

**Section 3.3 Temporary Clinical Privileges**

**Section 3.3-1 Circumstance**

The Chief of Staff and CEO may grant temporary privileges after the application is approved by the Department Chairman to which the applicant has applied, and Medical Executive Committee representative. Temporary privileges shall be granted pending final approval by the Board. All persons requesting or receiving temporary privileges shall be bound by the Medical Staff Bylaws and Rules and Regulations.

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**Section 3.3-2      Conditions**

Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the practitioner's qualifications, current competence, ability, and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirements of professional liability insurance. During a practitioner's period of temporary privileges pending Board approval, all charts generated will be subject to review and included in the provisional period process. Special requirements of consultation and reporting may be imposed by the Chief of Staff. Before temporary privileges are granted, the practitioner must acknowledge in writing that he has received and read the Medical Staff Bylaws, Rules and Regulations, and that he agrees to be bound by the terms thereof in all matters relating to his temporary privileges.

Requirements for proctoring and monitoring shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges.

**Section 3.3-4      Termination**

Temporary privileges may at any time be suspended or terminated under these Bylaws by the CEO after consultation with the Chief of Staff or any other Staff member responsible for supervision of the practitioner with temporary privileges. In the event of such termination, the Chief of Staff or, in his absence, the Vice-Chief of Staff shall assign another member of the Medical Staff to assume responsibility for the care of hospitalized patients under the care of the practitioner with temporary privileges. The wishes of the patient shall be considered in the choice of a replacement Medical Staff member.

**Section 3.4          Locum Tenens**

In routine cases, the application for locum tenens shall be processed via the designated department, or the Fast Track Process in the same manner as routine Medical Staff applications. (See Credentialing Policy, pg.5, Section 3.7.1). Following approval by the Department Chair or the FastTrack process, the Chief of Staff and CEO may grant locum tenens privileges. The file is considered approved for a two year period, provided licensure, DEA if applicable and professional liability insurance remain current. If more than sixty (60) days have elapsed since the practitioner's last assignment at SVRHC, a review of the practitioner's hospital quality file and National Practitioner Data Bank query will be performed.

**Section 3.4-1      Conditions**

Locum tenens privileges shall be granted only when the information available reasonably supports a favorable determination regarding the practitioner's qualifications, current competence, ability, and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirements of professional liability insurance. Locum tenens physicians will have full clinical rights and privileges of the physician whom they are replacing.

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**Section 3.5:                   Categories of the Medical Staff**

**Section 3.5-1                Categories**

The categories of the Medical Staff shall include the following: Active, Courtesy, Visiting Professor and Emeritus, as well as those Allied Health Professionals who are granted a scope of practice under a supervising physician. At appointment and each time of reappointment, the member's Staff category shall be determined. Unless otherwise determined by the Board, initial Staff appointments shall be Provisional.

**Section 3.5-2                Provisional Status**

**Section 3.5-3                Initial Appointments**

Except as otherwise determined by the Board, all initial appointments to any category of this Staff shall be provisional for a period of one year. Each provisional appointee shall be observed by the Chief of Staff and/or by the Chair of the appropriate department and/or the appropriate committees, or designee, to determine eligibility and the Staff category and clinical privileges to which he was provisionally appointed. A statement signed by the appropriate observing party regarding the results of observations shall be forwarded to the Medical Executive Committee.

**Section 3.5-4                Qualifications and Prerogatives**

The Provisional Staff shall consist of currently licensed practitioners, each of whom (a) meet the basic qualifications for membership set forth in Section 2.2-1 of the Credentialing Policy and (b) immediately prior to application and appointment was not a member (or was no longer a member) in good standing of this Medical Staff.

Members of the Provisional Staff shall (a) exercise such clinical privileges as are granted; (b) attend meetings of the Medical Staff, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment; and (c) not be eligible to hold office in this Medical Staff organization, but may serve on committees.

**Section 3.5-5                Observation of Provisional Staff Members**

Each Provisional Staff member shall undergo a period of observation by designated monitors. The observation shall be to evaluate the member's proficiency in the exercise of clinical privileges initially granted, and overall eligibility for continued Staff membership and advancement within Staff categories. Such observation shall evaluate the Provisional Staff member including, but not limited to, concurrent or retrospective chart review, consultation, and/or direct observation.

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Appropriate records shall be maintained.

**Section 3.5-6                      Action at Conclusion of Provisional Staff Status**

If the Provisional Staff member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement in the Active or Courtesy Staff as appropriate. Files deemed to have no concerns for quality and there was no difficulty encountered in verifying information and/or professional references, shall be deemed "Type I" files and shall be processed in the same manner as applications described in the Credentialing Policy, Section 3.7-1. All advancement files which do not fulfill the requirements of "Type I" as described in the Credentialing Policy, shall be deemed "Type II" files and follow the process as described in Section 3.7-2 of the Credentialing Policy.

**Section 3.5-7                      Renewals**

Provisional status may not be renewed for more than one six (6) month period. If the provisional appointee fails within that time period to furnish the certifications required for Staff membership or particular clinical privileges, as applicable, his membership shall automatically terminate.

**Section 3.6                        Active Staff**

**Section 3.6-1                    Qualifications**

The Active Staff shall consist of physicians (MD and DO); Podiatrist (DPM); with current Arizona licensure, each of whom (a) meets the basic qualifications for membership set forth in Section 2.2-1 of the Credentialing Policy; (b) has offices or residences which, in the opinion of the Medical Executive Committee, are located closely enough to the Hospital to provide appropriate continuity of quality care to his patients, within the guidelines of their department; (c) regularly admits patients to, or is otherwise regularly involved in the care of patients in the Hospital; and (d) has satisfactorily completed the designated term of the Provisional Staff category.

**Section 3.6-2                    Prerogatives**

Subject to availability of beds, each member of the Active Staff may admit patients without limitation, except as otherwise provided in these Bylaws or the Rules and Regulations; exercise such clinical privileges as are granted to him; vote on all matters presented at Staff meetings and of the department and committees of which he is an appointee; and hold a Staff, department or committee office.

**Section 3.7                        Courtesy Staff**

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**Section 3.7-1                      Qualifications**

The Courtesy Staff shall consist of practitioners with current Arizona licensure, including physicians (MD and DO), dentists (DDS and D.M.D.), and Clinical Psychologists (PhD-*with privileges for consultation only*) who meet the basic qualifications for membership set forth in Section 2.2-1 of the Credentialing Policy.

Courtesy Staff may not admit any more than twelve (12) patients annually to Sierra Vista Regional Health Center. Courtesy staff must be located closely enough to the hospital to provide continuity of quality care to his patients; or other arrangements must be made to ensure continuity of care of their patients. At a time of full Hospital occupancy or a shortage of Hospital beds or other facilities, as determined by the Hospital CEO, the admitting privileges of the Courtesy Staff members shall be subordinate to the Active Staff members. Courtesy Staff members must have satisfactorily completed the designated terms of the Provisional Staff category.

**Section 3.7-2                      Prerogatives**

Courtesy Staff members may: (a) exercise such clinical privileges as are granted to him; and (b) attend meetings of the Staff and the department and committees of which he is an appointee; but may not vote at Staff or department meetings or hold office.

**Section 3.8                              Allied Health Professionals**

**Section 3.8-1                      Qualifications**

The category of Allied Health Professionals shall consist of individuals who are duly licensed or certified as required by State law, and are credentialed through the Medical Staff, to include Nurse Practitioners, Physician's Assistants, CRNAs, Surgical Assists, and CNMs. Their applications to perform such functions shall contain a specific listing of a scope of practice requested, and will be processed and a specific scope of practice granted by the Medical Executive Committee and Board of Trustees. An appropriate fee, determined by the Medical Staff, shall be required. The name of an Active Medical Staff sponsor must be submitted with the Allied Health Professional application. The sponsor must have, or be recognized by the Medical Staff as having, similar privileges in the field in which the Allied Health Professional is applying. The sponsorship must be maintained for the entire period that the approval of scope of practice is issued. Reappraisal shall be acted on in the same timeframe as the sponsoring physician's reappointment.

**Section 3.8-2                      Prerogatives**

Allied Health Professionals are authorized to write orders as delineated by the Medical Staff. Such orders shall be countersigned by the attending or supervising physician within 24 hours. If for any reason, the sponsorship is withdrawn, the Allied Health Professional must resubmit a new application with new sponsorship. Allied Health Professionals who are credentialed through the

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Medical Staff (as outlined in the Bylaws, Section 3.8-1) are not members of the Medical Staff, but are under the supervision of a member of Active Staff. Accordingly, they have no admitting privileges, no voting privileges, no hearing or appeal rights, and shall not be permitted to attend regular or special meetings unless specifically requested to do so by the Chief of Staff.

**Section 3.8-3                    Limitation of Prerogatives**

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by sections of the Medical Staff Bylaws and the Medical Staff Rules and Regulations.

**Section 3.9                    Emeritus Staff**

**Section 3.9-1                Qualifications**

The Emeritus Staff shall consist of physicians (MD/DO) who do not actively practice in the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical standards. To be eligible for membership, the practitioner shall have been a member of Sierra Vista Regional Health Center Active Medical Staff for a period of at least five (5) years.

**Section 3.9-2                Prerogatives**

Emeritus Staff members are not eligible to admit patients, exercise clinical privileges in the Hospital, or vote or hold office in this Medical Staff. Members may serve on committees with or without vote at the discretion of the Medical Executive Committee. They may attend General Medical Staff quarterly meetings and Department meetings; for Department meetings, they shall notify the Chairman before attending. Emeritus Staff members may use the Medical Staff library facilities and search options. Members of this category will not be assessed fees or dues.

**Section 3.10                Visiting Professors**

Visiting Professors shall consist of practicing physicians, (MD, DO), who by their current and previous appointment to academic centers of excellence and previous contributions to the medical field, have agreed to participate in the care of patients, and teaching the Medical Staff at Sierra Vista Regional Health Center. Each visiting professor will have a sponsor from the active medical staff. Visiting Professors are granted privileges following approval by Department Chair or his designee, Chief of Staff or his designee, and MEC designee.

Visiting Professors may exercise clinical privileges within the guidelines of their designated department. Visiting Professors are not permitted to vote or admit any patients to Sierra Vista Regional Health Center.

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**Section 3.11                    Leave of Absence**

**Section 3.11-1        Leave Status**

A Staff member may take a voluntary leave of absence from the Medical Staff by submitting written notice to the Medical Executive Committee and to the CEO stating the exact period of time of the leave, which shall not exceed one (1) year. During the period of leave, the Staff member's privileges and prerogatives shall be inactive.

**Section 3.11-2        Termination of Leave**

At least fourteen (14) days prior to the termination of leave, or at any time earlier, the Staff member may request reinstatement of his privileges and prerogatives by submitting a written notice to that effect to the CEO for transmittal to the Medical Executive Committee. The Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of the member's privileges and prerogatives. Failure, without good cause, to request reinstatement or to provide a requested summary of activities shall result in automatic termination of Staff membership, privileges and prerogatives, without right of hearing or appellate review. A request for Staff membership subsequently received from a Staff member so terminated shall be submitted and processed in the manner specified for application for initial appointment.

**ARTICLE IV.            DEPARTMENTS**

**Section 4.1                    Organization of the Medical Staff**

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the medical staff, and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in section 4.5. When appropriate, the Medical Executive Committee may recommend to the medical staff the creation, elimination, modification or combination of departments. The current departments are: Medicine, Surgery, Maternal/Child, Emergency Medicine and Pathology/Radiology. When deemed appropriate, the MEC may create, eliminate, subdivide, and combine departments. Each department shall have a Chair and Vice-Chair appointed as described in Section 4.2 below.

**Section 4.2                    Qualifications, Selection, and Tenure of Department Chairs and Vice-Chairs**

- A. Each Chair shall be a member of the Active Medical Staff, willing and able to discharge the functions of his/her office. Department Chairs must be certified by an appropriate specialty board or must demonstrate comparable competence.

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- B. Department Chairs and Vice-Chairs shall be elected by their respective departments and shall hold office for a two year term;
- C. Department Chairs and Vice-Chairs may be removed from office for cause by a 2/3rd vote of the medical executive committee and a 2/3rds vote of the department members eligible to vote on departmental matters.
- D. The Department Chair shall have the overall responsibility for the supervision and satisfactory discharge or assigned functions of the department.

**Section 4.3                      Assignment to Departments**

Each member of the Staff shall be assigned membership on at least one (1) department, and to a division, if any, within such department. Members may also be granted membership and/or clinical privileges in other departments consistent with practice privileges granted. The exercise of clinical privileges within a department shall be subject to the policies and credentialing criteria of that department.

**Section 4.4                      Responsibilities of Department Chairs**

Each Department Chair shall have advisory responsibility for the following: (a) all clinically related activities of the department; (b) all administratively related activities of the department, unless otherwise provided for by the hospital; (c) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges; (d) recommending to the Medical Executive Committee and the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department; (e) act as presiding officer at departmental meetings; (f) assessing needs and recommending to the medical executive committee clinical program development/expansion projects (g) coordinating where necessary and actively participating/supporting the hospitals interdisciplinary performance improvement program; (h) develop and implement departmental programs for retrospective and prospective patient care review, practice monitoring, credentials review and privilege delineation, medical education, utilization review, and performance (quality) assessment and improvement; (i) generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systemic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the medical executive committee in coordination and integration with the hospitals interdisciplinary performance improvement process; (j) be a member of the medical executive committee and give guidance on the overall medical policies of the medical staff and make specific recommendations and suggestions regarding the department and its sections; (k) transmit to the medical executive committee the department's recommendations concerning practitioner appointments and all other activities of the department; (l) endeavor to enforce the medical staff bylaws, rules, policies, and regulations within the department; (m) implement within the department appropriate actions taken by the medical executive committee; (n) participate in every phase of administration of the department, including cooperation with the nursing service, ancillary services, and hospital administration in matters such

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as personnel (including assisting in determining the qualifications and competence of department / service personnel who are not licensed independent practitioners and who provide patient care services), supplies, special regulations, standing orders, and techniques; (o) recommending clinical privileges for each member of the department; (p) assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the department or the organization; (q) integrating the department into the primary functions of the organization; (r) coordinating and integrating interdepartmental and intra departmental services; (s) recommending a sufficient number of qualified and competent persons to provide care or service; (t) determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services; (u) the continuous assessment and improvement of the quality of care and services provided; (v) maintaining quality control programs, as appropriate; (w) orientation and continuing education of all persons in the department; and (x) recommending space and other resources needed by the department.

The departments shall meet when necessary, and shall maintain a permanent record of their findings, proceedings, and actions, and shall report to the MEC.

**Section 4.5                      Functions of Departments**

The general function of each department shall include:

- a.     Actively participating with the hospital wide performance improvement program for the review and improvement of clinical care.
- b.     Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department.
- c.     Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.
- d.     Review and evaluate departmental adherence to: 1) medical staff policies and procedures, and 2) sound principles of clinical practice.
- e.     Coordinate patient care provided by the department's members with nursing and ancillary patient care services.
- f.     Submitting written reports to the Medical Executive Committee concerning: 1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and 2) recommendations for maintaining and improving the quality of care provided in the department and the hospital; and 3) accounting for all professional and medical staff administrative activities within the department.

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- g. Meet at least quarterly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions.
- h. Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols.
- i. Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

**ARTICLE V. OFFICERS**

**Section 5.1 Officers of the Staff**

**Section 5.1-1 Identification**

The officers of the Medical Staff shall be Chief of Staff, Vice Chief of Staff, and Secretary/Treasurer.

**Section 5.1-2 Qualifications**

Officers must be members of the Active staff at the time of nomination and election and must remain members in good standing during their term in office. Failure to maintain such status shall immediately create a vacancy in the office involved.

**Section 5.1-3 Nominations**

The nominations shall be made by a Nominating Committee appointed by the Chief of Staff which shall convene at least one (1) month prior to the annual meeting and shall submit to the Secretary of the Staff one (1) or more qualified nominees for each office two (2) weeks prior to the annual meeting. In addition, nominations shall be allowed from the floor of the meeting at the time of the election.

**Section 5.1-4 Elections**

Officers shall be elected at the annual meeting of the staff. Only Staff members accorded the prerogative to vote for Staff officers shall be eligible to vote. Voting shall be by secret ballot unless otherwise requested. Absentee ballots shall be permitted. The Medical Staff Coordinator shall provide a ballot listing the names placed in nomination by the Nominating Committee, and any additional names nominated from the floor on the ballot. The absentee ballot must be turned into the CEO prior to the election meeting. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off

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election shall be held among all candidates except the one receiving the fewest votes. This procedure shall be repeated until one (1) candidate is elected by a majority.

**Section 5.1-5                      Term of Elected Office**

Officers shall be elected for a term of two years and until their successors are duly elected. A vacancy in any office shall be filled by the MEC for the unexpired portion of the term, subject to the automatic succession of the Vice Chief of Staff as provided herein.

**Section 5.1-6                      Resignations and Removals**

Any officer may resign at any time by giving written notice to the MEC and, unless specified therein, the acceptance of such resignation shall not be necessary to make it effective. Any officer may be removed by receipt of a petition signed by forty percent (40%) of the voting members of the Medical Staff and presented to the Chief of Staff. Such a petition shall initiate a recall election at the next regular staff meeting when it is determined that a Medical Staff officer has failed to perform the duties and responsibilities of the office as described in these bylaws. Nominations shall be taken from the floor. The recalled officer is considered automatically renominated. Voting shall be by secret ballot and absentee ballots shall be permitted.

The candidate receiving a majority of the vote from Staff members eligible to vote shall serve the remainder of the term of office. Each voting member of the Medical Staff shall receive a written notice that the recall election will take place at the next staff meeting before the meeting is called to order. Each elected officer of the Medical Staff may be subjected to only one (1) recall election during his term of office.

Criteria for consideration for removal of Medical Staff Officers are as follows:

1. Displays consistently poor judgement in medico-administrative matters.
2. Acts inappropriately when representing the Medical Staff as its elected officer.
3. Attends inconsistently when the Medical Executive Committee meets for business.
4. Displays disruptive behavior.
5. Disregards Medical Staff policies openly.
6. Ignores Medical Staff adopted Bylaws and Rules and Regulations when conducting Medical Staff business.
7. Fails to maintain Active category status.
8. Is physically or mentally incapable of fulfilling the office.

This is not an exhaustive list of criteria.

**Section 5.2                      Duties of Elected Officers**

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- A. The Chief of Staff shall serve as the chief administrative officer and principal elected official of the Medical Staff. As such he shall:
- (1) Aid in coordinating the activities and concerns of Hospital Administration, nursing and other patient care services with those of the Medical Staff;
  - (2) Be accountable to the Board, in conjunction with the MEC, for the quality and efficiency of clinical departments and performance within the hospital and for the effectiveness of the quality improvement activities delegated to the Staff;
  - (3) Develop and implement methods for credentials review and for delineation of privileges, continuing education programs, utilization review, current monitoring of practice and retrospective patient care review;
  - (4) Supervise the operation of the departments and, unless otherwise expressly provided, appoint the Medical Staff representatives to the Medical Staff and Hospital committees;
  - (5) Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Board, the CEO, and other officials of the Staff;
  - (6) Be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulation for implementation of sanctions where indicated and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
  - (7) Call, reside at, and be responsible for the agenda of general and special meetings of the Medical Staff;
  - (8) Act as Chair of the MEC, and as an ex-officio member of all medical staff committees with full voting privileges;
  - (9) Act as official representative of the Medical Staff as a member of the Board; and
  - (10) Act as triage officer if warranted by Hospital census.
- B. The Vice-Chief of Staff shall be a Medical Staff representative to the Joint Review Committee, and Vice Chair of the MEC. In the temporary absence of the Chief of Staff, the Vice-Chief of Staff shall assume all of the duties and have the authority of the Chief of Staff. He shall perform such additional duties as may be assigned to him by the Chief of Staff or the MEC.
- C. The Secretary/Treasurer shall be a member of the MEC and a Medical Staff representative to the Joint Review Committee. He shall, subject to the direction of the Chief of Staff, keep minutes of Staff meetings; assure that all notices of Staff meetings are given; be responsible for collecting and accounting for funds that may be collected in the form of Staff dues, assessments or application fees; be custodian of Staff records; and, in general, perform all

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duties incident to the office of Secretary/Treasurer and such other duties as may be assigned by the Chief of Staff.

**ARTICLE VI. COMMITTEES AND FUNCTIONS**

**Section 6.1 Designation**

Medical staff committees shall include, but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of committees established under this Article, and meetings of special or ad hoc committees and/or teams created by the MEC to perform specified and important Medical Staff functions. The committees described in this Article shall be the standing committees of the Medical Staff. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with, and approval by, the MEC. Medical Staff committees shall be responsible to the MEC.

**Section 6.2 General Provisions**

**Section 6.2-1 Terms of Committee Members**

Unless otherwise specified, committee members shall be appointed for a term of two (2) years, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

**Section 6.2-2 Removal**

Unless otherwise specifically provided, a committee member shall continue as such until the end of his appointed term. A Medical Staff committee or team member, other than one serving as an ex-officio member, may be removed by a majority vote of the MEC. If a member of a committee ceases to be a member in good standing of the Medical Staff, or loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed. An administrative staff committee member may be removed by action of the CEO.

**Section 6.2-3 Vacancies**

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an

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individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the MEC.

**Section 6.2-4                    Composition and Appointment**

A Medical Staff committee or team as established by the MEC may be composed of members of the active, courtesy, and provisional staffs and may include, where appropriate, allied health professionals and representatives from Hospital departments or agencies as are appropriate to the committee or team's functions. Unless otherwise specified, the Medical Staff members shall be appointed by the Chief of Staff and the Administrative members shall be appointed by the CEO.

Unless otherwise indicated, each chair shall be appointed by the Chief of Staff. The Chief of Staff may attend as ex-officio member with voting privileges on all committees. Only Active staff members with voting privileges may vote, unless otherwise indicated. The CEO or his designee may attend all committee and team meetings.

**Section 6.2-5                    Vacancies**

Vacancies on any Medical Staff committee or team may be filled by the Chief of Staff.

**Section 6.3                      Standing Committees/Teams**

The following committees shall be standing committees of the Medical Staff:

- A. Medical Executive Committee
- B. Joint Review Committee
- C. Surgery Department
- D. Medicine Department
- E. Maternal/Child Health Department
- F. Pathology/Radiology
- G. Emergency Department

**Section 6.4                      Additional Medical Staff Functions**

Other committees and teams are established by the MEC to ensure involvement of the Medical Staff in important matters and functions, including, but not limited to:

**Section 6.4-1                    Quality Improvement Activities**

- (a) Establishing systems to identify potential problems in patient care;
- (b) Setting priorities for action on problem correction;
- (c) Referring priority problems for assessment and corrective action to appropriate committees;

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- (d) Monitoring the results of quality assessment and improvement activities throughout the hospital; and
- (e) Assisting in developing and implementing Hospital policies and procedures.

The accomplishment of the above referenced functions may or may not require the existence of separate, established committees. The functions consist of collection of relevant information (monitoring) and presentation to the appropriate committees for discussion and action (evaluation and problem-solving). Evidence that these functions are being effectively accomplished at the committee level is included in committee reports to the MEC.

**Section 6.4-2                    Medical Records Review:**

- (a) Medical records are periodically reviewed to determine that they are timely, legible, complete, accurate, and adequate to serve as a source of needed information;
- (b) Rules and regulations related to medical records, including forms, timeliness of completion, and availability to attending physicians, are periodically reviewed and updated;
- (c) The format of the patient record is periodically reviewed, and recommendations regarding format improvements may be made.

**Section 6.4-3                    Utilization Review:**

- (a) The appropriateness of admission to the Hospital and use of ancillary diagnostic services, use of discharge planning, length of stay, discharge practices, consultations, and other factors related to appropriate utilization of hospital and physician services are reviewed.
- (b) The utilization review activities described above are guided by a written plan, and include review of patients regardless of source of payment. The Utilization Review plan is reviewed annually and revised as necessary.

**Section 6.4-4                    Pharmacy and Therapeutics:**

- (a) Utilization and administration of drugs, including antibiotics, is monitored. The information is evaluated and acted on at relevant meetings;
- (b) Assistance is provided in formulating policies regarding selection, distribution, and safety procedures for administering drugs in the Hospital.

**Section 6.4-5                    Blood Usage:**

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- (a) Monitoring, evaluation, and action include utilization of blood by Medical Staff members, preparation and availability of blood and blood products by the blood bank, and the following of established procedures in administering blood.

**Section 6.4-6                      Surgical Case Review:**

- (a) Monitoring, evaluation, and action include all aspects of surgical cases, including but not limited to indications, complications, and mortality.

**Section 6.4-7                      Infection Control:**

- (a) Participates in Hospital-wide efforts to control infections including, but not necessarily limited to, participating in: identification and analysis of the causes of nosocomial infections; development and implementation of effective preventive and corrective measures designed to minimize infection hazards; and response to recommendations and reports related to infection control received from the Nursing Department and/or other Hospital departments.

**Section 6.4-8                      Nutritional Support:**

- (a) Development of standards for monitoring and evaluating the quality of nutrition support services provided to patients, including parenteral and enteral products;
- (b) Monitoring and evaluation of the diet manual and patient educational materials;
- (c) Development of staff educational programs.

**Section 6.4-9                      Quality Council**

**Section 6.4-10                     IRB Committee**

**Section 6.4-11                    Critical Care**

**Section 6.5                        Standing Committee Functions**

**Section 6.5-1                     Medical Executive Committee**

The MEC shall consist of the Chief of Staff; Vice-Chief of Staff; Secretary/Treasurer; and the Department Chairs of the Departments. Currently the departments are: the Chair of the Surgery Department; the Chair of the Medicine Department; the Chair of the Maternal/Child Health

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Department; the Chair of the Pathology/Radiology Department; the Emergency Department Chair. Other members are: the Vice President of Nursing (ex-officio); and the CEO or his designee (ex-officio).

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

- (a) Representing and acting on behalf of the Medical Staff in intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;
- (b) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;
- (c) Receiving and acting upon reports and recommendations from Medical Staff departments, committees, and assigned activity groups and teams;
- (d) Recommending actions to the Board on matters of a medical-administrative nature;
- (e) Adopting policies regarding the structure of the Medical Staff, mechanisms to review credentials and delineate individual clinical privileges, granting of individual Staff membership and privileges, organization of quality assessment and improvement activities and mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, needed changes to Medical Staff Bylaws, and other matters relevant to the operation of an organized Medical Staff;
- (f) Evaluating the medical care rendered to patients in the Hospital;
- (g) Participating in the development of Medical Staff and Hospital policies, practices, and planning;
- (h) Reviewing the qualifications, credentials, performance, professional competence and character of applicants and Staff members, and making recommendations to the Board regarding Staff appointments, reappointments, assignments to departments, clinical privileges, and corrective action;
- (I) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in corrective action or review measures when warranted;
- (j) Taking reasonable steps to develop continuing education activities and programs for the Medical Staff;
- (k) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff;
- (l) Reporting to the Medical Staff at each regular staff meeting;
- (m) Assisting in the obtaining and maintaining of accreditation;
- (n) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

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- (o) Appointing such special or ad hoc committees or teams as may seem necessary or appropriate to assist the MEC in carrying out its functions and those of the Medical Staff;
- (p) Reviewing the quality and appropriateness of services provided by contract physicians;
- (q) Accounting to the Board and Medical Staff for the overall quality and efficiency of care rendered in the Hospital;
- (r) Participating in identifying community health needs and setting Hospital goals to implement programs to meet those needs; and
- (s) Representing and acting on behalf of the Medical Staff, subject to such limitations as may be imposed by the Bylaws.
- (t) The Medical Staff may be invited to the MEC by the Chief of Staff, for a specific purpose.
- (u) The Medical Staff may request an audience with the MEC.

The MEC shall meet as often as necessary and maintain a permanent record of its proceedings and actions.

**Section 6.5-2                      Joint Review Committee**

The Joint Review Committee shall consist of the President, Vice-President, and Secretary/Treasurer of the Board and like officers of the Medical Staff, and include the Chief Executive Officer. The President of the Board shall be Chair of this Committee. The purpose of the Joint Review Committee shall include, but not be limited to, reviewing any Medical Staff appointment in which the Board is disposed to act contrary to a Medical Staff recommendation. The Joint Review Committee shall also act as the "Appellate Board" as defined in the Hearing and Appellate Review Procedure.

The Joint Review Committee shall meet as called by the Chief of Staff, with the concurrence of the President of the Board, or by the President of the Board. Minutes of all meetings will be submitted to the full Board and the MEC.

**Section 6.6                      Representation on Hospital Committees**

Medical Staff members are assigned, as requested, to Hospital committees dealing with matters that affect the Medical Staff (i.e., Safety). Such committees operate in accordance with Hospital Bylaws and any applicable policies and procedures.

**Section 6.7                      Meetings**

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A Medical Staff committee established to perform one or more of the functions required by these Bylaws as determined by the MEC, the CEO, and/or the Chief of Staff shall meet as often as necessary to discharge its assigned duties, but not less than quarterly unless otherwise specified.

**ARTICLE VII. MEETINGS**

**Section 7.1 General Staff Meetings**

**Section 7.1-1 Regular Meetings**

There shall be an annual meeting of the Medical Staff each year in June. Regular meetings of the Medical Staff shall be held quarterly, a date of which is designated by the MEC. The annual meeting shall constitute the regular meeting in June. The Chief of Staff may call additional meetings if necessary. The date, place and time of the regular meetings shall be determined by the MEC, and adequate notice shall be given to the members.

The Chief of Staff, or such other officers or Committee Chairs the Chief of Staff or MEC may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members.

**Section 7.1-2 Agenda**

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and the MEC.

**Section 7.1-3 Special Meetings**

Special meetings of the Medical Staff may be called at any time by the Board, Chief of Staff, MEC, or shall be called upon the request of thirty percent (30%) of the members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the MEC within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the member of the Staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the meeting notice.

**Section 7.2 Committee Meetings**

**Section 7.2-1 Regular Meetings**

Committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required, except as otherwise provided in these Bylaws. The frequency of such meetings shall be as required by these Bylaws. The Committee Chair shall make

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every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

**Section 7.2-2                      Special Meetings**

A special meeting of any Medical Staff Committee may be called by the Chair thereof, the Chief of Staff, the MEC or thirty percent (30%) of the committee's voting members. No business shall be transacted at any special meeting except that stated in the meeting notice.

**Section 7.3                      Notice of Meetings**

Adequate notice stating the location and time of any Staff meeting shall be delivered personally, by mail, or orally by the CEO or his designee. Personal attendance at a meeting shall constitute waiver of notice of such meeting.

**Section 7.4                      Quorum**

The quorum requirements for the following meetings shall be:

- A. Medical Staff Meetings: Those present and voting;
- B. MEC Meetings: Fifty percent (50%) of the voting members of the Committee; and
- C. Committee/Department Meetings: Two.

**Section 7.5                      Voting and Manner of Action**

**Section 7.5-1                      Voting**

Only members of the Active Medical Staff may vote in Medical Staff department committees or Medical Staff elections. All duly appointed members of Medical Staff committees are entitled to vote on committee matters, except as may otherwise be specified in these bylaws.

**Section 7.5-2                      Manner of Action**

Except as otherwise specified, the action of a majority of the members present and voting at a meeting (at which a quorum is present) shall be the action of the group. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference.

**Section 7.6                      Minutes**

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant

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matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the MEC.

**Section 7.7                      Absence from Meetings**

All Active Staff members are required to attend assigned Department, Quality and MEC meetings as follows: 50% or three (3) meetings annually, whichever is lesser. General Medical Staff meetings will count as an attendance credit when attended, but will not be counted as an absence if not attended.

The physician shall be notified at the end of each year if his or her attendance is below the requirement. In the next twelve months, the requirements for membership must be met. At the time of reappointment, if the physician has not attended the required number of meetings:

1.     A fine of \$500 will be assessed.
2.     The physician shall immediately be placed on a one-year provisional period, during which he or she will be required to attend meetings according to the requirements, but will have no voting privileges.
3.     At the end of this one-year provisional period, if the physician has not attended the required number of meetings, his privileges will not be renewed.

**Section 7.8                      Special Appearances**

A practitioner whose patient's clinical course or treatment becomes a quality issue identified for further action will be notified of a request for his attendance at a committee meeting to address the issues. The Chair of the meeting shall give the practitioner at least four (4) working days advance written notice of the time, place, and subject matter of the meeting. Failure of the practitioner to appear at any meeting for which he was given special notice shall, unless excused by the MEC for good cause, be a basis for corrective action.

**Section 7.9                      Conduct of Meetings**

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

**Section 7.10                     Executive Session**

Executive session is a meeting or portion of a Medical Staff committee, (including MEC), which only voting Medical Staff committee members and official ex-officio members (CEO or his designee) may attend, unless others are expressly requested by the committee to attend. Executive

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session may be called by the presiding officer at the request of any Medical Staff committee member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring intensive confidentiality. The CEO, or his designee, may be excused from executive session portions of the meetings when clinical issues are discussed, but may return to the meeting prior to action being taken.

**ARTICLE VIII. CORRECTIVE ACTION AND HEARING AND APPELLATE REVIEW PROCEDURE**

Corrective action and hearing and appellate review procedures are governed by the Corrective Action and Hearing and Appellate Review Procedure of SVRHC, appended to these Bylaws as Appendix B.

**ARTICLE IX. CONFIDENTIALITY, IMMUNITY, AND RELEASES**

**Section 9.1 Agreement of Applicants and Practitioners**

Any applicant for staff privileges, and every practitioner and member of the Staff, and everyone having or seeking privileges to practice his profession or to render specified services in the Hospital, agrees that the provisions of this Article shall specifically control with regard to his relationship to the Staff, members of the Board, and the Hospital. By submitting an application for membership, by accepting appointment or reappointment to the Staff or clinical privileges, by exercising Staff privileges or temporary privileges, and by seeking to render and rendering specific services, such practitioners specifically agree to be bound by the provisions of this Article during processing of his application and at any time thereafter, and they shall continue to apply during his appointment and reappointment.

**Section 9.2 Privileges**

Any act, communication report, recommendation or disclosure concerning any applicant for Staff membership, clinical privileges or specified services performed, given or made by any practitioner or member of the Staff in good faith and without actual malice and at the request of any authorized representative of the Staff, Administration, the Board, the Hospital or any other health care facility or provider for the purpose of providing, achieving or maintaining quality patient care in the Hospital or at any other health care facility, shall be privileged to the fullest extent permitted by law. Such privilege shall extend to members of the Staff, the CEO, Administration officials, Board members and their representatives and to third parties who furnish information to any of them to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities or associations from whom information has been requested or to whom information has been given by a member of the Staff, authorized representatives of the Staff, Administration or the Board.

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Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff as a committee of the whole, and meetings of special or ad hoc committees or teams created by the MEC and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

**Section 9.3                      Immunity**

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be privileged. No action, cause of action, damage, liability or expense shall arise or result from or be commenced with respect to any such act, communication, report, recommendation or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with or on behalf of any activities of any other health care facility or provider including, without limitation, those relating to (a) applications for appointment to the Medical Staff or for clinical privileges; (b) periodic appraisals or reviews for reappointment and/or clinical privileges; (c) corrective action or disciplinary action, including suspensions or revocations of clinical privileges or Staff membership or licenses to practice medicine; (d) hearings and appellate review; (e) medical care evaluations; (f) peer review evaluations; (g) utilization reviews; and (h) any other hospital, department or committee activities related to quality patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person's professional qualifications, clinical competency, character, fitness to practice medicine, physical and mental conditions, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

**Section 9.4                      Release**

In furtherance of and in the interest of providing quality patient care, each applicant for clinical privileges, practitioner, member of the Medical Staff, and those Allied Health Professionals who are credentialed by the Medical Staff (see Bylaws, Section 3.8-1) shall, by requesting or accepting Staff privileges and/or membership, release and discharge from loss, liability, cost, damage and expense, including reasonable attorneys' fees, such person who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon request of the Hospital or any officer of the Staff, execute a written release in accordance with the import of this Article.

**Section 9.5                      Nonexclusivity**

The privileges and immunities provided in this Article shall not be exclusive of any other right to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise.

**Section 9.6                      Breach of Confidentiality**

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As effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of discussions or deliberations of Medical Staff committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate.

**ARTICLE X. GENERAL PROVISIONS**

**Section 10.1 Medical Staff Rules and Regulations**

The Medical Staff shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. Recommended changes to the Rules and Regulations shall be submitted to the MEC for review and evaluation prior to presentation for consideration by the Medical Staff as a whole under such review or approval mechanism as the Medical Staff shall establish. Following adoption, such Rules and Regulations shall become effective upon approval of the Board, which approval shall not be withheld unreasonably.

Rules and Regulations shall be reviewed, and revised if necessary, every two (2) years. Applicants and members of the Medical Staff shall be governed by such Rules and Regulations as are properly initiated and adopted. If there is a conflict between the Bylaws and the Rules and Regulations, the Bylaws shall prevail.

**Section 10.2 Staff dues**

The MEC shall have the power to set the amount of annual dues for each category of Staff membership and the amount of the processing fee for initial applications and to determine the manner of expenditure of funds received. The amount of annual dues may vary among staff categories.

The application processing fee, which is equal to staff dues plus all additional fees required to verify application information, shall be submitted before application processing begins. If accepted, this fee shall be counted as the first year's dues. There shall be no refund.

**Section 10.3 Authority to Act**

Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the MEC may deem appropriate.

**Section 10.4 Division of Fees**

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Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

**Section 10.5                      Disclosure of Interest**

All nominees for election or appointment as Medical Staff officers, Committee Chairs or the MEC shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the MEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

**Section 10.6                      Confidentiality**

The following applies to records of the Medical Staff and its departments and committees responsible for the evaluation and improvement of patient care: (a) records of the Medical Staff and its departments and committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential; (b) access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained; and (c) information which is disclosed to the Board or its appointed representatives, in order that the Board may discharge its lawful obligations and responsibilities, shall be maintained by that body as confidential.

Members of the Staff shall respect and preserve the confidentiality of all communications and information relating to credentialing, peer review and quality improvement activities. Any breach of this provision, except as required by law, shall subject the Staff member to corrective action.

**Section 10.7                      No Implied Rights**

Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy or right of action upon any person, except as expressly set forth herein. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the governance of the internal affairs of the Hospital. No person is authorized to rely on any provision of these Bylaws or the Rules and Regulations except as specifically provided herein and no person may personally enforce any provision hereof, except as specifically provided. These Bylaws and the Rules and Regulations are intended for professional use and governance only.

**Section 10.8                      Notices**

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally or

deposited in the United States first class mail, postpaid, to the person entitled to receive notice at his last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

**Section 10.9                    Distribution**

The officers of the Medical Staff shall ensure that a copy of these Bylaws and the Rules and Regulations, and all amendments thereto, are given to each applicant for privileges and each member of the Staff and are continuously available to members of the Staff upon request.

**Section 10.10                No Contract Intended**

Notwithstanding anything herein to the contrary, it is understood that these Bylaws and Rules and Regulations do not create, nor shall they be construed as creating, in fact, by implication or otherwise a contract of any nature between or among the Hospital or the Board or the Staff and any member of the Staff or any person granted clinical privileges or entitled to perform specified services. All clinical or other privileges are simply privileges which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations. Any provisions of these Bylaws may be amended, altered, modified or repealed at any time as provided herein.

**Section 10.11                No Agency**

Practitioners shall not, by virtue of these Bylaws or Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contact with the Hospital.

**Section 10.12                Entire Bylaws**

These Bylaws are the entire Medical Staff Bylaws and supersede any and all prior Medical Staff Bylaws, which, by adoption hereof, shall be automatically repealed.

**ARTICLE XI.                ADOPTION AND AMENDMENT OF BYLAWS**

**Section 11.1                Medical Staff Responsibility and Authority**

The Medical Staff shall have the responsibility and delegated authority to formulate, adopt, and recommend to the Board Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of

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Approved by the Board of Trustees 12-18-96; Adopted January 1, 1997  
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Reviewed Feb. 1999; changes approved by the Medical Executive Committee March 8, 1999; approved by the Board of Trustees--May 5, 1999  
Reviewed Mar. 2000; changes approved by the Medical Executive Committee April 10, 2000; approved by the Board of Trustees--June 28, 2000  
Reviewed Apr. 2001; changes approved by the Medical Executive Committee November 2001; approved by the Board of Trustees--November 2001

the professionally recognized level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community.

Neither the Medical Staff nor the governing body may unilaterally amend the Bylaws.

**Section 11.2                    Procedure**

Upon the request of (1) the MEC, the Chief of Staff, or the Bylaws Committee after approval by the MEC, or (2) upon timely written petition signed by at least ten (10) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws.

**Section 11.3                    Action on Bylaws Change**

All proposed amendments, whether originated by the MEC, another standing committee, or by a member of the active staff, must be reviewed and discussed by the MEC prior to an MEC vote. Such amendments may be recommended to the Board:

- A. By the MEC after a majority vote, provided that the proposed amendment(s) was first distributed to the members of the Active Staff at least twenty one (21) days prior to an MEC vote. The MEC's recommendation may be acted upon by the Board unless more than 10% of the Active Staff members object. If more than 10% of the Active staff members object to a proposed amendment, the Chief of Staff or the MEC shall schedule and hold a staff meeting at which the proposed amendment shall be presented, discussed and acted upon. The affirmative vote of the majority of those active staff members present and voting is required for passage. Absentee ballots will be permitted.
  
- B. The MEC shall have the power to adopt such amendments to the Bylaws as are, in the Committee's judgment, technical or legal modifications or clarifications; reorganization or renumbering; or amendments needed because of punctuation, spelling, or other error of grammar or expression. Such amendments shall be effective when approved by the Board.

**Section 11.4                    Board of Trustees**

Bylaw changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be withheld unreasonably. If Board approval is withheld, the reasons for doing so shall be specified by the Board in writing, and shall be forwarded to the Chief of Staff and the MEC. Medical staff members are provided with copies of the revisions in the Bylaw and Rules and Regulations.

**Section 11.5                    Exclusivity**

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The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

**Section 11.6**

These bylaws, and clinical privileges accorded under these bylaws, will be binding upon the hospital and medical staff of any successor in interest in this hospital.

**Section 11.7**

The hospital's affiliation with other hospitals, health-care systems, or similar entities shall not in and of itself affect these medical staff bylaws.

**Section 11.8                      Bylaws Review**

The Medical Staff Bylaws and Rules and Regulations shall be reviewed at least every two (2) years. The Chief of Staff, at his or her option, may choose to form an Ad Hoc Committee to review the Bylaws at least every two years. This Ad Hoc Committee shall review the Bylaws, appended documents, and the Rules and Regulations, and make recommendation to the Medical Executive Committee, who will follow the process for action on Bylaws change, as outlined in Section 11.3. In lieu of that option being exercised, the Medical Executive Committee itself will review the Bylaws, and follow the process as outlined in Section 11.3.

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