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DEFINITIONS

The definitions applicable in this Medical Staff Organization Manual are those stated in the Medical Staff Bylaws.

LEGEND FOR COMMITTEE ACRONYMS

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PART ONE. RESPONSIBILITIES AND AUTHORITY OF OFFICERS

1.1 RESPONSIBILITIES AND AUTHORITY OF GENERAL OFFICERS
The responsibilities and authority of the General Officers of the Staff shall be as set forth in Article 3 of the Medical Staff Bylaws.

1.2 RESPONSIBILITIES AND AUTHORITY OF DEPARTMENT CHAIRPERSONS/SERVICE CHIEFS
The responsibilities and authority of Department Chairpersons/Service Chiefs shall be as set forth in Article 4 of the Medical Staff Bylaws.
PART TWO. MEDICAL STAFF COMMITTEES

2.1 DESIGNATION
There will be a Medical Executive Committee (MEC) and the following standing committees responsible to the MEC: Credentials, Continuing Medical Education, Bylaws, Nominating, PHC, Cancer, and Peer Review. The principles governing committees are provided in Section 5.2 of the Medical Staff Bylaws. The manner of and authority for the appointment of members and chairpersons of committees are set forth in Section 5.2-6 of the Medical Staff Bylaws.

2.2 MEDICAL EXECUTIVE COMMITTEE
The composition and duties of the MEC are as set forth in Section 5.3 of the Medical Staff Bylaws. In addition, the MEC supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its clinical units.

2.3 CREDENTIALS COMMITTEE
2.3-1 PURPOSE AND MEETINGS
The Cred Com shall be the Cred Com of Martin Memorial Health Systems, Inc., which shall:

(a) Coordinate the Medical Staff credentials functions by:
   (1) Receiving and analyzing applications and recommendations for appointment, provisional period conclusion or extension, reappointment, clinical privileges, and changes therein, and recommending action thereon;
   (2) Monitoring that quality and utilization assessment and review, participation and other relevant information is integrated into individual credentials files and reviewing the same in making recommendations on reappointment and regranting of clinical privileges; and
   (3) Developing or coordinating, periodically reviewing, and making recommendations on the procedures and forms used in connection with each component of the credentialing process and recommending standards for the content and organization and overseeing maintenance of the individual credentials files.

(b) Evaluate the merits of new procedures or devices to be performed or used by Medical Staff members and reviews and makes recommendations on protocols established by the Departments/Services for new procedures or devices.

The Cred Com shall meet and report to the MEC and the Board as set forth in the Bylaws of Martin Memorial Health Systems, Inc.

2.3-2 COMPOSITION
The composition of the Cred Com shall be as set forth in the Bylaws of Martin Memorial Health Systems, Inc., and shall include:
(a) Not less than five (5) at large members from the Attending Staff/Active status of the Medical Staff of Martin Memorial Medical Center, Inc., with at least one (1) representative from each Medical Staff Department and [effective upon the first election following the opening of Tradition Medical Center] preferably one representative whose principal facility affiliation is Tradition Medical Center, nominated by the Medical Staff Nominating Committee and elected for two (2) year terms from and by the Attending Staff with Active status, with such election to occur in the manner and subject to the conditions described in the applicable Medical Staff Bylaws and related manuals, and one (1) of whom shall be elected to be Chairperson of this Committee. The Chairperson may not be a full time employee of a Martin Memorial Health Systems-affiliated entity. Each member must be board certified by his/her applicable specialty board or otherwise demonstrate that he/she possess comparable competence. Any individual who was a member of the Medical Staff as of July 1, 1993 shall be presumed to possess comparable competence.

The Chairperson of the Cred Com will be elected for one (1) two (2) year term by the Medical Staff as outlined in the Medical Staff Bylaws and will serve as a member of the MEC with vote. The Chairperson may serve no more than one (1) consecutive two (2) year term.

Any vacancies in the Cred Com shall be filled by appointment by the Medical Staff President.

(b) One (1) member appointed for a two (2) year term serving as the Martin Memorial-employed physician representative, with such appointment to occur in the manner subject to the conditions described in the applicable Bylaws of Coastal Care Corporation.

(c) Martin Memorial Health Systems’ Chief Medical Officer, ex officio and without vote.

(d) Martin Memorial Health Systems’ Director of Medical Staff Services, ex officio, as Staff and without vote.

2.4 CONTINUING MEDICAL EDUCATION COMMITTEE

2.4-1 PURPOSE AND MEETINGS

The Continuing Medical Education Committee (CMEC) directs or coordinates the development of continuing medical education programs for the Medical Staff which is responsive to the needs identified by physician recommendations; committee input, including the Cancer Committee; quality assessment and performance improvement findings; and developments pertinent to practice at the Hospital. The CMEC shall be tentatively scheduled every six (6) months, must meet at least annually, more frequently as needed, and reports on its activities to the MEC. Assisting members of the Medical Staff to obtain CME category one credits shall be a priority of the CMEC.

2.4-2 COMPOSITION

The Continuing Medical Education Committee includes:

(a) a Chairperson;

(b) at least two (2) additional Medical Staff members;

(c) Chief Medical Officer, with vote;
(d) Manager, Continuing Medical Education, without vote;
(e) Medical Staff President, without vote; and
(f) Chief Executive Officer, without vote. The membership is appointed for two (2) year terms by the President of the Medical Staff.

2.5 **BYLAWS COMMITTEE**

2.5-1 **PURPOSE AND MEETINGS**
The Bylaws Committee (BC) fulfills Staff responsibilities relating to review and revision of Medical Staff Bylaws and related manuals and Medical Staff Rules and Regulations. The BC meets at least biennially and reports to the MEC. BC members may participate in meetings by telephone, by e-mail, by facsimile transmission or by other written documentation evidencing the member’s intention concerning any business to be transacted at the meeting.

2.5-2 **COMPOSITION**
The BC includes:

(a) a Chairperson and five (5) additional Medical Staff members; and

(b) Medical Staff President, without vote.

2.6 **NOMINATING COMMITTEE**

2.6-1 **PURPOSE AND MEETINGS**
The Nom Com shall nominate, when required under the provisions of the Medical Staff Bylaws, one (1) or more qualified candidates for the general Staff offices, Department Chairpersons/Service Chiefs, Chairpersons of Quality Council and Credentials Committees and the at-large member(s) on the Cred Com. It shall meet as required under the Medical Staff Bylaws and otherwise as necessary to accomplish its function.

2.6-2 **COMPOSITION**
The Nom Com shall be composed of:

(a) President of the Medical Staff, as Chairperson and with vote; and

(b) two (2) most immediate Past Presidents of the Medical Staff.

2.7 **PHYSICIAN HEALTH COMMITTEE**

2.7-1 **PURPOSE**
This section addresses referral of Medical Staff members who possibly suffer chemical dependence, or a mental or physical impairment that may adversely affect the quality of patient care, for evaluation and initiation of treatment for the purpose of assisting the member and protecting patients.

2.7-2 **PHILOSOPHY**
Chemical dependence (including dependence on mood-altering drugs, such as alcohol, cocaine, opiates, and depressants) is seen as a medical condition that
requires treatment. Untreated or relapsing chemical dependence, or a mental or physical impairment that may adversely affect the quality of patient care, is incompatible with safe clinical performance in any medical specialty.

2.7-3 ASSISTANCE

(a) All Medical Staff members should share their concerns about dependence, or mental or physical impairment, in themselves or other members in confidence with the PHC.

(b) The PHC is dedicated to helping the Medical Staff members identify chemical abuse, and mental and physical impairments, and helping members to obtain treatment to alleviate the problem. Even though the Committee’s mission is to assist Medical Staff members, patient safety must be primary. Thus, if the Committee finds a risk of harm or danger to patients and the practitioner does not willingly withdraw from clinical practice, the Committee will ask the President of the Medical Staff to initiate corrective action.

2.7-4 CONFIDENTIALITY

(a) The PHC shall maintain strict confidentiality. It will release information only with the express agreement of the member, as needed to carry out Medical Staff duties, or as required by law. Releases to carry out Medical Staff duties shall be limited, insofar as possible, to protecting patients and carrying out Committee activities.

(b) The PHC shall periodically report on its activities to the MEC, without identifying individuals when possible.

(c) The PHC shall report directly to the President of the Medical Staff on the status of a particular case.

2.7-5 REPORTING AND INVESTIGATING PROCEDURES

The PHC will investigate all reports of impairment to determine whether a problem exists. This protocol applies to members who have impairments, as well as applicants who have a history of impairment.

(a) The investigation may include evaluation of written reports; interviews of associates, relatives, and others at the Hospital, office or home (when authorized by the practitioner); and chart review of records at this or other hospitals for the purpose of identifying impairment rather than assessing quality of care.

(b) If a problem might exist, the practitioner in question will be invited to meet with the Committee or a minimum of two (2) Committee members, to discuss the problem and the findings from the investigation. The interview will be informal.
(c) The PHC may ask the practitioner to be evaluated by a qualified practitioner, including a psychiatrist, other psychotherapist, or substance abuse counselor. The PHC will ask the practitioner to authorize disclosure of the results of the evaluation to the Committee. The Hospital may pay for the evaluation, although that is discretionary. The practitioner should be given a list of professionals acceptable to the Committee. The report should address the diagnoses, prognosis and treatment program recommendations.

(d) Practitioners who have chemical dependency abuse will be referred to the Physicians Recovery Network (PRN), and a treatment program of the practitioner’s choice approved by the PHC. Practitioners who have other types of impairments will be referred for appropriate treatment approved by the Committee.

(e) The PHC will draw up a contract between it and the practitioner, delineating the Committee’s expectations for treatment and monitoring. The contract, as a minimum, will require the member to agree to the following conditions, depending upon the nature of the impairment:

1. To provide documentation from an evaluating or treating professional that initial treatment has been provided and that the member may safely practice.
2. To abstain from using any drugs or alcohol, except as approved by the treatment program and the PHC.
3. To participate in an ongoing treatment program. Any specific terms, such as continuing psychiatric counseling, securing medical treatment, or attending physician recovery groups two (2) nights a week and Alcoholics Anonymous or Narcotics Anonymous two (2) nights a week, should be stated.
4. To agree to any indicated random testing of body fluids by the treatment program or as directed by the PHC.
5. To meet regularly, and at least quarterly, with a monitor appointed by the PHC.
6. To allow free and open communication between the treating professionals, the recovery support network, those persons responsible for verifying compliance with the re-entry agreement (including Medical Staff Services), and the PHC.
7. To request a medical leave of absence in the event the PHC finds that the impairment or failure to comply with the re-entry agreement presents a risk to patients.
8. To sign whatever forms are needed to authorize release of information from the treatment programs to the PHC, and request that reports be made regularly to the Committee, at defined time intervals (such as quarterly).
9. To acknowledge that any failure to comply with the conditions will result in immediate referral to the President of the Medical Staff for corrective action.
10. To provide for post treatment monitoring of a sufficient duration (usually two (2) to three (3) years or until fully released by the PRN).
(11) To participate in a regular review of the agreement, and to modify it as necessary to achieve the goals of continued recovery.

(f) When the treating program or the PHC concludes that the member cannot practice safely, the member shall request a leave of absence. Discontinuance of the leave shall be contingent upon: (1) the member satisfying the Committee that he/she can return safely to practice sufficient for the Committee to recommend a return from leave to the MEC; and (2) the member still chooses to comply with the Physician Assistance Program.

(g) Also when indicated based upon the severity and duration of the chemical dependence, or mental or physical impairment, the member may be required to: (1) pass an oral or written test administered by an appointed panel of Department members; and/or (2) be proctored on at least twenty (20) cases and for at least three (3) months, and have reports of satisfactory performance on the cases.

The investigation may be closed at any time it appears there is no problem.

2.7-6 PARTICIPATION
If the practitioner refuses to cooperate at any stage, the matter will be referred to the President of the Medical Staff, together with a statement that the practitioner is not participating in the Physician Assistance Program, and the PHC has reason to suspect that the member may be impaired as a result of chemical abuse, mental illness or physical injury or condition. The MEC should initiate its own corrective action investigation, and not ask the PHC to share the confidential information that was gathered during an investigation or while a member was fulfilling his/her agreement with the Committee. The PHC should be asked only to indicate what action may be necessary to protect patients. Other evidence should be developed independently in order to preserve the integrity of the Committee’s promises of confidentiality.

2.7-7 MONITORING
After successful completion of the treatment program for a minimum period, such as two (2) years, the PHC shall close the active case. It will open a monitoring case for a defined period of time, such as three (3) years, and review the practitioner’s status every six (6) months.

2.7-8 COMPOSITION
The PHC shall include:

(a) a Chairperson who shall be a physician;

(b) at least two (2) additional physician members;

The membership is appointed for two (2) year terms by the President of the Medical Staff. When appointing members to the PHC, consideration should be given to including in the membership, if practical, psychiatrists, physicians practicing in high risk areas (for example, surgeons and emergency medicine physicians), physicians with a prior history of chemical dependence or a mental or physical impairment, and senior Medical Staff members who are highly regarded among the Medical Staff
membership at large. Notwithstanding any other provision in the Medical Staff Bylaws or related manuals to the contrary, there shall be no limit on the number of consecutive terms served by any PHC member.

2.8 CANCER COMMITTEE

2.8-1 PURPOSE AND MEETINGS
The Cancer Committee provides policy direction and clinical leadership in all aspects of Hospital-provided cancer care. Its responsibilities cover the entire spectrum of care for cancer patients, including diagnosis, treatment, rehabilitation, follow-up and end-results reporting. The Cancer Committee supervises the cancer registry while planning and implementing patient care evaluation studies. The Cancer Committee shall meet at least quarterly, with reports of its meetings provided to the Quality Council, the MEC and the Board.

2.8-2 COMPOSITION
The Cancer Committee shall be composed of: (A) a Chairperson appointed by the Medical Staff President in consultation with the Chairperson of the Quality Council; (B) at least five (5) additional representatives from the Medical Staff, with at least one (1) board certified representative from surgery, medical oncology, radiation oncology, diagnostic radiology and pathology. Medical Staff representatives on the Committee shall include a cancer liaison physician; and (C) at least one (1) representative from each of the following administrative areas: Administration, Nursing, Social Services, Cancer Registry and Quality Management resources.

2.9 PEER REVIEW COMMITTEE

2.9-1 PURPOSE AND MEETINGS
The Peer Review Committee monitors overall and individual practitioner performance through medical case review and when necessary, Focused Professional Practice Evaluation (FPPE). The purpose of such review is to take reasonable measures to assure the competency of practitioners who have been granted Medical Staff membership and corresponding clinical privileges at Martin Memorial Medical Center. The Peer Review Committee meets monthly or as otherwise necessary to perform its responsibilities as more specifically set forth in the Quality Management Resources Policy regarding the Medical Staff/Dependent Practitioners.

2.9-2 COMPOSITION
The Peer Review Committee shall be composed of (a) a Chairperson, appointed every two (2) years in odd years, by the Medical Staff President in consultation with the Chairperson of the Quality Council and the Chief Medical Officer and (b) at least one designated representative from each Medical Staff Department and Clinical Service Line. Each designee shall be chosen by the Peer Review Committee Chairman and approved by the Medical Executive Committee.

2.9-3 CONFIDENTIALITY OF DELIBERATIONS
The Peer Review Committee shall strive to maintain strict confidentiality. It will release information: (a) as needed for the Medical Staff Leadership to carry out its duties as delegated to it by the Board of Directors and as consistent with the Medical Staff Bylaws; and (b) as otherwise required by law.
The Committee, through its Chairman, reports its findings to the Department Chair and/or the Medical Executive Committee, as appropriate.

PART THREE. AMENDMENT

3.1 AMENDMENT
This Medical Staff Organization Manual may be amended or repealed, in whole or in part, in the same manner as provided for in Article Thirteen of the Medical Staff Bylaws.