

THE JOHNS HOPKINS HOSPITAL

MEDICAL STAFF BYLAWS

RULES AND REGULATIONS

June 2009

The mission of The Johns Hopkins Hospital is:

To be the world's preeminent health care institution

To provide the highest quality care and service for all people in the prevention, diagnosis and treatment of human illness.

To operate cooperatively and interdependently with the faculty of The Johns Hopkins University to support education in the health professions and research and development into causes and treatment for human illness.

To be the leading health care institution in the application of discovery.

To attract and support physicians and other health care professionals of the highest character and greatest skill.

To provide facilities and amenities which promote the highest quality care, afford solace and enhance the surrounding community.

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**THE JOHNS HOPKINS HOSPITAL
MEDICAL STAFF BYLAWS
RULES AND REGULATIONS**

ARTICLE I

NAME

The name of the medical staff shall be the "Medical Staff of The Johns Hopkins Hospital."

For the purpose of these Bylaws, the words "Medical Staff" shall be interpreted to include all physicians and dentists who are authorized to provide care to patients of The Johns Hopkins Hospital (the "Hospital"), its outpatient facilities, and in any other medical care activity administered by the Hospital. The word "physician(s)" shall be interpreted to mean physician(s) and dentist(s). The words "Organized Medical Staff" shall be interpreted to include all members of the Active Staff.

ARTICLE II

PURPOSES

The purposes of the Medical Staff Bylaws Rules and Regulations (the "Bylaws") are:

1. To facilitate the provision of quality care to Hospital patients regardless of race, gender, sexual orientation, creed, disability, or national origin.
2. To promote professional standards among members of the Medical Staff.
3. To provide a means whereby problems may be resolved by the Medical Staff with the collaboration of the Board of Trustees of The Johns Hopkins Hospital (the "Board of Trustees").
4. To create a system of self-governance, and to initiate and maintain rules and regulations governing the conduct of the Medical Staff, subject to the ultimate authority of the Board of Trustees.

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into the Active Staff, Courtesy Staff, Associate Staff and Contract Physician Staff categories.

Section 3.01 The Active Staff

The Active Staff shall consist of physicians who regularly admit patients to the Hospital, or regularly practice a hospital-based specialty at the Hospital. Active Staff members are expected to participate in the teaching and/or research programs of their respective departments, as well as patient care. Failure to participate in these activities shall lead to reconsideration of the Active Staff appointment. Members of the Active Staff may serve on Medical Staff committees, be nominated for election as Medical Staff representative on the Medical Board, and vote in any meeting of the Medical Staff.

Specialty board certification, activity leading to specialty certification, or the equivalent, as determined by the appropriate Chief of Service, is a prerequisite for appointment to the Active Staff.

The Medical Staff appointment of those members of the Active Staff enrolled in an approved advanced specialty training program (ASTP) shall terminate upon the completion of or resignation from the training program unless the physician has applied for and been granted Active Staff status.

Section 3.02 The Courtesy Staff

The Courtesy Staff shall consist of physicians who only occasionally admit patients to the Hospital or act only as consultants. Courtesy Staff members shall not be eligible to vote or hold office in the Medical Staff organization. A member of the Courtesy Staff of the Hospital must be a member of the active staff of another hospital.

Specialty board certification, activity leading to specialty certification, or the equivalent, as determined by the appropriate Chief of Service, is a prerequisite for appointment to the Courtesy Staff.

Section 3.03 The Associate Staff

The Associate Staff shall consist of physicians who serve only in outpatient facilities, the newborn nursery, or in out-of-hospital medical care activities administered by the Hospital. Members of the Associate Staff are not eligible to vote or to hold office and may not admit patients to the Hospital.

Specialty board certification, activity leading to specialty certification, or the equivalent, as determined by the appropriate Chief of Service, is a prerequisite for appointment to the Associate Staff. Members of the Associate Staff are not eligible to vote or to hold office and may not admit patients to the Hospital.

Section 3.04 The Contract Physician Staff

The Contract Physician Staff shall consist of physicians who are enrolled in The Johns Hopkins University School of Medicine graduate medical education programs and are engaged by The Johns Hopkins Hospital or The Johns Hopkins University to provide medical services outside their training program at The Johns Hopkins Hospital. A Contract Physician must obtain prior approval for the outside activities in accordance with the Johns Hopkins University School of Medicine Moonlighting Policy or Extracurricular Activities Policy, and provide a copy of the contract under which they will be working at the time the credentialing process begins. Members of the Contract Physician Staff are not eligible to vote or to hold office. They may not serve as the attending of record or admit patients to the Hospital. Appointment to the Contract Physician Staff shall automatically terminate upon termination of the contract for activities outside of the training program at The Johns Hopkins Hospital.

ARTICLE IV

THE RESIDENT STAFF

The Resident Staff shall consist of interns, assistant residents, residents, and clinical fellows in the clinical departments who work under the supervision of the Chiefs of Service, and in accordance with Hospital and departmental job descriptions. Members of the Resident Staff assume responsibilities under such supervision for the safe, effective and compassionate care of patients on inpatient services, in the outpatient facilities and in out-of-hospital medical care activities administered by the Hospital, consistent with their training and experience. Resident Staff will be expected to participate in the medical education programs of the Hospital and the Johns Hopkins University.

Members of the Resident Staff shall comply with ongoing risk management education requirements and shall adhere to all applicable policies promulgated by the Committee on Graduate Medical Education and approved by the Medical Board and the Board of Trustees. Since Resident Staff are not considered members of the Medical Staff, their appointment, non-appointment, and terminations from the Resident Staff do not give rise to the fair hearing and appellate rights specified in Article XXV.

Members of the Resident Staff shall be graduates of, or students in good standing (e.g., sub-interns) of, approved or recognized schools of medicine, dentistry, or osteopathy. Graduates of approved or recognized medical schools elsewhere than in the United States, Canada, or Puerto Rico must present a valid ECFMG certificate from the Educational Commission for Foreign Medical Graduates prior to beginning the credentialing process. The Hospital may, on recommendation of a Chief of Service and with the approval of the Medical Board, require any member of the Resident Staff to be licensed in the State of Maryland.

ARTICLE V

THE AFFILIATE STAFF

The Affiliate Staff shall consist of those individuals who provide independent clinical services and who are not physicians or members of the Medical Staff. The Affiliate Staff shall include but is not limited to, doctoral scientists, clinical psychologists, clinical laboratory directors or practitioners, physician assistants, certified registered nurse anesthetists, certified nurse practitioners, certified nurse midwives, podiatrists and optometrists.

Affiliate Staff may exercise judgment within their licensure, certification, and/or area of competence; participate directly in the management of patients under the supervision or direction of a member of the Medical Staff; record reports and progress notes in patients' records; and write orders to the extent established by the appropriate Chief of Service and in accordance with applicable law. Affiliate Staff shall be appointed by the Board of Trustees in accordance with the procedures herein and shall agree to be governed by the Bylaws.

Appointments to the Affiliate Staff shall be for a period of not more than two (2) years.

Affiliate Staff who are neither Hospital nor Johns Hopkins University employees shall provide evidence of current professional liability coverage as provided herein.

ARTICLE VI

GENERAL CONDITIONS OF APPOINTMENT

Section 6.01 Qualifications

- A. The members of the Active Staff, the Courtesy Staff, the Associate Staff, and Contract Physician Staff shall have an unrestricted license to practice medicine or dentistry in the State of Maryland.
- B. At the time of initial appointment and continuously thereafter, members of the Medical Staff shall demonstrate their ability to provide quality patient care. They shall demonstrate their willingness to abide by the Bylaws, policies, and procedures of the Hospital as they currently exist or as amended from time to time and to discharge those Medical Staff obligations appropriate to their category of membership. Their professional conduct shall comply with the Hospital's Code of Conduct and generally accepted principles of medical ethics. Their qualifications shall include the absence, or adequate control, of any significant physical or behavioral impairment that affects or presents a substantial probability of affecting their skill, attitude, or judgment in the fulfillment of their duties. They shall demonstrate that they carry professional liability insurance coverage in the amount required herein. A qualified applicant will not be denied membership and/or clinical privileges on the basis of gender, sexual orientation, race, creed, disability, or national origin.

Section 6.02 Hospital and Community Need

Each application for membership on the Medical Staff shall be evaluated, and may be granted or denied appointment, in light of the needs of the Hospital and the community and the Hospital's ability to accommodate the expectations of the applicant. Factors considered shall include, but not be limited to, departmental criteria; current and projected patient care; teaching and research needs; the ability to provide required support services and facilities; current and expected patient load; actual and planned allocations of physical, financial and human resources to general and specialized clinical and support services; and long- and short-range development plans.

Section 6.03 Effect of Other Affiliations

A physician is not automatically entitled to Medical Staff membership, a particular medical staff category, departmental affiliation, or particular privileges because of prior, current, or pending status of privileges at the Hospital or elsewhere.

ARTICLE VII

DELINEATED CLINICAL PRIVILEGES

Except in an emergency, a credentialed practitioner may exercise only those privileges granted by the Board of Trustees.

Privilege determinations shall be based on prior and continuing education, training, experience; demonstrated current competence; judgment; interpersonal and communication skills; and professionalism, as documented and verified in the physician's credentials file including peer evaluations, observed clinical performance and documented results of Hospital and Departmental quality improvement programs. The exercise of privileges within a department is subject to departmental rules and regulations and the authority of the Chief of Service.

Section 7.01 Modification of Delineated Clinical Privileges

Modification of delineated clinical privileges is subject to the same approval process as described herein for decisions on the application/reapplication.

Section 7.02 Emergency Privileges`

An emergency situation is one in which serious harm or aggravation of injury or disease is imminent, or one in which the life of a patient is in immediate danger, and any delay in treatment could add to that danger.

In the case of an emergency, individuals appointed to the Medical or Affiliate Staff and granted delineated clinical privileges in any category are permitted to do everything possible, within the scope of their license, to save a patient's life or to save a patient from serious harm. In addition, the individual is obligated to summon appropriate assistance and to arrange for appropriate follow-up care, to the extent consistent with prevailing medical practice.

Section 7.03 Temporary Privileges

A. Pendency of Application.

Upon the written request, including justification, from the Chief of the clinical service in which the privileges will be exercised, the Chair of the Credentials Committee (the "Chair") acting on behalf of the President of the Hospital, or, when unavailable, the Vice President

for Medical Affairs, or Chair of the Medical Board, or the Vice Chair of the Medical Board acting as the Chair's designee, may grant temporary privileges pending action by the Credentials Committee, Medical Board and Board of Trustees on a completed and verified application for initial Medical Staff appointment. In such instances, temporary privileges may be granted until the application processing has been completed, but for no more than one period of forty-five (45) days.

To be considered for temporary privileges during pendency of application, the application must be complete and there must be no history of challenge to licensure or registration; no history of involuntary termination of medical staff membership at another organization; and no history of involuntary limitation, reduction, denial, or loss of clinical privileges. There must be verification of current licensure, relevant training or experience, current competence, ability to perform the privileges requested and compliance with all requirements for medical staff membership. A National Practitioner Data Bank query must be obtained and evaluated. The complete file must be deemed likely to receive a positive recommendation by the Credentials Committee.

B. Important Patient Need.

1. Care of Specific Patients. Upon receipt of a written request from the Chief of Service and in accordance with the Conditions specified in B.4 below, an appropriately licensed practitioner may be granted temporary privileges for the care of one (1) or more specific patients. Such privileges may be granted to a practitioner for the care of no more than three (3) patients in any calendar year.
2. Emergency Coverage. Upon receipt of a written request from the Chief of Service and in accordance with the conditions specified below, an appropriately licensed practitioner, who is not an applicant for membership, may be granted temporary privileges for the care of a designated group of patients for a specified, limited period of time.
3. Special Education. Upon receipt of a written request from the Chief of Service and in accordance with the conditions specified below, an appropriately licensed practitioner may be granted temporary privileges for a defined educational experience, which is approved by the Credentials Committee, under the supervision of a member of the Active Staff.
4. Conditions. Temporary privileges for important patient needs specified in this subsection may be granted following receipt and verification of (a) current Maryland license or approval by the State of Maryland of waiver of Maryland licensure, (b) proof of current malpractice coverage, (c) National Practice Data Bank information, (d) delineation of privileges from the practitioner's primary hospital, and (e) letter from the Chief at the applicant's primary hospital attesting to clinical competence.

Section 7.04 Disaster Privileges

Disaster privileges are granted only when the emergency management plan has been activated and the Hospital is unable to meet immediate patient needs. The following may grant temporary disaster privileges to licensed independent practitioners: a) the Director of the Center for Emergency Preparedness and Response (CEPAR) or designee, b) the Chair of the Credentials Committee, c) the Vice President for Medical Affairs, d) the Chair or Vice Chair of the Medical Board, or e) any Chief of Service in a department requiring emergency volunteers.

These privileges may be granted following a) the completion of the Disaster Privileges Form (in accordance with the Johns Hopkins Hospital Credentialing of Clinical Volunteer

Providers in Patient Influx Emergencies Policy), b) presentation of a valid government-issued photo identification issued by a state or federal agency (such as a driver's license or passport), and c) at least one of the following:

- 1) a current hospital photo identification card with professional designation identified,
- 2) a current license to practice,
- 3) a primary source verification of the license,
- 4) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC) unit, Emergency System for Advance Registration of Volunteer Health Professional (ESAR-VHP) program, or other recognized state or federal organizations,
- 5) Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (with such authority having been granted by a federal, state or municipal entity), or
- 6) Identification by a current Hospital medical staff member who possesses personal knowledge regarding the clinical volunteer provider's ability to act as a licensed independent practitioner during a disaster.

These providers will wear a temporary identification badge that readily identifies them as having Disaster Privileges. As soon as the immediate situation is under control, the Director of CEPAR will contact the Medical Staff Office to advise that Disaster Privileges have been granted and will forward the original Disaster Privileges forms. The Medical Staff Office will then verify each practitioner's information with primary source verification of licensure completed as soon as possible, but at least within seventy-two (72) hours from the time the volunteer has been granted disaster privileges. The Medical Staff will oversee the professional practice of the volunteer providers as described in the Credentialing of Clinical Volunteer Providers During Patient Influx Emergencies Policy, with a decision made within seventy-two (72) hours as to whether or not to continue the disaster privileges initially granted.

ARTICLE VIII

TERMS OF APPOINTMENT

Appointment to the Medical Staff and Affiliate Staff shall be for a period of not more than two (2) years.

Section 8.01 Provisional Appointments

Initial appointments to the Active Staff, Courtesy Staff, and Associate Staff shall include a provisional period of one (1) year. Members on provisional status are accorded all the rights of the category to which they have been assigned.

A. Monitoring Performance of Provisional Appointees.

1. The departmental Quality Improvement Committee, or a designated subcommittee of the department to which a provisional appointee is assigned, shall have the responsibility for monitoring the appointee's performance during the period of provisional appointment.
2. This monitoring will include, but not be limited to, evaluation of performance using information available to the departmental Quality Improvement Committee in its regular reviews of quality improvement, utilization review, and risk management.

3. Reviews conducted pursuant to subsection (2) above will be documented and given to the Chief of Service prior to his/her evaluation of the provisional staff member's suitability for full staff appointment.
- B. Conclusion of Provisional Appointment. To conclude a provisional period, the Chiefs of Service must attest to the Medical Staff member's satisfactory demonstration of clinical abilities and good citizenship.

Extensions of provisional appointments will be granted if physicians or their Chiefs of Service determine that the physician's clinical activities were insufficient to demonstrate the physician's abilities.

A member of the staff whose appointment is provisional and who does not meet the criteria for appointment to full Medical Staff status by the end of his/her initial appointment shall be scheduled for a personal interview with the Chief of Service of the appropriate department, or his/her designee, to discuss the termination of appointment to the Medical Staff of the Hospital.

Section 8.02 Contract Practitioners

- A. The staff appointment of any Medical Staff member whose appointment is solely the result of (1) a contractual relationship with The Johns Hopkins Hospital or another Johns Hopkins health facility/entity; (2) status as an employee, partner, or principal of, or in, an entity that has a contractual relationship relating to providing services to patients of The Johns Hopkins Hospital or another Johns Hopkins health facility/entity, shall terminate automatically and immediately on:
1. the expiration or other termination of the Medical Staff member's contractual relationship with The Johns Hopkins Hospital or another Johns Hopkins health facility/entity;
 2. the expiration or other termination of the relationship of the Medical Staff member with the entity that has a contractual relationship with The Johns Hopkins Hospital or another Johns Hopkins health facility/entity; or
 3. the expiration or other termination of the contractual relationship between the entity that has a contractual relationship relating to providing services to patients of The Johns Hopkins Hospital or another Johns Hopkins health facility/entity.
- B. If any of the provisions of this section arise while the application is in process, this shall constitute voluntary withdrawal of the application.
- C. In the event of such a termination of staff appointment, no fair hearing or procedural rights shall apply.

Section 8.03 Leave of Absence

To request a leave of absence, a staff member must submit to his/her Chief of Service a written request stating the reasons for the leave of absence and the anticipated length of such a leave not to exceed one year. A Chief of Service may request extension of an LOA by submitting a written request to the Credentials Committee for its consideration. The recommendation regarding return from an LOA shall be forwarded by the Credentials Committee to the Medical Board and the Board of Trustees. If the appointment will expire during an LOA, the staff member must apply for reappointment. Failure to reapply will result in expiration of the appointment, and an initial application will be required to rejoin the Medical, Resident or Affiliate Staff.

The Chief of Service shall forward his/her recommendation to the Credentials Committee which, after review, shall forward its recommendation to the Medical Board and Board of Trustees. A staff member on leave of absence shall not be permitted to admit patients or otherwise provide patient care services.

Upon return from a leave of absence, the medical staff member is required to submit to the Credentials Committee a written summary of his/her activities during the leave and if requested by the Credentials Committee, a physical or mental health evaluation, as set forth in Section 13.03.C (Conditions of Appointment) shall be submitted.

Section 8.04 Resignation

A staff member in good standing who wishes to resign from the Medical or Affiliate Staff must submit to his/her Chief of Service a written statement indicating the reason for the resignation and the effective date of resignation. Completion of obligations, including transfer of patient care responsibilities, completion of medical records, and transfer of administrative duties (if applicable), is required in order for a medical staff member to be considered "in good standing" at the time of resignation.

After completion of requisite work, including completion of all medical records, the Chief of Service shall forward his/her recommendation to the Credentials Committee indicating whether or not the staff member resigned in good standing. The Credentials Committee, after review, shall forward its recommendation to the Medical Board; the Medical Board forwards its recommendation to the Board to Trustees.

If a medical staff member resigns while under investigation, or in order to avoid investigation, the Hospital will report acceptance of the staff member's resignation to the appropriate agencies, in accordance with Maryland law and regulatory requirements. The Credentials Committee, the Medical Board, and the Credentials Committee of the Board of Trustees shall be notified of such action.

ARTICLE IX

THE HONORARY STAFF

Those physicians who have retired from the Medical Staff may be deemed Honorary Staff upon request of the Chief of Service, recommendation of the Credentials Committee and Medical Board, and approval of the Board of Trustees. Honorary Staff shall not participate in patient care and shall not be eligible to vote, to hold office, or to serve on standing Medical Staff committees. Honorary Staff need not meet the Conditions of Appointment (Article VI) requirements for Medical Staff membership and are not subject to reappointment every two years. Honorary Staff status may be terminated with or without cause by the Board of Trustees on recommendation of the Chief of Service, the Credentials Committee, and Medical Board. Procedural or fair hearing rights do not apply to the failure to grant, or termination of, Honorary Staff status.

ARTICLE X

APPROVED OBSERVERS

Section 11.01

Upon recommendation by the appropriate Chief of Service and the Credentials Committee, physicians who are not appointed to the Medical Staff and allied health professionals who are not appointed to the Affiliate Staff may observe clinical activities for educational purposes at the Hospital as Approved Observers. An applicant for Approved Observer status shall complete the Hospital's Observer Application form, including provision of government-issued photo identification. The information provided shall include, at a minimum, information regarding education, training and professional qualifications. The applicant shall complete the required HIPAA training and confidentiality statements. In addition, the

applicant shall submit to assessment for tuberculosis, and immunity to rubeola, rubella, and varicella prior to beginning the Observer experience. If the assessment for tuberculosis results in a positive finding, the Observer candidate will be referred to the Occupational Health Service for further assessment of the person's suitability for appointment as an Observer.

Section 11.02

Approved Observers are not members of the Medical or Affiliate Staff and they shall not participate in direct or indirect patient care or management. Approved Observers status shall be granted for no less than two (2) weeks and not more than 90 days in any one-year period. Approved Observer status may be terminated with or without cause by the appropriate Chief of Service, with notification to the Credentials Committee. Procedural and fair hearing rights do not apply to the failure to grant, or termination of, Approved Observer status. Physicians visiting for a period of less than two (2) weeks will be subject to the individual department's visitor policy.

ARTICLE XI

WAIVER OF QUALIFICATIONS

Any qualification required by these Bylaws, but not required by law or governmental or accrediting body regulation, may be waived at the discretion of the Board of Trustees on determination that such waiver will serve the best interests of the patients and the Hospital.

ARTICLE XII

APPOINTMENTS

Section 12.01 Request for Application

All requests for an application to the Medical Staff must be directed to the appropriate Chief of Service. The Chief of Service shall assess the appropriateness of the request, taking into account the needs of the Hospital and the community. Factors considered shall include, but not be limited to, department criteria; current and projected patient care, teaching and research needs; the ability to provide required support services and facilities; current and expected patient load; actual and planned allocations of physical, financial and human resources to general and specialized clinical and support services; and long-and short-range development plans.

Section 12.02 Submission of Application

Applicants for appointment to the Medical Staff and Affiliate Staff shall complete the Hospital's application form in the name in which they are licensed and an appropriate request for delineation of clinical privileges form and shall submit a valid photo identification issued by a state, federal or regulatory agency, referred to collectively herein as "the application forms." Failure to return the completed application forms within forty-five (45) days after receipt shall be considered a voluntary withdrawal of the request for appointment.

- A. The following information must be provided:
1. The name of the department and medical staff category in which privileges are requested.
 2. Privileges requested.
 3. Pre-medical, medical, professional and postgraduate education.

4. ECFMG number, if applicable.
5. National Provider Identification Number.
6. Visa and immigration information, if applicable.
7. Professional training, including all internships, residencies, and fellowships.
8. Postgraduate continuing medical education for the past two (2) years.
9. Current and previous hospital and health care affiliations and medical staff appointments.
10. Description of past and current professional practice.
11. Specialty/subspecialty board certifications, re-certifications, eligibility for certifications, memberships and fellowships in professional societies.
12. The status of all currently or previously held licenses, registrations or certifications to practice a health occupation.
13. The status of the applicant's Drug Enforcement Administration registration.
14. Names and addresses of four (4) professional references. Professional references shall not include more than two (2) current partners or business associates in practice, any relatives by blood or marriage, or the JHH departmental Chief.
15. Statement describing the following areas:
 - a. Licensure and Registration – Previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration;
 - b. Delineated Clinical Privileges – Failure to obtain, or voluntary or involuntary limitation, reduction or loss of clinical privileges at any hospital or health care organization;
 - c. Medical Staff Appointment – Voluntary or involuntary termination of medical staff appointment at any hospital or health care organization;
 - d. Disciplinary Actions – Previously successful or pending disciplinary actions concerning any professional society membership or fellowship, professional academic appointment, medical staff appointment or delineated clinical privileges at any hospital or health care organization. This includes formal or informal reprimands, imposition of conditions or probation of any sort, or imposition of sanctions or restrictions regarding participation in any private, federal or state health care insurance program (e.g., Medicare, Medicaid, health maintenance organizations, managed care organizations);
 - e. Training Program – Probation, suspension, resignation or termination in connection with residency or fellowship programs.
16. A statement concerning professional liability carriers and actions including a listing of at least the following information:
 - a. For the previous five (5) years:
Carrier and dates of coverage

Amount of coverage
Type of coverage
Reason for termination of coverage (if applicable);

- b. Involvement in professional liability claims and actions in the previous ten (10) years;
 - c. Restrictions or limitations on current professional liability coverage, if applicable; and
 - d. Continuity of coverage.
17. A statement about physical, mental or emotional health problems, including drug or alcohol abuse, which could impair the proper performance of the applicant's essential functions and responsibilities as a member of the Medical, Resident or Affiliate Staff.
18. A description of any criminal charges involving the applicant and the current status or resolution of any such charges.
19. The applicant's curriculum vitae.

B. Applicants shall:

- 1. Attest to the correctness and completeness of the application and acknowledge that any significant misstatements in, or omissions from, the application may constitute cause for denial or termination of appointment to the Medical, Resident or Affiliate Staff. In the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner, Medical Staff Administration (MSA) shall notify the practitioner by letter or documented phone call of the discrepancy. Within ten (10) business days, the practitioner shall provide a detailed, written explanation of how the discrepancy occurred. MSA will verify the new information and will retain the letter of explanation in the credentialing file.
- 2. Agree to appear for interviews in regard to the application.
- 3. Acknowledge that they have received a current copy of the Bylaws, and agree to abide by the Medical Staff Bylaws, Rules, and Regulations, and any applicable departmental and/or divisional criteria, as they currently exist or as amended from time to time.
- 4. Agree to maintain an ethical practice, including compliance with the Hospital's Code of Conduct and its confidentiality practices and policies.
- 5. Sign authorizations and statements which substantially state the following:
 - a. I understand that the information required herein is continuing in nature and I agree to inform the Hospital of any changes in the information provided, e.g., malpractice claims, legal actions, address, name, certification and dates, licensure, etc.
 - b. I authorize the Hospital and its representatives to consult with other hospitals and other health care organizations and their representatives and others, including professional liability carriers, in regard to this application and my Medical Staff appointment status and delineated clinical privileges.
 - c. I authorize the Hospital to obtain any information necessary to compile a complete professional liability insurance and claims history.
 - d. I authorize the Hospital to conduct an investigation for criminal history.

- e. I agree to cooperate with the terms and conditions of the Hospital's policy for testing for drugs of abuse and with policies regarding immunization.
- f. I agree that, upon the request of any board or committee responsible for credentials review, I shall undergo a complete physical and/or mental health evaluation concerning my ability to care for patients and/or my ability to work cooperatively with colleagues, support staff, and other members of the Hospital/Hopkins community, by a physician and/or other health care professional who is mutually acceptable to me and the board or committee requesting evaluation, and shall agree to allow the report of the evaluation to be made a part of the application.
- g. I release the Hospital, and its representatives and agents, from any liability for their acts or omissions performed in good faith and without malice in obtaining information and evaluating this application and for their actions performed in good faith as part of the quality improvement program, the credentialing process, peer review, and risk management evaluation activities.
- h. I authorize and consent to the release of all credentialing, performance, quality, utilization, disciplinary and other relevant information to any other Johns Hopkins Health System entity at which I am a member of the Medical, Affiliate or Resident Staff or to which I may apply, in connection with my application for appointment or reappointment or in connection with any peer review or disciplinary process, and I release the Hospital, and its representatives and agents, from any liability for releasing such information in good faith and without malice.
- i. I release all individuals and organizations (including but not limited to professional liability carriers, law enforcement agencies, medical associations, and licensing boards), who in good faith and without malice provide information to the Hospital and its representatives, from any liability in connection with this application and my Medical Staff appointment, status and delineated clinical privileges. I consent to the release of such information, including otherwise privileged or confidential information.
- j. I authorize and consent to the release of relevant information to other hospitals, health care organizations, and regulatory bodies with a legitimate interest in provider performance and the quality and efficiency of patient care, and I release the Hospital, and its representatives and agents, from any liability for so releasing such information in good faith and without malice.
- k. I agree to exhaust the administrative procedures afforded by The Johns Hopkins Hospital Bylaws before resorting to formal legal action if an adverse ruling is made with respect to my Medical Staff appointment, status, or delineated clinical privileges.
- l. I acknowledge that denial of appointment to the Medical Staff or Affiliate Staff may result in a report to the National Practitioner Data Bank and the appropriate licensing agency.
- m. I acknowledge that, as a member of the medical staff of The Johns Hopkins Hospital, I automatically will be included in the Organized Health Care Agreement with the institution as that term is defined under the implementing regulations of the Health Insurance Portability and Accountability Act of 1996.
- n. I acknowledge that, as a member of the Medical, Resident or Affiliate Staff of The Johns Hopkins Hospital, I will complete the minimum required HIPAA training courses.
- o. I agree to provide or arrange for continuous care for my patients.

Section 12.03 Conditions of Appointment

- A. An applicant for initial appointment to the Medical, Resident, or Affiliate Staff of the Hospital agrees to submit a urine specimen within ninety (90) days of the effective date of medical staff appointment to test for drugs of abuse. Procedures for confidentiality, specimen collection and laboratory testing follow guidelines issued by the National Institute on Drug Abuse (NIDA). Medical or Resident Staff with confirmed positive test results will be referred to the Professional Assistance Committee. Affiliate Staff with confirmed positive test results will be referred to the appropriate Human Resource Office (The Johns Hopkins University or The Johns Hopkins Hospital).
- B. Any person accepting appointment to the Medical, Resident, or Affiliate Staff of the Hospital agrees to immediate testing of blood and/or urine for controlled substances and/or alcohol upon appropriate request. An appropriate request is based upon suspicion of an impairment from alcohol and/or drug abuse and may be made by a Chief of Service, his/her designated representative(s) or the Vice President for Medical Affairs. Medical, Resident, or Affiliate Staff members who suspect another member of having an impairment have a responsibility to notify immediately the appropriate Chief of Service, his/her designated representative(s), the Professional Assistance Committee or Vice President for Medical Affairs of their concerns.

Any person who refuses such testing will be treated administratively as though they tested positive for alcohol and/or controlled substances. Administrative procedures to be followed in such instances will be those defined for the involuntary detection of the impaired physician.

Mandatory periodic drug and/or alcohol testing shall be required of any Medical, Resident or Affiliate staff member identified as impaired from drug and/or alcohol abuse disorders as part of ongoing treatment and monitoring of the impaired individual.

- C. Any person applying for appointment to the Medical, Resident or Affiliate Staff of the Hospital, as a condition of maintaining such appointment, agrees that, at the request of the Chief of Service, the Chief's designee, the Vice President for Medical Affairs, or a Fair Hearing or Corrective Action Committee of the Medical Board, they will undergo a complete physical and/or mental health evaluation concerning their ability to care for patients and/or ability to work cooperatively with colleagues, support staff, and other members of the Hospital/Hopkins community. This evaluation shall be performed by a physician and/or other appropriate health care professional who is mutually acceptable to the staff member or applicant and the party requesting the evaluation. The staff member or applicant shall agree to allow the report of the evaluation to be made available to the party requesting the evaluation.
- D. Any person applying for appointment to the Medical Staff, Resident Staff, or Affiliate Staff agrees to submit to assessment for tuberculosis, hepatitis C, and immunity to rubeola, rubella, varicella, and hepatitis B within ninety (90) days of the effective date of appointment to the Medical Staff.
- E. It shall be the responsibility of the Medical, Resident, or Affiliate Staff member to report immediately to his/her Chief of Service any investigation or actions taken against him with regard to any hospital appointment or privileges, licensure, certification, health care affiliation, or criminal charges.

Section 12.04 Processing of Application

- A. The information reported by the applicant shall be verified with primary source documentation or sources approved by accreditation bodies, and references and other information obtained as appropriate. In all cases, information must be verified no more than 180 days prior to the credentialing decision by the Board of Trustees. It shall be the applicant's responsibility and

burden of proof to provide information to support the requested status and privileges and to resolve any doubts that arise during the review of the application forms and related documents.

An application shall be deemed complete when all information provided has been verified and all necessary documentation has been provided or obtained. The completed application shall be forwarded by Medical Staff Administration to the appropriate Chief of Service for review.

- B. After receipt of a completed application, the Chief of Service, in consultation with the departmental Credentials Committee, shall review the application and related documentation and, taking into account relevant departmental criteria, make a recommendation concerning the application. This process shall include a personal contact between the applicant and the Chief of Service or his/her designee. The Chief of Service shall submit his/her recommendation, together with the application and related documentation, to Medical Staff Administration for transmittal to the Hospital Credentials Committee.
- C. The Credentials Committee shall conduct a review of the application and all related documentation and shall recommend that the application be: 1) approved; 2) approved with conditions or restrictions; or 3) disapproved. The Committee also may remand the application and related documentation to the Chief of Service for collection and consideration of additional information, together with a specific date for a response by the Chief of Service. The Credentials Committee shall submit its recommendations to the Medical Board. The office of record for the application and all related documentation is that of Medical Staff Administration.
- D. The Medical Board shall review the recommendations of the Credentials Committee and recommend approval, disapproval, deferral or remanding to the Credentials Committee of the recommendations. If the Medical Board decides to defer a decision in whole or in part, the deferred recommendation shall be reviewed at the next meeting of the Medical Board. If the recommendation of the Medical Board is favorable, such favorable recommendation shall be forwarded to the Board of Trustees for action. For favorable recommendations, the applicant will be notified of the decision of the Trustees within sixty (60) calendar days. If the recommendation of the Medical Board is adverse, the Chair of the Medical Board shall notify the applicant and grant him or her the opportunity for a hearing and review as described herein.

All adverse actions will be reported to the appropriate regulatory agencies, pursuant to the reporting requirements in State and/or Federal law.

- E. All action on the application shall be completed within 90 days of receipt of a completed application.

ARTICLE XIII

REAPPOINTMENTS

Section 13.01 Submission of Application

At least one hundred and twenty (120) days prior to the expiration of the appointment of a Medical Staff or Affiliate Staff member, Medical Staff Administration will provide the Staff member with an application for reappointment and the appropriate delineation of clinical privileges form, referred to collectively herein as "the application form." A staff member seeking reappointment shall complete the application forms, update the information requested in the application for reappointment, sign the acknowledgements, consents, and releases and return all the documents to Medical Staff Administration.

The applicant shall attest to the correctness and completeness of the information provided on the application and acknowledge that any significant misstatements in, or omissions from, the application may constitute cause for denial of reappointment to or summary dismissal from the Medical Staff.

The applicant must return the completed application for reappointment within thirty (30) days of its receipt. Failure to return the application forms within thirty (30) days may be deemed a voluntary resignation from the Medical or Affiliate Staff.

Section 13.02 Processing of Application

- A. Upon receipt of a completed reappointment application, Medical Staff administration shall review the application and obtain appropriate verifications and peer recommendations. It shall be the responsibility and burden of proof of the Medical Staff member requesting reappointment to demonstrate compliance with the requisite criteria for reappointment, as well as to resolve any doubts or inconsistencies. Failure of a Staff member to facilitate the Hospital's receipt of any required documentation within ninety (90) days of the receipt of the completed application forms by Medical Staff Administration may be deemed a voluntary resignation from the Staff. The Hospital shall not be responsible for any delay in reappointment due to a physician's failure to comply with this time frame.

If an applicant for reappointment holds delineated clinical privileges in more than one clinical service, reappointment review shall include attestation from each Chief of Service of the applicant's satisfactory clinical performance and citizenship.

- B. The Chief of Service shall review the application and make an appraisal of the individual's professional performance, judgment, and clinical and technical skills.

Factors to be included on the evaluation include:

1. Peer review of clinical performance;
2. Claims filed against the Staff member;
3. Utilization, risk management, and quality improvement data;
4. Adherence to the Medical Staff Bylaws, Rules and Regulations, Hospital and Medical Staff policies and procedures, including the Code of Conduct, (http://www.insidehopkinsmedicine.org/icpm/ORG007code_conduct.pdf) and any applicable departmental and/or divisional criteria;
5. Compliance with continuing medical education requirements;
6. Compliance with Risk Management seminar attendance requirements;
7. Compliance with HIPAA training requirements,
8. Compliance with annual tuberculosis screening requirements.
9. A review of current physical and mental health status as it impacts on the proper performance of applicant's duties and responsibilities;
10. Attitude, cooperation and ability to work with others; and
11. Other reasonable indicators of continuing qualifications.

- C. No application shall be reviewed until all information provided has been verified and documented and the application has been deemed complete.

- D. The Chief of Service, in consultation with the departmental Credentials Committee or any

subcommittee thereof, shall review the application and related documentation and, taking into account departmental criteria and peer recommendations, make a recommendation concerning the applicant. The Chief of Service shall submit his/her recommendation, together with the application, to Medical Staff Administration for transmittal to the Hospital Credentials Committee.

Section 13.03 Decision on Application

The remainder of the reappointment process is the same as for appointment procedures, including documentation of favorable or adverse recommendations with supporting rationales; however, when a physician has been granted delineated clinical privileges in more than one clinical service, a recommendation for reappointment from one Chief of Service shall be held by the Credentials Committee pending receipt of all such recommendations. The Credentials Committee shall review all relevant documentation, including current licensure, relevant training and current competence, before making a recommendation to the Medical Board.

A final decision in regard to reappointment must be made by the Board of Trustees, with notification of the decision provided to the practitioner within 60 calendar days.

ARTICLE XIV

PROFESSIONAL ASSISTANCE

Members of the Medical Staff, Resident Staff and Affiliate Staff who exhibit a physical or behavioral impairment such as alcoholism, drug abuse, or a mental or emotional problem which may affect their skill, attitude or judgment, may refer themselves on a voluntary basis to the Professional Assistance Committee and/or the Faculty and Staff Assistance Program (FASAP) for an assessment and possible treatment. The policies and procedures of the Professional Assistance Committee and FASAP shall guide the management of these voluntary referrals.

The Professional Assistance Committee and FASAP may be used either for voluntary referrals or for involuntary referrals in addition to, or as an alternative to, disciplinary action for members of the Medical Staff as described herein.

ARTICLE XV

MEETINGS

Section 15.01 Meetings of the Medical Staff

Meetings of the Medical Staff may be called by:

- A. the Board of Trustees;
- B. the Chair of the Medical Board;
- C. the Medical Board;
- D. the President of the Hospital; or
- E. the Chair of the Medical Board, within fourteen (14) days of receipt of a written request from at least ten (10) members of the Active Staff.

Notice of a Meeting shall be given by the person or persons calling the meeting at least five (5) days prior to the time of the meeting. Such notice shall include time, place, and agenda of the meeting.

Section 15.02 Regular Departmental Meetings

Each clinical department of the Hospital shall schedule and hold departmental conferences and other meetings in order to review quality improvement initiatives, patient safety activities, documentation quality, and other clinical matters of the department.

Members of the Medical and Affiliate Staff must satisfy departmental meeting requirements.

ARTICLE XVI

VICE PRESIDENT FOR MEDICAL AFFAIRS

- A. Qualifications. The Vice President for Medical Affairs shall possess the following qualifications:
 - 1. Active Medical Staff member in good standing.
 - 2. Demonstrated executive and administrative ability.
- B. Reporting Structure.

Reports directly to the Executive Vice President and Chief Operating Officer of The Johns Hopkins Hospital; and the Medical Board.
- C. Responsibility and Authority.
 - 1. Serve on The Johns Hopkins Hospital Medical Board.
 - 2. Monitor and support Medical Staff compliance with the Bylaws and policies.
 - 3. Be responsible for review, revision and dissemination of the Bylaws, as well as policies and procedures affecting Medical Staff activities.
 - 4. Oversee the activities of Medical Staff Administration, the Department of Hospital Epidemiology and Infection Control, the Medical Records Department, the Hospital Pharmacy, and Office of Pastoral Care at The Johns Hopkins Hospital.
 - 5. Serve on committees of The Johns Hopkins Hospital and The Johns Hopkins University School of Medicine.
 - 6. Work with individual department leadership to facilitate strategic planning of programs that promote The Johns Hopkins Hospital missions of teaching, research, and patient care.
 - 7. Monitor risk management activities throughout The Johns Hopkins Hospital.
 - 8. Serve as the medical liaison with the Hospital's insurance carrier.
 - 9. Be responsible for Medical Staff compliance with Hospital policies, Medical Staff Bylaws, and regulatory requirements from external organizations, e.g., the Joint Commission, the National Committee for Quality Assurance, Maryland Department of Health and Mental Hygiene, and other governmental and regulatory agencies,

10. In conjunction with the Associate Dean for Graduate Medical Education, be responsible for the development of policies concerning the education, duties, and welfare of the postdoctoral clinical fellows and house staff.
11. Serve as the Patient Safety Officer of the Hospital.

ARTICLE XVII

OFFICERS

Annually, the Board of Trustees, on recommendation of the Medical Board, shall appoint a Chair and a Vice Chair of the Medical Board to serve for one year beginning July 1.

The Chair of the Medical Board, with the concurrence of the Medical Board, shall appoint a Secretary of the Medical Board (the "Secretary"). The Secretary shall have no vote and shall serve until a successor has been appointed. He/she shall keep the records of the Medical Board and its committees.

Section 17.01 Chair of the Medical Board

- A. Qualifications. The Chair of the Medical Board shall possess the following qualifications:
 1. Membership on the Medical Board;
 2. Active Staff member in good standing;
 3. Demonstrated executive and administrative ability through training and experience;
 4. Recognized high level of clinical competence; and
 5. Ability to work cooperatively with the other members of the Medical Board, Hospital Administration, and the Board of Trustees.
- B. Selection.
 1. Annually, the Chair of the Medical Board shall appoint a committee of Medical Board members (the "Nominating Committee") to nominate a Chair and a Vice Chair of the Medical Board to serve for the year beginning July 1.
 2. The report of the Nominating Committee shall be presented to the Medical Board and shall be acted on by the Medical Board. The Medical Board recommendations shall be presented to the Board of Trustees for its approval.
- C. Term of Office. The Chair of the Medical Board shall serve for one (1) year and is eligible for re-election.
- D. Resignation. The Chair of the Medical Board may submit a letter of resignation to the Chair of the Board of Trustees.
- E. Removal from Office.
 1. The Chair of the Medical Board may be removed from office by action of the Board of Trustees or by a two-thirds vote of the members of the Medical Board if that action is ratified by the Board of Trustees.
 2. Acceptable grounds for removal include, but are not limited to:

- a. Failure to perform the duties of the position in a timely and appropriate manner.
 - b. Failure to support the Hospital's mission; and
 - c. Failure to satisfy the qualifications for the position.
 - 3. Removal from office alone has no effect on the physician's Medical Staff appointment status or delineated clinical privileges.
- F. Filling of Vacant Position. In the event of a vacancy, the Vice Chair of the Medical Board shall serve as Chair until the next election.
- G. Responsibility and Authority.
- 1. Transmit to the Board of Trustees (or its appropriate committee) and to the President, the views and recommendations of the Medical Staff and the Medical Board on matters of Hospital policy, planning, operations, governance and relationships with external agencies, and transmit views and decisions of the Board of Trustees and the President to the Medical Board and to the Medical Staff.
 - 2. Preside at Medical Board and Medical Staff meetings.
 - 3. Participate in directing efficient operation and organization of the administrative aspects of the Medical Staff.
 - 4. Review and enforce compliance with standards of ethical conduct and professional demeanor among the Medical Staff in their relations with one another, the Board of Trustees, Hospital administration, other professional and support staff, patients, and the community the Hospital serves.
 - 5. Monitor and support Medical Staff compliance with Hospital policies, the Medical Staff Bylaws, and regulatory requirements.
 - 6. Oversee implementation of decisions made by the Medical Board and by the Board of Trustees when appropriate.
 - 7. Direct the development, implementation, and organization of the Medical Staff components of the quality improvement programs and assure that the programs are clinically and professionally sound and are accomplishing their objectives.
 - 8. Advise the Board of Trustees, the Quality Improvement Committee of the Board of Trustees, the President and the Medical Board on matters affecting patient care (e.g., new or modified programs and services, recruitment and training of personnel, staffing patterns). With the President, assure that decisions of the Quality Improvement Committee of the Board of Trustees and the Board of Trustees are carried out.
 - 9. Advise, consult with, and report to the Quality Improvement Committee of the Board of Trustees concerning findings of the quality improvement program and matters pertaining to patient care.

Section 17.02 Vice Chair of the Medical Board

- A. Qualifications, selection, term of office, resignation, and removal from office provisions are the same as those outlined for the chair.
- B. Should the position become vacant, it may be filled by an interim election at the next Medical Board meeting.
- C. The responsibilities and authority of the position are to perform the duties of the Chair of the Medical Board in his/her absence, and to serve as Chair of the Administrative Committee of the Medical Board.

ARTICLE XVIII

CHIEFS OF SERVICE

Chiefs of Service in those Hospital departments that are simultaneously full departments in The Johns Hopkins University School of Medicine shall be identified by titles that combine a name suggestive of the departmental specialty with the phrase "in-Chief" in accord with the following examples: Physician-in-Chief, Gynecologist-Obstetrician-in-Chief, etc. Heads of other departments shall receive titles on recommendation of the Medical Board.

Section 18.01 Nomination, Selection and Appointment Process

The Board of Trustees, upon recommendation of the Medical Board, shall appoint a Chief of Service to be in charge of each of the Medical Staff departments. He/she shall serve until he/she resigns or is terminated. When a vacancy occurs, the Dean/CEO of Johns Hopkins Medicine, in consultation with the President of The Johns Hopkins Hospital (the "President"), shall appoint a search committee to interview qualified candidates and to nominate a candidate to the Medical Board. The Board of Trustees shall act on the Medical Board's recommendation by either appointing the nominee, or notifying the Medical Board that it will not appoint the nominee and requesting another nominee. When the vacancy occurs in a department that is simultaneously a full department in The Johns Hopkins University School of Medicine, the search committee shall represent both The Johns Hopkins University and the Hospital. The President shall be an ex-officio member of all Chief of Service search committees.

Section 18.02 Qualifications

A chief of Service shall possess the following qualifications:

- A. Active staff membership in his/her clinical department;
- B. Full-time appointment to the faculty of The Johns Hopkins University School of Medicine;
- C. Demonstrated executive and administrative ability through training and experience;
- D. Current Board certification or demonstrated high level of clinical competence in the field; and
- E. An expressed willingness to discharge faithfully the duties of the office and work cooperatively with other Medical Staff officers, the Administration, and the Board of Trustees.

Section 18.03 Term of Office

A Chief of Service shall serve at the pleasure of the Board of Trustees.

Section 18.04 Resignation

A Chief of Service may proffer his/her resignation to the Chair of the Board of Trustees.

Section 18.05 Removal From Office

- A. A Chief of Service may be removed from office by:
 1. The Board of Trustees; or
 2. Two-thirds vote of the Medical Board; if ratified by the Board of Trustees.
- B. Grounds for removal of a Chief of Service from office include, but are not limited to:
 1. Failure to perform the duties of the position in a timely and appropriate manner;
 2. Failure to support the Hospital's mission;
 3. Failure to maintain the qualifications for the position.

- C. Removal from office alone has no effect on Medical Staff appointment status or delineated clinical privileges.

Section 18.06 Responsibility and Authority

- A. Manage the department through cooperation and coordination with Hospital Administration.
- B. Coordinate planning with respect to the department's personnel, equipment, facilities, services, and budget.
- C. Communicate and implement within the department actions taken by the Medical Board, the Quality Improvement Committee of the Board of Trustees, and the Board of Trustees.
- D. Serve on the Medical Board, give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions regarding the department to the Medical Board, Hospital administration, and the Board of Trustees.
- E. Direct the development, implementation, and organization of the departmental components of the quality improvement program in cooperation with the Chair of the Medical Board, the Medical Board, other relevant Medical Staff committees, and the Quality Improvement Committee of the Board of Trustees. Work with and receive reports from the chair of the departmental Quality Improvement Committee.
- F. Monitor patient care and the professional performance of physicians and affiliate staff with clinical privileges in the department and present written reports to the Medical Board and other Medical Staff and Hospital committees when appropriate or required.
- G. Prepare and transmit to the appropriate authorities, as required by the Bylaws, recommendations concerning appointment, reappointment, delineation of clinical privileges, resignation and corrective action with respect to Medical Staff and Affiliate Staff members in the department.
- H. Enforce the Medical Staff Bylaws and Rules and Regulations, Hospital and Medical Staff policies and procedures, and department policies and procedures, including initiating corrective action, monitoring clinical performance, and ordering consultations to be provided or sought when necessary.
- I. Monitor professional conduct in the department. The Chief of Service shall make the Professional Assistance Committee aware of any impaired or disabled medical staff member in his/her department.
- J. Report to the Chair of the Medical Board on matters of immediacy, whenever necessary or requested, especially where action to coordinate clinical services, to maintain quality, or to assure patient safety is indicated .
- K. Report regularly to the President on issues relating to the Chief of Service's administrative duties for budget preparation and management, supervision of Hospital personnel, proper functioning of equipment, efficient clinical operations, and similar matters.
- L. Identify a designee to serve during absences.

ARTICLE XIX
PHYSICIAN ADVISORS

Each Chief of Service shall appoint a physician advisor.

A. Duties

1. Chair Departmental Quality Improvement Committee.
2. Serve on the Departmental Credentials Committee.
3. Serve on the Hospital Clinical Quality Improvement Committee.
4. Coordinate patient safety and quality improvement activities including, as appropriate, quality assurance/quality improvement, medical staff monitoring functions, credentialing, medical record documentation, drug usage evaluation, infection control, surgical and invasive procedures reviews, blood usage evaluation, utilization reviews and utilization of critical pathways.
5. Manage departmental risk management activities.
6. Monitor departmental compliance with regulatory requirements.
7. Regularly report to Chief of Service concerning activities and issues pertaining to areas of responsibility as outlined above.
8. Identify a designee to serve during absences.
9. Other responsibilities as defined by the Chief of Service.

ARTICLE XX
DEPARTMENTS

The Medical Staff shall be organized in the following Hospital departments: Anesthesiology and Critical Care Medicine, Cardiac Surgery, Dermatology, Emergency Medicine, Gynecology-Obstetrics, Medicine, Neurological Surgery, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Otolaryngology/Head and Neck Surgery, Pathology, Pediatric Surgery, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Psychiatry, Radiation Oncology, Radiology and Radiological Science, Surgery, Urology, and such others which may be authorized from time to time by the Board of Trustees on recommendation of the Medical Board.

ARTICLE XXI
MEDICAL BOARD

Section 21.01 Meetings

The Medical Board shall meet monthly.

Section 21.02 Duties and Responsibilities

It shall be the duty of the Medical Board to govern the Medical Staff and to advise the Board of Trustees on all matters relating to (1) the welfare of the Hospital; (2) the Medical Staff; (3) the medical care and treatment of patients in the Hospital; (4) the quality and the appropriateness of patient care; (5) the accreditation of the Hospital and any of its services; and (6) the medical education and research programs conducted by the Hospital. The actions of the Medical Board are subject to review and approval by the Board of Trustees.

The Medical Board has the following responsibilities:

- A. Govern, direct and coordinate the Medical Staff organization and its various functions.
- B. Monitor compliance with the bylaws, rules and regulations, policies and procedures of the Medical Staff and Hospital. Direct the review and revision of the Bylaws.
- C. Act on nominations for officers of the Medical Board.
- D. Act as liaison with the Board of Trustees and Hospital administration.
- E. Oversee and act on recommendations from committees of the Medical Board.
- F. Receive and review reports of the Credentials Committee and make recommendations to the Board of Trustees concerning individuals for Medical Staff membership and the delineation of clinical privileges.
- G. Review reports of the Graduate Medical Education Committee; the Joint Committee on Health, Safety and Environment; the Institutional Claims Committee; the Johns Hopkins Medicine Institutional Review Boards and the House Staff Council.
- H. Participate in planning for the provision of services required to meet the needs of the community, for Hospital growth and development, and for response to disasters in the community.
- I. Review and approve contracted clinical services to assure that the services meet Hospital standards.
- J. Make recommendations to the Board of Trustees pertaining but not limited to the following subjects:
 1. Structure of the Medical Staff;
 2. Guidelines for review of credentials for purposes of appointment and reappointment to the Medical Staff and for delineating individual clinical privileges;
 3. Termination of membership on the Medical Staff;
 4. Corrective action and fair hearing procedures;
 5. Quality of patient care; and
 6. Appointment of Chiefs of Service.
- K. Receive reports from the Quality Improvement Council.
- L. Report to the Board of Trustees.

- M. Direct the review and maintenance of Hospital accreditation as it relates to Medical Staff functions. Inform the Medical Staff of the Hospital's accreditation status and related requirements and priorities.
- N. Review annually the report and recommendations of the Administrative Committee of the Medical Board regarding the objectives, scope, organization and effectiveness of the Hospital's Quality Improvement Program, the Utilization Management Program and Risk Management Program. Report to the Board of Trustees and recommend revisions as necessary.
- O. Participate in the corrective action and fair hearing process through the Corrective Action and Fair Hearing Committees as described in Sections 23.01.B and 24.04 herein.

Section 21.03 Membership – The membership of the Medical Board shall include:

- A. Chiefs of Service
- B. Dean of the Medical Faculty and Chief Operating Officer, Johns Hopkins Medicine
- C. President of the Hospital
- D. Executive Vice President and Chief Operating Officer of the Hospital
- E. Vice President for Medical Affairs
- F. Elected Representative of the Medical Staff
- G. Chair of the Credentials Committee of the Hospital
- H. Chair of the Medical Staff Conference Committee
- I. Vice President for Nursing and Patient Care Services
- J. President of the House Staff Society Council

Section 21.04 Removal from Membership

Members of the Medical Board may be removed by action of the Board of Trustees or by a two-thirds vote of the Medical Board if that action is ratified by the Board of Trustees.

ARTICLE XXII

COMMITTEES

There are standing committees and subcommittees of the Medical Board as provided herein. The Chair of the Medical Board, in consultation with the Vice President for Medical Affairs, shall appoint and may remove the Chair of each committee and subcommittee of the Medical Board. The initial term of appointment shall be for four years, and may be renewed annually thereafter, in consultation with the Vice President for Medical Affairs, with the exception of the Medical Staff Conference Committee. Non-ex-officio members of each committee shall be appointed and may be removed by the committee chair. Members named by specific title may send a designee to act on their behalf.

The Chair of the Medical Board shall appoint special committees as may be required to carry out properly the duties of the Medical Staff and Medical Board. Such committees shall confine their work to the purposes for which they were appointed and shall report to the Medical Board. They shall not have power of action unless such is specifically granted by the motion that created the committee.

Each department shall have a Quality Improvement Committee and a Credentials Committee.

Section 22.01 Credentials Committee

- A. Duties and Responsibilities.

1. Receive from the Chiefs of Service recommendations for criteria for appointments and delineated clinical privileges and confirm their compliance with Hospital and regulatory requirements, including licensure, training and current competence.
2. Review recommendations from the Chiefs of Service for appointment, reappointment and granting of clinical privileges and confirm that the supporting data meet bylaws and regulatory requirements. The Committee is permitted to review appropriate departmental files, and to conduct interviews, if necessary, to carry out this function.
3. Develop procedures and guidelines to facilitate the credentialing system, to coordinate the Hospital and departmental components of the system and to maintain a consistently high level of medical competence across the institution.
4. Provide written reports concerning actions, evaluations and recommendations to the Medical Board.

B. Membership

1. Vice President for Medical Affairs
2. Five (5) or more members of the Active Medical Staff
3. Dean for Graduate Medical Education
4. Vice President for Nursing and Patient Care Services or designee
5. Legal Department representative
6. Medical Staff Registrar

C. The Credentials Committee shall meet monthly.

Section 22.02 Medical Staff Conference Committee

A. Duties and Responsibilities.

1. Consider and make recommendations to the Medical Board on any matter relating to Medical Staff concerns, the care of patients or the relations of the professional staff to the community.
2. Evaluate relevant reports from the Department of Patient and Visitor Services and internal and external sources, including but not limited to patient satisfaction issues.
3. Review proposed amendments to bylaws and make recommendations to the Bylaws Revision Committee.
4. Elect the Medical Staff representative to the Medical Board.

B. Membership and officers.

1. Annually, representatives of each clinical department shall be elected or selected to serve on the Medical Staff Conference Committee for the year beginning July 1.

Anesthesiology and Critical Care Medicine	1
Cardiac Surgery	1
Dermatology	1
Emergency Medicine	1
Gynecology-Obstetrics	1
Medicine	3
Neurological Surgery	1
Neurology	1

Oncology	1
Ophthalmology	1
Orthopedic Surgery	1
Otolaryngology-Head and Neck Surgery	1
Pathology	1
Pediatric Surgery	1
Pediatrics	2
Physical Medicine and Rehabilitation	1
Plastic Surgery	1
Psychiatry	1
Radiation Oncology	1
Radiology and Radiological Science	1
Surgery	1
Urology	1

2. In addition to departmental representatives, membership shall include:

Representative of the House Staff Council
 Elected representative of the Medical Staff
 Legal Department representative
 Nursing Department representative
 Director of Patient Relations
 Director of Regulatory Affairs
 Johns Hopkins Medicine Center for Information Services (JHMCIS) representative
 Director of Pastoral Care

3. Every two years, the committee members shall elect a chair, a vice chair and an Elected Representative of the Medical Staff.

C. Meetings – The Medical Staff Conference Committee shall meet monthly.

Section 22.03 Administrative Committee of the Medical Board (“the Administrative Committee”)

A. Duties and Responsibilities.

1. Prepare agenda for the meetings of the Medical Board, including review and recommendation of Hospital policies.
2. Develop background material on important issues. Persons both outside and within the Medical Board may serve on ad hoc committees for this purpose.
3. Prepare alternative solutions to problems and recommend a course of action to the Medical Board.
4. Follow up as needed on actions taken by the Medical Board.
5. Instruct standing committees, subcommittees and ad hoc committees, receive their reports, and forward material to the Medical Board for information and/or action as appropriate.
6. Annually review the Hospital Quality Improvement, Utilization Management and Risk Management Programs and report this review with recommendations, if any, to the Medical Board.

B. Membership. Membership shall include:

1. Vice Chair of the Medical Board, who shall serve as Chair
2. Vice President for Medical Affairs
3. Vice President for Nursing and Patient Care Services
4. President of the House Staff Council
5. The elected Medical Staff Representative to the Medical Board
6. Chair of the Medical Staff Conference Committee
7. Chair of the Credentials Committee
8. Chair of the Ethics Committee and Consultation Service
9. Chair of the Medical Care Evaluation Committee
10. Chair of the Clinical Quality Improvement Committee
11. Chair of the Risk Management Committee
12. Chair of the Patient Safety Committee
13. Representative from the Legal Department

C. Meetings. The Administrative Committee shall meet monthly.

22.03.01 Medical Staff Bylaws Committee

A. Duties and Responsibilities.

1. Conduct a review of the Bylaws, at least biennially, and recommend amendments as necessary with respect to the Medical Staff organization and functions.
2. Consider proposed revisions to the Bylaws between the biennial reviews.
3. Present proposed revisions and amendments to the Medical Staff Conference Committee for review and recommendation.

B. Membership. Membership shall include, but is not limited to:

1. Vice President for Medical Affairs
2. Representatives of the Medical Staff
3. Representative from the Legal Department
4. Secretary of the Medical Board
5. Vice Chair of the Medical Staff Conference Committee

C. Meetings. The Medical Staff Bylaws Committee shall meet as necessary.

22.03.02 Clinical Quality Improvement Committee

A. Duties and Responsibilities.

1. Evaluate the quality and appropriateness of medical care in the Hospital; identify and review interdepartmental and Hospital-wide patient care issues.
2. Assist in improvement of patient care through review, discussion and support of departmental quality improvement programs.
3. Discuss, assess, and make recommendations regarding intra- and interdepartmental problems in quality assessment/quality improvement, risk management, utilization management and credentialing.
4. Develop strategies to address quality improvement, medical staff monitoring functions, credentialing, medical record documentation, drug usage evaluation, infection control, blood usage evaluation, utilization reviews and utilization of critical pathways.

5. Receive reports at least quarterly from the Hospital's Utilization Review Committee regarding matters affecting the practice or performance of the Medical Staff.
6. Report to the Administrative Committee of the Medical Board and to the Quality Improvement Council.

B. Membership. Membership shall include, but is not limited to:

1. Department Physician Advisors
2. Vice President for Medical Affairs
3. Vice President for Nursing and Patient Care Services
4. Chair, Medical Care Evaluation Committee
5. Chair, Risk Management Committee
6. Director of Quality Improvement/Utilization Management
7. Hospital Risk Manager
8. Chair, Patient Safety Committee
9. Chair, Surgical and Invasive Procedure Review Committee

C. Meetings. The Clinical Quality Improvement Committee shall meet monthly.

22.03.02.01 Surgical and Invasive Procedure Review Committee

A. Duties and Responsibilities.

1. Evaluate cases with the following properties:
 - a. Cases in which the final pathologic diagnosis differs from the pre-operative diagnosis or from the diagnoses made from frozen section, and/or cytopathology.
 - b. Cases in which the original pathological diagnosis has been changed.
 - c. Cases with specific diagnoses selected for periodic reviews of specific operative and invasive procedures.
 - d. Surgical cases operated on at JHH following tissue diagnosis made elsewhere, for which pertinent slides have not been reviewed by JHH pathologists prior to the operation at JHH.
 - e. Autopsy cases in which the post-mortem diagnosis differs significantly from the pre-terminal diagnosis.
2. Each case found to merit review will have a written report generated that will include documentation and explanation of any event in question and any response from the attending physician. The report will be submitted to the appropriate Physician Advisors for department review and action.
3. Provide a list of cases reviewed and present the findings semiannually to the appropriate Chiefs of Service and to the Vice President for Medical Affairs.
4. Report to the Clinical Quality Improvement Committee any identified systemic problems requiring institutional or multidisciplinary alerts or action.

B. Membership. Membership shall include, but is not limited to:

1. Physician representatives from each Division of Anatomic Pathology, and from Dermatopathology and Eye Pathology.
2. Two or more representatives from Clinical Departments or Divisions
3. Representatives from Nursing
4. Representative from Pathology Administration
5. Representative from Department of Quality Improvement

C. Meetings. The Surgical and Invasive Procedure Review Committee shall meet at least quarterly.

22.03.03 Ethics Committee and Consultation Service

A. Duties and Responsibilities.

1. Provide consultation concerning questions of an ethical nature to health care workers, administrators, patients, or their representatives.
2. Serve as the Patient Care Advisory Committee for the Hospital.
3. Educate health care professionals, administrators, other hospital staff, and the community about ethical issues that arise in health care and ways to resolve ethical dilemmas.
4. Participate in the development, review and revision of the ethical dimensions of institutional policies (clinical and organizational).
5. Participate with members of the Johns Hopkins Health System and University to address organizational ethical issues.
6. Report and make recommendations to the Administrative Committee of the Medical Board.

B. Membership – Membership shall include representatives from:

1. Medical Staff
2. Department of Nursing
3. Department of Social Work
4. Administration
5. Community
6. House Staff and Fellows
7. Pastoral Care
8. Legal Department
9. School of Medicine
10. School of Nursing

C. Meetings. The Ethics Committee and Consultation Service shall meet monthly.

22.03.04 Patient Safety Committee

A. Duties and Responsibilities.

1. Support the establishment, implementation and evaluation of policies, procedures, processes and structures related to patient safety at The Johns Hopkins Hospital.
2. Monitor patient safety-related events and recommend improvement activities through the work of the Hopkins Event Action Team (HEAT) and recommend improvement activities.

3. Develop, implement and monitor patient safety education programs for Hospital medical staff and employees.
4. Support the functions and activities of the Risk Management Committee of the Medical Board as related to patient safety. Receive and evaluate reports from the Risk Management Committee.
5. Report monthly and make recommendations to the Quality Improvement Council and the Administrative Committee of the Medical Board.
6. Monitor compliance with Safety Regulations of external groups (e.g., The Joint Commission's National Patient Safety Goals and other standards, CMS, State of Maryland).
7. Monitor compliance with selected best practices as defined by external organizations, such as professional associations and purchasers.
8. Prioritize and make recommendations concerning operational and capital budget allocations in furtherance of patient safety.
9. Oversee the activities of the Comprehensive Unit-based Safety Program (CUSP).
10. Conduct periodic assessments of the organizational safety culture and recommend related follow up.
11. Endorse and encourage the inclusion of patients and families in patient care and safety improvement initiatives.

B. Membership. Membership shall include, but is not limited to:

1. Vice President for Medical Affairs, who will be chair of the Committee and who will also serve as the Patient Safety Officer of the Hospital.
2. Medical Director, Center for Innovations in Quality Patient Care
3. Patient Safety Manager and designated Staff
4. Chair, Risk Management Committee
5. Director, Occupational Health and Safety
6. Hospital Risk Manager
7. Associate Risk Manager
8. Medication Safety Officer
9. Department of Pathology representative
10. Director, Regulatory Affairs
11. Director, Quality Improvement/Utilization Management
12. Director, Hospital Epidemiology and Infection Control
13. Clinical Engineering Service Representative
14. Medical Staff representative(s)
15. Legal Department Representative
16. Chair, Graduate Medical Education Committee
17. Deputy Director, Communications and Public Affairs
18. Coordinator for Nursing Practice
19. Coordinator for Nursing Clinical Quality
20. Nurse Manager representative
21. JHMCIS representative
22. Director, Patient and Visitor Services
23. Departmental Directors of Quality and Safety
24. House Staff Council representative

25. Women's Board representative
26. Board of Trustees representative(s)
27. Representatives (without vote) from JHM Affiliates (JHHC, JHBMC, HCGH, JHCP, JHHCG)
28. Community representative

C. Meetings. The Patient Safety Committee shall meet monthly.

22.03.05 Professional Assistance Committee

A. Duties and Responsibilities.

1. Develop through training and education of Medical Staff members an enhanced recognition of impairment and an awareness of conditions that may lead to impairment.
2. Assist Medical Staff in dealing with any physical and/or behavioral impairments that may affect a staff member's skill, attitude or judgment.
3. Receive information and/or complaints concerning physicians who may be disabled, impaired, or distressed, and assess the information and/or complaint.
4. Evaluate individual cases and make recommendations for action, including treatment and monitoring.
5. Communicate with Hospital Administration or other appropriate official bodies when necessary to ensure quality of patient care and staff well being.
6. Develop and disseminate written policies and procedures designed to assist staff in dealing with physical and/or behavioral impairments that may affect a staff member's skill, attitude, or judgment.
7. Develop approaches for assessment and treatment of staff members with physical or behavioral impairments. The resources and experience of the Faculty and Staff Assistance Program may be employed.
8. Establish and maintain such liaisons as are necessary to assist in accomplishing the Committee's duties.
9. Report and make recommendations to the Administrative Committee of the Medical Board.

B. Membership. Membership shall include, but is not limited to:

1. At least four (4) members of the Medical Staff
2. Director, Faculty and Staff Assistance Program
3. Representative from the Department of Psychiatry
4. Representative of the Faculty and Staff Assistance Program (FASAP)

C. Meetings. The Professional Assistance Committee shall meet twice a month.

1. A quorum will consist of two non-FASAP physician votes and one FASAP representative vote.
2. Minutes will be taken at each meeting by a FASAP representative and will identify cases by Professional Assistance Committee (PAC) log number.

22.03.06 Risk Management Committee

A. Duties and Responsibilities.

1. Monitor the Hospital-wide program for incident identification and reporting.
2. Develop and implement mechanisms for timely evaluation of incidents which involve actual or potential risk in patient care.
3. Identify trends among the incidents and refer incident and trend summaries to appropriate committees when further action is necessary.
4. Monitor implementation of actions taken to correct problems in patient care and reduce identified risks.
5. Participate in the activities of the Hospital Risk Management Program including risk management education and the integration of risk management with quality improvement, patient safety and credentialing.
6. Receive regular reports from:
 - a. The Latex Subcommittee will report annually.
 - b. The Sedation/Analgesia Subcommittee will report quarterly.
 - c. Sentinel Event Action Group will report quarterly.
7. Provide regular reports to:
 - a. The Administrative Committee of the Medical Board.
 - b. The Patient Safety Committee.
 - c. The Quality Improvement Council.
 - d. The Chair of the Medical Board and the Vice President for Medical Affairs, including a list of cases reviewed and findings of the reviews.
8. Review the Hospital Risk Management Program and report this review annually to the Administrative Committee of the Medical Board.

B. Membership. Membership shall include, but is not limited to:

1. Vice President for Medical Affairs
2. Vice President for Nursing and Patient Care Services
3. Chair, Clinical Quality Improvement Committee
4. Director, Regulatory Affairs
5. Risk Manager, Hospital
6. Director of Risk Management
7. Director of Quality Improvement/Utilization Management
8. Representatives from the Medical Staff (5-7), one of whom shall act as Chair
9. Representatives from the Legal Department
10. Patient Safety Manager
11. Manager, Occupational Safety
12. Representative from the House Staff
13. Representative from Hospital Clinical Engineering Services

C. Meetings. The Risk Management Committee shall meet monthly.

22.03.07 Medical Care Evaluation Committee

- A. Duties and Responsibilities.
1. Evaluate the quality and appropriateness of medical care in the Hospital; identify and review interdepartmental and Hospital-wide patient care issues.
 2. Review reports from the Quality Improvement/Utilization Management Department. Assess the effectiveness of the quality improvement/utilization management components of the Hospital's Quality Improvement Program and report this assessment annually to the Administrative Committee.
 3. Review reports from the Nursing Quality Steering Committee, the Clinical Products Value Analysis Committee, the Social Work Quality Improvement Committee, the Medical Equipment Quality Improvement Committee and the Director of Pastoral Care.
 4. Supervise the activities of its subcommittees and work groups, receive and evaluate their reports and policy recommendations, address with them issues within their charges pertaining to patient safety, hospital activities and compliance with regulatory requirements.
 5. Report to the Administrative Committee of the Medical Board.
- B. Membership. Membership shall include, but is not limited to:
1. Chairs of the subcommittees of the Medical Care Evaluation Committee
 2. Director, Quality Improvement
 3. Director, Regulatory Affairs
 4. Chair of the Clinical Quality Improvement Committee
 5. Chair of the Nursing Quality Steering Committee
 6. Chair of the Social Work Quality Improvement Committee
 7. Chair of the Clinical Products Value Analysis Committee
 8. Hospital Risk Manager
 9. Representative from the Resident Staff
 10. Director of Pastoral Care
 11. Chair of the Medical Equipment Quality Improvement Committee
- C. Meetings. The Medical Care Evaluation Committee shall meet monthly.

22.03.07.01 Cancer Committee

- A. Duties and Responsibilities.
1. Develop and evaluate annual goals for the Cancer Committee to promote clinical, research, educational and program activities.
 2. Promote a coordinated, multidisciplinary approach to cancer care.
 3. Monitor quality of services provided to cancer patients.
 4. Monitor quality of cancer management and trends in cancer management through cancer patient care studies that focus on quality, access to care and outcomes related to cancer.

5. Follow standards established by the American College of Surgeons (ACoS) by
 - a) participating in ACoS Commission on Cancer national studies, and
 - b) developing and implementing policies and procedures to maintain compliance with ACoS standards.
6. Facilitate clinical research in cancer evaluation and treatment.
7. Supervise the cancer registry to ensure accurate and timely abstraction, staging and follow-up reporting. Perform quality control of registry data and encourage data usage and regular reporting.
8. Provide to the Medical Board and the Quality Improvement Council, through the Medical Care Evaluation Committee, an annual report in accordance with regulatory requirements.

B. Membership. Membership shall include, but is not limited to:

1. Physician liaison with the American College of Surgeons.
2. One or more board-certified physician representatives from Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology and Pathology.
3. Representatives from Oncology Administration, Nursing, Social Services, Cancer Registry, Quality Improvement, Community Services, Clergy, Pain Management, Clinical Research and Cancer Genetics.

C. Meetings. The Cancer Committee shall meet quarterly.

22.03.07.02 Clinical Data and Documentation Committee

A. Duties and Responsibilities

1. Review and evaluate the quality, content, format, clinical pertinence, accuracy, and accessibility of the medical record. The medical record includes electronic as well as paper data and documentation. As necessary, provide recommendations for modifications and improvements of current or proposed formats or documents.
2. Review requests for developing, purchasing, or updating systems for display of clinical information, and request assessment of the system by all parties whose data is to be displayed. Based upon these assessments, and upon Hospital and federal regulatory policies, approve or decline approval for the system proposed. Systems disapproved after this review shall not be implemented.
3. Monitor Medical Staff compliance with regulations that pertain to timely completion and clinical pertinence of the medical record.
4. Receive and review quarterly clinical pertinence reports of the departments.
5. Act as liaison with Hospital administration, Medical Staff, JHMCIS, and medical record professionals on matters pertaining to medical record practices and legal and regulatory requirements for record keeping issues.

B. Membership. Membership shall include, but is not limited to:

1. At least two (2) representatives of the Medical Staff
2. Radiology Department representative
3. Pathology Department representative

4. House Staff representative
5. Medical Records Department representative
6. Departmental Satellite Medical Records representatives
7. Quality Improvement / Utilization Management Department representative
8. Nursing Department representative
9. JHMCIS representative
10. Legal Department representative
11. Pharmacy representative
12. Nutrition representative
13. Casemix information management representative

C. Meetings. The Clinical Data and Documentation Committee shall meet monthly.

22.03.07.03 CPR Advisory Committee

A. Duties and Responsibilities

1. Evaluate the quality of CPR services in the Hospital, including outcomes information via an annual report.
2. Evaluate the appropriateness of emergency cart components and medical devices utilized for CPR on an annual and ad hoc basis.
3. Monitor quality improvement for CPR services and make related recommendations, through the Medical Care Evaluation Committee, to Hospital leadership.
4. Support training for personnel involved in the provision of basic and advanced cardiac life support, and make related recommendations, through the Medical Care Evaluation Committee, to Hospital leadership.
5. Assist with the development of systems designed to prevent the occurrence of code events in patients with signs and symptoms suggestive of impending cardio-respiratory failure.

B. Membership. Membership shall include, but is not limited to:

1. Representatives from the Departments of Anesthesiology, Surgery, Medicine, Emergency Medicine, and Pediatrics
2. Representatives from Medical Nursing, Surgical Nursing, Oncology Nursing, Pediatric Nursing, Outpatient Nursing, and Nursing Medical Shift Coordinators
3. Representatives from Respiratory Therapy, Pharmacy, and Pastoral Care
4. Representatives from Security, Communications, Central Stores, Central Services, and Clinical Engineering
5. Representative from the Legal Department

C. Meetings. The CPR Advisory Committee shall meet monthly.

22.03.07.04 Critical Care Committee

A. Duties and Responsibilities.

1. Monitor hospital's utilization of ICU resources.
2. Act as a liaison among clinical departments, Hospital Administration, Information Systems, and Department of Finance to facilitate efficient use and provision of critical care services.

3. Monitor quality of care in intensive care units and assist in resolution of issues on any matter relating to the provision of critical care, organization of critical care services, transport of critical care patients, alert hours, and the relationships among critical care units.
 4. Make recommendations to the Medical Board through the Medical Care Evaluation Committee on any matter relating to the Committee's charge.
- B. Membership. Membership shall include, but is not limited to:
1. Directors of the Adult and Pediatric Intensive Care Units, and Emergency Medicine (one of the Intensive Care Unit Directors will serve as chair)
 2. ICU Nurse Managers of Medicine, Surgery, Neurosciences, Oncology and Pediatrics.
 3. Hospital Administration representative
 4. Emergency Medicine, either physician or administrator
 5. Intermediate Care representatives
 6. JHMCIS Information Systems representative
 7. Director of Pastoral Care Services
 8. Director of Physical Medicine and Rehabilitation
 9. Respiratory Care Service representative
- C. Meetings. The Critical Care Committee will meet monthly.

22.03.07.05 Hospital Epidemiology and Infection Control Committee

A. Duties and Responsibilities.

1. Review, in conjunction with the Director of the Department of Hospital Epidemiology and Infection Control, programs to prevent and control healthcare-associated infections, and infections due to organisms that are epidemiologically important and/or resistant to multiple antimicrobials.
2. Receive and evaluate reports from the Department of Hospital Epidemiology and Infection Control.
3. Review policies and procedures designed to prevent or control the occurrence of infections, both healthcare-associated and those caused by epidemiologically important organisms. Provide advice to the Department of Hospital Epidemiology and Infection Control pertaining to its educational and research programs for the prevention and control of healthcare-acquired infections and epidemiologically significant organisms.
4. Recommend and/or institute studies and/or control measures when there is a risk of transmission of epidemiologically significant or multiply-antimicrobial-resistant organisms to patients or personnel.
5. Monitor reports from the antimicrobial management program. Advise and help implement antimicrobial restriction and oversight strategies. Develop policies designed to improve utilization of antimicrobial agents and to decrease antimicrobial resistance.
6. Assess possible and likely outbreaks, clusters, and other significant infectious events.
7. Develop and review policies and programs that address potential mass casualties due to infectious agents, such as those related to a potential bioterrorism attack or an emerging infectious disease (e.g., Severe Acute Respiratory Syndrome (SARS) or H5N1 influenza).

8. Assure that infection control procedures and policies meet all Federal, State, Local and other pertinent (e.g., The Joint Commission) regulations and guidelines.
- B. Membership. Membership shall include, but is not be limited to:
1. Representatives from the Department of Hospital Epidemiology and Infection Control including the Director, Associate Director(s) and Infection Control Epidemiologists.
 2. Representatives from Anesthesiology and Critical Care Medicine, Adult Infectious Diseases, Pediatric Infectious Diseases, Microbiology, Pathology, Surgery, Gynecology/Obstetrics, Pharmacy, Oncology, Occupational Health and Safety, Operating Rooms, Facilities, Central Sterile Supply, Hospital Administration, Environmental Services, the Antibiotic Management Program and Nursing.
- C. Meetings. The Hospital Epidemiology and Infection Control Committee shall meet at least monthly.

22.03.07.06 Laboratory Advisory Committee

A. Duties and Responsibilities.

1. Advise the Department of Pathology on the scope, availability, and relevance of laboratory services, including selection of reference laboratory services. Periodically review reports pertaining to clinical department assessment of laboratory services in terms of factors such as quality, timeliness and responsiveness to problems and inquiries.
2. Participate in the development and interpretation of quality assessment studies dealing with the appropriateness of test ordering, the effectiveness of test utilization and interpretation, and correlation with quality improvement activities in the clinical departments.
3. Advise the Department of Pathology regarding written and electronic communications to medical, nursing, and other Hospital staff.
4. Receive relevant information from operating divisions and central administration of the Department of Pathology.
5. Assist in the education of physicians and other staff in the appropriate use of pathology and laboratory services.
6. Evaluate all critical pathways, Ordersets, and similar materials concerned with Pathology and Laboratory Medicine tests and procedures
7. Evaluate IRB protocols that propose to perform patient care tests in a non-CLIA laboratory, a patient care test being defined as one whose results are provided to a subject or a subject's health care provider. These responsibilities may be delegated to one or more members of the Committee.
8. Serve as a resource for information or consultation for Johns Hopkins Medicine Institutional Review Boards and requesting investigators regarding Pathology and Laboratory issues.
9. Provide recommendations through the Medical Care Evaluation Committee to the Medical Board and Hospital Administration regarding improvement of pathology and laboratory services and their utilization.

10. Monitor and develop policies regarding the activities of sales representatives for laboratory diagnostics and in vitro devices within the Hospital.

B. Membership. Membership shall include, but is not limited to:

1. Department of Pathology Deputy Director for Clinical Services (Chair)
2. Members of the Medical Staff (5 or more) from departments that use Pathology and Laboratory services
3. Representatives from the Resident Staff (2 or more)
4. Representative(s) from Nursing
5. Representative(s) from Pharmacy
6. Representatives from the Department of Pathology Medical, Technical and Administrative Staff

C. Meetings. The Laboratory Advisory Committee shall meet monthly.

22.03.07.07 Nutrition Advisory Committee

A. Duties and Responsibilities.

1. Provide professional advice to the Nutrition Department regarding nutritional care of patients.
2. Periodically review and approve the Clinical Standards of Care, Nutrition Care Manual, pertinent protocols regarding nutrition care, and Quality Improvement Programs of all the Services in charge of the nutritional care of patients. These services include the Nutrition Department, the Adult Nutrition Support Service, the Pediatric Nutrition Support Service and Clinical Research Units (Pediatric and Adult).
3. Annually review the Enteral Formularies for the Hospital.
4. Evaluate the quality, safety and appropriateness of Nutrition support for the Hospital.
5. Evaluate and advise on new procedures or technologies of potential use by Nutrition Support (Pediatrics and Adult).
6. Review and advise on educational activities and materials for patients and for the staff of the departments and services delivering nutritional care.

B. Membership. Membership shall include, but is not limited to:

1. Representatives from the Nutrition Department, Adult Nutrition Support Services, the Pediatric Nutrition Support Service, Adult Clinical Research Unit, and Pediatric Clinical Research Unit.
2. Representatives from the Gastroenterology Divisions (Departments of Pediatrics and Medicine), Pharmacy, and Nursing (Pediatrics, Oncology, Psychiatry).

C. Meetings. The Nutrition Advisory Committee shall meet monthly.

22.03.07.08 Patient Education Committee

A. Duties and Responsibilities

1. Review and update patient education resources and standard teaching plans as found on the Patient Education Website (on the Nursing intranet website – www.insidehopkinsmedicine.org/nursing/pe/patient_education.html).
2. Review and update patient education material on the on-demand Patient Education Video System of the Johns Hopkins Patient TV/Phone System.
3. Review and update policies and procedures related to the development and documentation of patient education materials.
4. Advise developers of patient education material on content and format of the material to assure that it meets the standards for readability and presentation.
5. Review and update translated patient education materials.
6. Coordinate departmental patient education efforts to comply with regulatory requirements.

B. Membership. Membership shall include, but is not limited to:

1. Representative from the Medical Staff
2. Representatives from Physical Medicine and Rehabilitation, Pharmacy and Nutrition
3. Nursing Representatives from the Clinical Departments
4. Representative from Johns Hopkins Home Care Group

C. Meetings. The Patient Education Committee shall meet monthly.

22.03.07.09 Pharmacy and Therapeutics Committee

A. Duties and Responsibilities.

1. Serve in an evaluative, educational, and advisory capacity to healthcare providers and hospital administration in matters pertaining to the use of drugs.
2. Develop a formulary of drugs accepted for use at The Johns Hopkins Hospital and provide for its revision as required. The formulary shall be reviewed at least annually. The selection and deletion of formulary items shall be based upon objective evaluation of their relative therapeutic merits, safety, and estimated cost impact on the Hospital.
3. Monitor and evaluate adverse drug reactions and medication errors; make appropriate recommendations for system changes to prevent such occurrences.
4. Develop programs and procedures that help ensure ongoing cost-effective use of drugs with emphasis placed on clinical effectiveness, safety and the total cost of therapy.
5. Develop and monitor policies involving restrictions placed on the use of formulary and non-formulary drugs at The Johns Hopkins Hospital.
6. Review and approve all critical pathways, order sets, relevant research protocols and similar materials in which commercially available and investigational drugs are used. This may be accomplished by the Committee as a whole, or as delegated to a subcommittee or to individual members.
7. Develop and maintain policies and procedures involving the distribution and use of Complementary and Alternative Medications.

8. Provide professional and scientific input to the service and education functions of the Department of Pharmacy.
9. Educate physicians and other professional staff on matters pertaining to the use of drugs.
10. Monitor and evaluate the use of Controlled Substances (as defined by the DEA) to assure that these substances are properly controlled and that all appropriate regulatory standards are maintained.
11. Monitor and develop policies regarding the activities of pharmaceutical sales representatives within the Hospital.

B. Membership. Membership shall include, but is not limited to:

1. Director of Pharmacy or designee
2. Director, Division of Clinical Pharmacology or designee
3. Hospital Pharmacologist
4. Vice President, Medical Affairs
5. Chief Financial Officer (JHH) or designee
6. Representatives from Nursing
7. Physician representatives from clinical departments
8. Director of the Center for Pharmaceutical Outcomes and Policy
9. Representatives from Pharmacy, including at least one from the Investigational Drug Service

C. Meetings. The Pharmacy and Therapeutics Committee shall meet monthly.

22.03.07.10 Radiology Advisory Committee

A. Duties and Responsibilities

1. Advise the Department of Radiology and Hospital leadership on the scope, availability, and relevance of radiology services. Periodically review clinical department assessment of radiology services, including quality, timeliness, and responsiveness to problems and inquiries.
2. Participate in the development and interpretation of quality assessment studies dealing with the appropriateness of test or procedure ordering, the effectiveness of test or procedure utilization and interpretation, and correlation with quality improvement activities in clinical departments.
3. Advise the Department of Radiology regarding written and electronic communications to medical, nursing, and other hospital or referring staff.
4. Receive reports from operating divisions and central administration of the Department of Radiology.
5. Provide recommendations through Medical Care Evaluation Committee to the Medical Board and Hospital Administration regarding radiological services.

B. Membership. Membership shall include, but is not limited to:

1. Department of Radiology Deputy Director
2. Members of the Medical Staff (5).
3. Representatives from the Resident Staff (2), Administration, Nursing, and Department of Radiology Medical Staff (2)

C. Meetings. The Radiology Advisory Committee shall meet monthly.

22.03.07.11 Respiratory Therapy Committee

A. Duties and Responsibilities.

1. Evaluate the indications for respiratory therapy
2. Monitor the quality, safety and efficacy of respiratory services.
3. Assist in ensuring compliance with federal and other required respiratory therapy regulations and guidelines.
4. Assist in formulation of guidelines and policies pertaining to equipment cleaning, infection control, and other subjects relevant to respiratory therapy.

B. Membership. Membership shall include, but is not limited to:

1. Physician Representative(s), one of whom shall serve as Chair
2. Managers, Respiratory Care Services
3. Clinical Coordinators, Respiratory Care Services
4. Representatives from the Department of Nursing
5. Representative from Hospital Epidemiology and Infection Control
6. Representative of the Hospital Department of Quality Improvement/Utilization Management

C. Meetings: The Respiratory Therapy Committee shall meet monthly,.

22.03.07.12 Transfusion Practices Committee

A. Duties and Responsibilities

1. Review the practices relating to administration of blood and blood components within the Hospital.
 - a. Review the overall institutional utilization of blood products by type of component.
 - b. Advise clinical departmental Quality Improvement Committees and others on blood and blood component utilization. This shall include review of departmental transfusion monitoring activities. .
 - c. Provide oversight of processes that ensure prompt review, and documentation as indicated, for actual or suspected untoward events, including reported transfusion reactions, post-transfusion infections, or events associated with actual or potential patient harm as identified by the Risk Management Department or other bodies concerned with patient safety issues.
2. Review and approve sources of blood and blood components.
3. Review and evaluate new blood components or services for possible addition to the Blood Bank inventory and Hemapheresis and Transfusion Support (HATS) division..
4. Serve as a forum for discussion of transfusion practices and blood donation activities. Develop and update every two years, and as needed, the Johns Hopkins Transfusion Guidelines.
5. Assist in meeting compliance with regulatory requirements.

- B. Membership. Membership shall include, but is not limited to:
1. Director and Laboratory Manager of the Transfusion Medicine Division of the Department of Pathology.
 2. Medical director and manager of HATS division.
 3. Physician and nurse representatives from clinical departments.
- C. Meetings. The Transfusion Practices Committee shall meet quarterly.

Section 22.04 Departmental Quality Improvement and Credentials Committees

- A. Each department shall establish a quality improvement committee which shall address issues of quality improvement, utilization review, risk management, credentialing, medical staff monitoring functions, and the integration of these functions.
- B. Each department shall establish a departmental credentials committee to carry out the departmental credentialing functions.
- C. The Chief of Service shall appoint the membership of these committees, which membership shall include the departmental physician advisor.
- D. These committees shall report to the Chief of Service.
- E. The departmental Quality Improvement Committee shall meet monthly; the departmental Credentials Committee shall meet when necessary.

Section 22.05 Joint Committees of The Johns Hopkins Hospital and The Johns Hopkins University

There shall be joint committees of the Hospital and The Johns Hopkins University. The Joint Committees shall report to the Medical Board at least twice annually.

22.05.01. Johns Hopkins Medicine Institutional Review Boards

The Johns Hopkins Medicine Institutional Review Boards (JHMIRB) shall independently review each research project involving human subjects to assure the dignity, privacy, rights, and welfare of the individuals involved, the appropriateness of the methods used to obtain consent, and to weigh the risks and potential benefits of the proposed research. The Principal Investigator shall report all unexpected adverse events that put subjects at risk of serious harm to JHMIRB in accordance with the JHMIRB's requirements for event and deviation reporting. The Risk Management Department is to be notified promptly by the JHMIRB of all such events. The JHMIRB will monitor approved protocols periodically as necessary to document that consent forms are being appropriately used, and protocol procedures are as agreed upon. The chairs shall be appointed jointly by the Dean of the Johns Hopkins University School of Medicine and the President of The Johns Hopkins Hospital.

22.05.02. Committee on Graduate Medical Education

The Committee on Graduate Medical Education shall advise on the development of policies concerning the education, duties, and welfare of the house staff. The chair shall be the Associate Dean for Graduate Medical Education.

22.05.03. House Staff Council

The House Staff Council shall consider issues of importance to all residents, and bring them to the attention of the Associate Dean for Graduate Medical Education and the Vice President for Medical Affairs. The House Staff Council membership shall be composed of members of the Resident Staff.

22.05.04 Institutional Claims Committee

The Institutional Claims Committee shall review the professional liability activities of the Hospital, the Health System and the University. The chair shall be the Vice President and General Counsel for The Johns Hopkins Hospital and the Health System.

22.05.05. Joint Committee on Health, Safety and Environment

The Joint Committee on Health, Safety and Environment shall develop and monitor safety, health, and environmental policies designed to reduce hazards to patients, medical staff, employees, and the community. The chair shall be the Executive Director of Health, Safety and Environment.

ARTICLE XXIII

CORRECTIVE ACTION

Section 23.01 Corrective Action

A. Initiation of a Concern.

1. Members of the Medical and Affiliate Staff [referred in this Article XXIII as staff member(s)] have the responsibility to report any Staff member whose activities or professional conduct are, or are reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care, disruptive to Hospital operations, contrary to the bylaws, or below applicable professional standards. A statement of such concern may be initiated in writing by any Staff Member, describing the specific activities or conduct which gave rise to the concern. Concerns are automatically triggered by any action against a Staff Member's license, DEA or CDS registration, OIG exclusion or weapons policy violation.
2. Concerns may be reported to one of the following:
 - a. The Chair of the Medical Board;
 - b. The Vice Chair of the Medical Board;
 - c. The Vice President for Medical Affairs;
 - d. The Chief of the appropriate clinical service;
 - e. The President of the Hospital; or
 - f. Any Member of the Board of Trustees.
3. The recipient of the statement of concern as defined above shall immediately forward a copy of the written statement of concern to the Chair of the Medical Board and the Vice President for Medical Affairs.

4. The named Staff Member may be interviewed by the Vice President for Medical Affairs, the Chair of the Medical Board or their designees, following receipt of the written statement of concern.
 - a. This interview is discretionary and shall not be considered a procedural right, shall not constitute a hearing as defined in the Fair Hearing and Appellate Review section, shall be preliminary in nature and none of the procedural rules provided in Article XXIV shall apply.
 - b. At such interview, the named Staff Member shall be informed of the general nature of the concern and shall be invited to discuss, explain or refute such concern.
 - c. A written record of such interview shall be documented and maintained.
5. Potential Actions of the Chair of the Medical Board and Vice President for Medical Affairs.
 - a. If the Chair of the Medical Board and the Vice President for Medical Affairs agree that no further action is warranted, the investigation is terminated.
 - b. If the Chair of the Medical Board or Vice President for Medical Affairs conclude that further action is warranted, the Chair of the Medical Board shall convene a Corrective Action Committee of the Medical Board (CAC) as provided in Section 23.01.B herein and shall present the written statement of concern to the CAC. If the decision is to proceed with a CAC, the Chair of the Medical Board shall promptly notify the Medical Board and the President of the Hospital of the concern that has been received and shall continue to keep the President fully informed of all decisions and actions taken.
6. The Chair of the Medical Board shall promptly write to the named Staff Member regarding the reported concern and notify them whether the investigation is terminated or whether a CAC has been formed. If a CAC is formed, the notification to the named Staff Member shall be sent by certified mail and shall include a copy of Articles XXIII and XXIV of these Bylaws.

B. Convening the CAC.

1. If the decision to convene a CAC is made, it shall be convened to begin the investigation within fifteen (15) business days.
2. The membership shall be appointed by the Chair of the Medical Board and shall consist of:
 - a. Chair of the Medical Board or Vice Chair of the Medical Board or Vice President for Medical Affairs.
 - b. Two (2) Chiefs of Service
 - c. Two (2) medical staff members
 - d. Additional members as deemed necessary.

The Chair of the Medical Board shall appoint the Chair of the CAC. There must be at least three (3) members of the CAC present at any meeting at which action will be taken or at which substantive investigation will be conducted.

The membership shall not include the following: the Chief of any department in which the named Staff Member has an appointment and/or delineated clinical privileges, anyone who has reported the concern for investigation, anyone involved in the situation to be investigated, or any other person who has a conflict of interest as determined by the Chair of the Medical Board.

C. Investigation.

1. The investigation by the CAC shall include an interview with the named Staff Member and may include interviews with any other individuals who may have relevant information and appropriate consultants or persons with special relevant knowledge. The interviews shall not constitute hearings as defined in Article XXIV herein, shall be preliminary in nature, and none of the procedural rules provided in Article XXIV shall apply. A record of all CAC meetings shall be made.
2. A CAC may request that the named Staff Member undergo a complete physical or mental health examination as outlined in Section 12.03.C, Conditions for Appointment. Failure to comply with such a request shall result in automatic termination of appointment to the Johns Hopkins Hospital Medical Staff.
3. The CAC shall prepare a written report of the investigation as expeditiously as possible, but no later than forty-five (45) business days after convening the CAC. The report shall include a determination of whether the concern is founded or unfounded, and if deemed founded, shall recommend corrective action including but not limited to:
 - a. issuance of a warning or formal letter of reprimand;
 - b. imposition of mandatory education, counseling, or other action as deemed appropriate by the CAC;
 - c. imposition of a probationary period with requirements of consultation or supervision;
 - d. reduction or suspension of delineated clinical privileges;
 - e. revocation of Medical Staff appointment.
4. At any time during the course of an investigation the named Staff Member may resign. If such a resignation is accepted, the investigation shall be terminated. The Hospital shall report acceptance of the named Staff Member's resignation while under investigation, to the appropriate regulatory agencies. The Medical Board and the Board of Trustees shall be notified of such action.
5. Upon request by the CAC, the Chair of the Medical Board may extend any deadline for taking action under this Section 23.01.C for a reasonable period of time.

D. Action of the Medical Board.

1. The Medical Board Executive Session shall review the CAC's report and recommendations.

2. The Medical Board shall vote to uphold, modify or reject the CAC's recommendations. None of the following shall participate in the voting: the Chief of any department or head of division in which the Staff Member has an appointment and/or delineated clinical privileges, members of the CAC, anyone who has reported the concern for investigation, anyone involved in the situation to be investigated, or any other person who has a conflict of interest as determined by the Chair of the Medical Board. If the decision is that the concern is unfounded, the Chair of the Medical Board will notify the named Staff Member, the President of the Hospital and the Chair of the Board of Trustees of the decision and the corrective action process is terminated.
3. If the concern is determined to be founded by the Medical Board the recommended corrective action may be approved or modified.
4. The Chair of the Medical Board shall send notice of the recommended corrective action to the Board of Trustees, the President of the Hospital, the Vice President for Medical Affairs, and the Chief of any department in which the named Staff Member has an appointment or exercises delineated clinical privileges. The Medical Board shall provide notice of the action and attendant procedural rights required by Article XXIV herein to the named Staff Member.

Section 23.02 Summary Suspension

A. Criteria for Imposition.

Whenever the conduct of a Staff Member requires that immediate action be taken to protect the life of any patient or to reduce the substantial likelihood of imminent injury or damage to the health or safety of any patient, employee, or other person present in the Hospital, summary suspension of the Staff Member's appointment or any or all of the delineated clinical privileges may be imposed.

B. Imposition.

1. Summary suspension may be imposed by:
 - a. the Chair of the Medical Board or the Vice Chair, if the Chair is unavailable.
 - b. the President of the Hospital; or
 - c. the Vice President for Medical Affairs; or
 - d. the Chief of any Department or division in which the Staff Member exercises delineated clinical privileges.
2. The Staff Member may be notified verbally or in writing of the suspension and may be asked to leave the premises immediately and instructed not to return to the Hospital until further notification.
3. A summary suspension of a Staff Member's appointment or of all or any portion of the Staff Member's delineated clinical privileges shall become effective immediately upon imposition. When a Staff Member is summarily suspended, immediate notification shall be made to the Chair of the Medical Board, Vice President for Medical Affairs and relevant Chief of Service by the person who summarily suspended the Medical Staff Member.

4. The Chair of the Medical Board shall convene an ad hoc committee consisting of the Vice Chair of the Medical Board and two (2) additional members of the Medical Board within three (3) business days of the suspension. None of the members shall be in the same department as the Staff Member under suspension. The Medical Staff member under suspension shall be afforded an opportunity to appear at this special meeting of the ad hoc committee and present oral argument in opposition to continuation of the summary suspension. However, the Staff Member under suspension has no right to be present during the ad hoc committee's deliberations.
5. The ad hoc committee of the Medical Board may modify, continue or lift the suspension. If the ad hoc committee modifies clinical privileges or continues the suspension, then the Staff Member under suspension is entitled to the procedural rights outlined in Article XXIV herein. If the ad hoc committee lifts the suspension, the concern is forwarded to the Vice President for Medical Affairs or the Chair of the Medical Board for consideration of a CAC under Section 23.01.A.
6. If the Vice President for Medical Affairs or Chair of the Medical Board believes that continuation of suspension is necessary to protect patient safety, and the ad hoc committee recommends lifting the suspension, then a special meeting of the Medical Board shall be convened within three (3) business days. The decision of the Medical Board is final. The Hospital shall report the summary suspension to the appropriate regulatory agencies.

C. Notice.

1. When the ad hoc committee or Medical Board recommends an action which triggers procedural rights, the Staff Member under suspension shall be sent the notice required by Section 23.01.D within five (5) business days of the action.
2. All summary suspensions and actions or recommendations of the ad hoc committee shall be reported by the Chair of the Medical Board to the Medical Board at its next scheduled meeting.

D. Care of Suspended Individual's Patients

Immediately upon the imposition of a summary suspension, the appropriate Chief of Service or his/her designee shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended Staff Member's patients still in the Hospital at the time of such suspension until such time as they are discharged.

Section 23.03 Automatic Suspension or Limitation

A. Events Resulting in Automatic Suspension or Limitation

A Staff Member's appointment and delineated clinical privileges shall be automatically suspended, limited, terminated or inactivated as described in items 1 through 7 below, without a hearing or further review.

1. Licensure.

If the license to practice medicine or dentistry or other health occupation is:

- a. expired, then the Staff Member's appointment and clinical privileges at the Hospital shall be inactivated until the license is renewed. After ninety (90) days, if the license has not been renewed, the Staff Member's appointment and clinical privileges will be terminated;

- b. revoked, then the Staff Member's appointment and clinical privileges at the Hospital shall be revoked;
- c. restricted, then the Staff Member's appointment and clinical privileges at the Hospital shall be similarly limited or restricted;
- d. suspended, then the Staff Member's appointment and clinical privileges at the Hospital shall be suspended; or
- e. subject to conditions of probation, formal or informal reprimand, or limitation, regardless of whether such actions have been stayed, then the Staff Member's voting and office holding prerogatives at the Hospital will be suspended.

2. Controlled Substances.

Whenever a Staff Member's Drug Enforcement Administration certificate or prescribing authority is:

- a. expired, then the Staff Member's right to prescribe covered medications at the Hospital shall be inactivated until the certification is renewed;
- b. revoked, then the Staff Member's right to prescribe covered medications at the Hospital shall be revoked as of the date such action becomes effective and throughout its term;
- c. restricted, then the Staff Member's right to prescribe covered medications at the Hospital similarly shall be limited or restricted as of the date such action becomes effective and throughout its term; or
- d. suspended, then the Staff Member's right to prescribe covered medications at the Hospital shall be suspended as of the date such action becomes effective and throughout its term.

3. Professional Liability Coverage.

- a. The medical staff appointment and clinical privileges of any Staff Member whose professional liability insurance is lapsed for any reason, or whose coverage is not maintained in the minimum amount required under these Bylaws, shall be inactivated until evidence of coverage is provided. If evidence of coverage is not provided after ninety(90) days, the medical staff appointment will be terminated. These actions are not reported to state or federal authorities and do not invoke any rights to procedural due process under Article XXIV.
- b. Reinstatement of privileges due to lapsed professional liability may be attained by following the procedure in Section 23.03.B.

4. Risk Management

- a. The appointment and clinical privileges of any Member of the Medical, Resident, or Affiliate Staff who has not complied with Medical Staff Requirement Number 32 in the Rules and Regulations Section of these Bylaws shall be inactivated until evidence of attendance is provided. If evidence of attendance is not provided after ninety (90) days, the Medical, Resident or Affiliate Staff appointment and clinical privileges will be terminated. This action is not reported to state or federal authorities and does not invoke any rights to procedural due process under Article XXIV.

5. Medical Records.

- a. If, after a warning of delinquency from the Medical Records Department, a Staff Member has failed to complete medical records in a timely fashion, an automatic suspension may be imposed as provided in the Rules and Regulations.
- b. Such suspension shall continue until all the delinquent records of the individual's patients have been completed. Failure to complete the medical records after 60 days from the date of automatic suspension shall constitute an automatic revocation of clinical privileges. This revocation is reportable to state and federal authorities. If the Staff Member wishes to have an appointment and privileges, the Staff Member must reapply as an initial applicant.

6. Weapons.

If a Staff Member is found to be in violation of the Hospital's weapons policy (http://www.insidehopkinsmedicine.org/operation_integration/security/weapons.cfm), he/she will be subject to disciplinary action, up to and including termination of appointment and clinical privileges. Any disciplinary action, including termination, for a weapons policy violation does not invoke any rights to procedural due process under Article XXIV.

7. OIG Medicare Exclusion.

If the Staff Member is excluded, by the Office of the Inspector General (OIG), from participating as a provider in any federal healthcare program (e.g., Medicare, Medicaid, Champus, Tricare, etc.), his/her Medical Staff appointment shall be suspended.

B. Reinstatement of Appointment and/or Privileges after Non-Renewal

1. When the licensure, Drug Enforcement Administration (DEA) certification, or professional liability insurance of a Staff Member has been reinstated within 30 days of suspension for non-renewal, the Staff Member shall notify Medical Staff Administration of the reinstatement and provide a copy of the documentation which demonstrates reinstatement.
2. Medical Staff Administration, upon receiving the appropriate documentation, will automatically reinstate the Staff Member's appointment and clinical privileges without further review by the Chief of Service or Credentials Committee.

C. Reinstatement of Appointment and/or Privileges After Revocation or Suspension other than Non-Renewal

1. When the licensure or DEA certification of a Staff Member has been revoked or suspended for reasons other than described in Subsection A above, the Staff Member shall notify the Chief of Service of the appropriate Department, in writing, that the terms of the licensing or certifying agency have been met and that the reinstatement of Hospital appointment and clinical privileges is requested.
2. The Chief of Service shall review the request and submit a recommendation to Medical Staff Administration regarding the request for reinstatement.
3. Medical Staff Administration will transmit the Chief of Service's recommendation to the Credentials Committee for consideration at the next scheduled meeting. The provisions of Section 12.04 regarding the processing of applications shall apply to the Staff Member's request for reinstatement of privileges.

4. The Credentials Committee shall, after considering the Chief of Service's request for reinstatement and the facts under which the suspension or revocation was invoked and the terms under which reinstatement was granted, forward its recommendation regarding the request to reinstate Hospital appointment and clinical privileges to the Medical Board.
 5. The Medical Board shall, after considering all information gathered regarding the suspension or revocation and the terms of reinstatement make a recommendation to the Board of Trustees of the Hospital regarding the request to reinstate Hospital appointment and clinical privileges.
 6. The Board of Trustees of the Hospital may either accept the recommendation of the Medical Board or make its own determination on the reinstatement of Hospital appointment and clinical privileges, after consideration of all available information. A determination of the Board of Trustees to deny reinstatement of Hospital appointment and/or privileges under this Section will invoke procedural due process rights under Article XXIV.
- D. It shall be the responsibility of each Staff Member to report immediately to the Chair of the Medical Board and the Chief of Service of the appropriate department any proceeding, investigation, complaint, or charge that might result in any of the actions described above.

Section 23.04 Extension of Time

The Chair of the Medical Board may grant a reasonable request for an extension of any time limit within which action must be taken under this Article. Any such extension shall be disclosed to the Medical Board at the next meeting.

ARTICLE XXIV

FAIR HEARING AND APPELLATE REVIEW PROCEDURES

Section 24.01 Definitions.

The following definitions, in addition to those specifically provided elsewhere in these Bylaws, shall apply to the provisions of this Article.

- A. "Named Practitioner" means an applicant for Medical Staff or Affiliate Staff membership, or a member of the Medical Staff or Affiliate Staff, against whom an adverse recommendation or decision, as defined in this Article, has been made.
- B. "Appellate review body" means the group designated pursuant to this Article to hear a request for appellate review properly filed and pursued by a Named Practitioner.
- C. "Hearing committee" means the committee appointed pursuant to this Article to hear a request for an evidentiary hearing properly filed and pursued by a Named Practitioner.
- D. "Parties" means the Named Practitioner who requested the hearing or appellate review and the individual, body or bodies initiating or recommending the adverse action.

Section 24.02 Right to Hearing

- A. The following actions, if deemed adverse pursuant to subsection B. below, shall entitle the Named Practitioner to a hearing in accordance with the procedural safeguards set forth in this Article:
1. denial of appointment or denial of reappointment to the Medical Staff or Affiliate Staff or denial of requested Department affiliation;
 2. suspension of Medical Staff or Affiliate Staff appointment;
 3. revocation of Medical Staff or Affiliate Staff appointment;
 4. denial of requested delineated clinical privileges for which criteria of training or experience have been met;
 5. reduction in delineated clinical privileges;
 6. suspension of delineated clinical privileges;
 7. revocation of delineated clinical privileges;
 8. imposition and terms of probation;
 9. individual application of, or individual changes in, a mandatory requirement of consultation; and
- B. When recommendations or decisions are deemed adverse.
1. The summary suspension of a Named Practitioner is deemed an adverse action as soon as such suspension becomes effective;
 2. A recommendation or decision listed in Subsection A above shall be deemed adverse only when it has been:
 - a. recommended by the Medical Board; or
 - b. made by the Board of Trustees without a prior adverse recommendation by the Medical Board.
- C. Actions not deemed adverse.
1. The following actions do not trigger fair hearing rights:
 - a. warning;
 - b. referral to the Professional Assistance Committee or the Faculty and Staff Assistance Program; and
 - c. imposition of sanctions for failure to meet administrative requirements, including but not limited to violation of medical records policy.
 2. An automatic suspension or inactivation as described in Section 23.03 is not considered an adverse decision giving rise to a right to a hearing.

Section 24.03 Notice of the Right to Fair Hearing Process

- A. Within five (5) business days of an adverse recommendation or decision, the Chair of the Medical Board or his/her designee shall send by certified mail, return receipt requested, written notice thereof to the Named Practitioner. Such notice shall include a copy of Articles XXIII and XXIV of the Bylaws and the following information:
1. a description of the recommendation made or the corrective action proposed to be taken against the Named Practitioner;
 2. the basis for the recommendation or action proposed to be taken;
 3. the Named Practitioner has the right to request a hearing;
 4. a request for a hearing must be submitted in writing to the Chair of the Medical Board or such other individual who is named in the notice within thirty (30) days of the Named Practitioner's receipt of notification;
 5. failure to submit a proper or timely request pursuant to this subsection constitutes a waiver of the right to a hearing and to any appellate review, except as provided in Section 24.08.A., to which the Named Practitioner otherwise would have been entitled by these Bylaws;
 6. the Named Practitioner has the right to be represented by counsel;
 7. the Named Practitioner, upon reasonable request, may review and copy all reports and written recommendations made during the investigatory process and shall have reasonable access to all medical records that formed the basis of the recommendation for corrective action;
 8. additional concerns may be raised provided the Named Practitioner is given adequate notice.
- B. Request for hearing. If the Named Practitioner decides to request a hearing, such request shall be sent by certified mail, return receipt requested, and postmarked within thirty (30) days of receipt of the notice. In the alternative, the request may be hand delivered within thirty (30) days to the Chair of the Medical Board or such other individual who is named in the notice as the designee for receipt of such request.
- C. Waiver. A Named Practitioner who fails to request a hearing within the time and manner specified in Subsection B above waives his/her right to any hearing and to any appellate review to which he/she otherwise might have been entitled, except as provided in Section 24.08.A. However, any such waiver shall apply only to the matters that were the basis for the adverse recommendation or decision under Section 24.03.A. The effect of a waiver is that the decision of the Board of Trustees of the Hospital becomes effective immediately as the final decision in the matter. All adverse actions will be reported to the appropriate regulatory agencies, pursuant to the reporting requirements in State and/or Federal Law.

Section 24.04 Formation of Fair Hearing Committee

- A. If there has been a request for a hearing, the Chair of the Medical Board shall appoint a fair hearing committee (FHC).
- B. The FHC shall include not less than five (5) members of the Medical Staff who are appointed by the Chair of the Medical Board, one of whom shall be designated as the FHC chair. No Medical Staff member who has actively participated in the consideration of the adverse recommendation

or decision shall be appointed a member of the Committee. Membership shall not include the Chief of Service or Staff Members from the Named Practitioner's department.

- C. If the Chair of the Medical Board finds that the expertise of a professional with a practice similar to that of the Named Practitioner may be useful to the FHC, or upon request, the Medical Board may appoint a member of the Medical Staff or Affiliate Staff who exercises delineated clinical privileges in the same department or division as that of the Named Practitioner as a non-voting member of the FHC.

Section 24.05 Scheduling the Fair Hearing

- A. For Non-Summary Suspension: After receipt of a request for a hearing from a Named Practitioner who is not under suspension, the FHC Chair or his/her designee shall schedule and arrange for a hearing and shall notify the Named Practitioner of the date, time and place by certified mail, return receipt requested. The hearing date shall be no less than thirty (30) days, but no more than sixty (60) days, from the date that the notice of hearing is sent.
- B. For Summary Suspension: After receipt of a request for a hearing from a Named Practitioner who is under summary suspension, the hearing shall be held as soon as arrangements reasonably can be made but no later than ten (10) business days from the date the notice of hearing is received by the Named Practitioner.

Section 24.06 Conduct of Hearing

- A. There shall be at least three (3) members of the hearing committee present when the hearing takes place, and no member may vote by proxy. If a member of the FHC is absent from any part of the proceedings, that member shall not be permitted to participate in the deliberations or the decision.
- B. The FHC shall appoint an attorney who is not an employee of the Johns Hopkins Health System to serve as a hearing officer. In addition to the duties described below, a hearing officer shall advise the FHC on all legal matters and shall assist the FHC in its deliberations and in the preparation of its written report and recommendation, provided, however, that a hearing officer may not offer comments or advice on the substantive matters being considered by the FHC.
- C. The hearing officer shall preside over the hearing, determine the order of proceeding during the hearing to assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence, rule on all motions and evidentiary matters, and maintain decorum.
- D. The Named Practitioner shall be entitled to have access to any records or reports provided to the FHC.
- E. A record of the hearing shall be made in a manner chosen by the FHC.
- F. At least ten (10) business days prior to a hearing, the Named Practitioner and the party recommending corrective action shall supply each other with a written list of witnesses, if any, who will testify on their behalf, provided, however, that if the Named Practitioner is under summary suspension, the parties shall supply the written list of witnesses at least five (5) business days prior to the hearing.
- G. The personal presence of the Named Practitioner at the hearing is required. If the Named Practitioner fails without good cause to appear and participate in the hearing, the Named Practitioner shall be deemed to have waived all procedural rights under this Article, with the same effect as a waiver as pursuant to Section 24.03.C.

- H. Postponement of a hearing beyond the time set forth in Section 24.05 herein may be granted by the hearing committee upon the request of either party, and only upon good cause shown.
- I. The Named Practitioner shall be entitled to be represented by legal counsel subject to Section 24.11.E and may be accompanied and/or represented at the hearing by any other person of the Named Practitioner's choice.
- J. The hearing need not be conducted strictly according to the rules of the law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons rely in the conduct of serious affairs may be considered, regardless of the existence of any common law or statutory rule which might make such evidence inadmissible upon objection in a court of law. The hearing officer shall determine the relevance of the evidence proffered. The Named Practitioner shall be entitled to submit memoranda concerning any issue of procedure, law or fact at any time and such memoranda shall become a part of the hearing record.
- K. The individual or body which made the original adverse recommendation or decision shall appoint one of its members or another designee or designees (which may include legal counsel) to represent it at the hearing, and to be responsible for presenting evidence in support of the adverse recommendation or decision.
- L. The Named Practitioner shall have the right to call and examine witnesses, introduce written evidence, cross-examine any witness on any matter relevant to the issue of the hearing, challenge any witness, and to rebut any evidence.
- M. If the Named Practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.
- N. The Named Practitioner shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or decision lacks factual basis or that such factual basis or the conclusions reached therefrom are arbitrary, unreasonable or capricious.
- O. The FHC may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, but before the hearing is finally closed, the Named Practitioner shall be afforded an opportunity to submit a written memorandum in opposition to the recommended corrective action. If the Named Practitioner elects to file a written memorandum, a similar opportunity shall be afforded to the party presenting the case in support of corrective action. Any such memoranda shall be submitted simultaneously on a date established by the FHC. Upon receipt of any such memoranda, or at the conclusion of the presentation, if the Named Practitioner elects not to submit a written memorandum, the hearing shall be closed.
- P. After the hearing is closed, the FHC shall at a time deemed convenient by the FHC chair, conduct its deliberations outside the presence of the Named Practitioner for whom the hearing was convened. At the completion of the FHC's deliberations, the hearing shall be deemed to be finally adjourned.
- Q. Within thirty (30) days of the final adjournment of the hearing, the FHC shall issue a written report of its findings, including a recommendation that the original adverse recommendation or decision be affirmed, rejected or modified. This report, together with the hearing record and all other documentation considered, shall be transmitted to the parties and to the Medical Board.

Section 24.07 Procedure Following Hearing Report

- A. Within thirty (30) days after receipt of the FHC report, the Medical Board shall review the FHC report and issue a written recommendation thereon to the Board of Trustees of the Hospital. The FHC report and the hearing record shall be transmitted to the Board of Trustees along with the Medical Board's recommendation. If the Named Practitioner has waived his/her rights to a hearing, the Medical Board shall forward its recommendation and supporting material to the Board of Trustees.
- B. The Board of Trustees shall consider the material forwarded by the Medical Board and shall issue a prompt decision as to whether the recommended corrective action shall be imposed, rejected or modified.
- C. Within five (5) business days from the date of the decision by the Board of Trustees, the Board of Trustees shall forward its decision to the Named Practitioner by certified mail, return receipt requested. The Board of Trustees' decision shall be effective upon mailing to the Named Practitioner.
- D. If the Named Practitioner's privileges are already under suspension, the Board of Trustees shall issue its decision as soon as possible following receipt of the Medical Board's written recommendations.
- E. The time between the receipt of the FHC's report by the Medical Board and the Board of Trustees' decision following the hearing shall not exceed ninety (90) days.

Section 24.08 Right to Appellate Review

- A. Right to Appellate Review. When the Board of Trustees has reached its decision on a matter and that decision is one listed in Section 24.02.A, the Named Practitioner shall have the opportunity to appellate review of the Board of Trustees' decision. However, when the Named Practitioner has previously waived his/her right to a hearing and to appellate review pursuant to Section 24.03.C, the Named Practitioner shall have the opportunity for appellate review only if the Board of Trustees modifies the Medical Board's recommended corrective action.
- B. Request for Appellate Review by Named Practitioner. The notice mailed to the Named Practitioner pursuant to Section 24.03.A shall state that the Named Practitioner has ten (10) business days from the date of receipt thereof to request appellate review of the adverse decision. Such request shall be delivered to the Vice President for Medical Affairs, or to his/her designee as stated in the notice, either in person or by certified mail, return receipt requested, and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered in making the adverse decision.
- C. Waiver by Failure to Request Appellate Review. A Named Practitioner who fails to request appellate review within the time and in the manner specified in Subsection B above waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 24.03.C.
- D. Notice of Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the Vice President for Medical Affairs or his/her designee shall deliver such request to the Board of Trustees. As soon as practicable, the Board of Trustees shall schedule and arrange for appellate review, which shall be not less than thirty (30) days, nor more than sixty (60) days, from the date of receipt of the appellate review request; provided, however, that appellate review for a Named Practitioner who is under suspension then in effect shall be held as soon as the arrangements for it can reasonably be made, but not later than thirty (30) days from the date of receipt of the request for review. At least fifteen (15) days prior to the date scheduled for

appellate review, the Vice President for Medical Affairs shall send the Named Practitioner written notice by certified mail, return receipt requested, of the time, place and date of the appellate review. The time for the appellate review may be extended by the appellate review body for good cause shown and if either party's request is made as soon as is reasonably practicable.

- E. Appellate Review Body. The Chair of the Board of Trustees of the Hospital shall appoint a five (5) member appellate review committee, three (3) of whom shall be voting members of the Board of Trustees and two (2) of whom shall be members of the Medical Staff. Members must be present at all meetings. One of the members shall be designated as chair of the appellate review committee. No Medical Staff member who has actively participated in the consideration of the adverse decision or recommendation or is in direct economic competition with the Named Practitioner shall be appointed a member of this appellate review body.

Section 24.09 Appellate Review Procedure

- A. Nature of Proceedings. The proceedings by the appellate review body shall be in the nature of an appellate-type review based upon the record of the hearing and other proceedings before the FHC, that committee's report and all subsequent results and actions thereon. The appellate review body also shall consider the written statements, if any, submitted pursuant to Subsection B below and such other material as may be presented and accepted under Subsections D and E of this Section.
- B. Written Statements. The Named Practitioner seeking the appellate review may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any steps in the hearing process, and legal counsel may assist in preparation. This written statement shall be submitted to the appellate review body through the Vice President for Medical Affairs at least ten (10) business days prior to the scheduled date of the appellate review, unless such time limit is waived by the appellate review body. A written statement in reply may be submitted by the Medical Board, and, if submitted, the Vice President for Medical Affairs or his/her designee shall provide a copy thereof to the Named Practitioner at least five (5) business days prior to the scheduled date of the appellate review.
- C. Presiding Officer. The chair of the appellate review body shall be the presiding officer. He/she shall determine the order of procedure during the review and make all required rulings.
- D. Oral Statement. The appellate review body may but need not allow the parties or their representatives to appear personally and make an oral statement in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the appellate review body.
- E. Consideration of New or Additional Matters. New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only if permitted in the sole discretion of the appellate review body, following an explanation by the party requesting the consideration of such matter or evidence as to why it was not presented earlier.
- F. Powers. The appellate review body shall have all the powers granted to the hearing committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.
- G. Presence of Members and Vote. A majority of the appellate review body must be present throughout the review and deliberations. If a member of the review body is absent from any part of the proceedings, that member shall not be permitted to participate in the deliberations or the decision.

- H. Recesses and Adjournment. The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time deemed to be convenient by the appellate review body, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.
- I. Action Taken. The appellate review body, within thirty (30) days of the final adjournment of its deliberations, shall either (a) recommend that the Board of Trustees affirm, modify or reverse the adverse decision made by the Board of Trustees or, (b) refer the matter back to the FHC for further review in accordance with its instructions and for recommendations to be returned to it within twenty (20) days. Within fifteen (15) days after receipt of the FHC's recommendations after referral, the appellate review body shall make its recommendations to the Board of Trustees as provided in this subsection.
- J. Conclusion. The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

Section 24.10 Final Decision of the Board of Trustees

Within thirty (30) days after receipt of the appellate review body's recommendation, or, if appellate review has been waived, within thirty (30) days after receipt of the Medical Board's recommendations pursuant to Section 24.07, the Board of Trustees shall render its final decision in the matter in writing and shall send written notice thereof to the Named Practitioner and to the Chair of the Medical Board or the Vice President for Medical Affairs. The action of the Board of Trustees on the matter, following its receipt of the recommendation of the appellate review body, shall be immediately effective and final. All adverse actions will be reported to the appropriate regulatory agencies, pursuant to the reporting requirements in State and/or Federal Law.

Section 24.11 General Provisions

- A. Release. As set forth in Section 12.02.B.5 herein, by applying for or exercising delineated clinical privileges in the Hospital, a Named Practitioner agrees to be bound by the provisions relating to immunity from liability in all matters relating to hearings and appellate reviews under this Article.
- B. Waiver. If at any time after receipt of notice of an adverse recommendation or decision a Named Practitioner fails to make a required request or appearance or to proceed with the matter, the practitioner shall be deemed to have voluntarily waived all rights to which he/she might otherwise have been entitled under these Bylaws with respect to the matter involved.
- C. Review Period. In connection with any adverse action or decision as defined in this Article, the period of time from the date of receipt of the notice to the Named Practitioner under Section 24.03 and the date of the Board of Trustees decision under Section 24.10 of this Article shall not exceed two hundred (200) days, unless otherwise agreed to by the Named Practitioner. A request for postponement or temporary adjournment of a hearing by the Named Practitioner shall be deemed, to the extent granted, a waiver of the time limitations imposed by this subsection.
- D. Extension of Time. The chair of the FHC, the chair of the Medical Board or the chair of the appellate review body may grant a reasonable request by the Named Practitioner or the Hospital for an extension of any time limit within which action must be taken under this Article XXIV. Such extensions shall be reported to both parties and the chair of the Board of Trustees.
- E. Participation of Legal Counsel. When legal counsel attend and participate in a proceeding, it is with the understanding that they recognize the proceedings are not a judicial forum but a forum for evaluation of the Named Practitioner to render services. Accordingly, the FHC and/or the

appellate review committee retain the right to limit the legal counsel's participation in the proceedings.

ARTICLE XXV

RULES AND REGULATIONS

Admission

1. Except for emergency admissions, no patient shall be admitted until a provisional diagnosis and name of attending physician has been communicated to the Admitting Office. The provisional diagnosis for all admissions must be recorded in the attending physician's admission note.
2. The practitioner who arranges the admission of the patient shall be responsible for giving such information to the Admitting Office staff as may be necessary to protect the health and welfare of all patients. This shall include compliance with the policies promulgated by the Hospital Epidemiology and Infection Control Committee and approved by the Medical Board concerning the isolation and care of patients having a proven or suspected communicable disease.
3. Patients shall be admitted to the service appropriate for the established or provisional diagnosis. Admission of patients shall be in accordance with the urgency of their need for care.
4. The attending physician for inpatient care is the documented physician of record. Within the policies of the Hospital, the attending physician shall assume ultimate responsibility for all medical, ethical, and social aspects of the care of the patient.
5. When the attending physician expects to be unavailable to provide supervision of inpatient care, he/she shall arrange for coverage by a member of the Active or Courtesy Staff and document the plan in the inpatient medical record in accordance with the Continuity of Care Policy (<http://www.insidehopkinsmedicine.org/icpm/PAT011-continuity.pdf>).

Intra-Hospital Transfers and Discharges

6. Patients on a non-surgical service who are to undergo surgery shall be transferred to the appropriate surgical service at the time of surgery, unless other arrangements have been made in advance by the attending physician and surgeon, and an order to that effect has been recorded on a physician order sheet.
7. When a patient's care is transferred from service to service or within a service, a written order is required. If the attending physician is unable to be present to write the order, the attending physician may delegate the writing of the order to a member of the Medical, Resident or Affiliate Staff. The order for transfer must contain the name of the new attending physician unless the transfer is to an intensive care service. The transfer must be approved by the receiving attending physician of record who shall provide a progress note documenting acknowledgement of the transfer. Physician orders must be rewritten in accordance with Institutional policies, including the Medication Ordering Policy (http://www.insidehopkinsmedicine.org/icpm/PAT036med_orders.pdf).
8. Patients shall be discharged from the Hospital on the order of the attending physician or his/her designee.

Inpatient Consultation

9. All inpatient consultations shall be authorized by the patient's attending physician or designee and the consultation request shall include the specific question to be addressed by the consultant.

10. Any member of the Medical Staff or Affiliate Staff who consults on an inpatient shall record a note at the time the patient is seen. The consultant's preliminary assessment, including a written opinion that reflects an examination of the patient and review of the patient's medical record, must be completed within the next calendar day. The consultation note may be recorded in the progress notes of the medical record or on a special form approved by the Medical Board.
11. A consulting physician may only write an order or undertake treatment with approval from the patient's attending physician. The order shall be cosigned within the next calendar day by the attending physician or designee responsible for the patient. Orders must be authorized only by an authorized prescriber from the primary service, except for a) emergencies, b) administration of radiographic diagnostic agents, c) preoperative orders from anesthesiologists, and d) anesthesia care throughout the Hospital.
12. Consultation is appropriate in cases in which the diagnosis is obscure, when doubt exists as to the appropriate diagnostic and therapeutic measures to be utilized, and in surgical or procedural cases in which the patient may not be a good risk. The consultant must be qualified in the field in which advice is sought. The consultation shall include examination of the patient and review of the patient's medical records and a written statement, signed by the consultant, which shall be made a part of the medical record. When surgical procedures are involved, and a consultation is provided that is relevant to such surgical procedures, the consultation note shall be recorded prior to the procedure, except in cases of emergency surgery.
13. Only members of the Hospital Medical Staff may assume responsibility for the care of a patient.

Supervision of Residents

14. All clinical care provided by Resident Staff shall be under the supervision of the Chief of Service and his designees, in accordance with the written departmental supervision policy. The Chief of Service shall be responsible for seeing that documentation of this supervision is recorded in the patients' medical records.

Medical Records

15. A medical record shall be created for each inpatient upon admission.
16. History and Physical (H&P)
 - A. If an H&P is performed or reviewed and updated by someone other than the attending physician, the attending physician shall review the H&P and shall document concurrence or revision thereof as well as his/her own evaluation, impression, and recommendations for treatment. Medical student H&Ps are not included in this requirement.

B. Inpatient and Preoperative

1. All patients must have a history and physical examination (H&P) documented in the medical record within twenty-four (24) hours after admission to an inpatient unit and before surgery or invasive procedure requiring anesthesia or titrated (moderate or deep) sedation. **[Exception:** For emergency procedures, the H&P may be documented after the completion of the emergency procedure, but in no case more than 24 hours later.]
2. An H&P performed within thirty (30) days before admission or registration will satisfy this requirement if reviewed and updated by a member of the Johns Hopkins Hospital Medical, Resident or Affiliate Staff within 24 hours after admission and before performance of any surgery or invasive procedure requiring anesthesia or

titrated (moderate or deep) sedation. An H&P that is greater than 30 days old is considered invalid and may not be updated.

3. Components of the H&P shall include:

(a) History:

- i. Presenting symptoms/Indication for procedure
- ii. Relevant past medical history and social history (e.g., smoking, alcohol and drug history), and family history when appropriate
- iii. Relevant review of systems
- iv. Allergies and medications (e.g., listed on Home Medication List)

(b) A physical examination appropriate to the visit:

- i. Vital signs and weight as relevant to the admission or surgery (may be documented by Nursing)
- ii. Examination of those body areas relevant to the presenting problem or any planned procedure
- iii. Examination of the heart, lungs and airway for patients having invasive procedures involving titrated (moderate or deep) sedation or anesthesia other than topical, local or regional block (may be documented by Anesthesia)

(c) Relevant laboratory data

(d) Diagnosis

(e) Plan for care

C. Emergency Department and Ambulatory Visits

1. An H&P must be documented for all Emergency Department (ED) visits and ambulatory clinic visits.

2. Components of the H&P shall include:

(a) History:

- i. Presenting symptoms/Reason for visit/Indication for procedure
- ii. Relevant review of systems
- iii. Allergies and medications (e.g., listed on Home Medication List)

(b.) A physical examination, which may include mental status examination, appropriate to the visit

(c.) Relevant laboratory data

(d.) Diagnosis

(e.) Plan for care

D. An H&P is not required for:

1. Certain routine "minor" procedures such as venipuncture, peripheral IV line placement or insertion of a NG tube or indwelling urinary catheter.
2. Established ambulatory patients whose visit is expected to involve only administration of medication (e.g., outpatient chemotherapy administration visits, apheresis, blood transfusion, use of contrast media or medication in diagnostic testing).
3. Established ambulatory patients whose visit is expected to involve only a change in medication use (e.g., post-operative pain medication, Coumadin clinic visit); however, a medication and allergy list shall be documented in the medical record.
4. Established ambulatory patients whose visit is expected to involve only counseling (e.g., to discuss treatment options).
5. Cardiology echo or stress tests (with Definity, amyl nitrite, or dobutamine).

- E. **For invasive procedures that do not include titrated sedation (moderate or deep) or anesthesia other than topical, local or regional block** (e.g., procedures such as liver biopsy or paracentesis that involve puncture or incision of the skin, or insertion of an instrument or foreign material into the body, excluding routine “minor” procedures as defined in D.1. above).

An “evaluation note” that includes an examination of the body area(s) relevant to the safe performance of the procedure, as well as a review of pertinent laboratory tests and other diagnostic results, shall be completed.

17. Daily progress notes shall be entered in the medical record by the attending physician or a physician designee.
18. The Medical Staff, Resident Staff and Affiliate Staff shall date, time and sign, including provider identification number, all entries into the medical record.
19. With the exception of the Department of Psychiatry, the Obstetrics Service, and Clinical Psychologists in the Department of Physical Medicine and Rehabilitation, clinic notes, both structured and unstructured, must be entered into the Electronic Patient Record (EPR), and signed within thirty (30) days of the visit.
20. A Discharge Summary shall be completed on every patient within thirty (30) days of discharge. The Discharge Summary shall include: a) the reason for the hospitalization; b) significant findings; c) procedures performed and care, treatment, and services provided; d) condition at discharge; e) information provided to the patient or authorized person, as appropriate; and f) the presence of any reportable diseases. This summary, which may be drafted by a member of the Resident or Affiliate Staff, shall be reviewed and signed by the attending physician as part of the discharge procedure.
21. The attending physician is ultimately responsible for prompt completion of the death certificate. In the event of death, the medical record shall be taken immediately to the central Admitting Office. The Admitting Office will provide the record to the Medical Records Department or, in the case of an autopsy, to the Pathology Department. The Pathology Department shall return the record to the Medical Records Department within three (3) business days. (Refer to Care After Death Policy: http://www.insidehopkinsmedicine.org/icpm/ADT009_deathcare.pdf.)
22. The attending physician and/or responsible surgeon will be held accountable for compliance with medical record completion policies. A warning of delinquency shall be issued on a weekly basis to responsible physicians indicating that failure to complete medical records in accordance with medical record completion policies may result in suspension. A physician is considered to be delinquent if any medical record for which he/she is responsible remains incomplete for longer than thirty (30) days.
 - a. Sanctions as provided by the Medical Board will be imposed under the direction of the Vice President for Medical Affairs. Sanctions shall remain in place until the medical records are completed.
 - b. Disregard for the rules concerning medical record availability or completion will be referred to the appropriate Chief of Service and the Vice President for Medical Affairs.
23. Medical Records Department personnel shall review the medical records of all discharged patients to be certain that the medical records are complete and that the diagnosis in each case is properly recorded in a prominent place in the medical record and shows proper authentications.
24. All medical records are the property of the Hospital and shall not be removed from the Hospital except as otherwise required by court order, subpoena, or applicable law.

Orders

25. Diagnostic and therapeutic orders shall be recorded on a JHH order sheet or an electronic order entry system in accordance with Hospital policies on orders and abbreviations. All orders must include date, time, signature, professional designation and provider identification number. When an authorized prescriber is unavailable to write an order or when an emergency exists, verbal orders of authorized individuals may be accepted and transcribed by qualified personnel, as defined by Hospital policies. The authorized individual accepting the verbal order shall enter the order on the order sheet or the electronic order entry system, date, time, and sign the order and record the name of the authorized prescriber and the prescriber's identification number. An authorized prescriber from the patient's care team shall co-sign, date, and enter his/her provider ID number on such orders within the next calendar day. A password-protected electronic signature is considered equivalent to a handwritten signature for physician order entry, discharge summaries, operative notes and similar functions.

Drugs and Devices

26. Drugs used for patient care shall be listed in the U.S. Pharmacopoeia, National Formulary, or approved by the Food and Drug Administration. Use of other products, such as Complementary and Alternative Medicine (CAMs) shall be in accordance with Hospital policy. Drugs used for clinical investigations shall be approved for use by the Pharmacy and Therapeutics Committee and a Johns Hopkins Medicine Institutional Review Board. Nomenclature for ordering drugs shall be used in accordance with the Hospital's formulary system. The Hospital Pharmacy may interchange or dispense equivalent drugs for orders submitted in a proprietary name to the extent consistent with applicable law and hospital policy.
27. Devices and systems used in patient care, including diagnostic testing, shall be in compliance with the medical devices regulations of the Food and Drug Administration, other relevant state and federal regulations, and Hospital policies. Patient care testing, whether diagnostic or associated with a research protocol, is defined as any test or procedure whose results are communicated to the patient, the patient's family, and/or health care provider. Medical devices and systems that are classified as being experimental shall be approved for use by a Johns Hopkins Medicine Institutional Review Board. The physician who uses or requests the use of a medical device or system is responsible for assuring compliance with this rule, including the requirement to obtain the informed consent of the patient. Devices and systems used for diagnostic testing done in vitro shall be approved by the Department of Pathology prior to purchase or initiation of implementation.
28. Systems for display of clinical information, including electronic displays, shall be developed, updated, or purchased only after approved by the Clinical Data and Documentation Committee. That committee will approve such systems only after review and approval by the parties that originate the data, including clinical units, pharmacy, pathology, and radiology. This applies to data used for research and patient care, but does not apply to administrative uses or patient demographic information.

Research Involving Human Subjects

29. Research involving human subjects shall be conducted in a manner to assure that the welfare, health and safety of the subject are paramount. All clinical policies and procedures of The Johns Hopkins Hospital apply to subjects, participating in Institutional Review Board approved protocols. Subjects' rights, including the right to privacy, shall be preserved, and informed consent shall be obtained and documented in the medical record as required by applicable federal, state and institutional requirements. Such research initially shall be approved by the Johns Hopkins Medicine Institutional Review Board and thereafter be under its continuing review. Where such research involves the investigational use of drugs, it also shall be reviewed and approved by the Pharmacy and Therapeutics Committee. Where it involves performance of patient care laboratory tests in a non-

CLIA-approved laboratory, it shall also be reviewed by the Laboratory Advisory Committee or its designee.

Informed Consent

30. There shall be documented evidence in the medical record that the Institution's policy pertaining to informed consent has been followed.

Autopsies

31. Permission for autopsy shall be requested with two exceptions: 1) when the patient's or family's opposition was expressed during life and documented in the medical record; and 2) when the death falls under the jurisdiction of the Medical Examiner. Documentation of action taken shall be recorded in the death report form. No autopsy, partial or complete, shall be performed without consent of a relative or the person who has assumed responsibility for final disposition of the body. All autopsies shall be performed by the pathologist-in-chief or his/her designee. (See Care After Death Policy: http://www.insidehopkinsmedicine.org/icpm/ADT009_deathcare.pdf.)

Surgery

32. All operations performed shall be documented by the operating surgeon. A detailed operative report must be dictated immediately after surgery and must be signed within seven (7) days. It shall contain a description of the findings, the surgical procedure performed, the specimens removed, the post-operative diagnosis, the clinical stage of tumor as appropriate, and the name of the primary surgeon and any assistants.
- a. An operative progress note, which is separate and distinct from the dictated detailed operative report, shall be entered in the medical record immediately after surgery to provide pertinent information for use by any individual who attends the patient. It shall contain the name of the primary surgeon and assistants, findings, procedures performed and description of the procedure, estimated blood loss, blood products and fluids administered, specimens removed, and postoperative diagnosis.
 - b. All tissue or other materials removed at operation, except those exempted by the Medical Board upon recommendation of the Surgical and Invasive Procedure Review Committee, shall be sent to the Department of Pathology where a pathologist shall make such examinations as he/she may consider necessary to arrive at a diagnosis and sign his/her report. A copy of the pathologist's report shall be filed in the medical record.
 - c. All cases involving surgery at Johns Hopkins Hospital that are based upon a tissue diagnosis made elsewhere shall have pertinent slides reviewed by a pathologist privileged through the Department of Pathology prior to surgery. Exceptions are permitted for emergent procedures and for procedures which are independent of the specific pathologic diagnosis.

Medical Staff Requirements

33. New appointees to the Medical, Resident, and Affiliate Staff are required to attend a risk management seminar within the first four (4) months of appointment. All members of the Medical, Resident, and the Affiliate Staff are required to attend a Hospital-approved risk management seminar as frequently as may be deemed necessary, but no less than once every two (2) years. Unless the Member is on an approved Leave of Absence, failure to meet the requirement shall result in inactivation of Hospital appointment as described in Article XXIII, Section 23.03.A.4 of these Bylaws.
34. Members of the Medical, Resident and/or the Affiliate Staff shall report to the Legal Department all lawsuits in which they are named or may be named in their professional capacity as defendants.

35. When a complaint is filed by any regulatory or licensing body, against a staff member, the staff member shall inform the Legal Department and his/her Department Chair.

36. All members of the Active Staff, Courtesy Staff, Associate Staff, and Affiliate Staff shall be required to present to the Hospital evidence of professional liability insurance coverage, which evidence in the sole judgment of the Quality Improvement Committee of the Board of Trustees is determined to be acceptable for appointment and reappointment to the Medical Staff and the granting of delineated clinical privileges at the Hospital.

Evidence of current professional liability insurance in the minimum amount of one million dollars (\$1,000,000) per claim and three million dollars (\$3,000,000) yearly aggregate shall be presented, except that obstetricians and neurosurgeons shall provide evidence of current professional liability insurance coverage in the amount of three million dollars (\$3,000,000) per claim and five million dollars (\$5,000,000) yearly aggregate. In each case in which the Medical or Affiliate Staff member has had a "claims made" policy of professional liability insurance, evidence of extended claims reporting rights under a "tail policy" shall also be provided. Failure to purchase tail coverage within the time limit stipulated by the insurer will render the staff member ineligible for appointment or reappointment.

37. Members of the Medical, Resident and Affiliate Staff must comply with clinical policies and procedures of The Johns Hopkins Hospital as set forth in the Interdisciplinary Clinical Practice Manual and department-based policies.

ARTICLE XXVI

REVIEW AND AMENDMENTS

The Bylaws shall be reviewed by the Medical Staff Bylaws Committee at least every two years and amended as necessary to reflect the Hospital's current practice with respect to the Medical Staff organization and functions. The Committee's proposed amendments shall be submitted to the Medical Staff Conference Committee for review and recommendations. These recommendations shall then be submitted to the Administrative Committee of the Medical Board, and its recommendations shall then be submitted to the Medical Board. Following approval by the Medical Board, the proposed amendments shall be submitted to the Organized Medical Staff Members who are eligible to vote via special ballot, which will be mailed, faxed or e-mailed. Approval of proposed amendments by the Organized Medical Staff shall require an affirmative vote of the majority of ballots returned via mail, fax, or e-mail. Upon approval of the Organized Medical Staff, the Medical Board shall submit the proposed amendments to the Board of Trustees. The amendments shall be effective upon approval of the Board of Trustees. Neither the Medical Board nor the Board of Trustees may unilaterally amend the Bylaws. However, in the event that amendments to the Bylaws are required to bring the Hospital into conformity with applicable law and the Chair of the Board of Trustees determines, in his/her sole discretion, that there is not sufficient time to follow the normal process for adopting amendments, the Board of Trustees may adopt amendments to these Bylaws, which will become effective upon adoption by the Board of Trustees.

ARTICLE XXVII

ADOPTION

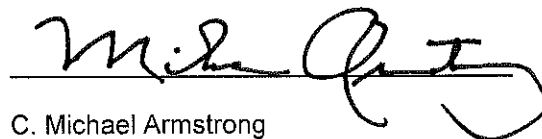
These Bylaws shall become effective and shall replace any previous Bylaws after these have been adopted by the Medical Board and the Organized Medical Staff and approved by the Board of Trustees of the Hospital.

Adopted by the
Medical Board of
The Johns Hopkins Hospital
February 24, 2009

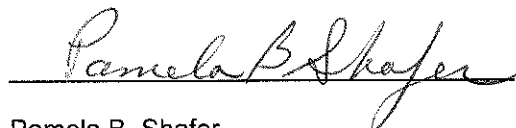


George J. Dover, MD
Chair, Medical Board

Approved by the
Board of Trustees of
The Johns Hopkins Hospital
June 3, 2009



C. Michael Armstrong
Chair, Board of Trustees



Pamela B. Shafer
Secretary, Medical Board



G. Daniel Shealer, Jr.
Secretary, Board of Trustees