Extreme Makeover for Medical Staff Bylaws: The New Joint Commission Medical Staff Standard Sends Hospitals Back to the Drawing Board

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Introduction
After over seven years of discussion and debate, The Joint Commission (TJC) has approved revised wording for medical staff standard MS.01.01.01 (formerly MS.1.20), which sets forth the requirements for medical staff governance and the content of governance documents. According to TJC, the new standard "contributes to patient safety and quality of care through the support of a well-functioning, positive relationship between a hospital's medical staff and governing body."

Under the new standard, TJC attempts to: (1) identify those provisions that must appear in the medical staff bylaws and are therefore subject to the review and approval of the organized medical staff; (2) define the relationship among the triumvirate that governs hospital-based medical practice: the hospital's governing body, the medical executive committee (MEC), and the organized medical staff; and (3) address conflicts that may arise between leadership groups regarding bylaws, rules and regulations, and policies. It is not surprising that the development of MS.01.01.01 has been a long and complicated journey.

The Long and Winding Road
The long journey to the newly approved MS.01.01.01 can be traced back to the early 2000s. In order to slim down medical staff bylaws and streamline medical staff management, many hospitals created additional governance documents, such as credentialing and appointment manuals, fair hearing plans, rules and regulations, and policies and procedures. Unlike the medical staff bylaws, which typically require the review and approval of the organized medical staff, the authority to adopt or amend such supplementary documents is usually delegated to an entity such as the MEC.

In 2002 and 2003, TJC proposed changes to MS.1.20 and the accompanying Elements of Performance (EPs). The changes were intended to provide greater specificity with regard to the medical staff organization and functions; recognize the medical staff as an "organized, self-governing body;" and strengthen the prohibition against any provision authorizing unilateral amendment of the medical staff bylaws. TJC also attempted to provide informal guidance regarding
the content of governance documents, stating that the medical staff bylaws must reference provisions regarding credentialing, privileging, appointment, and the fair hearing and appeals process, but the details related to such processes may be placed in supplementary documents, as long as such documents are subject to a review and approval process that is set forth in the bylaws.

The proposed changes resulted in considerable confusion regarding what it meant to “reference” certain provisions. In addition, critics contended that the revised standards were overly prescriptive, were inconsistent with the legal accountability of the governing body, marginalized the MEC, created unnecessary conflict and dysfunction, and required costly and unnecessary revisions to existing governance documents. What followed was a long debate about what content should go in which document, who should control the process, and what should happen when a disagreement arises.

In 2004, TJC issued additional informal guidance, which was followed by several retractions, field reviews, republished proposed standards, more confusion, and implementation delays. Then, in 2008, TJC announced a Task Force to examine implementation issues related to MS.1.20. Following the Task Force’s review and comments, an updated draft of MS.01.01.01 was reviewed by several professional organizations, resulting in a joint proclamation in support of the Task Force’s recommended revisions. In 2010, TJC conducted formal field reviews and subsequently announced its approval of the revised MS.01.01.01 standard on March 15, 2010.

Promotion of Quality and Safety
TJC recognizes that a hospital’s governing body is legally responsible for the quality and safety of services provided at the hospital by licensed independent practitioners and other hospital personnel. However, according to TJC, the clinical practice of physicians and other licensed practitioners can only be overseen by other licensed independent practitioners. Such practitioners form an “organized medical staff” that has the technical knowledge to provide oversight and evaluate the clinical services provided by practitioners with clinical privileges. Thus, a well-functioning, productive relationship between a hospital’s governing body and the organized medical staff is critical to promote the safety and quality of care provided to patients. MS.01.01.01 was designed to support this relationship by promoting clearly recognized roles, responsibilities, and accountabilities.

The organized medical staff is accountable to the hospital’s governing body with respect to the matters set forth below, and must collaborate with hospital leadership to mutually agree on the rules and procedures that will guide their interactions:

- Collecting, verifying, and evaluating each licensed independent practitioner’s credentials;
- Recommending to the governing body that an individual be appointed to the medical staff and be granted clinical privileges, based on these credentials;
- Setting requirements for medical histories and physical examinations (H&Ps);
- Terminating or suspending a practitioner’s medical staff membership or clinical privileges based on quality of care considerations (including a process for challenging such action); and
- Directing medical staff departments.

The process by which these activities are conducted and the roles and responsibilities of the organized medical staff and the governing body are set forth in governance documents, such as the bylaws, rules and regulations, and policies. TJC standards describe which processes, roles, and responsibilities must appear in the bylaws, and which may be placed in other governance documents.

What Must Be Included in the Medical Staff Bylaws?
The revised MS.01.01.01 and its accompanying EPs are intended to provide governing bodies and medical staffs with greater flexibility regarding which provisions must be placed in the medical staff bylaws, and which may be placed in other documents. However, the revised EP 3 specifies that every requirement set forth in EPs 12-36 must appear in the bylaws (see below). If such EPs involve a process, at a minimum, the basic steps of the process must be included in the bylaws. According to TJC, since the processes identified in EPs 12-36 have “a direct bearing on quality and safety of care,” such processes must be included in the bylaws and medical staff members need to participate in their adoption.

In addition to MS.01.01.01 mandates, certain EPs reflect provisions that must reside in the bylaws in order to ensure compliance with Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) requirements for the content of medical staff bylaws. The following is a summary of the EPs that must appear in the medical staff bylaws:

Privileging/Credentialing/Appointment

- Qualifications for appointment to the medical staff (CoP requirement).
- The process for medical staff appointment and reappointment.
- The process for credentialing and re-credentialing.
- The process for privileging and re-privileging (CoP requirement).

Adverse Actions

- Indications for automatic suspension of medical staff membership or privileges.
- The process for automatic suspension of medical staff membership or privileges.
- Indications for summary suspension of medical staff membership or privileges.
- The process for summary suspension of medical staff membership or privileges.
- Indications for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges.
The CoP requirement that the medical staff bylaws contain provisions describing the completion and documentation of H&Ps is perhaps the most unusual since neither CMS nor TJC requires guidance related to the documentation of any other service to be set forth in the bylaws. Since many hospitals currently describe H&P documentation requirements in the rules and regulations or policies, such requirements will need to be moved to the bylaws and subject to the review and approval of the organized medical staff.

What May Be Placed in Other Documents?
While the basic steps of the processes noted above must be set forth in the bylaws, the details associated with such processes, which may be subject to frequent modification, may be placed in the bylaws, the rules and regulations, or policies. If associated details are placed in a document other than the bylaws, the bylaws must describe: (a) what constitutes associated details; (b) where such associated details will reside; and (c) whether the adoption or amendment of such associated details can be delegated to the MEC (adoption/amendment of details that reside in the bylaws cannot be delegated).

Presumably, the organized medical staff could elect to delegate to the MEC the authority to adopt or amend all of the associated details placed in rules and regulations or policies, or could limit the MEC’s authority to certain associated details.

Adoption and Amendment of Bylaws, Rules and Regulations, or Policies
The requirement that the bylaws only be adopted or amended by the voting members of the organized medical staff (with the approval of the governing body) remains unchanged. However, the bylaws must describe the process for adopting and amending the bylaws and identify those medical staff members who are eligible to vote.

In addition, TJC made some important changes to the requirements for the adoption or amendment of medical staff rules and regulations or policies:

> The process for adopting and amending the medical staff rules and regulations and policies must be set forth in the medical staff bylaws.

> The organized medical staff must have the ability to propose amendments to the bylaws, rules and regulations, and policies directly to the governing body. However, if the MEC has the authority to adopt or amend the details associated with the processes set forth in EPs 12-36, the organized medical staff must first communicate the proposal to the MEC.

> If the MEC has the authority to adopt or amend the details associated with the processes set forth in EPs 12-36, and such details are placed in the rules and regulations, the MEC must notify the medical staff before it submits proposed changes to the governing body. If such associated details are placed in policies, the MEC does not need to notify the medical staff prior to submitting the proposed changes to the governing body, but must notify the medical staff of any newly adopted or amended provisions.
If there is a documented urgent need to amend the rules and regulations in order to comply with law or regulation, and the MEC has the authority to amend the rules and regulations, the MEC may provisionally adopt and the governing body may provisionally approve an urgent amendment without the prior notification of the medical staff. However the MEC must immediately notify the medical staff and the medical staff shall have an opportunity for retrospective review and comment. Presumably, the medical staff always has the opportunity to review and comment on any provision in the bylaws, rules and regulations, and policies.

Who Has Decision-Making Authority?
A long-standing point of contention in the ongoing debate over MS.01.01.01 is who should have the ultimate authority over the content of the medical staff bylaws and supplementary documents. Specifically, commentators have expressed concern that while the governing body is ultimately legally accountable for the quality and safety provided in the hospital, under MS.01.01.01 the governing body cannot unilaterally revise medical staff governance documents to achieve quality and safety goals without the approval of the organized medical staff. In fact, even if the governing body seeks to amend the medical staff bylaws to ensure consistency with law, regulation, or another TJC standard, it cannot do so without seeking the approval of the medical staff. While TJC permits a mechanism for provisionally amending the rules and regulations in order to comply with law or regulation, there is no such permitted mechanism allowing the governing body to provisionally amend the bylaws. At the same time, EP 4 provides that the bylaws, rules and regulations, and policies must be compatible with each other and law and regulation.

Thus, a governing body that cannot persuade the hospital’s medical staff to approve an amendment to comply with law or regulation appears stuck between a rock and a hard place: a violation of EP 1 (the organized medical staff adopts and amends the bylaws) or a violation of EP 4 (the bylaws must be consistent with law and regulation).

Despite this potential stalemate, TJC appears unwilling to support unilateral amendment of medical staff documents by the governing body, even to support compliance with law. According to TJC, conflicts between well-functioning leadership groups should be rare and adequately addressed by a formal conflict management process. In addition, while a hospital’s governing body is ultimately legally responsible for the quality and safety of care, TJC contends that the governing body cannot ensure quality and safety of care without collaboration among the governing body, hospital administration, and the organized medical staff. Thus, the revised MS.01.01.01 mandates such collaboration. The authority granted to the medical staff under the new MS.01.01.01 will require hospitals and their counsel to anticipate potential issues, ensure active and early involvement of the medical staff, and clearly communicate the rationale for needed provisions and amendments.

The Role of the Medical Executive Committee
Commentators also have questioned whether MS.01.01.01 diminishes the role of the MEC and promotes conflict between the MEC and the organized medical staff. According to TJC, if the medical staff (with the approval of the governing body) delegates the adoption and amendment of the rules and regulations and policies to the MEC, the MEC should continue to function as it has in the past. However, TJC has made some changes that affect the MEC’s authority. As described above, the organized medical staff must have the ability to propose the adoption or amendment of medical staff bylaws, rules and regulations, and policies directly to the governing body, without MEC approval, and the MEC must notify the organized medical staff of its proposed or adopted changes.

Providing the organized medical staff with a mechanism for bypassing the MEC may create confusion regarding the role of the MEC and result in conflict. Again, TJC contends that disagreements in well-functioning organizations will be rare, but requires the medical staff to adopt a process for managing such conflicts.

Conflict Management
TJC requires the establishment of formalized conflict management processes to address conflicts among leadership groups. Under EP 10, the organized medical staff must adopt and implement a process for managing conflicts between the organized medical staff and the MEC for issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. In addition, if conflicts regarding the medical staff bylaws, rules and regulations, or policies arise between the organized medical staff and the governing body, the hospital must implement its conflict management process (as set forth in TJC Leadership Standards).

Hospitals will want to avoid triggering the use of formal conflict management processes to address every conflict that might arise, such as a dispute about who gets the best parking space. In order to minimize the potential for conflict and avoid
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trigging an administratively burdensome conflicts resolution process, hospitals and medical staffs should clearly identify those circumstances that will require institution of the formal conflict management process and consider limiting these circumstances to those that involve conflicts over provisions related to or required by EPs 12-36.

Back to the Drawing Board
The revised MS.01.01.01 will require a substantial overhaul of most hospitals’ medical staff governance documents. As hospitals and medical staffs head back to the drawing board, hospitals and their advisors should:

Ensure Adequate Time for Review and Revision.
Hospitals should not underestimate the time necessary to educate interested parties, achieve consensus, and complete substantial revisions to medical staff governance documents. Administrators and medical staff, MEC and governing body members may raise concerns about required changes, and discussions related to mandated changes may prompt disagreement about other aspects of the governance documents, requiring multiple changes to governance documents and numerous meetings. In order to ensure compliance with the new standard by the March 31, 2011 deadline, hospitals should begin the review and revision process as soon as reasonably possible.

Maintain Consistency Among Amended Documents.
Hospitals that maintain multiple medical staff governance documents often develop substantive contradictions or inconsistencies in such documents as they evolve over time. As hospitals undertake the review and amendment process and place related information in separate documents, it is important to evaluate the content of such documents in relationship to associated information contained in other documents. When associated details are described in a document other than the bylaws, it is advisable to reference the section of the bylaws that sets forth the related provisions. Including such a reference will trigger review of relevant bylaw provisions to ensure that future amendment of associated details will be consistent with the basic provisions described in the bylaws.

Develop Manageable Conflict Management Processes.
Although TJC contends that MS.01.01.01 does not promote conflict among leadership groups, the changes required by the new MS.01.01.01 may result in confusion, particularly in the early stages of implementation. Hospitals are encouraged to carefully consider the structure of formalized conflict management processes and the circumstances that will trigger their implementation in order to avoid creating administratively burdensome conflict management processes.

Effectiveness
In order to provide hospitals and medical staff with adequate time to implement the required changes, the revised standard is effective March 31, 2011. Following the March 31, 2011 implementation date, TJC expects full compliance by all hospitals and critical access hospitals. Although the effective date is still over seven months away, the amendment of medical staff governance documents can be a complex process and hospitals and medical staffs should address necessary changes as soon as possible.

Questions?
Information about the revised MS.01.01.01, including Frequently Asked Questions, is available on TJC’s website at www.jointcommission.org or by utilizing the TJC Standards online question form at www.jointcommission.org/Standards/OnlineQuestionForm.

Conclusion
Most hospitals’ medical staff governance documents will require an extreme makeover to ensure compliance with TJC’s newly revised MS.01.01.01 medical staff standard. All hospitals must review their medical staff governance documents front-to-back for compliance, draft necessary changes, put such changes to the organized medical staff for vote, and secure the approval of the governing body. Achieving compliance with MS.01.01.01 will require multiple meetings with the organized medical staff, MEC, bylaws committee (if one exists), and governing body members. Implementing well-structured documents that promote efficiency, avoid conflict, and minimize administrative burdens will require more than just an understanding of the new MS.01.01.01. Hospitals and their advisors will need a clear understanding of the relationships between leadership groups, awareness of potential pitfalls, substantial diplomatic skills, and a fair amount of patience.
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ENDNOTES

1 Revisions to Hospital Medical Staff Standard MS.01.01.01 (formerly MS.1.20) (presentation slides), The Joint Commission, available at www.jointcommission.org/NR/rdonlyres/81A0E2F3-CA04-4DC6-905B-6449A76339B0/0/MS010101FINAL40810.pdf (last visited June 9, 2010).
4 Approved: Revision to Medical Staff Standard MS.01.01.01, 30(4) Perspectives, The Official Newsletter of the Joint Commission 1 (Apr. 2010), at 1.
5 Id.
6 The Joint Commission Standard MS.01.01.01, Introduction (2010).
7 Id.
8 The Joint Commission Standard MS.01.01.01, EP 3 (2010).
9 42 C.F.R. § 482.22(c)(4).
10 42 C.F.R. § 482.22(c)(6).
11 42 C.F.R. § 482.22(c)(3).
12 42 C.F.R. § 482.22(c)(2).
13 42 C.F.R. § 482.22(c)(5).
14 The Joint Commission, Frequently Asked Questions Regarding Standard MS.01.01.01 (formerly MS.1.20), p. 3, question 6, available at www.jointcommission.org/NR/rdonlyres/482C8506-5E06-425E-9034-CA8ABB7C4CDE/0/FAQs_MS_01_01_01.pdf (last visited May 17, 2010)
15 Id. at p. 6, question 12.
16 The Joint Commission Standard MS.01.01.01, EP 2 (2010).
17 Id. at EP 24.
18 Id. at EP 17.
19 Id. at EP 25.
20 Id. at EP 8.
21 Id. at EP 9.
22 Id. at EP 9.
23 Id.
24 Id. at EP 11.
25 Id.
26 Id. at EP 11.
27 Supra note 14, pp. 6-7, questions 12-13.
28 Supra note 16 at EP 8.
29 Supra note 14, p. 2, question 4.
30 Supra note 16 at EP 10.