MS.01.01.01 (FORMERLY KNOWN AS MS 1.20): THE JOINT COMMISSION’S STANDARD FOR MEDICAL STAFF BYLAWS

By Ann O’Connell, Esq.
Nossaman, LLP
Sacramento, CA

The Joint Commission (“TJC”) is an independent nonprofit organization that accredits more than 17,000 healthcare organizations. It establishes Standards by which it assesses organizations’ performance. This assessment is accomplished through periodic surveys of the healthcare organization. TJC accreditation is one means by which healthcare organizations may be “deemed” to meet Medicare “Conditions of Participation.”

It’s been almost three years since TJC adopted new Elements of Performance for its medical staff self-bylaws standard. “Elements of Performance” are the factors that TJC reviews to assess whether an organization’s performance meets a TJC “Standard.” At that time, MS 1.20 (as it was then known) caused quite a stir throughout the hospital/medical staff community. Such a stir, in fact, that TJC retrenched, forming a Task Force of industry experts to assist it in developing implementation guidelines. The Task Force, comprised of individuals representing hospital governance, administration, medical staff, and healthcare attorney constituencies began meeting in January 2008, at TJC’s headquarters in Oak Park, Illinois. After the first full day of robust discussion, exploring the background, the intent, and the varying viewpoints of its potential impact, it became clear to all that more than implementation assistance would be needed. At the request of the Task Force, TJC staff requested and received TJC Board authorization to do more – to revisit and ultimately restructure the Elements of Performance altogether.

Over the next two years, the Task Force convened multiple times, and collectively hammered out revisions to the Elements of Performance (“EP’s or “Elements”).

The Standard, now renamed MS.01.01.01, this consists of the Standard itself – “Medical staff bylaws address self-governance and accountability to the governing body” – as well as 36 different EPs that are deemed by TJC to reflect the characteristics of a self-governing medical staff and how it should account to the governing body. Its revised Elements were first endorsed by the organizations represented on the Task Force – American College of Physicians, American College of Surgeons, American Dental Association, American Hospital Association, American Medical Association, Federation of American Hospitals, and National Association of Medical Staff Services; they were disseminated for Field Review1 between December 2009 and January 2010; and ultimately approved, intact, by the TJC Board of Commissioners2 at its March 12-13, 2010 meeting, to take effect March 31, 2011. This article explores the changes made to the Elements of Performance for MS.01.01.01, including the rationale behind many of the various Elements, and some suggestions for implementation. It also addresses changes to the Standard’s introductory remarks (which are not “scored”3 Elements, but they do reflect the organizational “mind-set” that the surveyors bring with them in conducting institutional surveys) and definitions (these, too, are not scored).

The Revisions

The revisions consist of new or changed:
- Definitions
- Introductory comments
- Elements of Performance 1-36 (which replace current Elements 1-19)

Definitions

Five definitions are key to interpreting the Standard:
- medical staff
- medical staff bylaws
- medical staff, organized
- medical staff, voting members
- rules, regulations and policies

These definitions dissect key distinctions in terminology used throughout the Elements – particularly the differences between the “medical staff,” the “voting medical staff” and the “organized medical staff.” To be sure, the wording of these definitions is sometimes confusing, but, in essence, the medical staff refers to the group of individuals who become “members” of an “organization” (the organized medical staff), some of whom are granted voting rights (the voting members of the medical staff). The definition of “medical staff” tells one that licensed independent practitioners who hold hospital clinical privileges must be members of the organized medical staff, and that others who are privileged through the medical staff processes (i.e., allied health professionals) may be members of the organized medical staff.

Much time was spent in Task Force discussion on the need to include the modifier “organized” when referring to the medical staff – some anecdotally were concerned it inferred or portended something akin to “organized labor,” and others believing it was redundant, and simply meant the “medical staff.” Noting, however, that the phrasing has long appeared in TJC standards, and that it also populates the Medicare Conditions of Participation4 and AMA literature5, as well as some states’ laws and regulations6, the terminology was maintained, and the definition was
developed to describe what the phrasing means for TJC purposes.

The definitions also clarify that the medical staff bylaws may consist of more than one document; that they must be adopted by the voting medical staff (i.e., not the entire medical staff and not the medical executive committee) and approved by the governing body; and that they define the rights and responsibilities of the medical staff, its officers, persons, and groups within the medical staff organization; the self-governance functions of the medical staff; and the medical staff organization’s working relationship with and accountability to the governing body. Other documents – rules, regulations and policies – are also subject to adoption by the organization and approval by the governing body, but as one learns when delving into the Elements themselves, the adoption of these other documents may be effected through a variety of means – i.e., approval of the voting members of the medical staff is not the only way these other documents may be implemented: in some cases, if authorized by the bylaws, approval of these other documents may be delegated to a committee or even a person. The language about these other documents having the force and effect of bylaws was intended to preserve some discretion with respect to where the language suggested that only members of the medical staff were entitled to vote on their bylaws.\textsuperscript{7} The language about these other documents having the force and effect of bylaws was intended to preserve some discretion with respect to where to place certain provisions – e.g., clinical privileges lists – that for other reasons may need to be “deemed” to be bylaws.\textsuperscript{7}

The Introductory Comments

The Standard begins with introductory comments that set the stage for interpreting the Standard and its Elements of Performance. Although these introductory statements are not scored for accreditation purposes, they are important communications of TJC intent. Key introductory remarks include:

• “Self-governance” – At the outset, there is commentary about medical staff self-governance. This is a phrase that has long been part not only of TJC’s lexicon, but also appears in some states’ laws and regulations.\textsuperscript{8} Without diverging into the merits or meaning of the concept,\textsuperscript{9} suffice to say that, in the context of TJC’s medical staff Standard MS.01.01.01, it connotes a level of deference short of autonomy, as clarified in the second introductory paragraph: “To support its work, and its relationship with and accountability to the governing body, the organized medical staff creates a written set of documents that describes its organizational structure and the rules for its self-governance…These documents create a system of rights, responsibilities, and accountabilities….\textsuperscript{10}” not only between the organized medical staff and the governing body, but also between the organized medical staff and its members.

• Collaboration – The importance of collaboration is emphasized throughout the introductory remarks, and is noted to be critical to providing safe, high quality care in the hospital. This statement memorializes a consensus of discussion of the Task Force that when the medical staff, administration, and governing body are at odds, patient care and safety are likely to suffer.

• Governing body responsibility – Notwithstanding the need to collaborate, the introduction clearly acknowledges ultimate governing body responsibility.

• Voting rights – There is a clear acknowledgement that not all members of the medical staff will have voting rights, and that only those with voting rights can adopt and amend the bylaws. This statement clears up ambiguous language that appeared in the ill-fated 2007 MS 1.20 version of the Standard, where the language suggested that all members of the medical staff were entitled to vote on their bylaws.

• “Details” – One of the most troubling features of the 2007 MS 1.20 Standard was TJC’s confusing articulation and micromanagement of what must be in the bylaws, and what could be in other documents. Through a contorted series of explanations and definitions that read like an Escher drawing, TJC had attempted to edict that the requirements involving “processes” as well as the associated procedural details for certain Elements had to be in the bylaws; and that procedural details for other Elements could be in other documents. TJC also tried to explain the difference between a process and a procedural detail. While some of the same conceptual framework remains in the new Standard, TJC has abandoned its attempt to define these terms, and it assured the Task Force that approved the resulting language that it would not micromanage how the hospitals determined what comprises a “detail.”

The resulting comments instruct, in essence: For those Elements that require the medical staff bylaws to establish a process, the basic steps of the process must be described in the bylaws, and details of the process can, if the medical staff wishes, reside in other documents. The introductory comments go no further than that, leading some to fear that, despite what TJC staff has said about this to the Task Force, its on-site surveyors may superimpose their own interpretation as to what is a detail, and what is not. But, assuming that TJC will honor its commitment on this issue, the resulting expectations are relatively straightforward, as further discussed with respect to Element of Performance #3, below.

• Role of the Medical Executive Committee (“MEC”) – The role of the MEC is another issue that many believe contributed to the downfall of the 2007 Standard. Then, the introductory comments seemed to advocate dissonance: “The organized medical staff is \textit{urged} to determine what steps it will take if it does not agree with an action taken by the [MEC]. Such steps might include a process that would allow the organized medical staff, at its discretion, to \textit{extract} and consider an

\[\text{continued on page 12}\]
action by the [MEC] prior to the action becoming effective.” Many felt this undermined the authority and responsibility of the MEC, and would significantly impair the ability to recruit and retain medical staff leaders. While the new Standard has abandoned this strident approach, it does include some provisions that give greater voice to the medical staff and promote accountability of the MEC to the medical staff. Some of these provisions include the above-mentioned articulation of accountability of the organized medical staff to its members; an articulation of the MEC’s accountability to the organized medical staff; and its responsibility to seek out and convey the views of the medical staff to the governing body. While some critics of the new Standard question what this means, and whether it implies that the MEC must poll the medical staff on all decisions, that clearly is not the intent of these unscored introductory comments. Rather, the Task Force intended, and TJC staff has assured it will honor, measures encouraging representation and responsiveness to the pulse of the medical staff. This was deemed, by some, necessary to guard against perceived conscription of the MEC by physicians who are [too] closely aligned with hospital administration or other self-serving interests – e.g., by contracts, employment relationships, or otherwise. The actual measures expected to be implemented in this spirit are described in some of the Elements of Performance (see, e.g., EPs 3, 8, 9, 10, 11, and 20).

• Conflict management – The introductory remarks, and certain of the Elements, address the need for effective conflict management provisions, but of note, the specifics of these provisions are not articulated in the Standard. Rather, the comments punt to the Leadership Standard, where conflict management among various constituencies is addressed. There, too, however, there is nothing specific prescribed. Rather, at Leadership Standard LD.02.04.01, Element of Performance #4, we are told that conflict management involves such common-sense measures as:
  – Meeting with involved parties as early as possible;
  – Gathering information regarding the conflict;
  – Working with the parties to manage and, when possible, resolve the conflict; and
  – Protecting the safety and quality of care.

Of particular note, it does not dictate any particular conflict management process or outcome – leaving to the medical staff and hospital leadership discretion to develop means and measures that work for the circumstances at hand.

The Elements of Performance

As noted above, there are now 36 EPs. They have been generally reorganized to group together related elements, as follows.

• EPs 1 – 11 deal with the adoption, amendment, and general content of Medical Staff bylaws, rules and regulations, and policies.
• EPs 12 – 16 cover Medical Staff structure, appointment, privileges, and duties.
• EP 17 deals with voting rights.
• EPs 18 – 19 describe the selection and removal of officers.
• EPs 20-23 deal with the MEC.
• EPs 24 – 25 further describe requirements relating to adoption and amendment of bylaws, rules and regulations, and policies.
• EPs 26 – 27 deal with credentialing.
• EPs 28-33 deal with discipline.
• EPs 34-35 describe fair hearing requirements.
• EP 36 describes Medical Staff department responsibilities.

The Standard

The Standard itself is stated next, and it has not changed. It simply reads: “medical staff bylaws address self-governance and accountability to the governing body.” How the Standard is to be interpreted and scored is delineated in the Elements of Performance.

continued on page 22
### THE ELEMENTS OF PERFORMANCE (EP)

<table>
<thead>
<tr>
<th>Current EP</th>
<th>March 2011 EP*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The organized medical staff develops medical staff bylaws.</td>
<td>1. The organized medical staff develops medical staff bylaws, rules and regulations, and policies.</td>
<td>The new wording extends beyond just the bylaws, to include rules and regulations and policies. Some commentators have suggested that this wording necessarily excludes hospital management in these processes; however, there is no express or intended exclusion of cooperative development of any of these important documents. Indeed, the Standard’s introductory remarks, stressing the importance of collaboration, should be interpreted in this vein. The bylaws should include a provision that articulates a role for all affected parties, including, when appropriate, hospital administration and governing body.</td>
</tr>
<tr>
<td>2. The medical staff bylaws are adopted and amended by the medical staff.</td>
<td>2. The organized medical staff adopts and amends medical staff bylaws. <strong>Adoption or amendment of medical staff bylaws cannot be delegated.</strong> After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the Leadership chapter for requirements regarding the governing body’s authority and conflict management processes. See Element of Performance 17 for information on which medical staff members are eligible to vote.)</td>
<td>This change limits the authorization to adopt any bylaws or bylaw amendments: only the “organized medical staff” may do this – and by linking this to EP 17, the intent is that only voting members of the medical staff can effectuate adoption or amendment on behalf of the organized medical staff. Some hospitals have a practice of submitting proposed bylaws or amendments to hospital administration and/or the governing body for review and comment prior to adoption. Nothing in the new language precludes this practice – and in the spirit of collaboration, there’s no reason to discontinue this practice, as it is an effective way to avoid moving into a “conflict management” framework. However, it is clear that the governing body does not act upon (i.e., approve or disapprove) a proposed bylaw or amendment until after it has been approved by the voting member of the medical staff.</td>
</tr>
<tr>
<td>3. The governing body approves and complies with the medical staff bylaws.</td>
<td>See revised EP 2 regarding approval. 7. The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.</td>
<td>The wording changes here are intended to convey that the governing body retains discretion whether or not to approve medical staff bylaws; and also address some expressed concerns of the Task Force that the current language is overbroad in that the governing body members are not members of the medical staff and as such are not expected to “comply” with the bylaws. As revised, the expectation is straightforward: the governing body will uphold those provisions that it has approved.</td>
</tr>
</tbody>
</table>

*Bolded text reflects emphasis added by the author, and is generally intended to highlight language that is discussed further in the Comments column. Specific implementation suggestions are noted in *bold italics* and preceded with an *¢*.

continued on page 14
<table>
<thead>
<tr>
<th>THE ELEMENTS OF PERFORMANCE (EP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current EP</strong></td>
</tr>
<tr>
<td><strong>4.</strong> The organized medical staff enforces and complies with the medical staff bylaws.</td>
</tr>
<tr>
<td><strong>5.</strong> The medical staff bylaws, rules and regulations, and policies and the governing body bylaws do not conflict.</td>
</tr>
<tr>
<td>The medical staff bylaws include the following... [see also EP-19].</td>
</tr>
</tbody>
</table>

For those Elements of Performance 12 through 36 that require a process, the medical staff bylaws include at a minimum the basic steps, as determined by the organized medical staff and approved by the governing body, required for implementation of the requirement. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the Leadership chapter for requirements regarding the governing body’s authority and conflict management processes.)
THE ELEMENTS OF PERFORMANCE (EP)

<table>
<thead>
<tr>
<th>Current EP</th>
<th>March 2011 EP*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.g.:</td>
<td>EP 10 – requires a process to manage conflicts. (In California, for example, most hospitals already have some conflict resolution provisions(^1) that can be readily adapted.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EP- 14 – a process for privileging and reprivileging is already sufficiently addressed in most hospitals’ bylaws (i.e., even those who include more detailed provisions in the rules generally have the basic steps outlined in the bylaws).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Likewise, most hospitals’ bylaws already do address at least the “basic steps” of:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EPs 18 &amp; 21 – the processes for selection and removal of officers and MEC members;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EPs 24 &amp; 25 – the processes for adopting bylaws, rule and regulations, and policies;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EPs 26 &amp; 27 – the processes for credentialing and appointments;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EPs 31, 32, 33 – the processes for automatic suspension, summary suspension, and other discipline;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EP 34 – hearings and appeals (although some hospitals have moved these into separate manuals).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➔ For those hospitals, compliance could be achieved by either including a basic outline of the key steps in the main body of the bylaws, or by designating the separate hearing and appeal manual as a “bylaws” document (e.g., another “volume” or “part” – note the definition of “bylaws” recognizes that multiple documents may be involved; but also note, if they are “bylaws” they can only be adopted by the voting medical staff, not by the MEC). (see additional comments accompanying EP 15.)</td>
<td></td>
</tr>
<tr>
<td>6. The definition of the medical staff structure.</td>
<td>12. The structure of the medical staff. (CMS Condition of Participation [“CoP”] requirement).</td>
<td>The revised wording is more descriptive of what is required (by CMS), and what actually appears in most hospitals’ medical staff bylaws. ➔ If not already in the bylaws, a summary description of the medical staff organization would help assure compliance.</td>
</tr>
</tbody>
</table>

*continued on page 16*
### THE ELEMENTS OF PERFORMANCE (EP)

<table>
<thead>
<tr>
<th>Current EP</th>
<th>March 2011 EP*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. The definition of the criteria and qualifications for appointment to the</td>
<td>13. Qualifications for appointment to the medical staff. (CMS CoP requirement).</td>
<td>Here, again, the revised wording is more descriptive of what is actually required.</td>
</tr>
<tr>
<td>medical staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. When departments of the organized medical staff exist, the definition of</td>
<td>36. If departments of the medical staff exist, the qualifications and roles and</td>
<td>No substantive changes were made to these requirements.</td>
</tr>
<tr>
<td>the qualifications and roles and responsibilities of the department chair,</td>
<td>responsibilities of the department chair, which are defined by the organized</td>
<td></td>
</tr>
<tr>
<td>including the following: Qualifications (etc.) and Roles and Responsibilities (etc.)</td>
<td>medical staff and include the following: Qualifications (etc.) and Roles and Responsibilities (etc.)</td>
<td></td>
</tr>
<tr>
<td>9. A description of the medical staff executive committee’s function, size,</td>
<td>18. The process, as determined by the organized medical staff and approved by</td>
<td>While more detailed, the only substantive changes are those reflected in the highlighted language.</td>
</tr>
<tr>
<td>and composition, and of the methods for selecting and removing its members</td>
<td>the governing body, by which the organized medical staff selects and/or elects and removes the medical staff officers.</td>
<td>Some have expressed concern that this language undermines the inherent authority of the MEC.</td>
</tr>
<tr>
<td>and the organized medical staff officers.</td>
<td>19. A list of all of the officer positions for the medical staff.</td>
<td>➤ This concern can be ameliorated by careful drafting of medical staff bylaws that include a broad grant of authority and discretion to the MEC to act on behalf of the medical staff on all matters, so long as it does act in a manner that is not inconsistent with the medical staff bylaws. This grant of authority should empower the MEC to take actions that might not be specifically articulated in the bylaws (because bylaws cannot reasonably anticipate every decision the MEC will face), subject only to a general constraint of a consistent purpose.</td>
</tr>
<tr>
<td></td>
<td>20. The medical executive committee’s function, size, and composition, as</td>
<td>The process for selecting and removing officers is generally covered within the medical staff bylaws.</td>
</tr>
<tr>
<td></td>
<td>determined by the organized medical staff and approved by the governing body; the authority delegated to the medical executive committee by the organized medical staff to act on the medical staff’s behalf; and how such authority is delegated or removed.</td>
<td>➤ If these matters are relegated to other documents, the bylaws should at least outline the basic steps of the process.</td>
</tr>
<tr>
<td></td>
<td>21. The process, as determined by the organized medical staff and approved by</td>
<td>See above comments re MEC authority. Some have expressed concerns that this limits the MEC’s inherent authority.</td>
</tr>
<tr>
<td></td>
<td>the governing body, for selecting and/or electing and removing the medical</td>
<td>➤ This concern can best be ameliorated by a bylaws provision that grants broad authority and discretion to the MEC.</td>
</tr>
<tr>
<td></td>
<td>executive committee members.</td>
<td></td>
</tr>
<tr>
<td>10. That the medical staff executive committee includes physicians and may</td>
<td>22. That the medical executive committee includes physicians and may include other practitioners and any other individuals as determined by the organized medical staff.</td>
<td>No substantive changes.</td>
</tr>
<tr>
<td>include other licensed independent practitioners.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. That the medical staff executive committee is empowered to act for the</td>
<td>23. That the medical executive committee acts on the behalf of the medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff.</td>
<td>See above comments re MEC authority. Some have expressed concerns that this limits the MEC’s inherent authority.</td>
</tr>
</tbody>
</table>
## THE ELEMENTS OF PERFORMANCE (EP)

<table>
<thead>
<tr>
<th>Current EP</th>
<th>March 2011 EP*</th>
<th>Comments*</th>
</tr>
</thead>
</table>
| 12. A description of indications for automatic suspension or summary suspension of a practitioner’s medical staff membership or clinical privileges. | 28. Indications for automatic suspension of a practitioner’s medical staff membership or clinical privileges.  
29. Indications for summary suspension of a practitioner’s medical staff membership or clinical privileges. | No substantive changes.                                                      |
| 13. A description of when automatic suspension or summary suspension procedures are implemented. | 31. The process for automatic suspension of a practitioner’s medical staff membership or clinical privileges.  
32. The process for summary suspension of a practitioner’s medical staff membership or clinical privileges. | Here the only substantive change relates to the “process” language, which, as noted above, requires a description of the “basic steps” to be included in the bylaws.  
For those hospitals that do not already include these in the bylaws, a summary description of the “basic steps” should achieve compliance – and TJC has indicated it will not second-guess the medical staff’s own determination of the level of detail required or what actually comprises an “associated detail” that can be in the rules or policies. |
| 14. A description of the mechanism to recommend medical staff membership and/or termination, suspension, or reduction in privileges. | 30. Indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges.  
33. The process for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges. | EP 30 will need to be carefully addressed so that MECs and governing bodies retain discretion to address matters not specifically itemized in the bylaws.  
Additionally, if the medical staff typically covers these matters in a separate document, see comments relating to new EP 3, above, for suggestions to achieve compliance. |
| 15. A description of the mechanism for a fair hearing and appeal process. | 34. The fair hearing and appeal process … which at a minimum shall include:  
• The process for scheduling hearings and appeals.  
• The process for conducting hearings and appeals.  
35. The composition of the fair hearing committee. | See comments relating to new EP 3, above, for suggestions to achieve compliance (when hospitals have their fair hearing plans set out in separate documents).  
As to the level of detail necessary to achieve compliance with the “basic steps” requirement, consider the level of detail specified in the Health Care Quality Improvement Act of 1986 for the key elements of a presumably fair hearing. One would expect a comparable level of detail would suffice. |
| 16. A description of the credentialing process. | 26. The process for credentialing and recredentialing licensed independent practitioners, which may include the process for credentialing and re-credentialing other practitioners. | See comments relating to new EP 3, above, for suggestions to achieve compliance (when hospitals have their credentialing policies set out in separate documents). |

continued on page 18
### THE ELEMENTS OF PERFORMANCE (EP)

<table>
<thead>
<tr>
<th>Current EP</th>
<th>March 2011 EP*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. A description of the privileging process (including temporary and disaster privileging).</td>
<td>14. The process for privileging and re-privileging licensed independent practitioners, which may include the process for privileging and re-privileging other practitioners. (CMS CoP requirement).</td>
<td>No substantive change.</td>
</tr>
<tr>
<td>18. A description of the process of appointment to membership of the medical staff.</td>
<td>27. The process for appointment and re-appointment to membership on the medical staff.</td>
<td>No substantive change.</td>
</tr>
<tr>
<td><strong>This EP is not in effect at this time: 19.</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• When administrative procedures, associated with processes described in the medical staff bylaws for corrective actions, fair hearing and appeal, credentialing, privileging, and appointment (EPs 12-18), are described in medical staff governance documents that supplement the bylaws (i.e., rules and regulations, and policies).</td>
<td>See EP 3.</td>
<td>See comments above relating to new EP 3.</td>
</tr>
<tr>
<td>• The mechanism for the approval of the administrative procedures, which may be different from that for adoption and amendment of the medical staff bylaws, is described in the medical staff bylaws.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Criteria to identify those administrative procedures that can be in the supplementary documents are described in the bylaws, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The administrative procedures are approved by both the medical staff and the governing body through the bylaws-described mechanism.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Additional clarification of this EP, communicated by way of an TJC “E-Mail Blast” in the fall of 2004 significantly confused and ignited the field and contributed to the backlash that led to formation of the Task Force. The Joint Commission on Accreditation of Healthcare Organization, Clarification to Hospital Requirements for MS.1.20, EP 19, October 21, 2004 (webposting originally at http://www.jcrinc.com/8187, has expired).
## THE ELEMENTS OF PERFORMANCE (EP)

<table>
<thead>
<tr>
<th>Current EP</th>
<th>March 2011 EP*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>No current JC standard or CMS CoP.</td>
<td>8. The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body.</td>
<td>Some have expressed concern that EP 8 undermines the authority of the MEC, and that EP 9’s requirement for prior communication to the medical staff unduly hampers the MEC and is inefficient.</td>
</tr>
<tr>
<td></td>
<td>9. If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the medical executive committee. If the medical executive committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff. This Element of Performance applies only when the organized medical staff, with the approval of the governing body, has delegated authority over such rules, regulations, or policies to the medical executive committee.</td>
<td>The language reflects a compromise [several Task Force members initially were opposed to any rulemaking by the MEC] that, coupled with the provisions of EPs 10 and 11, are believed to be generally workable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TJC does not prescribe any of the specifics as to how these provisions are to be effectuated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The bylaws should state how the organized medical staff can go about proposing a bylaw, rule, or policy (or amendments thereto) For example, setting a minimum threshold of support necessary to get a matter out for vote – perhaps by a petition signed by X percent of the voting member. The number established should be realistic in light of the size of the medical staff. A large medical staff might set the threshold at 10 percent; whereas a smaller staff might want a higher threshold, e.g., 25 percent.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• With respect to MEC adoption or amendment of rules and regulations, TJC does not dictate how the MEC is expected to communicate to its members. One practical way to meet this requirement is to maintain a medical staff/executive committee website, and post pending changes prior to adoption. To be sure, this additional step may result in some delays in moving matters through the MEC, but note: it only applies to rules and regulations, not to policies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Also note also, the MEC still has the ability to adopt policies without prior notification, so long as they communicate the adopted-policy to the medical staff (once the policy has been approved by the governing body).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Here, too, use of a website to communicate new policies would be an effective way to implement this requirement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(See additional comments regarding EPs 10 and 11).</td>
</tr>
</tbody>
</table>

continued on page 20
### THE ELEMENTS OF PERFORMANCE (EP)

<table>
<thead>
<tr>
<th>Current EP</th>
<th>March 2011 EP*</th>
<th>Comments*</th>
</tr>
</thead>
</table>
| No current JC standard or CMS CoP. | 10. The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication. If necessary, a revised amendment is then submitted to the governing body for action. **Note:** Please see the Introduction to this standard for further discussion of the relationship of the voting members of the organized medical staff to the medical executive committee. | The TJC does not direct what the conflict management process must be, nor does it direct how the conflict is to be resolved, giving medical staffs significant discretion to craft provisions that will work for their setting.  
> **Borrowing from the provisions in the Leadership standard, the process should involve these four key features:**  
  - Meeting with involved parties as early as possible;  
  - Gathering information regarding the conflict;  
  - Working with the parties to manage and, when possible, resolve the conflict; and  
  - Protecting the safety and quality of care.  
> **The bylaws should also include provisions that direct a reasonable minimum number of medical staff members who would be required to initiate a formal conflict resolution process on its behalf (i.e., this process is not intended to address individual grievances), as well as a simple forum, written or by meeting, for articulating the issues, and a final decision authority (which, in light of the ultimate legal responsibility of the governing body, would generally be the governing body).**  
11. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the medical executive committee, if delegated to do so by the voting members of the organized medical staff, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action. Many hospitals currently have a provision allowing the MEC to adopt emergency provisions – be they bylaws, rules, or policies. This EP was vigorously debated by the Task Force, and reflects a compromise that preserves emergency rule-making authority, but does not authorize emergency amendment of medical staff bylaws. This EP also calls for a conflict resolution process; but it does not dictate the outcome of that process, so medical staff’s have considerable discretion to craft a workable process.  
> **As suggested above, key elements of any such process should include:** clearly stating what the minimum number of medical staff members would be required to invoke the conflict resolution process, and clearly describing how impasses would be resolved – keeping in mind the ultimate responsibility of the governing body to approve [or disapprove] proposed bylaws, rules, and policies. |
<table>
<thead>
<tr>
<th>Current EP</th>
<th>March 2011 EP*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. A statement of the duties and privileges related to each category of the medical staff. (CMS CoP requirement).</td>
<td>15. The roles and responsibilities of each category of practitioner on the medical staff (active, courtesy, and so forth). (CMS CoP requirement).</td>
<td>Most bylaws already include this. Some, however, cover these provisions in the rules and regulations. EP 3 instructs that the requirement itself must be addressed in the bylaws, but details may be housed in other documents. <strong>If necessary, a summary chart of medical staff categories and key rights and responsibilities can be added to the bylaws, with more detailed provisions covered in the rules and regulations.</strong></td>
</tr>
<tr>
<td>20. Requirements for completing and documenting medical histories and physical exams. The medical history and physical exam are completed and documented by a physician, an oromaxillofacial surgeon, or other qualified individual in accordance with state law and hospital policy. (CMS CoP Requirement).</td>
<td>16. Requirements for performing medical histories and physical examinations, in accordance with law and regulation. (CMS CoP Requirement).</td>
<td>This Medicare CoP causes some consternation because of the level of detail that is typically involved in a hospital’s H&amp;P recording requirements. However, the language “in accordance with law or regulation” is intended to modulate what must be in the bylaws. Most state laws and regulations do not require H&amp;P requirements to be stated in the bylaws; and the Medicare CoP only specifically requires articulation of provisions regarding who may perform H&amp;P and the timeframes for completion of the H&amp;P. Other provisions detailing the content of the H&amp;P are not required by law to be stated in the bylaws, and thus can still be housed in rules and regulations or policies.</td>
</tr>
<tr>
<td>17. Those members of the medical staff who are eligible to vote.</td>
<td></td>
<td>Most bylaws already include this.</td>
</tr>
<tr>
<td>19. A list of all the officer positions for the medical staff.</td>
<td></td>
<td>Most bylaws already include this.</td>
</tr>
<tr>
<td>24. The process for adopting and amending the medical staff bylaws.</td>
<td></td>
<td>Most bylaws already include this.</td>
</tr>
<tr>
<td>25. The process for adopting and amending the medical staff rules and regulations, and policies.</td>
<td></td>
<td>Most bylaws already include this.</td>
</tr>
</tbody>
</table>
MS.01.01.01 The Joint Commission’s Standard for Medical Staff Bylaws
continued from page 12

Concluding Remarks

Clearly there is much room for interpretation with this Standard and its Elements of Performance. While the Task Force strove to clarify the overall intent and content, the wording is less than perfect. In that regard, and in this author’s opinion, it reflects a typical work-product of a committee, where differing points of view, differing points of emphasis, and differing styles are all quilted together into a final product. The Task Force recognized that, in the end, some provisions could benefit from further wordsmithing, but it also recognized the importance of stopping. Every time the Task Force revisited a section, new issues arose, and new discussions ensued. In the final analysis, these changes reflect what the Task Force members agreed; though a compromise, is a significant improvement over what was initially presented for the Task Force’s “implementation” assistance.

Finally, in moving from 19 to 35 Elements of Performance, one might reasonably conclude that TJC is getting more, rather than less, prescriptive about the operation of its accredited hospitals’ medical staffs. However, a careful evaluation of the changes reveals a clear shift in intent – away from the micromanagement reflected in the 2007 iteration of the Standard and toward discretion for each hospital and medical staff to craft what will work for them. That said, there are areas where the authority of the MEC has been constrained, and the authority of the organized medical staff has been expanded. How significantly these changes will actually impact the dynamics of medical staff leadership, medical staff operations, and hospital/governing body/medical staff relations depends, in large part, on how the changes are implemented. Careful drafting of medical staff bylaws can preserve leadership authority and discretion, while maintaining the all-around accountability that the Standard is intended to promote. Then, it will be up to TJC to follow through with the assurances made to the Task Force, and, in particular, to assure that its surveyors are held to implementing the Standard in the manner intended.

Ann O’Connell is a partner in the Sacramento office of Nossaman, LLP, and a 1977 graduate of University of the Pacific, McGeorge Law School. For the past 33 years, her practice has focused exclusively on healthcare law. Her areas of expertise include: medical staff bylaws; credentialing of physicians and allied health professionals; peer review and disciplinary proceedings; as well as a variety of contracting, regulatory, and general healthcare legal issues. Ms. O’Connell frequently serves as a hearing officer in medical staff hearings; has served as Vice-Chair and Chair of American Health Lawyers Association’s Medical Staff, Credentialing, and Peer Review Practice Group; and is a Past-President of the California Society for Healthcare Attorneys. In addition to editing the California Hospital Association’s Model Medical Staff Bylaws for many years, she has co-authored and edited the American Health Lawyers’ Association’s Peer Review Hearing Guidebook (2008). From 2008 - 2010, Ms. O’Connell served on The Joint Commission’s MS.1.20 (MS.01.01.01) Task Force, representing California Hospital Association. She may be reached at aocconnell@nossaman.com.

Endnotes

1 Field Review is a step in the process by which TJC generally promulgates new Standards and Elements of Performance. Proposed Standards and EPs are published in draft form for comment by affected providers and other interested parties. Comments received during Field Review sometimes result in changes to the proposed Standards and EPs or may inform and affect the way the surveyors conduct their evaluations once the Standards and EPs are finally adopted. For more background on TJC, see http://www.jointcommission.org/aboutus/.

2 The Board of Commissioners is TJC’s governing body. According to information posted on TJC’s website [http://www.jointcommission.org/AboutUs/Fact_Sheets/board_commissioners.html], “Board members have diverse experience in health care, business, and public policy. The board consists of 29 voting members, including physicians, administrators, nurses, employers, a labor representative, health plan leaders, quality experts, ethicists, a consumer advocate and educators.”

3 Scoring refers to the numeric values given to the organization’s level of compliance with any particular element. The scoring of EP compliance determines an organization’s overall compliance with a standard. EPs are scored using the following scale: (0) insufficient compliance, (1) partial compliance, (2) satisfactory compliance, and (NA) not applicable. Scoring of each EP consists of two components: compliance with the requirement and compliance with the track record. For a full explanation of the scoring methodology see 2010 Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH), Joint Commission Resources (2010).

4 The Medicare Conditions of Participation are the requirements that healthcare facilities must meet to be eligible to participate in the Medicare program. The Medicare Condition regarding the medical staff appears at 42 C.F.R. 482.22, and requires that “[t]he hospital must have an organized medical staff....” Beyond that, there is little guidance as to what that means, other than that “[t]he medical staff must be well organized....” “[t]he medical staff must be organized in a manner approved by the governing body,” “[t]he responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor....” and “[t]he bylaws must...[describe] the organization of the medical staff.”

5 Indeed, the AMA has an entire “Organized Medical Staff Section,” that, according to its on-line mission statement “provides a direct and ongoing relationship between the AMA and medical staff organizations. The Section debates issues and develops policy ....” However, no definition, per se, was noted in these on-line materials. [http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section/about-us/purpose-mission-commitment.shtml]

6 For example, in California, hospital licensing regulations require that “[e]ach hospital shall have an organized medical staff responsible to the governing body for the quality of care rendered to patients.” 22 California Code of Regulations § 70703(a).

7 For example, the Medicare Conditions of Participation require that the “bylaws” describe the privileges of the members of the medical staff, and CMS has published an interpretation
to the effect that this is deemed to apply to clinical privileges. See CMS Letter, November 12, 2004, to State Survey Agencies, Ref: S&C-05-04, available at: https://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter05-04.pdf. Most hospitals describe their clinical privileges requirements in supplemental rules and policies. A bylaws provision that recognizes these supplemental rules and policies to have the force and effect of bylaws may help establish compliance with this CMS interpretation.

8 See, e.g., California Business and Professions Code section 2282.5 and 22 California Code of Regulations, section 70701(F).

9 No doubt, there are varying interpretations of the meaning of “self-governance,” and in particular of the level of “independence” it connotes. Having its origins in a deference to “organized medicine”’s maintaining control of the professional aspects of medical practice (i.e., those aspects for which medical training, professional judgment, and licensure are needed), it has morphed over the years into what some believe to be a more political concept that involves primarily a series of rights vis-à-vis the hospital (even more so than professional responsibilities relating to care of patients). This author has opted not to divert the focus of this article into the larger discussion of the meaning or pertinence of self-governance in today’s hospitals. For more on how the American Medical Association perceives – and advocates – “self-governance,” see, e.g., Physician’s Guide to Medical Staff Organization Bylaws,” (Fourth Edition, 2010), American Medical Association. For more on the pertinence of self-governance in the contemporary hospital, see the widely disseminated letter from Brian M. Peters and Robin Locke Nagele to Robert A. Wise, M.D., October 5, 2009, re: “White Paper Comment re: Working Draft of Possible Replacement for Standard MS.01.01.01 (formerly MS.1.20) as of March 27, 2009.” The latter is a provocative bit of work, developed by attorneys Peters and Nagele in specific response to MS.01.01.01, and calling upon TJC to, in essence, stop the train and start looking at a new paradigm for hospital/medical staff relations. While TJC opted to complete what it had started with MS.01.01.01 (and more importantly at least for the short term, to rectify the problems with the 2007 version of MS.1.20), there is clearly more work to be done. With healthcare reform now actually under way – calls for clinical integration, more cost cutting, more individuals to serve – there will be more need than ever not only for a collaborative relationship among hospitals and their medical staffs, but also for leadership within the medical staffs.

10 MS.01.01.01 (Rationale), http://e-dition.jcrlinc.com/Frame.aspx.

11 Mandated in by California Business and Professions Code § 2282.5.

12 42 U.S.C. § 11101, et seq. This Act established reporting requirements relating to certain peer review actions, and established immunities for actions taken in accord with certain standards as articulated in the Act.

The Editorial Board provides expertise in specialized areas covered by the Section. Individual Board members were appointed by the Interest Group Chairs and Editor Marla Durben Hirsch. If you are interested in submitting an article to the magazine, you may contact one of the Editorial Board members or Ms. Hirsch. With the establishment of the Editorial Board, the Section strengthens its commitment to provide the highest quality analysis of topics in a timely manner.

Marla Durben Hirsch
Potomac, Maryland
301/299-6155
mdhirsch@comcast.net

Lisa L. Dahm
South Texas College of Law
Houston, TX
eHealth, Privacy & Security
Editorial Board Chair
713/646-1873
ldahm@stcl.edu

Howard D. Bye
Stoel Rives LLP
Seattle, WA
Employee Benefits & Executive Compensation
206/366-7631
hdbye@stoel.com

Michael A. Clark
Sidley Austin Brown & Wood
Chicago, IL
Tax & Accounting
312/853-2173
mclark@sidley.com

Benjamin Cohen*
Office of Hearings
Dept. of Health & Human Services
Baltimore, MD
Payment & Reimbursement
410/786-3169
benjamin.cohen@hhs.gov
* serving in his private capacity, not as a representative of CMS or HHS, and no endorsement by them should be implied.

Marcelo N. Corpuz III
Walgreens Health Services
Deerfield, IL
Business and Transactions
630/964-8228
marcelo.corpuz@walgreens.com

Jason W. Hancock
Hospital Corporation of America
Brentwood, TN
Health Care Facility Operations
615/372-5480
jason.hancock@hackeslawcare.com

Bruce F. Howell
Bryan Cave
Dallas, TX
Medical Research, Biotechnology & Clinical Ethical Issues
214/721-8047
bruce.howell@bryancaive.com

Charles M. Key
Wyatt, Tarrant & Combs, LLP
Memphis, TN
Liaison to the Publications Committee
901/537-1133
ckey@wyattfirm.com

Rakel M. Meir
Tufts Health Plan
Watertown, MA
Managed Care and Insurance
617/923-5841
Rakel_Meir@tufts-health.com

Monica P. Navarro
Frank, Haron, Weiner and Navarro
Troy, MI
Physician Issues
248/390-2323
mnavarro@fhwnlaw.com

C. Elizabeth O’Keeffe
Dartmouth-Hitchcock Medical Center
Lebanon, NH
Public Health & Policy
603/650-5361
Celeste.E.O’Keeffe@hitchcock.org

Leonard M. Rosenberg
Garfunkel, Wild & Travis, PC
Great Neck, NY
Healthcare Litigation & Risk Management
516/393-2260
Irosenberg@gwtrlaw.com

Andrew B. Wachler
Wachler & Associates
Royal Oak, MI
Healthcare Fraud & Compliance
248/544-0888
awachler@wachler.com