



California Medical Association
Physicians dedicated to the health of Californians

January 27, 2010

The Joint Commission
Division of Standards & Survey Methods
MS.01.01.01 Field Engagement
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

Re: Field Review for Standard MS.01.01.01 (Formerly MS.1.20)

To Whom It May Concern:

The California Medical Association (CMA) submits these comments to support in large part the proposed Standard MS.01.01.01 which is currently subject to field review. However, CMA does believe that aspects of the proposal run counter to the concept of medical staff self-governance and therefore urges that a few additional modifications be taken to improve patient care. Nonetheless, CMA believes the proposal is a vast improvement over the existing standard and urges that it not be modified in a manner that dilutes a medical staff's ability to protect patients through self-governance.

The Joint Commission has demonstrated leadership in protecting quality patient care for patients throughout the nation. There is no question that in today's environment, hospitals and medical staffs face growing tensions due to various economic and legal pressures.¹ As a result, policymakers have been urged to develop policies that achieve stronger alignment through increased communication.² Proposed MS.01.01.01 is that driver. It will improve patient care by (1) opening channels of communication between the hospital and medical staff, (2) involving all appropriate parties in the decisional process for important patient protection policies, and (3) making information more accessible. The proposed standard recognizes that those physicians who are expected to maintain quality of care in the hospital have the necessary input, early on, to ensure that patients are protected. The process contemplated is not only efficient and fair, but also consistent with every national and state effort to demand increased transparency and good governance to maintain the public trust.

¹ Robert A. Berenson, et al., "*Hospital-physician relations: Cooperation, competition, or separation?*" Health Affairs, Web Exclusive, December 2006.

² *Id.*

As currently proposed, Standard MS.01.01.01 will provide some increased protections for patients in today's strained environment and the benefits to be achieved by this Standard by far outweigh any incidental costs that may be required for compliance. For example, the Standard will:

- Protect patients from inappropriate hospital intrusions by non-clinicians in medical decision-making and medical staff self-governance that, without the Standard (and as requested below, modified to delete the authorization for non-clinicians to serve on the medical executive committee) will likely continue to occur;
- Be easily achievable, without the expenditure of undue resources. Indeed, CMA's own Model Medical Staff Bylaws have already been amended and distributed with minimal effort and cost;³ and
- Create a culture of patient safety throughout the entire medical staff, as opposed to in a few medical staff leaders.

Recommendations for Improvement

While CMA is supportive of the direction the Joint Commission has proposed for MS.01.01.01, CMA believes a number of the changes are not in the best interests of patient welfare and urges that they be modified as requested below.

First, CMA is troubled by proposed EP4—as it could be interpreted in a manner inconsistent with the concept of self-governance. That proposed Element of Performance merely requires "compatibility" between medical staff and hospital bylaws and policies. The current Element of Performance prohibits "conflict" – a concept that we believe better protects self-governance. Indeed, CMA policy goes further to provide that any hospital policy that conflicts with those of the medical staff shall not be given effect and shall not be applied to the medical staff or its individual members. *See* 2010 CMA Model Medical Staff Bylaws, ¶15.5. We urge that current EP5 be retained.

Second, CMA is concerned about the change from current EP4 which requires that the medical staff enforce and comply with the medical staff bylaws to proposed EP6, which reads that the medical staff enforces the "bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances, and taking action in others." CMA does not understand the rationale supporting this proposed change. For example, while it could be interpreted as providing a fuller description of the expectation of Standard, it could also be interpreted as limiting a medical staff's ability to challenge instances where the governing body has infringed on medical staff self-governance. *See*, for example, California Business &

³ We are happy to provide the Joint Commission with a full copy of CMA's Model Medical Staff Bylaws upon request.

Professions Code §2282.5. The added "definition" here only serves to add confusion and CMA urges that the existing EP be retained.

Third, with respect to proposed EP11, we do not believe that any amendments, even those that are **truly** necessary to comply with law or regulation, and needs to be done on an "urgent" basis, should be made without prior medical staff notification. Virtually anything could be considered to be "urgent," theoretically justifying an "amendment," and this is a bad precedent for the Joint Commission to take, particularly since what is at issue are documents that are designed largely for procedural details. Further, even assuming such "urgent" authority were needed (which we seriously question), the medical staff should have notification contemporaneously with the notification to the Medical Executive Committee, with the ability to ratify or modify the amendment, as appropriate.

Finally, we are concerned about the authorization to include "other individuals" in the medical executive committee. *See* proposed EP22. This is not required by Medicare law and could result in the weakening of the medical staff to the extent that the "other individuals" do not place patient care interests first and foremost. We urge that this language be deleted.

Draft MS.01.01.01 Significantly Improves Patient Protection

CMA is aware that the Joint Commission has received comments critical of the public safety improvements to be made to MS.01.01.01 and of the traditional medical staff model generally. The solution they seek is an environment fraught with the potential for substandard care, ambiguity and distrust due to centralized decision-making. CMA urges the Joint Commission to retain its commitment to protect patients through a medical staff that is truly self-governing and transparent. Any retreat from its current patient-protective stance will be a tremendous step backwards in efforts to improve quality of care.

Little needs to be said as to why ensuring that individual medical staff members should have a voice protects patients. Improved participation through earlier and more productive involvement will yield better results. Particularly since it is the medical staff's responsibility to assure that proper standards of medical care and ethical practices are established and maintained by the medical staff itself, medical staff members should have a say to ensure that they are able to fulfill their mission. Proposed MS.01.01.01., therefore, provides transparency that is so necessary to enhance effective operation and oversight.

With the proliferation of cost-containment measures, hospitals have found it increasingly necessary to exert control over physicians' use of hospital services.⁴ There are dangerous signs that hospitals, in an effort to reduce costs and increase revenues, are inappropriately interfering

⁴ *See* Craig W. Dallon, "Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions," 73 Temp.L.Rev. 597 (2000).

in clinical issues, usurping the role of physicians and their medical staffs to provide quality care. These actions have resulted in or have the potential to result in patient harm. For example:

- In Redding, California, despite the medical staffs' objections to the hospital that there was inadequate peer review over cardiac services (where the physicians in charge of those services were "heavy admitters" and also financially tied to the hospital), substandard and unnecessary cardiac procedures were performed on more than 700 patients.⁵
- Small California community hospitals have been taken over by a for-profit chain, Prime Healthcare, whose business strategies include unilaterally imposed "medical oversight and management programs" to reduce (potentially inappropriately) length of stays.⁶ Significant concerns have been raised that patients in these hospitals are placed in jeopardy not only because of the hospitals' "medical management" but also the possibility of being turned away due to their uninsured status.⁷
- A San Diego physician has proven to a court that he had shown a probability of prevailing on the merits of his claim that he was retaliated against by a hospital as a result of his advocacy for patient care.⁸ In this case, despite his order that his trauma patient be transferred to another hospital with a pelvic specialist, without his knowledge, the patient had surgery at the initial hospital, which was unsuccessful. That patient was later required to undergo another surgery by the specialist at the other hospital.
- In Ventura County, a hospital unilaterally imposed a "conflict of interest" policy upon its medical staff, without regard to quality of care, disenfranchising well-

⁵ As a result, among other things, the hospital's owner, Tenet Healthcare, paid over \$60 million to the Federal Government to settle federal fraud claims, and \$395 million for patients to settle their civil tort claims. *See* BNA Health Law Reporter, "Prosecutors Reach Overall Settlement of Allegations of Unneeded Cardiac Surgery," November 17, 2005; *see also* Regina Cabral Jones, "Chapter 683: Extending Whistleblower Protections to Members of the Medical Staff of Health Facilities," 39 McGeorge L.Rev. 519 (2008).

⁶ *See for example, "Effect of Prime Healthcare Service's Acquisition of Paradise Valley Hospital on the Accessibility and Availability of Healthcare Services"*, Prepared for the Office of the California Attorney General, January 12, 2007.

⁷ *See* Daniel Costello, "Hospital group rejects system and cashes in," Los Angeles Times, July 15, 2007.

⁸ *O'Meara v. Palomar-Pomerado Health System*, 2007 WL 731376. Though unpublished and thus not citable to a court as precedent, the case is one of many that illustrate the importance of necessary patient safeguards.

qualified physicians and resulting in a deterioration of the quality of care.⁹ A similar conflict of interest policy was recently declared invalid by another court.¹⁰

- The United States Department of Justice intervened in a case where it is being alleged that in return for "heavy hitters" referring patients to the hospital, a cardiology group was rewarded with, among other things, the opportunity to bill patients for follow-up procedures and leadership positions in the hospital's administration.¹¹ Not only did this relationship exclude other cardiology groups from being assigned time to the hospital's heart station, but also, the physician who complained about the relationship was terminated from his post as Assistant Director of Cardiology.

And these dangers are only expected to increase as more and more hospitals, fifty percent of which are operating at a loss,¹² shift their focus from patient care to hospital survival.

MS.01.01.01, as proposed, will only serve to protect against such abuses. Providing medical staff members with the ability to determine policies that govern their very mission to assure the quality of care in the hospital is integral to protecting patients.

Conclusion

In sum, the transparency that will be created with proposed MS.01.01.01 translates into good governance. Having such fundamental "details" as to how and under what circumstances physicians may provide care to their patients at a hospital in the bylaws themselves, subject to a vote by those who are charged to implement them, is integral to the provision of quality patient care. The proposal goes to the heart of the medical staffs' right to self-governance and its ability to account to the hospital for the quality of care. As California's Legislature aptly stated when delineating a medical staff's right of self-governance:

"The Legislature finds and declares that providing medical care in hospitals depends on the mutual accountability, interdependence, and responsibility of the medical staff and the hospital governing bodies for the proper performance of their respective obligations."

⁹ See *Medical Staff of Community Memorial Hospital of San Buenaventura v. Memorial Hospital of San Buenaventura*. Cal. Supr. Ct. No. Civ. 219107.

¹⁰ See *Murphy et al v. Baptist Health* In the Circuit Court of Pulaski County, Arkansas No CV 2004-2002 (2/27/09).

¹¹ See *United States v. Health Alliance of Greater Cincinnati*, (50 Ohio, No. C-1-3-167), 2008 WL 5282139 (S.D. Ohio).

¹² See Lisa Giron, "Half of Nation's Hospitals Running Losses," Los Angeles Times, March 2, 2009.

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See Section 1 of Stats 2004, Chapter 699 (SB 625) codified as California Business & Professions Code §2282.5.

The Joint Commission's proposal providing for increased transparency and good governance will only serve to ensure that "mutual accountability, interdependence and responsibility" is, in fact, achieved.

Sincerely,

A handwritten signature in black ink that reads "J. Brennan Cassidy, M.D." with a circled "10" at the end.

J. Brennan Cassidy, M.D.
President, California Medical Association

cc: Mark R. Chassin, M.D.
President, Joint Commission
Robert A. Wise, M.D.
Vice President, Standards and Survey Methods