THE JOINT COMMISSION TELECONFERENCE
STANDARD MS.1.20
THURSDAY NOVEMBER 1, 2007

CATHY BARRY-IPEMA: Welcome to today's telephone conference call with Joint Commission officers Dr. Paul Schyve, senior vice president; Dr. Robert Wise, vice president Standards and Survey Methods; and Hal Bressler, general counsel. Also joining us is John Herringer from our Standards Interpretation Group. I am Cathy Barry-Ipema, chief communications officer for The Joint Commission. Dr. Wise will open up the call today with remarks focused on the revised medical staff standard, MS 1.20, that takes effect July of 2009. We hope you were all able to listen to last week's call on the revised Leadership Chapter that takes effect January 2009. When Dr. Wise's comments are concluded today we will take questions from the audience regarding the revised medical staff standard, MS 1.20.

It is my pleasure to introduce Dr. Robert Wise, vice president Standards and Survey Methods at The Joint Commission.

DR. ROBERT WISE: Today we are going to be speaking about MS 1.20. That standard is the medical staff bylaw and addresses self-governance and accountability to the governing body. There are going to be two discussions today. One will be a bit about what the principle of that standard is and the other one is concerning the issues of implementation. While the principle is clear, there have been lots of questions about the implementation. And, in fact, one of the reasons that the implementation date is July 2009 is specifically because we understand some of the complexities of the implementation and the need to hear from the field and continue to talk this through.

MS 1.20 is a specific case of the general issues in leadership which you heard Dr. Schyve speak a great deal about last week. But the point of the leadership standard is that the leadership groups work together to fulfill specific accountabilities. It is the governing body's accountability who has ultimate authority for all the quality and safety of care in the facility, but it is the medical staff which can be the eyes and the ears of the governing bodies of these issues of quality and safety as they relate to the licensed independent practitioner. And to fulfill this accountability, the medical staff must be able to exert independent judgment on these issues of quality and safety.

MS 1.20 lays out the framework that allows the medical staff to achieve the independent judgment so that they can look at these issues of quality and safety as it relates to the independent practitioner. The medical staff's areas of accountability touch on four different ones. The first is that it oversees the quality and safety of the work of the licensed independent practitioner. The second, it is expected to do ongoing evaluations of all licensed independent practitioners. The third is that it reviews the systems and the processes that relate to the work of the licensed independent practitioner. And the last is expected to report these findings to the governing body. These are the principles which are embedded in MS 1.20.

The issues of implementation have been talked about extensively and we have gotten lots of communication from the field. And actually it is through listening to the field and from their concerns that I will make some of my remarks. There have been essentially three major issues that we have heard. The first one has to do with the impact of MS 1.20 on the authority of the medical executive committee and the concern that it has been greatly decreased. It should be remembered that the medical executive committee represents a voice of the medical staff. It's not an independent body. MS 1.20 allows the medical staff access to the governing body, generally if it feels if the MEC is no longer a voice that

speaks for its concerns. We find that this happens very infrequently, and we would expect that the work of the MEC would continue as it normally has. We have put this possibility in where the medical staff can speak directly to the governing body if it feels that it is a situation where it is necessary.

The other question that has come up is who is the voting medical staff who does vote on the bylaws? We do agree that when we read our document it actually is a confusing issue which we hope to clarify. We also believe that this is a crucial issue. Generally, the medical executive committee would be viewed as too small of a group to make these types of decisions on a regular basis. But we also know that there are hospitals where the number of licensed independent practitioners with privileges on the medical staff is so large and a very small percentage of them may actually be actively involved in the organization. It was our expectation that neither of these groups would actually be the voting members who looked at the bylaws. And this is an area, in fact, where each organization will have to spend a significant amount of time seeing who currently are the voting members of their medical staff and is that the right group who can thoughtfully make the decisions of the bylaws.

The last concern that we have often heard is that there is a belief when reading the document that every single document that relates to quality and safety must be jointly approved. Again, upon our reading of the document, we understand how that can be understood in that way. But I think it is important that you hear that that was not our intent. We understand that medical staff bylaws in the policies and procedures and rules and regulations are often very large, and it was never meant that all of those documents would be jointly approved. The standards give the medical staff and the governing body flexibility to work out which amount of those documents are jointly approved. The standard speaks to two areas, first the requirements which are the processes, and then the procedural details

which are the details of that process. These are the jointly approved documents, but there a huge number of details that are typically delegated to others, such as the medical staff committees or the departments. The governing body and the medical staff together can agree at which level of detail must be jointly acted upon. We would assume that there is a large percentage of material that, in fact, is not acted upon jointly, that is delegated to these bodies. For example, it is often delegated to departments to go through a complex process of looking at issues of privileging and how decisions of re-privileging would be made. It's been those decisions that are then sent up to a committee often to make the final decision, the privileging that would eventually get to the governing body.

The standards allow us flexibility and it would mean that two different hospitals may have come to two different decisions on which documents must be jointly approved. And even over time a single hospital may decide that a certain group of documents are jointly approved and over time it may expand or contract those documents. This is just a brief overview. Certainly, there are going to be a lot more specific questions and we expect most of the rest of this time to answer those. Thank you.

QUESTION: It seems to me as I listen to your discussion, The Joint Commission is suggesting that there needs to be, for want of a better word, a systems approach to thinking about the way in which care is delivered. And through this suggestion of change you're encouraging more communication with the governing body and you're not being prescriptive about the processes, but rather trying to make certain that independence is exercised on the part of the medical staff in their role as practitioners in helping to assure excellent delivery of care to patients. And you're giving those institutions and physicians two years to work this out in a collaborative manner. Is that the essence?

Dr. PAUL SCHYVE: Yes, I think that nicely describes the essence and I'd like to pick up on one of the first things you said. I think that what this reflects is that the role of the medical staff in creating safety and quality within the hospital is becoming broader than it was in the past. In the past the focus was on whether each individual member of the medical staff was competent and committed. And the medical staff was required to make that determination, make a recommendation to the governing body for privileging and appointment to the medical staff. Now I think that there's a much better understanding of the role that the systems and processes the people work in play in creating safety. And, in fact, in the absence of paying attention to those systems and processes, the individual competence and commitment is not sufficient. And so this actually calls on the members of the organized medical staff to collectively work further with those in the organization, the governing body and administration on creating safer systems.

QUESTION: There's a lot of information that we have historically and over the last several years taken from the bylaws and put into policy and procedure. And now much of that needs to go back into the bylaws. Is it acceptable to make the documents as they stand now, rather than policy and procedure, just make them addendums or appendices to these bylaws? Is that okay?

DR. ROBERT WISE: Let me ask a question. Obviously, one important part of the medical staff bylaws is that they are going to be adopted by the medical staff and approved by the governing body. So I guess one question would be are the things that were moved outside of the bylaws, are those in fact jointly approved documents? If they aren't, then they would be problematic. You could not just move those back into the bylaws, but would have to go through the procedure of having them adopted and approved.

CALLER: They have been jointly approved. And we do review and approve our bylaws as they stand every year so they would be jointly approved every year.

DR. PAUL SCHYVE: As Bob described, it essentially is the governing body and the medical staff which will determine at what level of detail do things need to be in the bylaws and at what level of detail can things be in other documents that are still jointly approved. So, what I would suggest is that rather than assuming that all the things in those other documents now need to be moved into the bylaws, that the question instead is whether the governing body and the medical staff concur that what's in the other jointly approved documents is appropriate and what's in the medical staff bylaws is appropriate. And if there's some non-concurrence over that then that, in fact, will need to be resolved.

QUESTION: How exactly would you define how hospitals should get their medical staff involved? I think it was mentioned earlier that you're not trying to define these processes, but I was just trying to get some clarification on that.

DR. ROBERT WISE: Medical staffs have generally split out into a group that is actively involved and a group that has tended to be peripherally involved. I'm assuming you're now talking about the group that is more actively involved. I think it would be very difficult, and what medical staffs around the country have found, is that they often end up giving privileges to a large number of licensed independent practitioners who may not even show up on site or at most once a year. I think that it would be obviously quite difficult to engage that group. I think the important part is to try to focus on who is actively involved and who really has a significant interest in the working of the organization. How one actually involves

them I'm not sure of the specifics, but I think it really has to do with more of targeting the right group than attempting to probably engage everybody.

DR. PAUL SCHYVE: To be involved doesn't necessarily mean that that individual is actively working on one of the quality and safety projects. It's who are the people who are active within the organization, and who collectively will be taking responsibility for the responsibilities of the medical staff? Obviously, the medical staff then itself may create committees and so on of individuals within that larger medical staff who carry out certain kinds of projects. For example, there might be a committee that works with IT around the design of new information technology systems. But it's the group that are invested enough from both the point of view of the governing body and of the medical staff themselves to collectively assume that responsibility for oversight.

QUESTION: There's a portion of the standards that indicate that the medical staff themselves can propose bylaws, rules and regs, and amendments directly to the governing body. What would be the expected process to occur when this happens? Sometimes this happens and should it go directly to the governing board? Should it be kicked back to the MEC because sometimes there is some research that needs to be done to see if it needs to stand or if it is something that's doable? What happens if the medical staff doesn't agree with the proposal?

DR. ROBERT WISE: I'm sorry. I thought you were asking the question of the medical staff on the rare occasion it might actually send something directly to the board?

CALLER: Well, I'm just looking at the section that talked about that the medical staff can also propose medical staff bylaws, rules and regs, policies and amendments thereto directly to the governing body.

DR. ROBERT WISE: We actually believe that that is the EP, and I think you were speaking to number four. That would be a rare process if that's not the normal process that the organization uses. The MEC is usually a voice of the medical staff. There are some rare occasions where, in fact, the MEC may not be speaking for the medical staff. So this was really an EP that was not put in there as the expectation it would be the normal role of business, if that's not that the process that the medical staff used but it was essentially to be used as an exception if they felt it was necessary.

QUESTION: With the new revision, our bylaws committee and medical staff felt that the whole medical staff could dilute the power or the voice of those of our active members. The committee felt that non-active members have little investment with the governing structure of the hospital and put the active staff at risk in granting votes to a pool of individuals unfamiliar with the day-to-day effects of the bylaws of the medical staff. They felt with the new guidelines there'd be no future changes to the medical staff, bylaws, and rules and regulations. So, if we propose something to the board, the board approves it, goes through the process, gets it approved, then the medical staff in whole can then go and try and change it. Then you put an animosity between the medical staff and the board of the hospital. This doesn't make sense. Can you expand on that please?

JOHN HERRINGER: I think Dr. Wise tried to explain this in his discussion about making a decision as to who was actually eligible to vote on the bylaws. Element of performance

number 18 asks you to do that and have that in the bylaws. So, just as you're describing, it may not be appropriate for the entire medical staff to be weighing in on all of the various changes or proposals because it might dilute the impact. So, as part of number 18, you would decide what group of all the medical staff actually can vote on the bylaws. So, you can have a medical staff of 1,000, but really decide that it's a group of 300 people that are actually going to be the one's voting. And that way you do have the authority to control who you want to participate in that oversight and that approval process.

DR. PAUL SCHYVE: Number 18 that John was just referring to says that the bylaws determine who is eligible to vote on the medical staff bylaws and their amendments. There are other references to something being done by the entire medical staff. The intent is that that's the same group. When the phrase is that it's the entire medical staff that does something, it means that group of people—the organized medical staff—who are the people who can vote. So the problem, of course, is that different hospitals define their medical staff differently. Some define it as only that group. Other hospitals may have something called the medical staff that has many different sections, some of which vote, some of which don't. So, for all practical purposes, as you read these standards think that when we talk about the entire medical staff, when we talk about those that have the vote, even when we use the phrase the organized medical staff, we're talking about that group who is assuming that responsibility for the oversight of quality and safety and accountability to the governing body and who, in fact, have the vote on the bylaws.

QUESTION: Yes, I have a question regarding the standards regarding privileging and how much information needs to be in the bylaws versus the policy. In the standards it states that

the process for privileging individuals must be included in the bylaws but that's very vague. So how do we know how much to include in the bylaws versus what procedural details or any policy if this is one of the elements where it states it's required to be in the bylaws?

DR. ROBERT WISE: Something as complex as privileging and re-privileging there is going to be a high level process, and that high level process must be captured in the bylaws which would be adopted by the medical staff and approved by the governing body. But under that there are levels of detail and under that there are levels of detail, and, in fact, this is one of the issues that does produce those volumes. It will be a discussion which the governing body and the medical staff are engaged with to make a determination that once they have determined the overall process that is jointly approved, the amount that can be delegated, for instance, it's very common that significant portions of re-privileging would be delegated to different departments, that how much of that can be delegated to departments without any need for joint action versus at what level would the medical staff and the governing body consider that there are levels of detail beyond just the high level description that, in fact, continue to require joint approval. So The Joint Commission is not going to take the position of determining which level of detail has to be jointly approved. This is really the expectation that the medical staff and the governing body engage in this and come to a decision. Even that decision, over time, can change.

HAL BRESSLER: Another way to put that, is that the intention is not to give the surveyors a check list of items and say, make sure this item is in the bylaws or this item is not in the bylaws. That is not the intention of The Joint Commission. Rather, it's like a lot of other Joint Commission standards. We've kind of handed this to you and said we really want you to think about it, and work it through, and we'll defer to your judgments made in good faith

on how to do this. What the standard does require is discussion between and among the medical staff, administration and governance about how to handle all this, and I know that in itself can be controversial.

DR. PAUL SCHYVE: The reason why so many of us are weighing in on this answer is because that question goes to the heart of many of the questions that people have asked us about this new standard. So the other point I would make, and I think Bob actually made a reference to this in his introductory comments, that decision between a governing body and a medical staff about what level of that cascading level of detail, where are they going to draw the line at what they think needs to be in the bylaws and what can be in other documents. That line could change over time for even the same medical staff-governing body combination. It may change over time, for example, as the membership changes and perhaps the level of the trust between the two changes. It may change because the level of trust between the medical executive committee and the rest of the medical staff changes over time. So those are not once and for all decisions. They really reflect the working together of the governing body and the medical staff on an ongoing basis. And, therefore, it may change as some of those decisions change over time.

CALLER: Okay, the standards specifically say that any procedural details associated with EP 9 through 25 must be in the medical staff bylaws, so this to me states that everything regarding granting privileges must be in the bylaws.

DR. PAUL SCHYVE: If you go into many hospitals, you may well find literally five volumes of material that deal with credentialing. Some of it is at a high level of here's what the medical staff or the executive committee does and here's what the board does. Then it gets

down in the detail about what the credentialing committee does. There may be a credentialing committee in both the medical staff and the governing body. Then it gets down into further details about what each department does and those details may differ from department to department, for example. So if you think about walking in and looking at five notebook volumes sitting on the table you could say, oh well, that's all the details. Does that mean that all of that has to go into the bylaws? Clearly, the answer is, obviously that wouldn't have been the intent. The intent, however, would be that the organization thinks through, meaning the governing body and the medical staff, what of those needs to be in the bylaws. The difference between the section that talks about the procedural details in the bylaws versus the section that talks about that they can be in other documents really is saying that one expects that there will be more level of detail for that first list of things, this is numbers 9 through 25, and probably less level of detail for items 26 through 33 in the bylaws themselves. But it's still the decision of the governing body and the medical staff jointly, as to what level of detail that will be—whether they said this level of detail no longer needs to be in the bylaws, we're going to have it in other documents. They may well be jointly approved documents.

QUESTION: We're wondering what category will the EPs be in for this particular standard? If these become all category A or B elements of performance there are 33 of those and those are rather onerous when you look at one strike you're out.

JOHN HERRINGER: Can I just remind you that with the Standards Improvement Initiative the scoring mechanisms are going to change in 2009. So we're developing that, finalizing it, so you might not even see the use of the same terminology, category A and B and C. So everything will be changing in all chapters of the manual.

DR. ROBERT WISE: I do appreciate your comment that there are a number of difficult things in here and that the idea that one strike and you're out, as you're saying, might be a pretty difficult way to deal with all 33 of those and that is a helpful piece of information.

QUESTION: You keep talking about the need for the medical staff and the board to work through these issues and so the purpose of this if we're talking the active medical staff, how do you envision the active medical staff and the board discussing this as a whole? I mean, are you envisioning that meetings need to be called where all the active medical staff are called to come and the board? Because I think traditionally people had thought that that's why the active medical staff voted in its medical executive committee members so that they could, in fact, engage in these functions on behalf of the entire active staff. I'm just having a hard time understanding how the active medical staff is supposed to engage in all of these discussions with the board and what the role of the MEC is in relation to all of that.

JOHN HERRINGER: I don't think The Joint Commission would want to try to prescribe any particular mechanism or format. Depending on the size of your medical staff, we have some that have a medical staff of five, they could have a lunch meeting and discuss this quite openly. If it's quite large you might do some sort of a teleconference or use an email format where you're collecting information and sending emails back and forth for comment with draft formats and questions and answers and whatever. It really is up to you to determine what mechanism, what's the availability of the medical staff, what's going to really work for you.

DR. ROBERT WISE: I think the other point is that, as you said, many organizations are currently using their medical executive committee. There is no reason that that, in fact, should not continue.

CALLER: So, are you saying that you can use the MEC to serve that purpose on behalf of the active medical staff?

DR. PAUL SCHYVE: Yes, if the active medical staff is comfortable with that. When you made the comment earlier in your question about the MEC has been elected, one of the issues actually is that there are now hospitals in which the MEC is primarily not elected. For example, the MEC may be composed primarily of department chairpersons who are sometimes chosen and often, at least, paid by the hospital. And that's a very common model, for example, in academic centers and in many ways works very well since the department chairs are also the ones who are overseeing the quality of care going on within their individual departments. But, you could see how that could potentially result in the MEC's view about what should be done about quality and safety could potentially not actually reflect what the rest of the active medical staff believes is the right way to deal with a particular question of quality and safety. So, it's not as if the MEC is always chosen and elected by the medical staff. Now in those cases where it is, it may well be the MEC that carries this out. As I think Hal said earlier, the real issue is to rejuvenate in a new way the relationship between the medical staff and its obligations for the quality of care, with what goes on in the rest of the hospital. And that may mean that the board and the medical staff both create a committee. The committee may already exist through the MEC. It may be the board has the committee called a quality and safety committee of the board. The board

may want that, so it's going to differ from organization to organization. It's going to differ depending on the size of the organization, the size of the medical staff, et cetera.

DR. ROBERT WISE: There was no intent in the standards to attempt to change or disrupt a working flow of communication. So we're going to find, we expect, the overwhelming majority of hospitals in the country are satisfied with the flow of communication. There is nothing in the standards that, in fact, would disrupt a successful process.

QUESTION: Folks, in light of the apparent massive amount of time, energy, and cost that's going to be involved in every hospital having to go through this process can you give a reason as to what problem this was intended to address? And if so, why were the draft field review documents of last year discarded and changed at the last moment?

DR. ROBERT WISE: You actually have a few questions there. The first one is the expectation of the amount of time and money that is going to be put into this. We have talked to a number of people. I don't believe that is going to be true. In fact, we would do what is necessary to attempt to avoid that. One of the concerns that we have heard is that these changes will, in fact, be viewed as so onerous and create so much extra baggage with little value. That is not something that we believe to be true, and it's one of the reasons that the implementation date is July 2009. Specifically, if there are misunderstandings, and organizations seem to be putting in an unnecessary amount of effort, that is something that we can engage the field about.

As for your issue of why this has been done. I think we've actually already touched upon that several times. It's important to understand that this document MS 1.20 and the discussions that have occurred over the last four years, really began in 2003 with the simple

attempt to try to organize the medical staff chapter that most people agreed was in chaos. And a simple attempt to try to pull out what was in the bylaws, what was in the policy, procedures, rules and regulations, and we came up with what we thought was a pretty straightforward reorganization of MS 1.20. In fact, it turns out to be the first time that anything that clear had been presented, and from that moment on, we understood that, in fact, there was no agreement with what MS 1.20 is. It is really now the first document that is clearly set out how the medical staff is accountable to the governing body. And then allows what I have talked about, the ability to have its independent judgment so that it can speak to the governing body around issues of quality and safety, about licensed independent practitioners. That really is the goal of this, and up to this moment, there is not a standard that clearly laid that out.

HAL BRESSLER: The concept of an organized medical staff is something that is organized and is supposed to, in an organized fashion, further the interests of quality and safety and work with the governing body and not solely represent the individual interests of medical staff members. It's something, of course, that is derived back from the 1919 American College of Surgeons standard. It's in all the laws and regulations across the country. I know that there are experienced people, people who I believe are thoughtful, who believe that that concept is ridiculous. Who believe that if it ever existed it does not work now and that you can't expect there to be anything organized as a medical staff to enhance quality and safety. The Joint Commission disagrees. Others disagree. There is going to be a lot of discussion, in my view, in the next five, 10,15 years about whether that American model works. And these standards are kind of setting out the challenge to everybody who believes in that model, be it organized medicine, be it governing bodies, whatever administration, to show that it will work because, as Paul and Bob have said, the

need for doctors to recognize that their responsibilities to their patients goes beyond simply being an individual, competent doctor in that hospital if they're going to actively practice in that hospital. That challenge is now out there for everybody and we'll see what happens in the next five or 10 years. And we'll see whether this model lasts and works that's been around for so long.

I'll give you the example that I like to use. You have a hospital putting in some new IT system, electronic health records or so forth. Now in our view, obviously, a hospital doing that should get medical staff input. And the view of these standards and the leadership standards is not that that means you just find some person who's interested in IT who is a doctor on the staff and have that person provide that input. The concept is, obviously, you're going to find one or two people most interested in that, but there is supposed to be something organized that that person can go to and get feedback from the organized medical staff as to what's needed in that electronic system and something organized that that person can go back to and provide information about what's being done. Again, I know that there are people who don't believe that is realistic, who believe that concept is ridiculous. And we shall see in the coming years.

DR. PAUL SCHYVE: Let me also take a moment to address your other question which was about the field review. When we conduct a field review it really has two purposes. The first purpose is to try to get information from the field around the issues in a proposed standard. If you recall we had actually carried out two field reviews in this case. The first one was a proposed standard that essentially said everything will be in the bylaws, and the second field review was a standard that essentially said everything can be any place. And we got a lot of feedback from both those field reviews. In fact, we concluded that we had basically heard all the issues with regard to the standard itself in those two field reviews.

I'm sure you realize that because of the number of responses and the representation of who they come from, we can't use the field reviews somehow as a vote, but rather, as an information gathering source for the people—task forces or staff—as they try to develop proposed standards for the board. And that, we thought, we had actually gotten already, and I think as we look at the comments that have come in now, that we already have heard all those issues raised in the two first field reviews.

The second purpose of the field review, however, is a purpose in which we inform the field of what we're about to do and listen for anything new. And in this particular case, I think it was a disadvantage that we had not carried out a final field review for that second purpose. I do not believe we would have learned more information at that point about what the issues were, but it did, as you suggested, somehow take the field by surprise. And I think while we were up against a time period to try to resolve this after having already spent three years on it, it would have been probably preferable for us to send it out again and let people know here's where we are.

QUESTION: If you assume that you have documents in place, maybe decades old that say that the rules and regulations may be amended by the medical executive committee with board approval, is it anticipated that the medical staff now needs to review that delegation and ratify it? Or can you simply go with the status quo?

DR. ROBERT WISE: I guess it would depend upon whether these things touch in any particular part of the standards. There's a good chance that what you are talking about may fall outside of these different points in the standard. I think the only time there would be a potential difficulty is if there was no part of this that was in the bylaws and that if you find EP 11 or 12 or something requires it, I think you have to sit down and take a look at what

exactly you have. I think it's a good chance that everything has already been ratified assuming there is something in the bylaws that speaks to that process might in fact be okay.

DR. PAUL SCHYVE: The kind of questions that are asked both today and from other sources about how we're going to implement this and how exactly will it be surveyed are very helpful to us. All the details of what a surveyor might do to survey this haven't been laid out, and part of that comes from the kind of questions that are asked. But let me say the kind of questions a surveyor would ask would be, have you got some reference in your bylaws to all the things that are listed in this list? If somebody had bylaws that simply didn't say anything about credentialing, for example, obviously that would not be in compliance with MS 1.20. So that's the issue.

Now, the second question is, do the governing body and the organized medical staff concur on what level of detail they need to have in the bylaws versus other places? And if they concur on that, that's not going to be second-guessed by the surveyor. Let me just repeat that last statement, it's not the surveyor's, not going to be the surveyor's job to second guess those decisions. The final thing I think that means is that the surveyor isn't going to be looking for something that says there was a ratification vote by the governing body and by the medical staff for the way the things are currently written. The way they're written today if in fact the governing body and the medical staff are comfortable with that and aren't proposing any changes and are comfortable with the level of detail that's there, all the surveyor needs to hear is yes, they concur on that. It's not as if there's a ratification vote.

QUESTION: Would it not have been easier to just simply change the requirement that maybe MEC members be elected rather than appointed?

DR. PAUL SCHYVE: Actually, the question has been raised from time to time. The problem is, that there are some settings that say, gee the role for example of the employee department head is one that it would be much less efficient and effective if they were not actually part of the medical executive committee. So, it depends on what the structure of the organization is. The other thing, frankly, that can occur is that sometimes even when they are elected, if the organization has said we will support this individual. You elect them, you choose them as the medical staff but then we will support them by paying them for the time they spent on those, shall I say administrative duties. That, in and of itself, sometimes creates the potential, at least perception, of conflict of interest from the medical staff's point of view. So that's why we haven't actually changed the standard to say that, although that same question has been raised before.

QUESTION: I was wondering if you could give a little bit of guidance on EP 20, the part that requires that the bylaws address the delegation of authority to the MEC, specifically how it's removed. Most of the medical executive committees that I have seen are elected.

DR. ROBERT WISE: This is under the medical staff bylaws and must include the requirement in any associated procedural details of the medical staff executive committee's function, size, and composition, the authority delegated to the MEC committee by the organized medical staff to act on its behalf and how such authority is delegated or removed. We actually aren't giving guidance on exactly the process you use to do that, we're only saying that this must be in the bylaws, that there be a process that the organization figures

out to be able to do these things. And the part that you asked about how is authority delegated or removed, while it needs to be in the bylaws, we are silent on the process in which the individual organization could use.

CALLER: But, for example, most bylaws provide obviously a process for removal of the medical staff officers who make up, who always sit on the MEC. Are you saying there needs to be something even beyond that, a process to remove the actual delegated authority?

DR. ROBERT WISE: The first part is that the medical staff makes decisions on the function, the size and the composition, so that it is the medical staff that determines the function of the MEC. So that would mean at some point it can change that function, increase it, decrease it, et cetera. Yes, so there would need to be a process in how a decision, how a function is determined, and how that function might be changed.

JOANNE HOPKINS: But that could be for example by amending the bylaws?

DR. ROBERT WISE: Yes.

QUESTION: Many of our physicians practice not only at our hospital, but also practice in other hospitals and facilities. A number of those physicians who are on our medical staff also are owners-investors in a specialty hospital. And those same physicians who are owners-investors and those who practice elsewhere are often times the most difficult for us to work with, relative to compliances, delinquent medical records or other safety and quality initiatives that MEC and the board have adopted. And as ridiculous as it may seem, they've

even been successful in passing resolutions to do away with The Joint Commission survey and to no longer be an accredited facility, as their facilities are not accredited. Can you help me understand how giving the organized medical staff as a whole the ability to adopt bylaws, rules and regulations and policies and amendments will not undermine the MEC who are elected by their departments in my facility, nor challenge and undermine the authority of the board or the governing body?

DR. PAUL SCHYVE: That's a great question because it reminds us of the huge variability in terms of the situations that different organizations face. We, by the way, accredit literally 12-bed hospitals with two member medical staffs to obviously 1,000-plus bed hospitals with 1,000 medical staff numbers, so it's difficult to have something that meets and says do it this way as if that's going to meet everybody's needs. I have a couple comments. One is that's an example in which this question about who should be the voting members of the medical staff is relevant. The second thing is, while the medical staff or the MEC, depending on what it is and what the rules are, can adopt something, it has to be approved by the governing body. So, the fact that the medical staff in the example you described, is unhappy with something that the MEC has brought forward to the governing body and has been approved by the governing body, the fact that the MEC wants to say, wait a minute, we want to do it differently, is still dependent upon approval by the governing body which may say, no we don't want to change from what had been proposed by the MEC. So, the ultimate responsibility in all cases for what is best in terms of the quality and safety of care, the ultimate accountability lies with the governing body.

CALLER: It just appears to me that via this proposed standard change that my competition will have a louder and stronger voice and create more chaos than actually further the cause of safety.

DR. PAUL SCHYVE: I understand the concern you're raising, but I would argue that I think that ultimately, in that case, it's the position of your governing body that is going to determine whether or not the organization is doing the best thing for quality and safety. And secondly, you obviously are interested in having the medical staff members buy into that or at least live by it. So it really does depend now on under that kind of circumstance with the governing body position. And over the long term, obviously, this is an opinion here but over the long term if the medical staff is unable as a medical staff to say this is important for us to do for quality and safety I think the organization as a whole is at a disadvantage in terms of creating quality and safety for the patients.

QUESTION: I am most interested in all the questions that have been posed and the cost that is going to be incurred and the conflict that is being created between the medical staff and the board with this proposed standard. Given that the standard as it has been advanced is much different than the field review standard, what data do you have to substantiate why you have advanced this standard as it is?

DR. ROBERT WISE: I think it's important to note that certainly since 2004, when we attempted to clarify what the standard was, we had realized that essentially we have been without a standard, anything of substance, that talked to this issue of the ability for the medical staff to essentially be the eyes and ears for the governing body of what is going on with quality and safety for the licensed independent practitioners. This is a crucial issue,

and it is not something that we could have allowed to remain in that situation. The issue of evidence I think I would go back to what Hal Bressler has said, this has been basically part of American medicine certainly since 1919, and at least at this point will continue to be. It certainly has been part of what The Joint Commission standards have been about for a long time. So, essentially, what is being done here is not a new idea that is being promulgated. It's essentially clarifying a position that has been seriously confused and in fact the vacuum has sat for a prolonged period of time. And I would also still want to say the conclusion you're drawing about the amount of tension it's going to cause across the country, the cost, we don't actually believe that. And if it turns out that we're seeing tension that is unanticipated, it is something that we clearly do not want and we'll have to look at issues of implementation.

HAL BRESSLER: I agree with Bob that we're not expecting that this standard will cause conflict between medical staffs and governing bodies, and it's troublesome to think about the idea that encouraging communication between medical staffs, governing bodies, administration about quality and safety issues and how to handle procedures and processes that are supposed to further quality and safety will cause conflict. If that's true, then it certainly does challenge the American model.

CALLER: With all due respect I do believe the voluntary medical staff model has changed since 1919, and the relationships with boards being the ultimate accountable authority is the relationship that must be clear. And as Dr. Wise stated, there is much need to rework this standard and to clarify the intentions because as it has been advanced it does not match the field review and the feedback that was provided.

CHUCK MOWLL: On your advice and the advice of others that we received yesterday with the Hospital Advisory Council, there is an immediate need and we've agreed to that—to put out a concise, clear, advisory to hospitals with exactly some of the things we said here on the phone and Dr. Wise and Dr. Schyve have summarized really what the intent of this change was and what it's focused on doing. And I think some of the input that we received yesterday from other hospital senior leaders, including yourself, was very helpful in saying, did you really mean this or did you mean this? I don't think it was ever our intent to turn the hospital's world upside down at all. It really was to encourage this collaboration and foster communication and teamwork, and the leaders to focus in on the real thing which is good, high quality patient care. We don't want to detract from that, we want to contribute to that. And so, we will work on that document and we're going to work on that collaboratively with you and others to make sure that it's readable. So that should be right around the corner. Thank you.

QUESTION: I'd like to ask if you could clarify further what is meant by requirements for performing medical H&Ps?. I think this is in keeping with a broader need for clarification. I appreciate that you'll put out a communication. This is EP 17, are these requirements for performing of the medical practitioner, of the defined content, and requirements for completion, all of those things and who may approve changes of that? Is that something that can obviously be delegated out in detail but, in fact, has to be defined within the bylaws? I'm just not sure what the content or what's meant by requirements.

JOHN HERRINGER: Actually, that particular element of performance is one of five: 9, 10, 11, 16 and 17 that are CMS requirements for bylaw's language. So the CMS particular COP is 482 222 C5, if you'd like to look it up. They do require that the requirements for an

H&P be included in the bylaw. In my mind, it would typically be the fact that it's done by somebody authorized, it's no more than 30 days old, 24 hours after admission, the requirement for an update.

CALLER: Okay, I did not know, because in context we're talking here about the medical staff and defining scope and responsibility. So, in here, you're talking pretty much on parallel with CMS.

JOHN HERRINGER: Yes, exactly.

HAL BRESSLER: Again, the CMS requirements, to some degree, impacted the placement of these items. We've described the great discretion The Joint Commission is going to view this standard with regard to how medical staffs and governing bodies agree. I can't guarantee what CMS would do on its conditions of participation.

QUESTION: Are you are equating active to organized to voting staff? There seems to be some conflict in your use of the active, for example, the designation of active within an institution and the medical staff. Can you clarify that?

DR. ROBERT WISE: Actually, the term active medical staff does not appear here. It is a term that is frequently used throughout the country to designate the group of medical staff members who are viewed as having the right to vote. They just happen to be active, meaning they're involved with the hospital. What's important here is EP 18, which says that it is in the bylaws the practitioners who are eligible to vote on the medical staff bylaws and their amendments. That's really the issue. So, that's the point, that it's in the bylaws of who

actually is able to vote. The term active was just part of casual conversation here and really just reflects a term that is often used in the field.

DR. PAUL SCHYVE: The other two places where there are references that we've used slightly different language to mean the same thing, if you look at EP 4, which refers to the organized medical staff as a whole, as an ability to adopt medical staff bylaws. Some people have said, gee that sounds like something bigger than the ones that are to vote. And the point is no, that's the same group. The organized medical staff as a whole is the same as the group that has the vote.

CALLER: And is that the same as your term today—the active medical staff as designated by the institution within their credentialing process?

JOHN HERRINGER: Actually, that would be your decision. It may be that you want to make the people voting be the same group of people that are really there taking care of your patients. That's going to be your decision. If you want to have one group called active and a larger group voting, that would be your decision. But, you know, typically it is the active medical staff that also votes.

DR. PAUL SCHYVE: The other place where that reference comes up is in another standard in the medical staff chapter which says the majority of medical executive committee voting members must be physicians that are active. So, meaning, in fact, that they are actually taking care of patients in the organization. But it doesn't have to be equivalent to this organized medical staff that has the vote. It may well be, as John is saying, in many places, but it doesn't necessarily have to be identical.

QUESTION: I applaud what you're trying to do at The Joint Commission because I think for a long time medical staffs have brought up quality issues and been told over and over again that when it comes to the bottom line about providing the care it's about the economics and not necessarily about the quality. And over and over we present things to the governing body or to the state and we're told that the legislature doesn't have the funding to be able to provide that level of quality. Do you think these new rules give us some additional ammunition to be able to lobby to provide for more dollars or higher quality of care in cases where we just are not able to give that quality of care due to financial constraints or restraints?

DR. ROBERT WISE: This is really about the medical staff, the governing body and the support of quality and safety of care. There was no anticipation for it to be used beyond that. I'm not sure we have a comment on that particular use.

DR. PAUL SCHYVE: I will comment on that. As a psychiatrist I can tell you historically that there was a time in which there was a dramatic improvement in the quality of care in state hospitals when the directors of state hospital systems adopted as a policy seeking Joint Commission accreditation. Because it was the first time that issues around quality of care at least came to the attention of those in the legislature and sometimes in the executive branch about what the quality issues were. So rather than describing it as leverage, let me describe it as it can have a positive educational effect.

QUESTION: We all agree that the governing board is the ultimate authority and yet when I read the introductory paragraph as we've discussed, all of the requirements from standard MS 1.20 must be jointly approved by the medical staff, medical exec, and governing board.

If the governing body is the ultimate authority and they cannot make decisions in the interest of patient care which may be at odds with the medical staff, aren't we giving them the responsibility without the authority?

DR. ROBERT WISE: Typically, the language that is used is that the medical staff adopts bylaws and the governing body approves. That really is how this is discussed. When we talk about the idea of jointly approved, we're not talking about necessarily equal votes. We're talking about involvement of both groups. So, The Joint Commission is very clear that it is the governing body that has the final decision, that the medical staff adopts and the governing body does the final approval.

HAL BRESSLER: I'm not sure we answered this gentleman's question. This usually comes up in the context, as you stated that we want medical staff bylaws jointly approved. And the way it comes up is that someone will call with a hypothetical question, and we'll say the governing body has responsibility. And what if a bylaw's change is required to comply with law, and the medical staff won't jointly approve to comply with law or The Joint Commission standards or something like that? There are legal controversy over when a governing body or whether it can do it in this state or that state and so forth, but my answer is always well, under those circumstances, of course. If you have the authority in your state to unilaterally amend and you need to do so to actually comply with law and that's clear, of course you should do that. But you're still going to be cited by The Joint Commission because we're worried about your hospital in the context of the philosophy that's been expressed here. If you've got a governing body and medical staff that can't even work together to change a medical staff bylaw to comply with law, we're worried about the collaborative relationship in your hospital and we're going to cite it, and then we're going to

work with you and see what it means or doesn't mean in terms of quality. So it's not a challenge to the ultimate authority of the governing body. What it is is a statement of principle that the governing body needs that medical staff to fulfill its accountability. And that these standards are a challenge, in my view, to organized medicine and medical staffs across this country to do what they need to do.

CALLER: Certainly what you're saying is reasonable, but I would suggest that perhaps the phrasing of jointly approved should be altered to reflect exactly what you're thinking.

DR. PAUL SCHYVE: We've used the phrase, jointly approved, quite often as short hand for adopted by the medical staff and approved by the governing body. I've run into other situations where people have pointed out that can be interpreted a different way. So, perhaps we should actually try to avoid using that as a shorthand.

QUESTION: My question is, where law permits, it's been my understanding that if the law does not dictate that you must do this but simply permits a particular governing body and medical staff to make a change in credentialing or privileging, what is your suggestion for the medical staff to be able to recommend to the governing body that they not implement the law without there being a fight over it? I know your concern is that they be able to work together. A practical example of that would be where a particular discipline wants to be members of the medical staff. They have never been members of the medical staff before, if they become members of the medical staff then later on they want to acquire new privileges but it then becomes very confusing to another department in the medical staff because that is a duty they previously held singly. So, I really want some advice on how the

medical staff could continue to work with the governing body in a friendly relationship and work out these difficult issues.

DR. PAUL SCHYVE: First, a comment about the issue of permissive law versus required law. I think Hal's comments earlier about if the governing body is required to pass a law to comply with something; my recollection is actually there is at least one state that requires that a hospital admit a particular discipline to the medical staff. That's a requirement. Permissive is certainly something that would be then discussed by the governing body and the medical staff although again the governing body would actually have the final decision-making power. Let me also point out that there is both a quality of care rationale for that, obviously, since they are also ultimately responsible, but there is also a kind of a legal reason for that. Why is it that we say that the medical staff recommends privileges for somebody, but the governing body is the one that actually grants them? Part of that is to help the governing body and the medical staff avoid accusations of conflict of interest that might arise if it's the medical staff that makes the final decision. So you're dealing with something which I think a number of hospitals certainly have faced.

The final point I would make is that when two bodies, in this case, the governing body and the medical staff and probably the administration is going to be involved in this, when they are trying to collaborate there clearly will be times when there is disagreement. It can't come to a consensus resolution. And, under those circumstances, it is ultimately the governing body that has the responsibility to make the decision, but that's one of the reasons why in the Leadership Chapter there is a new section that deals specifically with having mechanisms in place to try to manage conflicts. I remember an early version of that talked about conflict resolution, but there's a recognition that sometimes the conflict is going

to continue. There's simply a disagreement that can't be solved but that there are methods to try to manage that in a way that can continue to maintain a collaborative relationship.

QUESTION: I've been going through most of what you've been talking about for the last year with my medical staff. One of the issues they've had has been the unilateral decisions by administration and the board of trustees over what the medical staff had wished for and they have since moved to implement new medical staff bylaws based on the annotated version of the California Medical Association bylaws which address a lot of what everyone has been talking about today already in their language. These bylaws, for those of us that are out there grasping at straws to try and get answers to this solution are very, very well drafted, and I would encourage everyone that is in need of some of this language to get a hold of someone at the California Medical Association and take a look at them. Our medical staff issues have been moving away from what you're actually saying. They want to be more independent and more self-governing and less involved with administration. So, I'm on the opposite end of this pendulum and would like some advice. Basically, my medical staff is moving to the opposite direction of this standard. This standard is encouraging them to work jointly, and they're moving to be independent of the board. They do not want administrative interference in medical staff issues.

CATHY BARRY-IPEMA: If there are issues that they would like the organization to address, even though they're working autonomously, wouldn't they have to eventually work with their governing body?

CALLER: Well, we are hoping that's what's going to happen, but up to this point in time it has been much more difficult to get that to happen because of what has been talked about

today. Financial issues, staff cuts—just the general way that health care is going financially across the country has become a real issue. So, my medical staff is making an attempt to be more responsible for quality of care, but is still having a problem with getting the money and getting what they need to get proper quality of care with equipment.

HAL BRESSLER: The type of things we're talking about here, in terms of being adopted and approved require both governing body and medical staff approval. You can't have medical staff bylaws that are effective without governing body approval. Of course, what The Joint Commission would say as we've suggested earlier, is that if your medical staff thinks that it can operate independently of the governing body in terms of working on the systems of the hospital to improve quality and safety, working with the governing body and the management, it is behind the times. And if the governing body and management thinks it can ignore what is referred to with something or other that's organized in terms of a medical staff, what The Joint Commission is saying is you are behind the times. Again, we've had other callers who have said The Joint Commission and that model is wrong. And, all of you will have to decide if your governing body and something that's organized as a medical staff are not working together, what The Joint Commission is saying is your patients aren't getting as safe, high quality care as they would otherwise get.

CALLER: And I would have to agree with that.

DR. PAUL SCHYVE: If I understood correctly, your question was in many ways less focused on what's in the bylaws and MS 1.20 and in some ways focused on the thing we talked about last week which was that we're only going to have safety and quality if there is

this collaborative relationship. And what you're saying, is that at least in California a number of the medical staffs are trying to separate rather than work with.

HAL BRESSLER: And the medical staff should not be saying, go away, governing body, we know best and you shouldn't be involved in trying to figure out or work with us on quality of care. And the governing body, the management according to The Joint Commission, should not be saying, medical staff, you don't know a thing about what this hospital needs. Just be quiet. The Joint Commission's theory, the American model theory is that that doesn't work. Other people on this call have suggested that's unrealistic in other contexts.

CALLER: It seems to me that it is going to be an ongoing concern for medical staff and for the governing board, and right now facing the issues that the governing board could potentially not approve an already approved bylaw again brings us to this head-to-head battle and what do we do to get around this? What kind of compromises do we make to assure that there is, in fact, what you're saying, and that is the quality of care we need for our patients?

HAL BRESSLER: I don't think we can answer that question today.

QUESTION: I still don't feel that we got an answer to a question that was asked early on, which was, there was a proposal made almost three years ago, and then after significant field input there was the October 2006 version of what MS.1.20 might look like, which seemed to be developing a pretty good consensus, and all of a sudden in the last documentation that came out it's significantly different and reverts to what was essentially the first set of documents that came out for review. And I think from this call it's very clear

that there's language that's confusing. There seems to be terms that are not clearly understood by the field, and we're going to have a very difficult time with implementing this. And I just wonder what kind of process or opportunities there might be for revisiting this at the board level of The Joint Commission.

DR. PAUL SCHYVE: At this point we recognize that we need to do a lot of work in terms of communication to the field, and it may mean making some revisions to the introductory material for the chapter to try to make clear what the intent is, and to allay some of the concerns that people have had about what is this going to mean in terms of work. Secondly, I think we need to make a better connection, as we've tried to do on this call, between what the role this has in the context of a new Leadership Chapter which people actually have said, yes, this is right. This is what we should be doing. So there'll be a lot more that you'll hear from The Joint Commission in terms of how this would be implemented, which obviously is also going to be reflected in how we educate the surveyors about this. Again, good that we have the time that we have to make these changes.

We had actually decided not to try to put anything out between the time the standard was adopted until we had these calls. We were trying to make sure we understood from people who were calling in and asking questions what the questions were. What kind of things we needed to clarify and then quickly put out that kind of clarification. Our fear was that if we had answered all these questions as they came up that we would end up making answers that then turned out to be not useful as we heard further questions. Unfortunately that meant that obviously everybody in the field has been sitting there kind of stewing for a period of time thinking that this was going to mean things that it didn't mean. So we will be doing a lot of work in terms of making sure that we've got good communication about the clarification.

QUESTION: Early on in response to one of the questions the answer was that the intent was not to have the medical staff circumvent the med exec committee and go directly to the board, but if they did, the thought was that that would be a rare occasion, an exception. If it was thought that it would be a rare occasion, then was there consideration that there just be a grievance mechanism versus modifying or having the medical staff go directly to the board? And then another comment was made in response to a question, that if the med exec was voted in by the active medical staff then it actually could be deemed the active medical staff. But, in the standard it states that regardless of whether the executive committee is in power to act on behalf of the organized medical staff that the organized medical staff as a whole still has the ability to go directly to the governing board. So, that was confusing to me.

DR. ROBERT WISE: Let me try to answer a piece of the question. There is the expectation that there be a close and trusting relationship between the MEC and the medical staff. As it is outlined here, and as I've said, the MEC is supposedly a voice for the medical staff and there is a certain efficiency and convenience to have an MEC, so it can speak directly to the board. If, at some point, the medical staff finds that it is circumventing the MEC, and on a regular basis going to the board with things that should have gone through the MEC, well you immediately see that there is now a difficulty where the medical staff no longer sees that the MEC is its voice. That is the difficulty that would need to be dealt with. So, we would see that as a problem that there is something going on between who is in the MEC and why it is not reflecting the voice of the medical staff. So that's really an issue for the medical staff and the organization to look at why this is happening on a regular basis.

CALLER: Well, I guess in that experience then, it would seem to me that the appropriate mechanism would be a mechanism by which to change out the leadership in the med exec versus creating a dysfunctional system of having the medical staff circumvent leadership. In any organization, when you've got an empowered leadership and voice if you're creating a work around, then you're essentially disempowering that leadership structure, and as I read it, spending my entire career in a hospital, you're just creating a dysfunctional system by creating a work around to the leadership structure. And then I was a little confused because I thought I heard and I wrote it down, that if the medical executive is voted in by the active medical staff, then it was up to the organization to define what the active medical staff is, and if, indeed, they could define the med exec, but then the standard is contradictory to that statement that was made. And I know those are two different questions.

HAL BRESSLER: First of all, it seems to me that if you go back to the theory, to the understanding, to what's involved here, a governing body would want to know with respect to quality and safety issues, that a medical staff disagrees with its leadership. And as Bob and Paul have said, we would think that would occur very rarely. But you would think that a governing body would want to know that. Second, in cases where it becomes so confrontational there was nothing in the standards before that prevented, and this happened, that a medical staff would tell the governing body that anyway. And so what the standard is essentially saying is, think about this. It's not intended to put in people's minds do this and undercut your leadership. It is intended to say, think about this. The unusual circumstances that would come up and how do you guys want to handle this? And so that's the way I would do that.

CALLER: I would recommend if there is going to be opportunity, now that you've had response again from the field of how we all feel this would be disruptive, that I would encourage, if indeed the intent was for the governing body to know if the medical staff at large was not happy with its voice, that there be a mechanism to change that voice. And, I would recommend that the standard be focused on that particular issue and not a system by which you are creating chaos. Because you've got two mechanisms to the board, but I would encourage you to consider then perhaps there should be a standard requiring that organizations have a mechanism by which they can have a system by which they can change out the leadership if it's not working, if there' s evidence that it's not working.

HAL BRESSLER: I heard a lot of concerns today which is important and we want to hear. But I didn't hear everybody say that they thought this would be horribly disruptive, which I think is what you said.

DR. ROBERT WISE: I believe that the thought that you have that the medical staff has the authority to make changes is in fact already in EP 20 where it is in the bylaws—the function, size and the composition. There are essentially two issues here. One is, if for some reason the organized medical staff believes that there is such a significant issue that they want to speak directly to the governing body, that is not going to be prohibited by our standard, and the other one is obviously that if the medical staff believes that this continues to be necessary it already will have the authority to make the changes as in function, size, and the composition.

QUESTION: My question is addressed again to this number four and the issue of the ability of the medical staff to propose amendments directly to the governing body. First of all, I

have trouble understanding why it's really necessary because I think at least our medical staff members would not be shy about writing to the chairman of the board and putting forth any concerns that they might have. My question, though, is really whether a process such as the following would be acceptable to meet the requirement. I'm a little bit concerned about having this be disruptive, and I'd want to see something analogous to what you see in corporate bylaws that provides for a petition that a certain number of people have to sign, or that this has to be agreed upon by a certain number of medical staff members because otherwise it just seems to me if people have already expressed a distraction and it's difficult for us to tell what is representative of what the medical staff really want. So I would recommend that The Joint Commission consider something like that or, can you tell me now whether you think my suggesting something like that to our medical staff for the bylaws would meet the standard?

DR. PAUL SCHYVE: Yes, it would meet the standard. In fact, we would assume that the medical staff and the governing body would want to have this addressed in a way that said that there was a significant number of the medical staff, et cetera. We clearly did not anticipate that this meant that any one or two medical staff members could suddenly make a proposed amendment to the governing body. So I think that part of the responsibility of the medical staff is actually propose an appropriate mechanism for that that could be approved by the governing body along the lines of the type of proposal you make.

QUESTION: I appreciate what The Joint Commission has done because the Achilles heel of the American model of our hospitals, mentioned quite a bit in this discussion, has been the disparity or the location of authority in one body and the responsibility in the other. I appreciate what The Joint Commission has done because it looks like to me that this is a

baby step in the right direction. I do not feel that it will cause any more chaos then already exists in the environment today. To that end, I am aware that the American Medical Association in August 2003 established a working group to work on and develop recommendations for addressing the increasingly conflicted physician-hospital relationship. In March of 2004, the American Hospital Association leadership and AMA board and others agreed to develop this document. That document was developed collaboratively and it was widely circulated and it was defeated resoundingly by the district of the AHA. That document, I believe will be before the House of Delegates of the American Medical Association next week at its interim meeting. I would suggest that that probably will become policy of the AMA from looking over that report and if it does, it kind of lays down the terms of engagement for hospitals and when I say hospitals, I'm referring to governing bodies and administrations and their organized medical staff. Does The Joint Commission have any thoughts about some such type of a document as terms of engagement for these two bodies because there has been and will continue to be a lot of conflict until the two lead organizations agree upon a document by which these negotiations should be conducted? I would appreciate your thoughts on the subject.

HAL BRESSLER: I can think back to the medical staff task force that we had. We had medical staff task force leaders, including one of the AMA representatives, on that task force, who was from New Orleans. She was a very wise person and rather than focus on high level understandings or agreements, what she was talking about was what's happening in the field? What's happening at the individual hospitals? Are organized medical staffs and their leadership trained and willing to accept the responsibilities that they're supposed to have? And she was free to admit that she thought a lot of organized medical staffs were not doing that, and that the focus needs to be on having the medical

staff—just as this is true for the governing bodies, because there is a lot lacking there we've learned—step up to the challenge. So, I think we can lose sight of talking about theoretical, high level understandings on how people should work together as opposed to focusing on stepping up to the challenge on what responsibilities people will take in the field.

DR. PAUL SCHYVE: Actually, when it was first being developed jointly, we had wanted to learn from that document, as part of our leadership task force, but as was pointed out, it wasn't jointly adopted. But we're certainly interested in seeing what comes from that document, and also appreciate and what I think is part of the suggestion that there may be ways that The Joint Commission can help facilitate some more dialogue, particularly now that we have this new Leadership Chapter, some more dialogue among AHA, AMA, Federation of American Hospitals, and so on, that may be able to come to at least some helpful advice to the field about how to carry out this collaboration.

CATHY BARRY-IPEMA: Thank you very much to everyone who took the time to participate in today's call. We hope it was of value to you. Please remember to visit the Joint Commission website at www.jointcommission.org or your secure extranet site for more information on this topic. You will also receive an e-mail with a toll free number that you can call to hear a play back of today's call, which was nearly two hours in length, and a written transcript will also be available on our website and the extranet within the next few weeks. The free playback number for the October 25 call is also available on our website as well and posted to the Joint Commission Connect, your secure extranet site.