

NEW JOINT COMMISSION STANDARD FOR  
MEDICAL STAFF BYLAWS

By: Lawrence Downs, Esq. and Arthur J. Timins, Esq.

The extreme factual pattern in the matter of Lawnwood Medical Center, Inc., etc., v. Randall Seeger, M.D., etc., which was litigated to the Florida Supreme Court in 2008, is instructive. There the hospital's Board sought to terminate the privileges of two pathologists and requested the medical staff, through the Medical Executive Committee (MEC), conduct peer review as to the two pathologists based on its assertion of their alleged commission of health care fraud and a history of misdiagnoses. However, the medical staff did not recommend disciplinary action against the doctors. The Board, however, summarily suspended the privileges of the two pathologists. In a subsequent court action those privileges were reinstated. Instead of heeding the court's direction, the Board reacted by summarily removing the elected medical staff officers and the MEC. Once again the hospital's high-handed unilateral actions were successfully challenged in court. The hospital Board then unilaterally adopted new bylaws which provided that under certain circumstances the Board could unilaterally amend the Medical Staff Bylaws. However, this new provision conflicted with the existing bylaws, which required a vote of at least sixty percent of the medical staff to effectuate a substantive change to the bylaws. The latest high-handed action of the Board resulted in a further lawsuit, which resulted in the Florida Supreme Court's restoration of "a framework for cooperative governing in which the medical staff plays an important role..." in the governance of the hospital.

While the end result of the Lawnwood Medical Center litigation was positive, the stubborn arrogance of the hospital's Board is stunning. However, the question now becomes: how arrogant and intransigent would that Board have been had it been facing loss of

accreditation through the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) for its actions?<sup>1</sup>

In 2007 the preface to the American Medical Association's Physician's Guide to Medical Staff Organization Bylaws declared,

“... [t]he governance structure and functions of the medical staff are defined in its bylaws. These bylaws constitute a contract between the governing body [of a hospital] and the medical staff, so it is essential that the bylaws include provisions that ensure medical staff involvement in the medical decision-making of hospitals, integrated delivery systems, or health plans.”

While this is the ideal, the reality has unfortunately become otherwise.

Over roughly the past ten years the concept of a fairly bargained “contract” between a hospital and its medical staff has slipped away, as did the ideal that the medical staff was anything like an equal partner of the hospital administration as to medical decision-making. Instead of providing a blueprint for self-governance, medical staff bylaws explicitly have come to incorporate language making the staff subservient to “paramount” power and authority of the Board of Trustees of the hospital and the bylaws “of the Board of Trustees.” For example, instead of the organized medical staff retaining the exclusive authority to propose amendments to its own bylaws, this authority was explicitly or in practice delegated to the Medical Executive Committee or even to a hospital officer. And, membership on that executive committee frequently has come to include hospital officers who were entitled to participate in every discussion and vote of the committee. And, physicians employed by the hospital have come to function as officers of the medical staff.

---

<sup>1</sup> The Florida Supreme Court in its opinion explained, “... The adoption of the Medical Staff Bylaws, although not the specific terms, was a requirement for Lawnwood to maintain its accreditation, through the Joint Commission for the Accreditation of Health Care Organizations ...” (emphasis supplied) However, after March 31, 2011, the adequacy of specific terms in the Medical Staff Bylaws will be a requirement of the Joint Commission.

Lending momentum to this trend has been the reluctance of many medical staffs to utilize independent legal counsel, notwithstanding the clear admonishment of the American Medical Association that “hospital medical staffs retain their own attorney so that the medical staff will have its own legal advocates for guidance.” (AMA Policy Compendium sec. 235.992)

On March 12, 2010, the Joint Commission adopted a new standard concerning medical staff self-governance and bylaws, numbered MS.01.01.01 effective March 31, 2011.

MS.01.01.01 is comprised of thirty-six (36) Elements of Performance (EPs) that now must be included in the medical staff bylaws of each accredited hospital. The professed goals of these include the promotion of self-governance of the organized medical staff, with accountability to the governing body, so that there is a well functioning relationship with clearly defined roles for everyone. Another objective is that the organized medical staff and the Medical Executive Committee work in close collaboration with each other.

Some of the important EPs are: only the organized medical staff may submit proposals to amend the medical staff bylaws to the governing body, and this function may “not” be delegated by the staff (EP3) or usurped by others, that the medical staff bylaws and the governing body bylaws are to be “compatible with each other” (EP4) rather than one being paramount, that the governing body “upholds” the medical staff bylaws, rules and regulations and policies that it has approved (EP7), that the medical staff has the ability to adopt bylaws, rules, regulations and policies and to propose them “directly” to the governing body (EP8), that individual medical staff “members” may directly communicate with the governing body relative to a rule, regulation or policy (EP10), and that the Medical Executive Committee is to act “on the behalf of the medical staff between meetings of the organized medical staff” (EP23).

One tactic utilized by hospital administrators to gain an edge has been to take the initiative to have the medical staff bylaws drafted by attorneys retained by the hospital. In so doing, the proposed bylaws have been crafted to provide the hospital with unfair advantages to the detriment of the organized medical staff. For example, the requirements for depriving physicians of their hospital privileges have been lowered or made less fair in some instances. However, EP2 of MS.01.01.01 will now require that,

“[t]he organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. 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.” (emphasis supplied)

So it is now required that the organized medical staff initiates the process of adopting or amending medical staff bylaws, and the role of the governing body is limited to only approving that which the staff has first proposed. Obviously one advantage of making such a proposal is the prerogative to draft that proposal.

EP 23 also warrants special attention and provokes the following questions: how can the Medical Executive Committee be said to act “on behalf of the medical staff” when representatives of the hospital administration are members of the executive committee, with unfettered access to all discussions and deliberations of the committee, or are physicians employed by the hospital? If the executive committee structurally cannot be perceived as capable of acting “on the behalf of the medical staff between meetings of the organized medical staff” is not the hospital noncompliant with MS.01.01.01? In this regard it deserves emphasis that the “AMA (1) supports the right of any hospital medical staff committee to meet in executive session, with only voting members of the medical staff present, in order to permit open and free discussion of issues such as peer review and to maintain confidentiality; and (2)

encourages individual medical staffs to incorporate provisions in their bylaws to affirm this right.” (AMA Policy Compendium H-235.987)

Advocates need tools with which to work. With a helpful boost from vigilant and competently represented medical staffs, MS.01.01.01 appears to offer the potential to become an effective mechanism to reverse the tilt in favor of hospital administrators.