

MS.1.20: AN OPPORTUNITY TO RESTORE MEDICAL STAFF GOVERNANCE AND ESTABLISH NEUTRAL PEER REVIEW

Joint Commission Medical Staff Standard 1.20 (MS.1.20) has been a polarizing issue between hospitals and physicians since first proposed in August 2006. Opposition from organized medicine to the first proposal resulted in a substantially revised proposal in July 2007, which responded favorably to organized medicine's concerns and prompted an equal and opposite reaction from the hospital industry.

The July 2007 version would have provided several significant protections for physician medical staff members, i.e.:

1. The Standards would have confirmed the requirement that amendment of the Medical Staff By-Laws required approval of both the medical staff and the hospital leadership;
2. The Standards would have specified required content for Medical Staff By-Laws, thereby preventing hospitals from shifting key provisions from the By-Laws to rules and regulations, which would not have been protected by the bilateral approval requirement;
3. The Standards would have established a process for removal of medical staff leaders and the direct proposal of by-law amendments by the Medical Staff as a whole.

These Standards were intended to become effective on July 1, 2009. The significant opposition from the hospital industry has caused the Joint Commission to backpedal, appoint a taskforce to study the problem in January 2008, and to announce in June 2008 the suspension of the implementation of MS.1.20 until it can be further reviewed. Physicians in organized medicine must seize this opportunity to impact this review process for two reasons:

1. The Joint Commission has acknowledged physician concern about inequities in the Medical Staff governance process and has signaled its willingness to attempt to incorporate physician's concerns in the new Standards; and
2. The Joint Commission Standards are national uniform standards, which hospitals seeking Joint Commission accreditation must satisfy, thereby establishing a position of leverage that physicians could never independently create.

Joint Commission Standards would apply regardless of the provisions of the Healthcare Quality Improvement Act or any state's peer review protection or confidentiality acts. There would be no need to seek legislative amendment at any level.

Sham peer review is a national problem, not because of its prevalence, but because there is little in the way of significant protection. Peer review is typically done by physicians, or at least with the mutual cooperation of physicians. Most physicians concede that fair and neutral peer review is common and the peer review system works well enough that it need not be overhauled. Sham peer review occurs when the normal peer review process is subverted to serve institutional political or economic objectives. All physicians should also concede that medicine is never

perfect; if you look hard enough and long enough, you are bound to find enough evidence to at least create the impression of a concern for substandard care.

Once that impression has been created, the typical peer review process only requires that medical staff committees and hearing panels decide whether there is enough evidence to justify the action taken by the hospital. Operating from an abundance of caution and perhaps fear of potential negligent credentialing litigation, the easy choice is to say that all of the evidence might not actually prove substandard care, but that it was at least sufficient for the hospital to be concerned enough to justify its actions. At that stage, adverse peer review action has already been taken, the harm has already been done, the physician has already been removed from the staff and from possibly the staffs of several other hospitals in a domino affect, and all the kings' horses and all the kings' men cannot put Humpty Dumpty together again. The status quo can never be restored!

The solution to preventing sham peer review requires just a little sunshine. State sunshine laws were enacted to allow appropriate monitoring. If the physicians being investigated were entitled, by the due process provisions of the by-laws, to appoint one member to any investigating committee and one member to any hearing panel, that single vote would not be enough to change the actual outcome of any decision. However, that "peer review monitor" would be sufficient, just by being able to report and explain the proceedings, to stop the process that physicians have labeled as sham peer review.

How can the hospital industry reject such a proposal? It does not change governance rights. It does not give the investigated physician control over any part of the process. If the hospital industry maintains that sham peer review does not occur, then it might have no impact at all. Without any parade of imaginary horrible consequences, how can the Joint Commission refuse to support a request as reasonable as this?