Duties and Responsibilities of the Governing Body
VOLUME 4

Section 1.0

Duties and Responsibilities of the Governing Body

Introduction

The governing body, also called the board of trustees or board of directors, has the ultimate responsibility and authority over the organization. The governing body delegates the day-to-day operations of the hospital to the chief executive officer (CEO) and medical staff leaders; however, the governing body has legal responsibility for the performance of the organization.¹ ²

Duties of the Governing Body

The governing body has a fiduciary duty to the organization. A fiduciary duty is a legal obligation to act solely in another party’s (i.e., the healthcare organization’s) interests³ and includes the “duty of care,” the “duty of loyalty,” and for nonprofit hospitals, the “duty of obedience.”⁴ ⁵

Duty of care

The duty to care requires governing body members to make decisions in good faith and in a manner they reasonably believe is in the best interests of the non-profit organization.⁶

The duty to care may be divided into two basic functions:

- The decision-making function
- The oversight function⁷

When making decisions for the hospital, governing body members are expected to ask questions and conduct due diligence in order to gain an understanding of the consequences of the decisions they are making.⁸ However, it is reasonable for governing body members to rely upon the recommendations from reliable sources.

The oversight function relates to the responsibility of governing body members to supervise the organization’s operations, including the quality of care provided within the organization. Governing body members fulfill this obligation, in part, by making the final decision regarding the appointment of providers to the medical staff, approving privileges for staff members, and reviewing and acting upon quality reports. Again, governing body members have an obligation to ask questions about the organization’s structure and operations in order to determine whether a sound system is in place for assessing and ensuring quality care.⁹

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When determining if a governing body member is meeting the duty to care, the prudent layperson standard is applied. This essentially means that the governing body member must act with the same prudence with which an ordinary person in a similar position would act. Prudent governing body members ensure that they understand governance and what is expected of them. They prepare for governing body meetings and ask questions to facilitate informed decision-making.¹⁰

**Duty of Loyalty**

The duty of loyalty requires governing body members to act honestly and faithfully with respect to the organization, even when the hospital’s best interests are adverse to the interests of the governing body members. To avoid violating the duty of loyalty, governing body members should abstain from activities that may result in personal gain or enrichment of a close family member or friend.¹¹ Organizations should have a conflict-of-interest policy to guide governing body members when these situations occur.¹² The Joint Commission’s Standard LD.02.02.01 states, “The governing body, senior managers and leaders of the organized medical staff address any conflict of interest involving leaders that affect or could affect the safety or quality of care, treatment and services.”¹³ The Elements of Performance for Standard LD.02.02.01 speak to defining conflict of interest in writing and developing a written policy that addresses how to address and disclose.¹⁴

**Duty of Obedience**

Governing bodies of non-profit organizations have a duty to ensure that the organization works towards achieving the charitable purpose and mission of the organization, as defined in the articles of incorporation or bylaws. The mission statement of most non-profit hospitals includes a commitment toward quality patient care.

Additionally, Element of Performance 1 for Standard LD.02.01.01 from The Joint Commission states, “The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital’s mission, vision, and goals.”¹⁵

### Responsibilities of the Governing Body

The responsibilities of the governing body of healthcare facilities are addressed by:

- CMS Conditions of Participation
- The Health Care Quality Improvement Act
- The Sherman Act, the Clayton Act and other antitrust legislation
- The Americans with Disabilities Act
- Other state and federal discrimination statutes and healthcare-related laws
- The Joint Commission, DNV and other accrediting agencies

This discussion describes some of the essential responsibilities of the healthcare governing body.
Governing Body Operations

The governing body is responsible for sustaining the governing body itself. For example, the governing body develops and enacts governing body bylaws and other governing body policies, recruits new governing body members, trains and orientates new governing body members, organizes governing body committees, conducts governing body meetings, and conducts governing body evaluations.\(^\text{16}\)

As the governing body is responsible for the performance of the entire organization, it is essential that strong individuals are selected. Governing body members should be not only willing to participate, but also possess the skills and competencies to provide leadership to the organization. The IRS Form 990 recommends that a majority of governing body members are “independent.”\(^\text{17}\) Form 990 defines an independent governing body member as follows:

1. The individual is not compensated as an officer or employee of the organization or any of its subsidiaries.
2. The individual does not, as an independent contractor, receive compensation or other payments exceeding $10,000 from the organization or any of its subsidiaries.
3. The individual and the individual’s family members are not a party to a business transaction that is required to be reported on Schedule L of the Form 990.\(^\text{18}\)

As discussed above, the governing body should develop and enforce a policy prohibiting conflicts of interest. The policy may include conducting an annual survey of governing body members to identify any ownership or investment interests that would disqualify them as a member.\(^\text{19}\)

Governing Body Orientation and Education

Having governing body members with clinical expertise is also important. Three separate Elements of Performance for The Joint Commission’s Standard LD.01.03.01 speak to this, stating that the governing body provides the organized medical staff “with the opportunity to participate in governance” and to “be represented at governing body meetings (through attendance and voice) by one or more of its members” and that organized medical staff members “are to be eligible for full membership in the hospital’s governing body, unless legally prohibited.”\(^\text{20}\)

It should be noted the Centers for Medicare Services revised the Governing Body and Medical Staff Conditions of Participation for hospitals in September 2014. With regard to governing bodies, the revisions removed the requirement that a hospital’s governing body must include a member of the medical staff and added a new requirement that the governing body must consult directly with the individual responsible for organization and conduct of the medical staff or his/her designee.\(^\text{21}\) With regard to the medical staff, the revisions clarify that categories of physicians other than MDs and DOs (e.g., doctor of dental surgery or of dental medicine, doctor of podiatry, doctor of optometry, chiropractor) may be appointed to the medical staff, as may some non-physician practitioners (e.g., physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical
psychologist, anesthesiologist’s assistant, registered dietician or nutrition professional), provided that such appointment is consistent with state law.22

All governing body members will benefit from an initial orientation program and ongoing educational programs that are designed to provide uniform information regarding the responsibilities of governing body members. The management team and risk management personnel can and should be instrumental in providing orientation and ongoing education to governing body members. Education may be provided at governing body meetings, governing body retreats, seminars, conferences and through distribution of internal and external publications.23

Governing body orientation should include, but not be limited to, the following topics:

- The organization’s mission and structure
- The governing body’s legal duties
- The organization’s policies
- An overview of the health organization, its partners and facilities
- Current legal trends
- Code of ethics
- Finance and reimbursement
- Quality and safety performance
- Compliance and conflict-of-interest issues24, 25

Promoting Effective Governance and Ensuring Financial Health

Corporate bylaws set forth the responsibilities of the governing body with regard to making determinations regarding general organizational policies and providing direction and counsel on hospital management, strategic planning and development. Activities include establishing overall plans and policies, supervising the CEO, ensuring that sufficient resources for the organization are in place, ensuring compliance with rules and regulations, and representing the organization to external stakeholders.26

Governing body members have a fiduciary responsibility for the sound financial management and operation of the organization. Element of Performance 4 of The Joint Commission’s Standard LD.04.01.03 states, “The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.”27 Sound financial oversight encompasses paying attention to all matters that might impact the organization’s viability.

One of the governing body’s most important governance functions is selecting a qualified and competent chief CEO. Day-to-day responsibility for operating the organization is delegated to the CEO, the chief operating officer (COO), the vice president of medical affairs/chief medical officer (CMO)/chief of staff, and senior managers. The governing body is responsible for strategic planning and providing oversight. Effective governing bodies set performance expectations for the CEO, provide support and resources, and evaluate the CEO’s performance in furthering the organization’s mission and achieving their stated objectives.28
Demonstrating Commitment to Quality, Risk-Control and Patient Safety

The governing body is ultimately responsible for the quality and safety of care provided by the healthcare organization and its practitioners, including physicians and other staff members. Because of the existing potential for significant liability and loss exposure, the governing body members must acknowledge and faithfully carry out their responsibilities to work toward achieving the highest quality of care and patient safety.

Corporate negligence may be alleged if a quality monitoring system is not in place to evaluate and monitor the performance and competence of practitioners, or if actual or potential patient care problems are not investigated. Negligence may also be alleged if actions are not taken to address identified deficiencies.

Some years ago, the Institute for Healthcare Improvement (IHI) published Getting Boards on Board: Engaging Governing Boards in Quality and Safety as part of its 5 Million Lives Campaign. It is still considered a seminal publication for developing healthcare governance. The author identified six activities that all governing bodies should incorporate into their processes:

- Set aims. The governing body should set specific goals for improving quality and patient safety.
- Get data and hear stories. Consider starting governing body meetings with a story, from the perspective of a patient and/or a patient’s family member, regarding some harm that has occurred in the organization. While data are important, stories “put a face” on the data and make it personal.
- Establish and monitor system-level measures. Use a dashboard tool.
- Change the environment, policies and culture. Support patients, families and staff members when an adverse event occurs.
- Learn, starting with the governing body. Educate the governing body members on “governing body best practices” so that they can be the best governing body possible. Spread the philosophy and practice of education throughout the organization.
- Establish executive accountability. Align executive compensation with the achievement of quality goals.

Since the article was published, many healthcare organizations have adopted its recommendations. A survey and report published in 2012 revealed that 83 percent of board chairpersons and 71 percent of CEOs had developed precise quantifiable objectives related to service quality and patient satisfaction. The report also indicated that a significant majority of CEOs are held accountable for defined objectives during the performance review process.

While it is not the role of the governing body to become involved in the day-to-day operational aspects of quality and risk management, it does retain accountability for establishing and monitoring the effectiveness of the risk management, patient safety and quality improvement programs. It is recommended that, from an oversight perspective, the governing body participates in the analysis and evaluation of corporate risks and in improving patient safety. The Joint Commission recommends that hospital leaders should consider the following to optimize patient safety and quality of patient care:
- Using data to drive and support decisions
- Developing a hospital-wide plan and providing resources
- Implementing a system to communicate progress on key indicators and activities
- Managing changes to improve performance
- Providing adequate staffing

The Centers for Medicare and Medicaid Services (CMS) also addresses the responsibilities of hospital governing bodies with regard to quality and patient safety, to wit:

§482.21 Condition of participation: Quality assessment and performance improvement program

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

(a) Standard: Program scope.
   (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.
   (2) The hospital must measure, analyze and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations.

(b) Standard: Program data.
   (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization.
   (2) The hospital must use the data collected to--
      (i) Monitor the effectiveness and safety of services and quality of care; and
      (ii) Identify opportunities for improvement and changes that will lead to improvement.
   (3) The frequency and detail of data collection must be specified by the hospital's governing body.

(c) Standard: Program activities.
   (1) The hospital must set priorities for its performance improvement activities that--
      (i) Focus on high-risk, high-volume, or problem-prone areas;
(ii) Consider the incidence, prevalence, and severity of problems in those areas; and
(iii) Affect health outcomes, patient safety and quality of care.

(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

(3) The hospital must take actions aimed at performance improvement and, after implementing those actions the hospital must measure its success, and track performance to ensure that improvements are sustained.

(d) Standard: Performance improvement projects. As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects.

(1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations.

(2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes.

(3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.

(4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.

(e) Standard: Executive responsibilities. The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:

(1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.

(2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.

(3) That clear expectations for safety are established.

(4) That adequate resources are allocated for measuring, assessing, improving and sustaining the hospital's performance and reducing risk to patients.

(5) That the determination of the number of distinct improvement projects is conducted annually.34
Hospitals also have other incentives to improve healthcare quality. For example, under the healthcare reform law of 2010, CMS began to link hospital reimbursement to publicly-reported quality outcomes. CMS further impacted hospital finances by refusing reimbursement for hospital-acquired conditions. Some private health insurance companies have adopted the same or similar positions.

Quality Reports to the Governing Body

It is recommended that the governing body regularly receives and considers reports generated by internal quality review systems. Element of Performance 13 of The Joint Commission’s Standard LD.04.04.05 states that, at least once a year, leaders are to provide the governing body with written reports on the following:

- All system or process failures
- The number and type of sentinel events
- Whether the patients and the families were informed of the event
- All actions taken to improve safety, both proactively and in response to actual events
- For hospitals that use Joint Commission Accreditation for deemed status purposes: The determined number of distinct improvement projects to be conducted annually
- All results of the analyses related to the adequacy of staffing

It is also recommended that the governing body receives reports of the findings of external review entities (e.g., The Joint Commission, state department of health). Doing so will help governing body members understand the review process and provide them with an overall impression of the facility’s quality and continuing needs for performance improvement. When undesirable variations in performance occur, the governing body must ensure that appropriate performance improvement activities are undertaken. Examples of quality indicators for governing body review, in the form of quarterly summary reports and related corrective action reports, include, but are not limited to:

- Outcome of publicly reported quality indicators
- Outcomes of core measures
- Hospital-acquired conditions trending
- Infection data
- Comparative overall mortality rates, severity-adjusted
- Neonatal and maternal mortalities
- Perioperative mortalities
- Facility-incurred patient injuries and traumas
- Comparative rates for hospital-acquired infections
- Patient complaints, categorized by type and grievance resolution
- Patient satisfaction survey trends
- Patient fall rates, grouped by severity and outcome
• Adverse drug reaction and medication error rate, grouped by severity, outcome and causes
• Unplanned transfer to other acute care facilities
• Staff member recruitment, shortage, retention and turnover rates
• Staff member complaints
• Staff member satisfaction survey reports
• Medical staff complaints
• Medical staff satisfaction survey reports
• Content analysis summaries (i.e., positive, negative or neutral ratings) of newspaper and electronic media stories about the healthcare organization

In addition to receiving and reviewing reports, the governing body must continually assess whether the organization is meeting the health needs of its community. This is important to determining how well the facility is tailoring services to its community and to maintaining its tax-exempt status with the Internal Revenue Service.  

The Affordable Care Act of 2010 has imposed requirements for charitable tax-exempt hospitals. Some of these hospitals have employed strategies to address community health needs. One healthcare system developed policies to integrate community health activities into its mission and established advisory committees that include members of the governing body and the community. Another healthcare system developed a community health-focused improvement plan after obtaining input at community meetings. Such efforts can go a long ways toward demonstrating a hospital's commitment to the community and how it prioritizes needs that are important to residents.

The risk management professional can play an integral role by providing the governing body with education and resources to assist it in discharging its quality and patient safety oversight responsibilities at an optimal level.

**Monitoring the Governing Body’s Effectiveness**

Consistent with the principles of continuous performance improvement, the governing body is responsible for carrying out its own responsibilities and assessing the effectiveness of its activities on the organization as a whole. The Joint Commission addresses the governing body’s responsibility for evaluating its planning process in the following Elements of Performance:

- Leaders evaluate the effectiveness of planning activities. [LD.03.03.01, EP 7]
- Leaders evaluate the effectiveness of processes for the management of change and performance improvement. [LD. 03.05.01, EP 7]  

Governing body evaluation of its success in promoting quality and patient safety throughout the organization is also addressed by The Joint Commission in the following Elements of Performance:

- Leaders regularly evaluate the culture of safety and quality using valid and reliable tools. [LD.03.01.01, EP 1]
Leaders evaluate how effectively data and information are used throughout the hospital. [LD.03.02.01, EP 7]
Leaders evaluate the effectiveness of communication methods. [LD.03.04.01, EP 7]
Leaders evaluate the effectiveness of those who work in the hospital to promote safety and quality. [LD.03.06.01, EP 6]

The governing body should also annually review how well it facilitated meeting the organization’s targets and goals with regard to the following:

- Decreasing adverse events and near-miss events
- Decreasing the number and severity of new claims
- Nearing 100 percent compliance with respect to high-risk procedures, as evidenced through audits
- Decreasing variation in standard procedures
- Improving the resolution of difficult patient events, as evidenced by clinical case reviews
- Decreasing the number, type and severity of patient complaints
- Implementing recommendations made as a result of survey assessments of clinical services and risk management practices

Such a review is only helpful if the results are used to develop action plans which are designed to enhance governing body performance.

The performance and contributions of individual governing body members should be evaluated, particularly with regard to the following:

- Mission, vision and strategic plan
- Business conduct and no conflict of interest
- Participation in community benefit projects
- Opinions on compensation and evaluation of leaders
- Ongoing governing member education and responsibilities
- According to a survey reported in 2012, when CEOs and board chairpersons were asked what type of assessments their boards use, 64 percent of the CEOs and 46 percent of the board chairpersons replied that their boards use a regular full board assessment. Additionally, 60 percent of the surveyed board chairpersons indicated that “individual board member assessment results are used to create an action plan to improve the performance/contribution of each board member.”

Conclusion

As the healthcare landscape continues to evolve, the governing body must be poised to facilitate the provision of safe, high-quality care. To do this, governing body members need to commit to continually learning and understanding all aspects of healthcare governance. They must also embrace the day-to-day regulatory and financial challenges of an industry that is vital to the community it serves.
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7. Ibid.
8. Roberta Carroll (Series Ed.) and Peggy Nakamura and Roberta Carroll (Volume Eds.), p. 82.
9. Ibid.
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18. Ibid.
19. Ibid.
20. The Joint Commission, Accreditation Requirements – Hospital Program.
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28. Roberta Carroll (Series Ed.) and Peggy Nakamura and Roberta Carroll (Volume Eds.), p. 84.

29. The Joint Commission, *Accreditation Requirements – Hospital Program*, Standard LD.01.03.01.


32. Ibid.

33. The Joint Commission, *Accreditation Requirements – Hospital Program*, Standard LD.03.05.01.

34. 42 CFR §482.21.


37. The Joint Commission, *Accreditation Requirements – Hospital Program*.


39. Ibid.

40. Ibid.

41. Ibid.

42. The Joint Commission, *Accreditation Requirements – Hospital Program*.

43. Ibid.


45. Mary K. Totten, “Hospital Governance in the U.S.: An Evolving Landscape.”

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The medical staff and its activities are key components of a healthcare organization. The interaction between the governing body and the medical staff is integral to developing and executing an organization’s strategic goals, securing resources, and measuring progress in delivering high-quality patient care and remaining financially viable. The absence of a strong relationship between the governing body and the medical staff can result in poor governance and associated liabilities.

Theories of Liability

The governing body is responsible for appointing members to the medical staff. This appointment process is one of the most important governing body functions related to the quality of care. In the area of medical staff member appointment and reappointment, hospitals face liability exposure from both patients and members of the medical staff. Patients may allege that a member of the medical staff was negligently credentialed. A member of the medical staff may claim that the governing body wrongfully denied his/her application for appointment or reappointment to the medical staff.

The doctrine of corporate negligence – sometimes referred to as negligent credentialing – may be used to bring a lawsuit directly against a hospital. The doctrine or theory of corporate negligence, as it applies to healthcare organizations and their alleged duty to ensure the qualifications of the physicians who practice there, was first adopted in the 1965 Illinois case of Darling v. Charleston Community Hospital. In the Darling case, the Supreme Court of Illinois ruled that hospitals have an independent duty to ensure that high-quality care is provided and that a hospital can be held “accountable for negligently screening the competency of its medical staff.”

As mentioned above, a medical staff member who believes that he/she was denied appointment or reappointment to the medical staff may also pursue an action against the hospital. Hospitals have a duty to comprehensively determine the qualifications of an applicant before appointing the applicant to the medical staff. The governing body has the final say on appointments and reappointments and thereby can become the focus in a denial of appointment/reappointment case. Courts will look to whether reasonable care, due diligence and fairness were exercised throughout the appointment/reappointment process. These duties are imposed by statutes and a number of legal rulings. In the area of medical staff membership, an appropriate procedural due
process is addressed by the Health Care Quality Improvement Act of 1986. By complying with the Act's provisions for giving notice and allowing a fair hearing, the organization is granted immunity for actions taken in good faith.³

The best protection against claims based upon denial of appointment/reappointment is to have well-defined criteria for granting appointment to the medical staff. The following are recognized as reasonable criteria: required qualifications (board certification/eligibility), evidence of standard knowledge and skills, and provisions related to character or conduct. Once the criteria have been established, it is important that they are applied consistently, without regard to race, gender, national origin, handicap, etc. The governing body must ensure that criteria are in place, that the criteria are reasonable, and that the criteria are applied fairly and evenly.

Some governing body members may not be familiar with medical issues and may feel uncomfortable asking questions regarding issues of medical judgment. However, the improvement and safeguarding of patient care through quality review processes is an essential element of every healthcare organization's mission. For this to be meaningfully accomplished, those involved in the professional medical peer review process need unrestricted freedom to evaluate individual practitioners and the care provided, and to do so in an atmosphere of complete confidentiality.

**Governing Body Duties and Responsibilities Related to the Medical Staff**

The responsibility and authority of healthcare organizations to review the qualifications and performance of medical staff members is now well established. This responsibility has been underscored and reinforced through statutory requirements, the requirements of CMS, the standards of accreditation entities (e.g., The Joint Commission, DNV-National Integrated Accreditation of Healthcare Organizations [NIAHO], the Healthcare Facilities Accreditation Program [HFAP]), and precedent-setting legal decisions.

**CMS Requirements**

In a September 2014 transmittal, CMS clarified the governing body’s responsibilities to the medical staff, to wit:

Additionally, §482.12(a) was revised by the final rule to add a new requirement at §482.12(a)(10) that the governing body must consult directly with the individual responsible for the organization and conduct of the hospital’s medical staff, or his/her designee. The consultation is required to be periodic throughout the year (where we expect it to occur at least twice in a fiscal or calendar year) and to include discussion of matters related to the quality of medical care provided to the hospital’s patients. For a multi-hospital system using a single, unified governing body, there must be consultation directly with the individual (or designee) responsible for the medical staff in each hospital within its system.⁴

Also, with regard to the medical staff making recommendations to the governing body, the transmittal clarified some prior language, to wit:
Section 482.22(a)(2) was revised to address an inadvertent omission of regulatory language in our prior guidance. The full text now reads: “The medical staff must examine the credentials of all eligible candidates for medical staff membership and make recommendations to the governing body on the appointment of the candidates in accordance with State law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations, in addition to the requirements contained in this section.”

The healthcare organization and governing body are obliged to use reasonable care to:

- Verify the accuracy of information provided on the application for medical staff membership
- Inquire as to why certain questions on the application were left unanswered
- Investigate disclosed practice problems
- Adhere to internal procedural guidelines, those of recognized accreditation agencies (e.g., CMS, The Joint Commission, DNV-NIAHO, HFAP), and relevant statutory and regulatory requirements

Since the governing body has legal responsibility for the quality of care in the institution and oversight of the medical staff, its members should receive orientation and education from the risk management professional on the principles of risk identification, loss prevention and control, and on regulations and standards to assist them in discharging their responsibilities. The educational process should also include a review of aggregated data regarding patient safety and physician practice patterns, an explanation of variances, and an analysis of claims activity for the selected time period. The risk management professional may seek the assistance of legal counsel and insurance company representatives to help convey additional significant information to the governing body.

### Accreditation Requirements

**The Joint Commission**

The Joint Commission addresses the interaction of the governing body and the medical staff in several standards applicable to hospitals:

- **LD.01.05.01** - The hospital has an organized medical staff that is accountable to the governing body.
- **LD.02.02.01** - The governing body, senior managers, and leaders of the organized medical staff address any conflict of interest involving leaders that affect or could affect the safety or quality of care, treatment and services.
- **LD.02.03.01** - The governing body, senior managers, and leaders of the organized medical staff regularly communicate with one another on issues of safety and quality.
MS.01.01.01 – Medical staff bylaws address self-governance and accountability to the governing body.

MS.01.01.03 – Neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations.

MS.07.01.01 – The organized medical staff provides oversight for the quality of care, treatment, and services by recommending members for appointment to the medical staff.

EP 5 – Membership is recommended by the medical staff and granted by the governing body.6

Whatever methods are chosen for effective collaboration between the governing body and medical staff, it is crucial that open and honest communication take place.

DNV National Integrated Accreditation for Healthcare Organizations (NIAHO®)

The NIAHO® addresses the interaction of the governing body and the medical staff in several accreditation requirements:

**MS.1 Organized Medical Staff**

The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

**MS.3 ACCOUNTABILITY**

The medical staff shall be organized in a manner approved by and accountable to the governing body and shall be responsible for the quality of the medical care provided to patients.

**MS.7 MEDICAL STAFF BYLAWS**

SR.1 The medical staff shall be appointed by the governing body and operate under bylaws, rules and regulations adopted and enforced by the medical staff and approved by the governing body.

SR.2 Changes to the medical staff bylaws, rules and regulations shall require approval of the medical staff and the governing body.

SR.3 The medical staff bylaws shall describe the organization of the medical staff and include a statement of the duties and privileges of each category of medical staff to ensure that acceptable standards are met for providing patient care for all diagnostic, medical, surgical, and rehabilitative services.

SR.4 Medical staff bylaws shall include provisions for mechanisms for corrective action, including indications and procedures for automatic and summary suspension of medical staff membership or clinical privileges.

**MS.9 PERFORMANCE DATA**
Practitioner specific performance data is required to be evaluated, analyzed and appropriate action taken as necessary when variation is present and/or standard of care has not been met as determined by the medical staff. Performance data will be collected periodically within the reappointment period or as required as a part of the peer review process. This may include comparative and/or national data if available. …

**Interpretive Guidelines:**

The governing body must ensure that the medical staff is accountable to it for the quality of care provided to patients. The governing body must be provided with information (data) in order to evaluate the quality of care provided to patients.

The hospital must define and measure the respective elements within this standard to generate a quality profile for each medical staff member to be used for evaluation as a part of the appointment and reappointment process.

**MS.11 GOVERNING BODY ROLE**

SR.1 The governing body shall appoint members of the medical staff and approve clinical privileges after considering the recommendations of the existing members of the medical staff and ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.
SR.2 The governing body may elect to delegate the authority to render initial appointment, reappointment, and renewal or modification of clinical privileges decisions to a committee of the governing body.
SR.3 The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.
SR.4 A complete application shall be acted on within a reasonable period of time, as specified in the medical staff bylaws.

**Interpretive Guidelines:**

The governing body, with the advice of the medical staff, is responsible for the appointment and reappointment of the individual practitioners of the medical staff and their respective delineation of privileges.

This process may be carried out by a committee that has been delegated by the governing body to oversee the appointment and reappointment of medical staff members and their respective delineation of privileges. The process for appointment and reappointment will be carried out within a reasonable timeframe as defined within the medical staff bylaws.

The hospital cannot grant appointment, reappointment and allow privileges that are solely based upon certification, fellowship, or membership in a specialty body or society.
The Interpretive Guidelines for MS15 provide that the governing body must also ensure that a doctor of medicine or osteopathy is responsible for the care of each patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization. 

## Conclusion

A healthcare organization that strives for and facilitates a strong relationship between its governing body and medical staff will reap untold benefits in delivering high-quality and efficient patient care. The organization will also be recognized as vital to the community it serves when it reaches out to the community to determine and develop programs to address the most pressing healthcare needs.

## References

2. Ibid.
5. Ibid.
8. Ibid.

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