CMS Steps Up Oversight of the Joint Commission

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The Joint Commission on the Accreditation of Healthcare Organizations, which provides the standard in hospital accreditation in the United States, will soon be subjected to greater federal oversight.

Congress recently eliminated the Joint Commission's "unique deeming authority" for hospitals as part of the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331), which was enacted in July. That means that the Joint Commission, like other accrediting bodies, will need to apply to the Centers for Medicare and Medicaid Services in order for its accredited hospitals to be deemed to have met the conditions of participation in Medicare. Previously, the Joint Commission's deeming authority had been automatic and was not subject to oversight by the CMS.

Officials at the Joint Commission supported the intention of the change, and plan to apply to CMS for hospital deeming authority. The Joint Commission and other accrediting bodies already apply to CMS for deeming authority in other areas, such as home care, laboratory, and ambulatory surgery accreditation programs.

Under the new law, the Joint Commission will have 24 months to apply to CMS for deeming authority and to be recognized. During the transition period, accredited hospitals will not be affected by this change, according to the Joint Commission.

In 2004, the U.S. Government Accountability Office (GAO) issued a report that called on Congress to consider giving the CMS greater authority over the Joint Commission's hospital accreditation program. GAO investigators examined state agency validation surveys for 500 hospitals accredited by the Joint Commission and found that the Joint Commission had missed most of the serious deficiencies picked up during the state reviews. ■

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the aid delivered" (*Perkins v. Howard*, 232 Cal.App.3d 708 [1991]).

There is no universal definition of gross negligence, but the term is frequently equated with willful, wanton, or reckless misconduct.

One can think of gross negligence as aggravated negligence, involving more than mere mistake, inadvertence, or inattention, and representing highly unreasonable conduct, or an extreme departure from ordinary care where a high degree of danger is apparent (Prosser, W.L. et al., eds. "Prosser and Keeton on Torts," 5th ed., St. Paul, Minn.: West Publishing Co., 1984, pp. 211-4).

In most cases, Good Samaritan statutes do not require doctors to come to the aid of strangers, but protect against liability arising out of negligent rescue.

Statutory protection is generally excluded for Good Samaritan acts performed within a hospital setting under the theory that doctors have an ongoing relationship with the hospital and are already obligated to provide emergency care within its walls.

A minority of states such as California and Colorado do provide immunity irrespective of the location of aid.

Commentators have observed that very few lawsuits have involved Good Samaritan doctors and that such laws are both unnecessary and ineffective.

Those who are averse to helping will remain on the sidelines even with the protection of the law.

In a 1963 survey by the American Medical Association, approximately half of responding physicians said they would render emergency help, and this did not depend on whether there was a Good Samaritan statute in place (Sanders, G.B. First Results: 1963 Professional-Liability Survey. JAMA 1964;189:859-66). ■

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