

# The Government Inspector

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Before every Joint Commission visit to our hospital I can't help recalling the classic novel *The Government Inspector* by the Russian author N.V. Gogol. In this work Gogol satirizes the corrupt officials of a small provincial town who hear a rumor that a government inspector will soon be arriving and who subsequently mistake an impostor for the real inspector.

As in the novel, a visit to a hospital from the Joint Commission's "inspector" begins with a rumor. Although Joint Commission inspections occur with more or less predictable regularity, the exact time of the visitor's arrival is always a matter of guesswork. And, as in the novel, the anticipation of "the visit" is a time of palpable anxiety that initially afflicts the administration and subsequently spreads to clinical and support staff, all the way down to the folks who clean the floor. After all, even housekeeping is expected to have the correct answer on hand if an inspector asks an all-important question.

We are told, in hushed tones, that a sister hospital was "dinged" on such-and-such, the such-and-such usually being a matter of trivial clinical significance but of paramount importance to the culture of "compliance." And so in preparation for the visit, policies are read and reread, correct answers rehearsed, and walls are adorned with posters listing the Joint Commission's Patient Safety Goals.

## The History of Hospital Accreditation Organizations

The American College of Surgeons, formed in 1913, was the first body that conducted voluntary hospital inspections starting in 1918. The Joint Commission on Accreditation of Hospitals (JCAH) was formed in 1951 as a joint venture of the American College of Surgeons, the American Hospital Association, the American Medical Association, and the Canadian Medical Association. At its inception, JCAH was to be an independent nonprofit organization that provided voluntary accreditation for meeting established minimum quality standards.

By 1970 the goals of JCAH inspections were changed from making certain that medical facilities met minimum necessary levels of safe care, to ensuring that they delivered highest achievable levels of care. The company's name was changed to Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1987, and in 2007 its name was shortened to the Joint Commission. Although technically Joint Commission accreditation remains voluntary, without such accreditation a medical facility is not likely to obtain

state licensure required for operation.<sup>1</sup> When the Joint Commission says "jump," the hospital had better ask "how high." The answer is likely to be "higher than last time."

The officials in Gogol's satire were, indeed, corrupt and had good cause to fear the visit of a government inspector. In general it makes sense that a badly run public service institution be held accountable for its faults and that some mechanism should exist for correcting the way it functions. It also makes sense that a hospital or a clinic that cares about its reputation should be interested in showing that the care it provides is safe.

Although one might not necessarily look forward to having one's performance checked, the objection to inspection is diminished if the inquiry is perceived as reasonable and in one's own best interest. However, over the years meeting Joint Commission safety requirements has become akin to hitting a moving and ever-smaller target. One would think that hospitals previously accredited by the Joint Commission would already be providing safe care, after addressing deficiencies discovered on multiple prior inspections. But where past errors no longer occur, there is always a possibility of finding new errors, especially if what did not count as an error on previous inspections is redefined as one on future visits.

One gets the impression that goals such as "safety" and "compliance" cannot and are not meant by the Joint Commission to be achieved in reality. Like the horizon, they are intended to recede as soon as they appear within reach because what constitutes compliance today will not necessarily do so tomorrow. Indeed, the very idea that hospitals should be able to demonstrate continuous improvement in the services they provide means that there is no end to possible improvements in quality of care and that "quality healthcare" will always remain an elusive goal. Such an expectation also guarantees a perpetual source of income for an accrediting institution such as the Joint Commission.

## Joint Commission Finances

When I asked Joint Commission inspectors a few years ago who paid their organization to perform a "survey," the surprising answer was that the fee was paid by the hospital undergoing the inspection. In other words, hospitals pay the Joint Commission a fee in exchange for being certified by this organization as delivering care that meets its standards. In this way the Joint Commission functions very much like

the American Board of Medical Specialties (ABMS), which extracts a regularly occurring fee from individual doctors for maintenance of certification by the same board.

The reason behind the requirement that hospitals and individual physicians maintain—in other words, continuously justify—their respective certifications is ostensibly protection of the public, as defined by the agencies that grant them. Put another way, the Joint Commission and the ABMS take money from hospitals and physicians for the protection of other people, which is an interesting variation of the protection racket. Unfortunately, unlike the Joint Commission, which now has to compete against other accrediting bodies (see below), ABMS retains a monopoly over board certification.

It does not take a great leap of imagination to consider the possibility that the Joint Commission explains its relevance by disguising its own financial needs as the needs of the public to receive safe care.

A full Joint Commission survey costs a hospital an average of about \$46,000.<sup>2</sup> In 2005, the Joint Commission's income from survey fees reportedly amounted to \$92.3 million, and total compensation and benefits of then-president Dennis O'Leary amounted to close to \$2 million.<sup>3</sup> Between 2008 and 2009, the Joint Commission's net income, according to its IRS Forms 990, spiked by 170 percent, from \$3.6 to \$9.8 million.<sup>4</sup> By 2013 the Joint Commission reported a net income of more than \$14 million, even after paying almost \$93 million in salaries to its employees.<sup>5</sup> In 2015 the Joint Commission reported that its net revenue was \$12.9 million and that its CEO earned close to \$1.3 million.<sup>6</sup>

Of note, the Joint Commission is exempt from paying income tax.

It appears that collecting money from hospitals anxious to assure the public that they provide safe care is an extremely profitable business. Since it is the Joint Commission that defines what constitutes safe care, paying the Joint Commission is how hospitals demonstrate that the care they provide is safe. And since the definition of safe care changes all the time, an organization such as the Joint Commission is guaranteed an income in perpetuity. The notion that medical organizations have the burden of showing “continuous improvement” serves the Joint Commission well by ensuring that the agency's services will always be needed.

As for who monitors the monitors, it is interesting to note that no one accredits the Joint Commission. It appears to regulate itself, something an individual hospital apparently cannot be relied upon to do.

In July 2008, Congress enacted a law requiring the Joint Commission and any other accrediting body seeking “deeming status” to apply for such status through Centers for Medicaid and Medicare Services (CMS).<sup>7</sup> Although the Joint Commission still surveys the vast majority of U.S. hospitals, it no longer has a monopoly on its services. As of 2008, CMS had granted deeming authority to two other organizations: Healthcare Facilities Accreditation Program (HFAP) and Det Norske Veritas Healthcare, Inc. Perhaps in

time more competition among hospital accrediting bodies will result in reduced costs and a lower regulatory burden to U.S. hospitals.

## Preparing for the Next Visit

Despite the “unannounced” nature of our next Joint Commission survey, our hospital is in the midst of preparing for it. News of visits to sister hospitals and rumors of the problems discovered during these inspections approach us like so many storm clouds. We passed with only a few problems last time, but who knows what new deficiencies will be found this time around? A recent e-mail from the hospital's administration stated that the arrival of the surveyors should not be announced over the hospital's public address system and that until their identities are verified the surveyors are to be confined to the lobby.

Gogol would have found this amusing.

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