

Medical Staff in Need of Change

Explore a revolutionary way to reorganize your medical staff

By Dennis J. Purtell, JD

MEDICAL STAFF ROOTS date back to initial quality improvement efforts of physician leaders such as Ernest A. Codman, a surgeon who led in the initiation of review of the quality of surgical care in the early 1900's.

Paul Starr noted in *The Social Transformation of American Medicine*¹ that the American College of Surgeons first took a formalized approach to hospital surgical review in 1919, establishing a voluntary standard that ACS-approved hospitals must affiliate physicians into a "definite medical staff."

In addition to dealing with the intense financial and competitive elements then dividing organized medicine, the surgeons recognized a need for an organized quality evaluation of surgical services that required a more formal organization of surgeons at hospitals.

These concepts matured to create the Joint Commission on Accreditation of Hospitals (JCAH) in 1951.

The historical development of hospitals from charities sponsored by wealthy patrons to today's medical centers was not an easy road. Three centers of authority and power emerged:

1. The governing board
2. Physicians
3. Executive management

"Instead of a single governing power, three centers of authority are held together in loose alliance," Starr states. "Hospitals remained incompletely integrated, both as

IN THIS ARTICLE...

With demands on hospital medical staffs growing more complex, the days of volunteer or popularly elected medical staff leaders are fading fast. Take a look at the history of medical staff leadership and learn about dramatic changes that could make your medical staff function more smoothly.

organizations and as a system of organizations—a case of blocked institutional development, a precapitalist institution radically changed in its functions and moral identity but only partially transformed in its organizational structure."

Medical staff regulation

The initial Standards by the JCAH (now the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO) required accredited hospitals to have organized medical staffs.

The medical staff was responsible for overseeing the clinical practice and quality of care provided by physicians at the hospital. While recognizing the ultimate responsibility for patient care in a hospital is vested in the governing board, a *de facto* delegation of most of these functions to the medical staff exists in hospitals.

External regulation of hospital medical staff functions was very limited until the advent of the federal government payment programs in the 1960s. Additional regulation stemmed from judicial decisions establishing the doctrine of corporate liability of hospitals for the professional negligence of independently practicing physicians providing care at the hospital.

The *Darling v Charleston Memorial Hospital*² and *Johnson v. Misericordia Hospital*³ cases clearly established that hospitals have liability responsibility for patient injuries caused by acts or omissions of physicians on the medical staff.

This responsibility exists even if the physician is not employed by the hospital, but while acting as an independent contractor. Fulfillment of some of the regulatory responsibilities of hospitals is accomplished through the effective performance of an organized medical staff.

In particular, this includes:

- Credentials review
- Appropriate privilege delineation
- Quality of care and risk management activities

As hospital responsibilities increased, the ability to get physicians to perform required medical staff functions diminished.

Physician involvement has been, in effect, quid pro quo. That is, in exchange for the hospital providing the essential professional and technical staff assistance, equipment and supplies to support patient care, physicians are expected and required to provide voluntary services in medical staff leadership, service on committees and departments.

Recent developments

Until the last decade, the quid pro quo approach functioned fairly effectively. Volunteer physician services generally fulfilled the primary functions of a medical staff.

These activities included:

- Reviewing physician credentials
- Making recommendations for staff appointment and clinical privileges to the hospital governing body
- Reviewing quality of care in committee and clinical department activities
- Participating in hospital clinical services planning
- Providing continuing medical education
- Participating in the accreditation process and other regulatory compliance



Pressure to produce strong financial results requires medical staff physicians to devote more time to patient service and less time to medical staff responsibilities.

The scene changed dramatically in recent years.

Medical staff leadership activities matured into real jobs requiring special skills. Collaborative medical staff relationships often transformed into competitive camps of physicians with differing allegiances.

Medical staffs of the past were often composed of independently practicing physicians. Today, many hospital medical staffs are a mixture of hospital-employed physicians, physicians providing services under exclusive specialty service agreements and independent physicians.

Pressure to produce strong financial results requires medical staff physicians to devote more time to patient service and less time to medical staff responsibilities. All this reduces physicians' willingness and ability to provide the volunteer medical staff leadership services required by hospitals.

With more complex medical staff tasks, hospital support staff is now handling functions formerly performed by physicians. In some places, intense differences exist between a hospital's governing board and executive administration policy direction and the views of

physicians on the medical staff. All of this strains the internal working relationships.

The process of selecting leaders sometimes compounds the problems. Elections are most often used to choose medical staff officers. Department chairs are generally appointed or elected by the medical staff. Leadership is usually rotated, resulting in inconsistent quality. It is seldom based on a thoughtful evaluation of the leaders' competency.

This "sharing of the burden" method can give way to organizational disasters. Many tasks are now managerial and few physicians possess adequate management training. This greatly narrows the pool of competent physician leaders who can handle the tasks.

Minor medical staff organizational changes

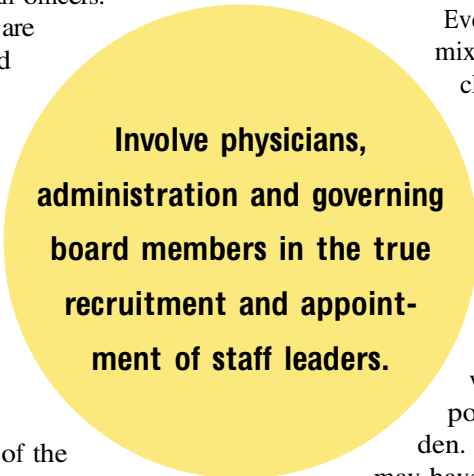
In recent years, hospitals and medical staff physicians tried to address these challenges through minor evolutionary changes.

Examples include:

- Lengthening the term of office for the medical staff president (In years past, the chief of staff or staff president often served a one-year term. In most hospitals today, presidents serve multi-year terms following a term as president-elect.)
- Offering formal training for medical staff leaders
- Paying the medical staff leader a stipend to offset income lost because of medical staff duties
- Recognizing a clinical department

chair as a management function, appointed by the governing body

- Providing funding and training of medical staff administrators so people with proper skills handle medical staff activities



Involve physicians, administration and governing board members in the true recruitment and appointment of staff leaders.

Even with a mixture of these changes, however, most hospital medical staffs continue to maintain ingrained dysfunctional components.

Many physicians view leadership positions as a burden. Physicians who may have the talent for leadership eschew the positions.

The pool of available, talented and willing physician leaders in many hospitals has decreased to a critical level.

Even in hospitals with a director of medical staff affairs, it is common for a physician who lacks credibility with medical staff members or lacks the talents and skills necessary to perform the job to fill the position.

Nothing better dramatizes these challenges than situations where a corrective action, or the denial, reduction or termination of a physician's appointment or privileges at a hospital is taken.

These actions are always difficult. Peer physicians acting in a voluntary capacity possessing little if any training in such matters are often reluctant to undertake adverse action involving a fellow physician even if corrective action is apparent. Hospital medical staff structures often hamper more than help in these cases.

Revolutionary approach to medical staff leadership

It may be time for a more revolutionary approach to medical staff leadership.

Two primary goals of a new structure should be:

1. Centralization of responsibility and authority for medical staff activities in a recruited core group of selected and trained physicians
2. A significant reduction in the total time required of medical staff members performing committee and department functions

Reduced committee time cannot lessen ongoing improvements in the quality of a medical staff's core elements. To the contrary, patient care should measurably improve from the changes or they are not worth undertaking. Core elements include:

- Assurances of quality care
- Participation by physician leaders in the hospital's policy formulation and strategic planning
- Credentials review and privilege determination
- Appropriate corrective action and assistance in external and internal compliance programs

In a major restructuring of a medical staff, serious efforts should be made to:

1. Involve physicians, administration and governing board members in the true recruitment and appointment of staff leaders in lieu of an election process.
2. Establish that the core group of recruited and trained physicians actually perform current medical staff functions, resulting in a reduction or elimination of the authority and responsibility of the staff acting as a whole.
3. Delegate increased authority and responsibility to the core group of physician leaders.

4. Reduce clinical time for physician core group leaders in exchange for time devoted to the medical affairs management.
5. Fairly compensate the core group leaders for their medical staff work.
6. Implement programs for leadership succession.
7. Provide formal management leadership education and training opportunities.
8. Establish contractual terms of at least three years for the core group leaders to ensure continuity.
9. Be willing and able to discontinue leadership status of physicians who are not able to perform the necessary functions.
10. Establish effective communication programs directed to all physicians on the medical staff regarding the activities of the core leaders.
11. Provide a qualified and empowered support staff.
12. Minimize surprises and misunderstandings—both at the hospital and with external review organizations such as the JCAHO or state regulators.
13. Replace existing medical staff organizational documents with those that include only essential organizational elements, to be supplanted by policies developed and put in place by the core leadership group.
14. Take appropriate corrective action and hold fair hearing when professional review actions impact individual staff members.

The core leadership group—perhaps titled the Professional Division Board or PDB—should meet often. PDB meetings to perform most of the functions of the current committees and clinical departments could easily consume two to four hours a week.

Establishing a competent, trained and committed physician

leadership core group should free up other staff physicians to provide clinical services for patients. A major reduction in committee functions should save hospital expenses by reducing support staff time and other management expenditures now committed to medical staff affairs.

Credentialing, and the time spent in processing appointments and reappointments, should be shortened if core leadership is authorized to directly appoint physicians to the staff and extend clinical privileges. These actions need to be subject to the authority of the governing board.

If the hospital is accredited, efforts at restructuring a medical staff need to comply with JCAHO expectations. Current JCAHO standards continue to require certain structural and organizational components of a professional medical staff.

JCAHO comfort in this regard, as well as compliance with state administrative codes, may direct that some existing medical staff terminology and format be retained.

However, to avoid falling into existing patterns of complexity, documents establishing the new format should not attempt to parallel or merely amend existing medical staff bylaws, rules and regulations. New documents can include:

- A Governing Document that sets forth the Professional Management Division's structure, authority and responsibility
- A Credentialing Policy addressing the form and substance of the appointment and privilege delineation process
- A Corrective Action and Fair Hearing Plan
- Contracts for leadership services

Making such sweeping changes may be difficult for some hospitals and physicians on the medical staff. If a hospital and its medical staff are

only able to implement a few changes of significance, it is recommended that priority be given to:

- Replacing the election process for medical staff leaders with a process of recruitment, selection and appointment
- Making a significant investment in training and education of staff leaders
- Lengthening the tenure of leadership
- Delegating clear authority and responsibility to a trained group of core leaders of the medical staff

Finally, there clearly are legal implications and requirements for implementing organizational modifications. However, it is crucial that credible, knowledgeable and creative physician leaders undertake the primary responsibility to initiate these changes. ●

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2. *Darling v. Charleston Memorial Hospital*, 211 N.E.2d 253 (Ill. 1965).
3. *Johnson v. Misericordia Community Hospital*, 301 N.W.2d 165 (Wis. 1981).