Eulogy to the Hospital Medical Staff

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The traditional organized medical staff structure that most hospitals utilize today formed in the mid-1900s. It has outlived its usefulness and is no longer relevant. It developed when physicians shared a generally uniform relationship to the hospital—the "voluntary independent medical staff"—and when quality was defined as an attribute of physicians as individuals. The organized medical staff's focus on credentialing and peer review reflected this traditional perspective. Physicians were the stewards of quality patient care. The organized medical staff determined the credentials of individual physicians and, therefore, the quality and scope of practice that occurred in the hospital. The hospital was accountable for "community mission," such as care of the uninsured and vulnerable, and efficiency of operations.

This situation has changed dramatically over the past decade. Quality has been redefined as a property of systems, which includes, but extends far beyond the quality of individual physicians. Today's context is being shaped by powerful forces. Public reporting and pay-for-performance require hospitals to focus on system-based quality, introducing such patient care systems as electronic medical records, CPOE and on-line decision support, eICUs, simulation and team training, and "bundles" of care processes that have been demonstrated to improve quality and patient safety. At the same time, growing economic pressures on physicians, including the recent report of declines in net income ranging from 8—13% over the past decade, have led physicians to focus intensely on hospital efficiency to increase their productive capacity. In addition, the growth and competition for scarce capital and the challenges of caring for uninsured and vulnerable populations often pits physicians against each other and against the hospital. Finally, the "medical staff" no longer refers to a singular relationship between physicians and the hospital, but rather to a broad portfolio of relationships that extends from the traditional "customer" to contractor, employee, and joint venture partner, as well as more sophisticated business relationships.

The forces reshaping physician-hospital relationships are reshaping clinical care as well. Advances in science and technology are leading to the reorganization of care into focused, specialized, integrated, multidisciplinary, patient-centered service lines to attract market share and improve clinical outcomes, quality, efficiency, and financial performance. These service lines require a level of integration that many hospitals find difficult to achieve within the traditional physician-hospital organizational model, leaving all parties unsatisfied and frustrated.

In analyzing the old operating model, many are learning that it links a *management* structure (the hospital) to a *governance* structure (the organized medical staff), which fails to address the current needs of patients, physicians, and the hospital. Hospital management structures are externally focused and are designed to produce measured outcomes through the definition of external goals and internal accountabilities and authority. Physician governance structures, on the other hand, are more internally focused on ensuring representation, fairness, and parity through the establishment of organizational oversight and policies and adjudication of conflict. This is an unlikely recipe for success in today's dynamic and competitive healthcare environment.

One of the attributes of effective management structures is that individuals can make commitments on behalf of other individuals and hold them, and in turn be held, accountable, with consequences for non-fulfillment. Physician governance structures, however, focus on the whole and are not capable of achieving the same level of accountability, except in

oversight of the leader. While the President of the Medical Staff is officially accountable to the medical staff as a whole, the role typically does not have comparable authority to set expectations and hold others accountable to a traditional organization like a hospital.

The one physician management structure that is potentially capable of achieving this goal is the clinical department. Yet in many hospitals, it, too, functions more as governance than management. Physician leaders are often elected to short-term positions of departmental leadership on the basis of clinical reputation, not demonstrated management or leadership. They are typically unable to make commitments on behalf of others and hold them accountable for fear of undesired political consequences such as loss of referrals or because they lack the needed leadership and management capabilities. Therefore, the traditional Medical Staff Organization will be unable to be an effective partner with hospital management in the pursuit of quality and efficiency until it establishes effective management structures of its own.

To complicate matters further, advances in science and technology have dramatically altered the landscape of practice, with the evolution of patient-focused, multi-disciplinary service lines and centers of excellence. These clinical practice structures are often at odds with the traditional departments and disciplines, rendering the traditional medical staff organization progressively less relevant. While certification remains the basis for credentialing for the moment, we are witnessing the development of new clinical disciplines. While we believe that the reorganization of clinical care will ultimately lead to new disciplines and raise the position of clinical service line leaders to the forefront of management, we also believe that strengthening and developing the role of departmental leader (Chief of Service) as a *management* position capable of making and ensuring commitments is an intermediate step in the migration of physician leadership from governance to management. In the meantime, the medical staff and hospital need to live in the uncomfortable reality of being in two worlds at once.

The traditional marriage of hospital management and physician governance, therefore, does not achieve the optimal balance between accountability and authority at multiple organizational levels. In response, we are beginning to witness the emergence of new clinical-management structures, effectively pairing physicians who represent the variety of relationships with the hospital with hospital management, including nursing, quality, and operations. These structures, jointly sponsored by the organized medical staff leadership (physician governance) and administration (hospital management), are beginning to demonstrate superior market, financial, and clinical outcomes by forging a path in this time of transition. They require the hospital to share some authority with the medical staff, but only when the medical staff has demonstrated increased cohesion and effectiveness and the ability to accept greater accountability for joint leadership of strategic and clinical performance. The role of the Chief Medical officer is critical to success in these new models, and needs to be redefined to achieve the desired outcomes. At a minimum, hospitals need to reevaluate their physician-hospital structures and consider alternatives to replace a structure that has outlived its usefulness. The medical staff construct played an important role in hospitals for nearly three quarters of a century, but it is now time to recognize its limitations and transition to structures more suitable for our times.

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