NEW TRAINS; OLD TRACKS
Thoughts on the need for new medical staff structures
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Few dispute that hospital and health system boards are ultimately responsible for the success of the mission, stewardship, and performance of the organizations they govern. The board, consistent with tradition and supported by the expectations of the Joint Commission, delegates at least initial determinations on quality, peer review, and credentialing as well as the overall governance of the "medical staff" to the medical staff, which generally is lead by an elected President and a Medical Executive Committee.

As recently as a quarter century ago, the construct of "medical staff" — the relationship between each physician and the hospital — was a well-defined customer–supplier relationship. Today, the relationship is much more complex, representing a broad portfolio of operating models, including customer–supplier, contractor, vendor, employer, and joint venture partner, to name just a few. The idea that this portfolio of interactions can be interpreted, let alone managed, as governance by the medical staff under a single set of governing bylaws, rules, and regulations is generously optimistic, and is the cause of much tension between hospitals and their affiliated physicians.

However painful that tension may feel, it pales when compared to the confusion (and sometimes outright hostility) that exists within hospitals and medical staffs around the distinctions between medical staff governance and hospital physician management. This confusion is the result of an unwitting collusion between physician medical staff leadership and physician hospital leadership. While both roles represent important elements of physician leadership, each function is distinct and clearly bounded, even though in practice the roles and their execution often overlap. This confusion between medical staff governance and physician management is a highly significant — albeit unrecognized — contributor to underperformance in many hospitals.

Of medical staff governance

Medical staff governance refers to the activities of the leadership body that establishes and adjudicates policy for the hospital's organized medical staff in areas delegated to it by the hospital's board. The medical staff governing body, almost universally referred to as the Medical Executive Committee, is accountable to the hospital's board (although some oversight accountability may be delegated to hospital executives) for establishing policies that govern physician activities such as credentialing, privileging, and peer review. The governing body may or may not be delegated direct responsibility for oversight of hospital quality.

It is critical to note that the officers and members of the governing body are elected leaders of the organized medical staff. As such and according to the conventions of democratic process, their peers ("electors") demand they be of the physicians, by the physicians, and for the physicians. Yet, in truth, the formal medical staff organization and its governing body exist at the pleasure of, and are ultimately accountable to, the hospital's trustees. In all instances, the care of patients is the final focus of all organization missions. The board is responsible for overseeing the success of that mission. What is really delegated to the medical staff is execution of those traditional functions within its expertise that are necessary for the success of that same mission. So, while medical staff elected leaders think they must answer to those who elected them, they may be of the physicians and by the physicians but must be for the patients.

The domain for which medical staff governance is responsible is really quite limited. In practice, however, it has become expeditious for the Medical Executive Committee, as the only formally-sanctioned leadership body of physicians, to act as an advisory sounding board on a broad range of hospital issues, including hospital policies, strategy, operations, and marketing. In short, the Medical Executive Committee is often used as a work-around whenever the imprimatur of the physicians is deemed advisable by hospital leadership.

Of physician clinical management

By contrast, physician leaders holding clinical management positions such as department chair or chief, clinical, functional, or unit director are hospital managers, accountable to hospital administration for the management of their discrete hospital departments, units, or functions. They are not managers of medical staff departments. The medical staff does not have a departmental or unit-based structure. Instead, these clinical managers are managers of the hospital, by the hospital, for the hospital — ultimately, once again, for the patient. They are functional middle managers in an organizational structure, responsible for bringing the perspectives of their dominion to the enterprise and for integrating it with the whole. Clinical managers are also responsible for performance outcomes within their area of responsibility. While the Medical Executive Committee is accountable to the hospital board and the physicians, physician managers are accountable to hospital executive management. As "management," they are accountable to the board, through the CEO, for the organization's overall performance. So, herein lies the root of the contemporary problem that many hospitals are facing:

• Physician managers lack appropriate authority to carry out their responsibilities, since the only "effecter arm" sanctioned to manage individual physician performance is the Medical Executive Committee. The MEC's only real tools are escalating sanctions leading up to a recommendation of removal from the medical staff. Therefore official intervention is generally limited to relatively egregious breaches of expected behavior.

• Any seasoned manager will attest that "weapons" are ineffective management tools for most day-to-day issues.

• Effective management is not inherently a democratic process, and cannot be administered using the democratic processes associated with governance. The economic, cultural, and personal relationships among physicians make management difficult enough, and it does not need to be made even more challenging by using processes more appropriate to governance.

While Medical Executive Committee members can and should be elected by the body politic, physician managers — as leaders of hospital departments and functions — must be appointed, managed, and compensated for their activities by the hospital. It is the only way to honor the expectations and accountabilities required for producing the outcomes necessary in today's environment.

Why the old model worked in the past

In the historic customer-supplier relationship, the confusion around management and governance was largely irrelevant. The medical staff was a loosely-coupled body requiring and demanding little or no authority or accountability. Each physician governed and managed a private practice in which accountability was to oneself, and quality was an attribute of each individual physician's practice rather than an attribute of the system of care. In today's competitive and highly-regulated environment, the emphasis must necessarily be on results — more specifically clinical and service quality, safety, and business performance. With growing competition for market share, public reporting, increasing consumerism, pay-for-performance, non-payment for avoidable errors ("non-performance"), and a myriad of other performance expectations, neither hospitals nor the physicians on their medical staffs can afford to operate under the loosely-coupled structures and functionalities that appeared to work in the past. In short, the old saw that "all organizations are perfectly designed to produce the outcomes they produce" is once again reinforced…and the old design is no longer acceptable.

What is required today

Hospitals and their medical staffs, independently and together, must confront the brutal fact that, without redesign, they are organized to sub-optimize performance. Everyone measures outcomes in quality and safety and strives to design clinical approaches that produce laudable public report cards. However, the inability to provide high quality care in areas where there is little dispute over what to do for patients (and in those areas not yet under national public scrutiny) also reflects unproductive competition for resources, physicians disenfranchisement, operating inefficiencies, lack of meaningful physician involvement in hospital strategy, and lack of engagement and alignment of the members of the medical staff with each other as well as with the enterprise. Yet, even in the face of predictable resistance, those hospitals and healthcare systems that have demonstrated the will to execute meaningful medical staff redesign and introduce innovative physician-hospital operating models universally experience improvement in physician morale, engagement, loyalty, and satisfaction, while at the same time producing the superior outcomes — in clinical, quality, safety, satisfaction, market share, and business performance — that can only be realized by meaningful partnerships between hospitals and the physicians on their medical staff.

We can all benefit from the lesson that Amtrak learned when it introduced the Acela high-speed train in America's Northeast Corridor. High-speed trains can travel only as fast as their tracks permit. Today's healthcare environment requires high performance: The organizational platform of physician leadership used by most hospitals today represents old tracks that do not support that level of performance. New trains cannot be optimized on old tracks.