

## **The Modern Evolution of Community Hospital Medical Staffs**

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In a 1990 speech, Paul Starr, Pulitzer Prize-winning author of “The Social Transformation of American Medicine,” stated “*No matter how dramatically you think healthcare has changed in the last decade, now is the time before the revolution. Year by year, the existing system is coming unstuck.*” He has proved prescient. When historians document the modern era of health care, they are likely to identify especially the second half the 1990’s as a time in which traditional community hospital medical staff structure and function, after a long history of success dating from the 1917 American College of Surgeons Hospital Standardization Program, began to devolve. This devolution continues now several years into the millennium. Many factors are weighing on this painful organizational process:

1. Economic pressures are increasingly influencing physicians to focus more energy on their private practices. Particularly primary care physicians – family practitioners, general internists, pediatricians and ob/gyns – find economic pressures dictate more office time, even as maintaining a hospital rounding schedule becomes less cost efficient. With less and less of their practices hospital-based and less time spent in the hospital, ties both to the hospital and other members of the medical staff tend to weaken. A result can be less time and willingness to serve in traditional “voluntary medical staff” roles.
2. Some managed care strategies, whether intended or otherwise, have had the effect of pitting physician interests against those of hospitals, thus loosening the historical ties and obligations that physicians have felt toward their practice hospitals. Physicians continue to be paid on a fee-for-service basis – encouraging them to ever more – even as hospitals are under increasing pressure to decrease costs per case. Differing viewpoints have often led to overt conflict between hospital administrations and their medical staffs, some so extreme as to resemble actual “battles for the soul of the hospital.”
3. Even specialists who maintain more of a hospital-based practice are caught up in this loosening of their sense of medical staff obligations. Physicians who a decade ago accepted without question their obligation to provide emergency room coverage are now demanding payment in some instances, refusing outright in others.
4. Further exacerbating this “loosening” phenomenon, many physicians in traditional practice setting have experienced considerable “disempowerment” relative to other forces (third party payers, the hospital, even their own patients as consumerism emerges). They see their ability to influence income relegated to seeing ever more patients, even as their expenses rise relentlessly. Disempowered people are not as likely to respond to “obligations of good citizenship” as those who feel more in command of their microcosms.
5. The millennium is witnessing a clear emergence of a “generation gap” of physicians between a) older physicians who inherited the era of “professional absorption” (very long hours) and “loyalty” to one’s hospital, and b) younger physicians, perhaps equally dedicated to practicing good medicine, but also more committed to family and “lifestyle” outside their profession. This phenomenon can create misunderstanding and resentment within medical staffs, which are, in turn, not conducive to effective medical staff functioning.

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6. Many of the above factors have also discouraged established physicians from recruiting new partners. In some cases, and in order to meet community coverage needs, hospitals have perceived the need to step into the vacuum created, recruit independently and sometimes actually hire physicians. This can lead to yet another cleavage within medical staffs of the traditional independent physicians and those employed by the hospital. The former often tend to see themselves at a disadvantage as they compete with these “hospital subsidized” practitioners.
7. As yet another consequence of revenue pressures on physicians, they are seeking non-practice revenues to augment income received in actual patient care. Typically such revenue cannot be created de novo; it instead preys upon what had previously been part of the hospital’s revenue stream. At its mildest form this typically involves pulling some lab or minor procedural work from the hospital. At worst physicians are making capital investments in facilities that they own, and in which they can independently perform a wide variety of potentially highly remunerative diagnostic and therapeutic services. Indeed, this phenomenon can be seen as so threatening to the financial integrity of community hospitals that temporary bans on the building of specialty hospitals have occurred and continue as of this writing.
8. In some localities this latter problem has resulted in blatant economic credentialing. A hospital in Idaho recently removed 5 practitioners from its medical staff solely based on what the hospital perceived as these physicians’ skimming profitable patients to their facility, even as they continued to use the hospital for less remunerative patients. Legal actions surrounding this type of conflict continue around the U.S.

In sum, the relationship between hospitals and their medical staffs has often featured ongoing tensions that have been studied and described extensively in the literature. But modern medical economics appears in many instances to be driving a deep wedge between some community hospitals and at least some members of their medical staffs. In fact the fundamentally unstable nature of the hospital organizational chart is proving not only too weak to strengthen the “ties that bind” physicians to hospitals, it actually contributes to the weakening of this bond. (Figure 1) This structure, “invented” by the American College of Surgeons in 1917 for its Hospital Standardization Program (forerunner of JCAHO), has survived largely intact for nearly 90 years. It represents what Ian Morrison, in his landmark 1996 book, “The Second Curve,” might call a “1<sup>st</sup> Curve” hospital organizational structure. And its fundamental design flaws and resultant instability are finally coming clearly to light. For example, while the medical executive committee is legally accountable to the board, the physicians comprising this committee are typically elected by their colleagues, thus creating a political body, a “mini-democracy” within the overall hospital structure. We thus have a group of physicians legally accountable up to the board, and simultaneously down to those who have elected them. One could hardly devise consciously a more bizarre and unwieldy accountability structure for an institution under ever heavier pressures to become more accountable.

This hospital structure is consistently demonstrating its inability to “get the job done” regarding necessary hospital/medical staff functions – effective committee work, fostering effective maintenance of JCAHO leadership standards, providing effective clinical input into patient microsystems design, etc., etc. Indeed, the future viability of this organization, as it has existed traditionally is now called into question by a number of knowledgeable observers. Hospitals

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who need to forge effective integration of physician leadership perspectives into daily operations management are experimenting with a variety of creative approaches to effectively integrating physician leaders into hospital governance. Figure 2, representing an early “2<sup>nd</sup> Curve” hospital (i.e., true, 21<sup>st</sup> century hospital), is a composite organizational diagram that illustrates trends of the last decade in actual hospital functional evolution. This diagram illustrates:

1. The persistence of the medical staff and its executive committee, though in a much reduced presence than that implied by Figure 1, which derives from an era where physicians clearly dominated hospitals.
2. A powerful movement toward “service line management,” that is, the design and construction of care (micro)systems not just around individual physician-patient interactions, but instead around the broader needs of coherent groups of patients – women’s health, cancer centers, cardiac services, etc.
3. The need to integrate specific physician leaders into what are de facto part, even full time management positions. In this model individual physician manager/leaders are far more fully integrated into daily operational design and decision-making than was the case under Figure 1 hospital governance.

This latter phenomenon is only being hastened by the advent of two new and growing “specialties” – hospitalists and intensivists, who spend all their time in the hospital. These two groups of physicians are “naturals” for populating the central circle of Figure 2. A recent conversation with one offered a glimpse toward the future. Here’s how he describes it: “I’m in the hospital for a full 12-hour shift, have electronic medical record as well as telephone contact with the attendings who refer their patients, and know all of the patients within my geographic area. I also know well the nursing and other staff. We have daily team meetings attended by all where we debrief the past 24 hours and plan for the next. We understand one another’s roles clearly and work as a genuine team. We’re constantly talking about how we might improve systems to function more effectively and efficiently – and to be able to spend more of our time with patients. The communication and coordination is far beyond what I could ever have achieved when I was trying to straddle my outpatient and inpatient practices.”

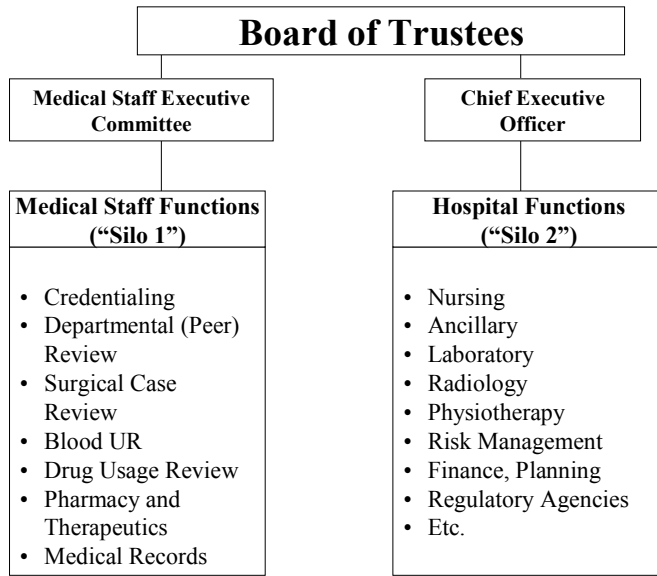
Finally, how really does a 2<sup>nd</sup> Curve medical staff culture differ from one still tied to the 1<sup>st</sup>? Figure 3 represents a brief characterization of these differences.

What is the future evolution of the hospital and its medical staff? No one can be certain. But taking all of these factors together it is hard not to conclude that we are moving toward something resembling a practice of the British National Health Service since its inception shortly after World War II. A majority of physicians will be almost totally outpatient in their orientation, while a group of hospital-based specialists increasingly see the hospital as “home.” If this evolves, it appears likely that the latter group, perhaps augmented with procedurally oriented physicians who both use the hospital actively and continue to see patients in non-hospital settings, will largely fill the vacuum we now observe as the traditional hospital medical staff fades into history.

And what should current hospital leaders do now? Again, there is no clear answer. But it would appear prudent, if one believes that the traditional medical staff is, in fact, in an irreversible

decline, to take a pro-active stance in creating the future hospital-medical staff structure and physician relationships. Nationally recognized health systems expert Dr. Stephen Shortell has written about the “creative destruction” of obsolete health care entities. Perhaps the hospital medical staff organization might prove a fruitful focus for study and action around this concept.

## Our organizational heritage, circa 1918 *Our structural “fatal flaw”*



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Figure 1 – The “1<sup>st</sup> Curve” hospital organizational structure

## The Vision: Systems Designed Around Those We Serve

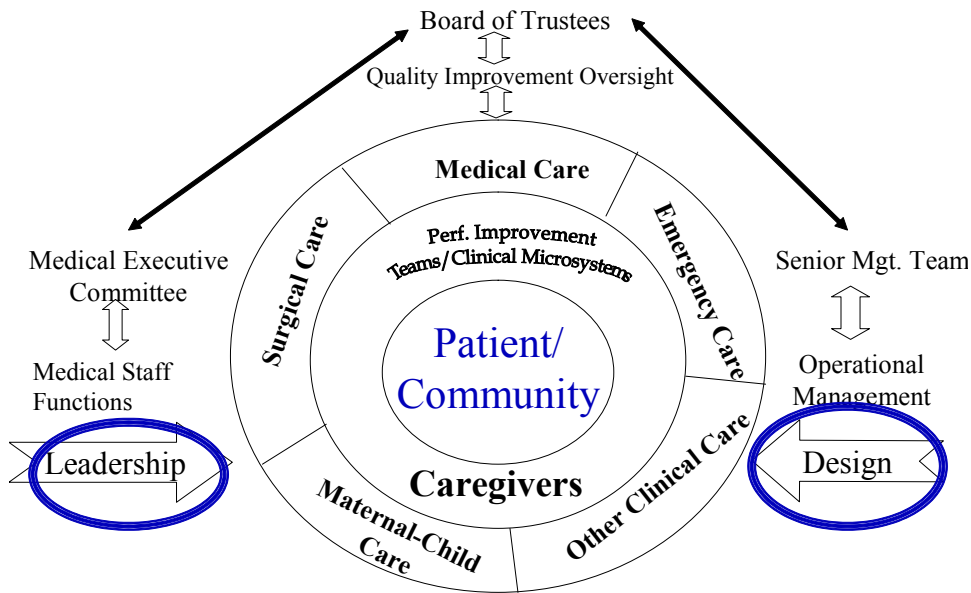


Figure 2 – a transitional, nascent “2<sup>nd</sup> Curve” hospital organizational structure

## 1<sup>st</sup> and 2<sup>nd</sup> Curve Medical Staffs

### 1<sup>st</sup> Curve

- Complex structure: many departments, committees
- JCAHO/compliance focus; patient relevance marginal
- Supposed to actively engage all physicians in numerous departments and committees
- Reactive to environment, diminishing local control
- Physician influence diminishing
- “Medical politics” dominate much activity
- Leadership “thankless,” leaders thus often reluctant

### 2<sup>nd</sup> Curve

- Simple structure, short bylaws
- Patient care focus; clinical micro-system design major activity
- Wide communication for all, but relatively small time commitment for most physicians
- Pro-active, vision-driven, *creating* local environment
- Physician influence increasing
- Patient care focus dominates activity
- Leaders trained and honored/rewarded, enthusiastic about roles

Figure 3 – contrasting 1<sup>st</sup> and 2<sup>nd</sup> Curve hospital medical staffs