

The Organized Medical Staff: Should Anyone Care Anymore?

Alice G. Gosfield, Esq.*

Every hospital has an organized medical staff, but of what value is this organizational construct in the current environment? Given the New World Order of quality improvement, patient safety, the malpractice crisis, and the multiple demands physicians struggle to accommodate on a daily basis, it is time to reconsider the role of the medical staff. This article looks at the legal basis for the medical staff's role; considers typical medical staff bylaws; and addresses some of today's hottest potatoes between medical staffs and boards, all in light of the new quality era.

Based on more than 25 years of working with medical staffs on these issues, and reflecting themes around clinical practice guidelines (CPGs), the author makes the case that although the medical staff is still a vital component of the hospital's mission, both in the bylaws and in its functions, today's staff can be revitalized in ways that can be far more meaningful to physicians and far more likely to propel quality.

Key Words: Medical staff; hospital medical staff; hospital governing boards.

Editor's Note: *The information is presented here as a service to readers. It is not intended as legal advice. We have provided information that is up to date, but rules often change. No one should rely on this information alone and should obtain current, informed legal guidance with regard to the issues contained herein. The author makes no representations or guarantees regarding the information contained herein.*

From the Institute of Medicine's (IOM) reports on health-care quality in America, to the Leapfrog Group's push for computerized physician order entry (CPOE), channeled referrals to centers of excellence, and use of hospitalists, to new responses to the malpractice insurance crisis, the public policy lens has refocused on hospitals. For hospitals to succeed in meeting market and policy demands for improved quality, they must rely on the physician members of their medical staffs. Yet, in many ways, the traditional trappings of hospital-medical staff relations call into question the continuing vitality of this essential relationship.

The physicians on the staff represent disparate economic home bases—from direct employment with the hospital or system, to recently merged megagroups, to small and solo practices. Often in competition with each other, these clinicians come together in common cause only around their use of the hospital's resources to meet their own needs in treating their patients.

Medical staff participation in critical hospital quality activities is, in many ways, at an all-time low.

Medical staff participation in critical hospital quality activities is, in many ways, at an all-time low. A recent study found that 20 percent of medical staff members ac-

*Alice G. Gosfield and Associates, P.C., 2309 Delancey Place, Philadelphia, PA 19103; phone: 215-735-2384; fax: 215-735-4778.
Copyright © 2005 by Greenbranch Publishing LLC.

count for 80 percent of the clinical work in hospitals. Even among long-time medical staff loyalists, though, many physicians do not perceive that the medical staff organization, its role, or activities offer anything meaningful to them. Medical staffs, hospital boards, and administrations are at loggerheads throughout the country over issues that are absorbing to them but tangential to the real goals of an organized medical staff.

LEGAL MANDATES

A hospital has no business to conduct without the physicians who make up its medical staff, order its services, and refer to the other physicians on the staff. Nothing happens in the hospital without a physician order somewhere at the genesis of the activity.

The medical staff, therefore, is delegated the responsibility to advise the board . . .

The theory behind the role of the organized staff is that the lay board of directors, charged with the legal and fiduciary responsibility to assure the quality of care rendered in the hospital, is neither trained nor competent to judge quality of care and clinical competence of the physicians. The medical staff, therefore, is delegated the responsibility to advise the board on these matters, while the board retains the legal authority to make all the ultimate decisions.

Rules and Procedures

To implement this advisory function, there must be a system that entails rules and procedures. This need is recognized in three primary sources of law:

- The Medicare Conditions of Participation for hospitals
- The Joint Commission on Accreditation of Health-care Organizations (JCAHO) standards, which are drawn into the law by virtue of hospitals seeking “deemed status” where their JCAHO accreditation serves to qualify them for Medicare
- Some state hospital licensing regulations—the threshold for operating a hospital within a state’s borders

The Medicare Conditions and the JCAHO standards both require that the medical staff have bylaws that establish the mechanisms by which they will accomplish their tasks. Some state hospital licensing regulations impose similar requirements. They do not direct how the staff is to operate, other than in general principles pertaining to fairness and involvement of the staff in matters at the board level that affect them; but they do establish the overall responsibilities to review staff applicants and members, as well the quality of care rendered within the institution.

Even as the JCAHO has thoroughly changed its accreditation standards to be less prescriptive and more ori-

ented around performance improvement, the traditional chapters on governance and medical staffs have changed far less. On the other hand, as far as the JCAHO is concerned, the leadership of the medical staff is expected to play a significant role in the overall leadership of the organization in support of its quality mission.

. . . the leadership of the medical staff is expected to play a significant role in the overall leadership of the organization in support of its quality mission . . .

Another legal influence on medical staff activities is the Health Care Quality Improvement Act (HCQIA), which provides immunity from antitrust liability for those who engage in quality review through professional review actions. To be eligible for the protections, though, the processes used to make judgments that affect membership and/or clinical privileges must meet certain procedural safeguards. As a result, the HCQIA drives due process and to which types of activities such procedures pertain. As part of this regulatory scheme, the National Practitioner Data Bank (NPDB) was established to provide a clearinghouse that hospitals are expected to consult to be sure the physicians under review do not have reported problems with licensure, peer review, or malpractice.

. . . the Health Care Quality Improvement Act (HCQIA) . . . provides immunity from antitrust liability for those who engage in . . . professional review actions.

Physicians conducting reviews are often so fearful of the potential implications of an NPDB report that they struggle to fashion corrective actions to avoid reporting. For example, a mere documented concern in the credentials file, terms of probation, a letter of reprimand, mandated consultation with another practitioner, profiling of the practitioner on a more intense basis, mandated continuing education, and even a required psychiatric examination would not be reportable to the NPDB unless the physician’s membership or privileges could not be exercised until those actions took place. On the other hand, mandated co-privileges with another practitioner, mandated consultation before being able to exercise privileges, and suspension of privileges pending psychiatric examination are all reportable.

In addition, the demands of the formal process required to claim the immunity protection also have a chilling effect on the medical staff’s will to act. As a result, many medical staffs acknowledge in the bylaws the directives of the HCQIA but try to avoid its harshest impacts except in the most egregious circumstances. This brings us to what bylaws typically take into account.

TYPICAL MEDICAL STAFF BYLAWS

Over the past 25 years two approaches to drafting bylaws have emerged:

- The typical version where a single document contains within it all substantive matters including the fair hearing plan
- An approach popularized by the Harty, Springer and Mattern law firm, which uses a multi-volume approach—one document is the actual bylaws, another states the credentialing process, another the organizational structure (e.g., committees, departments), another the fair hearing plan, and yet another the rules and regulations.

... the demands of the formal process required to claim the immunity protection also have a chilling effect on the medical staff's will to act ...

The theory here is that the documents not labeled “bylaws” are policies that are more easily amended. Given the essence of what the staff does, why would you want to amend these documents easily? The medical staff bylaws, in the totality of what they establish for the medical staff and hospital, are the constitution of the medical staff and therefore ought not to be amended willy-nilly with changing fashions.

Some bylaws that manifest a particular orientation are: those where the credentials committee reports directly to the board and not to the medical staff executive committee; those where the board must approve officers, elected department chairs, and all committee chairs; and those where the credentials committee consists of the past five presidents of the medical staff. These all reflect a concern that the medical staff is unable to manage its own affairs. This is not to say that medical staffs do not act out. They do, and they have been known to get into pitched battles with the administration and board over issues that hardly merit the attention they are given. The control features just described, however, tend to reflect a belief that the medical staff will misbehave even when there is neither evidence nor history to support that belief.

Typical Bylaws Contents

Bylaws usually address the basic relationship between the board and the staff, the purposes of the staff, and provide, as the JCAHO requires, that neither party may unilaterally amend them. The qualifications for membership (e.g., board certification, location within the community, ability to respond to an emergency within a specified time) are set forth along with licensure, malpractice insurance, continuing education, and other fundamental requirements. The extent to which the medical staff absorbs anti-

referral laws and other ethical proscriptions into the bylaws also varies.

Some bylaws . . . reflect a belief that the medical staff will misbehave . . .

Bylaws set forth staff categories, which distinguish the prerogatives and responsibilities of the members. They balance citizenship rights (voting in the general meetings, committees and departments, serving in leadership positions) with obligations (paying dues, treating indigents in the emergency department, taking emergency on-call responsibilities, proctoring other physicians). There was a time when staffs had many categories.

As the hospital world has changed, though, these traditional issues have been joined by new ones . . .

Over time, however, simplicity has become the hallmark of usable bylaws, so the number of categories has decreased. Still, typical concerns include whether the courtesy staff category should be allowed, and if so, how few interactions qualify them for their limited roles; whether consulting staff should be allowed to vote at all; and whether honorary staff should pay dues. As the hospital world has changed, though, these traditional issues have been joined by new ones: Should employed hospitalists vote? Should primary care physicians who never set foot in the hospital be medical staff members when the medical staff cannot vouch for their quality? Can physicians who are employed by the hospital or one of its affiliates serve as real representatives of the medical staff on staff committees? These questions define the culture of the staff.

Cultural decisions can be made around many other features of bylaws, ranging from the burdens of proof in the fair hearing process, to how nominations for staff officers get made, to whether department chairs are elected or contracted with the hospital. The context of a medical staff is nuanced, but the nuances frequently exist in provisions, reflecting the staff memory of a bad experience—so the bylaws are drafted to prevent its recurrence. These matters can present major political dilemmas in the staff, but they rarely are about the real work of the staff, which is to safeguard the quality of care in the institution.

CURRENT MEDICAL STAFF HOT POTATOES

In this changing era of quality improvement certain contentious issues have arisen between medical staffs and boards. These include economic credentialing, on-call obligations, cross-department privileges, use of non-physician practitioners (NPPs), and communications.

Economic Credentialing

This term has come into fashion to describe a variety of hospital behaviors that take into account the economic impacts of the physician's care in making membership and privileging decisions. It used to be that this term was used primarily with regard to membership decisions that turned on the economic efficiency of the physician—whether a physician's patients typically stayed longer than the diagnosis-related group contemplated average, for example. Today the term is used to describe decisions to reject medical staff applicants or candidates for leadership positions because they are invested in a competing facility, such as a specialty hospital, ambulatory surgery center, or imaging center.

Physicians are sometimes asked to complete highly detailed disclosure documents extending beyond their ownership to any financial relationship they or family members may have with competing institutions. Often this is really a tacit demand by the hospital for referrals since the investment itself obviously has no implications to the hospital. It is the expected referral to the competing entity that raises concerns. The tensions surrounding these issues are considerable. Whether they implicate the fraud and abuse laws is under consideration by the Office of the Inspector General.^{1,2}

Other related activities include:

- Loyalty oaths—a pledge not to sell a practice or invest in a competitive entity without offering the hospital a right of first refusal
- Requirements to dedicate a portion of the practice to the institution
- Requiring as a condition of heart station interpretation rights, for example, that the cardiologists refrain from offering the same studies in their own practices

These are inappropriate policies. There is, in fact, a completely legitimate basis to evaluate certain referral patterns of physicians. The volume of services that certain critical physicians will perform in the hospital introduces a real quality issue. Over and over again, those concerned with quality have learned that the best way to assure good outcomes, particularly for high-risk surgical procedures, is for a hospital to have the opportunity to do many of them repeatedly, involving the same teams of practitioners—nurses, physicians, operating room technicians—who are used to dealing with each other as a team. This is the premise behind the Leapfrog Group's recommendation of evidence-based hospital referral.

It is entirely appropriate for a hospital to determine that for certain critical services it will award clinical privileges only to those physicians who perform a sufficient volume of procedures there to assure that not only will the team approach to quality be provided, but also that the number of procedures performed is sufficient to effectively monitor the physician's quality over time, and thereby assure the capacity of the hospital resources to meet patients'

needs for those specific services. If the medical staff has insufficient data to gauge clinical competence, the hospital would have to seek quality-relevant data about the practitioner from other institutions. Then there is no guarantee the requisite clinical information will be made available, since the other institution will have its own constraints on sharing patient and/or peer-review data.

On-call Obligations

Increasingly, physicians are wary about responding to requests to treat patients in the emergency department, since to do so establishes a doctor-patient relationship with all the attendant liability issues, as well as the payment concerns when patients are indigent or uninsured. Some physicians actively seek to be on the on-call rotational schedule for the emergency department. Others try to avoid it. Some medical staffs mandate participation. Some leave the decision to the department.

Increasingly, physicians are wary about responding to requests to treat patients in the emergency department . . .

The actual obligation to screen, stabilize, and treat under the Emergency Medical Treatment and Active Labor Act (EMTALA) is imposed on the hospital. Once a physician is on the call schedule, though, failure to respond appropriately to a request to attend a patient can trigger a \$50,000 civil penalty. There are quality issues associated with who is obligated to or permitted to respond to emergency patient needs. How hospitals meet their obligation and the extent to which they impose these burdens on physicians contributes to other tensions, both between the medical staff and the administration, as well as among medical staff members, especially when some take coverage and others do not.

Cross-department Privileging

Here it is the advances in medicine and technology that create tensions within the medical staff. Vascular centers of excellence, women's centers, and cancer centers are all examples of ways in which hospitals seek to consolidate multidisciplinary services. Sometimes the physicians seek to do so for their own reasons. Today, more and more physicians of different specialties seek privileges to provide the same services. This raises many issues. How these get mediated so the hospital's overall strategic goals are accomplished without threatening the subtle fabric of referrals that define how medical staff members interrelate can be a significant challenge. For example, when cardiologists, radiologists, vascular surgeons, and general surgeons all start crossing each other's borders to do interventional procedures, how will peace be maintained in the valley?

Using NPPs

Increasingly, physicians are finding that using non-physician practitioners (NPPs) as both physician extenders and substitutes can substantially enhance the time they spend with their patients. Some of these clinicians are recognized by payers, including Medicare, for direct billing. In addition, Medicare has recently significantly liberalized the way NPPs and physicians can work together to provide patient visits in the hospital when they are part of the same group practice. This phenomenon will increase the pressure on staffs to review and credential these individuals.

... physicians are finding that using nonphysician practitioners (NPPs) ... can substantially enhance the time they spend with their patients.

Communication between Board and Staff

Here is where the rubber hits the road in terms of how much the medical staff is likely to be creative about the new quality environment. How the board (and administration) communicates with the physicians colors its entire relationship with the medical staff and, in many places, has become a flashpoint in medical staff-hospital relations. Hospitals often are happy to let the physicians tend to the credentialing/privileging activities, but involve them in no other major strategic initiatives until most of the substantive decisions have been made. In some ways, medical staffs have contributed to this counterproductive dynamic by their insistence on self-governance and autonomy. Medical staffs do not have a strong track record with regard to collaborative decision making, but they have not been given many opportunities in this realm, either.

... often there are critical issues ... [where] the physicians are the last to know what is being planned.

Sometimes the board or administration adequately anticipates those issues on which there is likely to be real medical staff restiveness, such as when the board decides to take an otherwise open department and make it subject to an exclusive contract. Very often, however, there are critical issues such as strategic planning, manpower planning, budgeting, and capital expenditures (particularly on information technology) where the hospital seeks major change in its clinical culture, and the physicians are the last to know what is being planned.

If quality is really to improve in hospitals, the dynamics between the board and administration and the staff will have to change to a far more explicitly collaborative process.

RETHINKING THE PROCESS

Nothing happens in a hospital without a physician order. Without the willing hearts and minds of the physicians, real progress in quality will remain elusive. Yet, physicians are staggering under the crushing weight of administrative burdens imposed on them by regulation and payer contractual demands. To get them to a point where they can actively propel quality in the hospital, the hospital will have to help them standardize what they do, simplify the demands imposed on them, and make their environment more clinically relevant to the way they think and treat. When this happens, physicians cannot help but recapture time they lose now in inefficiencies. They can spend this time developing stronger, healing relationships with their patients and engaging in activities at the hospital that have meaning for them, including medical staff activities.

To bring these principles to bear, it is important to articulate a continuum of medical staff involvement: where it is imperative, important, useful, or not a priority. I have articulated such a continuum and continue to refine these ideas.^{3,4} Each institution should have its own list, collaboratively developed and articulated. Once this happens, clear principles of engagement between the staff and hospital can change the context in significant ways (see sidebar).

Whether a new collaborative process is documented in the bylaws is not really the point. The real issue is identifying those matters on which the medical staff ought to be involved if the goals of the hospital—with regard to quality and the needs of the physicians—are to be met.

SIMPLIFY, STANDARDIZE, MAKE CLINICALLY RELEVANT

To simplify physicians' lives, give them back time, and improve quality, one of the most significant advances may be the use of clinical practice guidelines (CPGs) collaboratively selected and used both in the physician office and the hospital setting. CPGs offer advantages to physicians in their private practices as the foundation for much of what they do and how they organize their work administratively and clinically.⁵ CPGs can also play the following new roles in the medical staff.

1. Much of the debate over cross-department privileging turns on who is competent to perform which services. JCAHO requires uniformity in quality throughout the institution. In addition, in awarding new privileges, it has long been the practice to have other physicians proctor the new entrants. Yet, the proctors rarely know what they are to be evaluating. If the medical staff were to adopt CPGs, they could be used to guide the proctoring process (and privileging decisions generally).
2. Where physicians seek to work with NPPs, who does what, when, is often posed as a confounding concern in establishing the boundaries between NPPs' and

physicians' functions. As long as the NPPs are credentialed, if a group of physicians choose to treat in accordance with a CPG, why couldn't the medical staff privilege the group on that basis? If the medical staff were to adopt a CPG for a condition to be used to determine what should be done for a patient, who is doing what would become less of a concern.

3. Standing orders can be a contentious problem when imposed by the hospital. Yet, if in a collaborative process the medical staff selected CPGs to drive standing orders and processes of care, imagine how much time could be saved in documentation, including of the scope of the physicians' own services in the institution, which they could then use for their own billing while meeting the hospital's needs and enhancing quality.
4. The difficulties in effective corrective action often turn on the problems in medical staff members sanctioning their friends and peers. The persuasion and, indeed, even coercion that medical executive committee and fair hearing committee members are subject to in the corrective action process can be so unpleasant as to impede appropriate action. Above all, the amount of time physicians must spend working up the case and taking it through the fair hearing process is extremely disruptive to those who are dragooned into such service.

A medical staff using CPGs could track conformity, evaluate results, and if a real problem arises, outsource the tedium of the investigation and fair hearing processes. The procedures could be conducted based on the staff-selected CPGs. That outside process could present its findings in light of medical staff standards upon which the medical staff structure would then act. This would maintain the integrity of medical staff control, provide clear parameters for the outside reviewers, and save the medical staff members for their highest and best use in the process. Without clear parameters for judgment in the form of CPGs, though, this is much more difficult.

The difficulties in effective corrective action often turn on the problems in medical staff members sanctioning their friends and peers.

Astonishingly enough, the Stark regulations (based on the 1989 law prohibiting physician referrals to entities in which the physician has a financial interest) even provide a basis upon which the hospital can actively assist in training medical staff members in ways that will benefit the hospital and the physicians in their own practices. (See 42 CFR §411.357 (o).) The regulations explicitly permit hospitals to supply physicians with training in compliance. The application of CPGs in broad ways (including those addressed here) as part of that training can impel

PRINCIPLES OF ENGAGEMENT BETWEEN MEDICAL STAFF AND HOSPITALS

1. When physicians are essential to implementation of a hospital initiative, the medical staff should be involved at the earliest stages of the discussion and planning.
2. To involve the staff, it is critical to identify the real leaders, who often are the physicians with the right titles—department chair, president, etc.—but sometimes other physicians are the real spiritual leaders of the medical staff culture.
3. For any collaboration to work, there must be trust between the parties—often where it has broken down already. To win trust back, the medical staff and hospital representatives must do what they say and say what they do, consistently, over time.
4. For trust to develop there must be open, frequent, candid communication, including on negative and difficult issues. At the same time, the process should have appropriate confidentiality safeguards in place, recognizing the sensitive nature of the strategic, competitive matters at issue where the medical staff moves into areas beyond traditional credentialing and privileging.
5. The players in the process must be willing to be held accountable for their participation. That means that when the process yields a decision, the participants should support it even when they disagree with it. Dissent is fine, but if the mechanism operates fairly, then a properly concluded decision involving the medical staff and the administration and/or board should not be undermined and second-guessed out of pique. To agree to collaborate means no one wins all the time.
6. Accountability also means that if a representative is to participate in meetings or discussions, that person must make the commitment and fulfill the obligation to be there. Physicians are notoriously bad about this on the grounds that their patients come first. To have a quality-driven hospital where the patients can come first safely, the physicians should make arrangements for coverage when they are involved in important medical staff activities. Similarly, if the hospital representatives do not show up consistently or adhere to the same principles, they simply show the medical staff the process doesn't matter—also a common and counterproductive approach.
7. Documenting the process eliminates disagreements over what was understood, solidifies the nature of the undertaking, and speaks to other stakeholders, internal and external, who will want to understand what the hospital-medical staff relationship is about.

medical staff quality endeavors while it enhances compliance for the physicians and the hospital.

CONCLUSION

The organized medical staff performs vital functions for the hospital and must be engaged if the hospital is to move forward on quality. Coordinating the quality initiatives of the hospital with the physicians' related private practice needs can create a synergy with real power.

To expand the medical staff's role beyond credentialing and privileging can give the hospital far better access to useful expertise and can give the physicians a significantly more meaningful role in shaping their hospital work environment. By rethinking the real value of the medical staff, the physicians can contribute more and get more from the relationship, which can only ultimately redound to the benefit of the patients. ■

REFERENCES

1. Gosfield A. Letter to the OIG, 2003 Jan. 17; <http://www.gosfield.com/PDF/oigv2.pdf>.
2. Gosfield A. The Doctor-Patient Relationship as the Business Case for Quality. *Journal of Health Law* Spring 2004. Vol. 37#2: 197-223; <http://www.gosfield.com/PDF/DrPatientRelationship.pdf>.
3. Gosfield A. Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Care Organizations. AMA Organized Medical Staff Section (OMSS) White Paper, 1998. http://www.ama-assn.org/ama1/pub/upload/mm/21/quality_culture.pdf.
4. Gosfield A. Whither Medical Staffs?: Rethinking the Role of the Staff in the New Quality Era. *Health Law Handbook*. WestGroup, 2003. <http://www.gosfield.com/PDF/AGG.CB%202003.Ch4.pdf>.
5. Gosfield A, Reinertsen J. Doing Well by Doing Good: Improving the Business Case for Quality. http://www.gosfield.com/PDF/uft-a_White_Paper_060103.pdf.