What is wrong with your medical staff?

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As a physician, you bring your patients to a hospital to provide them needed care and to access quality patient care delivery systems supporting your hospital practice. To do so, you belong to the hospital medical staff, which provides direct means for you to participate in peer review, set the standard for the care provided, and add your voice to those of other physicians and other professionals to determine how clinical decisions are made at the hospital.

So, how is that working for you?

With physicians employed by hospitals, independent physicians under pressure, and hospitals taking over review and quality functions, the medical staff can be so transparent as to be invisible, failing to fulfill the intent of an organization of clinicians that oversees care provided within the bricks and mortar, schedules, and wards under management and support staff hired by the hospital board of directors. Does your medical staff measure up as the quality standard setter and change engine in charge of all things clinical, or is the medical staff change engine stalled out, just doing what it is told? Look out for the following problem areas.

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Organization

The minimum requirement to meet Centers for Medicare & Medicaid Services (CMS) requirements, and Joint Commission or Det Norske Veritas (DNV) accreditation standards, is that there is "an organized medical staff." How organized is your medical staff?

Most medical staffs are organized into departments, comprised of single specialties or related subspecialties. The Joint Commission, which certifies most United States hospitals to meet the federal Conditions of Participation for Medicare, recognizes the role departments should play in standard-setting, requiring, for example, that the data to be collected in ongoing peer review "is determined by individual departments and approved by the organized medical staff."[1] Nonetheless, some hospitals employ non-physician quality assurance staff who determine and cull the data that the hospital is more interested in, placing it in front of physicians who are not aware that the medical staff organization is to set the data points for its use in improving patient care.

Medical staffs are also organized into committees, comprised of different specialties to handle tasks that span departments. Increasingly, "medical staff" committees are made up of hospital administrators, who are paid to attend or even run the "medical staff" committee meetings. Are committees of your medical staff limited to, or at least representative of, your medical staff?

How do medical staff decisions get made? Organizations of the size, complexity, and responsibility of your medical staff have basic elements to assure transparent and effective decision-making. These common structures can be found in organizations ranging from the Girl Scout Council to a church vestry, but are rare occurrences in medical staff organizations. For example, does your medical staff have a budget, and a finance committee to oversee it?

The medical staff has—or should have—dues, and ought to have a budget to determine how funds are allocated and simple procedures governing which officers sign checks. Your local school parent teacher association has this much structure, but medical staffs have either not faced this, or in some cases have been discouraged from handling money matters by hospital management.

Medical staffs also need, but almost never have, basic conflict of interest policies, governing who can serve in medical staff leadership and what conflicting interests should be sorted out in assigning peer review duties or deciding who is and is not qualified to perform procedures or recommend therapies, despite American Medical Association (AMA) policy recommending conflict of interest policies for all medi-

cal staffs.[2] The medical staff conflict of interest policy should call for identifying physicians who have financial relationships with the hospital (such as employment or exclusive contracts) to guard against manipulation, while protecting them from retribution from the hospital when the physicians support the quality decision even when it does not advance the hospital's bottom line. Medical staff decision-making should be transparent and geared toward decisions that will promote quality patient care.

Code of Conduct

What is in the code of conduct that applies to the medical staff? If you don't know now, you might later find out the hard way that it prohibits conduct that would not occur to you as being "inappropriate" or "disruptive"[3]—such as conduct that competes with the hospital system. As most corporations and other organizations do, the hospital corporation has a code of conduct, which will apply to physicians unless the medical staff adopts a medical staff specific code of conduct governing its members' behavior. Hospital codes of conduct are designed for employees but often do not translate well to physicians who are not employees, directing complaints to the Human Resources Department instead of to peer review, or punishing violators who, for example, are automatically "disruptive" when they admit patients because a poorly written Code condemns "conduct that adds to the workload of the staff." Physician behavior should be addressed and controlled as warranted by the organized medical staff in the medical staff's code of conduct.[4]

Meetings

Medical staffs that have meeting requirements that do not work for the medical staffs are medical staffs that do not work. Many medical staffs have outdated requirements for meetings that are either unenforced or unenforceable, so that the medical staff never takes an action because it never has a forum. If your medical staff does not meet, consider revising your structure to permit virtual meetings that can take place online, over an extended period during which physicians can log in and comment, vote, and otherwise participate.

Bylaws

The home for medical staff organization is its medical staff bylaws. Do your medical staff bylaws need some housecleaning? If the basic organizational problems described here are not resolved in your medical staff bylaws, the answer must be "yes." In Wisconsin, medical staffs have the benefit of a court ruling that medical staff bylaws are a contract.[5] Medical staff bylaws are strengthened by this holding, but it is crucial that the medical staff bylaws are current and helpful for the medical staff. It's your contract with the hospital—make it a good one. And if your medical staff's hospital is accredited by the Joint Commission, know that changes in the accreditation requirements are pending and may be put into operation in 2011. Stay tuned for changes for your organized medical staff.

References

1. Joint Commission standard MS 08.01.03, Element of Performance 2.
2. American Medical Association. AMA Policy Compendium H-225.957.
3. Joint Commission standard LD 03.01.01, Element of Performance 4.
4. American Medical Association. AMA Council on Ethics and Judicial Opinion E-9.045.
5. *Austin v Mercy Health System,* 1995 WL 525250 (Wis. App.).

WHITEC

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- ambulatory clinics connected to a public or critical access hospital.
- community health centers or rural health clinics.
- other ambulatory settings predominantly serving uninsured, underinsured and medically underserved populations.

Each participating practice will complete an initial readiness assessment. Then, an individualized plan will be developed to provide a methodical process and needed services for achieving effective EHR implementation. For those practices that have already adopted and are striving for meaningful use, tailored assistance will be available.

Other WHITEC services include the following:

- workflow analysis and redesign tools.
- technology selection.
- contracting and purchasing tools.
- assistance with implementation.
- best practice information in privacy and security.
- assistance in interoperability and health information exchange.
- EHR optimization.

Practices interested in working with WHITEC are encouraged to complete an Application to Participate form, which is available on WHITEC's website: www.whitec.org. For more information, visit the website or e-mail QandE@wismed.org.

Reference

1. Margolis J. The great, the awful and the scary. What adopters have to say about implementing an EHR. *MGMA Connexion*. 2008; July: 24-27.

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