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The Hospital Board at Risk and the Need to Restructure the Relationship with the Medical Staff: Bylaws, Peer Review and Related Solutions

John P. Marren, G. Landon Feazell,** Michael W. Paddock****

This extensive article is intended to introduce a central thesis to pose the fundamental question for both our consideration and for a series of articles to follow. That question is: “*Does the current structure of the hospital governing board and medical staff support and promote quality and patient-centered care, or is it seriously flawed?*”

I. THE MAGNITUDE OF THE HEALTH CARE QUALITY CHALLENGES

The focus of this analysis is not intended to join the debate raging in the United States about how many preventable deaths occur from medical error. Rather, the issue is how shocking it is that we know so little about health care quality – at the national and local levels. It is appalling that we must extrapolate from small samples of data to consider crude elements such as how many people are injured or die needlessly in American hospitals annually.

American medicine, with its exceptionally trained and devoted physicians and clinicians, and with all its technology and innovations, is without parallel in the world. Yet the quality of health care in the United

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States has become the subject of intense controversy in recent years. The disparity between these two realities results from inconsistencies in care, not from potential capability. Quality, in so many ways and throughout industries and businesses, is about consistency, reducing “defects” and variability in processes.

There is no intention here to join the debate over how many deaths are preventable in health care or about distinctions between words such as “error” or “adverse event.” Kenneth W. Kizer, M.D., President and Chief Executive Officer of the National Quality Forum, states that “the whole debate about numbers misses the point” in the controversy in health care circles over the number of patient deaths due to medical errors.¹ The tragedy in American health care is that it has not achieved its potential to deliver consistent, high quality, error-free medical care. The challenge for the health care quality movement is to create and implement the framework and methodology to become the catalyst for health care in America to reach its full potential.

After the release of the Institute of Medicine (“IOM”) report, *To Err is Human*,² hospital deaths from medical “errors” became the focus of the health care quality debate. The impact of this report and the subsequent controversy is clearly caused by its most frequently referenced death toll figures of 44,000 to 98,000 per year. The accuracy of these figures has been widely challenged, ranging from criticisms of the methodology of the original studies upon which the report is based,³ to criticisms of the terminology used in the report by an author of the original study, Troyen A. Brennan, M.D.⁴

There are many intriguing sources of controversy in the debate, including

1. DELOITTE & TOUCHE/DELOITTE CONSULTING, HEALTH CARE REVIEW, PREFERRED ACTION TO TALK, HEAD OF NEW NAT’L QUALITY GROUP FOCUSES INITIAL EFFORTS ON PRODUCTS TO PREVENT MED. ERRORS, IDENTIFY SAFE PRACTICES, AN INTERVIEW WITH KENNETH W. KIZER, M.D., M.P.H., PRES. AND CEO, NAT’L QUALITY FORUM (2001), <http://www.qualityforum.org/AugHCR01.pdf>.

2. See COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM*, (LINDA T. KOHN ET AL., eds., 2000), http://stills.nap.edu/html/to_err_is_human [hereinafter IOM].

3. See, e.g., Rodney A. Hayward & Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors: Preventability Is in the Eye of the Reviewer*, 286 JAMA 415 (2001); THE DOCTORS CO., AN ‘EPIDEMIC’ OF MED. MALPRACTICE? A COMMENTARY ON THE HARVARD MED. PRACTICE STUDY, <http://www.thedoctors.com/advocacy/ourcause/harvardstudy/commentary.asp>.

4. Troyen A. Brennan, *Sounding Board: The Institute of Medicine Report on Medical Errors – Could It Do Harm?* 342 NEW ENG. J. MED. at 1123 (2000). For a different perspective of the methodology to improve quality in health care from the systems approach of the IOM, see also Stephen R. Latham, *System and Responsibility: Three Readings of the IOM Report on Medical Errors*, 27 AM. J.L. & MED. 163, 163-179 (2001).

Dr. Brennan's careful consideration of the distinctions between "adverse events", rather than "medical errors." The quantification of medical errors and the publicity surrounding it have sparked unprecedented national debate and consideration of health care quality by the public at large. Lucian L. Leape, M.D., a colleague of Dr. Brennan's in the original studies and member of the IOM's committee has stated, "[t]he speed and intensity with which this report from the National Academy of Sciences captured media, public, political and professional attention surprised everyone. And, it is no passing fad – attention to patient safety has not subsequently flagged, it has increased."⁵

The surprise in health care quality should not be the attention generated by the IOM report, but rather that there is so little known about the fundamental statistics on health care quality in America. It is significant to recognize that the IOM figures were extrapolated from studies of the medical records of several relatively small patient populations dating back to 1984 in New York hospitals, and then extended to Utah and Colorado hospitals.

While there may be debate as to the precise rate of preventable deaths in American hospitals, there is a developing body of knowledge about the "defect rates" in the current delivery of health care.⁶ For example, the IOM Report also estimates that over one million patients are injured by medical treatments annually in the United States. However, it is important to look at the medical literature beyond the perspective of the IOM to understand the magnitude and etiologies of the challenges created by dis-quality in health care.

Many important contributions to understanding health care quality include studies that classify quality challenges into the following three (3) categories:

1. Overuse – defined as providing a health service when its risk of harm exceeds its potential benefit;
2. Underuse – defined as failing to provide an effective service when it would have produced favorable outcomes; and
3. Misuse – defined as avoidable complications to appropriate health care.⁷

Mark R. Chassin, M.D., analyzes the clinical studies in the medical literature within this framework and then concludes the following reaches the following conclusion:

5. Lucian L. Leape, *Forward: Preventing Medical Accidents: Is "Systems Analysis" the Answer?*, 27 AM. J.L. & MED. 145, 145 (2001).

6. Mark R. Chassin, *Is Health Care Ready for Six Sigma Quality?*, 76 MILBANK Q. 565, 576-78 (1998).

7. *Id.* at 570.

As the research literature makes clear, quality problems of all three varieties abound in American medicine. The majority of these problems are not rare, unpredictable, or inevitable concomitants of the delivery of complex, modern health care. Rather, they are frighteningly common, often predictable, and frequently preventable. Viewed by those companies that have committed themselves to the most advanced applications of industrial quality management, the magnitude of the failures or quality defects in the provision of health care must seem stupefying.⁸

Overuse occurs when patients get what they do not need, or when patients undergo treatments or procedures from which they will not benefit. Underuse occurs when patients do not get what they do need, such as beneficial health services. Misuse occurs when patients receive appropriate health services, but those services are provided poorly, exposing patients to unnecessary risk of preventable complications.

Insight into examples of clinical quality for each of the categories of overuse, underuse, and misuse for specific medical conditions and the causes of those defects can be summarized as follows:

OVERUSE etiology:

- Payment incentive, such as fee for service;
- Physician enthusiasm for intervention;
- Primary care physician expectation of specialist (coronary angiography, upper GI endoscopy, knee arthroscopy, etc.);
- Patient expectation (antibiotic, x-ray, laboratory, etc.); and
- Fear of malpractice (“defensive medicine”).⁹

Examples of overuse from medical research include hysterectomies, where sixteen percent performed in a group of managed care plans were determined to be inappropriate (ranging from ten percent to twenty-seven percent among plans),¹⁰ coronary angiography and revascularization,¹¹ and antibiotic therapy.¹²

8. *Id.* at 566.

9. *Id.*

10. Steven J. Bernstein et al., *The Appropriateness of Hysterectomy: A Comparison of Core in Seven Health Systems*, 269 JAMA at 2398 (1993).

11. See Lange & Hillis, *Use and Oversue of Angiography and Revascularization for Acute Coronary Syndromes*, 338 NEW ENG. J. MED. 1838, 1838-9 (1998).

12. Ralph Gonzales et al., *Antibiotic Prescribing for Adults with Colds, Upper Respiratory Tract Infections, and Bronchitis by Ambulatory Care Physicians*, 278 JAMA, 901, 901-904 (1997). Twenty-one percent prescribed antibiotics to ambulatory patients to treat colds or other viral respiratory infections, conditions for which they are useless, and the defect rate was 210,000 per million. See *id.*

UNDERUSE etiology:

- Financial barriers (i.e. lack of insurance, the imposition of co-payments and deductibles, benefit packages not covering preventive care, etc.);¹³ and
- Rapid and recent accumulation of an enormous amount of clinical efficacy data.¹⁴

Underuse of beta-blockers is an example from medical research. Seventy-nine percent of eligible heart attack survivors fail to receive beta blockers, which results in a defect rate of 790,000 per million (less than Sigma Level One).¹⁵ Another example is the alarming rate of patients with clinical depression who are not detected or treated adequately: fifty-eight percent, with a defect rate of 580,000 per million.¹⁶

MISUSE etiology:

The medical literature is much less definitive about the causes of misuse than the other two categories of problems.¹⁷ Examples of misuse in the literature include the following:

- Errors in diagnosis (22%);
- Mishaps related to non-invasive, non-drug-related treatment (21%);
- Mistakes in medication use (12%);
- Technical complications of surgery (8%); and
- Surgical wound infections (6%).¹⁸

Dr. Chassin considered these quality concerns and examples of health care performance and observed:

If the performance of certain high-reliability industries, whose standards of excellence we take for granted, suddenly deteriorated to the level of most health care services, some astounding results would occur. At the defect rate of 20 percent, which occurs in the use of antibiotics for colds, the credit card industry would make daily mistakes on nine million

13. Chassin, *supra* note 6, at 573.

14. *Id.* at 574.

15. Stephen B. Soumerai et al., *Adverse Outcomes of Under Use of Beta Blockers in Elder Survivors of Acute Myocardial Infarction*, 277 JAMA 115, 115-121 (1997) (only 21% receive beta blockers).

16. Kenneth B. Wells et al., *Detection of Depressive Disorder for Patients Receiving Prepaid or Fee-for-Service Care*, 262 JAMA 3298, 3298-3302 (1989).

17. The experience and insight of the authors is far greater than the literature with the problem of misuse; however, this discussion is beyond the scope of this article.

18. Chassin, *supra* note 6, at 576-77.

transactions; banks would deposit 36 million checks in the wrong accounts every day; and deaths from airplane crashes would increase one thousand fold.¹⁹

The prestigious Robert Wood Johnson Foundation agrees with Dr. Chassin's conclusions about how other businesses regard the variances from best practices by health care. In other industries, leading businesses view defect-free processes as their central business strategy for increasing market share and profits. These businesses would not tolerate error rates comparable to those currently experienced in health care.²⁰

What we know for sure is that there is far too much overuse, underuse, and misuse to tolerate in a complex, high risk, patient dependent, and financially burdensome industry. We also know from previous studies that a no-fault approach would simply cost too much to be practical.²¹

One prevalent misconception from the IOM report on medical errors has emerged in the deployment of resources and focus on preventing medication errors. The single greatest contribution to health care from the IOM report has been to develop and install computerized medication order entry systems. However, as the studies on overuse, underuse, and misuse clearly demonstrate, and the IOM report emphatically states, the primary source of medical errors and the greatest health care quality challenge is the failure to diagnose (approximately 21% of the medical errors). After a careful review of proprietary databases of liability insurance carriers, it seems clear that medical malpractice claims data would reveal exactly the same conclusion.

The more frequently expressed number of deaths from medical error is

19. *Id.* at 569-70.

20. ROBERT WOOD JOHNSON FOUND., CALL FOR PROPOSALS: PURSUING PERFECTION, RAISING THE BAR FOR HEALTH CARE PERFORMANCE 4 (2001) available at <http://www.rwjf.org>. Understanding the validity of quality measures is central to comprehension of the overuse, underuse, and misuse approach to quantifying quality of patient care. In general, valid quality measures assess either processes (diagnostic or therapeutic interventions) or outcomes (health states that people experience). Process measures are valid quality measures when their relation to important health outcomes have been proven. The frequency with which heart attack survivors receive beta-blockers is a valid quality measure because these medications improve survival in this clinical situation. For a health outcome to be a valid quality measure, it must be related conclusively to a process or group of processes that can be modified to improve the outcome. Thus, the number of babies born with HIV infection is a valid measure of quality of care because treatment with zidovudine has been proven to reduce the transmission of infection from mother to infant. Cardiogenic shock, on the other hand, has been proven to respond to specific treatment regimens; therefore, deaths from that cause are not valid measures of health care quality.

21. David M. Studdert & Troyen A. Brennan, *Toward A Workable Model Of "No-Fault" Compensation For Medical Injury In The United States*, 27 AM. J.L. & MED. 225, 225-252 (2001).

the IOM's high number in the range totaling 98,000 deaths per year.²² This estimate of deaths from medical errors in hospitalized patients is understated, because it is based on calculations excluding emergency department and same day surgery deaths.²³ Other estimates are much higher, however, when outpatient deaths are included in the calculation. The widely quoted figures from David Lawrence, M.D., former Chief Executive Officer and Chairman of the Boards, Kaiser Foundation Health Plan and Kaiser Foundation Hospitals, total 400,000 deaths per year due to medical accidents and mistakes.²⁴ The National Quality Forum has, on occasion, adopted an estimate of 180,000 preventable deaths per year, including the outpatient population.²⁵ Thus, the mortality calculation is not indicative of the totality of the magnitude of the quality problem since patient injury – morbidity – from error has not been sufficiently included in the public deliberations.

Some indicators of the magnitude of the quality of care deficiencies in American health care are evident in the following summary:

- Medical error results in as many as 180,000 deaths per year and as many as 98,000 hospital deaths per year (equivalent of 1 jumbo jet crashing daily);²⁶
- 25% of hospital deaths are preventable;²⁷
- 33% of hospital procedures expose patients to risk without improving health;²⁸
- 33% of all laboratory tests with abnormal results are not followed up by physicians;²⁹ and
- 30% acute care patients and 20% chronically ill patients receive care not indicated.³⁰

22. IOM, *supra* note 2, at 26.

23. Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370, 370-76 (1991); Lucian L. Leape et al., *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 NEW ENG. J. MED. 377, 377-84 (1991).

24. O'Dwyer's PR Services Report, p.68 (October, 1999).

25. NAT'L QUALITY FORUM (FORUM FOR HEALTH CARE QUALITY MEASUREMENT AND REPORTING), A CALL TO ACTION 2 (2001), available at www.qualityforum.org/ [hereinafter NAT'L QUALITY FORUM].

26. *Id.*; IOM, *supra* note 2, at 1.

27. Dubois RW, Brook RH, *Preventable Deaths: Who, How Often, and Why?*, 109 ANNALS INTERN. MED. 582, 582-89 (1988).

28. Brook RH et al., *Appropriateness of Acute Medical Care for the Elderly: an Analysis of the Literature*, 14 HEALTH POL'Y 225, 225-242 (1990).

29. *Id.*

30. NAT'L QUALITY FORUM, *supra* note 25, at 2; IOM, *supra* note 2, at 1.

According to the Robert Wood Johnson Foundation, the risk of death from riding on a set of recalled Firestone tires is much lower than the risk of death from avoidable hospital error. The startling contrast for risk of death is 91 per million versus 2,917 per million, or a 32 times greater risk of death in health care.³¹ This perspective states the magnitude of the problem in a current and easily understandable context.

In the context of the business of medicine, the impact of these types of calculations becomes quite significant. Dr. Lawrence of the Kaiser Foundation makes the following analysis:

According to the IOM report, two studies, one done in New York using data from 1984 and a second conducted in Colorado and Utah using 1994 data – found that 2.9 percent and 3.7 percent, respectively, of hospital admissions experienced an adverse event due to medical management of their care. Of this amount, 58 percent in New York and 53 percent in Colorado and Utah were considered preventable. If these percentages are applied to all hospital admissions in the United States, the costs of preventable adverse events ranges between \$17 billion and \$29 billion with over one-half of this amount going exclusively toward health care costs. This figure represented roughly 2 percent of total national health care expenditures in 1996.³²

However, as is noted by Dr. Kizer at the outset of this section, the debate about the numbers misses the point, and these calculations of such summary indicators of quality should not be the focus of national and scientific attention. The failure in the United States to establish the fundamentals of a market-based health care system with such key capabilities as standardized measures of quality must be the focus. Further, as this analysis is presented, the distinction between health care and health of Americans should not be overlooked when addressing access and inconsistencies in quality care. As Barbara Starfield, M.D., concluded, “[t]he fact is that the US population does not have anywhere near the best health in the world.”³³

Our consideration is not directed at how poor health care quality is or is not. Rather, it is upon an analysis of the root causes of deficiencies in quality, clearly established in the medical literature from the causes of overuse, underuse and misuse, and from the wide ranging summary indicators of dis-quality presented above.

31. See ROBERT WOOD JOHNSON FOUND., *supra* note 20, at 4.

32. *Do No Harm – Reducing Medical Errors and Improving Patient Safety*, Council of State Governments Health Policy Monitor 6(1): 1-4 at p. 1 (CSG, Lexington, Kentucky, 2001).

33. Barbara Starfield, *Commentary: Is US Health Really the Best in the World?*, 284 JAMA 483, 483-85 (2000).

II. THE PROCESS OF ASSURING QUALITY

The solutions to the health care quality challenges are processes of care that utilize evidence-based best practices and that are patient-centered, effective, efficient, and safe with error-proofing. These processes must recognize that value is an element of quality, and while evidence-based they must be financially logical. This solution must be accompanied by a companion system for credentialing based on current clinical competence and managing misconduct or incompetence for all areas of overuse, underuse, and misuse.

The alarming statistics that are prevalent when considering health care quality are not the central message of the 1999 IOM report on medical errors. The central thesis of the report is that errors are caused by faulty systems, and the solution to patient safety and to health care quality challenges is the human factors approach to designing safe systems.³⁴

Medicine remains in many ways a craft-model, cottage-based industry, and there is really no such thing in most settings as a “deliberately designed health care system.” Careful study of the several recent pronouncements from the IOM in both the errors and quality roundtable projects demonstrates the mounting national focus on implementation of systems and processes of health care as the initiatives that will be adopted by purchasers, payers, regulators, and ultimately, by providers of health care.

After a careful review of the collection of reports from the IOM, including the roundtable quality studies, it seems clear that the IOM is creating a two-pronged approach to the solution to errors in health care and improving patient safety: first, selection of appropriate treatment plans rooted in evidence-based medicine; and second, monitoring proper and safe implementation once the right protocol is selected.

Dr. Leape believes that another reason the IOM report on medical errors captured public and professional attention is because it packages what he terms the “shocking news with a compelling remedy.”³⁵ The solution is that medical errors can be prevented by systems re-design. Leape noted that:

[t]his idea that errors are primarily caused by systems failures and not human failures is a truly transforming concept. It turns on its head our long-held beliefs and assumptions about why people screw up and what to do about it. It is truly a paradigm shift. Early evidence also suggests

34. See IOM, *supra* note 2.

35. Leape, *supra* note 5, at 146.

that it works.³⁶

Martin Merry, M.D., a nationally recognized health care quality consultant, (incorporating the analysis of Paul Ulig, M.D.), emphasizes the root cause of the current health care quality challenge as the “absence of carefully designed error-proofing infrastructure.”³⁷ Throughout the last century, medicine has and continues in this millennium to achieve extraordinary scientific advances and product innovation (invasive procedures, artificial devices, pharmaceuticals, and similar products).³⁸ During the same period, health care has seen virtually no process innovation. The health care culture still features a fairly rigid professional hierarchy, isolation of clinical care from institutional management, and virtually no coordinated design of systems of health care around the true needs of the patients.

Without parallel advances in the delivery of care through innovation and implementation of processes, the impact of these advances in medicine relies upon outdated methods of work. This absence of carefully designed work processes sets up physicians, nurses, and ancillary clinical personnel to fail. Working harder will not improve quality in this workplace. Only working *differently* will succeed.³⁹

Dr. Merry then concludes that the following items cause the fundamental defect in the health care system:

- Complex health care processes;
- Unsupported by a carefully designed error-proofing infrastructure;
- Thus relying upon people checking people at the myriad of “hand-offs”; and
- Creating a maximum performance capability probably around 4 sigma (an error rate of approximately 6% or defect rate of approximately 6000 defects per million, similar to the rate of lost airline luggage).⁴⁰

The subsequent publication of the IOM’s *Crossing the Quality Chasm: A New Health System for the 21st Century* is an academic effort to provide solutions to the health care quality challenges. For the purposes of this discussion, several key insights from this publication are instructive. First,

36. *Id.*

37. Personal correspondence from unpublished presentations by Martin Merry, M.D. to Landon Feazell, one of the authors.

38. See generally IOM, *supra* note 2.

39. Stephen M. Shortell & Jeff Selfberg, *Working Differently: The IOM’s Call to Action*, HEALTHCARE EXECUTIVE, Jan./Feb. 2002, at 6.

40. Martin D. Merry, Address Before the ASQ-Milwaukee Metropolitan Association of Commerce CEO Breakfast Meeting (Nov. 6, 2002).

the proposed solutions are framed in five (5) key strategies:⁴¹

1. There must be total commitment by all stakeholders to care that is safe, effective, patient-centered, timely, efficient, and equitable;
2. Ten (10) rules (see below) should guide patient-clinician relationships with comprehensive systems support;
3. Designing systems will be premised upon evidence-based best practices approaches;
4. All parties must collaborate to redesign systems; and
5. The “broader environment” (culture) must be changed in four (4) key areas (see below).

The ten (10) “rules” of Strategy 2 are helpful to considering board-senior management-medical staff relationships, as follows:⁴²

1. Continuous healing relationships;
2. Customize to patient needs and values;
3. Patient is the source of control;
4. Share knowledge/information with patient;
5. Evidence-based clinical decisions;
6. System must be safe;
7. System must be transparent;
8. Beyond reaction, anticipate needs;
9. Waste of resources and patient time is decreased; and
10. Greater cooperation among clinicians.

Strategy 5 for changing the health care cultural environment is crucial to our understanding of improving the board/senior management/medical staff relationships:

1. Expeditiously apply and disseminate scientific knowledge and best care practices;
2. Optimally apply information technology;
3. Align payment policies with quality improvement, and build in stronger incentives for quality enhancement, and
4. Prepare work force to make a smooth transition into a revamped, modern health care system.⁴³

41. See INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (Mar. 2001), available at <http://www.nap.edu/books/0309072808/html>.

42. See *id.* at 61-62.

43. See *id.* at 145-224. For a concise and condensed synthesis and understanding of this Institute of Medicine publication, see Donald M. Berwick, *A User's Manual for the IOM's 'Quality Chasm' Report*, HEALTH AFFAIRS, May/June 2002, at 80.

Fundamental to the consideration of designing safe, effective, and efficient systems that support physicians at the “sharp end” is the insight from human factors research that we move from the current blaming and punishment approach to a *blameless* environment. The solutions equation must encompass both the concept of a blameless environment, as well as the responsibility of the board working with the organized medical staff to credential physicians on the basis of demonstrated current clinical competence. It must be recognized that *some* errors are due to misconduct, motivated in some isolated instances by greed or even clinical incompetence, which manifests its consequences in all three areas of overuse, underuse, and misuse. Dr. Leape stated his concern for deliberate violation of rules for personal benefit, concluding that these cannot be tolerated and pointing out where discipline is appropriate:

The problem is that we have typically conflated the two, making the assumption that any error is proof of misconduct, or, at the very least, of not being careful enough when in fact it rarely is. Experience shows that separation of the two types of errors is usually not difficult. Good managers have little trouble recognizing the truly careless or rule-breaking worker. These must be dealt with appropriately. As James Reason puts it, what is needed is neither a blameless nor a blaming culture, but a *just* culture, one in which those who violate the norms and behave irresponsibly are dealt with appropriately.

A major professional failure of medicine has been that it has not dealt effectively with this segment of practitioners, but left it to state boards and the tort system, which, by definition, can only respond retroactively after a patient has been injured. This, too, calls for a “systems” solution; a system for identifying problem physicians *before* their actions result in patient injury and providing them with appropriate help and remediation, while protecting patients from harm. In some cases, referral to the state board for disciplinary action or restriction of privileges may be necessary. To do this requires hospital staffs to be much more aggressive in developing performance standards, monitoring behavior, and taking action to correct problems than they have in the past. If they are to do this – and we should all pray they will – they need much more support from both the regulatory and legal establishments than have been forthcoming to date.⁴⁴

The solution to the health care quality challenges, as noted above from the IOM reports, *must* be two-pronged, as the challenges are multi-factorial. The challenges of overuse, underuse, and misuse are very different

44. See Leape, *supra* note 5, at 148.

problems with different root causes and motivations requiring different solutions.

Peer review in health care has become undervalued and misunderstood, and in many instances essentially abandoned in favor of other approaches to measuring and improving quality of care. Many of the health care quality professionals who publish and speak on the subject do not understand problem physicians as clearly as Dr. Leape; others choose to speak only of the blameless culture proposed by Dr. Reason without referencing his concept of neither a blameless nor blaming culture, but just a culture.⁴⁵ Some choose to consider peer review as “toxic,” inconsistent with a learning organization where peer review is only educational in purpose, while others choose to simply acknowledge the problem, then dismiss it. For example, one of the early leaders of the Continuous Quality Improvement (“CQI”) and Total Quality Management (“TQM”) movements, Donald M. Berwick, M.D., made the case arguing against peer review as a quality control (“inspection”) methodology.⁴⁶ In comparing a “blaming” culture in “Hospital A” to a “blameless” culture in “Hospital B,” a table was created that presented false assumptions and attributed incorrect traits to peer review, as follows:⁴⁷

Table 1. Comparison of Peer Review and Quality Improvement

<i>Characteristic</i>	<i>Peer Review</i>	<i>Quality Improvement</i>
Object of study	Physicians	Processes
Types of flaws studied	Special	Common and special
Goal	Control	Breakthrough
Performance referent	“Standard”	Capability/need
Source of knowledge	Peers	All
Review method	Summative	Analytic
Functions involved	Few	Many
Amount of activity	Some	Lots
Linkage to design, operations, and business plan	Loose	Tight
Tampering (unpredictable events)	Common	Rare

The argument defines “peer review” as an inspection technique not to be

45. JAMES T. REASON, *MANAGING THE RISKS OF ORGANIZATIONAL ACCIDENTS* at 252 (1997).

46. See Donald M. Berwick, *Commentary: Peer Review and Quality Management: Are They Compatible?* *QUALITY REV. BULL.*, July 1990, at 246.

47. See *id.* at 249.

the focus of the CQI/TQM model, as set forth specifically in the following:

Reliance on inspection to improve quality	vs.	Inspection as an element of total quality management
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The conclusion of this pivotal exposition stated: “[l]et the record show that in the total quality management of the future the peer review professional can and should be a key player.”⁴⁸ However, no role for peer review was ever meaningfully established in the CQI/TQM model and any effort to achieve the notion of the stated conclusion was stifled. As a result, peer review was labeled inappropriately as “bad apple hunting,” and as health care specialists, we knew it was being relegated to being treated as “not dealing with the real issues.”

The significant forces of the very real disincentives against peer review, discussed below, coupled with the excuse not to perform peer review, as discussed above, have combined to result in feeble to non-existent review of sub-optimal care in American health care. The dramatic impact of meaningful and insightful peer review, learning from clinical experience, has been lost by avoidance. At the outset, it is unconscionable not to investigate the causes of medical errors and to take definitive steps not to repeat these errors. America would not consider for one moment failing to investigate causes behind accidental plane or NASA space events, and even focuses on the need to have such investigations conducted by outside, independent review bodies. But more significant, the use of peer review to improve quality from the perspectives of reducing risk in such clinical contexts as patient selection and reducing costs has not been recognized and achieved.

The lone example in the medical literature of using peer review to improve outcomes and reduce risk while reducing cost is published by the Department of Surgery at Stanford University School of Medicine.⁴⁹ These achievements required peer review coupled with positive physician feedback. Peer review processes such as described by Stanford are essential to boards, senior management, and medical staffs in breakthrough improvements in health care quality in the United States.

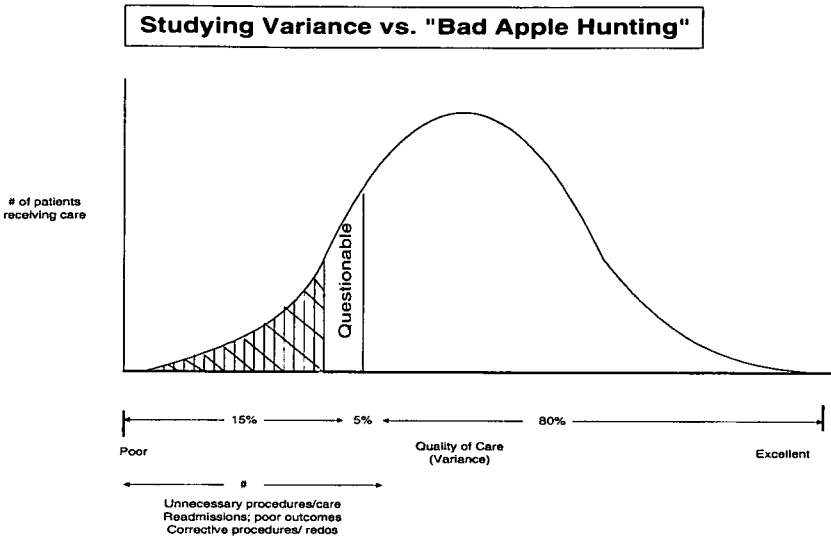
The early continuous quality improvement insights, however, resulted in a very compelling and accurate departure from the basic flaw in any quality improvement process that relies solely upon peer review and disciplinary

48. Extracted from Early Instructional Courses of the Institute for Healthcare Improvement, Boston; and personal correspondence between Janice J. Ophoven, M.D., The Crackleberry Group, St. Paul, Minnesota, and Landon Feazell (one of the authors).

49. Cornelius Olcott, IV et al., *Institutional Peer Review Can Reduce the Risk and Cost of Carotid Endarterectomy*, 135 ARCHIVES SURGERY 939, 939-42 (2000).

actions. The CQI argument postulates that 15% of physicians are responsible for the vast majority of significant variance from quality and that this 15% is responsible for 80% of medical errors and defects. If you eliminate the 15%, you do not move (and thereby improve) the remaining 85% of care, and thus fail to significantly impact quality of patient care.⁵⁰

Figure 1:



So the CQI argument has always been, let “them,” the undefined “someone else’s” of the quality world, worry about the 15%.

The physician-specific root causes of overuse, underuse, and misuse have, for the most part, not been addressed. The CQI methodology focuses primarily on identifying variance (“common” and “special cause”) and has not succeeded in many ways, because it has failed to address and change the major root causes of variance. There is again no methodology to find and to analyze the root causes of problems, no design to catch mistakes before they happen, and no commitment to the difficult task of changing behavior in a fragmented health care system essentially without processes of care to measure (the focus of CQI/TQM).⁵¹ The existing CQI/TQM movement has further chosen to remain essentially intellectual and has not established a business case for financial gain inherent in improving quality. The existing need to dramatically and rapidly improve health care quality,

50. See *supra* text accompanying note 48.

51. See Proceedings of “Changing Physicians’ Behavior”, University of Wisconsin Medical School, Continuing Education, Oct. 12-13, 2002 (on file with author).

frequently referenced as “breakthrough” quality initiatives, requires unwavering commitment from the top of the organization. This should be in the form of new leadership with new techniques – new questions, new perspectives, and new voices.

The challenge in health care is to recruit leadership to the health care quality opportunities:

For all its spending on health care, the United States is still plagued with quality problems in its health care institutions and practices. While calls for quality improvement have not been ignored, no coherent strategy has yet been put in place to answer them. One reason for this . . . is a leadership void. A leader could come from any of several groups, including consumers, government, employer-purchasers, and the health industry and professions themselves. But the obstacles remain, and with few notable exceptions, the ‘quality chasm’ remains unbridged.⁵²

The most frightening possibility for the health care industry and its professionals is that the leadership (and proffered strategies) will come from outside health care, as it has in the past, from payers, managed care and increasing governmental regulation. Dr. Chassin and Elise Becker, a co-author with Dr. Chassin, describe a possible strategy for some large hospitals and integrated delivery systems (“IDS’s”) that are financially positioned to access the capital necessary to undertake the leadership essential to this cause. They discuss the possibility of implementing a strategy that first targets quality improvement priorities that would produce financial returns, despite payment incentives that do not uniformly promote, and often directly conflict, with quality goals.⁵³

Recent research confirms that involving all constituencies, including governance, senior management, medical staff leadership, and clinical quality improvement in equally meaningful ways is important to a successful quality program. The study results suggest that leadership from the top promotes clinical involvement in CQI/TQM. Further, study results indicate that leadership for quality in health care may come from several sources, primarily boards, senior management, and the physician leaders.⁵⁴ The hospital board plays a significant role in creating a corporate culture for quality to become the motivating business strategy.⁵⁵ Beyond the legal

52. Elise C. Becker & Mark R. Chassin, *Improving the Quality of Health Care: Who Will Lead?*, 20 HEALTH AFFAIRS at 164 (2001).

53. *See id.* at 174.

54. Bryan J. Weiner et al., *Promoting Clinical Involvement in Hospital Quality Improvement Efforts: The Effects of Top Management, Board, and Physician Leadership*, 32 HEALTH SERVICES RES. 491, 491-96 (1997).

55. *See* Barbara Arrington et al., *Continually Improving Governance*, 40 HOSP. &

accountability of the board, the most important leadership capability is “the board’s position as a nexus for planning, implementing, and institutionalizing” the hospital’s quality endeavors.⁵⁶ The board further plays a key role in promoting clinical involvement in quality initiatives by maintaining the “continuity of purpose,” particularly in situations of senior management turnover.⁵⁷

If the governing board and the medical staff are at the epicenter of promoting quality of care within a hospital, then the hospital itself, as an organization, is at the epicenter of the nationwide effort to promote quality of care. Third party payers, such as managed care organizations, utilize credentialing standards that select participating physicians on the basis of quality of care (as well as economic performance); however, these organizations often rely on the hospitals themselves to identify high quality practitioners. For example, a managed care organization will allow a physician to participate in its program if that physician enjoys medical staff privileges at any one of many regional hospitals (a process called “secondary verification”). The managed care organization is satisfied with the practitioner’s ability to render quality care to the extent the hospital has so determined.⁵⁸

JCAHO, which understandably promotes the provision of high quality care, is unable, on a ground level, to ensure quality care. In fact, the JCAHO Standards simply require accredited hospitals to utilize processes that are acknowledged to promote quality of care, i.e., peer review and corrective processes. Both Congress and state legislatures recognize the virtues of peer review.⁵⁹ These third parties not only acknowledge the crucial role of the hospital in furthering quality of care, they in fact rely on the hospital as an organization that can achieve high quality of care.

HEALTH SERVICES ADMIN. 95, 97 (1995); see generally Bryan J. Weiner & Jeffrey A. Alexander, *Hospital Governance and Quality of Care: A Critical Review of Transitional Roles*, 50 MED. CARE REV. 375, 376 (1993).

56. Weiner et al., *supra* note 54, at 495.

57. David Blumenthal & Jennifer N. Edwards, *Involving Physicians in Total Quality Management: Results of a Study*, in IMPROVING CLINICAL PRACTICE: TOTAL QUALITY MANAGEMENT AND THE PHYSICIAN, 229, 261 (David Blumenthal and Ann C. Scheck eds., 1995).

58. Robert Miller & Randall R. Bovbjerg, *Efforts to Improve Patient Safety In Large, Capitated Medical Groups: Description and Conceptual Model*, 27 J. OF HEALTH POL., POL’Y & L. at 401 (2002).

59. 42 U.S.C. § 11101 (2000); Illinois Hospital Licensing Act, 210 ILL. COMP. STAT. 85/10.2 (1996).

III. UNDERSTANDING THE ACCOUNTABILITY OF THE HOSPITAL GOVERNING BOARD FOR QUALITY OF CARE; AUTHORITY OF THE HOSPITAL GOVERNING BODY TO MAKE DECISIONS IMPACTING QUALITY OF CARE

To the extent that quality of care is a "hospital issue," it remains an issue for the individual practitioners with medical staff privileges, the organized medical staff itself, and the hospital governing board. It is disingenuous for practitioners and medical staff leaders to first proclaim that no quality of care issue exists, and second, that to the extent one *does* exist, it can and should be addressed solely by practitioners. Such proclamations ignore basic tenets of corporate and health care law. It is equally irresponsible to assert that only the hospital governing body and administrators should be responsible for quality. For practitioners, medical staff leaders, and governing boards (which very often consist of laypersons) to fully understand the role of the governing board in addressing issues of quality of care, it is necessary to examine the legal duties owed by hospital governing boards.

The major jolt to the established, if not divided, relationship between the organized medical staff and the hospital governing body occurred on Saturday afternoon, November 5th, 1960. That day, a linebacker for Eastern Illinois University, Dorrence Darling II, broke his leg trying to shed a block and make a tackle.⁶⁰ Darling was rushed to the emergency room at Charleston Community Memorial Hospital, where Dr. John Alexander, the on-call physician, applied traction and placed the leg in a plaster cast.⁶¹ Shortly after the cast was applied, Darling continued to remain in great pain and, ultimately, his toes became swollen, black, cold, and insensitive.⁶² Not until three days later did Dr. Alexander remove the cast; a witness said the stench of rot was the worst he had smelled since World War II.⁶³

Darling remained at Charleston Community Memorial Hospital for two weeks, whereupon he was transferred to Barnes Hospital in St. Louis and placed under the care of Dr. Fred Reynolds, the head of orthopedic surgery at Washington University School of Medicine and its affiliate, Barnes Hospital.⁶⁴ Dr. Reynolds found that the application of the cast to the leg had caused severe swelling and hemorrhaging, which in turn interfered with blood circulation, which caused the leg to become mostly dead tissue.⁶⁵ After several operations, Darling's leg was amputated eight inches below

60. Darling v. Charleston Cmty. Mem'l Hosp., 211 N.E.2d 253, 255 (Ill. 1965).

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.* at 255-56.

65. *Id.* at 256.

the knee.⁶⁶

Darling settled a lawsuit against Dr. Alexander, but maintained a lawsuit for negligence against Charleston Memorial.⁶⁷ An Illinois jury returned a verdict for Darling and against Charleston Memorial; the appellate court affirmed.⁶⁸ On appeal before the Supreme Court of Illinois, Darling contended that he had established that Charleston Memorial was negligent in 1) permitting Dr. Alexander to perform orthopedic procedures within the hospital; 2) failing to require that Dr. Alexander review his operative procedures in order to bring them up to date; 3) failing, through its medical staff, to provide adequate supervision of the case; and 4) failing to require consultation after complications arose.⁶⁹

Like the multitudes of hospitals before it, Charleston Memorial argued that it could not be liable for Dr. Alexander's malpractice, as:

only an individual properly educated and licensed, and not a corporation, may practice medicine. Accordingly, a hospital is powerless under the law to forbid or command any act by a physician or surgeon in the practice of his profession. A hospital is not an insurer of the patient's recovery, but only owes the patient the duty to exercise such reasonable care as his known condition requires and that degree of care, skill and diligence used by hospitals generally in the community.⁷⁰

In turn, Darling argued that the state's licensing regulations, accreditation standards, and bylaws defined the duties that Charleston Memorial had breached.⁷¹ Thus, the dispute between Darling and Charleston Memorial centered on the duties that a hospital owes to its patients with respect to the practitioners on its medical staff, and the medical care rendered by those practitioners, if any.⁷²

The Supreme Court of Illinois found that hospitals had progressed beyond the era when they were simply large 'workshops' for independently practicing physicians, that by examining the manner in which hospitals operated, it was apparent that hospitals did more than simply "furnish facilities for treatment."⁷³ The court found that, as of 1965, the average patient arriving at a hospital expected that the hospital would attempt to cure them, and not just the individual practitioners acting inside and on their

66. *Id.*

67. *Id.* at 255.

68. *Id.*

69. *Id.* at 256.

70. *Id.*

71. *Id.* at 257.

72. *Id.* at 256.

73. *Id.* at 257.

own accord. Most importantly, the court found that state licensing regulations, hospital accreditation standards, and Charleston Memorial's own bylaws "demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient."⁷⁴

As a result of this watershed holding, i.e., that hospitals are responsible and accountable for selecting the practitioners that care for its patients, hospitals had to become diligent in 1) determining which practitioners they appointed to their medical staffs; 2) ensuring that the practitioners maintained up-to-date practices; and, most importantly, 3) supervising all care rendered within their walls, including that of the medical doctors. To truly and fully grasp the cratering impact of this holding on contemporary hospital governance and operations, it is instructive that Charleston Memorial's chief executive officer felt no inhibitions to utter the following testimony at trial:

As the Board's representative, I did nothing to see that Dr. Alexander reviewed his operating techniques for the handling of broken bones. So far as I know, Dr. Alexander may not have reviewed his operating techniques since he was first licensed to practice in 1928. No examinations were ever given. I never asked questions of the doctor about this matter. The governing board, neither through me nor through any other designated administrative representative, ever checked up on the ability of Dr. Alexander as compared by medical text books . . . I never made any effort to see that Dr. Alexander, or any other physician admitted to practice more than thirty years ago, read them.⁷⁵

Naturally, it did not take long for the plaintiffs' bar to extend *Darling* as far as it could. In 1972, an Arizona appellate court determined that a hospital was negligent in not following up on discrepancies in a physician's reappointment form.⁷⁶ California appellate courts followed suit,⁷⁷ along with the Nevada Supreme Court,⁷⁸ and the Georgia Supreme Court.⁷⁹ A

74. *Id.*

75. *Darling v. Charleston Cmty. Mem'l. Hosp.*, 200 N.E.2d 149, 171 (Ill. App. Ct. 1964).

76. *Purcell v. Zimbelman*, 500 P.2d 335, 340-41 (Ariz. Ct. App. 1972) (holding that the hospital had a duty to the public to allow the use of its facilities only by such independent staff doctors as are professionally competent and who treat their patients in full accordance with accepted and established medical practices).

77. *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 337 (1982) (holding that a hospital owes a patient a duty of selecting and reviewing the competency of its staff physicians carefully even where the physician is an independent contractor in relation to the hospital as opposed to an employee or agent of the hospital); *Bell v. Sharp Cabrillo Hosp.*, 260 Cal. Rptr. 37, 41 1339 (1989).

78. *Oehler v. Humana, Inc.*, 775 P.2d 1271, 1272 (Nev. 1989).

hospital was found negligent in not restricting the scope of a practitioner's privileges after becoming aware of wrongful acts committed by the physician.⁸⁰ Another hospital was liable for not being able to detect a physician that concealed his medical errors.⁸¹ Clearly, going through the motions of accepting reapplication forms and filing them away was insufficient; actual diligence was due.

In 1981, in the middle of the burgeoning of corporate negligence, the Wisconsin Supreme Court once again informed hospital governing boards that the buck stopped with them.⁸² The court noted that while a governing board could delegate to its medical staff the board's duty to select competent physicians, it could not delegate to its medical staff the accountability for negligently selecting incompetent physicians.⁸³ A patient, James Johnson, sued both his orthopedic surgeon, Dr. Lester Salinsky, and Misericordia Community Hospital ("MCH") for negligence. During a surgical procedure performed by Salinsky at MCH, Johnson's femoral nerve and artery were damaged, and Johnson lost the use of his right leg. Johnson claimed that Salinsky had committed medical malpractice, and that MCH was negligent: 1) in selecting Dr. Salinsky as a member of its medical staff; 2) in allowing Dr. Salinsky to perform orthopedic surgery procedures when it should have known that Dr. Salinsky was not qualified to perform such procedures; and 3) in failing to investigate Dr. Salinsky's capabilities. Johnson and Dr. Salinsky settled prior to trial, but Johnson maintained his suit against MCH.⁸⁴

In Dr. Salinsky's application for privileges on MCH's medical staff, Salinsky claimed that he enjoyed privileges at three other hospitals, and that such privileges had never "been suspended, diminished, revoked or renewed."⁸⁵ Salinsky also failed to answer questions regarding his malpractice insurance. The record showed that MCH's administrative staff failed to contact any of Salinsky's references and failed to investigate Salinsky's application. The record further showed that, had MCH conducted such an investigation, it would have found that Salinsky did not enjoy privileges at the hospitals he claimed to, that one hospital had denied

79. Mitchell County Hosp. Auth. v. Joiner, 189 S.E.2d 412, 414 (Ga. 1972) (hospital corporate negligence is comparable to that of the owner of a motor vehicle permitting an incompetent, inexperienced or reckless driver to operate its motor vehicle).

80. Cronin v. Doud, 168 Ill. App. 3d 665 (1988).

81. Corleto v. Shore Mem'l Hosp., 138 N.J. Super. 302 (1975).

82. Johnson v. Misericordia Cty. Hosp., 301 N.W.2d 156 (Wis. 1981).

83. *Id.*

84. *Id.* at 158.

85. *Id.* at 159.

him privileges, and that one hospital had restricted his privileges.⁸⁶ Moreover, orthopedic surgeons in the community considered Salinsky to be an inferior practitioner. In addition, seven malpractice suits had been filed against Salinsky before MCH granted him privileges. Johnson introduced expert witnesses that testified that hospital authorities, given this record, would not appoint Dr. Salinsky to their medical staff. The jury found for Johnson and against MCH; MCH appealed, but the appellate court affirmed.⁸⁷

Specifically, MCH appealed on two issues to the Wisconsin Supreme Court: whether a hospital owes a duty to its patients in selecting its medical staff and granting privileges, and if so, what is the standard of care that a hospital must employ in performing that duty?⁸⁸ As to the first issue, the court held that a duty of care is imposed whenever it is foreseeable that a party's conduct may cause harm to someone.⁸⁹ The court then determined that the "failure of a hospital to scrutinize the credentials of its medical staff applicants could foreseeably result in the appointment of unqualified physicians surgeons to its medical staff. Thus, the granting of staff privileges to these doctors would undoubtedly create an unreasonable risk of harm or injury to their patients."⁹⁰ Therefore, a hospital governing body, as part of its accountability for the quality of all care rendered within the hospital, owes a duty to its patients in selecting its medical staff and granting privileges.

The court also supported this holding as consistent with the public's perception of the modern day medical center. "The concept that a hospital does not undertake to treat patients, does not undertake to act through its doctors and nurses, but only procures them to act solely upon their own responsibility, no longer reflects the facts."⁹¹ To support this, the court cited the complexity of hospital operations, the appointment and employment of practitioners, and the fact that hospitals charge patients and are reimbursed for medical diagnosis, care, treatment, and therapy.⁹²

Once the court established that a duty existed, it examined whether MCH

86. *Id.* at 161.

87. *Id.* at 157-58.

88. *Id.* at 163.

89. *Id.* at 164.

90. *Id.*

91. *Id.*

92. By finding that a hospital's duty of care was established by a level of 'foreseeability,' first, and the public's perception, second, the Wisconsin Supreme Court differed from the Illinois Supreme Court, which found that such a duty of care was established by law, regulation and private accreditation standards. The Wisconsin Supreme Court refuted MCH's argument that the Wisconsin statutes actually negated any common law duty of care. *See id.* at 170-71.

had exercised the same level of investigative care that most hospitals exercise under like circumstances.⁹³ The court determined that MCH had not made a reasonable effort to determine whether Dr. Salinsky was qualified to practice on its staff and that, had MCH made such an effort, it surely would have known of Dr. Salinsky's incompetence.⁹⁴ Finally, and most importantly, the court held that:

the delegation [to the medical staff] of the responsibility to investigate and evaluate the professional competence of applicants for clinical privileges does not relieve the governing body of its duty to appoint only qualified physicians and surgeons to its medical staff and periodically monitor and review their competency.⁹⁵

In the context of implementing the doctrine of corporate negligence in its state's common law, the Wisconsin Supreme Court clarified the roles that the governing body and the medical staff play within their relationship. A governing body may delegate duties to its medical staff, including the duty to investigate and recommend practitioners, but it can never delegate the accountability for any failure to adequately perform those duties.⁹⁶

The facts in *Johnson*, however, were convenient for the Wisconsin Supreme Court's holding. Dr. Salinsky had been appointed after neither MCH's governing body, nor MCH's medical staff had taken any steps to investigate his competency. But what about the situation where a governing body relies on its medical staff to either recommend or not recommend the appointment of a practitioner, the medical staff recommends that a practitioner be appointed, and the governing body disagrees? Or vice versa? If a hospital is ultimately accountable for the quality of care rendered within its walls, including being accountable for the reasonable investigation of an applicant's credentials, what are the implications for a governing body of a hospital that disagrees with the recommendations of its medical staff? In other words, have the courts recognized that it may be reasonable for a group of laypersons (the governing body) to disagree with the medical staff's professional recommendations regarding the professional competencies of an applicant?

The short answer is yes. On June 13, 1979, the President of Northwestern Memorial Hospital ("NMH") informed Dr. Edir Siqueira, a neurosurgeon, that his clinical privileges were being summarily suspended

93. *See id.* at 171.

94. *Id.* at 161.

95. *Id.* at 174.

96. *Id.* at 164.

pursuant to NMH's medical staff bylaws.⁹⁷ Dr. Siqueira requested a hearing pursuant to those bylaws. On November 7th, 1979, an ad hoc committee of medical staff members was appointed, and a hearing was convened. Further hearings were convened from November 1979 throughout April 1980, at which times Dr. Siqueira had the opportunity to present and cross-examine witnesses and introduce documentary evidence. On April 16th, 1980, the ad hoc committee issued a written report, determining that the summary suspension should be modified, and Dr. Siqueira returned to a "restricted practice of neurosurgery."⁹⁸ The Medical Executive Committee ("MEC") of the medical staff disagreed with the ad hoc committee and recommended that the summary suspension be maintained indefinitely.⁹⁹ The Board of Directors of NMH adopted the recommendation of the MEC.¹⁰⁰

Dr. Siqueira filed for injunctive relief in the Circuit Court of Cook County, seeking to have the indefinite suspension declared void.¹⁰¹ The parties agreed to limit the proceedings to Dr. Siqueira's two legal claims, only one of which is important here: that the suspension violated NMH's medical staff bylaws because the MEC did not have the authority to recommend indefinite suspension to NMH's Board of Directors, and further, that NMH's lay Board of Directors did not have authority to accept the MEC's recommendation over the findings of the ad hoc committee.¹⁰²

Dr. Siqueira specifically claimed that the MEC did not have authority to recommend indefinite suspension to NMH's Board of Directors because, under the bylaws, the MEC could only "receive" the ad hoc committee's report.¹⁰³ Further, Dr. Siqueira argued that the MEC was not competent to make determinations on professional conduct and competency, as not all of the MEC members were physicians. As stated, Dr. Siqueira also claimed that NMH's Board of Directors was not competent to make determinations on professional conduct and competency, as not all of the Directors were physicians.¹⁰⁴ On these legal issues, the circuit court granted NMH's motion for directed verdict, and Dr. Siqueira appealed.

Central to the appellate court's judgment was a statement in the preamble to the medical staff bylaws that the medical staff's responsibility for quality of care at NMH is "subject to the ultimate responsibility and authority of

97. *Siqueira v. Northwestern Mem'l. Hosp.*, 477 N.E.2d 16, 17 (Ill. App. Ct. 1985).

98. *Id.* at 18.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.* at 19.

104. *Id.*

the Board of Directors.”¹⁰⁵ Other relevant bylaws provisions included 1) a statement that the Board of Directors may restrict, terminate or remove privileges of staff member upon an MEC recommendation, provided that the member is entitled to a hearing; 2) a statement that the ad hoc committee’s report and recommendations are to be forwarded to the MEC “for information” and to the Board of Directors “for resolution;” and 3) other MEC duties, such as “to make recommendations to the Board of Directors on matters which require Board action,” “to review disciplinary problems” and “to review clinical privileges . . . and recommend . . . changes it deems appropriate.”¹⁰⁶

The court reasoned that these provisions, common to most medical staff bylaws, in substance if not in form, outweighed the other bylaw provision where the MEC was only supposed to “receive” an ad hoc committee’s report “for information” purposes.¹⁰⁷ Thus, the court determined that the MEC certainly had authority to make its own recommendation. The court then turned to the issue of whether either the MEC or the Board of Directors had the authority or expertise to resolve matters concerning professional competency and conduct, as neither the MEC nor the Board were entirely constituted of physicians.¹⁰⁸

On this issue, the court once again noted that the Preamble to the bylaws stated that the medical staff is subject to the ultimate authority and responsibility of the Board of Directors.¹⁰⁹ Moreover, the bylaws also stated that nothing “shall abridge the right of the Board of Directors to take such actions as seem to them necessary or desirable under the circumstances.”¹¹⁰ Finally, the court noted that, under the bylaws, the ad hoc committee report was to be submitted to the Board of Directors “for resolution.” In its most important statement, the appellate court stated that the Board of Directors could impose final suspension even if both the ad hoc committee and the Medical Executive Committee had voted to lift the suspension, as “under the medical staff bylaws, the Board of Directors reserves the power to make the final resolution. [Claiming that the Board consists of laypersons would] neither involve the construction of the bylaws nor change the clear meaning of the bylaws.”¹¹¹ In so holding, the court determined that, because a governing board consisting of laypersons is ultimately accountable for the quality of care rendered within the hospital, it must have the ability to make

105. *Id.* at 18.

106. *Id.*

107. *Id.* at 19.

108. *Id.*

109. *Id.*

110. *Id.* at 20.

111. *Id.*

all decisions regarding quality of care, even if they must supercede contrary decisions of interested practitioners.¹¹² This holding is the touchstone for all hospital governing boards – organized medical staff relations.

With respect to decisions that impact the quality of care rendered within a hospital, but neither contravene the judgment of practitioners nor reflect on an individual practitioner's privileges or competence, the governing board of a hospital enjoys even greater legal authority. For instance, the President of Michael Reese Hospital and Medical Center ("Reese") appointed Dr. Hawkins as Acting Chair of the Department of Psychiatry.¹¹³ Six months later, a new President of Reese appointed Dr. Hawkins as the permanent Chairman of the Department of Psychiatry, but did so in contravention of Reese's Medical Staff Bylaws, as the President neither appointed a search committee nor obtained the approval of Reese's Board of Trustees.¹¹⁴ Another physician, Dr. Weissman, had served as both a member of Reese's Board of Trustees and as Director of Education and Training and, in his capacity as a member of Reese's Board of Trustees, opposed a proposed merger between Reese and the University of Chicago. After Dr. Weissman revealed this opposition, Dr. Hawkins, acting in his capacity as the Chairman of the Department of Psychiatry, demoted Dr. Weissman from Director of Education and Training to Unit Chief of a floor in the Department of Psychiatry. Dr. Weissman resigned but sued Reese for the severance benefits that it refused to provide. Dr. Weissman claimed, *inter alia*, that the demotion was improper because Dr. Hawkins had been improperly appointed Chairman of the Department of Psychiatry in contravention of the Medical Staff Bylaws.¹¹⁵

The court, which agreed that Dr. Weissman's reliance on the medical staff bylaws was tenuous, stated that "[a]lthough violation of the Medical Staff Bylaws may create legally enforceable rights in the context of a removal from or reassignment to a medical staff position, they do not create the same rights in the context of changes in administrative positions."¹¹⁶ The court relied on two provisions – one each from the hospital corporate bylaws and the medical staff bylaws – to arrive at its holding: 1) the hospital bylaws stated that the medical staff bylaws extend rights to medical staff who concurrently serve in executive or administrative positions with the Hospital insofar as the professional membership privileges of such persons at the Hospital are concerned, but not with regard to their executive

112. *Id.*

113. *Weissman v. Michael Reese Hosp.*, 1989 U.S. Dist. LEXIS 11064 *2 (N.D. Ill. 1989).

114. *Id.*

115. *Id.* at *14.

116. *Id.* at *15.

or administrative positions; and 2) the medical staff bylaws stated that the bylaws are intended to provide a framework for medical staff activities.¹¹⁷

The court then found that Dr. Weissman did not have a claim arising under the medical staff bylaws because his demotion was of an administrative nature, as opposed to a demotion of a professional nature.¹¹⁸ Finally, the court also stated that Dr. Weissman had only cited medical staff bylaw provisions dealing with appointment and that such appointment provisions did not bear on the hospital's removal powers. The Seventh Circuit expressly affirmed this reasoning.¹¹⁹ Therefore, a governing board's ability to make decisions related to the provision of quality care apparently are not hindered by practitioners' medical staff bylaws "rights" that are not directly related to the practitioners' professional competencies.

Perhaps the holding central to *Weissman* is more powerfully stated in *Mahan v. Avera St. Luke's*, a more recent case from the Supreme Court of South Dakota.¹²⁰ Succumbing to competition from a physician group practice's new day surgery center, the governing board of Avera St. Luke's, the only full-service hospital in a 90-mile radius of Aberdeen, South Dakota, opted to close its medical staff to applicants for orthopedic surgery privileges. The members of the group practice who were also members of Avera St. Luke's medical staff sued the hospital, claiming that the hospital's actions breached the medical staff bylaws.¹²¹ The physicians successfully enjoined the hospital's closing of the medical staff. The Supreme Court of South Dakota reversed; it found that the hospital's delegation to the medical staff of the power to "appoint and review medical personnel to the medical staff" did *not* trump the Board's ability to make "all decisions relating in any way to, or incidentally affecting, medical personnel issues."¹²² The court recognized that the medical staff bylaws were derived from the hospital corporate bylaws and, therefore "any judicial analysis must begin with an examination of the [hospital corporate] bylaws."¹²³ Because any and all of the medical staff's powers were delegated to them from the governing body, the hospital had the "authority to make business decisions without first consulting the medical staff."¹²⁴ The court thus allowed the hospital to close any portion of the medical staff.

The Supreme Court of South Dakota opinion represents the principle that

117. *Id.*

118. *Id.*

119. See 1991 U.S. App. LEXIS 10225 *2 (7th Cir. 1991).

120. *Mahan v. Avera St. Luke's*, 621 N.W.2d 150, 153 (S.D. 2001).

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

the governing body, if it is to be accountable for the quality of care rendered within the hospital, must have full and unimpeded legal authority to make any and all decisions related to the provision of quality care that do not directly speak to individual practitioner's professional competencies. We further know, from *Darling, Johnson, and Siqueira*, that governing bodies have full legal authority to make decisions related to the provision of quality of care that either contravene the judgment of practitioners or speak to individual practitioners' professional competencies. They are only "impeded" by the procedural rights granted to practitioners via medical staff bylaws.

While it may appear to some that these principles of common law conflict with the explicit hospital accreditation standards of the JCAHO, it is a conflict in appearance only. For example, JCAHO Medical Staff Standard 2 states that "[e]ach medical staff develops and adopts bylaws and rules and regulations to establish a framework for self-governance of medical staff activities and accountability to the governing body."¹²⁵ It is our experience that medical staff leaders and representatives who exuberantly embrace the concept of self-governance and self-monitoring as within the exclusive purview of the medical staff construe this Standard to mean "JCAHO requires the hospital to allow the medical staff to govern itself." The implied meaning of this statement, of course, is that JCAHO prohibits the hospital from governing the medical staff. Not only is such a belief wrong (*Darling, Johnson, Siqueira, Weissman, and Mahan*), it ignores the last half of the JCAHO Standard: a medical staff should develop and adopt bylaws and rules and regulations not only as a framework for self-governance, but also as a framework for "accountability to the governing body."¹²⁶ JCAHO embraces the principles of common law discussed above; those who do not are those who, in their independent medical staff zeal, misunderstand and misinterpret JCAHO.

On the other hand, recognizing the full legal accountability of the governing board for the quality of care rendered by the health care organization, and thus the full authority of that governing board to make all decisions related to the quality of care rendered, will not alone improve the quality of care rendered within a hospital. Recognition of ultimate accountability must then be translated into demonstrated action and outcomes to assure and dramatically improve quality. The questions that confront us are these: if governing boards are ultimately accountable for the quality of care rendered within their hospitals, and are thus ultimately

125. JCAHO, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK (2002), MED. STAFF STANDARD 2, at MS-3.

126. *Id.*

accountable for the effectiveness of peer review and measuring quality, what are governing boards doing that has allowed for the current situation? Or, more appropriately, what are they not doing? Maybe most appropriately, what obstacles must they remove to achieve quality measurement and performance goals?

In trying to answer those questions, two realities become apparent. First, that we are aware that quality is not being assured to the extent necessary to reduce overuse, underuse, and misuse, and as illustrated above in roman numeral II, we have a significant body of knowledge on exactly how to measure quality and enhance patient safety. The question becomes: is there something about the relationship between the board, which is responsible for quality, and the medical staff, which has historically been delegated the responsibility for quality, that needs to be restructured to achieve patient safety goals?

IV. THE STRUCTURE OF THE BOARD-MEDICAL STAFF RELATIONSHIP

Boards of Trustees are legally and ethically responsible for the quality of patient care in their hospitals; however, they do not have the structure and function to know the quality of care being provided, much less the architecture to solve quality problems and to proactively improve the quality of patient care. It is imperative that we examine that structure to determine whether the structure facilitates the solution or enhances the problem.

A. *The Hospital Board-Medical Staff Architecture*

The thesis presented here now focuses on the central question at the beginning of this article, postulating that the current structure of the hospital governing board and medical staff does NOT promote quality and patient-centered care, and that it is seriously flawed. The fundamental flaw in the existing architecture of hospitals exists in the form of interdependent, yet independent and discordant relationships between the hospital boards of trustees and the medical staffs. Dr. Martin Merry characterizes the various health care cultures as “silos.”¹²⁷ He concludes that these silos create the traditional obstacles to promoting quality in health care. We propose that Dr. Merry’s concept of silos is correct, and we believe that health care culture traditionally encounters obstacles to promoting quality in hospitals when the various existing “cultures” are understood in terms of the following three silos:

127. Letter from Martin Merry, M.D., Senior Advisor for Medical Affairs, New Hampshire Hospital Association, to Landon Feazell (on file with author).

- Organizational Culture (our “structural silo”);
- Professional Cultures (our “professional silo” including Dr. Merry’s third “Culture of Blame, it’s someone else’s responsibility” silo); and
- Fragmented Quality Information Culture (our “informational silos”).¹²⁸

These silos and disparate cultures are each carefully considered and analyzed below.

B. Structural Silos of the Organizational Culture

The organizational or “structural silo” has evolved to create and preserve the medical staff as a separate entity, struggling to find and define some sort of legal relationship to the hospital, such as a contractual relationship. The separate medical staff is a sacrosanct entity recognized in the law and insisted upon by organized medicine and physicians in hospitals throughout the United States. In terms of quality, it is the physicians and the medical staffs, as well as organized medicine, who first insisted on quality in hospitals and created standards and monitoring to assure improved clinical environments for physicians to practice.

The American College of Surgeons in 1917 created the Hospital Standardization Program.¹²⁹ This program called for several of the early standards that have led to the present system of hospital organization. These standards included provisions for a medical staff, credentialing, “quality assurance” with monthly morbidity/mortality meetings for learning and improving practice, medical records standards, and laboratory and x-ray standards.¹³⁰

The organizational diagram of the Medical Staff in relationship to the Board of Trustees paints the very vivid picture of the structural silos, as illustrated in Figure 2, again proposed by Dr. Merry.¹³¹

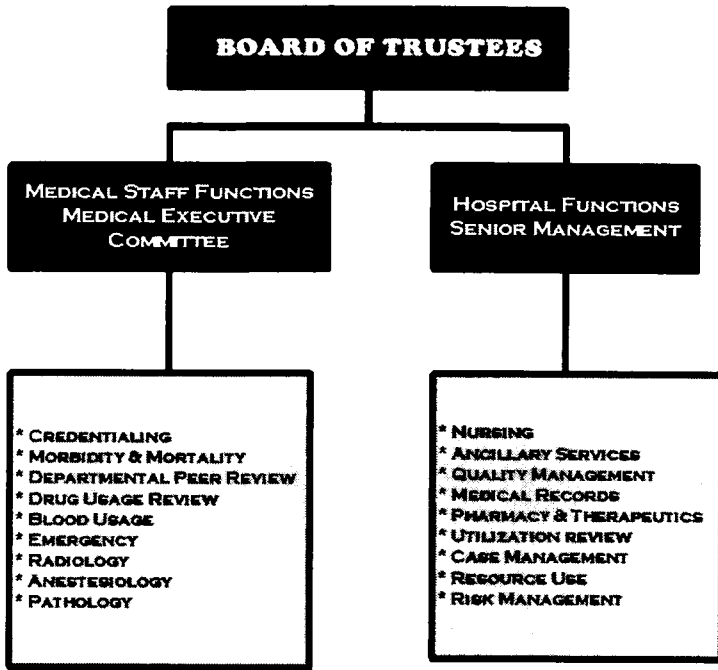
128. *Id.*

129. JOINT COMM’N ON THE ACCREDITATION OF HEALTHCARE ORG., A JOURNEY THROUGH THE HISTORY OF THE JOINT COMMISSION, *available at* <http://www.jcaho.org/about+us/history/index.htm>.

130. *Id.*

131. Merry, *supra* note 127.

Figure 2: Structural Silos of Organizational Culture

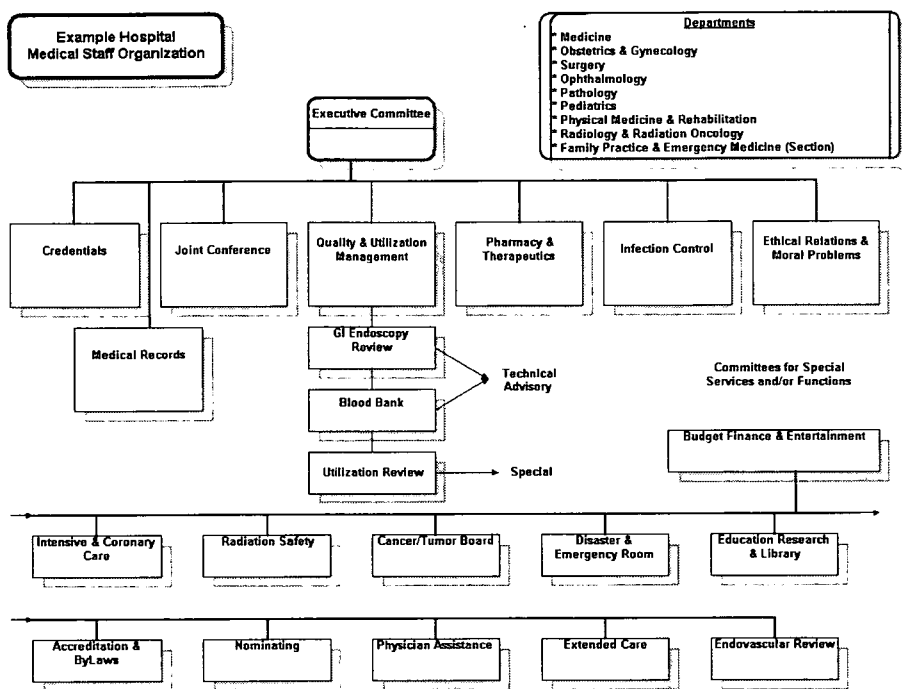


From an operational perspective, these silos perpetuate dis-quality, rather than promote quality. The forces of this structural barrier to interdependence and perpetuation of independence prevents any solution to the fundamental flaw in health care from being meaningfully addressed, much less solved. After recognizing the significance of these organizational silos, it is then crucial to understand the fundamental flaw in precluding true health care quality and the etiologies of that flaw.

The architectural silo of the medical staff is made even more complete by adding organizational complexity with a massive committee structure devoted to a variety of matters, with a particular focus on quality of care. Indeed, in our experience from reviewing Medical Staff Bylaws from around the country, we have found that many bylaws contain statements in their preambles indicating that quality of patient care is the primary reason for their being. The Medical Staff then organizes to look at quality *exclusively* from the physician’s perspective. Many hospitals have made dramatic changes in their medical staff committee structures, but the following example of a recent committee structure (demonstrated in Figure

3) is not unusual.¹³²

Figure 3: Sample Committee Structure



Such complex and overtaxing committee structures are even encouraged by state medical societies in their model medical staff bylaws.¹³³

The effect and impact of these structural silos is that they are vulnerable to all the problems inherent in physician and hospital motivations and disincentives and turn the medical staff and its physicians inward on “physician exclusive” issues. In the structural culture of blame, it is frequently the fault of the nurses or limitations of the system in examining quality. This structure and the demand of physicians and organized medicine for physician self-governance, self-monitoring, and self-discipline creates an impenetrable barrier to the concepts of creating safe, efficient, and effective systems and processes of care. The architecture further isolates the physicians from any forces outside the medical staff to attempt to regulate the types of misconduct and potential incompetence concerns as discussed.

132. See ILL. STATE MED. SOC’Y, MODEL MEDICAL STAFF BYLAWS (2003), available at <http://www.isms.org/member.html>.

133. *Id.*

This separate but equal architecture, however, is not merely a current phenomenon. The current silo structure of the relationship between the medical staff and the governing body has been developed over many years. To fully understand the size of the quality of care obstacles inherent in the current relationship between the medical staff and the hospital governing body, it is necessary to examine how those obstacles were built.

The gestative period for the “organized medical staff” began shortly after the American Civil War, when organized nursing had already placed its roots in hospitals by pushing the need for cleaner, antiseptic or aseptic environments.¹³⁴ Cleaner environments, in conjunction with the innovative use of ether as an anesthetic, paved the way for success rates in a greater variety of surgical procedures.¹³⁵ As surgery became a more prestigious and demanded service, the costs of traveling to patients’ homes became prohibitive, i.e., fees were easier to develop if the patients came to the surgeon. As the nineteenth century stigma of being a hospital patient slowly faded away (i.e., the stigma of the hospital being only a last, filthy refuge for the sick, dying poor), the hospital became the logical locale for surgeons to ply their trade in clean environments.¹³⁶

Almost immediately, pressure for admissions was high and hospitals began to track lengths of stay. Prior to the turn of the century, hospitals counted lengths of stay in the number of weeks; by 1923 American hospitals had a turnover ratio of twelve and a half days.¹³⁷ Understandably, hospitals experienced a mission shift – where hospitals had previously extended their charitable and religious care to providing morally-based boarding homes for the poor, the active medical treatment of disease and surgical treatment of injury soon became the sole basis on which hospitals operated.

As the upper class became aware of the benefits of receiving inpatient hospital care, hospitals ceased building wards and instead constructed wings of private and semi-private rooms. “Hospitals had gone from treating the poor for the sake of charity to treating the rich for the sake of revenue and only belatedly gave thought to the people in between.”¹³⁸ As hospital expansion burgeoned, so did operational budgets. While large donations persisted, patients (typically the wealthy) shouldered the bulk of the costs through higher fees.¹³⁹

134. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE – THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* 156 (1982).

135. *Id.*

136. *Id.* at 157.

137. DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM* 42-43 (1971).

138. Starr, *supra* note 134, at 159.

139. *Id.* at 160-61.

Simultaneously, the typical American non-hospital corporation was undergoing a similar revolution. Prior to the turn of the century, trustees and directors often ran the day-to-day operations of the company, but the Industrial Revolution (and the wave of conglomerations that came with it) had made such hands-on involvement prohibitive, if not downright impossible.¹⁴⁰ Thus, many corporate boards of that era began to place what is now known as “executive authority” in the hands of senior and salaried staff and management. By the early twentieth century, higher-ranked employees ran the day-to-day operations and turned to trustees and directors only for approval and/or consideration of the larger matters.¹⁴¹

In hospitals, the timing of the “board-management revolution” had a double impact. First, trustees may have felt the contemporary urge to delegate their operational duties to salaried employees.¹⁴² Second, trustees, who had previously been the largest donors to the hospitals, and thus, the chief source of cash flow for the facilities, recognized the impact of private pay.¹⁴³ Whereas hospitals had previously depended on the beneficial donations of their trustees, the increased demand for hospital and surgical services had led to higher physician fees (especially for those in private rooms), and thus hospitals became more dependent on income from patients than income from benefactors.¹⁴⁴ The trustees were becoming less important than the physicians that worked within the hospital.¹⁴⁵ Therefore, as the trustees felt the urge to delegate their responsibilities to others (and be bothered only by issues of severe policy change), it only made sense to delegate hospital operations to the revenue-producing physicians themselves.¹⁴⁶

The physicians were more than amenable to seizing hospital operational authority. One prominent Chicago physician entered this in the American Medical Association’s Journal:

[w]hen the industrial revolution of the seventeenth century began it found Europe peopled with independent tradesmen. . . . Now we find the homeless, tool-less dependent machine operators far removed from the people who furnish a market for the standardized product of their toil. The hospital is essentially part of the armamentarium of medicine . . . If we wish to escape the thralldom of commercialism, if we wish to avoid

140. *Id.* at 161.

141. *Id.*

142. *Id.*

143. *Id.*

144. *Id.*

145. *Id.* at 162.

146. *Id.*

the fate of the tool-less wage worker, we must control the hospital.¹⁴⁷

The physicians fortunate enough to seize this operational authority deftly organized themselves into closed medical staffs that excluded the vast majority of other practitioners from having the ability to practice within the hospitals, and thus from maintaining a living.¹⁴⁸

In turn, the physicians previously excluded from the closed medical staff opened their own hospitals to combat the closed-staff hospitals.¹⁴⁹ The closed-staff hospitals, feeling the force of the invisible hand of competition, succumbed and accordingly opened their medical staffs to any willing providers.¹⁵⁰ Those physicians already on closed medical staffs complained that the opening of the closed staffs would allow for quacks and snake-charmers, and thus patients would receive lower quality care. Physicians excluded from the staffs heard such cries only as a pretense for preserving status, not quality. But money talked, and hospital boards opened the staffs. Thus, in the first quarter of the 20th century, physician affiliations with hospitals boomed.¹⁵¹

As physicians joined medical staffs *en masse*, the professional associations of which the physicians were members were taking parallel, supporting steps. For instance, in 1919, in what experts largely regard as the formal conception of the organized medical staff,¹⁵² the American College of Surgeons released a “statement,” whereby any hospital could receive the College’s approval – whether its medical staff was open or closed – but only if the hospital’s affiliated physicians were organized into a “definite medical staff.”¹⁵³ A definite medical staff would only include competent and reputable physicians that did not split fees, that adopted and adhered to bylaws, that held monthly meetings, and that reviewed clinical experiences. While it is instructive that professional associations were refining guidance on medical staff bylaws and peer review as early as 1919, one should not regard those developments as the ‘birth’ of peer review. Much like every profession, ‘peer review’ began the first time two physicians exchanged ideas on how to treat certain symptoms.

While the work of the associations’ was not the impetus for peer review, it introduced the concept into the formal process of accepting or rejecting a

147. Bayard Holmes, *The Hospital Problem*, 47 JAMA at 320 (1902).

148. Starr, *supra* note 134, at 162.

149. *Id.* at 165.

150. *Id.*

151. *Id.* at 167

152. Dennis J. Purtell, *Medical Staff in Need of Change*, 28 PHYSICIAN EXECUTIVE 64 (2002).

153. Mark A. Kadzielski et al., *The Hospital Medical Staff: What Is Its Future?*, 16 WHITTIER L. REV. 987, 988-89 (1995).

practitioner as a member of a medical staff.¹⁵⁴ But not surprisingly, earlier contemporary studies found that the decision to admit a physician to the medical staff turned not on matters of professional competence, but rather on considerations of ethnicity, workability, and background. One hospital administrator revealed that:

[i]n the earlier days we had competitive examinations, but we had to discontinue those. The person who did best on an examination might not show up well . . . He might lack tact; he might not show presence of mind in crises; or he might not be able to take orders. And more than likely the persons who did best on the written examinations would be Jewish.¹⁵⁵

In 1934, the physician domination of hospitals via the organized medical staff may have reached its zenith. That year, the American Medical Association (“AMA”) stipulated that it would only accredit those hospitals that required their staff members to also be members of the local medical society.¹⁵⁶ But depression-era economics also saw a great push for efficiency and structure, and the various hospitals dominated by physicians, while able to generate revenues, were unable to cut costs. As society recognized both the need for hospital conglomeration and the physicians’ unwillingness to conglomerate, a large interest in procuring capable hospital administration bloomed.¹⁵⁷ As hospitals merged and grew in size, administrators not only relieved the physicians of the burdens of resolving the more day-to-day, complex decisions of a corporate organization, but obviously gained power in steering the direction of the hospital. Medical staffs continued to concentrate on rendering care. The fragmentation of those that ran the hospital and those that delivered care had begun. The autonomy of physician cultures, the professional silos (see below) and the accompanying “culture of blame,” or “the responsibility of someone else,” were established. The silos had been built.

V. SELF-REGULATING AND SELF-MONITORING WILL NOT ASSURE QUALITY

The modern hospital governing body cannot rely solely on a self-regulated and self-monitored medical staff to assure successful accomplishment of quality goals. There are significant obstacles that prevent even a generally well-intentioned medical staff from taking action.

154. *Id.*

155. Starr, *supra* note 134, at 168.

156. *Id.* at 168.

157. *Id.* at 178.

A. Self-Governance, Self-Monitoring, and Self-Disciplining

Organized medicine at the national and state levels has made considerable efforts in recent years to support the fundamental concept of physicians through their medical staff structure being “self-regulating.” These concepts have achieved a degree of reverence and a sacrosanct nature. When these concepts are advocated, they are not typically expressed with reservation tied to the explicit role of the hospital governing body.¹⁵⁸ It is important to remember that these terms are a product of history, AMA dedication, and, to some extent, a reading of the JCAHO accreditation standards. It is therefore necessary to consider the problems these concepts create and further consider whether they make sense in light of modern quality concerns.

Jerome P. Kassirer, M.D., former editor of the *New England Journal of Medicine*, states that a “fundamental tenet of a learned profession is its obligation to self-regulate, self-monitor, and self-discipline its members.”¹⁵⁹ His assessment of medicine concludes:

Unfortunately, when it comes to setting standards of accountability and ethical behavior, our professional organizations and medical institutions have often faltered. In the guise of accountability, their efforts have often yielded lax standards that were intentionally and flagrantly self-serving. This is pseudo-accountability. When such deceptive practices are uncovered, the public reacts – sometimes overreacts – and so do legislators. The aspirations of our profession would be better served if we set our standards of self-regulation unimpeachably high.¹⁶⁰

Recent deliberations by an international task force (the Medical Professionalism Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine) puts the “pseudo-accountability” concerns of Dr. Kassirer into a much broader context of professional responsibility.¹⁶¹ These concerns are expressed at the individual physician level as “A Physician Charter,” proposing re-expressions of old tenets for medical professionalism. This challenge for professionalism is powerfully significant in the new era of patient-centered care. In essence, the patient has always been the focus of physician care

158. *Exeter Hosp. Med. Staff v. Bd. of Tr. of Exeter Health Res. Inc.*, 810 A.2d 53 (N.H. 2002) (holding that a medical staff is not a legal entity separate from the hospital, but a subordinate administrative unit).

159. Jerome P. Kassirer, *Pseudoaccountability*, 134 ANNALS OF INTERNAL MED. 587 (2001).

160. *Id.*

161. See Harold Sox, *Medical Professionalism in the New Millennium: A Physician Charter*, 136 ANNALS OF INTERNAL MED. at 243 (2002).

since the very beginning of the profession and the admonition to “do no harm.” The broader reality of this Charter inherently includes the business context of health care.¹⁶²

The heart of the Charter is based upon three fundamental principles:

- The Principle of Primacy of the Patient Welfare;
- The Principle of Patient Autonomy; and
- The Principle of Social Justice.¹⁶³

The Physician Charter for Medical Professionalism is thus a set of three commitments. The concepts of patient autonomy and patient welfare must be at the center of the physician-patient relationship. According to this view, the center of patient care is not in the physician’s office or in the hospital. The center is where people live their lives, in the home and the workplace, with the physician as an advisor, often one of many, to an autonomous patient.¹⁶⁴ Experts in patient safety are beginning to agree and to discuss that the single greatest contributing human factor resulting in error and hindering clinical performance improvement is this autonomy factor. The most compelling work to date on this topic is by Dr. J. Silverson, as published in the *MGMA Journal*.¹⁶⁵

Traditional Physician Compact

Autonomy
Protection
Entitlement

New Physician Compact

Customer/Patient Focused
Interdependence
Ownership of Issues
Delegated Authority

To understand why there is a “quality problem” in developing a solution (or at least parts of a solution) at the hospital level requires an appreciation of the stressors on the ability of the underlying, traditionally independent medical staff’s ability to apply correction. In examining the stressors impacting the medical staff’s ability to implement modern quality measures, we are forced to ask the following questions: first, is it likely that they will be able to overcome such difficulties; and, second, whether the board, under the current “delegated quality” model, is able to assist the medical staff in overcoming these quality hurdles.

162. *Id.*

163. Sox, *supra* note 161, at 244.

164. *Id.* at 243.

165. Silverson J, Kornacki, *Creating a Physician Compact that Drives Group Success*, 47 MED. GROUP MGMT. J. 54, 54-62 (2000).

B. Self-Regulation and the Difficulties of Implementing Quality Management

Physicians are not the logical candidates to lead the charge toward developing these essential systems and processes of care. Thus, the organizational structure isolating them from hospital quality initiatives and depriving the hospital “silo” of physician involvement for a multi-disciplinary approach is the single most significant obstacle to this national consensus for impacting quality. Even at the level of attempting to get physicians to cooperate and adopt such systems, once designed, the challenge with or without changing the architecture is difficult. Physician resistance to clinical practice guidelines, or any nomenclature that one would attempt to devise for implementation of such processes of care, has been characterized into a framework for considering physician perceptions and attitudes in the *Journal of the American Medical Association* (“*JAMA*”).¹⁶⁶ The seven barriers to physician adherence to practice guidelines have been categorized as follows:

Knowledge

- Lack of Familiarity (volume of information, time needed to stay informed, guideline accessibility)
- Lack of Awareness (volume of information, time needed to stay informed, guideline accessibility)

Attitudes

- Lack of Agreement with Specific Guidelines (interpretation of evidence, applicability to patient, not cost-beneficial, lack of confidence in guideline developer)
- Lack of Agreement with Guidelines in General (guidelines in general too “cookbook”, too rigid to apply, biased synthesis, challenge to autonomy, not practical)
- Lack of Outcome Expectancy (physician believes that performance of guideline recommendation will not lead to desired outcome)
- Lack of Self-Efficacy (physician believes that he/she cannot perform guideline recommendation)
- Lack of Motivation/Inertia of Previous Practice (habit, routines)

Behavior

- External Barriers/Patient Factors (inability to reconcile, patient preferences with guideline recommendations)
- Guideline Factors (guideline characteristics, presence of contradictory guidelines)

166. See Michael Cabana et al., *Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement*, 282 JAMA 1458, 1458-65 (1999).

- Environmental Factors (lack of time, lack of resources, organizational constraints, lack of reimbursement, and perceived increases in malpractice liability).¹⁶⁷

Measurement of clinical performance will inevitably shift from the current “implicit model”¹⁶⁸ to an “explicit model” (or at least some combination) measuring performance against agreed evidence-based best practice models. As peer review and clinical performance measurement evolve from professional judgment in the current implicit model, peer review in standardized and objective processes will be a critical transition in any performance improvement plan and implementation initiative.

The second major barrier to self-regulated medical staffs being solely responsible for quality, as delegated by the board, is that physicians neither provide, nor are they responsible for all aspects of patient care. Health care is delivered by *teams* of clinical professionals.

The patient care in “silo 2” by those from “Hospital Functions” in Figure 2 above is beyond the purview of the medical staff. Quality measurement and performance improvement extends far beyond the physicians, who must rely upon these institutional elements and senior management to provide quality care to their patients. However, just as this responsibility for care is fragmented, in an organization that depends upon having systems and processes, so is the information for quality performance measurement fragmented. It is literally impossible for the medical staff to develop such quality data, integrate it into their quality processes, and to be responsible to the board for implementing necessary improvements.

Health care quality has developed in part as a “solution de jur” enterprise, and the process of measuring and improving quality is comprised of a variety of techniques and approaches. The result is an extremely data-driven but disconnected and fragmented “system.” Quality initiatives that exist in many hospitals might include the following gamut of quality activities and databases:

- Peer review with clinical indicators;
- Performance measures;
- Core measures;
- Quality variance analysis (CQI/TQM);
- Patient safety programs, including near miss reporting;
- Root cause and sentinel event analysis;
- Special studies;
- Utilization management/resource use analysis;

167. *Id.*

168. Robert H. Brook et al., *Special Communication: Health System Reform and Quality*, 276 JAMA 476, 476-80 (1996).

- Case management;
- Benchmarking and quality “dashboards;”
- Risk management and incident reporting; and
- Administrative database analysis, including related software products.

The crucial defect in this disparate system of quality, risk, and utilization data is that these are essentially “silos” of information. Few if any hospitals and medical organizations are proficient at aggregating this data and converting it to precise information to identify the quality challenges of the organization. Continuous improvement and targeted monitoring are equally difficult.

The result is that the Board receives very scant and often meaningless data with little or no insight into the clinical quality challenges and opportunities of the organization. The good news is that the Board is rarely “burdened by insight.” The bad news is that the Board is deprived of any meaningful oversight opportunity, and the appearance of authority and responsibility is illusory.

The responsibility for medical staff membership and privileges within the Board authority for credentialing also extends beyond the limits of data available to the medical staff. An insightful physician-specific practice profile, as recommended by Daniel A. Lang, M.D.,¹⁶⁹ demands comprehensive quality information from throughout the health care organization.

The challenges of providing quality data to the Board have become more serious since the IOM report and the recognition of quality analysis techniques, such as root cause analysis. Take the example of mortality data. A customary model for presenting mortality rates (deaths as a percentage of discharges) is to divide deaths into categories for “expected” and “unexpected” (after peer review to determine the cases for each category). This data is often broken down by quarters, with year-to-date totals, and benchmarked against other mortality rates, perhaps with comments as analysis of trends.¹⁷⁰ After the public nature of the IOM report on medical error and preventable deaths, prudent Boards will want to know which of these deaths were deemed “preventable,” what measures have been taken to analyze the root causes of these preventable deaths, and what measures have been taken to assure that such a death does not reoccur. Most likely, this information will be requested on a monthly basis to eliminate unnecessary time delay. Reporting quality information to the Board has

169. See DANIEL A. LANG, *MEDICAL STAFF PEER REVIEW: MOTIVATION AND PERFORMANCE IN THE ERA OF MANAGED CARE* (2000).

170. See Barry S. Bader, *Informing the Board About Quality, Keys to Better Governance Through Better Information* 45 (1991) (published jointly by the Hosp. Trustee Ass’n of Pa. and Bader & Associates).

arguably become much more comprehensive and demanding. And without question, the challenge of measuring and improving quality has moved far beyond the exclusive purview of a self-regulated medical staff.

With this insight into the disincentives for physician commitment to quality initiatives and the need for continued development of new technologies for measuring and improving health care, the concept of a complete delegation of quality responsibility to the medical staff by the governing body begins to seem preposterous. Examined further, however, it is clear that such a delegation is irresponsible and ill-fated by any hospital governing body. The emphasis on the fundamental flaw in health care quality and patient safety must be on the absence of carefully designed and error-proofing systems and processes of care in the health care infrastructure.

Clearly, there is no guarantee that the organized medical staff of a hospital is motivated, prepared, or knowledgeable and without conflict to be the catalyst or engineer for designing, implementing, monitoring, and continuously improving processes of care. Physicians are essential to such process design and use, but they cannot in the current environment and state of health care be expected to be the sole participants in such endeavors. However, developing processes of care is the future for measuring health care quality. Indeed, electronic medical records and quality of care software products in the future will require *embedded clinical knowledge into work processes at point of service in real time*.

VI. THE STRUCTURAL SOLUTION: REVISING HOSPITAL AND MEDICAL STAFF BYLAWS

A. Hospital Bylaws

The concept that quality is a responsibility shared by the governing body and the medical staff is probably readily acceptable to all health care constituencies. Nonetheless, physician associations fail to advocate that the governing body is fundamentally responsible, but rather cling to the self-governing, self-monitoring notion when advising their members as to how to structure medical staff bylaws.¹⁷¹ While the AMA admits to the hospital's responsibility in certain sections of its proposed bylaws, clearly the loudest message coming from the AMA and state medical societies is tremendously weighted in favor of self-governance and diminishes the importance of the role of the governing board. For example, the AMA

171. AM. MED. ASS'N, PHYSICIAN'S GUIDE TO MEDICAL STAFF ORGANIZATION BYLAWS 11 (2d ed. 2002).

provides the following sample medical staff bylaw regarding “purpose:”

The medical staff is organized to promote quality and to improve the quality of care delivered in this institution. Recognizing its responsibility for the overall quality of clinical services provided by its members, the medical staff organizes itself for the purpose of self-governance in conformity with these bylaws. These bylaws are binding on the medical staff and the hospital.¹⁷²

As the Supreme Court of South Dakota stated in *Mahan*, all medical staff duties are those delegated to it by the hospital, and thus any analysis of the impact of bylaws must begin with an analysis of hospital bylaws.¹⁷³ The first hospital bylaw, with respect to the medical staff, should state that the hospital, or the corporate entity, organizes the medical staff. It is not uncommon to see existing hospital bylaws that merely discuss the interrelations of the hospital and the medical staff, i.e., that are silent as to the conception of the hospital’s organized medical staff. Like all good corporate bylaws, hospital bylaws discuss the organization and membership of the corporation, i.e., the hospital itself. Good hospital bylaws, then, should also discuss the organization and membership of the organized medical staff.

Thus, the hospital bylaws should have a provision which clarifies that the governing body organizes the practitioners with privileges at the hospital into a medical staff, under medical staff bylaws approved by the governing body; that, when necessary, the medical staff bylaws will be revised to reflect the hospital’s current practices with respect to medical staff organization and functions; that the governing body only considers medical staff recommendations regarding appointments to the medical staff; and that each member of the medical staff has appropriate authority and responsibility for the care of his or her patients, subject to the limitations contained in both the hospital bylaws and the bylaws, rules, and regulations of the medical staff.

Directly following the hospital bylaw provision that organizes the medical staff, the hospital should explicitly detail the duties that it delegates to the medical staff. It is typical, but unfortunate, to see hospital bylaws that simply state “the medical staff is responsible for the quality of care rendered within the hospital.” Such a provision is overly abbreviated and perpetuates the misunderstanding that the medical staff’s duties are owed solely to patients, when in reality they are owed to both patients and the governing body.

Thus, the list of medical staff duties should be exhaustive. For instance,

172. *Id.* at 11.

173. *See Mahan*, 621 N.W.2d at 153.

with respect to issues pertaining to quality of care, the bylaws should state that the governing body assigns to the medical staff the responsibility for 1) providing appropriate professional care to the hospital's patients, with the full and complete understanding that the governing body maintains the ultimate authority and responsibility for the quality of care provided in the hospital; 2) ensuring that only a member of the medical staff with admitting privileges admits patients to the hospital; and 3) ensuring that only appropriately licensed practitioners with clinical privileges are directly responsible for a patient's diagnosis and treatment.

However, the hospital should further expand upon the medical staff's duties. The medical staff should be charged with the responsibility of developing appropriate standards of professional care within each of the medical staff departments, and should report them to the governing body. The medical staff should further be responsible for the continuing review and appraisal of the quality of care rendered within the hospital, as compared against developed standards, including the identification and resolution of problems and the identification of opportunities for improving patient care. The medical staff should be responsible for enforcing these standards.

Much like the definition of 'services' in a thorough services agreement, the hospital should use a fine-tooth comb in describing the duties and responsibilities that it delegates to the medical staff. This clarifies, for the medical staff, the role of the governing body and, for the governing body, the role of the medical staff. Once the duties and responsibilities are defined, the hospital bylaws should state that the governing body retains the ability to rescind any and all delegated duties if the medical staff fails to perform. This concept, recognized by common law (*Siqueira*), is rarely implemented in existing hospital bylaws. The following is a good example of a potential medical staff bylaw provision regarding the governing body's ability to rescind its delegation of quality responsibilities:

Any delegation or assignment of responsibility or authority from the governing body is conditioned upon the presumption that the governing body, in accordance with applicable laws and regulations and accreditation standards, is responsible for effective quality assurance. Therefore, to the extent that the governing body in its discretion believes that the medical staff or its leadership fails to act fully and completely in accordance with the medical staff bylaws and the hospital bylaws with respect to any delegated or assigned responsibility or authority, the governing body retains the right to rescind any such delegation or assignment and take all actions necessary to assure quality, to include, without limitation, establishment of quality systems, development of policies and procedures for medical staff actions, appointment and

removal of medical staff officers, and amendment of medical staff bylaws.

B. Medical Staff Bylaws

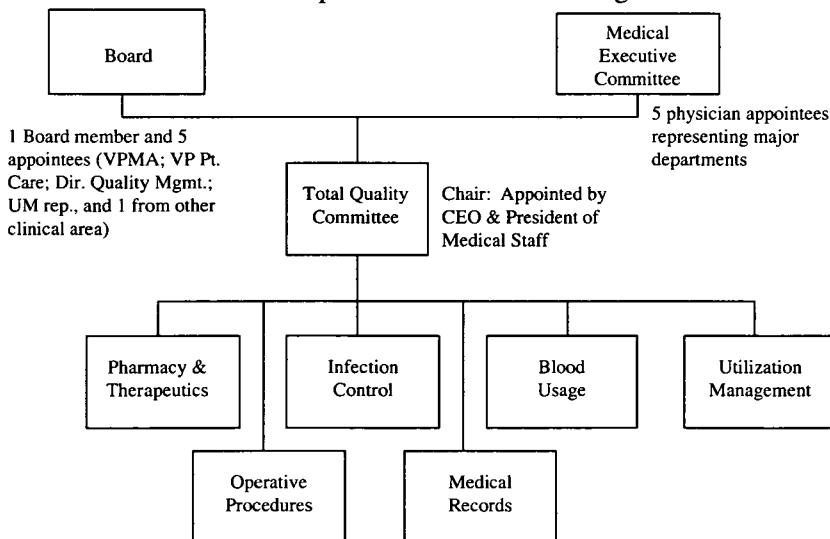
Once the contours of the medical staff's duties and responsibilities are defined in the hospital bylaws, and the scope and boundaries of the staff's powers are clarified, it is then necessary to more fully examine the relationship between the governing body and the medical staff, i.e., the medical staff bylaws should be drafted or, more likely, amended. There are standard medical staff bylaw provisions that should be common to all medical staff bylaws, but with respect to the quality of care responsibilities delegated in the hospital bylaws, certain provisions are necessary to ensure a fundamentally sound relationship between the governing body and the medical staff.

First, the medical staff bylaws must immediately clarify that, in light of the governing Board's ultimate accountability for the quality of care, the delegated responsibilities regarding quality care are entirely contingent upon the medical staff's demonstrated performance of that responsibility. The language used in the medical staff bylaws should mirror or closely follow the pertinent provision of the hospital bylaws. It is important that this language is included in both the hospital and medical staff bylaws, as it is more likely that the individual practitioners take a copy of the medical staff bylaws home with them (as opposed to the hospital bylaws), and it is certain that the practitioners have agreed, in writing, to adhere to the medical staff bylaws. Not only the organized medical staff, but also the individual practitioners that constitute the medical staff, should be cognizant of their roles within the organization. Sample language could be:

It is the express intent that the medical staff shall perform all medical staff responsibilities set forth in these bylaws in accordance with the terms of these bylaws, without intervention from the governing body, except as specified in these bylaws. However, the governing body specifically reserves the authority to take any direct action that is appropriate with respect to any individual appointed to the medical staff or given clinical privileges or the right to practice in the hospital. Such actions taken by the governing body shall follow the procedures outlined in these bylaws. The delegation of the medical staff's responsibilities is conditioned upon the presumption that the governing body, in accordance with applicable laws and regulations and accreditation standards, is responsible for effective quality improvement. Therefore, to the extent that the governing body, in its discretion, believes that the medical staff or its leadership fails to act fully and completely in accordance with the

medical staff bylaws and the bylaws of the hospital with respect to any delegated or assigned responsibility or authority, the governing body retains the right to rescind any such delegation or assignment and take all actions necessary to assure quality, and to include, without limitation, establishment of quality systems, development of policies and procedures for medical staff actions, appointment and removal of medical staff officers, and amendment of medical staff bylaws.

Second, it is important to further the dual goals of 1) integrating the governing body and medical staff with respect to managing the quality of care rendered within the hospital;¹⁷⁴ and 2) creating universal recognition that the duties delegated to the medical staff by the governing body are non-exclusive. For this reason, the medical staff bylaws may be amended to create a multidisciplinary quality improvement committee organized to monitor and improve quality. Its purpose should be to assure that the medical staff and hospital are fulfilling their responsibility to maintain quality patient care and are accountable for quality improvement activities. This quality improvement committee must report directly to the Board of Trustees. Its membership must consist of at least one member of the governing body, certain hospital administrators (including the chief executive officer), certain medical staff leaders, including the department chairpersons, and at least one nursing representative. This joint quality committee must also be responsible for the following sub-committees:



174. See, e.g., Dennis J. Purtell, *Medical Staff in Need of Change – Explore A Revolutionary Way to Reorganize Your Medical Staff*, *PHYSICIAN EXECUTIVE* 64, 66 (2002) (integrate governing body and medical staff in leadership decisions).

The functional duties of this committee are to provide the governing board and medical staff with quality dashboards and benchmarking, peer review clinical indicators, performance measures, an administrative database, core measures, variance analyses (CQI/TQM), patient safety/near miss reporting, risk management/incident reporting, sentinel event/root cause analyses, utilization/resource use analyses, and other special studies. This scenario is in contrast to the earlier diagram, wherein all quality committees lead to the medical executive committee, and not to a joint medical staff, hospital committee.

Third, the medical staff bylaws must condition a practitioner's eligibility for reappointment to the medical staff on the achievement of a certain standard, most likely a "departmental minimum encounter." For instance, a radiologist must be eligible for reappointment only if she reviewed a specific number of images within her last appointment period. Likewise, an internist must be so eligible only if she tallied a certain number of patient encounters. To further the goals of an integrated institutional management team responsible for the quality of care rendered within the hospital, the quality improvement committee (or one of its subcommittees) must be responsible for defining each department's required minimum encounter level.

Fourth, the medical staff bylaws must expressly state that the nominees for medical staff officership and department chairperson positions must meet certain qualifications and, further, are subject to Board approval. If the governing body, the organized medical staff, and the individual practitioners are to perform their duties of assuring high-quality care, those aspiring to medical staff leadership positions through which those duties are to be performed must be able to demonstrate high quality care achievements.¹⁷⁵

These qualifications must include the following: a record consonant with and supportive of the purposes and mission of the hospital; teamwork skills and a positive attitude toward patients, colleagues, and other hospital personnel; objectivity in dealings with others; a record free from questions concerning quality of care; an understanding of, and compliance with, relevant JCAHO Standards, state laws and regulations, and other laws governing inpatient and outpatient services; an awareness of, and respect for, the ethical, professional, and financial needs of the hospital and its physicians and nurses; all appropriate credentialing; the absence of probation or any other restriction or corrective action process; and a practice primarily based at the hospital. In any instance, the candidate must provide all information that the governing body reasonably requests.

175. *Id.*

Fifth, and finally, the medical staff bylaws must reflect the ability of the governing body to initiate, on its own accord, corrective action against any practitioner. Most crucial to this provision is a clarification that the governing body has the ability to resume corrective action against a practitioner should the medical staff either fail to adequately perform peer review or fail to achieve a result that the governing body deems reasonable. This clarification, nothing more than a restatement of the legal authority that the hospital governing body already retains, may read as follows:

If the medical staff fails to timely investigate a request for corrective action or submit a written report thereon, or if the medical staff fails to act upon the request and report, or the governing body determines that the medical staff's recommendation is not reasonable, using an objective standard based upon the weight of the evidence available at the time of the recommendation, the governing body may either direct the medical staff to initiate another investigation of the matter or itself initiate corrective action. Before initiating corrective action on its own, the governing body may, but is not required to, allow the affected staff member to appear to speak before it. If the governing body itself initiates corrective action, it shall also specify the corrective action it proposes to impose. If the affected staff member does not timely exercise his or her process rights, the proposed action of the governing body shall become final.

C. *The Non-Responsive Medical Staff*

The AMA steadfastly defends the position that the medical staff bylaws constitute not only a contract between the governing body and the organized medical staff, but also a contract between the governing body and each individual practitioner.¹⁷⁶ The AMA also provides an abbreviated list of the states that adhere to this position.¹⁷⁷ But unlike any well-drafted contract, medical staff bylaws typically do not contain crucial contractual elements and specifically lack provisions for remedies upon breach. The AMA's recommendations do not include instances when the medical staff fails to act; the medical staff bylaw provisions proposed above serve to remedy any failure of the medical staff.

Invariably, if a hospital governing body is certain that threshold quality standards are not being achieved, and the medical staff refuses to act, it is imperative that the governing body act—whether or not these provisions are present in the medical staff bylaws. If the medical staff refuses to engage in

176. AMA, *supra* note 171, at 5.

177. *See id.* at 5.

peer review, the governing body must retain external peer review organizations in order to assure quality care. If the medical staff does engage in peer review, but only by going through the motions to 'adhere' to bylaw procedures and in order to unreasonably acquit inferior practitioners of charges of inferior practice, the governing body must act on its own and revoke, suspend or restrict staff privileges accordingly.

If the medical staff is unwilling to amend the medical staff bylaws to conform to the law, the governing body must make the amendments unilaterally. To the extent that amendments are necessary, medical staff involvement is always beneficial. In fact, JCAHO Medical Staff Standard 2.1 provides that neither a medical staff, nor a governing body can unilaterally amend medical staff bylaws.¹⁷⁸ However, unilateral amendment may be necessary in the extreme circumstances where medical staff refusal to participate would cause even more severe accreditation and liability issues than those caused by the governing body's decision to unilaterally amend the bylaws. When JCAHO Standards are read as a whole, as they are meant to be, it is clear that JCAHO would embrace this concept.¹⁷⁹ JCAHO Governance Standard 2.4 specifically states that "the hospital's governing body or authority provides for compliance with applicable law and regulation."¹⁸⁰

What happens when a medical staff refuses to engage in peer review, or at least meaningful peer review? What happens when medical staff leaders refuse to discipline practitioners committing fraud? What happens when a medical staff cannot muster a quorum of members to attend a meeting called for the specific purpose of approving amendments to the medical staff bylaws that are necessary for the hospital to comply with the law? In other words, if the governing body is to deem the medical staff bylaws as a contract, what happens when the medical staff fails to perform, i.e., breaches this contract? What steps should the governing body take then?

It is easier for the governing body to answer this question once it acknowledges what can happen if it chooses do nothing. Recently, in *United States v. United Memorial Hospital*, federal prosecutors filed criminal charges against United Memorial Hospital and two physicians, alleging that the physicians and the hospital knowingly allowed a physician to remain on the medical staff and continue to perform unnecessary pain

178. JCAHO, *supra* note 125.

179. *See, e.g.*, JCAHO *supra* note 125 (stating: "the hospital's governing body or authority ultimately is responsible for the quality of care the hospital provides. To carry out this responsibility, the governing body or authority provides for the effective functioning activities related to delivering quality patient care, performance improvement, risk management, medical staff credentialing, and financial management.").

180. JCAHO, *supra* note 125, Medical Staff Standard 2.4.

management procedures.¹⁸¹ It is significant that the physicians indicted are the former Chief of Staff and the Chairman of the Professional Activities Committee.¹⁸² These physicians were not accused of submitting false claims themselves, or even benefiting financially from any false claims. They were accused of blocking an investigation of one physician on the medical staff who repeatedly performed unnecessary pain management cases at the hospital.

Simultaneously, an ongoing Board review of these pain management concerns included a discussion with a subcommittee of the Board, in which the hospital's chief financial officer advised the subcommittee that the pain practice generated \$1,300,000 of net income for the hospital during the preceding three months.¹⁸³ The chief financial officer later reported to the full Board that this pain practice accounted for one-third of hospital's bottom line. The physician leaders recently pled guilty to misdemeanors in state court. The hospital pled guilty of wire fraud; the plea will be suspended only if the hospital continues to undergo a strict compliance program, including external review.¹⁸⁴

Knowing that a hospital can be found criminally guilty for the failure to discipline a physician and, further, that it is ultimately and civilly accountable for all facets of the quality of care rendered within the hospital, the governing body cannot, should not and must not take lightly any medical staff unwillingness or incapability to achieve high quality of care. Courts have held governing boards ultimately accountable for the failures of their medical staff¹⁸⁵ and have given governing boards ultimate authority to take drastic actions;¹⁸⁶ accordingly, a governing board must have the resolve to take drastic action, when necessary, to protect the hospital and the community from inferior care.

D. The Incentive-Disincentive Imbalance

It behooves us at this point to consider again why a medical staff may not act and, in fact, why a hospital may not be inclined to act. The delegation

181. Press Release, U.S. Attorney's Office, W. Dist. of Mich., United Memorial Hospital, at <http://www.usdoj.gov/usao/miw/press/press112601.html> (last visited Mar. 18, 2003).

182. *See id.*

183. *See id.*

184. *See id.*

185. *See Siqueira*, 477 N.E.2d at 20 (since a hospital governing board consisting of laypersons is ultimately accountable for the quality of care rendered within the hospital, it must have the ability to make all decisions regarding quality of care, even if those decisions must supercede contrary decisions of the medical staff).

186. *See Mahan*, 621 N.W.2d at 160 (hospital governing body has full and final authority to close down sections of medical staff).

of the responsibility for measuring and improving quality to the Medical Staff is destined for failure if simply viewed within the inherent constraints of the imbalance of disincentives over incentives for a passionate commitment to quality care. For the hospital, the negative financial consequences of a commitment to quality are daunting:

- Cost of full time employees for measuring quality, meeting with physicians, and the costs of lost time and commitment to resources for purchasing equipment, nursing and staffing ratios;
- Potential of significant lost revenue for eliminating unnecessary and non-indicated procedures and maximizing coding for billing of conditions supplemented by complications identified during such procedures;
- Loss of physicians who do not want to be scrutinized when other welcoming hospitals will accept their practices unconditionally;
- Fewer physicians on staff as the result of adhering to strict standards for credentialing highly qualified and experienced physicians;
- Significant costs of any attempt to remove physicians for dis-quality for the costs associated with summary suspensions or corrective actions, fair hearings, and the probable attempts to litigate or obtain injunctions in civil courts associated with legal fees, external peer review consultants and expert witnesses; and
- Risk of inflammatory public response to any corrective actions if patients, loyal public, and possibly nurses, demonstrate public support for the sanctioned physician.

The favorable financial benefits associated with a commitment to quality are difficult to prove, and remote at best, considering the following:

- The relationship between profit and quality of care has been a difficult proposition to attract chief executive officers and chief financial officers to become engaged in quality initiatives;
- The clear correlation between reducing length of stay and clinical resource management have been substituted for previous endeavors to focus on quality as a source of potential financial incentive;
- Medical liability insurance companies have been resistant to significantly reward hospitals for focusing on quality to reduce premiums and bonus payments are relatively small as an financial incentive;
- Reduction of liability for negligent credentialing is perceived as having no potential favorable benefit, especially from the perception that the savings is to insurance companies and not the hospital;
- Third party payers have given little financial incentive for commitment to true quality versus reduction of costs and limiting access to care;
- Hospitals have essentially been willing to risk the extraordinary negative public notoriety that attaches for publicity from flagrant medical errors;
- Failure to appreciate the financial cost of negative perceptions of hospitals and their physicians on lost patients and revenue; and
- Public recognition for excellence in quality of care from publicly disclosed morbidity and mortality data have been extremely limited to date.

For the physicians, the disincentives to a commitment to quality measurement and improvement include:

- Physician reluctance to become involved in any potential negative comments on the care of colleagues, simply from a personal, professional, and “there but for the grace of God” connotation;
- Fear of retaliation by physicians negatively impacted from any quality involvement, such as peer review activities;
- Fear of losing revenue from reduced referrals, particularly for specialists dependent upon referrals for financial success;
- Negative impact on collegial morale within the organization for any appearance of “bad apple hunting;”
- Fear of exposure to litigation from sanctioned physicians based on restraint of trade, defamation, anti-trust, and similar legal theories; and
- Physicians are rarely paid for time spent on quality measurement and improvement but are very aware of the loss of time to devote to the private practice of medicine.

The favorable incentives for physicians to become involved in quality initiatives are primarily ethereal in nature and believed to be illusory by physicians. The primary motivating factor is that physicians are, by their character and professional commitment to serving patients, first interested in improving human lives and placing professional responsibility above personal interests.

Physicians understand very clearly the intensity of these competing interests within the medical staff. Insight into the concern within hospital medical staffs for such competing interests is best demonstrated in the factual basis for the corrective action affirmed in *Austin v. McNamara*.¹⁸⁷ Physicians are inherently distrustful of hospital efforts, even from fellow medical staff members, to discipline or take corrective action against fellow physicians. When a neurosurgeon contended in a fair hearing that other neurosurgeons at Santa Barbara Cottage Hospital had conspired with concerted actions to shut down his practice, the hearing panel of six impartial physicians and a state judge found that the Medical Executive Committee’s decision to revoke staff privileges “was unreasonable” and reinstated Dr. Austin to the medical staff (after 70 hours of testimony and twelve volumes of transcripts and exhibits).¹⁸⁸ The panel recommended that clinical privileges be reinstated but conditioned by i) mandatory consultations and ii) periodic outside independent neurological surgery case review.¹⁸⁹ The court ultimately ruled that the Health Care Quality Improvement Act protected the process and actions of the Medical

187. *Austin v. McNamara*, 731 F. Supp. 934 (C.D. Cal. 1990).

188. *Id.* at 934, 937.

189. *Id.* at 937-98.

Executive Committee.¹⁹⁰ This case, of course, is at the opposite end of the spectrum from the factual basis of bias and lack of objectivity in the infamous case of *Patrick v. Burget*,¹⁹¹ which examined the subject of challenging competitors in an effort to eliminate or restrict competition or for personal vendettas.

Donald M. Berwick, M.D., and his colleagues observe that the challenge of getting productive clinical involvement from physicians is perplexing and pervasive for health care organizations.

Institutions launching quality improvement programs almost always ask: How shall we involve doctors, who do not seem to see themselves as players in processes, whose financial incentives impede participation in project teams and data collection activities, and who do not strongly believe that their interests are tied to the improvement of the health care organizations they work in? In fact, barriers to physician involvement may turn out to be the most important single issue impeding the success of quality improvement in medical care.¹⁹²

VII. RECOMMENDATIONS

How does a governing board ask itself, and provide its own independent answers, to the following questions: does our hospital provide quality care to its patients? Where are our most pressing and demanding opportunities for clinical quality improvement?

Key 1 – Educate to make all parties aware, with insight and understanding, of the Board’s ultimate responsibility for quality and patient safety and the obstacles of the Structural Silo, the Cultural Silos and the Informational Silo.

- Education – what data to see, what format to analyze, standards for quality, understanding where we are now and where we want to be;
- Structure analysis – corporate and medical staff bylaws examination;
- Legal analysis to understand board liability and implications of authority and responsibility for quality;
- Develop legal protection for all peer review and quality information, minimizing access by protection from potential discovery; and
- Assure conformity with the Health Care Quality Improvement Act, HIPPA, and other federal and state laws and regulations.

Key 2 – Analyze thoroughly the Informational Silo and the specific

190. *Id.* at 938; the Health Care Quality Improvement Act of 1986 has been codified at 42 U.S.C.A. § 11101.

191. *Patrick v. Burget*, 486 U.S. 94, 105-06 (1988).

192. DONALD BERWICK ET AL., *CURING HEALTH CARE: NEW STRATEGIES FOR QUALITY IMPROVEMENT* 151 (1990).

elements of the fragmented quality data and information processes to integrate all quality information for improved decision-making.

- Review all internal and external sources of quality information, focusing on:
 - Analysis of administrative database for complications, volumes, and referral patterns
 - Analysis of the medical staff minutes for peer review and management of sub-optimal outcomes, considered in parallel with other sources of quality data from root cause analysis, patient safety, utilization and length of stay data (resource use, if available), special studies, performance measures and core measures, CQI/TQM variance analysis, and other sources
 - Analysis of all hospital-based physician contracted services for quality of care review from emergency medicine, anesthesia, radiology, pathology, and similar physician groups
 - Analysis of external data sources from all regulatory agencies, state and federal databases, payers, medical malpractice insurance studies, and all patient satisfaction data, as well as other available sources
 - Analysis of the risk management database for whether sub-optimal cases are being identified and quality improved – (examine “surprise rate”)
 - Analysis of credentialing throughput and output for whether current clinical competence data is considered for renewing membership and allowing specific privileges
 - Analysis of institutional quality studies and analysis from all nursing and ancillary services
- Evaluate all aggregated quality and clinical performance measurement data in both the context of what the information shows (diagnosis) and how any quality issues have been addressed (treatment) for assessment of whether the information is valid, what issues were identified, and whether the solutions are logical, implemented, monitored, and whether the “gains” from the solution are now consistently performed; and
- Review and evaluate whether the sources of quality information meet the needs of the organization, including how the information is formatted, benchmarked, and reported to a Board level entity.

The analysis, preferably using a method such as cross-functional mapping, should include the following basic considerations:

- Who collects the data – supervisor, staff, individual skill sets, to whom they report within organizational structure?
- What processes are utilized to determine quality projects, priorities, and design?
- How is the data collected – what software or processes?
- What linkages and correlations occur (or are intended) between the activities?
- Who receives the data – how is it integrated and displayed (at all levels)?

- ❑ What are the budgetary commitments for each activity?
- ❑ What actions are taken, by whom, with what impact (success), and how are they communicated up and down the organization?

Key 3 – Create a formal multidisciplinary body within the Board structure to be responsible to the full Board for all aspects of quality and patient safety that is trained, focused, and empowered to rapidly and effectively implement change and to achieve optimal quality and patient safety.

- Create at the Board level a multidisciplinary entity to review and evaluate all sources of quality information available;
- Develop a working relationship between the full board and the organized board entity for reporting and decision-making; and
- Assess and develop roles and responsibilities of senior management and the medical staff within this organizational structure.

Key 4 – Evaluate the performance of each of the components of the new organizational structure to determine if the quality improvement and patient safety is working and achieving expected results and outcomes.

- Review and evaluate whether the organization is identifying sub-optimal care and dealing with any overuse, underuse, and misuse;
- Analyze whether peer review and other quality information is resulting in improved care and development of safe, quality processes of care and elimination of liability exposure and sub-optimal care; and
- Evaluate whether the board is receiving and acting upon adequate and insightful clinical information to credential physicians.

Key 5 – Integrate the quality structure and function at the Board and Senior Management level with strategic planning for the organization.

- Focus quality initiatives to align clinical improvements with strategic planning initiatives;
- Assess quality as perceived by the patient-customers in the marketplace within the context of strategic priorities for clinical improvement; and
- Require external measurement of hospital-based physician practices for contractual performance assessment and consistency with board expectations of quality.

Key 6 – Evolve to implementation of evidence-based best practices as defined processes of care, tested before implementation with “failure mode and effect analysis” (FMEA) and measured for optimal quality performance and continuously monitor for determined expectations.

- Evaluate whether medical staff rules and regulations and nursing policies and procedures are being implemented with performance measurement for conformity;
- Analyze what standards, if any, are necessary to implement evidence-based best practice models and to measure clinical performance in an “implicit” model;
- Determine what medical staff processes must be implemented to improve patient care for the Board to establish necessary standards; and

- Determine what organizational systems and processes must be implemented to improve patient care for the Board to establish necessary standards.

VIII. CLOSING OBSERVATIONS

Several observations regarding the rapidly evolving health care environment are critical to putting these quality challenges into proper perspective for health care organizations committed to surviving and thriving. First, the most recent report of the IOM, *Leadership by Example: Coordinating Government Roles in Improving Healthcare Quality*,¹⁹³ clearly establishes the agenda of the federal government to develop clinical performance measures for comparative analysis of hospitals to be regularly published for the public, similar to the recent nursing home and long-term care facilities. The national agenda to establish and measure clinical performance and to publish comparative results is further evident from the development of thirty-one performance measures by the National Quality Forum.¹⁹⁴ Second, recent pronouncements by Thomas Scully, Administrator of the Centers for Medicare & Medicaid Services, clearly state the federal agenda to pay more money to hospitals that provide quality care based upon developed criteria.¹⁹⁵

The national agenda to improve health care quality is clearly becoming established. Performance measures, far more precise and targeted than those currently in use by most health care organizations, will be implemented, measured, and comparative results published for consumers. The IOM initiative to develop clinical practice protocols and to measure performance against defined evidence-based best practice models will soon become reality. Efforts to tie payment for health care to the quality of performance on a scale to reward quality care will drive the marketplace toward the value equation for focusing on quality.

Those who gain insight and understanding into quality as a fundamental and driving business strategy will be the successful health care organizations of the future.

193. COMM'N ON ENHANCING FED. HEALTHCARE QUALITY PROGRAMS, LEADERSHIP BY EXAMPLE: COORDINATING GOVERNMENT ROLES IN IMPROVING HEALTHCARE QUALITY (2002).

194. THE NATIONAL QUALITY FORUM, HEALTH CARE NATIONAL PERFORMANCE MEASURES, INTERIM REPORT, <http://www.qualityforum.org/news/txhospGrp1publicweb.pdf>.

195. Interview with Thomas Scully, *People who perform better will be paid more*, MODERN HEALTHCARE, Sept. 16, 2002.