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A hospital's medical staff, the independent physician organization required under state law and accreditation standards,[1] plays a critical role in assuring quality care and improving patients' outcomes in the hospital setting. This essay is based on the legal presumption that a medical staff is a voluntary association, a legal entity distinct from, but inexorably tied to the hospital it serves,[2] and it will analyze the role of the medical staff amidst the dynamic changes occurring in the health care arena.

Illinois courts have recognized that the medical staff structure of a hospital is central to the quality of care rendered. The Illinois Supreme Court has acknowledged the existence of a "separate professional medical staff," distinguishable from the hospital, that is responsible for the quality of medical services rendered.[3] Further, Illinois courts have recognized the rights of an individual member of the medical staff as against the hospital and medical staff.[4] However, tumultuous changes in the relationship between physicians and hospitals concerning the delivery of health care, as well as broader societal changes, including the accelerating pace of

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1. HOSPITAL ACCREDITATION STANDARDS 271 (Joint Comm'n on Accreditation of Healthcare Org. 2002) (describing the requirement for the establishment of a medical staff as a component of hospital accreditation); 210 ILL. COMP. STAT. 85/10.4 (2000) (setting forth mechanisms within the Illinois Hospital Licensing Act for the granting of medical staff privileges).

2. 735 ILL. COMP. STAT. 5/2-209.1 (2000) (stating that a voluntary unincorporated association means any organization of two or more individuals formed for a common purpose, excluding a partnership or corporation).

3. Berlin v. Sarah Bush Lincoln Health Ctr., 688 N.E.2d 106, 113-14 (Ill. 1997); *see* Carter-Shields v. Alton Health Inst., 777 N.E.2d 948, 957 (Ill. 2002).

4. *See* Head v. Lutheran Gen. Hosp., 516 N.E.2d 921, 927 (Ill. App. Ct. 1987) (finding that the medical staff bylaws form a contract that sets forth the rights of an individual member of the medical staff as against the hospital and medical staff). *See also* JOHN J. MILES, HEALTH CARE & ANTITRUST LAW, § 10:10, § 10:71 (2002) (discussing the split in federal courts over the issue of whether a medical staff entity is sufficiently separate from its hospital to allow a lawsuit for conspiracy between the two in medical staff credentialing complaints under federal antitrust law).

technological advancements and introductions of new medications; the increasing cost of care; the decline in reimbursement; the regulatory climate; the societal take on legal liability; the transformation of small-charities into multi-billion dollar businesses; and the change in the physician's status in society have all made it more difficult for medical staffs to perform their fundamental function as champions of quality of care.

One reason for evaluating quality of care is the cost of medical care in the United States and the increasing percentage of the nation's gross national product it consumes.[5] Given the aging of the population, and the predictions of the acceleration of this aging phenomenon,[6] one might ask whether enough is being spent on medical care, rather than too much. There can be no doubt, however, that the increasing cost to society, particularly to business and government, calls into question whether the costs are providing maximum value. In this context, value is a function of improving quality and lowering costs. The increasing cost of medical care places great pressure on all health care leaders to deliver greater value by improving quality.

Quality, however, has been very difficult to measure. The collection of data, along with its analysis, has proven unwieldy until the relatively recent advent of electronic data gathering. Electronic data gathering allows, and will continue to allow, medical staffs to accurately record what treatment given a patient, or collection of patients with similar medical problems, receives. This type of data will also provide more information on how the treatment and interventions by the medical staff affected the patient's ultimate outcome.[7] Without electronic tools, however, the collection and

5. Stephen Heffler et al., *Health Spending Projections for 2001-2011: The Latest Outlook*, HEALTH AFFAIRS, Mar.-Apr. 2002, at 207 (stating that national health expenditures are projected to reach $2.8 trillion in 2011, growing at a mean annual rate of 7.3% during the forecast period 2001-2011. Further, the authors note that they expect health spending to grow 2.5% per year faster than the GDP, so that by 2011 it will constitute approximately 17% of GDP, up from its 2000 level of 13.2%); *see also* AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUM. SERVS., PUB. NO. 02-P022, FACT SHEET: HEALTH CARE COSTS (Sept. 2002) (setting forth facts on how much the United States spends on health care as a part of its gross domestic product).

6. *See* ADMIN. ON AGING, U.S. DEP'T OF HEALTH & HUM. SERVS., OLDER POPULATION BY AGE: 1900 TO 2050, http://www.aoa.gov/aoa/stats/AgePop2050.html. The number of Americans over age 65 is expected to reach 16.4 percent of the population by 2020 and 20.7 percent of the population by 2040. *See also* Frank B. Hobbs & Bonnie L. Damon, U.S. BUREAU OF THE CENSUS, CURRENT POPULATION REPORTS, SPECIAL STUDIES, PUB. NO. P23-190, 65+ IN THE UNITED STATES (1996), http://www.census.gov/prod/www/titles.html (reporting on the specifics characteristics, for example, health, geographic distribution, of those 65 and older in the United States).

7. *See generally* Barbara L. Kass-Bartelmes & Eduardo Ortiz, *Medical Informatics for Better and Safer Health Care*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, RESEARCH

interpretation of that data on patients' medical problems and subsequent treatment had proven impossible, for all practical purposes.[8]

Even with the growing availability of electronic data gathering, the ability to measure outcomes varies based on different aspects of care; for example, from the inpatient to outpatient arena, and from objective technical aspects of care to more subjective areas, such as communication skills. The uniqueness of each patient, and each patient's "episode of care," makes it more difficult to measure the quality of outcome, despite advances in electronic data gathering.

Because the quest for quality has proven elusive, various surrogates for quality have been utilized, including patient satisfaction. Patient satisfaction surveys have measured just about everything, including food quality, room temperature, staff courtesy, and explanation of patient's illness. What these satisfaction surveys have not been able to measure, however, is the quality of the outcome. Other measurements include a variety of "Top 10" lists that include physician survey data, market share, numbers of cases, and cost per procedure. While providing fodder for conversation and marketing campaigns, it is debatable as to how accurately these types of lists reflect true quality of care. In fact, it is interesting to note the results of physician surveys regarding various definitions of "outstanding" hospitals is very frequently at odds with surveys of insurance payers or other lay groups.

Thus, the driving force behind medical improvement over the past fifteen years has been a focus on the second part of the value equation – cost. Cost is easier to measure than quality. Moreover, in the United States, the vast majority of health care costs are borne by employers and government.[9] Because this third party arrangement has become the standard, it is natural that the payers are primarily concerned with what impacts them the most – the cost of the care. Because the measurement of quality remains elusive, controlling the payers' costs becomes the main measurement metric.

Over the last several years, it has become clear, at least to the patient/consumer, that the cost of care may not correlate with the quality of

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IN ACTION, June 2002, *at* http://www.ahrq.gov/data/informatics/informatria.htm; U.S. DEP'T OF HEALTH & HUM. SERVS., PUB. NO. 02-0031.

8. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUM. SERVS., PUB. NO. 96-P014, USING COMPUTERS TO ADVANCE HEALTH CARE (Jan. 1996), *at* http://www.ahrq.gov/research/computer.htm (concluding that the adoption of computerized clinical information systems in health care lags behind use of computers in most other sectors of the economy).

9. Katherine Levit et al., *Inflation Spurs Health Spending in 2000*, HEALTH AFFAIRS, Jan.-Feb. 2002, at 172 (noting that public spending in 2000 accounted for forty-five percent of all national health expenditures, and private spending, the remainder).

care received.[10] Low-cost care is not seen as high quality. The public perception, therefore, is that health care organizations that focus on cost reduction do so at the peril of quality of care. This public perception has led to increasing pressures on managed care organizations to balance consumer and employer needs against their traditional business model of cost reduction through increased emphasis on utilization management and other techniques.[11] In other words, the absolute reduction of the payers' cost does not necessarily translate into improvement of care. This has resulted in "HMO bashing" in the media over the past several years as well as the stagnation, or actual shrinkage, of HMO growth in many markets, including Chicago.

In reaction to consumerism, as a result, insurance companies, hospitals, and doctors' practices have adopted practices that are commonly used in other industries in an attempt to measure the quality of care received. For example, the health care industry has substituted objective indicators to measure quality.[12] They have utilized satisfaction surveys to look at issues other than the cost of the care received, in an attempt to quantify the quality. Given the difficulties that any patient has in assessing outcome, the surveys generally measure parameters that have nothing to do with actual outcomes of care. Rather than focus on the elusive quality of outcome, these types of surveys focus on the "patient experience." Communication with physicians and others, education received regarding the medical condition, the cleanliness of the facilities, the quality of the food served, the responsiveness of ancillary personnel, and fulfillment of expectations at time of discharge are amongst the metrics. One such substitute is patient satisfaction surveys that attempt to measure all aspects of a patient's experience, including such factors as food quality, room temperature, and

10. Joseph P. Newhouse, *Why is there a Quality Chasm?*, HEALTH AFFAIRS, Jul.-Aug. 2002, at 13-14 (discussing the cost-quality nexus).

11. *See generally* Debra A. Draper et al., *The Changing Face of Managed Care*, HEALTH AFFAIRS, Jan.-Feb. 2002, at 11 (describing the pressures on managed care plans).

12. Several government initiatives and numerous private organizations have been founded to study and evaluate quality of health care based on objective factors. For a list of government quality initiatives, see www.ahrq.gov. For example, the National Committee for Quality Assurance (NCQA) measures quality health care by evaluating "quality oversight and improvement initiatives at all levels of the health care system from evaluating entire systems of care to recognizing individual providers who demonstrate excellence." Nat'l Comm. for Quality Assurance, *The State of Health Care Quality: 2002*, at http://www.ncqa.org. The Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), in addition to its health care organization accreditation programs, has implemented a performance measurement program, at http://www.jcaho.org/pms/index.htm. The American Accreditation Healthcare Commission (also known as URAC) has been formed to set forth uniform standards for utilization review, at http://www.urac.org. Finally, the U.S. Government has created a clearinghouse for evidence-based clinical guidelines, at http://www.guideline.gov.

staff courtesy. While all of these items are of some importance, none actually get to heart of the matter – the outcome of the treatment rendered. These surveys have been criticized as "conceptually flawed and methodologically weak."[13] Further, one study has shown that physicians are unlikely to rely on the results of patient satisfaction reports to change their practices.[14]

Part of the difficulty in measuring quality by using outcome-based studies, particularly in physician practices, is related to the primitive nature of clinical data-gathering in many hospitals[15] and in virtually all physician practices.[16] The vast majority of patient records are still recorded with pen and paper and analysis of outcomes involves a labor-intensive undertaking for which few organizations, even insurance companies, are willing to pay.[17] The availability of the electronic medical record will revolutionize data-gathering and will make the measurement of medical outcomes more easily achievable, as well as less expensive.[18] To this end, the federal government has launched an aggressive research program conducted by the Agency for Healthcare Research and Quality to increase efforts to use computers in health care. These efforts focus on hospital information systems used to maintain medical records, provide clinical guidance, track outcomes, and facilitate cost savings.[19]

Computers alone will not be nearly enough. Computers, and those operating them, will need to know what to measure and how long to measure. Deciding these important issues will involve the physicians delivering the care. Quality measurement requires the involvement of those best able to determine the critical factors that will influence physician behavior – physicians and other health care clinicians who actually provide care. Only physicians have the expertise to choose the parameters that will

13. Angela Coulter & Paul D. Cleary, *Patients' Experiences with Hospital Care in Five Countries*, HEALTH AFFAIRS, May-June 2001, at 245.

14. Elizabeth A. Rider & James M. Perrin, *Performance Profiles: The Influence of Patient Satisfaction Data on Physicians' Practice*, PEDIATRICS, May 2002, at 752.

15. *See generally* USING COMPUTERS TO ADVANCE HEALTH CARE, *supra* note 8 (concluding that the adoption of computerized clinical information systems in health care lags behind use of computers in most other sectors of the economy).

16. *See generally* Joyce Sensmeir, *Advancing the State of Data Integration in Healthcare*, HEALTHCARE INFO. & MGMT. SYS. SOC'Y (2002), *at* http://www.himss.org/content/files/AdvDataIntegration.pdf (addressing the degree and level of computer use in hospital and physician practices); *see also* HEALTHCARE INFO. & MGMT. SYS. SOC'Y, *HIMSS/AstraZeneca Clinician Wireless Survey (2002)*, *at* http://www.himss.org/ASP/surveys_list.asp (exploring the use of computers and information technology in outpatient clinical settings).

17. *See* Sensmeir, *supra* note 16.

18. *Id.*

19. USING COMPUTERS TO ADVANCE HEALTH CARE, *supra* note 8.

result in meaningful information that can be examined, improved upon, and widely disseminated. In hospitals, it will be up to the physicians on staff to evaluate practice standards and apply them locally. At multiple steps along the way, only the physicians on a hospital staff have the knowledge, influence, and ultimately, the major responsibility for insuring quality medical care.[20]

It is important to acknowledge the conflicts of interests that exist when hospitals and their medical staffs attempt to promote quality care. For hospitals and hospital systems, there is intense pressure to manage costs to remain competitive in the market place.[21] Executives are expected to manage to costs per discharge to achieve targeted budget goals that are in line with industry standards. For many hospitals and systems, this means decreasing the ratio of nurses to inpatients, offering services that compete with physicians, eliminating money losing programs that have community impact, overlooking quality issues with physicians who improve the hospital's bottom line, and deferring capital expenditures on superior medical equipment. Cost pressure has led to hospital closures,[22] mergers,[23] and changes in the level and types of services offered. Hospital executives are frequently evaluated by their ability to manage their costs without sufficient understanding on the ramifications on quality.

Medical staff members have different conflicts. In evaluating the quality of care rendered by their peers, most medical staff members prefer to remain non-confrontational and overlook or underemphasize legitimate concerns about performance. On the opposite end of the spectrum, physicians may be overly critical in evaluation of peers whom they deem as unwanted competition. This is seen especially at the time of initial application for staff privileges in an area where there is real or perceived competition for services.[24] Medical staff leadership is in the position to

20. Sensmeir, *supra* note 16.

21. *Compare* CCH-EXP, MED-GUIDE ¶ 4202, *Inpatient Hospital Prospective Payment System* (noting that some of the pressure is attributable to the Medicare prospective payment system which pays hospitals a predetermined amount intended to cover all of the hospital services based on a patient's diagnosis, thus creating a profit/risk-based incentive for hospitals to economize), *with* CCH-EXP, MED-GUIDE ¶ 3401, *Introduction* (stating that unlike hospitals, physician services continue to be reimbursed by Medicare on a fee-for-service basis). See Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 438 (1988), for a description of the dichotomy in prospective payment systems between physicians and institutions.

22. From 2000 to 2002, 96 hospitals closed, *at* http://www.modernhealthcare.com/docs/openclose.pdf; Mary Chris Jaklevic, *Fewer Hospitals Close Doors in '01*, 32 MODERN HEALTHCARE, at 22 (2002).

23. For information on hospital mergers in 2000 through 2002, see Vince Galloro & Jeff Tieman, *Hitting the Brakes*, 32 MODERN HEALTHCARE, at 22 (2002).

24. These observations are based on the author's own experience as a member and

understand these conflicts, recognize them, and manage them for the good of the patients served by the hospital.

In addition, many medical staff bylaws deal with potential conflicts arising from perceived competition. These bylaws address issues that arise with respect to medical staff membership or clinical privileges and often prohibit economic competitors from serving as adjudicators of credentialing, peer reviews, or other issues of medical staff membership and privileges.[25] Because the results and processes of the medical staff's peer review are largely protected from discovery under peer privilege laws, the effect of economic competition is more difficult to detect and prevent through law or contract.[26] Ultimately, however, hospitals hold the final authority to determine which physicians gain membership on medical staffs or obtain clinical privileges.[27] Moreover, some state laws grant hospitals the authority to make those decisions based on factors unrelated to an individual physician's objective qualifications, education, or experience.[28]

Although some of the conflicts among medical staff are recognized, there are no easy answers to managing them. A starting point is for hospitals, systems, and medical staff leadership to acknowledge these conflicts. Without a certain degree of trust, empathy, and meaningful leadership, conflicts can solidify prejudices. As such, board members, physician leadership, and executives should take an enlightened approach to hospital management and organization. Each of these groups needs to recognize the different role that each plays in contributing to quality, based on the different experiences and training of each. This approach suggests that the hospital and its medical staff serve as a check and balance on one another. Like a democratic form of government, it is far from perfect, but it is better than other alternatives.

The importance of the medical staff structure in the delivery of quality care is not a new notion. Up until recently, the voluntary medical staff structure took major responsibility for teaching, patient morbidity, mortality, drug utilization, and program development.[29] Even charitable giving involved substantial participation by the medical staff members. Over the past forty years, with the availability of Medicare funding and the explosion of available inpatient services, spectacular hospital growth has

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leader of a hospital medical staff.

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

26. 735 ILL. COMP. STAT. 5/8-2101 (2000); 210 ILL. COMP. STAT. 85/10.2 (2000).

27. *See* 210 ILL. COMP. STAT. 85/10.4 (2000).

28. *See, e.g.*, 210 ILL. COMP. STAT. 85/10.4 (2000).

29. For a description of the historical role of physicians in the medical profession see generally PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).

been accompanied by the development of a sophisticated management structure of full time administrators and physician executives who have played an ever larger role in the fiscal and medical management of hospitals and their progeny, the health care system. In many instances the voluntary medical staff structure and the full time administrative structure exist in parallel and the responsibilities of both bodies have become increasingly blurred.

Further, with the growth of hospital employed physician administrators, there has been a de-emphasis on the role of the voluntary, non-employed, community based medical staff. This is the result of several simultaneous factors. The increasing financial wherewithal of hospital facilities, the increasing patient loads vying for physicians' time in the office, the change in focus of health care from the inpatient to the outpatient setting, and the steep decline in physician reimbursement over the past ten years have made it difficult for many physicians to remain committed to medical staff activities. Economic realities require a more intense focus on clinical practice, rather than on medical staff activities. Additionally, the hospital is no longer viewed as the center of the medical universe by many physicians. There are many physicians who spend ten percent or less of their time in the hospital seeing patients. The vast bulk of professional time is spent in the office, the outpatient surgery center, or other care settings. Physical absence from the hospital, along with financial and time pressures, has led some physicians to overlook their professional responsibilities to peers and the community when it comes to medical staff activities. Some hospital administrators have nurtured this withdrawal in the belief that it eliminates troublesome medical staff interferences with hospital business initiatives. What has been lost to the general public, including some of "organized medicine's" most vocal critics, is that reimbursement to physicians for their professional services has declined at a much greater rate than has reimbursement to hospitals for the services they provide at the physician's direction. Thus, a number of factors have combined to diminish voluntary medical staff activity, which has increasingly become the purview of hospital employed physician and non-physician administrators.

One could argue that a less active medical staff is not in the patient's or the community's best interest. Given the intense financial pressures on hospitals and systems to "perform," can the public assume that these same administrators will necessarily be those in the best position to champion quality of care? Thus, there is an increasing need for the reexamination of the medical staff structure with an eye on its revitalization.

The medical staff organization affects the quality of care in several distinct ways. First, the medical staff organization plays an important role in screening and evaluating the qualifications of physicians who wish to

join the medical staff. It is up to the members of the medical staff, or their designees on a credentials committee, to ensure that a physician is competent. This means that the physician's credentials are in order, his peers can attest to his skills, and patients in the hospital will be well served by the addition of the new physician. Once a new physician is on staff, it remains up to his peers to make sure that the care delivered is consistent with the community standard. For a given physician, there may be problems with sample size that may make this assessment difficult, if not impossible, for a non-physician. However, physicians working together over time will develop a good sense of the level of care delivered by a peer, in terms of overall quality, as well as more subtle nuances, such as communication skills and empathy. A professional record can be established and reviewed at regular intervals to ensure performance to a standard that is acceptable. There is no substitute for this peer scrutiny.

Second, the medical staff is responsible for broad areas of clinical care and exercises its expertise and influence through committees that oversee a number of important functions that contribute to quality. In addition to the credentialing of physicians, medical staff committees include pharmacy, quality management, ethics, utilization review, information technology and library, and multidisciplinary programs such as cancer care.[30] In all of these areas, the medical staff provides a critical balance to the executives of a hospital or system who are responsible for financial performance. Thus, in addition to critical expertise, the Medical Staff structure provides a viewpoint that is somewhat removed from pure financial performance. In an "industry" such as medicine, success cannot be measured in terms of dollars generated.

The medical staff provides balance because its structure is not simply an appendage to the hospital structure. It is a separate organization, made up of independent and hospital-employed physicians, who utilize the hospital for a portion of the medical services they provide.[31] The Joint Commission for the Accreditation of Healthcare Organizations ("JCAHO") looks upon the medical staff organization as the cornerstone of quality in hospitals.[32] As part of its accreditation process, the JCAHO requires medical staff

30. HOSPITAL ACCREDITATION STANDARDS, *supra* note 1, at 292 (requiring departments and other facets of the organized medical staff to meet certain functions and reflect a specified structure).

31. Mark A. Kadzielski et al., *The Hospital Medical Staff: What is its Future?*, 16 WHITTIER L. REV. 987, 988 (1995) (sketching a brief history of the hospital medical staff as an entity).

32. HOSPITAL ACCREDITATION STANDARDS, *supra* note 1, at 271 (stating that the organized medical staffs function is to lead the "assessment and improvement of both clinical and non-clinical processes and the resulting patient outcomes primarily dependent on individuals with clinical privileges").

members to exercise professional leadership in measuring, assessing, and improving the performance of hospitals within which they practice. Specifically, the JCAHO standard states that the "self-governing medical staff shall have overall responsibility for the quality of the professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore to the governing body."[33] It should be emphasized that JCAHO recognizes the importance of the medical staff being independent from, but accountable to, the Board of Directors, and not the management of the hospital or system.[34]

Accountability for this delegated responsibility can be promoted in several ways. Board members should be present at medical staff committee meetings to understand the pertinent issues. Boards should routinely have access to medical staff members at their own committee meetings. These improved communication mechanisms could foster understanding and assist both the hospital administration and the medical staff in achieving their mutual goal of improving quality and patient outcomes. Having accountability mechanisms is place does not mean, however, that the independence of the medical staff structure should be compromised.

The legislatures of several states have recognized the medical staff structure as apart from the hospital structure, specifically for the purpose of monitoring the quality of care delivered in the hospital setting. In states like Illinois, there is a well-accepted public policy that only licensed physicians should be engaged in the practice of medicine.[35] As interpreted by the Illinois Supreme Court in *Berlin v. Sarah Bush Lincoln Health Center*,[36] ownership or control of the professional judgment of physicians by lay persons would constitute interference with the physician's duty of loyalty to his patient and be dangerous to public health.[37] This concept, known as the prohibition on the corporate practice of medicine, is widely recognized.[38] In *Berlin*, the Court acknowledged that hospitals were different from other types of corporations and recognized a narrow exception that patients would not be at risk when receiving care from physicians employed by hospitals. In reaching its conclusion, the *Berlin*

33. *Id.* at 272.

34. *Id.* at 288 (prohibiting a hospital or medical staff from unilaterally amending its medical staff bylaws).

35. *See* 225 ILL. COMP. STAT. 60/3 (2000) (stating that only licensed persons may practice medicine).

36. Berlin v. Sarah Bush Lincoln Health Center, 688 N.E.2d 106, 110 (1997).

37. *Id.*

38. For a description of the general corporate practice of medicine doctrine in Illinois, see Jessica A. Axelrod, *The Future of the Corporate Practice of Medicine Doctrine Following Berlin v. Sarah Bush Lincoln Health Center*, 2 DEPAUL J. HEALTH CARE L. 103 (1997).

court stated that the "concern for lay control over professional judgment is alleviated in a licensed hospital where generally a separate professional medical staff is responsible for the quality of medical services rendered in the facility."[39] The importance of this distinction was reinforced when the Illinois Supreme Court recently ruled in *Carter-Shields v. Alton Health*[40] that a not-for-profit corporation owned by a hospital and physicians may not engage in the practice of medicine, because of its inability to demonstrate that the medical judgment and quality of care rendered by physicians was sufficiently independent of lay control as required by the Illinois Medical Practice Act.[41]

The JCAHO standard, these recent cases, and the actions of several state legislatures all reaffirm the notion of an independent medical staff organization whose primary reason for existence is to promote the practice of quality medicine in the hospital. If not the physicians, then whom? There is no alternative and ways must be found to make the medical staff more effective in performing this vital and primary function.

To be sure, there have been and will continue to be barriers or difficulties in the medical staff achieving its authorized role from governance; that is, the promotion and improvement of the quality of care delivered. The increasingly chaotic and punishing business environment has led many hospital and system leaders to focus on "margin," sometimes to the virtual exclusion of "mission." Many hospital systems have hired multiple consultants to assist with the improvement of the bottom line.[42] In many instances, their recommendations have included the "streamlining" of hospital processes to improve efficiency and reduce redundancy. In some cases, this "streamlining" has included suggestions that would diminish the independent medical staff's role in care oversight, as well as strategic planning, resource allocation, and program development. There is no doubt in my mind that this gradual estrangement of the voluntary medical staff from the "business end" of hospital administration has contributed to a self-fulfilling prophecy of decreasing medical staff involvement.

Of course, medical staff members and their elected leadership are by no means blameless. An important part of a physician's professional responsibilities and duties is to participate in the process of care oversight and improvement in the hospital. However, financial pressures have come to bear not only on the hospitals and systems that own them, but on the physicians as well. In fact, reimbursement for physician services has

39. *Berlin*, 688 N.E.2d at 113-14.
40. Carter-Shields v. Alton Health, 777 N.E.2d 948, 957-58 (2002).
41. *Id.* at 959.
42. This observation is based on the author's personal experience.

suffered far more significant erosion over the past ten years than has hospital reimbursement. All physicians are working harder as they attempt, sometimes unsuccessfully, to maintain income.

In place of the voluntary medical staff structure, many hospitals have hired a variety of physician and non-physician administrators who are responsible not only for business performance, but for a variety of care and patient safety issues as well. These hospital employees are given an agenda, frequently linked to financial performance, and may view concerns about patient outcomes as secondary. While there is the necessity of financial viability, health care is not a business that is based solely on the bottom line. There are times when patient concerns, comfort, and outcome will cost more, and it may be difficult for a hospital or system employee to admit as much. An independent medical staff organization can express its opinion much more freely than an employed physician or non-physician administrator.

Hospital administration is empowered by board governance. However, the oversight provided by the board, especially at not-for-profit systems, may not be based on solid medical or business expertise. In some situations, the board's actions are dependent on hospital executives who may provide just enough information to see things the administration's way. It is understandable that many lay board members may not have the time or the expertise to understand the dynamics of health care today. Given the well publicized nature of business ethics today, it may be relatively easy for a system or hospital executive to convince a sympathetic board that "streamlining" a hospital may include marginalizing the physicians working there. These conversations are usually cloaked in terms suggesting that doctors are self-serving or not team players. In reality, these same physicians simply may be vocalizing the need for greater patient comfort, for new and superior methods of care, or for a stronger voice in the decision making process. The medical staff, by virtue of its independence, has the right and duty to ensure that hospitals are not run solely for the financial reward of the executives who manage them, or even the bodies providing governance and ownership. Hospitals are managed and governed as a community trust, with many different interest groups involved, including the voluntary medical staff.

The question arises as to who bears the consequences if poor quality occurs in the hospital. First and foremost, these consequences are borne primarily by the patient and his family, sometimes lifelong or even beyond the patient's lifetime. When emotional and physical injury occurs, the financial consequences faced by hospitals and physicians, while significant, is secondary. That being said, the responsibility for poor quality care is shared by the physician and facility involved. Thus, it is reasonable that

both parties work together to improve care and outcomes. Although the hospital is generally seen as the "deep pocket" in medical malpractice lawsuits, the physician may suffer greater proportionate financial injury. In the current malpractice climate, an adverse outcome may make malpractice insurance rates prohibitively high or the insurance itself literally unobtainable. In addition to financial injury, the emotional strain takes a personal toll on the physician involved that has no institutional equivalent.

The malpractice situation in Illinois has become onerous enough that all physicians have an interest in lowering their risk through education and other proactive risk management strategies. However, the current evidence is that continuing medical education for physicians is not as useful as it should be. The concept of continuing medical education is to help physicians remain current. The impact of CME, therefore, would be greatest if it could be applied in real time, at the bedside. With the increasing availability of computer assistance at the bedside, protocols and treatment suggestions could be placed at the physicians' fingertips, which would have an immediate impact on the physician's knowledge base and on the patient's outcome. These steps forward involve the input of physicians locally who can help decide what information will be most useful.

Risk reduction for physicians translates into risk reduction for the hospital. For most physicians, risk reduction is most effective when offered in the form of peer education. Like other professionals, physicians want to do a good job. If presented with peer data that can be used to improve care, a physician is inclined to study the data and apply it to his practice. If outcome data can be trended and reviewed, most physicians are eager to improve outcomes. This is part of the competitive nature of physicians who are selected and trained to achieve high levels of performance. Only the medical staff can create the milieu where peer review is embraced and formalized, trending is available for review, and the medical staff structure is empowered to educate or, if necessary, discipline individuals whose quality is found wanting. The challenge in the hospital, as elsewhere, is to create a risk-free environment where learning and improvement, instead of finger pointing, are the goals. In this regard, physicians are the ones best situated to provide professional peer review and education.

There are many ways the hospital administration can help the medical staff pursue a program of quality improvement. Resources must be allocated to allow for data gathering and collecting. Incident reports might include data regarding poor outcomes or unprofessional behavior. The data would be and should be available in digestible form for peer review. As we have learned from other industries, faulty systems and processes may be in place that contribute to bad outcomes. These will need to be reviewed and improved upon to positively affect future outcomes. This will generally

require the cooperation of nursing and administration. Thus, quality management, which requires physician input and leadership, cuts across multiple layers of hospital administration and explains the hospital's liability in instances of malpractice. Although physicians can and should lead the way, the input from others in the hospital environment is critical for improvement.

The most successful hospitals and systems will be those who embrace the concept of an active medical staff structure. Hospital governance and administration will not only invite participation, but also find ways to support that participation. Enlightened administrators understand that an active medical staff organization may not be "streamlined" from a business point of view, but that the benefits far outweigh the perceived detriments. Physicians will become invested in the activities of the hospital and take a more personal interest in hospital success, regardless of how that is measured. Where their input is sought, there will be greater interest in outcomes of projects. Newer technology and treatments can be more quickly assimilated. There can be greater physician buy-in into medical education initiatives. Physicians have a high level of expertise that can be tapped, at far less cost than outside consultants, with faster buy-in and initiation of quality improvement projects.

The cost of this participation is minimal, particularly in comparison with the amount of money spent by systems on outside expertise. Not only are the costs lower, but the buy-in is considerably greater because local medical staff members will have to live with the changes enacted. This is a far different scenario than with consultants who leave the scene, generally long before suggested changes are acculturated. Although it may, at first glance, first feel counterintuitive, hospital administrators must help reawaken the sense of professional responsibility that a physician has to the hospital and the community it serves. By inviting the participation of the staff in all aspects of hospital activities, and emphasizing the importance of physician participation, hospitals can do much to restore what has been lost in the last several years of the sense of "ownership" that physicians previously had related to the hospitals in which they practice. An added benefit to this approach, from a business perspective, is the added loyalty that medical staff members will feel toward a hospital where they are viewed as welcomed collaborators.

The hospital environment is an increasingly complex one. Medical staff participation in this environment is considerably more time consuming than it has been in the past. While the members of the staff have generally funded support for medical staff activities in the past, it is worth considering whether the hospital should financially support the medical staff activities related to hospital care improvement. In many areas,

meaningful physician participation requires time and effort that should be compensated. To maintain independence, especially in championing important but controversial points of view, this funding should be through the medical staff mechanism, based on a budget that is easily understood by medical staff members and hospital administrators alike. The cost, compared to current consulting costs, would result in considerable savings. In addition to supporting physician time, educational programs need to be undertaken to address the insufficient understanding that most physicians have regarding basic business principals in the management and governance of large enterprises.

Improved hospital/system governance can have a positive impact on the relationship between hospitals and their medical staffs. Board members should be sought out who have insight into the medical environment. Medical staff members, in addition to management, should present issues and problems to the Board so that different perspectives can be more fully understood. In some cases of medical staff/hospital relations, management may want to minimize issues that are viewed as important by the medical staff. Boards should include members of the medical staff who can regularly provide a "real world" perspective for Board members who do not "live" in the world of health care. Medical staff input will not always prevail nor should it. Nevertheless, it must be included as one of several groups with an interest in the hospital development and well-being. This is particularly important in situations where a system board may sit at some distance from one or more system hospitals. With the development of multi-hospital systems, it is increasingly likely that governance will sit at some distance, physically and emotionally, from the hospital setting.

Medical staffs should continue to be recognized as independent and autonomous organizations whose existence is critical to care improvement in the hospital. Specific efforts should be made to emphasize the independent nature of the organization, such as the election of medical staff officers, the funding of the medical staff organization, and the powers of the medical staff input at the level of the medical staff executive committee and other medical staff committees. The unbiased and encumbered input of staff members through these vehicles will pay tremendous dividends not only in care improvement, but in financial performance as well.

With this input and support, the bar can be raised regarding the quality of medical staff input into hospital care. Individuals with expertise can be asked to participate in quality improvement efforts, with the knowledge that their input is important and valued. Together with hospital administrators, projects and outcome measurements can be identified that are the medical staff's responsibility. A culture can be created where the professional responsibilities of physicians regarding quality of care and other aspects of

behavior within the hospital are viewed more positively and personally. Ultimately, the quality of medical staff applicants will improve by virtue of the understanding that applicants will be expected to be active contributors to the overall welfare of the hospital. This expectation will rest not with hospital administration, but with the medical staff itself.

The pattern across the country appears to undervalue and undermine the role of the medical staff by excluding its leaders from key developments and stripping powers away through medical staff bylaw amendments, sometimes without the knowledge or consent of the medical staff. This pattern suggests that hospital and system executives may be more concerned about consolidating power and expediting decision making and less concerned about the short term and long term impact on medical staff morale and quality of care. The loss of trust in each other that results from these power struggles poses a major barrier to leaders thinking creatively and constructively about how to improve the overall patient experience and outcome.

In summary, the relationship of hospitals and systems and the medical staffs that work in those settings should be brought back into balance. The multiple factors which have recently brought that relationship to an imbalance must be opposed by enlightened governance, progressive professional administration, and, most importantly, by medical staff organizations who recognize and assert their role and responsibility in leading care improvement initiatives.