ACCOUNTABILITY AND ACTION

Affirming the Five Key Elements of the Board–Medical Staff Relationship

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Nothing is more important to the sustainability of a health care organization than its relationship with its medical staff.[1] The history of the relationship between health care organizations and their medical staffs has not, however, always been a positive one. Whether the relationship between the two entities is mutually founded and represents real partnership often determines the viability and effectiveness of the organization. As usual, this effectiveness begins with the organization's board of trustees.

The board's obligation is to ensure that the organization's resources are directed in ways that fulfill its mission, achieve its strategic imperatives, and advance the health care of those it serves.[2] Although the ends are not negotiable, the means are. Through the formulation of policy, the setting of direction, the exercise of fiduciary responsibility, and evaluation of the CEO, the board ensures the organization's successful continuance.

In achieving these objectives, the board has no greater partner than its affiliated physicians. This is the relationship most vital in ensuring the health of both the organization and the people it serves. Most health care organizations do not employ the members of their medical staff. Usually, medical staffs are made up of independent physicians who use the organization as a vehicle for providing support and services for their own patients. This highly independent relationship between physician and organization has been the source of much anxiety and stress. As a result of this high level of physician independence, medical staffs are usually not tightly organized. The diversity and independence of such a staff inevitably has a tremendous impact on the action and function of the health care organization. The actions of medical staff members can often be nonaligned, unilateral, diffuse, and contentious. The organization, in dealing with its medical staff, usually must work with specific key physicians (who only in rare instances hold formal leadership positions), frequently those who make significant contributions to the organization's financial and operational success. Unfortunately, this approach often has a deleterious effect on relationships with *other* members of the staff, whose services, when aggregated, are as valuable as any single physician, no matter how large his or her contributions. For the organization's CEO, trying to manage this situation can be an administrative dance.

Because the relationship between physicians and the organization is so important, the former should have formal representation on the board. Physician board members do not, however, represent physician constituencies. For physicians on the board to represent the interests of the medical staff would be inappropriate, a concept incompletely understood by many physicians in governance. Rather, physician board members should represent a physician *perspective* within the governance format. Membership in governance activities means acting as an advocate for the interests of the organization.

Critical to an understanding of the relationship between the board and the medical staff is knowledge of the governance processes that indicate the continuing interaction between the organization and its physician partners. It is through these process dynamics, when they are a continuous and ongoing part of the board's operations and expression of its relationship with physicians, that system effectiveness is ensured.

There are five critical areas of intersection between board and physicians that are essential to a strong and meaningful relationship:

- Strategy setting
- Capital planning
- Credentialing and privileging

• Ensuring clinical quality

• Measuring medical staff satisfaction

Although other elements of physician-board relationships certainly exist, these five represent 90 percent of physician-related issues and challenges in health care organizations. Creating effective mechanisms to address each of these five relational elements will go most of the distance necessary in ensuring a positive and sustainable partnership.

> The capital-planning process tends to be fraught with emotional challenges.

Strategy Setting

Nothing is more critical for the viability of a health care organization than the accuracy of its direction setting.[3] Through its strategic activity an organization engages its own future. However, when planning for the future, the organization must realize that it has a large number of stakeholders who can either facilitate or constrain the organization's ability to obtain its objectives. Although the board certainly has an obligation to set strategic direction, it must choose one that will be embraced by its stakeholders. This is especially true with regard to physicians. A good part of the strategic process should include activities that solicit physician insights, opinions, and values concerning the organization's priorities. From this process, the board will gain important insights.[4]

The engagement of physicians in the strategic process should include both a written as well as a very visible collective deliberation vehicle (e.g., a physician input session).[5] A written survey allows the board to obtain information concerning the desires, insights, and needs of individual practicing physicians and medical groups. Written surveys give the board a clearer picture of physician views than can such facilitated exercises as the "future search," "consensus priority setting," or "nominal group." Surveys provide two key pieces of information concerning the organization's future:

• The medical staff's understanding of the organization's strategic direction

• The medical staff's view of the board's strategic priorities

Any physician values an honest and open line of dialogue between him- or herself and the organization. Yet, even with open lines of communication, no organization can meet all of its physicians' wishes or requests at any given time. It is critical that the board, as it sets strategic priorities and determines the distribution of resources necessary to obtain its objectives, communicate both the content and the rationale of its decisions. Physicians are unhappy when they suspect that the board has been involved in favoritism, closeted decision making, behind-the-scenes political machinations, and dishonest dealing.

Capital Planning

When related to physicians, the capital-planning process is always fraught with dangers and challenges. Every physician related to the organization will tend to see his or her equipment and technology needs as critical to effective practice. For many physicians, the way an organization addresses its capital distribution is an indication to them of their standing with senior leadership. Of course, these sentiments are not held by physicians alone. An organization's various department leaders are as committed to their individual capital needs as are physicians. At every level, the capital process is fraught with difficult emotional challenges.

Here again, good process and honest dialogue is critical. Often, health care organizations create for themselves very detailed, objective, and thorough capital priority setting processes. In doing so, however, leaders tend to forget that the capital-planning process carries with it a relational and emotional content. This reality is often over-

Involving Physicians in Capital Planning

When considering the allocation of capital, health care organizations should:

• Include physicians in setting priorities in the allocation of departmental capital

• Keep the capital process transparent and objective

• Communicate directly to physicians the reasons for making decisions regarding capital

• Give individual physicians an opportunity to react to capital decisions that do not match their own priorities

A Performance Evaluation Framework for Physicians

In devising a performance-evaluation framework for its physicians, a health care organization should apportion the tasks as follows:

- The board empowers physicians to design an effective medical performance process.
- The board approves the physician performance-evaluation process within the context of board-set expectations concerning quality.
- Physicians monitor medical practice; the board monitors the effectiveness of the process.
- Board and medical staff leaders adjust the evaluation process as technology and standards of measure change.

looked or glossed over by leaders, instead of incorporated into the deliberative process. Each physician needs to feel invested in and valued by the organization. The processes that leaders use to make capital determinations must in some way exemplify this value and incorporate it into the priority setting and the mechanisms for communicating selected capital priorities.

Physician leaders should be involved at every stage of the capital-planning process. Each year physician leaders should be rotated through the various components of the process to ensure that physician membership changes and a full range and variety of physician specialties and insights are included at the various stages of the process. Within the capital-planning dynamic, a team of physician leaders should participate with system leaders in an organized and systematic capital priority-setting process. Through this dynamic, the physicians themselves should, using an objective process (e.g., a physician presence in the final selection of the services to be affected), have a clearly articulated mechanism incorporated into the greater capital-planning process and ultimately influence in the final set of capital priorities.

Equally important are the communication and information dynamics associated with capital-planning decisions. Once they have arrived at their decisions regarding capital priorities, the organization's leaders should implement a mechanism (e.g., one-to-one meetings of the CEO and physician leaders) that communicates those decisions and the rationales behind them in a personal and interactional format. Leaders should pay attention as closely to the communication of both the process and outcome of decision making as they do to the decision making itself. When significant services are issues at stake and specific physicians have argued seriously for the capital needed for them, leaders must communicate personally the decisions, the rationales for them, and possible options related to future opportunities with regard to the specific capital issue.[6]

Credentialing and Privileging

A health care organization has no function more important than ensuring the quality of the care provided by it. Attracting high-quality physicians and ensuring a continuous high level of medical practice is a core function of the organization's board. However, this cannot occur with any level of effectiveness unless the board first develops a strong relationship with the organization's medical leaders and its medical staff. Such a relationship must operate at two levels. The organization must have:

- A regular, organized, and formalized process for credentialing and reviewing every member of the medical staff
- A legally rigorous and timely corrective-action process designed to address any irregularities in practice, clinical process, or medical outcomes

Most organizations possess rigorous credentialing programs. Fewer, however, have an effective evaluation process for members of their medical staffs.[7] Boards are extremely reluctant to take on medical practice concerns with individual physicians.[8] It is not uncommon, even in an era of high sensitivity to medical risk and error, to read about physicians who, despite long histories of compromised practice, have not been dealt with by their organization in a timely or effective manner. In such cases, the result is often financial, legal, and organizational costs. Had these organizations maintained and had been faithful to a continuous, effective medical staff-evaluation process, these serious and deleterious outcomes could certainly have been avoided.

Boards must keep on top of the medical staff credentialing and review process. This does not mean that they need to micromanage medical staff credentialing, privileging, and evaluation. What it does mean, however, is that boards must themselves critically review the processes to ensure that they are sufficiently rigorous and represent state-of-the-art technology. Here again, the board's active and dynamic interaction with the medical staff and its leadership will be a critical moderator of its ability to ensure an effective credentialing and evaluation process. Indeed, the process will be evidence of the high quality of the relationship between the board and the medical staff. At least once a year, the board should devote part of its agenda to evaluation and assessment of the mechanisms and processes associated with staff credentialing, privileging, and performance evaluation. Concurrently, medical staff leaders should enhance and improve the credentialing process, thereby reaffirming the value of its medical staff members.

Important elements that are often overlooked in medical staff evaluations are communication effectiveness, comparative financial performance, and measures of quality of care. Techniques for addressing these elements more critically have begun to emerge in the last decade. Health care organizations can—using high-quality algorithms, quantifiable clinical protocols, comparative financial performance measures, interdisciplinary relationship assessments, and individual performance portfolios—now obtain a more complete evaluation of physician performance and relationships. It should not be the board's obligation to review these portfolios; this is a medical staff responsibility. However, the board should make sure that these tools are available and used effectively by the medical staff as a part of the ongoing credentialing and privileging process.

Ensuring Clinical Quality

The reputation of every health care organization reflects its commitment to building real quality in its health services.[8] In the past, quality has been a matter more of rhetoric than measurement. Today, however, the technological means are available for more clearly defining the relationship between clinical process and quality outcomes. Because quality used to be such a subjective thing, patients and others in the community had only a minimal interest in it. Only in the past decade have information technology and clinical processes come together to produce both form and format for attaining truly valid measures of the relationship between clinical process and quality outcomes.

Even so, health care organizations and individual providers have been slow to truly "get serious" about designing and incorporating measures of quality and value into their clinical work. It is true that the cost of converting information systems so as to link clinical, financial, and operational processes is considerable. An ability to truly monitor all the elements related to quality care requires a well developed, linked, and integrated information infrastructure. Doing so, moreover, requires health care professionals to effectively embrace and use information technology as an ongoing part of clinical work. But the learning curve in this process is significant. It demands an absolute, unwavering commitment on the part of organizational and clinical leaders to create and use the information system consistently so as to successfully produce meaningful performance data. To improve clinical quality, they must believe the data, evaluate it, and use it in making decisions about personal performance improvement. Short of such a full-scale effort, quality will remain elusive.

Health care organizations have a special obligation to ensure that their health services reflect contemporary reality and the optimal art of clinical practices and processes. The transition to effective new models of clinical service and care will reflect the commitment of both the board and executive leadership. The coming of the information age obliges organizations to change their clinical structures and systems. Such a commitment requires a real willingness to learn and apply new technologies and processes. This often means stretching, challenging, and raising consciousness about emerging problems and opportunities. Technological innovations in performance accountability and measurement of the relationship between process and product are now changing the fundamental characteristics of health care work, most notably in clinical performance.

It is in this arena that the partnership between board and medical staff becomes critically important. As the technologies, techniques, and tools associated with ensuring performance make it more possible to measure clinical outcomes, board and physician leadership must ensure medical staff compliance and competence. Because this clinical and technological revolution is so transformative, careful engagement in and education of the medical staff will be an integral component of future success. Physicians need not worry about heightened scrutiny of their professional practices and subsequent clinical results. To improve clinical quality, organizations must build a structured process that maintains a data-driven approach in a way that assesses physician performance objectively. Doing so will require a strong, sustained relationship between board and medical staff, one involving a regular dialogue that is consistently informed by an effective clinical information system and constantly encouraged by a mutual commitment to advancing the quality of care.

Building an effective clinical quality performance process is no longer an option. The issue

Creating a Context for Quality

The board should, in creating a context that encourages improved quality, accept the following axioms:

- Evaluation of a physician's performance should include evidence of his or her involvement in establishing evidence-based clinical processes.
- A physician's participation in the organization's clinical quality activities should be seen as evidence of his or her commitment to medical quality.
- The organization's interdisciplinary quality activities should demonstrate how medical "best practices" were integrated.

for the board is not if or when such a process should be constructed, but, rather, how to build it successfully while ensuring full engagement in and ownership by the medical staff.

Measuring Medical Staff Satisfaction

Few things are more important to a health care organization than a fully engaged and satisfied medical staff. This engagement and satisfaction will not occur by itself. Like any other relationship, the one between the organization and the medical staff requires constant attention. Boards must be aware of the perceived state of their relationship with the medical staff. Many are the health care leaders and organizations who have come to regret their lack of attention to this key relationship.

The board should expect regular status reports regarding medical staff satisfaction issues and concerns. It should have specific data on current physician views of therapeutic changes, financial concerns, admission and service issues, business and strategic decisions, capital priorities, interdisciplinary interactions, and quality of care concerns. The board should expect to deal as regularly with physician concerns as it does any other item on the governance agenda.

The board's goal should be to become aware of key physician issues before they become critical. Highly effective board and executive leaders are able to anticipate both positive and negative physician reactions to important organizational decisions, and, by anticipating these reactions, to make the appropriate adjustments and responses to them. Certainly, not all board decisions can or should match physician perceptions and satisfy physician wishes. At times, legitimate differences must be accepted as a part of effective strategic positioning and planning. Not every physician can benefit from the choices that boards must make to ensure the organization's future viability. What physicians complain most about is not so much board decisions they disagree with—even those that affect their professional or personal lives—but the fact that good communication did not occur before the decisions were made. Descriptors such as "sabotage," "hidden agendas," "insensitivity, and "uncaring leadership" are often heard in such situations. The resulting mistrust can be an insurmountable barrier to any future relationships.

"Growing" the Relationship

These five key areas of relationship between health system board and medical staff constitute a checklist for good board-medical staff leadership. It is wise to periodically be reminded of these basic relationship imperatives. It is in failing to address these foundational relationship issues that a high percentage of health system-medical staff problems originate. Including them on the board's regular agenda will be of critical importance to advancing board-medical staff relationships.

Awareness of this fact is certainly growing, but one continues to be surprised by the frequency with which serious crises involving medical staffs arise in even the most the routine health care services. Attention to the simple details of human interaction and communication, as well as the formal inclusion of these issues in the governance process, goes far in ensuring a positive and committed relationship between these important stakeholders. □

Measuring Physician Satisfaction

When measuring physician satisfaction, health care organizations should keep in mind the following axioms:

- Because each organization has its own culture, that culture must be taken into consideration when devising indicators of physician satisfaction.
- Physicians should be involved in the identification of satisfaction measures.
- The board should conduct physician-satisfaction processes at regular intervals.
- Response to the outcomes should be quick and fit the specific issue.

NOTES

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8. See R. Barry, A. Murcko, and C. Brubaker, *The Sigma Six Book for Healthcare*, Health Administration Press, Chicago, 2002.