

Medical Staff Structure

Information Paper

Overview

As we approach the 21st century, many health care entities have moved toward consolidation. Concurrently, medical staffs have come to the realization that they, too, must reassess their structure in order to remain an effective partner in the hospital-physician relationship. In a recent study 30% of medical staffs are in the midst of reorganizing, 29% have reorganized, or 23% are thinking about it. Most commonly, the objectives are to improve staff efficiency and reduce staff/committee meetings.¹

The JCAHO recently implemented a change in their MS.1 standard to allow for more than one medical staff in a particular health care organization if it makes sense to do so. This change in JCAHO philosophy emanated primarily from hospital mergers/affiliations whereby a much larger and potentially geographically distanced organization with multiple “campuses” replaced multiple independent facilities. Nonetheless, JCAHO would prefer to see consolidation of the medical staffs of previously independent facilities wherever possible.

Emergency medicine is deeply involved in this change process. This is due not only to health care entity mergers, but also to the unique contractual arrangements that exist between hospitals and emergency medicine groups. In many instances the emergency department (ED) services contract is written in a manner that supersedes the medical staff bylaws, therefore often relinquishing due process rights and effectively ceding to the administration total control of the hospital-based contracted physician groups. Emergency medicine has always been a transitional specialty and needs to continue to be aware of the environmental needs and changes.

An additional consideration is that emergency physicians (EPs) are often viewed by other medical staff members as “fence sitters”, due to the close contractual relationship that exists between the hospital and the ED group. The perception is that EPs are more aligned with the interests of the hospital than with the bulk of the medical staff. This perception makes it more difficult for EPs to have a core and meaningful role in medical staff organizations and medical staff structures.

Medical staff structure models vary tremendously. As pertains to the interests and concerns of emergency medicine, direct hospital employment of EPs where such arrangements exist, as well as unique ED services contract considerations, often influence how the emergency medicine department is structured within a given medical staff configuration. Emergency medicine has achieved autonomous department level status in many institutions, yet with the trend to minimize the number of meetings and members of the hospital governance groups, this is likely to change in coming years.

In this information paper, we will discuss some of the more common medical staff organization models in an attempt to broaden our membership’s awareness of these issues. As in politics, medical staff structures are local, i.e., arranged to meet the overall needs and desires of a given medical staff. There is no right or wrong. The bottom line is that individual EP groups and EDs must understand the pros and cons of the various medical staff structures, in order to advocate for the most useful local relationship.

¹ *Healthcare Leadership Review*, November 1997.

Types of Medical Staff Structures

Many medical staffs are structured with an autonomous Department of Emergency Medicine, similar to other clinical departments such as medicine, surgery, anesthesiology, obstetrics, pediatrics, etc. There is a chairperson for each department who sits on the Medical Staff Executive Committee meeting, usually chaired by the president of the medical staff. A typical medical staff organization is shown in Figure 1.

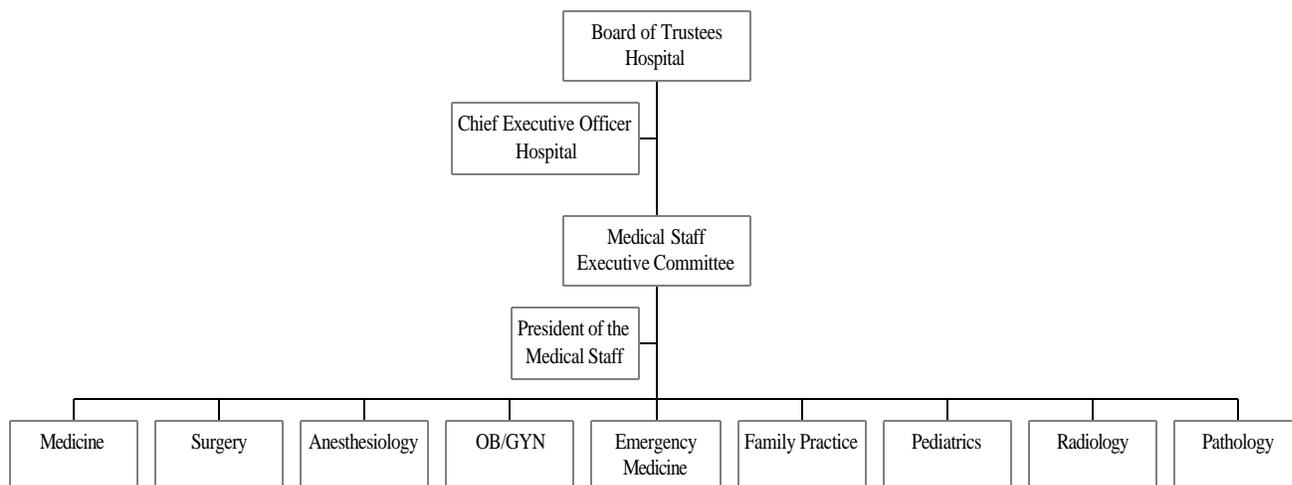


Figure 1. Typical Medical Staff Structure

There are advantages to an autonomous Department of Emergency Medicine. The staff physicians feel they have more input into the patient care policies and can better advocate directly for their patients.

Peer review and credentialing are usually the responsibility of the department chairperson, who is usually an EP. The staff EPs often feel that their issues and their concerns are being heard by a person who understands the unique practice of emergency medicine.

The department chair in this model sits on the Medical Staff Executive Committee and, therefore, is involved with the global issues of the medical staff and/or the hospital. He/she is able to directly address these issues from an emergency medicine standpoint.

There are disadvantages also to an autonomous Department of Emergency Medicine. There are more monthly meetings that need to be attended by physicians, especially the department chairperson and other medical staff leaders who are trying to resolve interdepartmental issues. The bureaucracy of trying to get agreement on policies and issues affecting multiple departments can be both time-consuming and frustrating.

When the Department of Emergency Medicine speaks at the Medical Staff Executive Committee or with hospital administration, it is often viewed as a small department without a significant power base, again causing delays and frustration in effecting change.

To mitigate some of the disadvantages, the chairperson of the Department of Emergency Medicine must be a good communicator. He/she must build bridges with the chairs of the other clinical departments and with hospital administration. The chairperson should spread some of the administrative duties to other members of the department to allow them to have a real input into the clinical affairs affecting patient care. In addition, this will free the department chair to meet on a frequent basis with his/her peers. Both intradepartmental and interdepartmental meetings must have specific agendas and be time limited. Unnecessary meetings must be eliminated.

Many medical staffs are restructuring to become more efficient. There is usually a consolidation of departments and/or committees. Often, emergency medicine is placed in the Department of Medicine (Figure 2). Other services often contained within the Department of Medicine include internal medicine, family practice, neurology, psychiatry and radiology. In a similar model, emergency medicine is placed in the Department of Surgery (Figure 3), which may also include anesthesiology, pathology, and various surgical subspecialties. In some instances, emergency medicine is part of a separate department of Community/Ambulatory Medicine (Figure 4). Within this department, there are other services such as family practice, psychiatry, outpatient medicine, as well as emergency medicine.

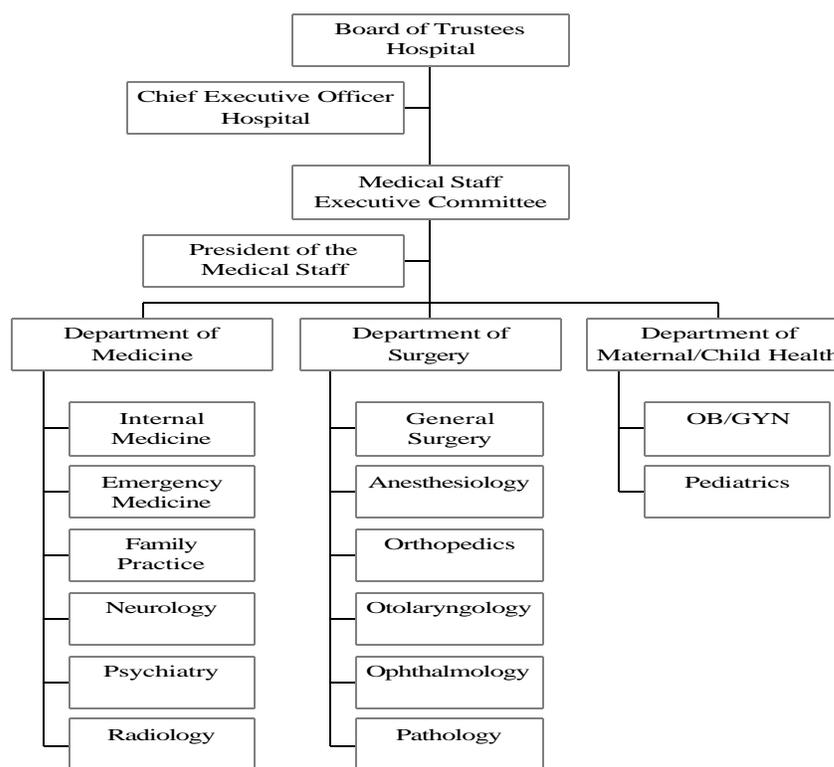


Figure 2. Department of Medicine Structure

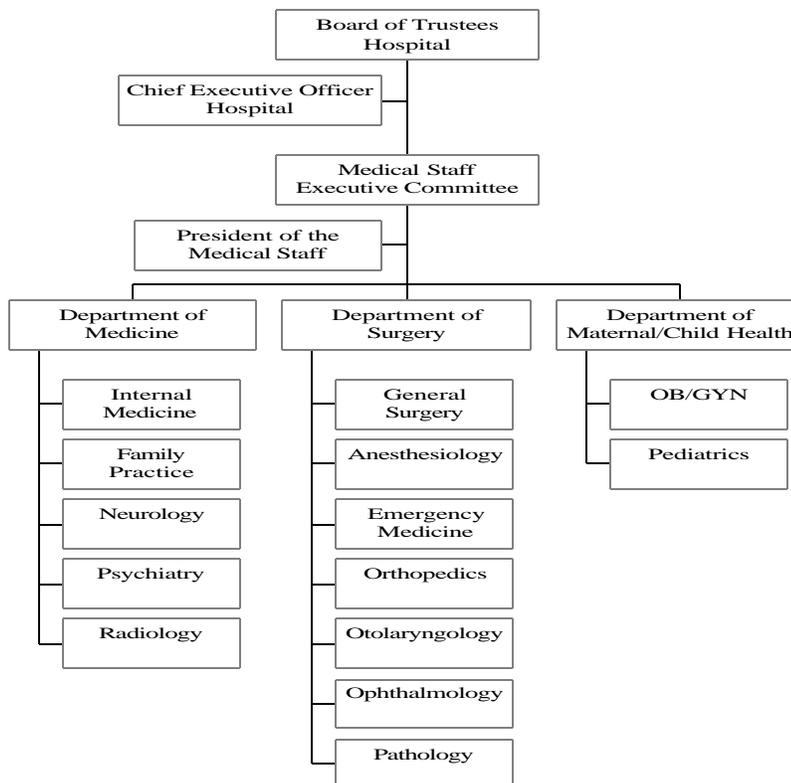


Figure 3. Department of Surgery Structure

Less common models of medical staff structure may include: a department of hospital-based physicians, a multispecialty group, or a physician-hospital organization. A Department of Hospital-Based Physicians may include emergency medicine, radiology, anesthesiology, pathology, and hospitalists; leadership of the department may rotate from one specialty to another, or a strong leader could provide ongoing direction.

For a multispecialty group, a good example is the Permanente Medical Group, which is part of the Kaiser Permanente health maintenance organization. Once a physician is voted in as a Permanente shareholder, he/she has equal standing and a vote in the governance of the medical group. An elected chief of the ED negotiates with the physician-in-chief of the Permanente medical facility to allocate resources within the budget.

Physician hospital organizations (PHOs) are becoming more common as a vehicle for contracting with insurers/employers to assure quality care and manage costs. As managed care continues to increase, such joint ventures between physicians and hospitals are also likely to increase and may ultimately be incorporated into the medical staff structure.

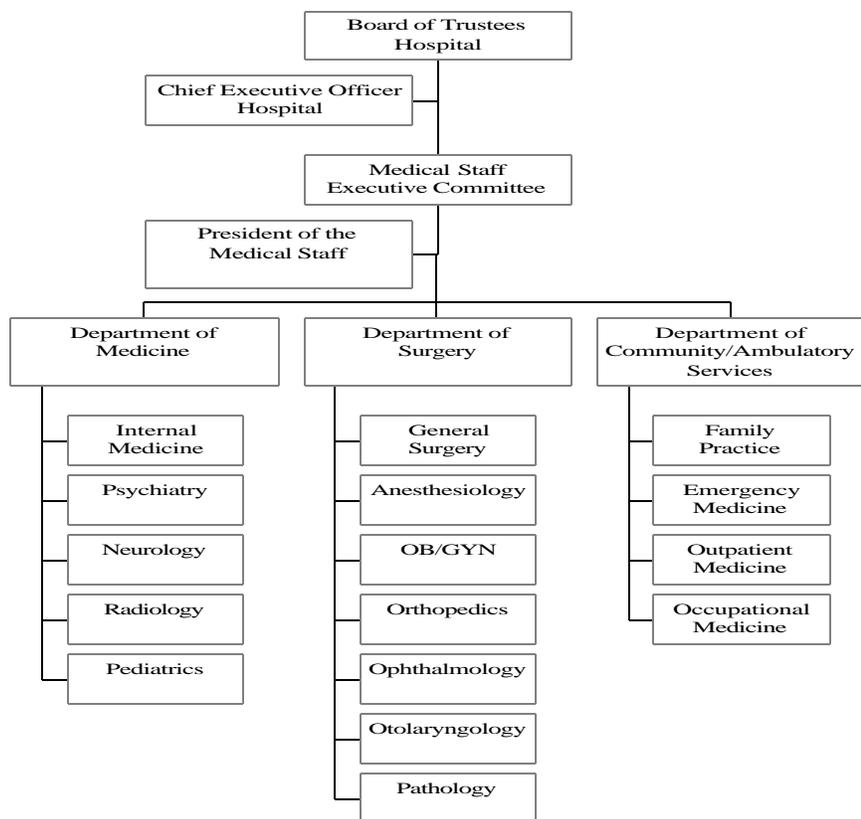


Figure 4. Department of Community/Ambulatory Services

There are certain advantages for emergency medicine to be in a larger department. The consolidation of departments means fewer meetings for medical staff members to attend and a decrease in the bureaucracy. Issues that need resolution can be handled within the department as opposed to additional separate meetings between two autonomous departments. Once consensus within the department occurs, there is an increased ability to negotiate with other departments and hospital administration. Decisions within the department are then easier to implement. Communication among the different services within the department is enhanced.

With the consolidation of departments, fewer medical staff leaders are needed, freeing other members of the department to pursue other activities. The medical staff leader or department chair has a broadened area of responsibility and, therefore, a greater knowledge of the issues facing the medical staff and the hospital. Getting agreement on a course of action is easier with fewer medical staff leaders or department chairs because of their greater understanding of the issues.

The disadvantages of consolidated departments with fewer medical staff leaders are that EPs and other members of the medical staff may feel disconnected and disenfranchised. Emergency physicians and other members of the medical staff may feel a loss of their ability to advocate for patients and a loss of professionalism. Staff EPs may feel a loss of influence on patient care policies. Because peer review and credentialing usually fall into the purview of the department chair, EPs may have difficulty if the department chair does not understand the role of EPs.

In addition, the responsibilities and time commitments of the medical staff leaders or department chairs are greatly increased. This will require increased remuneration for these leaders. In the past in many smaller hospitals, the department chairs and medical staff leaders were voluntary positions, while payment will now be required if significant time commitments and responsibilities continue to increase.

In the model of consolidated departments, EPs must strive to be in leadership positions. The only hospital committee that JCAHO now requires is the Medical Executive Committee (MEC), which underscores the significance of this particular committee within the hospital power structure. It is essential that an EP either sit on the MEC or be represented by another physician who has a strong interest in promoting the welfare of the ED. All other medical staff functions required by the JCAHO can be maintained within medical departments or divisions rather than in a particular committee structure. Patient care policies, department operations, credentialing, peer review, performance improvement, due process, and medical staff bylaws are among the important activities that can be accomplished in a variety of ways. To mitigate the disadvantages within the department there should be a distinct service of emergency medicine. Responsibilities for peer-review and credentialing of EPs should be delegated to the Chief of Emergency Services. Emergency physicians should have a separate meeting at least quarterly to give input to the service chief concerning peer review, credentialing and patient care policies. The emergency services chief must be influential enough to get the department to endorse those issues that are important to emergency medicine.

There is no perfect medical staff structure. There are advantages to an autonomous Department of Emergency Medicine just as there are advantages to consolidating departments, with emergency medicine being part of either the Department of Medicine or Department of Ambulatory Medicine. The increased efficiency and decreased bureaucracy that comes with consolidating departments is offset by the loss of autonomy and the feeling by EPs of being disenfranchised and unable to advocate for their profession or for their patients. The advantages of an autonomous department of emergency medicine is offset by the decreased powerbase and the difficulty in obtaining consensus as well as the increased number of meetings. In general, it is believed that most EPs would rather have an autonomous department where their concerns can be addressed directly to the department chair, to the medical staff leadership, or to the hospital administration leadership.

Recommendations to Consider

If EPs find they have no choice but to be consolidated into a larger department, the EPs would be well-advised to insist on the following:

1. A separate identified service within the department for addressing the issues concerning emergency medicine, including:
 - a. a designated service director leader;
 - b. primary responsibility for reviewing and approving the credentials of the EPs;
 - c. primary responsibility for doing peer review for issues that arise concerning EPs;
 - d. primary responsibility for reviewing and revising patient care policies that affect the patients presenting to the emergency service area.
2. Regular meetings of the service so that the EPs have an opportunity to present their views on issues.
3. The leader of the emergency service should have a direct reporting relationship and hopefully, a significant influence with the department chair.

*Developed by members of the Subcommittee on Medical Staff Structure
Emergency Medicine Practice Committee
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