Medical Staff Organizations: A Persistent Anomaly

Instead of rehabilitating a failed model for organizing medical care, reformers should devote their energy to devising a new one.

by Ken Smithson and Stuart Baker

ABSTRACT: Medical staff organizations (MSOs) originated to reconcile hospitals’ hierarchical management structure with the professional autonomy demanded by physicians. MSOs’ primary purpose is to hold physicians collectively accountable for patient safety and clinical performance. However, in an era of declining hospital activity, most physicians no longer understand this. More often, they view the MSO as a political body whose purpose is to foster physicians’ interests with the hospital’s administration and board of trustees. In many hospitals, it is difficult to determine whether the MSO is the key to clinical improvement or the biggest barrier.

In their paper, Elliott Fisher and his colleagues show that by combining the right data with the right software, it is possible to describe the care of populations relative to specific hospitals and the physicians that refer to them. They suggest that performance information could be the basis on which “extended hospital medical staffs” could be assigned accountability for the quality and cost of communities’ health.

Beyond the technical considerations, the larger question is the suitability of this solution. Robert Berenson and colleagues’ paper and our own research indicate that the present vitality and effectiveness of medical staff organizations (MSOs) is alarmingly low and declining rapidly. Before charging MSOs with the care of entire communities, we believe that it is worth reviewing their origins, structure, and current reality.

History and organizational structure.

MSOs were the solution to a dilemma that arose from the collision of two social movements almost a century ago. Hospitals were restructuring along the lines of the bureaucratic model that was rapidly replacing other types of organizational structures. Elliott Jaques called these “management accountability hierarchies (MAHs).” An MAH’s ultimate authority flows from an “association,” examples include investors, communities, professions, religious groups, and so on. The association chooses its representatives in the form of a board, determines goals and objectives, and selects executives to manage the MAH organization, which in turn performs work.

However, associations are fundamentally different from MAHs because their members are equal to each other; accountability is limited to a mutual interest in the organization. As a result, associations have a poor track record controlling the behavior of their members;
consider recent headlines on clergy, lawyers, accountants, and members of Congress.

In contrast, MAHs have the authority to employ, fix wages, determine work content, and do performance appraisals; authority and accountability are delegated in tiers down through layers of management. Although they were uncommon at the beginning of the twentieth century, by the end of that century it is estimated that 90 percent of the work in the United States was carried out by MAH organizations.

While hospitals were reorganizing, physicians were struggling to maintain autonomy. All around them, white- and blue-collar workers were being absorbed by corporations or joining unions. Physicians argued that their relationship with patients was unique and that being accountable to a third party constituted a conflict of interest. Further, in making life-and-death decisions, they felt that their role merited special considerations; among these was the precept that only physicians could judge other physicians’ performance. Physicians were virtually unique in their ability to pull this off; preserving autonomy became the key to their economic success throughout the twentieth century.4

Boards were confronted with competing demands of organizational efficiency versus physician autonomy. They responded by splitting responsibilities. The hospital administration was accorded oversight of the plant, employees, and finances. Responsibility for patient safety, clinical performance, and admitting privileges went to physicians, who implement through an “association,” the MSO. Thus was born American hospitals’ peculiar bifid organizational structure and many a local saga.

**Environmental issues.** Each year VHA polls the executives of its 1,400 member hospitals to identify their most important concerns. In recent years these concerns included revenue, clinical quality and patient safety, and maintaining an effective workforce. Inevitably physician relationships are also near the top of the list. Periodically, VHA also conducts national surveys of physicians to understand their perspectives and the most pressing issues. It turns out that there is overlap in only one important area: Hospitals and physicians are both very concerned about revenue.5

This reflects the sea-change in health care economics since the advent of managed care. Third parties now effectively control pricing. Real physician income has lagged inflation for years, while office overhead has increased twofold, mostly for administrative functions mandated by the government and health plans.

In a business environment characterized by high fixed overhead and inelastic pricing, the primary strategy is increasing the volume and dollar value of goods and services. Given the nature of their work, most physicians are able to increase their income only by seeing more patients and doing more cases. The rate-limiting factor is physicians’ time. For those few with the necessary capital, there are also opportunities to compete profitably for higher-value services usually provided in other sectors. As Berenson and colleagues point out, a key target in many markets is services traditionally provided by acute care hospitals.

Although increasing service volume and value might work at the individual physician level, the ultimate feedback mechanism is national health care spending. When total use multiplied by price exceeds the national budget, the Centers for Medicare and Medicaid Services (CMS) is obliged to reduce physician reimbursement (in 2007 a reduction of 5 percent is planned, and health plans will surely follow), and the cycle begins anew.6 The result is a system that pits physicians against other physicians and is perfectly designed to accelerate inefficiency and clinical mediocrity. But we digress.

**Impact on MSOs.** Hospitals’ revenue is tied closely to their medical staffs. Physician participation is essential to improving effi-
ciency and clinical performance. As more and more payers pitch "pay-for-performance," these issues are becoming even more pressing. But who exactly do hospitals work with?

The majority of doctors on the medical staff are office based and preoccupied with maintaining their own incomes. Although still loyal, they have to balance the value of the hospital activities against the opportunity costs of lost office revenue and time with their families. It is no surprise that they are spending less and less time in the hospital.

Increasingly, patients who need hospitalization are referred to hospitalists; intensivists; and trauma, emergency, and other hospital-based specialists. Although these specialists make up only 20 percent of the medical staff, they do 80 percent of the work in the hospital.

In the past, the office of President of the Medical Staff was the pinnacle of a physician’s career. Now MSO leaders are often selected by the administration and must be paid for their efforts. Overall, physicians’ trust in administration and MSO leaders is marginal.

Perhaps most disturbing of all, most physicians no longer understand that they are collectively responsible for patient safety and clinical performance. In fact, a majority believe that this role has been assumed by the hospital administration.

MSOs’ safety record. The scorecard on MSOs’ twentieth-century performance ensuring patient safety and clinical excellence is the Institute of Medicine’s report To Err Is Human and the scant progress made since it was published in 1999. Our research indicates that each year nearly half of physicians see patients who sustained severe injuries or died as a result of medical errors, but only a few physicians are dissatisfied with the current level of safety in the hospital. Although they might not be pleased with the results, physicians somehow don’t identify with them.

MSOs are just not cut out for effective accountability. Their only real authority is the power to restrict or revoke privileges. As associations, they must work within an arcane political structure and follow detailed due process. Officers are subject to sizable legal risks that further discourage discipline. Many an aggressive MSO officer has learned, to his or her chagrin, that the worst physicians always have the best lawyers. The cards are heavily stacked in favor of physician autonomy versus their accountability.

How, then, do hospitals improve clinical performance? The short answer is, seldom through their MSO. Most common appears to be what is called the “shadow system.” Physicians interested in a particular topic or clinical issue volunteer their time and skills as part of a multidisciplinary team working outside the MSO. The administration supplies the necessary human and performance improvement resources. Working together, the team identifies and tests solutions. Once validated, the reforms are reviewed by the MSO for formal approval. The MSO’s role is not clinical leadership but “advice and consent.”

Although MSOs have managed to survive the twentieth century, as an organizational structure, they are an anomaly and a poor candidate for the twenty-first. There is little reason to believe that in their current guise, MSOs would be any more effective outside the hospital where they have no authority. Responsibility for communities’ health clearly needs to be matched with accountability, and physicians are an essential element. Given what we know of MSOs, however, the nation’s energy would be better spent developing innovative models than rehabilitating a failed one.
NOTES


