Board Oversight of the Medical Staff: A Critical Responsibility

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Hospital board members must grapple with enormous governance challenges in these tumultuous times. In healthcare, we see volatile market forces, rapid technological change, reimbursement uncertainties, and political incoherence on the national stage consuming the attention of boards trying to chart a viable path forward for their institutions. In such an environment, it is easy to overlook the critical responsibility the board has to oversee the hospital's organized medical staff. Indeed, the governing board truly has only two direct reports: the hospital (or health system) CEO and the organized medical staff.

The major tasks delegated to the medical staff may seem routine and "old hat" to long-standing board members. However, the truth is that medical staffs (and therefore the boards that oversee them) are being faced with new and growing challenges that go to the heart of whether a hospital delivers safe, high-quality care. For example, the area of practitioner credentialing (possibly the most valuable patient safety activity a hospital undertakes) continues to see significant new developments. Most hospitals and health systems are dealing with rapid growth in non-physician practitioners, telemedicine physicians, locum tenens doctors, part-time and low-volume practitioners, aging healthcare providers, and applicants with some element of concern in their backgrounds. These concerns can range from malpractice history to episodes of impairment, and from incidents of unprofessional conduct to requests for privileges for which the applicant has minimal experience.

Too many boards rely exclusively on their medical staffs to vet credentialing concerns without really knowing how well physician leaders are performing this work. Most hospitals and health systems underinvest in physician leadership training and therefore the quality of medical staff review for any particular practitioner application may vary widely. How is a board to know whether reliance on medical staff input is justified? Indeed, most boards do little to educate directors on best practices in credentialing and medical staff oversight. This results in a great deal of "rubber stamping" of medical staff membership and privileging applications at the board level.

The Consequences of Poor Oversight

The adverse consequences of poor governance oversight of the medical staff can be significant. Lawsuits are on the rise from coast to coast that allege corporate negligence on the part of hospitals and health systems for inadequate or improper credentialing of staff members. These can be large financial judgments and can do serious harm to the reputation of a community hospital. Doctors who claim they were kept off staff or lost privileges for improper reasons or without reasonable due process can win even larger judgments that include punitive damages.

Boards can get their institutions in trouble by being either too passive in their medical staff oversight or by being improperly intrusive. Passive boards usually lack sophistication regarding good credentialing or peer review practices, fail to question medical staff leaders appropriately about their recommendations regarding applicants, rarely (if ever) carry out audits of the credentialing process to ensure that it is functioning properly, and overlook "red flags" in order to fill understaffed clinical specialties.

An example of such board passivity can be seen in the 2013 lawsuit, *Guinn v. Mount Carmel Health*. Dr. Guinn, a private cardiologist on the medical staff, sued after he was suspended and subsequently had non-renewal of his electrophysiology privileges. He won a judgment of over a million dollars against both the hospital and the doctor who initiated the investigation of his privileges. The peer review and credentialing processes in this case were blatantly corrupted, yet the board failed to notice any deficiencies in the events that took place.

The opposite situation occurs when one or more board members advocates aggressive steps against a medical staff member without the concurrence of medical staff leaders. While the governing board has final say over medical staff membership and privileges, overriding medical staff recommendations can be a treacherous road to travel. Such a move can rupture good working relationships with physician leaders and can lead to harmful litigation.

An example of this is seen in a recent case, *Miller v. Huron Regional Medical Center*. In that situation, at least one board member reportedly became concerned about the quality of a medical staff surgeon because of complaints from his neighbor suggesting poor care. The board demanded aggressive peer review and pressured medical staff leaders to curtail the surgeon's practice. Medical staff leaders could not substantiate the concerns expressed at the board level, but communicated to the surgeon that she had incurred the displeasure of the governing body. The surgeon cut back her surgical activities in response and the hospital reported this action to the National Practitioner Data Bank. Dr. Miller, in turn, filed a lawsuit. While the litigation

Key Board Takeaways

Medical staff oversight is a critical board responsibility that can easily be overlooked in today's busy healthcare environment. Hospital and health system boards should:

- Insist that both physician leaders and directors are adequately educated to address the latest challenges in medical staff credentialing and peer review.
- Consider periodically requiring an audit of medical staff credentialing functions to ensure they are rigorous and contemporary.
- Utilize a checklist to identify credentials applications, which will require discussion at the board level and prevent "red flags" from flying under the radar.
- Ask hospital and physician leaders to keep the board abreast of efforts to address practitioner morale and burnout.

is not fully concluded, at this point the doctor has been awarded over a million dollars in damages because she clearly was not treated with the requisite due process and objectivity required. While it is important for board members to ensure that medical staff leaders are adhering to proper process and objectivity when carrying out peer review and making credentialing recommendations, this case illustrates that the board itself can be guilty of such breaches.

Going Beyond Peer Review and Credentialing

Board oversight of the medical staff goes beyond ensuring the delegated activities of peer review and credentialing are sound. In today's healthcare environment, strong working relationships with the professional community are essential. The board should be interested in how well the medical staff develops a culture of collegiality and excellence, and how collaborative and respectful the interactions are between doctors, management, and the board. Success in these areas reduces staff turnover, improves recruitment, and helps set the stage for success in quality improvement efforts and moves to create a high-reliability care environment. Numerous engagement tools are available to assess the attitudes of medical staff members and boards can get firsthand knowledge by inviting key physicians to board retreats or to participate in strategic planning activities.

The epidemic of physician burnout in hospitals and health systems across the country is a matter that should be of concern to every board. Physician burnout has been linked to increased rates of medical errors, turnover, and higher mortality ratios in hospitalized patients. The actions of management and physician leaders have been shown to have a significant impact on the magnitude of practitioner burnout. Boards should stay informed of the efforts being made by both hospital and medical staff leaders to gauge the extent of staff burnout and to ameliorate factors known to contribute to its rise.

In 2018, despite the tumultuous state of the healthcare industry, hospital boards cannot afford to neglect their core responsibility to bring diligence to medical staff oversight.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. He can be reached at tsagin@saginhealthcare.com.