Medical Practice in Organized Settings

Redefining Medical Autonomy

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- Physicians are perplexed by the ongoing erosion of their individual professional autonomy. While the economic forces underlying such change have received much attention, the evolution of new organizational forms that modify and often diminish medical autonomy is less well understood. The practice of medicine is becoming more organized and more hierarchical. We emphasize the importance of organized medical groups, including the medical staff organization, as structures for appropriate peer monitoring, and for counterbalancing the burgeoning influence of governance and administrative constraints on practice. There is an ongoing tension within organizations between management, governance, and physicians. Over time one or another of these groups achieves some measure of dominance, but good management requires a balance of power. The role of the medical staff, which is poorly represented in some health care institutions and under threat in others, is considered. In general, we find that medical work is becoming more hierarchical, and that physician “leaders” do not substitute for collegial processes. (Arch Intern Med. 1989;149:1509-1513)

Health care provision in the United States is increasingly monetarized, organized, computerized, centralized, and paradoxically more competitive and regulated. Changes in the ways in which care is provided, and in the structure of medical practice in organized settings have resulted in significant modification and diminution of medical autonomy.

In the midst of a changing system, physicians often feel beset. They are monitored and “managed” by regulators, insurers, administrators, lawyers, and even, at times, by patients. They are lectured by academics, who endeavor to define “quality” of care, and provide prescriptions for maintaining high-quality care, limiting resource expenditures, and enhancing equity of access. Practitioners look to colleagues for support and, at times, find economic competitors. Their professional organizations are concerned about possible loss of tax-exempt status, and they carefully monitor these activities, seeking legal consultation so as not to run afoul of possible antitrust litigation. And when the physician speaks of the perceived importance of independent practice, that interest is often dismissed by others as self-centered, or economically defined, or as unrelated to scientific knowledge.

This article is directed toward an understanding of the evolving structure of the organization of medical care in health care settings, and to how structure impacts medical autonomy. We explore sources of conflict between administrators and physicians found in the organizations and systems in which they work and the implications of such conflict for the provision of medical services. We consider how the roles of physicians might be structured within organizations. Issues of interprofessional conflict or collaboration are not addressed in this article as we do not wish to obscure the nature of relationships of physicians to organizational management and to the organization. Finally, because our major focus is on practice and the provision of care, we only touch on those environmental issues (eg, regulatory, antitrust, economic) that impact on organizational change and the nature of medical staff organizations.

THE PHYSICIAN IN THE ORGANIZATION

Within our nation, physicians historically have perceived the organizations that served them and their patients as settings for individual practice. Their authority over other professional groups was expressed through prescription, and not bureaucratically. The physician was not an employee of the hospital to whom authority had been delegated. Long-established tradition and the enactment of medical and nursing licensing laws gave the physician the right to require others to ensure that reasonable medical orders were carried out when they were written for patients for whom the physician was responsible.

During this century, as the hospital gained in importance as a setting for practice, physicians sought to strengthen and to preserve their role as independent practitioners. Rosenberg, in his scholarly examination of the development of the hospital in America, describes the continual flux in relationships among hospital governance, physicians, and administration. In the early history of our nation, trustees controlled health care organizations, while physicians struggled to assert some influence. As medicine became more technical and
scientific, the role of physicians became more prominent in the
definition of policy and practice. Later, as health care settings
became more complex, administration became a significant
independent force, and with it arose the development of bu-
reaucratic structures to order the work of other professionals
and nonprofessionals.

The evolution of the organized medical staff in the hospital
setting formalized medical control over the conduct of the
clinical work. It insisted on the collegial relationship of physi-
cian to physician, and it defined the nature of the clinical
responsibilities of other professionals. It determined who
might be admitted into practice within the hospital and what
qualifications for practice might prevail. The structured med-
ical staff provided for limited regulation of practice through
professional peer review. It provided a setting in which indi-
vidual practitioners could meet and work together.

Today, over one quarter of all physicians are employed, and
physicians are now often subordinates in organizations over
which the profession once exerted control. Individual physi-
cians are increasingly monitored by organizational seniors.
Organizations now detail individual task goals, monitor their
attainment, and regulate the means by which such goals are
realized. Not only is the individual authority of the physician
diminished, but professional expectations as to their status in
the organization, their rights, and the treatment accorded
them by managers and other clinicians may be frustrated.

Yet, health care institutions remain dependent on extensive
medical oversight of practice. Freidson describes how organ-
izations have maintained medical oversight while limiting the
influence of individual practitioners. Freidson identifies
significant stratification in medical practice. Elite groups,
largely based in academic and research settings, have devel-
oped. Their members have significant roles in professional
organizations and government committees and planning
groups. They act to “develop standards enforced to govern
the performance of the rank and file professional worker.” Freid-
song also describes the growth of an ever enlarging group of
midlevel functionaries who help administer the systems in
which their colleagues work, using the criteria established by
elite groups.

The role of the full-time medical director is one established
by hospitals to serve as liaison between the administration,
who pays his or her salary, and the medical staff. The Ameri-
can Medical Association identifies the rationale for such a
position: “A physician is best equipped to facilitate communi-
cation between the medical staff and administrators... Having
a physician skilled in medical administration reassures the
medical staff that administration is genuinely concerned
about the unique demands physicians face in the prac-
tice of their profession. At the same time, the hospital’s chief
administrative officials need assurance that complex policy
questions which directly affect clinical issues are being han-
dled by a competent full-time manager who is knowledgeable
about medical procedures and also aware of modern manage-
ment techniques” (Hospital Medical Staff Section Newslet-
er, June 1987).

The full-time chief is accountable to management, yet if his
colleagues reject his leadership, he cannot function. Thus,
most of these individuals are selected from within their own
hospitals where they walk along a precarious boundary be-
tween hospital management and physician colleagues. They
must negotiate administrative, clinical, and political de-
mands. As physicians enter into bureaucratic leadership
roles, they become accountable to and often directed and
managed by numerous others. Indeed, as physicians become
employees responsible for clinical units, they assume manage-
rial authority, often without explicit definition of the scope or
limits of their responsibility, authority, and accountability.

There seems to be a paradox, for as medical care gets more
complex there is less and less time and opportunity to become
managerially competent. Yet, physician managers are ex-
pected to understand both clinical and managerial tasks.

With the proliferation of new health care services (eg, Health
Maintenance Organizations [HMOs], emergiceters, com-
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munity mental health centers) physicians have been tied
more clearly and firmly into the administrative structure of
organizations, often in subordinate, dependent roles. These
new services have developed without structured medical staff
components that establish clear medical standards and over-
sight of practice. Few have structures resembling the tradi-
tional medical staff organization, and they are not required by
accreditation review processes. For example, a recent review
of the Joint Commission on Accreditation of Health Care
Organizations requirements for HMOs highlighted the impor-
tance of the examination of the structure of management (Mod-
ern Healthcare. March 1988:25). In addition, review of
medical practice is mandatory, but no specific structure is
required for medical staff organization. In 1988, the Joint
Commission on Accreditation of Health Care Organizations
proposed standards for community mental health centers and
other nonhospital based facilities that give the governing
authority the right to more heavily identify professional and
medical staff structure. No requirement for an organised
medical staff exists. In the Joint Commission on Accredita-
tion of Health Care Organizations’ review of HMOs and com-
munty mental health centers, formal examination of governance
and administration is important. Monitoring medical care is fun-
damental. However, the organization of medical care can be
hierarchical and bureaucratic with a defined medical supervi-
sory structure, and it does not require an organized medical
staff.

While physicians are deeply concerned about the impor-
tance and the relative independence of the medical staff in
hospital settings, only limited attention has been paid to this
issue in smaller facilities (eg, HMOs, freestanding rehabilita-
tive facilities, community mental health centers) even when
these facilities are part of larger corporate bodies (Modern
December 18, 1987:3). Physician administrators in these set-
tings are often untrained for their responsibilities, including
responsibility for the oversight of practice activities. Younger
medical administrators who pursue administrative training
may be identified as lacking clinical credibility. Older, senior
clinicians pressed into such work may have limited interest or
aptitude for the work. These medical-administrator roles are
particularly problematic and their incumbents are often
caught between the, at times conflicting, interests of medical
staff members, with whom they work, and the organization,
which pays their salary.

The development of new organizational structures in health
care reflects changes in financing, increased legal accountabil-
ity of management and governance, and changes in the growth
of information technologies. These changes modify the
relationships among actors both within and across groups in
the health care provision professions. Perhaps the most dis-
rupting change is that the physician is more distant from the
patient’s office, the patient’s family. More technological and
specialized practice, as well as economic forces, including produc-
tivity goals that define average time per visit and patient visits
per day, contribute to this. This means that care is no longer
continuous or entirely personal. The fundamental way in
which these changes have been addressed is through the
organizations in which care is provided. As physicians are
increasingly filling subordinate roles in organizations, man-
agement must thoughtfully integrate them into organiza-
tional structure.
STRUCTURING THE ROLE OF PHYSICIANS IN THE ORGANIZATION

An organization that employs a significant number of professionals is almost necessarily filled with tensions, ambiguities, and extraordinarily complicated relationships. In these settings each professional is required to recognize two separate authority structures: professional authority and hierarchical organizational authority. A critically important organizational task is the development of a sense of some congruence between organizational and professional goals.

The Organized Medical Staff

Within hospitals, the organized medical staff has represented the needs of physicians to administration and to governance structures. It serves to legitimize the work of the physician, to reinforce medical values, and to challenge expediency in patient care. It sets internal standards and holds members accountable to the standards they set; it serves professionals, hospitals, and patients.22

As the practice of physicians and health care organizations becomes more regulated and subject to increased legal challenge, the independence of the organized medical staff is under repeated attack. Since hospital governance has the established responsibilities to ensure that only qualified staff and physicians practice, and to monitor that competence on an ongoing basis, some hospitals have tried to influence medical staff decisions, even going so far as to veto medical staff elections (Modern Healthcare. January 22, 1988:42). Such challenges usually bring prompt and acrimonious response.

With increasing numbers of physician employees, questions have been raised as to their ability to act independently in the election of their own medical staff officers and even whether to grant them the freedom to do so. When physician employees are union members, the situation becomes even more confused because of concerns that arise about whether medical staff deliberations might become settings for playing out union-management disagreements.

Some medical staff bodies are incorporating and securing ongoing independent legal consultation. In the public sector and in proprietary hospitals with paid physician staffs, many medical staff bodies have little independence and are integrated into the hospital structure, with medical staff officers holding defined institutional roles (eg, medical staff president defined as hospital chief of staff). According to an article in Modern Healthcare (January 22, 1988:42), the governing authority has some role in the selection of medical staff officers in 26% of hospitals.

Combining the roles of full-time medical director with president of the medical staff, while appealing to many administrators (we know whom we placed in charge), has significant consequences. As medical director (Hospital Medical Staff Section Newsletter. June 1987), one is in a hierarchical role in the hospital with superiors and subordinates. The president of the medical staff is a peer; perhaps the first among equals, but in all senses a peer. The combination of roles often serves to limit or to repress important conflict; it may act to limit adequate discussion of areas of potential disagreement between clinical and administrative priorities, particularly through agenda control. It may even undercut important institutional checks and balances in the guise of efficiency.

A far more serious problem is the wish or even the attempt by hospital boards and other forms of governance and administration to control the structure of the medical staff. For example, in the state of Missouri, the Department of Mental Health proposed a regulation that would allow state hospital superintendents to appoint medical staff officers, a proposal opposed by medical and psychiatric groups (State Update. September 18, 1987:4). Preservation of an independent voice for the medical staff is enhanced by retaining the responsibility for the election of their own officers.

New clinical settings (eg, community mental health centers, HMOs) have evolved without independent medical staff structures. Physicians, particularly physician-employees, in such organizations often know little about how they may legitimately exercise authority on behalf of patients, and are perplexed by their great perceived responsibility and significantly reduced authority. For example, psychiatrists in freestanding community mental health centers22,23 have described concern about the lack of clear standards for practice and the need for formal identification of medical authority in areas of clinical practice.

As employees, they may have little sense of how they may influence priorities, and little time or opportunity for interaction with colleagues. Many such settings have implicitly identified their physician employees or contractors as high-priced technical help, requiring them to meet productivity standards that leave little time for each patient contact, and almost none for medical staff activities. Physicians who protest administrative controls for clinical reasons may be subject to administrative sanctions (eg, role redefinition, new tasks, rescheduling).

More insidiously, the assumption is often tacitly made that hierarchical review by medical “seniors” serves the purpose of peer interaction and review. Combined with technological developments that permit external review of care (Contract Health Care. March 1988:26) by insurers and others using systems that may have been designed by nonmedical experts, the individual practicing physician may well feel like a buffetted, unsupported, and ineffective practitioner.

Other Organized Medical Groups

In an increasingly competitive environment, physicians have organized to negotiate with hospitals and other health care settings to provide contracted services. They have organized to form joint ventures, large freestanding multispecialty group practices, and to gain control of health care services (Medical World News. September 14, 1987:66). Attention is beginning to be directed to the management of such organizational entities.4

The economic rationale for such organization is clear. What may be somewhat less appreciated is that such organization also serves the needs of physicians to interact with one another, to provide consultation, and to help monitor quality of care in a noncompetitive environment.

Organization moves autonomy over practice from the individual to the group. The process is uncomfortable for most physicians, and organized medical staffs have been settings for significant interprofessional dispute and even collision with poor care as well as for collaboration. However, if medical autonomy over practice is to be maintained, physicians need to learn to work together to oversee practice activities. Various commentators suggest different ways in which this might occur. Freidson describes the role of medical academic elites in defining standards that are hierarchically prescribed and then monitored in health care settings. Chapman advocates a role for specialty societies in the development of standards. Reed and Evans advocate a system of “physician-driven organizations,” nonprofit group practices that are tied into independent but unspecified peer review systems.

As practice becomes more organized, we anticipate increased dispute about how standards are set, and which physicians ought to be involved in the standard-setting process. In this work, consideration must be given to the continuing
preference of most physicians for independent practice. We suggest that in any of the models, which may be used to help delineate parameters of practice, standards require clinical testing by practitioners.

The development of large data sets and of the epidemiology of practice variation has refocused quality assurance activities on outcome measures: on measuring high-volume, high-risk conditions, on the validity of expert opinion, and on acute care. These strategies can improve practice. However, much of the care our patients need is for the consequences of chronic and often disabling conditions, where caring as well as care is important. Physicians need to be actively involved in seeking to develop standards, and in reviewing the care of these patients.

The medical staff organization evokes responses similar to a psychological projective test. Various individuals or groups see in it a reflection of their own concerns. Some physicians complain that medical staff activities are uncompensated work that carry the possibility of legal liability. Others are outraged that the care they provide is subject to anyone's review. Other physicians are concerned that, in an ever more litigious world, medical staff peer review activities may become discoverable evidence leading to suits and countersuits. Some attorneys view medical peer review activities as self-serv ing and designed to protect incompetence. Others believe that medical staffs have as their primary intent the establishment of economic advantage and monopoly over practice. There is partial truth in each of these views. However, the overriding issue for society is how best to insist on professional accountability without curtailing individual practitioner initiative and independence. The public and practitioners require some measure of protection, and structured medical activities provide both accountability and some measure of protection.

Physicians come together to review the quality of care and to serve patients, physicians, and health care organizations. There are data that suggest that current structures may be capable of benefiting all these parties. For example, Flood and Scott in an interesting study confirmed that the power of the surgical staff to regulate its members is related to quality of care.

In a study of how for-profit psychiatric hospitals contend with the professional-administrative split, one of us (J.H.A., unpublished data, 1981) found that on a number of dimensions, including growth rate, occupancy, and length of stay, hospitals with an overlapping unit and professional/departamental structure, with routine coordination between the two, seemed to be better performers than those that had either a unit or a departmental structure. One of the chief ways in which this can happen is the working through of differences as they relate to the hospital in the overlapping hierarchy. Thus, in what are identified as matrix organizations, senior professionals and administrators are able to meet and discuss their, at times, disjointed views of issues, resulting in outcomes that enable both sides to continue to function with each knowing the position of the other. Such structures are designed to counter the general move toward heteron onous professional organizations, that is, structures in which the professionals are subordinate to the administrative hierarchy and therefore without a unique position.

COMMENT

The world of health care continually changes. It is increasingly organized and bureaucratized. The physician's relationship to the patient is more distanced, and technology furthers collegial separation with the advancement of subspecialization. With increased interpersonal distance, more technology, and more bureaucracy, malpractice suits are more common and awards are greater, contributing to practitioner dissatisfaction. The cycle feeds on itself; solutions tend to be institutional ones and they make care more bureaucratized, computerized, and standardized. Even the expansion of the medical science base is increasingly driven by nonphysicians. Physicians experience less and less autonomy in a great range of arenas. Simultaneously, legal and organizational mandates continue to insist on individual physician responsibility in the face of physician concerns that adherence to organizational policies is at odds with providing the best possible care. Yet the multitude of changes (e.g., greater bureaucracy, less autonomy for the physician, the need to be responsive to payers and others in the environment) have not altered the crucial tasks fulfilled by physicians. Their contribution to the quality of care remains central. Their concern with the ethical dimensions of practice is fundamental to high-quality medical care. Structures, particularly the medical staff organization, which both facilitate professional work and collegial interaction, and attend to organizational requisites, need to be maintained and enhanced.

Our society spends billions of dollars on work performed in organizations. Yet in health care, we tend not to take the work of organizations seriously, as worthy of scholarly attention or investigation. We tend not to teach about the organizations in which we work. Our residents have only limited exposure to the work of the medical staff in monitoring quality. The physicians we train are ever more proficient in providing acute care, yet they are at times inattentive to patient behaviors that impact health. The work of training medical administrators is seen as outside the purview of medical schools. If we expect physicians to participate responsibly in the governance of their profession, we need to teach them about that work and about the review of that work.

We should also encourage organizational research, as there are many relevant questions that need to be answered. Are HMOs more efficient than family practitioners in providing continuity of care; and if so, for whom? How do structures influence professional behavior and how does this impact on the nature and quality of care? Other fruitful issues that might be explored include studies of organizational structures and policies that decrease or elevate professional stress. We should also wish to study whether increased professional stress is reflected in poorer clinical care outcomes. The role of the medical staff in different types of hospital structures should be carefully studied. Another study might examine the effect of organizational structures on the entry of patients into specific types of care.

Our lives are increasingly spent in organizational contexts. Structures impact our autonomy, relationships with others, and ability to be effective. The organization of medical practitioners within clinical facilities serves professional and patient needs, and provides an important counterbalance to "bottom-line" decision making.

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