

Foreword

Some of you who are physician executives will likely remember these old but timeless gags: The “tie vote” of 25-3 at the medical executive committee (MEC) meeting meant that three loud, negative voices scuttled a year’s worth of work by hospital leadership. The fact that you missed the last three MEC meetings meant that you were next year’s president.

Now, these gags take on a more serious tone: The medical staff leadership reaffirms that a once-a-month, two-hour meeting after office hours will provide sufficient time to deal with all of the impending quality and safety initiatives coming our way under the Affordable Care Act. In fact, these circumstances are no longer mere gags that draw nervous laughter at medical meetings; they need to be seen through fresh eyes in this era of accountability. Enter Jon Burroughs and his contributors, who successfully translate this serious tone to a pragmatic set of approaches that can help even the most reluctant healthcare leaders grapple with the inevitable changes that we face in our industry. With the impressive group of contributors from across the United States whom Burroughs invited to weigh in, he has fashioned a how-to guide that tackles many of the myths of the medical staff structure with the aim of achieving collaborative change.

When one examines the history of the organized medical staff, it is clear that among its traditional priorities were preservation of established referral patterns, maintenance of professional autonomy, and vigilance in its control over nonclinician CEOs to ensure that they protected the physicians’ territory. In short, the traditional medical staff’s structure, spanning nearly 50 years in the post–World War II era, was about preserving the status quo. Now, with the status quo in our industry largely untenable as a model for the future, Burroughs gives us hope that we can reconcile the situation and emerge with effective strategies for the future.

This book is not for everyone. Surely there remain members of the medical profession who yearn for an idealized, 1965-style era of unfettered professional autonomy and the perceived ability to do everything and anything for every patient and to reap economic reward, even if that reward comes with a poor clinical outcome. Yet others recall the era of “See one, do one, teach one” without analyzing the appropriateness or effectiveness of the *one*. At the other end of the spectrum, some in the healthcare leadership profession believe that the only model for the future is of the employed doctor who works in a tightly managed, hierarchical structure driven by economic incentives to minimize testing.

In my view, Burroughs presents a middle ground that recognizes that social change cannot occur overnight, even in the face of an economic crisis, like the one we face in healthcare delivery. Without hyperbole and with an outstanding

supporting cast, Burroughs calmly outlines new structures, tools, and processes that can preserve some of the more laudable aspects of medical staff interaction, such as collegial support, peer review, and a sense of professional community, in a multidisciplinary team-based model. Therefore, this book should be read by all healthcare leaders and stakeholders who aspire to bring physicians and management together to achieve the necessary goal of world-class quality at the lowest possible cost.

Kudos to Burroughs and his contributors. I recommend this book for healthcare leaders at all organizations where physicians are called on to make an important contribution for the future of the organizations in which they work.

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