

## So They Want You To Be Their Medical Director

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Clinicians, especially physicians, who become “medical directors” of facilities or agencies incur more responsibilities than they sometimes realize. Clinical administration, such as medical director roles and duties, creates personal, professional, management, and forensic issues. For some, their day-to-day work changes little; others experience a shift in duties and relationships, particularly duties to and relationships with the *organization* (as contrasted with its patients) that are unfamiliar to most clinical professionals. One who accepts such a position should understand the organization’s needs and expectations and, within bounds of professional ethics, be prepared to meet them. Even medical directors of very small organizations, such as small private hospitals or clinics, routinely, and sometimes unknowingly, incur administrative and/or legal responsibilities for which they may later be held accountable. (*Journal of Psychiatric Practice* 2011;17:208–211)

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A few weeks ago, a colleague was invited to become medical director of a private mental health facility. He asked me to discuss the pros and cons of such an appointment, including the roles he would be expected to carry out and how the allegiances he would assume might affect his professional liability, his clinical and professional identity, and his career. This article addresses some of the things we talked about, largely generic topics relevant to many positions of clinical administration and leadership. It includes, but often goes beyond, “forensic” topics.

There is no overreaching definition of “medical director.” The phrase is often defined in contracts, job descriptions, facility policies and procedures, and occasionally in rules for public sector agencies. Positions called “clinical director” or something similar may or may not be the same as “medical director” in a particular setting.

**Good for you.** First, congratulations. If you have been approached to become a medical director, I hope that means the organization courting you recognizes your fine clinical talents, impeccable reputation, and management skills.

**But.** Second (and please don’t take this personally), why do they want *you*? Try to be painfully honest about what the organization wants in its medical director and why they think you can supply it for them. (Hint: Your clinical and administrative skills may not be at the top of the list.) They’re willing to spend good money for the things they hope you’ll provide, and *they almost certainly expect to make many times your salary as a result of hiring you.*

I recommend considering medical-director-like positions a little cautiously, particularly when the invitation comes from a private sector facility or business. The organization may or may not want you primarily for those fine clinical talents, impeccable reputation, and management skills.

That’s shocking, I know. Without singling out specific organizations, it is fair to say that private companies (including for-profit and not-for-profit hospitals and clinics) must almost always be about making money. That’s neither good nor bad; it’s just business. However, in clinical fields, it is a business in which money is made (and survival depends) on customers’ problems, and occasionally on their gullibility and/or carefully selected insurance coverage (forgive me if my mind wanders to television ads for Medicare-financed scooters).

Some organizations have few compunctions about using psychiatrists and other licensed professionals

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for credibility and marketing purposes, not just (and maybe not primarily) for their clinical expertise. They may need a qualified medical director simply to be eligible for a particular license, accreditation, level of care, or form of reimbursement; to correct or address a licensing or accreditation shortcoming; or as a vehicle for admissions, service utilization and management, or shaping length of stay.

## Examine the Facility/Organization

I am not saying that psychiatrists and other clinicians shouldn't work with private facilities or other businesses. (I spent several years in private health-care management, and my forensic practice is decidedly "for-profit.") *The points are to know as much as you can about the organization and its expectations for you, to understand what you are willing—and not willing—to do in your medical director role, and to stick to your guns both before and after you sign the contract.\** (Consider it a bad sign if your discussions in those directions seem to cool their enthusiasm about you.)

Learn as much as you reasonably can about the facility, clinic, or business, including its parent company and other subsidiaries. Look at reliable information produced by the organization itself (such as organizational charts, policies and procedures, and comments from employees and associates) and by others (including licensing and accreditation history, local and national reputation, and references from peers). Don't be swayed too much by news media alone; it's easy to get undeserved good or bad press, and part of your role may be to help correct past problems. If you've been approached by a private facility or company, it's often helpful to look at its website and other marketing materials for hints about both the organization and its expectations for its future medical director.

For example, do they market directly to patients or families (who are likely to be less discerning than referring clinicians, and who can be desperate for help). Do they promise or imply high rates of success or cure (especially in terms unlikely to be used by a prudent clinician)? I recently saw the website for an eating disorders facility that said, on the first page,

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\*You have the company's ear and a fair amount of power before you sign the contract. Those will almost certainly decrease exponentially after you sign.

that "everyone" can have a "full recovery." That seems very close to a broad guarantee of results (something ethical clinicians almost never offer). Moreover, it appears to hold out a level of hope to distressed potential patients (and to their families, who often refer them and pay their bills) that prudent clinicians probably would not express. If the facility offers free assessments to determine need for care and eligibility for admission, do they *ever* turn down a well financed or well insured, clinically safe applicant after that "assessment"?

## Examine the Medical Director Position and Its "Fit" for You

Take out a handkerchief. Now dab your eyes, gently removing both the stars and the dollar signs that appeared in them when you were first approached about that medical director position.

Carefully examine the medical director's job description. Be alert when asked to "write your own job description." It's great to be able to include things you believe are important, but most organizations do not accept your items as the whole story. Examine expectations concerning the medical director as expressed by the organization's policies, procedures, top management, your proposed superior, one or two former medical directors, applicable statutes or agency rules (e.g., for public sector positions) and, last but not least, the organization's lawyers (i.e., as written into the contract). You're looking for the things you *must do*, the things you're *allowed to do*, the things you're *not allowed to do*, the things you *can or cannot reasonably influence*, and the things you *take responsibility for*. Do not ignore the last item; it can bite you.

Who will be your new boss? Your new peers? Your subordinates? Who's your boss's boss? Who will be within your sphere of influence? Whose sphere of influence will *you* be in?

Consider the following:

- Understand that you will incur certain new, perhaps unfamiliar liabilities as a medical director. Check the final job description (not just the draft they asked you to write) carefully. The contract—unless it's drawn up by *your* lawyer—may or may not protect you from important liability options. Have your own lawyer, who should have relevant experience, examine the contract before you sign it. Be certain you have reasonable liability insur-

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ance coverage for your acts, duties, and omissions as medical director.

- Avoid a medical director position that seems simply to be a title with some extra money attached (see case examples below).
- Organizations place high value on having a medical director who works well with both their clinical and non-clinical members, and works especially well with its senior leadership. Ask yourself the extent to which your ability to get along with everyone is likely to be correlated with always doing what the organization's upper management wants you to do. Then ask yourself whether or not that is generally in the best interests of the organization's patients.
- Assuming the medical director reports to a senior administrator and is an active member of the organization's management team (both of which should be the case unless the position is limited to only a part of the organization, such as a particular clinical unit), you should visualize the medical director's role as including a close relationship to the senior leadership's *business* goals. Your boss, usually not a physician, is probably friendly but is not particularly your "friend." Picture the two of you handcuffed together in a jungle, each depending on the other. (Note that you can make a nice living without the organization, but the administrator you report to usually doesn't have your employment safety net. He or she depends far more than you on the organization's business success.)
- Those who become full-time (and often even part-time) medical directors must carefully configure (or reconfigure) many of their peer relationships within the organization. The corporate expectation of your medical director role is part of the *organizational* structure, not to be "one of the docs"; if not, you're getting the title for some other reason.
- Be a bit cautious about an offer that says you will have a substantial medical director role and also do lots of patient care. Many medical director positions are not full-time (and even when they are, one may still see patients), but *their organizational duties, responsibilities, expectations, and liabilities cannot easily be set aside*. When seeing patients, one must give them attentive care, placing their interests uppermost when treating or consulting. It will be difficult to split clinical and administrative roles, even when they're scheduled at different times of the day.

- I listen carefully when I hear that the medical director of an organization (usually a small one) is expected to provide the bulk of the psychiatric role as well—approving admissions, admitting, treating, discharging, and so on—for a large percentage of a facility's patients. When that occurs, the title often exists for some purpose such as simply encouraging one to admit lots of patients; creating a figurehead for marketing, licensing, reimbursement approval, or organization credibility; or to keep one from admitting patients to a competitor.
- If the facility is part of a larger business (such as a medical center or chain of treatment facilities), one has even less ability or authority to affect policy and quality. In such cases, the senior administrator reports to someone outside the facility, and must pay more attention to *his or her* boss's priorities than to yours. That's just business, and not necessarily bad, but a prospective medical director should understand how such circumstances may affect patient care and fit with one's own objectives, ethics, and career plans.

### Food for Thought: Case Examples.

*Dr. A., a psychiatrist, rented office space from a small group of counselors. He was flattered when the group asked him to become its medical director. He signed an agreement to accept the title of "medical director" and to provide case supervision, psychiatric oversight, and medical backup for both licensed and pre-license therapists, all in return for a flat stipend.*

*Over time, Dr. A. developed confidence in the therapists' abilities, and rarely second guessed their work or their prescribing recommendations. Time spent supervising dwindled as his own patient load increased.*

*Some months later, one of the counselors' patients committed suicide. Dr. A. was surprised to find himself named in a lawsuit, since he couldn't recall ever seeing the patient and didn't believe he had had any doctor-patient relationship. Review of the counselor's records revealed a therapy note several months earlier which said "Dr. A. agrees with the diagnosis of major depressive disorder, (antidepressant medication) prescribed." There was a brief entry by Dr. A. around the same date which documented an antidepressant prescription with several refills. There was*

*no record of any subsequent discussions with the patient or the counselor (who had been seeing the patient once or twice a month at the time of the suicide).*

Why might a lawyer—or the patient—view Dr. A. as a participant in such a patient's care? What administrative responsibilities affecting patient care might have been required of Dr. A? In what ways might he have been thought to be negligent and thus named in the lawsuit? Do you think he was negligent?

*Dr. B.'s responsibilities as medical director of a private psychiatric hospital with a large substance abuse unit included encouraging legitimate admissions by the attending staff and helping manage length of stay to optimize hospital revenues. Both he and the hospital administrator were pleased with Dr. X., their primary substance abuse admitter. Dr. X. was a successfully recovering alcoholic who both understood treatment principles and enjoyed great credibility in the local medical and substance abuse communities.*

*His admissions represented a significant, well insured portion of the facility's patient mix, and he received a substantial stipend for being part-time "clinical director" of the substance abuse program (ostensibly for genuine clinical director duties, not as payment for admissions).*

*Dr. B. eventually became aware that Dr. X. was using suburban Alcoholics Anonymous meetings,*

*usually many miles from the hospital, to "recruit" patients, and that he sometimes promised "good food and maybe a little extra" to those who would sign themselves in. Dr. B. was concerned and brought the issue to the hospital administrator.*

*The administrator initially joked about Dr. X. "trolling for patients," then appeared to be concerned as well. After a few moments of listening to Dr. B., the administrator's reaction was, "Is Dr. X. doing anything illegal?...Those meetings are confidential, right?...We need him; how can we deal with this without driving him away to another hospital?"*

Was Dr. X. likely to be doing anything illegal? Unethical? What aspects of the relationship between the medical director and administrator are important in this situation? What should the medical director's priorities be? Are they likely to be different from the hospital administrator's priorities in such a matter? Is there any room for compromise on Dr. B's part?

### **The Last Word**

Becoming a medical director is one way to spread your influence beyond individual patients. This and other healthcare management roles can have broad positive impacts on patients (and future patients), clinicians and caregivers, care delivery systems, and even healthcare policy. If clinical administration fits your style, and you have developed the necessary skills, consider it; we need you out there.