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The Function of a Medical Director in Healthcare Institutions: A Master or a Servant

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ABSTRACT: The function of a medical director is presented along with features of efficiency and deficiencies from the perspective of healthcare system improvement. A MEDLINE/Pubmed research was performed using the terms "medical director" and "director", and 50 relevant articles were selected. Institutional healthcare quality is closely related to the medical director efficiency and deficiency, and a critical discussion of his or her function is presented along with a focus on the institutional policies, protocols, and procedures. The relationship between the medical director and the executive director is essential in order to implement a successful healthcare program, particularly in private facilities. Issues related to professionalism, fairness, medical records, quality of care, patient satisfaction, medical teaching, and malpractice are discussed from the perspective of institutional development and improvement strategies. In summary, the medical director must be a servant to the institutional constitution and to his or her job description; when his or her function is fully implemented, he or she may represent a local health governor or master, ensuring supervision and improvement of the institutional healthcare system.

KEYWORDS: medical director, healthcare, quality, improvement, function

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Introduction

In a healthcare facility, the medical director (MeD) is responsible for medical supervision and overall regulation of all medical facets that may affect the institutional healthcare system (IHS).[1] Professionalism in healthcare facilities is a minimal requirement that does not allow compromises given that the issue is simply a matter of life or death. Though medical responsibilities are directly related to the attending physician liability, the impact of the IHS on an individual medical practice is significant, including organization, availability of critical care units, equipment, interdisciplinary work, and quality of nursing care.[2,3] Accordingly, the MeD must be deeply involved in the regulation and implementation of the IHS;[3] respect, fairness, integrity, responsibility, mindfulness, and professionalism are essential values that MeD must possess and cultivate. These value undoubtedly have a significant impact on the quality of the IHS.[1] This study is a review of the function of the MeD in a healthcare institution, and the impact of the MeD on IHS is discussed with an insight into improvement strategies. Through a MEDLINE/Pubmed research, 232 articles were analyzed and only 50 articles found to be relevant were selected.

Background

In general, the quality of IHS is mainly affected by governmental policy and national resources; however, when national policy has minimal influence on private hospitals, local policy and resources become the main issues involved in the function (or malfunction) of the IHS. The executive director (ExD) (also known as the chief executive officer, CEO) and the MeD have both a major role in the implementation of local policy for an efficient IHS, and their collaboration is critical for an optimal outcome.[2,4] Thus, the role of the MeD in regulating and improving the IHS is predominant and should be a priority and a continuous concern.

Theoretically, the MeD is typically recruited according to his competencies and professional records. A human resources manager is naturally qualified to evaluate a candidate for a MeD position, though the final decision belongs to the administrative council (or board). In general, there are many institutional "actors" in the administrative board. Among these, three are publicly and apparently active, including the MeD, the staff director, and the nursing director.[2,5] In an environment where private institutions are predominant, ExDs are often stakeholders or simply owners of the healthcare facility, and the MeD is commonly recruited via a direct designation by the ExD.[6] This scenario does not guarantee a qualified person for the MeD position, the MeD may stand for the ExD and he may become the most potent and influencing "actor" among the other administrative members.[7] Conversely, this scenario may result in relative or total submission of the MeD to the ExD, moreover, the main concern of the MeD may be shifted from fulfilling his job description to satisfying the ExD given the frail procedure through which he or she has been recruited.[8]

Medical Director: Position Profile and Job Description

General duties. The medical field became a turbulent environment due to extreme regulatory and financial constraints;[9] accordingly, physician determination and competency are more than ever a must in order to continue to provide social health promotion. The MeD must ensure an adequate environment for the professional well-being of the working forces, notably the physicians. The MeD is responsible for developing and improving the foundation policy, protocols, and procedures given that these issues reflect the core of the institutional constitution.[1] Moreover, the MeD must supervise directly or appoint medical commissions involved in the functioning of the IHS. Theoretically, the MeD is responsible for every process that may interfere directly or indirectly with the quality of the IHS; he or she must develop cooperation between medical departments, physicians, paramedics, and other working personnel; also, the MeD must be available and capable of evaluating and managing any acute dysfunction in any medical unit and with the shortest reasonable delay.[10,11] In addition, the MeD must adopt an exemplary behavior, also he or she should cultivate and promote the spirit of trust and professionalism in the institution; also the MeD must have a three-dimensional, broad mind, thinking globally and applying locally in order to improve medical practice even when some tools are not always available in a good but less than perfect medical domain.[12,13]

Policy, protocols, and procedures. The MeD has essential functions that consist of developing, approving, and updating the general institutional policy, protocols, and procedures. Moreover, the MeD must ensure that adequate implementation of these processes is achieved according to predefined standards. Notably, medical commissions are a valuable tool for assessing the performance of protocols and procedures, including regulations for medical care in case of emergencies, use of pharmaceutical drugs,[14] and use of medical equipment and supplies. In addition, the MeD must assess the applicability of processes regarding emergency plans supposed to be executed in case of fire, natural disasters, or massive casualties (war, epidemic, etc).[15] Moreover, the MeD must have sufficient knowledge and awareness for problem anticipation and solving, although pre-defined algorithms may allow a specific automatic management of some potential incidents in the institution.

Continuous quality improvement. In an environment where competitiveness has become a major issue, professionalism and high standards must prevail; accordingly, the MeD must develop and approve an applicable continuous quality improvement program, including a plan and a timetable to assess the efficiency of corrective measures.[16] A continuous quality improvement program allows monitoring and evaluation of the activities of each medical unit; also, individual staff performance is assessed. Accordingly, improvement procedures with measurable outcomes are created and applied.[1] Of note, medical commissions help substantially in implementation of a successful continuous quality improvement project.

Patient care audits. Performed by qualified appointees, audits must be scheduled regularly. They involve any feature that may interfere with the quality of IHS, including quality of care and patient safety.[17] Medical records are the responsibility of the attending physician, and the evaluation of the quality of care is based mainly but not only on the documentation found in medical records. Medical audits are required as a rule to ensure that patient care meets the expected standards and the audits reports must be analyzed. Corrective measures are then adopted before being archived. The objective of audits is to assess the quality of care and to fix any potential deficiency regarding the clinical performance. The audits must also document the availability and efficacy of physicians and para-medical personnel in case of emergencies or critical cases.[15,18]

Scientific activities. Scientific research, publications, congresses, in-hospital medical teaching, continuous medical training, and education represent essential tools in this context. Continuing education programs for physicians is essential for maintaining standards in the institution; moreover, medical students, paramedics, technicians, and registered nurses are required to pursue a continuous education program. Certifications (with continuous medical education credits) delivered upon completion of an education or training are mandatory to keep administrative files up-to-date for each individual involved in the IHS. The MeD must have an evolutionary behavior to pursue a continuous training, and this is a key issue for efficiency of MeD in healthcare facilities.[18] In addition, he or she must enhance adequate collaboration between the healthcare facility and affiliated institutions, mainly the school of medicine (if any).[19] This culture should be given a

Table 1. Summary of the different subsets of traits belonging to the MeD role [(1) behavioral and Ethical; (2) Medical and Scientific; (3) Administrative and managerial].

BEHAVIORAL & ETHICAL PROFILE	MEDICAL & SCIENTIFIC PROFILE	ADMINISTRATIVE & MANAGERIAL PROFILE
Equity and Fairness	Medical teaching	Physician administrative record
Respect and Trust	Scientific activities	Indicators of outcome
Exemplary behavior	Medical record	Policies, protocols and procedures
Maintain ethical principles	Professional competitiveness	Ensure medical Equipment
No excessive conviviality	Malpractice management	Interaction with Nursing Directory
No displaced authority	Continuous quality improvement	Interaction with Staff Directory
Communication expertise	Ensure patient satisfaction	Interaction with Executive Director
No medical sectarianism	Patient care audits	Interaction with Financial Director
Leadership	Availability, Organization	Availability, Organization
Moral integrity	Evolutionary mind	Thoughtful problem solver
Responsibility, mindfulness		Critical situation analyst

high priority and should be included in the institutional policy in order to stay up-to-date in a continuously evolving domain. Table 1 is a summary of the "job description" of the MeD, taking into consideration different subsets of traits related to behavioral, medical, and managerial profiles.

Discussion

The role of the MeD is changing over time;[20] it is evolving from strictly medical roles to an expanded set of roles that include managerial duties. Accordingly, the above listed job description is theoretical and indicative rather than restrictive, and other additive functions may be assigned by the ExD on a case-by-case decisions. Some of these additive duties may overlap with those of the nursing director or the staff directory. Figure 1 and Figure 2 are schematic representations of the parallel and serial relationships, respectively, between the ExD and MeD.

Despite the different backgrounds and areas of expertise, the relationship between the ExD and MeD is crucial to the successful implementation of the IHS,[21] and the success of this relationship is the responsibility of both parties. Although the MeD should keep in alignment with ExD, significant divergences may emerge in real world. In this case, there must be some instructions to follow in order to preserve the institutional constitution.[22] However, the MeD must preserve ethical and moral principles, and he or she must defend institutional regulations;[23] therefore, his or her compliance with ExD should not be transformed to a blind submission or slavery.[8,24]

The major workforce of a medical institution is represented by physicians, and the relationship between the MeD and the physicians is crucial and must be based on trust, respect, and professionalism rather than displaced authority and/or excessive conviviality.[25,26] In an environment made turbulent by financial interests and aggressive competitiveness, the MeD must promote professionalism and ethical values represented by fairness, integrity, and non-discrimination among physicians.[1]

The MeD must encourage multidisciplinary work for a better quality of care, with a special attention to preserve the role of attending physician according to medical ethics and medical aptitudes especially in critical care units.[27–29] Financial issues should not delay medical care, particularly when the patient condition is critical.[30] In addition, the MeD has to ensure physician protection against malpractice and therefore malpractice insurance[31] must be a requirement to keep the administrative file up-to-date. Written patient consent must be obtained upon hospitalization, the consent form must contain all "necessary" information that the patient may require, and an additional consent form may be required on a case-by-case decision.

The MeD has to lead and promote an institutional culture based on the principle of "patient first"; satisfactory collaboration between physicians, nurses, and paramedics is essential. The MeD must promote this process with the nursing and staff directors.[32] The MeD must be a thoughtful problem-solver and critical situation analyst. He or she should help to apply knowledge efficiently to improve outcomes[15] and be devoted, capable to address every expected or non-expected incident efficiently. Accordingly, the MeD must have an evolutionary or revolutionary mind to deal with every situation, particularly when major issues are in stake; for this purpose, he or she must hold brain-storming meetings with experts, define the dysfunction, measure the consequences, analyze corrective measures, apply new tools for adjustment, and use indicators to assess efficacy of rectifications tools. Like any tool, its efficiency is highly dependent on whether it is used appropriately and on the right problem. Applied tools must be organized into performance improvement project with eventually new protocols and procedures adapted to the new situation.[33]

An MeD must be an expert in skilled communication given that he or she may be easily found at the negotiating

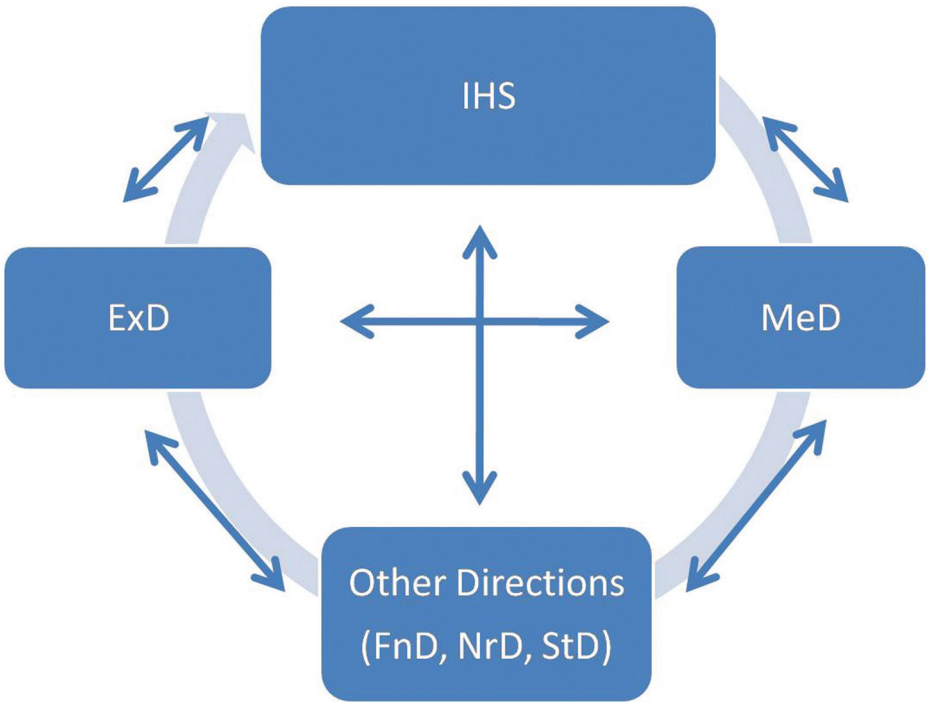

Figure 1. Function of the MeD with a parallel scenario: the main role of the MeD is medical rather than managerial when interaction with other directions is similar or even less than that of the ExD.
Abbreviations: FnD, financial director; NrD, nursing director; StD, staff director.

table with leaders from business, insurance, or other healthcare-related societies. Accordingly, the MeD may need to follow training programs in order to be prepared for an evolving function beyond medical responsibilities.[34,35] Continuous and targeted training are essential to provide a clinical leadership image and identity in terms of professional value of the MeD.[36,37]

In view of this, the MeD should be coherent with his position, being a master regarding managerial skills, being in alignment with the ExD without being a slave, and being a servant to the institutional constitution. This profile aim to ensure patient safety and best care, to implement an institutional culture based on trust, equity, professionalism, and respect. The MeD has to acquire sufficient authority in order to implement the institutional policy, otherwise his or her function is simply relinquished[38,39] and he or she may be transformed to a bystander MeD.

The primary allegiance of the MeD should be addressed to the patients' welfare and to the clinicians who care for them, not to authorities or politicians. The MeD has to control and restrict any abusive or irresponsible behavior of physician(s) in charge of each medical unit or division in the institution; a neutral behavior of the MeD in this context may simply imply a suspicious complicity with the above mentioned Physician(s). In fact, he or she must be in alignment with the institutional constitution represented by policy, protocols and procedures; additionally, the MeD should not become a self-servant, servant of his fears, mainly the fear of being dismissed by the ExD, or even servant of his instincts and subjective inclinations.[40,41] Rather than becoming self-servant, the ideal MeD may reach an altruistic sense and ultimately the successful MeD is the one capable of making the institutional policy as his own policy and to be genuinely driven to attain this goal.[42]

The MeD must have the qualities of a leader[23,40] and these qualities may be inherent to his personality but also have to be acquired and developed; essential qualities include fairness with adjusted authority. Excessive authority leads to abuse, lack of authority leads to laxity, authority without fairness leads to injustice, fairness without authority leads to inefficiency, and lack of fairness may lead to discrimination.[43] The MeD position may generate a structural tension inherent to his function, this is mainly related to the disparate demands of Physicians with different professional cultures. Accordingly, this tension can be displaced to manifest into personal and professional stress, and so the challenges of the function are significant.[44]

When healthcare systems are predominantly private, many administrative leaders (including the ExD) are frequently owners or stakeholders in the institution; subsequently, merging administrative and financial goals in the same persons put the IHS at stake. In addition, religious, political, and social influences on private healthcare institutions are sometimes predominant and many private foundations have a religious background. Professional chaplains as administrators will succeed when they are well-prepared to manage the different and variable situations

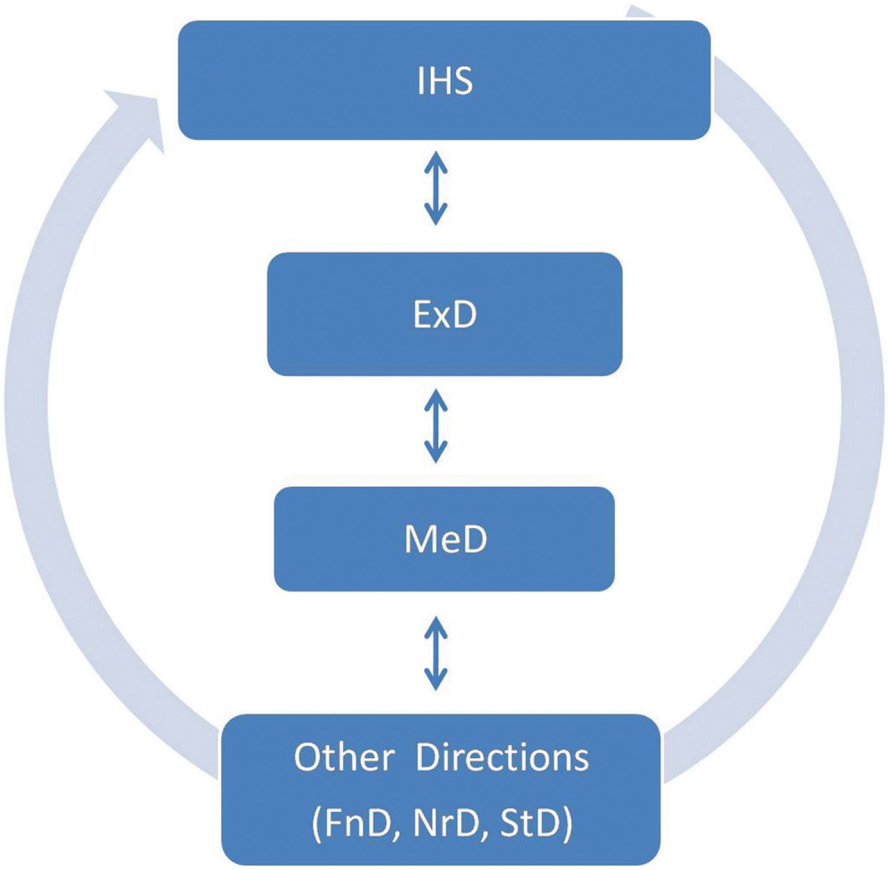

Figure 2. Function of the MeD with a serial scenario: the main role of MeD is managerial rather than medical when interaction with other directions is mainly via the MeD who transmits the process to the ExD.
Abbreviations: FnD, financial director; NrD, nursing director; StD, staff director.

encountered in the healthcare ministry.[45] Moreover, the political and/or financial impact on quality of care is serious and the access to some healthcare institutions is deeply compromised for populations with limited income in an environment where healthcare system is increasingly expensive. Accordingly, we estimate that the role of the MeD is predominant to fight against medical sectarianism, to keep human values at the top[46,47] by offering medical care for every single patient, regardless of background or financial condition with equity, professionalism, and humanity, *as stated in the Vatican II documents.*[48]

In a rapidly changing world, digital technologies create significant challenges that the MeD must be capable of following to gather, store, and treat information, and this is an essential tool for an efficient management of healthcare facilities.[49] The MeD must have adequate clinical awareness to identify factors of efficiency or deficiencies in his task performance; the differentiation between perceptions and intentions of the MeD is essential, being good is having both good intentions and perception, being bad is having good intentions with bad perception; *the worse scenario is when there are both bad intentions and perception,* which can go far enough to practice defamatory acts on Physicians for defending some suspicious intentions.[50] Finally, even "perfect" MeDs must have a mandate, and however successful he or she may be, he or she may be "badly" regarded when mandates accumulate for decades and without visible term of office; this may create unrest among health care professionals.

Conclusion

The MeD function is evolving from a pure medical to a more managerial and influencing position; in a changing world where private healthcare systems are becoming more and more predominant, the role of the MeD is crucial to maintain human values, equity, professionalism, and to fight against medical sectarianism. The data analyzed and discussed above reveal the role of the MeD, whether a master, a servant, or a slave. The MeD can be master when he is a real servant of the institutional constitution and mission, the mission that he has agreed to be in alignment with it. Before considering any institutional healthcare reform, one must ensure whether all MeD duties are efficiently implemented and applied, because they may be simply relinquished. Guided by wisdom and fairness and using reasonable authority, MeD(s) can be true local health governors and together they can contribute to a more efficient and accessible healthcare system.

Footnote: In this paper, we sought to be as comprehensive as possible and the description of the MeD as performed is not aimed to be applicable to any specific country, specific healthcare system or specific institution; additionally, the paper is not aimed to be applicable to any "moral" or "physical" personality having the role of medical director. Any trait evoked or discussed in this paper and potentially found in any healthcare system, institution or personality is purely and simply an incidental finding.

Author Contributions

Conceived and designed the experiments: AK. Analyzed the data: AK, BR. Wrote the first draft of the manuscript: AK, BR. Contributed to the writing of the manuscript: AK, BR, JCL. Agree with manuscript results and conclusions: AK, BR, JCL. Jointly developed the structure and arguments for the paper: AK, BR, JCL. Made critical revisions and approved final version: AK, BR, JCL. All authors reviewed and approved of the final version.

DISCLOSURES AND ETHICS

As a requirement of publication the authors have provided signed confirmation of their compliance with ethical and legal obligations including but not limited to compliance with ICMJE authorship and competing interests guidelines, that the article is neither under consideration for publication nor published elsewhere, of their compliance with legal and ethical guidelines concerning human and animal research participants (if applicable), and that permission has been obtained for reproduction of any copyrighted material. This article was subject to blind, independent, expert peer review. The reviewers reported no competing interests.

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