Exhibit A

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Opinion | CONTRIBUTING OP-ED WRITER

Shouldn't Doctors Control Hospital Care?

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Who ultimately should be in charge of care at our nation's hospitals — physicians or businesspeople?

In January 2016, the board of directors at Tulare Regional Medical Center, a small community hospital in central California, voted to terminate the elected leaders of its medical staff office. Medical staff offices help ensure that patient needs are kept separate from business imperatives, such as increasing hospital profits. They have historically operated independently of hospital administrators.

Citing deficiencies in the elected leaders' performance, the Tulare board appointed new officers without an election. The board also passed new bylaws written without the input of the hospital's physicians, including some stating that physicians' "status" at the hospital would depend on the number of patients they admitted — in other words, their economic value to the facility.

Not surprisingly, Tulare's doctors were furious; within six months, roughly half of them left the hospital. With the support of the California Medical Association, a lawsuit was filed calling for reinstatement of the original medical staff officers and bylaws. The association said that the Tulare board's actions violated California law on medical staff self-governance and posed "an existential threat to independent hospital medical staffs." The hospital countered that its actions were not only lawful but also needed to keep it operating properly.

The case, which went to trial but has been postponed because the hospital filed for bankruptcy protection, is ostensibly about protecting medical staff members from administrative interference. But it is a symptom of a much bigger problem in American medicine: the gradual loss of autonomy by physicians at our nation's hospitals.

A generation ago, physicians actually ran most hospitals, and medical staff offices commanded great influence over how care was delivered. Doctors were able to leverage a cultural perception of high-minded knowledge for an unusual degree of professional independence.

But much has changed over the past several decades. As spending outpaced hospital budgets, business executives increasingly took over. There were also concerns about uneven clinical quality, for which doctors were held responsible and became subject to regulatory oversight. Once the epitome of independent professionalism, physicians watched their autonomy shrink rapidly.

Today, less than 5 percent of America's roughly 6,500 hospitals are run by chief executives with medical training. Most hospital executive suites are disproportionately filled with lawyers or businesspeople. Indeed, the number of non-medically trained hospital administrators has gone up 30-fold in the past 30 years, while the number of physicians has remained relatively constant. Independent practices are also disappearing, as hospitals buy them up and put doctors on salary. The result for many physicians is the feeling that they are pawns of a big organization that does not want to hear, let alone act on, their concerns.

Doctors were once expected to scrutinize and, when necessary, challenge administrative actions on behalf of patients. No more.

The dispute at Tulare must be viewed in the context of this larger struggle. As hospital managers make decisions based on business, not clinical, imperatives, both patients and their care providers are getting squeezed. For example, doctors are being pressed to discharge patients quickly — sometimes too quickly — to maintain "throughput." There is a focus on increasing the rates of profitable procedures, such as orthopedic and heart surgeries, at the expense of relatively poorly remunerated general medical care. Administrators are even exerting control over traditionally

medical domains, such as the credentialing of new physicians with hospital privileges. If a hospital board can dismiss elected medical officers with impunity, as at Tulare, it will indicate to many doctors the increasingly tenuous nature of the position they currently hold.

The very best hospitals in America are still run by physician chief executives — Toby Cosgrove at the Cleveland Clinic, for example, and John Noseworthy at the Mayo Clinic. The Mayo Clinic says that it is physician-led because "this helps ensure a continued focus on our primary value" — namely, that "the needs of the patient come first." Indeed, a study in 2011 found "a strong positive association between the ranked quality of a hospital and whether the C.E.O. is a physician." Overall hospital quality scores were about 25 percent higher when physicians, not business managers, were in charge.

Of course, correlation does not prove causation; it is certainly possible that better hospitals *choose* physicians as their leaders. But when day-to-day decision making is done by people with clinical training, it appears that patients do benefit.

There are many factions to blame for the corporate takeover at America's hospitals. Doctors need to accept some of the responsibility, too. If we had taken better care of our institutions, perhaps there would not have been a need for others to manage them for us.

How the court rules in the Tulare case, once it resumes, will have profound consequences for whether medical staffs can do their work independently of nonclinical administrators. And it will also provide an answer to the more important question of who should be in charge of hospital care.

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