

## **Emergency Physicians in Hospital Leadership** *an Information Paper*

As the specialty of emergency medicine matured over the past three decades and many career emergency physicians became senior members of their medical staffs, emergency physicians' involvement in hospital leadership increased. Evidence of this increase includes growing numbers of emergency physicians maintaining positions of hospital leadership and advancing levels of authority and responsibility. Today, emergency physicians participate actively in all levels of hospital leadership – from entry-level medical staff committees up to health care entity Chief Executive Officers (CEOs). This article recognizes this development and reflects upon its impact on the specialty of emergency medicine, the house of medicine, and the global health care delivery system.

### **Why is emergency physician involvement in hospital leadership important?**

Emergency physician visibility as integral, respected members of the medical community accelerated over recent years. Although one can argue that the television drama “ER” fails to realistically portray the working world of the emergency physician, the success of the series is one indicator of emergency medicine's rise to prominence over the past decade. During the 1990s, hospital administrators and health care organizations began to better recognize the position of the emergency department (ED) as the primary access point of the hospital, with EDs often accounting for 50% or more of total hospital admissions. Simultaneously, a growing number of EDs instituted operational efficiency improvements, such as rapid triage and bedside registration, in an effort to improve service to patients. Some hospital systems, such as HCA-The Healthcare Company, launched marketing campaigns aimed at raising the visibility of their EDs. Recent events, such as the terrorist attack on the World Trade Center and acts of bioterrorism punctuate emergency medicine's role— on the front line of health care in the US. Both the medical and lay communities now increasingly look to emergency physicians for answers to inquiries, formerly directed to other specialists, regarding bioterrorism, disaster management, trauma, and other medical urgencies and emergencies. As hospitals and health care organizations make management, operational, and marketing decisions, the presence and input of emergency physician leaders is pivotal to ED patients and emergency physicians.

Other compelling reasons for emergency physician involvement in hospital and health care system leadership include:

- An 8% reduction in the number of EDs in the US since 1980 coupled with an increase in the number of emergency visits to more than 100 million annually;
- An increase in the number of uninsured and underinsured patients;
- An expansion of obligations pursuant to the Emergency Medical Treatment and Labor Act (EMTALA);
- The absence of a federal prudent layperson standard for all payers;
- The absence of federal tort reform in the face of growing malpractice settlements and awards, with emergency medicine currently comprising approximately 15% of all medical malpractice suits;
- The expanding crisis of access to emergency malpractice coverage at reasonable rates;
- The growing emphasis on patient satisfaction survey data as a barometer of ED and emergency physician performance without appropriate regard for the impact on ED patient satisfaction of factors outside of the EDs direct control (eg, process for moving admitted patients to inpatient rooms, responsiveness of staff physicians on-call to the ED, hospital and ED registration policies, and ancillary services).

This set of circumstances not only provides emergency physicians the opportunity to hold leadership positions, but an obligation to do so. The opportunities are numerous. In light of the emergency physician's interface with hospital medical staff, administrators, ancillary departments, nursing staff, and the community, no physician is

better positioned than the emergency physician to assume a leadership role within hospitals and health care systems.

### **What is Hospital Leadership and Governance?**

Governance structures exist to ensure that entities behave in a manner that is responsive to stakeholders. Hospitals in the US vary widely in terms of governance structure - profit vs. nonprofit, private vs. public ownership, as well as their type of external financial interest (eg, shareholders, voters and donors). Notwithstanding such variance, the formal governance structure of most hospitals shares more similarities than differences. All hospitals have some ultimate governing body, referred to as “board of trustees,” the “board of directors,” or the “board of governors,” which oversees the hospital’s management. “Governance” can be defined as “the structure and process used to direct and manage the business, and professional affairs of the organization to assure the achievement of its’ mission.” Essentially, the board represents the hospital’s owners and is accountable to the community, as well as other stakeholders.

The board is ultimately responsible for all activities of the hospital and board members are appointed, elected, or selected in accordance with the hospital corporation bylaws. Regardless of the method of selection, most if not all board members are provided with orientation sessions and continuing education concerning their responsibilities. Typical duties of board members include:

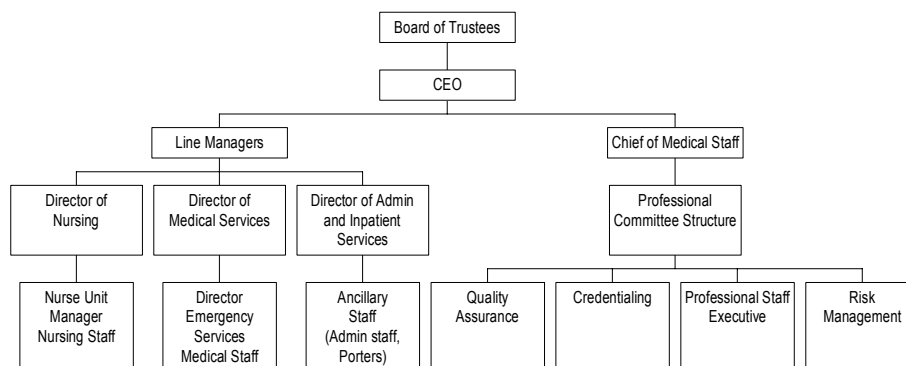
- Setting strategic direction and goals of the hospital;
- Selecting the CEO and evaluating his or her performance;
- Setting significant policies by which the hospital operates;
- Ensuring that the hospital has adequate resources;
- Monitoring the financial performance of the hospital;
- Monitoring the achievement of goals and objectives;
- Ensuring effective management information systems are in place;
- Developing a communication plan for stakeholders; and
- Delegating responsibilities to managers and committees.

Most board members have a responsibility to multiple constituencies, including the hospitals:

- Patients;
- Community;
- Owners;
- Employees; and
- Contractors

Hospital boards delegate the responsibility for day-to-day management to the CEO or President of the institution. This individual further delegates decision-making authority to line managers and professional committees for policies and procedures regarding medical care (*see Figure 1*). Most hospitals operate in accordance with a set of bylaws that outline the organization and processes for the institution. Such bylaws often specify an elaborate committee, as well as reporting structure. The remarkable consistency of the nation’s hospital organizational structure is due, at least in part, to the recommendations of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Of relevance to physicians in general, including emergency physicians, is the fact that recommendations emerging from hospital committees significantly affect hospital governance, management, administration and medical staff activities. Emergency physicians have numerous opportunities to be involved at each level of the governance structure, with corresponding effect on hospital operations.

Figure 1: Hospital Governance Structure



The ACEP information paper *Medical Staff Structure* may be accessed from the ACEP web site and provides additional, excellent information regarding various medical staff structures and emergency medicines' role within them.

For community-based or rural EDs, primary targets for emergency physician involvement include the medical executive committee (MEC) or similar medical staff leadership committee, and the emergency services committee (ESC). The MEC generally occupies the top position of the professional committee structure, generally is chaired by the chief of the medical staff, and provides recommendations directly to the hospital CEO and board of trustees. The ESC generally is multidisciplinary, often consisting of non-physician hospital directors of ancillary departments, hospital business office and risk management representatives, emergency nursing leaders, physician staff representatives, and emergency physician designees.

### **How does one get started in hospital leadership?**

The first step toward involvement in hospital leadership is to learn the governance structure of your hospital. This requires review of the hospital rules and regulations and the medical staff bylaws. Credentialed medical staff may obtain copies of these documents upon request from the hospital administrative office. Obtain a printout of the chairs and members of hospital committees for reference. Conversations with long-term hospital physician and administrative staff can be enlightening and informative. Become familiar with the process for committee member and chair appointment or election.

The second step toward achieving a role in hospital leadership is to become familiar with critical or time-sensitive issues facing the hospital and its medical staff. These issues may include community perception of the hospital, issues of staff recruitment and retention, hospital occupancy issues, and others. Some hospitals and chiefs of staff appoint task forces or physician panels to address certain critical issues, which provide an immediate opportunity for involvement through volunteerism.

Third, the emergency physician should become involved in hospital governance and medical staff leadership in whatever capacity is available. Appearing as a guest at committee meetings, such as the hospital credentialing committee, information management committee, medical advisory committee, or surgical advisory committee often leads to substantial discussions regarding emergency physicians and ED operations. Express an interest in committee chairpersonship to the chief of staff elect, who often is empowered to appoint individuals to these positions. Review of the hospital rules and regulations and medical staff bylaws often reveals outdated, deficient approaches to issues involving the ED and emergency physicians, such as inpatient resuscitation policies, on-call physician responsiveness, EMTALA responsibilities, "merit badge" medicine obligations for emergency physicians, and admission order writing obligations. A diplomatic offer to submit appropriate draft revisions to these documents can establish the emergency physician as a recognized expert in these arenas.

Networking within the hospital organization also assists the emergency physician in building relationships with those individuals participating in hospital leadership and governance. These individuals can help the emergency physician be in “the right place at the right time” by improving awareness of opportunities for involvement. In addition, one can build valuable relationships that not only further administrative goals, but also enhance the quality of emergency services available to patients.

Fourth, the emergency physician medical director or designee should aggressively, but diplomatically, seek to achieve two goals, if not pre-existent: chairpersonship of the ESC or its equivalent by an emergency physician and a voting position on the hospital MEC or its equivalent. These goals may not apply to academic EDs, whose goal often is to achieve status as an independent department within the hospital structure.

The ESC generally bears responsibility for review of ED quality assurance (QA) or performance improvement (PI) issues, ED patient complaint issues, ED JCAHO preparedness issues, ED ancillary services issues, and other operational issues directly pertinent to ED function. Often, the ESC reports and provides recommendations to another committee (depending upon the structure of ED governance and oversight), such as the medical advisory committee or the surgical advisory committee. Also, non-emergency physicians chair many ESCs. A meeting between emergency physician leadership, hospital administrators, the chief of staff, and the chief of staff elect often leads to a better understanding of and appreciation for emergency medicine’s growth and maturation as a specialty over the past three decades. Presentation of information such as emergency medicine’s status as a primary board specialty, ACEPs policy statement, “Model of the Clinical Practice of Emergency Medicine,” and the growth of information relative to ED operations can create a compelling case for emergency physician leadership of the hospital’s ESC.

The MEC is the most prominent of the medical staff committees within most medical staff governance structures. This committee synthesizes reports and recommendations from the various hospital and medical staff committees. The MEC then has immediate decision-making capability or makes recommendations directly to the hospital CEO and Board of Trustees. The MEC traditionally is chaired by the hospital Chief of Staff and is composed of the various hospital department chiefs. The hospital CEO or another high-ranking member of the hospital administration generally attends and participates. Often, the MEC membership includes chiefs or medical directors of certain pivotal divisions, such as the emergency department. However, many hospital MECs lack a voting membership position for the ED medical director, despite the vital function and importance of the ED to the hospital.

Most MECs allow, or even encourage, attendance at meetings by active medical staff members as guests. The MEC sometimes contends with confidential or discreet issues that require the absence of non-members from the room for some portions of an MEC meeting. Nonetheless, a very effective means of demonstrating the absolute need for emergency physician presence on the MEC is the regular attendance of an emergency physician leader as a non-voting member. This presence leads MEC members to recognize the vital importance of emergency physician input and advice on the wide range of matters under MEC discretion. A meeting with the hospital Chief of Staff by the emergency physician leadership can lead to an arrangement for formal, regular MEC attendance by the emergency physician medical director or designee.

Once the emergency physician group establishes a strong MEC presence, the emergency physicians find themselves in a strong position to lobby for modification of medical staff rules and regulations that may be necessary to create an official voting membership position for the emergency physician medical director or leader. Such a membership provides the ED with the appropriate role and voice in the hospital and medical staff governance structure.

In addition to the ESC and MEC, most medical staff committees benefit from and welcome the active participation and membership of an emergency physician. Very few emergency physician groups monetarily compensate emergency physician group members for medical staff and hospital committee participation, because most emergency physician groups view such committee participation as fundamental to the success of the emergency physician group. Some groups require membership on at least one medical staff or hospital

committee by all full-time emergency medicine group members as an effective means of networking within the hospital medical staff and creating a firm voice for the interests of ED patients and staff members.

The path to hospital and medical staff leadership initially requires one to raise their hand to accept a sometimes difficult or unwieldy task. Meeting, or even exceeding the expectations of a position or task often leads to more substantial leadership duties within a committee or subcommittee. Responsibilities that at first glance seem menial or tedious open doors to more prestigious, desirable positions and responsibilities down the road.

Involvement in hospital governance requires the development and exercise of a new skill set that often is not intuitive to physicians. The independence and autocracy of direct patient care disappears when the emergency physician pursues effective, diplomatic solutions to problems through the hospital and medical staff governance process. The emergency physician leader must develop a more global view of issues effecting not only emergency medicine, but also the hospital, its patients, the medical staff, the administration, and the community. Active participation in hospital governance often requires patience and a focus on both short-term and long-term goals. Active participation in hospital governance and medical staff affairs teaches many effective communication and diplomatic skills over time. Alternatively, the emergency physician may choose to accelerate development of the requisite skill set necessary for success. ACEP offers significant information and educational opportunities relative to physician leadership development. The American College of Physician Executives (ACPE) is an additional resource for physician management educational opportunities. Business school seminars or masters of business administration (MBA) programs offer a more intensive approach to leadership and managerial development.

In summary, there are numerous, excellent opportunities for emergency physician leadership within the medical staff and hospital governance structure. The pursuit of leadership positions by emergency physicians is of profound importance to the continuing development and success of our specialty. This article offers a brief summary of medical staff and hospital governance structures and offers strategies for emergency physician involvement, participation, and leadership.

*The following members of the Emergency Medicine Practice Committee contributed to the development of this paper.*

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*February 2002*

**The following are summaries of subcommittee member interviews of people in various positions of hospital governance.**

**Gail Anderson, Jr., MD, MBA, FACEP**  
**Medical Director,**  
**Harbor-UCLA Medical Center**  
**and Acting CMO, Los Angeles County**  
**Department of Health Services**  
**Prepared by Dr. Alex Rosenau**

Gail Anderson is no stranger to the challenges of leadership, especially negotiation and conflict resolution. Dr. Anderson meets challenges that are system-wide these days, even as he continues to draw upon his emergency medicine roots. “Leadership must be available on a continuous basis, which can be difficult since the hospital business cycle usually follows the standard 5 day/40 hours per week format and makes traditional shift work in the ED impractical.” Dr. Anderson notes that “Being perceived as the specialty that takes the main impact on the health safety net helps tremendously with our credibility.” He adroitly cautions that, “It takes a skill set...to be a logical, appropriate change agent rather than an intimidating, posturing type.” His MBA, from Emory University, provided him with the language and additional skill set necessary for successful leadership.

Medical Director of Harbor-UCLA Medical Center, Acting CMO of the Los Angeles County Department of Health Services, and former Senior Vice President, Medical Affairs of Grady Health System in Atlanta, Dr. Anderson identifies his emergency medicine training and experience as essential to his role in decision-making, communication and negotiation. Physician tailored management courses, temporary administrative assignments, and medical staff committee work are great ways to get started.

“Never pit one against the other, make the pie bigger, minimize harm and reductions,” are lessons he has learned and that he practices. Dr. Anderson’s years of service continue to underscore his mantra, “Advocate for the patient first and your support will be solid.”

**Leslie R. Searls, DO, FACEP**  
**Chief of Medical Staff**  
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**Ingham Regional Medical Center**  
**Lansing, MI**  
**Prepared by Dr. Oliver Hayes**

Les Searls, a practicing emergency physician at Ingham Regional Medical Center (IRMC), was elected to the position of Chief of the Medical Staff, as well as membership on the hospital corporation’s Board of Trustees. Dr. Searls path to a leadership position in hospital governance began when he realized, as a hospital-based physician in a contracted group, that most decisions made in the hospital impact the emergency department, as well. Moreover, being actively involved in hospital committees – and, therefore, governance - allowed him to appreciate, understand, and affect decision-making throughout the hospital. He believes that emergency physicians who make themselves available and valuable to the organization strengthen their group’s contractual relationship with the hospital. His initial committee involvement led to his nomination by the medical staff to serve on the hospital’s Board of Trustees and as Chief of the Medical Staff. The main issues he has had to deal with involve on-call physician responsibility to the emergency department and credentialing issues. Because of his involvement at the highest level of the hospital, the importance of the emergency department to hospital goals, as well as the need for prompt on-call physician response to the ED became priority items for both CEO and Board action. Overall, he considers the time spent on hospital governance as a good investment of his time and energies.

**John Jeter, MD, MHA, FACEP**  
**CEO, Hays Medical Center, Hays, KS**  
**Prepared by Dr. Randy Case**

John Jeter was a mid-career, academic emergency physician when he became frustrated with the bureaucracy in his institution. He felt there wasn’t enough physician involvement. There was too much top-down decision making. There seemed to be a disconnect between hospital management and

the physicians, and the physicians weren't doing anything about it. So he resolved to do something about it – and to get involved in hospital management! He enrolled in the University of Colorado's Masters in Health Administration distance learning program, spending 2 weeks a semester on campus and the rest via the internet. At the conclusion of his program, the Vice President, Medical Services position opened at Hays Medical Center, in his hometown of Hays, Kansas. Dr. Jeter, who believes “you have to seize opportunity when it finds you,” says now he had “no idea” what he was getting into. He moved back home and dove in. A year and a half later, he applied for the position of Interim CEO, and six-months after taking that job, he was named permanent CEO. Now, Dr. Jeter is head of the organization – responsible for its strategic direction, financial performance, liaison between the medical staff and the Board, and for overseeing the management team of the institution. In his 6 years at the helm, he has improved care, instituted new services, and corrected the trust and communication problems that existed previously.

Dr. Jeter says that emergency physicians are different than most – they are “uniquely qualified to be involved in hospital management.” The reason is that emergency physicians tend to think not just about individual patients, but about populations of patients – about the community. Because the ED is the front door to the hospital, emergency physicians are tied to the institutions. “They are thinking from the same plane as management already.” On the other hand, he observes, “Clinicians are smart, but it's amazing what we don't know!” For example, he confesses, “I really didn't know how to manage people. And I really didn't know finances.”

His advice to others interested in “doing something about it” is “You can't count on getting lucky. Rather, luck finds those who are prepared for it.” He advises appointment to as many medical staff committees as possible. “Be ready to move – to go through the recruitment process. Find a mentor or coach in management. Join the American College of Physician Executives. Go to graduate school. These steps will help you to get noticed. They are your ticket to an interview.”

**Nancy J. Auer, MD, FACEP**  
**Vice President of Medical Affairs Swedish Health Systems, Seattle, WA**  
**Prepared by Dr. Randy Case**

Nancy Auer was in the middle of her term as President of ACEP when her predecessor left as Vice President of Medical Affairs of Swedish Health Systems, a 3-hospital system in Seattle, Washington. The institution asked Dr. Auer to take the reins, but she demurred because of her pressing ACEP responsibilities. So, they held the job open 6 months for her – and they saved all the work, as well! Dr. Auer credits her term on the Board of ACEP, as well as her experience as the first female President of the College as providing her with “a serious education in health policy and governance.” Her 12 years of prior experience, as Administrator of the ED at Swedish – including operational control of all the staff in the ED, not just the physicians – also gave her the instincts and the expertise to take on the larger role in institutional governance.

Her biggest challenge has been to get the disparate medical staffs of the 3 hospitals to merge smoothly ... and to think it was their idea, all along! She has also faced the serious and regrettably common healthcare challenge of allocating scarce resources – which totaled less than a third of the funds requested. Her guiding principal in management decision-making, finely honed by her ACEP leadership service, has always been “What does this mean to the patient, and to patient care?” She also advocates for those interested in hospital governance to develop their ability to listen well – so as to understand the issues, and to let the other person feel heard.

**Jeff Whitehorn**  
**Chief Executive Officer, Southern Hills Medical Center, Nashville, TN**  
**Prepared by Dr. Tim Seay**

“Southern Hills' focus on emergency medicine is critical to our hospital mission,” says CEO Jeff Whitehorn of Southern Hills Medical Center. At 37,000 visits, and growing, this Nashville, Tennessee ED owes much of its success to John H. Proctor, MD, MBA, FACEP – a member of the

hospital's Board of Trustees and also Chair of ACEPs Emergency Medicine Practice Committee.

How does Mr. Whitehorn contend with criticism of having a “contract doctor” on the board of trustees? He is quick to point out that, “John has earned the respect of his peers and has proven to be an outstanding leader here. The trustees are the stewards of the hospital and John has been an integral part of this. He brings a wealth of knowledge to the team and we are pleased to have him on the board.”

Did he make the right choice? “Absolutely. When you think of Southern Hills Medical Center, you think of its ED. This is what we're known for in the community of Nashville.” And he points out that 2001 was the best year in the history of the ED at Southern Hills Medical Center.

**Keith T. Ghezzi, MD, FACEP**  
**Managing Member, Ghezzi & Associates**  
**LLC**  
**Prepared by Dr. Randy Case**

Keith Ghezzi believes that involvement in hospital governance is a natural extension of the skill set of emergency physicians – making quick decisions in the face of limited information, as well as convincing our medical colleagues to take a particular course of action. Dr. Ghezzi served as Medical Director and Chief Operating Officer of George Washington (GW) University Hospital, and then Vice President, Inova Health System as well as Chief Operating Officer of Inova Fairfax Hospital (Fairfax), prior to enrolling in the Wharton School of the University of Pennsylvania to earn his MBA degree. At Wharton, he learned more about the decision making process and came to see more clearly that good clinical emergency medicine skills, while highly suitable and useful, are not entirely sufficient to excel in hospital governance. He views management as being every bit as much a profession as being a clinician.

Dr. Ghezzi started down this path by “dabbling” at GW, reading a ton of management books, recruiting a mentor, and taking leadership seminars. He “got tagged” by his institution to serve in several high profile positions, such as chairman of the Institutional Review Board, Co-director of the Trauma Center, and Director of the Ronald Reagan

Institute of Emergency Medicine, followed by his appointment as Medical Director and then Chief Operating Officer. In that role, the chairs of the clinical services reported to him and he initially had responsibility for clinical quality, utilization, and GME. His responsibilities grew to include operation of the laboratory, radiology, nursing, and support services. He teamed with GW's Chief Financial Officer (CFO) to restore the hospital to profitability, allowing its continued operation and, ultimately an acquisition, which will result in a new hospital being built.

At Inova Fairfax Hospital, a 656 bed institution with over \$400 million in revenue and approximately 6,000 employees, Dr. Ghezzi had primary operational and fiscal responsibility for the hospital while coordinating cardiac care, emergency services, trauma, oncology, and women's and children's service lines system-wide. He also launched a major clinical outcomes and quality initiative. He was a primary proponent of a fiscal expansion that would see the Children's unit transition into the Inova Fairfax Hospital for Children, preserved the flight program, expanded the trauma staff, and will almost double the size of the ED and operating rooms.

Since graduating from Wharton, Dr. Ghezzi has been practicing emergency medicine at Fairfax and developing a health care private equity fund.

His advice to anyone interested in institutional governance is to get involved on a volunteer basis, so as to establish your credibility and reputation, while considering an advanced degree – such as an MBA, MPH, MHA, etc. - or other formal management training in areas like leadership, finance, program planning, strategy and marketing. Although hospital management may sound alien to a purely clinical emergency physician today, it will not be in the future, he reassures, because emergency physicians touch all parts of the hospital in their everyday work. And that is a unique perch from which to get started in governance.