ASSOCIATION EUROPÉENNE DES MÉDECINS DES HÔPITAUX
EUROPEAN ASSOCIATION OF SENIOR HOSPITAL PHYSICIANS
EUROPÄISCHE VEREINIGUNG DER LEITENDEN KRANKENHAUSÄRZTE
EUROPESE VERENIGING VAN STAFARTSEN
DEN EUROPÆISKE OVERLÆGEFORENING
ΕΥΡΩΠΑΪΚΟΣ ΣΥΛΛΟΓΟΣ ΝΟΣΟΚΟΜΕΙΑΚΩΝ ΙΑΤΡΩΝ ΔΙΕΥΘΥΝΤΩΝ
ASSOCIAZIONE EUROPEA DEI MEDICI OSPEDALIERI
DEN EUROPEISKE OVERLEGEFORENING
ASSOCIAÇAO EUROPEIA DOS MÉDICOS HOSPITALARES
ASOCIACIÓN EUROPEA DE MÉDICOS DE HOSPITALES
EUROPEISKA ÖVERLÄKARFÖRENINGEN
EVROPSKO ZDRŽENJE BOLNIŠNIČNIH ZDRAVINIKOV
EUROPSKA ASOCIACIA NEMOCNICNÝCH LEKAROV
EUROPSKA UDRUGA BOLNIČKIH LIJEČNIKA
ЕВРОПЕЙСКА АСОЦИАЦИЯ НА СТАРШИТЕ БОЛНИЧНИ ЛЕКАРИ
ASOCIATIA EUROPEANA A MEDICILOR DIN SPITALE

Document :	AEMH 10-037
Title:	**CMAJ Article** **Hospital management: "It needs Doctors – Doctors need it"**
Author :	**Peter Richardson, MD**
Purpose :	**Information**
Distribution :	**AEMH Member Delegations**
Date :	**3 May 2010**

Hospital management: It needs doctors, doctors need it

Peter Richardson, MB, BS, FRCSC

A close friend of mine, a professional in another field in another country, joined his national civil service. He had a PhD and had also been the gold medalist in his year in a supplementary planning course. He rose steadily in the ranks of the professional staff in his ministry until he was finally considered senior management material and put in a bridge position overseeing one professional branch of the ministry.

At this new level all his peers and remaining seniors were trained administrators, not professional specialists or scientists. In fact, they prided themselves in knowing next-to-nothing-in-particular about the primary expertise in which their ministry purported to hold sway, but they were equally pleased to consider themselves experienced administrative "all rounders" who could "manage" anything.

This friend of mine submerged, without impact, before he understood that no matter how irrefutable were his technical analyses and professional recommendations, they were often ineffective or ignored simply because he had not learned to pay attention to such things as political imperatives and interdepartmental priority struggles "in the national interest".

By the time he understood that the national interest itself was arbitrarily redefined whenever the current political leaders saw need for new directions, he had given up the struggle and taken early retirement.

There is a lesson for doctors in that. Once, it was normal for senior physicians to be medical superintendents of public health care institutions and hospitals, but such positions of power and influence have slipped away from us. Along the way we have isolated ourselves in "doctor think" and "doctor talk". In pursuing our interests as applied biologists and tribal shamans we have, by default, let most of the really important decisions in public policy and planning for health care pass into the hands of others, usually trained administrators.

The story has been told of the successful wife who deferred to her husband in all the important decisions — who to vote for, whether to support free trade with the United States, or whether the Oilers would survive the trading of Gretzky. She reserved for herself only the unimportant decisions, the ones involving day-to-day running of the household, planning the family menu, buying the children's clothes, and planning the family vacation. Who had the most impact in that house? Which is really important, the remote and, therefore, theoretical, or the practical issues one can personally influence?

While we doctors have been playing our purely clinical roles and thinking we were racking up brownie points through our hard work, others have been running the hospital "house" for us, and often without us. And they have become good at it.

Today, they and their political and bureaucratic masters see that costs are getting out of hand and that physicians can be the clue to controlling them. Certainly, patients who demand care create the costs, but who decides if and when to let them in and whether the need is an emergency? And who decides when discharge is appropriate and what treatment, at what implicit cost, is required? It is doctors, of course, and we would have it no other way. Yet having said that, we must also accept responsibility for being involved in the fair coordination, distribution and utilization of the public resources available to deal with the demand for service.

Money in the public treasury is finite, and totally open-ended demands for it present all of us with a difficult situation. There are ways of coping, though. For example, at the provincial cabinet level political decisions are made by ministers, even if on limited "discretional" questions only. At the hospital level there is a budget controlled by the Ministry of Health, and there are local by-laws, provincial standards and regulations, a governing body and a team of managers overseeing the efforts of the professional staff and allied and support workers. Physicians can and should make an impact at all of these levels if we are to have an effective, ongoing say about limits being placed on our own professional lives.

We must either help to devise fair controls or face the inevitability of having them imposed upon us. To this end, we need some basic understanding of both political processes and the characteristics of managers, and how

Peter Richardson is medical director, Inuvik Regional Health Board, Inuvik, NWT.

managers differ from clinicians.

Doctors have difficulty viewing hospital activities from an organizational perspective because we are trained to look at each tree — each patient — and not the forest, and we carry this blinkered view into relationships with others. Society needs us to think more in terms of community needs, both beyond and within the hospitals where we work. We must become managers, the people who strive to attain quantifiable goals by utilizing limited resources, and do so by directing and managing the activities of other people. What follows is a personal view of some ways in which we can become effective participants in medical management.

Many doctors pass through the stages of their respective hospital medical staff hierarchies, but their interest and impact during this process varies. Special training brings understanding, and it is well worth while learning "committeemanship": Speaking first and loudest is no guarantee of success.

I think the most important factor in getting physicians involved in hospital management is a cooperative atmosphere. Physicians must show respect, courtesy and consideration towards those in administration. Get to know the administrative staff; drop in for informal visits — not just to complain. Consider the hospital cafeteria a place to meet people, to network. Make friends, because friends become allies.

At the department-head level there are obvious bridges to be built with members and heads of other professional groups whose work affects our own. Do not be aloof. We are members of a team and by ourselves do not know "most" or "best" about everything.

For the chief of staff, a regular, probably weekly, private briefing session with the hospital administrator is essential. I think the chief of staff should be a regular participant at meetings of the hospital's senior administrative staff. This group usually comprises the executive director, his assistant directors and the director of nursing, all of whom have "line" responsibilities for various functions and departments. This is usually the key planning group at a hospital and medical input, given in a friendly fashion, can achieve wonders.

I do not want to delve into the evolving role of the chief executive officer's relationship with the medical staff. Whether you accept that the administrator, as CEO, is responsible for the management and quality control of all personnel and functions in the hospital, including the medical staff, or you believe fervently that the medical staff organization should retain an independent identity and report separately to the Board of Management, do not go before the board at cross purposes with your executive director. Work things out, at least to the point of a reasonable compromise, before the board meets.

Doctors must remember that the Board of Trustees is the ultimate power and authority and that it represents the public. It is appropriate to advise and strive to influence and convince administration and the board, but remember this: It is the board's role to set policy and its prerogative to differ with us and even to decline to follow some of our "expert" advice.

In all our dealings with the board, administration and other staff members, at least some of whom do continue to look at us as the leaders in the health care field, we can be assured that if we are knowledgeable and accessible, our expertise will be recognized — at least most of the time. If we respect the skills and accomplishments of others, we will be respected ourselves.

When we become effectively involved in the management of a hospital our presence and activities should make a difference. The difference our involvement makes can affect the institution's goals, its planning, its staff relationships, and the quality of its patient care. It will also affect the return the community gets out of its hospital in terms of programs and services for the public dollars spent there.

And those seem like reasonable objectives that we, too, can take some satisfaction in pursuing.■

Medicine isn't the only degree worth attaining

It is time we showed more respect for people whose university degrees were earned in fields other than medicine. We all know, even if we are reluctant to acknowledge it, that the MD is not the most intellectually prestigious doctorate awarded by our universities. In some English-speaking countries, including the one in which I graduated, universities award only a bachelor's degree upon graduation from medical school, even if it is a double- and, in some cases, a triple-header.

In those jurisdictions the MD is a "higher degree" of varying academic distinction, yet somewhat more comparable to the doctorates awarded in other faculties, albeit of considerably less distinction than a PhD. Attainment of our qualifying degree requires no more intellectual ability than is needed for the master's degree which, these days, is the minimum qualification for most senior positions in health care administration.

Moreover, when we graduate in medicine, we do not know very much about the history, philosophy, politics, economics or law of the health care field in general, or of hospital administration in particular. Administrators do know such things, by training and through experience.

← For prescribing information see page 1222