Part II

Leadership

CHAPTER 3

Organizational Structure, the Governing Body, and the CEO

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KEY TERMS

Chain of command
Classical theory of organization
Multihospital system
Organizational structure (tall or flat)
Pyramid organization
Span of control
Specialization
Team of three
Appointing the medical staff
Board of trustees
Fiduciary duty of the board of directors
American College of Healthcare Executives (ACHE)
Chief executive officer (CEO)
Chief operating officer (COO)
Ex officio member
Inside activities
Networking
Outside activities
Respondent superior

THEORIES OF ORGANIZATION, INTRODUCTION OF CONCEPTS

Introduction: Common Organizational Management Principles

Any organization may be viewed from a macro sense or a micro sense. For example, are we choosing to examine the entire Veterans Administration (VA) system, a single VA hospital, or a department within a VA hospital?

A hospital system may span across a nation or function within a single state or city. In the VA system, for example, there are approximately 175 hospitals, 400 clinics, and 126 nursing homes providing services to American veterans. The system is managed from a central office in Washington, DC; regional offices oversee several states, and local administrators supervise each hospital. This and many other hospital systems take on a pyramid **organizational structure** (Figure 3-1).

Efforts are being made to modernize the pyramid structure by making it flatter. Better organizational success can be achieved by expanding the scope of control to allow important decisions to be made at lower levels in

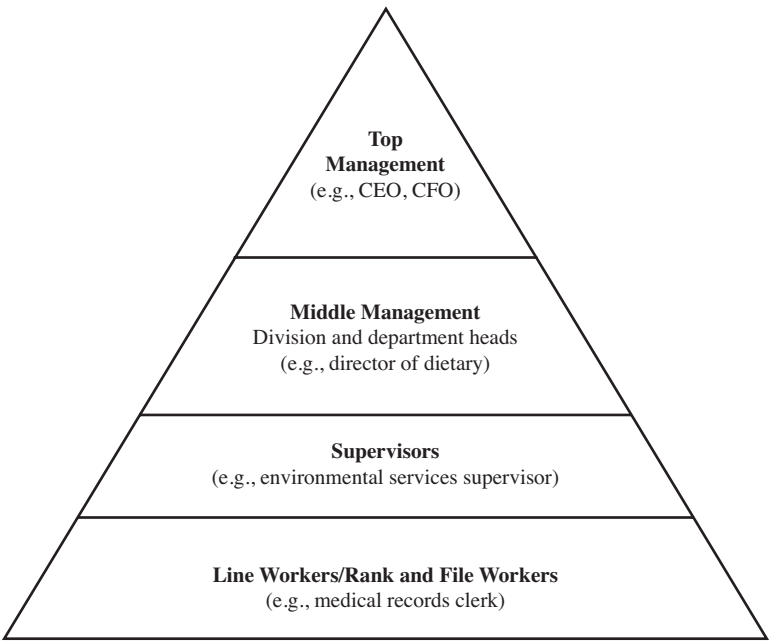

FIGURE 3-1. Pyramid organization.

the organization. For example, instead of the head of a department seeking the approval of an assistant administrator who oversees several departments, then the assistant administrator seeking the approval of a vice president (VP) who supervises a significant portion of the hospital, and then the VP discussing this with the chief executive officer (CEO), the decision can be made at the department level, provided the department stays within the previously approved budget.

For example, the imaging department may budget for an updated computed tomography (CT) scanner during the annual budget process. During the budget process, various CT models are discussed within the department, with input from members of the department (radiologists) who will directly use them, along with anticipated prices. After the board and chief hospital management approve the overall hospital budget, sometime during the next year, the imaging department will select a vendor, a final price, and a service contract. At the appropriate time, the department staff can act autonomously and initiate the transaction without being slowed down by red tape during the purchase, delivery, installation, and training period.

Hospitals also may use **organizational theory** to supervise personnel. According to the concept commonly known as "**span of control**," a manager can effectively and directly supervise a limited number of people (usually 8 to 10). This is especially true for the functional areas of housekeeping, dietary services, and nursing.

There is also specialization of labor within the organization of a hospital. **Specialization** refers to the ways in which a hospital organizes to identify specific tasks and to assign a job description and position number to each person. For example, a nurse's aide has a specific job that differs from that of a licensed vocational nurse (LVN, sometimes called a licensed practical nurse [LPN]), and an LVN differs from a registered nurse (RN), who in turn differs from a nurse practitioner or clinical nurse specialist.

Position numbers are assigned to each position so that the administrator can control the number of employees who are budgeted to work. If position #135 is an RN and the RN leaves the hospital's employment, only an RN may fill the vacant position #135.

In addition to the pyramid structure or the more modern, flatter structure discussed previously, organizational theory may be used to form teams (Figure 3-2). Such teams cut across department lines and are used for special projects, for limited time periods. For example, when a hospital is preparing for a Joint Commission survey, which usually occurs every 3 years, an

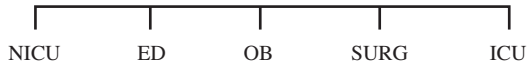

FIGURE 3-2. Product-line management (nursing).

intense effort is often made during the last 12–18 months before the survey. Teams are formed to focus on each standard of the survey. Teams may also be formed to study anticipated projects or product lines before the hospital commits large resources to them. For example, a team could be formed to brainstorm about new clinic locations and what each clinic would offer. Such a team might be comprised of personnel representing the physical therapy, pediatric, and OB/GYN departments in order to correctly anticipate the array of services needed to meet the needs of each clinic. Teams provide a useful tool because they foster cooperation, place authority in the hands of those who best know the processes involved, and can be disbanded and reformed for other projects when the need arises.

Product-line management is also very useful. Under this scheme, hospitals or divisions within the hospital are organized according to a specific product line. These categories may also be referred to as strategic business units. For example, a hospital might elect to organize around its surgical or obstetrical services or products within a formal department, such as nursing.

Line and Staff Functions

Line managers are usually viewed as supervisors who direct workers and sometimes have the authority to hire and fire, whereas staff members are usually assigned routine tasks they are expected to complete. Nurse managers have line authority, and floor nurses have staff functions.

ORGANIZATION CHART

In an overall view of a hospital, the **board of directors** (sometimes called the **board of trustees**) occupies the position at the top of the chart. The board hires and fires the **CEO** (sometimes called the executive director, administrator, or president), and also sets policy for the hospital. It is the final authority for the hospital and bears a fiduciary (greater-than-normal) responsibility for the people the hospital serves.

The CEO is responsible for the day-to-day operations of the facility and usually has some flexibility in managing it. The same general administrative hierarchical principles apply, whether the organization takes the form of a pyramid or a more modern, flatter organizational shape. Depending on the size of the organization, the administrator may be aided by associate administrators, assistant administrators, a **chief operating officer (COO)**, or, in a very small operation, an administrative assistant who reports to the administrator in an informal manner.

In a 100-bed hospital, one would expect to find a COO or a single assistant administrator. In a 200-bed operation, there may be a couple of assistant administrators. In addition to this, in nearly all cases, there is also a chief financial officer (CFO) and a chief nursing officer (sometimes called the director of nursing (DON) or VP of nursing). These senior staff personnel (COO, DON, and CFO) stand ready to oversee the hospital in the absence of the CEO. The number of senior staff personnel will vary with the size of the hospital, which is usually measured by the number of beds. (In counting beds, it is wise to understand what the hospital is claiming when it is speaking of its capabilities. The hospital may be licensed by the state for 342 beds, but it may only have set up 250 beds, and may only have an average daily census and personnel capable of caring for 150 patients. The remaining space may simply be used for storage.)

Just below the senior staff (COO, CFO, and DON) is the middle management group, which represents the departmental level of management. At the departmental level, generally four major types of functions are carried out: (1) nursing functions, (2) business or fiscal functions, (3) ancillary or professional services, and (4) support services. It is usual in a mid-sized hospital to have at least four distinctive administrative or functional groups that answer to the CEO or COO, with a VP responsible for each area (Figure 3-3).

Although an organization chart serves to portray formal lines of reporting, it certainly does not portray informal lines of authority and reporting. Many leaders may not be included in such a chart, yet they are the personnel to whom the rank and file turn in times of misunderstanding or confusion. Those in top- and mid-management positions would be wise to understand this structure and keep these people informed and close by when needed.

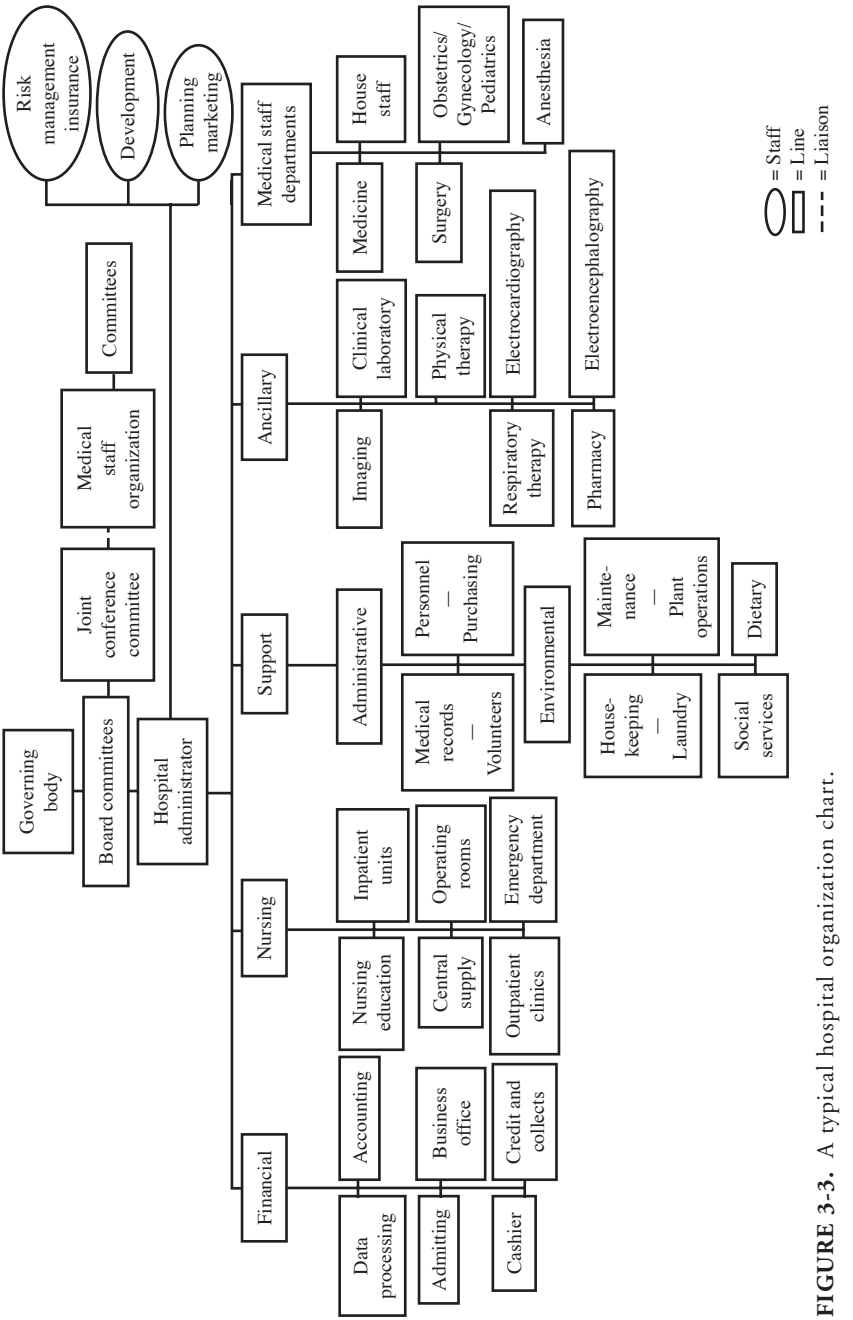

FIGURE 3-3. A typical hospital organization chart.

TEAM OF THREE—A VERY IMPORTANT CONCEPT

A complex acute-care medical center has three major sources of power: (1) the board of directors, (2) the CEO or administrator, and (3) the medical staff of the hospital. In an ideal world, these three would work in harmony to make the hospital the best it could be. In reality, this is too often not the case. Let us examine the power relationships among these groups.

Medical Staff

The activities of the medical staff significantly affect the management and governance of an institution. Physicians make daily decisions to admit patients, and depending on where they have admitting privileges, they can choose to send their patients to ABC Medical Center, MNO Medical Center, or XYZ Medical Center. If they believe ABC has better medical equipment, they may send their patients there. If, on a particular day, it is raining and the physician does not wish to drive across the city, the harsh and simple fact is that for that day, the physician may choose to have his or her patients admitted to the XYZ facility just because it is closer. The wise hospital administrator must understand that each physician is the hospital's customer, and the hospital must do everything it can to please that customer. The golden rule in hospital management is: Nothing happens until the physician admits the patient. A hospital would sit empty without the loyalty of its medical staff.

Usually, the medical staff can vote for members to serve on a hospital executive committee that also includes senior hospital management members (CEO and COO), or a joint conference committee comprised of board members, senior management executives, and elected physicians. In other instances, some hospital boards will allow one or two physicians to serve as board members.

Board of Directors

The board of directors may be elected by members of the community to oversee a local hospital or appointed by the corporation that owns the hospital, the county judge, or even the hospital CEO (and there are probably a host of other options).

In addition to hiring and firing the CEO, the board also has the important function of approving privileges for each physician. If Dr. Smith wishes to deliver babies, she must apply to the OB/GYN committee, the medical staff, the CEO, and finally the board of directors, who have the final say. These same board members may remove the privileges of any physician.

Chief Executive Officer

The CEO is responsible for the day-to-day management of the hospital. He or she can decide which product strategies to pursue, where to open clinics, and which marketing campaigns to launch—in short, affecting nearly everything the hospital does. It is up to the CEO to work in close harmony with both the board and the medical staff to maximize the efficiency of the hospital.

CORPORATE RESTRUCTURING OF THE HOSPITAL

Corporate restructuring, or the segmentation of certain hospital assets and functions into separate corporations, has become a popular strategy to help hospitals adapt to changes in regulations and reimbursements. The most prevalent form of corporate restructuring is when a hospital becomes a subsidiary of a parent holding company or foundation. Inpatient care usually remains the primary function of the hospital corporation, and nonprovider functions may be transferred to other corporations related to the hospital. The parent holding company and nonhospital subsidiaries are able to enter into less-restrictive joint ventures with physician groups and other healthcare providers than would be allowed by the traditional hospital structure. The traditional reasons for corporate restructuring include the optimization of third-party reimbursements, tax considerations, government regulations, flexibility, and diversification.

MULTIHOSPITAL SYSTEMS

An increasing number of freestanding hospitals are becoming part of a larger, **multihospital system**. In a multihospital system, two or more hospitals are managed, leased, or owned by a single institution. Some of the common advantages of multihospital systems include economies of scale

in terms of management and purchasing, the ability to provide a wide spectrum of care, and increased access to capital markets.

ALLIANCES

Another development in the structuring of hospital systems is the creation of alliances. An alliance is a formal arrangement among several hospitals and/or hospital systems that establishes written rules for its members to follow. Unlike hospitals within a multihospital system, those in an alliance retain their autonomy. The advantage of an alliance is the development of a network of support among hospitals. For example, hospitals might join in an alliance to gain purchasing power or form a preferred provider organization to offer selected services to customers or patients at special rates. A disadvantage is that antitrust issues may arise from such alliances. Each hospital should consult with its legal counsel before it commits to an alliance.

THE GOVERNING BODY—A DEEPER DISCUSSION

Introduction

As we discussed in the previous section, the governing body (also referred to as the board of trustees, board of directors, or board of governors) is the organized entity that bears the ultimate responsibility for all decisions made within the hospital. The board essentially functions as the owner of the hospital and is accountable to the community. Board members are often elected by the community, just as school board members are elected. They hire and terminate the CEO/administrator and approve the privileges of all physicians.

The situation is slightly different in the case of for-profit companies that own many hospitals. Although the for-profit company has a corporate board at its central headquarters, each hospital within the company may have its own local governing board whose members are usually appointed by the local administrator (who is an employee of the for-profit company). This second board generally gives advice to help safeguard the community's best interests. This local board can only make recommendations (and can recommend to the company that the administrator be replaced, since he or she is an employee of the company and not of the local

hospital; often the for-profit company will replace a valued administrator by simply transferring him or her to a different company hospital).

The trustees are ultimately responsible for managing the hospital's assets and setting policy. They assume a fiduciary responsibility (defined as a "greater than normal duty") similar to that of attorneys to their clients, or physicians to their patients). The courts have found that the governing body is responsible for all activities within the hospital. Members who serve on the governing body clearly have a significant responsibility.

Trustees are usually private citizens who often want to help their neighbors and community. One of the original reasons for selecting private citizens as hospital trustees was to secure financial support for the institution. By appointing local citizens who had some influence (and affluence), the hospital could guarantee a certain amount of contributions to underwrite its overall operations and care of the poor. Today, however, hospital boards frequently appoint individuals who have particular skills that can help the hospital; for example, they might be able to provide legal advice, accounting assistance, or business and management support. Modern hospitals have a multitude of legal and accreditation requirements. The board of trustees is required by law to watch over the hospital and its operations.

Nonprofit hospital trustees generally serve without pay; they are prohibited from profiting financially from their membership on the board of trustees. The rewards for being a trustee are the satisfaction of having delivered a service to others in the community, and the achievement of a certain level of status in the community. However, trustees have the additional burden of protecting the patients from all foreseeable and preventable harm, which they accomplish by approving the privileges of each medical staff member.

In part because of the scandals at Enron, Tyco, and other corporations, there is an increased sensitivity to board oversight and conflicts of interest. As part of a public service establishment, hospital trustees may be vulnerable to lawsuits and should ascertain whether the hospital carries director and officer (D&O) insurance on their behalf.

Hospitals are increasingly coming under public scrutiny. Some areas, including New York City and Washington, DC, have prohibited hospital trustees from doing business directly or indirectly with the hospitals in which they serve. More commonly, a state will require that trustees make full public disclosure of their business interests and dealings with

the hospital they represent. Hospitals are well advised to comply fully with the procedures for disclosing conflicts of interest, even though it can be shown in many cases that overlapping trustee interests can actually work to the hospital's benefit. For example, a trustee might give an institution a favorable loan or expert advice on investments.

A Profile of the Governing Body

Just as hospitals vary considerably in size, purpose, and makeup, so do their boards. The average hospital board today has 17 members. Smaller hospital boards may have 8 or 9 members, and the larger hospital boards may have about 25 members. Typically, a board is predominantly composed of business executives, but it may also include members of the legal and accounting professions. Physicians sometimes serve as representatives of the medical staff, but they may or may not have voting power. Interest in and commitment to the hospital, followed by financial business skills, are the leading criteria for selecting trustees. Trustees are frequently chosen from among the more outstanding members of the community. It is common to find representatives with inherited wealth serving on boards. A more recent trend, however, has been to encourage community or consumer representation on boards. As to the age of a typical board member, we can generalize that about half are older than 50. The majority of board members have a business or healthcare background. Most often, the CEO of the hospital is a board member, but usually only a small percentage of boards will grant the CEO voting privileges.

The qualifications of a potential trustee must be carefully reviewed. Hospital trusteeship demands certain essential traits, including dedication to hospital business, management skills, involvement in the community, political influence in the community, and a cooperative attitude.

As mentioned earlier, in some areas of the country, hospital boards are similar to school boards in that board members are elected by the local citizenry. In rural areas and small towns, it is common to have an election every 2 years and elect a portion of the board. Civic-minded people usually run for the board, but often these people are not the most informed about hospital matters. An additional caveat is that the board members might see themselves as the boss of the CEO, instead of collectively acting with one voice. Horror stories abound among rural administrators, including tales of individual board members wandering

the halls of the hospital, attempting to order employees to do certain tasks. It is the wise CEO who brings in an outside consultant for periodic board-member education, instilling a collective spirit within the board so that its members will act with one voice and stay within their agreed bounds of distant oversight.

Hospital boards typically meet 10 to 12 times a year, usually on a monthly basis. This is reasonable considering that a board might not meet during one of the summer months or during the holiday season. Board terms vary considerably, but the average term of membership is slightly in excess of 3 years, with a majority of hospitals stipulating no limit to the number of consecutive terms a board member may serve.

FUNCTIONS OF THE BOARD OF TRUSTEES

The basic function of the governing body is to protect and guide the hospital's mission in accordance with the institution's structure and the needs of the community. Since the board of trustees has an explicit or implicit obligation to act on behalf of the community's interest, it has a **fiduciary** responsibility to the community. This responsibility is founded upon trust and confidence, and involves (1) controlling the hospital and assuring the community that the hospital works properly, (2) ensuring that the hospital acts in a fiscally responsible manner, (3) appointing and removing members of the medical staff, and (4) appointing a capable CEO.

Hospital trustees help to set hospital policies. These policies are general written statements or understandings that guide or channel the thinking and actions of the medical staff and administrator in the decision-making process. The trustees' functions are summarized in Exhibit 3-1.

A hospital system may include a local board of trustees and a corporate board of the multihospital system. However, the local governing body retains primary responsibility for key medical staff relationships. The assumption of a role as a trustee in a multihospital system need not mean the loss of autonomy of the local hospital governing board.

Selection and Evaluation of the CEO

The trustees have an obligation to hire a competent CEO to oversee the day-to-day management of the hospital. One of the board's most important functions is to investigate and review the qualifications of a

Exhibit 3-1. Primary functions of the board of trustees.

Members of a board of directors or a board of trustees attain their positions in one of three ways. They are either elected by their fellow citizens (such as school board members or hospital district board members), are appointed by county officials (such as the county judge appointing county hospital board members), or are appointed by company officials, in the case of for-profit hospital companies appointing local citizens to their local hospital board. Most boards usually derive their authority and power from the hospital charter that created the hospital, or from state statutory regulations.

To encapsulate major points of the board's functions, it is nearly universally agreed that boards serve to:

- Interview, appoint, and sometimes discharge the chief executive officer (CEO).
- Engage in periodic strategic planning with the CEO and key medical and senior hospital staff members.
- Provide a mission statement that meets the needs of the hospital's target population. In this regard, the board should periodically discuss with the CEO his/her vision for the future and the board should assist in goal setting.
- Assist in providing a sound financial platform—this can be, but is certainly not limited to, a monthly review of key financial statements, a review of the annual budget, approval of spending for major capital equipment, approval of all hospital contracts, and approval of all insurance products.
- Approve all additions to and changes in the medical staff. The board also reviews and approves all changes to medical staff bylaws and standards. The Joint Commission carefully reviews this aspect to ensure the board is appropriately carrying out its oversight function.
- Be a liaison with the public to assist the public's understanding of the mission of hospital. Board members may be popular speakers for civic organizations and should represent the hospital when necessary.

Boards are often regulated by local, county, or state regulations. Members must be thoroughly familiar with open meeting laws and statutes that address conflict of interest issues. Wise hospital boards should insure coverage through director and officer insurance policies. As the guiding hand, board members are liable for potential litigation.

potential CEO, and decide which one to select. Hospitals are a big business, and trustees must seek executives who have strengths in planning, organizing, and controlling, as well as proven leadership skills. The board delegates to the CEO the authority and responsibility to manage the everyday operations of the hospital, but it retains the ultimate responsibility for everything that happens in the hospital. The relationship between the CEO and the governing board is primarily that of employee–employer, but not in the usual sense of the term. Since the hospital is a very special type of organization, the relationship between the CEO and the governing board is in fact similar to a partnership. Just as it is the responsibility of the governing board to hire the CEO, it must also discharge the CEO if necessary. Determining whether this is necessary can best be accomplished by having a contractual arrangement described in clearly understandable terms.

Relationship with the Medical Staff

The hospital medical staff operates under its own bylaws, rules, and regulations, but the physicians on the medical staff are accountable to the board of trustees for the professional care of their patients. The board of trustees is responsible for exercising care in appointing physicians to the staff. The medical staff carefully reviews a physician's application file, including credentials, references, and requested privileges. The medical staff then recommends to the board of trustees which privileges should be granted to the applicant. The trustees act upon these recommendations. The board can choose to grant the privileges, to request further information from the medical staff, or to reject the privileges outright.

The board of trustees is legally responsible for care provided in the hospital by attending physicians and hospital employees. In the case of *Darling v. Charleston Community Memorial Hospital*, the court pointed out that a board of trustees has a duty that may go beyond simple delegation of authority to the medical staff. In the Darling case, the court held that the hospital corporation was liable because it did not intervene through its employees to prevent damage that occurred to a patient through the negligence of one of the hospital's physicians. In another landmark case in 1973, the courts found in *Gonzales v. John J. Nork, MD, and Mercy General Hospital of Sacramento, California*, that a hospital owes the patient a duty of care. In this case, Dr. Nork performed 36 unnecessary operations over a 9-year period.

The court noted that the board of trustees has an obligation to purge the hospital of incompetent physicians. This case reconfirmed the board's corporate responsibility to ensure quality of care. It cannot be delegated.

The CEO and the chief/president of the medical staff also have major roles to play. Together with the board, they can develop and implement a quality-improvement program. The board's job is to monitor the program. This includes receiving monthly reports on the medical staff's performance as measured against standards, concurring with medical staff recommendations, or developing the board's own recommendations to improve quality in the institution.

The board of trustees generally delegates the hospital's daily medical affairs to the medical staff. The medical staff carries out these functions according to its own bylaws and regulations, but these bylaws and regulations are periodically reviewed and approved by the board. The board's joint conference committee includes representatives from the medical staff and administration, and serves as the main committee between the medical staff of the board and its administrator.

How Does the Board Operate?

The board of directors or trustees operates under the bylaws of the hospital. The bylaws spell out how a hospital board must operate to attain its objectives. Typical bylaws include a statement about the hospital's purpose and the responsibilities of the board. They also contain a statement of authority for the board to appoint the administrator and the medical staff. Additionally, bylaws outline how board members are appointed and for what period of time. Most bylaws indicate an elaborate committee structure. It is through these board-of-trustees committees that the governing board usually accomplishes its goals. This committee structure is frequently established along special functional lines. There is a remarkable consistency throughout the nation's hospitals in terms of board committee structure. Perhaps the reason for this consistency is the impetus for review of hospital bylaws and suggestions from The Joint Commission.

The most common committee is the executive committee, which is found in the vast majority of hospitals. Other examples would include a finance committee and a planning committee. Generally, recommendations made by the separate committees affect the governance, management, and administration of the hospital, as well as the hospital's medical staff.

It is the duty of the board to carefully select the members of these board committees. The caliber of the recommendations that emerge from these committees, and subsequently the caliber of the resulting board action are frequently a result of the quality of the committee assignments. By applying leadership skills and delegating management responsibilities, and working closely with these board committees, the CEO frequently can provide the ultimate key to success in all aspects of the hospital's operation.

Today, hospital boards usually operate like any other corporate board. Board members are accustomed to providing an independent voice. Clearly, hospital trustees are respected for their independence and their overview of the hospital. This is the result of an increasing need to make hospitals more efficient and competitive.

THE CHIEF EXECUTIVE OFFICER

Introduction

CEOs (also referred to as hospital administrators or presidents) come from many different backgrounds. At one time, they were likely to be chosen from the ranks of the nursing department. In many religion-based hospitals, it was common for the CEO to be selected from among members of the religious order or retired clergy. Some administrators worked their way up from the business office to become the hospital's CEO. It was also common in some hospitals for a retired executive or physician to assume the CEO position.

Such upward mobility through the ranks is not common today. CEOs are now products of universities. The first university course for hospital administrators started in the mid-1930s. After World War II, as the field of hospital administration became more and more complex, the demand for trained hospital administrators multiplied. One of the greatest influences on the advancement of hospital administration was the formation of the **American College of Health Care Executives (ACHE)** in 1933. The college encourages high standards of education and ethics, and only those administrators who meet the college's requirements are admitted as members. Today, a number of universities in the United States and Canada provide formal training of hospital administrators, and offer graduate and undergraduate degrees in hospital or healthcare administration.

A master's degree is the most widely accepted degree for a person applying for a position in health administration, and is required for the CEO position in most hospitals; usually the candidate will have a Master of Science in Healthcare Administration (MS-HA). Many people interested in healthcare administration choose instead to pursue a Master of Business Administration (MBA), Master of Public Administration (MPA), or Master of Public Health (MPH) degree. The formal training program for hospital administrators covers three general areas: (1) administrative and business theory, (2) the study of various components of healthcare services and medical care, and (3) the study of hospital functions, including organization and management within the hospital and the role of the hospital in the larger picture of healthcare delivery systems. The three basic types of skills developed in training are technical, social, and conceptual.

Historical Functions of the Administrator

The hospital CEO of the 1930s and 1940s chiefly conducted **inside activities**; that is, he or she dealt primarily with internal operations of the hospital. The administrator was concerned with matters that directly affected patients treated at the hospital. This involved bargaining with employees, developing proper benefit packages, and determining the best methods and techniques to manage the institution. However, beginning in the 1950s and continuing into 1970s, increasingly strong labor unions, third-party payers, and governmental agencies all began to significantly affect the hospital industry. During this period, the role of the administrator became a dual one, involving issues both inside and outside the hospital. More sophisticated and specialized management techniques were required to operate a hospital effectively, and the CEO became more involved in activities outside the hospital.

Today the CEO has to strike the proper balance between outside and inside activities. It is typical today for the CEO to delegate everyday hospital operations to the assistant administrator/COO, who often is also in charge of all the ancillary and support-services departments. The CEO might spend about 80% of his or her time outside the hospital visiting members of the medical staff in their offices, members of the board, or local government officials.

According to the ACHE, the governing authority must appoint a chief executive who is responsible for the performance of all functions of the institution and is accountable to the governing authority. The chief

executive, as the head of the organization, is responsible for all functions, including the medical staff, nursing division, patient support services, technical support, and general services support, which are necessary to ensure the quality of patient care. In many cases, the CEO also leads in recruiting new members of the medical staff.

Inside Activities of the CEO

The inside activities of the CEO include duties such as reviewing and establishing hospital procedures, supervising hospital employees, overseeing fiscal activities, and maintaining internal relations. Traditionally, the CEO's job is to attend to those tasks that directly affect patients. For example, it is the responsibility of the CEO to see that the building and its facilities are in adequate order and the personnel are qualified to fulfill their specific job requirements. Legally, the CEO and hospital must answer for acts of employees under the principle of "**respondeat superior**" (a Latin phrase meaning the master is responsible for the acts of the servant). Another traditional CEO function, which is even more important today, is to serve as a liaison to the hospital's physicians. The administrator must keep both the physicians and the governing board informed regarding the hospital and its plans. Other important tasks include the recruitment of new medical staff and retention of existing staff.

Generally, CEOs attend board meetings to communicate ideas, thoughts, and policies that will aid the hospital. The CEO assigns the responsibility of preparing annual budgets to the chief financial officer, the director of nurses, and the assistant administrator. The budgets are then presented by the CEO and approved or changed by the board of trustees. This process includes identifying services that need to be offered, as well as equipment that must be purchased. Although the CFO usually negotiates reimbursement rates with third-party insurance plans (such as Blue Cross and Medicare) and prepares monthly financial statements and statistical data to present to the board, the CEO should always review these documents with the CFO before they are presented to the board.

Maintaining a positive relationship and effective communication with the hospital's governing body, medical staff, employees, and patients is important. The official relationship between the CEO and governing

body is that of an employer and employee, but actually the CEO and board function as partners. The administrator represents the board in the institution's daily activities and must turn the board's wishes into administrative action. When administrators are members of the board, they hold the title of president of the institution and may serve as a liaison to the chairman of the board. CEOs can become active, with voting privileges, or act as **ex officio members** on strategic board committees, including nominating, bylaws, and planning committees. However, it is uncommon for the CEO to be chairman of the board.

The CEO should act in partnership not only with the board of trustees, but also with physicians and with other healthcare personnel in the institution. Under the best circumstances, the administrator will have a mutual understanding with, respect for, and trust in members of the medical staff. One of the key responsibilities of the CEO is to communicate with the hospital's medical staff. It is the CEO's job to see that the physicians have the proper tools in the right place at the right time to carry out their critical functions within the hospital.

Successful CEOs must be effective in keeping their medical staff members informed about organizational changes, board policies, and decisions that will affect them and their patients. Although hospital medical staff are ultimately answerable to the board and its management, they are also self-governing and have their own bylaws. The administrator should be sensitive to the medical staff's needs for self-governance and support. From time to time, tensions will naturally arise between the medical staff and administration. Frequently the sources of this conflict can be attributed to poor communication. The CEO must communicate effectively with the medical staff if the hospital is to function efficiently. Consequently, the CEO must always be available to medical personnel. It is a good idea for the CEO to attend the monthly medical staff meeting to foster good communications.

Many of the CEO's day-to-day challenges involve hospital employees. Employees must look to the CEO as their work leader. In this capacity, the CEO must keep employees informed about the critical role their services play in the successful operation of the hospital. This is easier to achieve with nurses and others who deliver direct patient care, but the CEO must continually inform all employees of their mission and importance. While managing employees at all levels, it is critical for the CEO to

show objectivity, understanding, and fairness. The CEO must exercise the authority to employ, direct, discipline, and dismiss employees with these important principles in mind.

Finally, the CEO has a vital role in patient relations. The CEO must fulfill all legitimate patient requests for general comfort and care to assist in the patient's recovery. In dealing with patients, the CEO must also understand the needs of the patients' friends and relatives. It is important for the CEO to ensure that confidential patient information is protected.

Outside Activities of the CEO

The **outside activities** of today's CEO are numerous. They include periodically visiting all physicians in the community and encouraging them to use the hospital, relating information to the community about the hospital, building relationships with and lobbying government contacts, and participating in educational and planning activities. One of the roles of the modern administrator is to educate the community about hospital operations and healthcare matters. This is usually done through hospital publications and community lectures. It is the CEO's responsibility to present a positive image of the hospital. Public-relations duties are considered key outside activities, and the CEO must promote public understanding of hospital programs through the mass media.

One of the most valuable functions of today's CEO, together with the CFO, is to negotiate contracts with third-party payers (insurance companies) who pay the patients' bills. This is a time-consuming activity that requires a combination of management and negotiation skills. With the advent of Medicare in 1966, hospitals and government became more deeply intertwined. Today's CEO must stay on top of the latest government rules and regulations concerning funding, reimbursement, and planning issues. CEOs meet with governmental reimbursement agencies, planning bodies, and politicians to stay current and to lobby for the hospital's interests. CEOs may lobby on an individual basis, with area CEOs, or as part of regional or national groups through hospital associations.

Interacting with public vendors and other health administrators and agencies is vital to the CEO's mission. The CEO's job is to remain in close contact with the community that sponsors the hospital or healthcare institution. The CEO must realize that the institution has a responsibility

to the public, and the public has a right to be informed. The CEO has to maintain high ethical principles in dealing with vendors, and be impartial and objective when representing the hospital in business transactions. Neither the institution nor the administrator can accept favors, commissions, unethical rebates, or gifts from vendors in exchange for doing business with a certain company.

Frequently, CEOs telephone each other or meet to gain additional information about a particular topic, insight, or problem, or just to discuss institutional plans and situations. This professional courtesy helps administrators broaden their own perspectives and strengthen their problem-solving abilities. This is referred to as **networking**. However, discussing pricing or agreeing as to which hospital will deliver which services is probably counterproductive, and possibly also in violation of antitrust laws.

Assistant Administrator or Vice President

One of the most important responsibilities of the CEO is to select and hire a competent administrative staff. The administrator's staff is given the responsibility of seeing that the hospital is run smoothly and efficiently. The assistant administrator or VP (sometimes referred to as the COO) is in charge of hospital operations and assists the CEO in coordinating all hospital activities, including support, ancillary, and fiscal services. Typically, there are assistant administrators or VPs in charge of all major functional areas in the hospital (Figure 3-4).

The administrative assistant is frequently involved in staff functions and is a junior member of the hospital's administrative team. The administrative assistant plans and participates in studies and programs that help the CEO in the hospital. Frequently, the administrative assistant will serve as a liaison between the hospital administrator and some of the other functioning hospital departments.

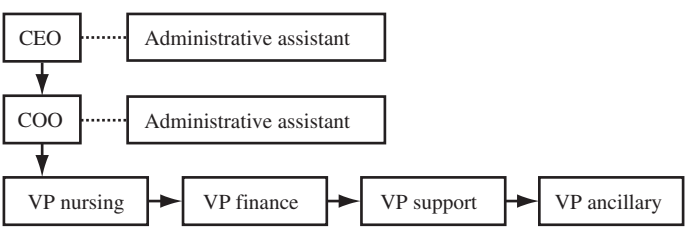

FIGURE 3-4. Typical organization of vice presidents.

THE FUTURE FOR CEOS

Although hospitals are not growing in number, they certainly are becoming much more complex. This has resulted in a middle management level in hospital administration, which means more management positions for healthcare administrators. Other changes in the healthcare industry are also leading to new jobs in hospital administration, such as VP of Regulatory Affairs and VP of Corporate Compliance. With respect to female hospital administrators, the future looks bright. A review of the number of students who are entering graduate programs in hospital administration shows nearly an equal number of men and women.

CHAPTER REVIEW

1. What is a **chain of command**?
2. Discuss the difference between line and staff functions.
3. What is a span of control?
4. What is product-line management?
5. What are some advantages of forming teams to undertake certain projects? What would be the disadvantages?
6. Discuss the concept of corporate restructuring. What are the pros and cons for a hospital?
7. You are the CEO of a 200-bed, free-standing hospital in a large city with 36 other hospitals. Discuss with your board members the pros and cons of becoming part of a multihospital system.
8. Discuss as an alternative the idea of joining an alliance.
9. What is meant by fiduciary?
10. How do not-for-profit and for-profit boards differ?
11. Why is director and officer insurance important?
12. What are five functions of the board of directors?
13. What is the importance of the board's bylaws?
14. Discuss the profile of a typical hospital board member. How might the person become a member of the board?
15. What relationship does the board of directors have with the medical staff? Discuss at least three important things the board does that directly affect the hospital's physicians.
16. What are some functions of the CEO?

17. What do we mean by activities outside the hospital?
18. What are some activities inside the hospital that should concern the CEO?
19. What is the typical function of the COO?
20. Discuss the term "respondeat superior." If an employee is sent to a local hardware store for plumbing parts, is the hospital liable for his or her traffic accidents while he or she is driving his or her own vehicle?
21. What are the steps involved in advancing within the ACHE?
22. Visit the ACHE website at http://www.ache.org and download the CEO employment contract that is available. Why is this an important document?
23. What are the typical rights and duties of an ex officio member of the board?