

Chapter 7

Meeting With the Board.

By Thomas A. Naegele, DO

I was requested to meet with the Hospital Board at their quarterly meeting to go over the gruesome 4 fiasco. So, on October 15, I went to the evening meeting at the local country club, one of the perks for being a board member, a great meal at the country club once a quarter.

I had time so I prepared for the worst. After all, 5 weeks into my work, 4 people were fired and some big changes were made. Ms Winter the administrator was a friend of Betty's, making it very difficult for her and a strain on the relationship. During the investigation, it had started looking as though Ms Winter, the administrator maybe involved with the illegal activities so much that she too may end up being fired. I hoped that she was smart enough to resign before it got to that. I decided that I better prepare on my own, for Ms Winter would no doubt be looking to point the finger at me, in the hopes that the resultant problem would be falling completely into my lap.

One must keep in mind that it takes a certain amount of "Sleeze Factor" to want to get involved heavily into politics. Hospital administration does require some politiking, just how much, is different from facility to facility.

For the next month, I did a lot of inquiry, being very careful not to let Ms Winters or any of the other administrative types know what I was doing. I started by calling on the phone as many of the physicians that had left or had been fired over the last 3 years. I told them that from my understanding that they were mere pawns in the game and that I was interested in hiring them back and wanted to keep their CVs on file. As I talked to them over time, I gained a lot of insight and found that many of these physicians were excellent in their own right and their efforts at trying to give patient care of excellence was rewarded with getting kicked out. I also found out that two of my present physicians, Dr Woods and Dr Cinde, may also be pathologic type 2s and the stories I heard were very concerning. Additionally, there was a Dr Richards, a local Family Practice physician with some very incriminating stories about him. All three of these physicians may even

be involved with real crimes. Over my short stay, I had noticed that Dr Richards, the local Family Practice physician, was always hanging around the hospital, even late into the night. This was weird, as this is not normal activity. Some of the physicians that left had seen Dr Richards giving IV medicines to different patients and it just so happened that the patient went into cardiopulmonary arrest shortly after seeing this interaction. And quite remarkably, Dr Richards was there, and miraculously saved the patients' life. As this was seen by 4 of the physicians that left for various reasons, I knew it was most likely true, now, the next step was to catch him. I had a lot of information, I knew I had to be careful with the information I was to present, and all of my accusations needed 100% proof. I took my time and prepared a dog and pony show on the information that I could back up 100%. I was ready.

I prepared a Corel Presentations show using my laptop computer and a computer projector (Corel Presentations is similar to Power Point, in the sense that a Mercedes Benz and a Volkswagon are both cars, Corel Presentations is a much more functionable program, reserved for those that have a more sophisticated appreciation for computer presentations).

I arrived at the Country Club at 18:40 for the 19:00 meeting. I wasn't the first to arrive early. The board was made up of 10 members, and of course Ms Winter the administrator. Ms Winter had a tape recorder that they used to tape the minutes and then one of the secretaries would type them up for later approval. We had a very nice dinner in the dining room over looking the golf course. After which we all retired to the Board room. I had previously set up my computer so that everything was in proper running order. I do like to test everything out ahead of time, as it saves embarrassment.

They were many topics on the agenda for the Board to discuss that evening. I was requested to be the first topic, I suspected because these were private meetings and after my discussion, I would be excused and talked about behind my back. With the proper introductions, I was given the chair.

"I have been asked to go over why we had to fire Betty, Carol, Donna and Jane. All four have worked for Mercy for many, many years. They have long been known as dedicated workers. What happened and how it happened I will do my best at explaining. As you will see, all four started with the best of intentions.

There was no planned malice there was no planned crimes. Through time, without any checks and balances they drifted from the main theme of patient care to their own agenda of power and control. I am not even sure that they knew where they were going, it just slowly happened and when it got recognized it was so far out of line, that even they didn't know how it had happened and how they got there," I started.

"Years ago, when Sisters of Mercy Medical Center had just been built, the Emergency Department contract was given to a group called 'Medical ER Group,'" I continued. Gaithus Bendum, MD was the President of the group. Dr Bendum had made an arrangement to give 24 hour service to Mercy when the patient volume was very low. In fact, during this time, more than ten years ago, for the entire first year, the ER volume did not exceed 3500 patients. Two physicians covered the whole contract and it was common for them to work for an entire week at a time."

"Betty, Carol, Donna and Jane had been working for Mercy for a very long time and all were there when Dr Bendum started the contract. In fact, a discussion with any of the four, will reveal that Dr Bendum was the best doctor that they had ever worked with. As things started getting busier, Dr Bendum encouraged the nurses "to get things ready" for him. Though there was never any written policy, Dr Bendum more than encouraged the nurses to order tests on the patients that came in, to start IV lines and to even give medicines so that the patient would be "ready" for when the doctor came out to determine the final disposition. In the beginning, the four nurses were much more cautious, and they would call and talk with Dr Bendum in the call room to get guidance. As the years went by, in the nurses minds they needed less and less guidance and they felt that they had learned to be mini doctors from the training and encouragement of Dr Bendum. When the volume got to the point that a 24 hour shift was the maximum that a physician could do, Dr Bendum moved and sold the contract to another group. However, the change never occurred in the minds of the four nurses. They felt that they had ownership in this emergency department and that they knew best. Unfortunately, none of these ancillary service testing request protocols were ever written down. None of the medicine protocols were ever written down. In fact none of these activities that the nurses were doing was in their job description, nor approved by the ER hospital Committee. Though, they had been doing these activities under the approval of Dr Bendum, this was not a voted on nor agreed upon committee

protocols. Thus, in reality, these nurses were "practicing medicine without a license." They were acting well out of bounds of their nursing license jurisdiction and it basically put the hospital into a very precarious situation. For the safety of the patients and to stop any further hospital liability, there was only one solution and it was necessary to act quickly for the hospital liability was climbing every day they worked. As a person hired in hospital management, (that is the Director of the Emergency Department) by the board, I knew that I needed to act in such a way that the hospital would maintain its integrity and have no appearance of associated liability for maverick employees.

Over the last few years, the volume of this emergency department has grown to 24,000 patients per year. The community is still growing and it is expected that the ER patient volume will grow with it. The ER has gone from 7 day shifts, to 3 day shifts, to 24 hour shifts to two 12 hour shifts per day and now to three 12 hour shifts per day, and in the future, we will most likely have continuous double or even triple coverage."

"Betty, Jane, Carol and Donna all started with the best of intentions. But somehow, somewhere along the line, it started to get personal," I continued on.

"Lets look at the statistics just from the last two years. There are 186 nurse shifts on average per month, of which there are 14 full time nurses. Betty, Jane, Carol and Donna have been working for Mercy for more than ten years each. Looking at their work records, one would say that these people are good solid workers."

"However, when one starts to take a look at the whole picture, not just 4 people, but the whole team, that is when one starts realizing that something just is not right," I explained. "There are 10 other nursing positions, and the turnover rate is inexcusable. While Betty, Jane, Carol and Donna have all been here for 10 years, the next senior members are 4 nurses that have almost made one year. In the last two years, I will only go over the last two years because we do not have enough time to get into more than that but just to let you know, I do have the information available for those that would like to go over it. Anyway, in the last two years, there have been 47 nurses hired, all have quit except for the ones we have now. The cost of orientation, of hiring, of sign on bonuses and more, make Betty, Jane, Carol and Donna the highest paid nursing staff in the entire USA. I called every nurse that was here during the last two years and interviewed them on this

problem. There was one common theme, none of them could work with the "gruesome four." The "gruesome four" has been the local nickname for Betty, Jane, Carol and Donna, we are not trying to be bigoted nor a problem, but during this investigation, it seemed to be true to the spirit of our investigation and our discoveries. Many of the nurses saw Betty and Carol hide equipment so that Betty or Carol would be called in later, one to be the heroine and save the day for finding the equipment and two to be able to clock in and get a little bit of overtime pay. Remember when Betty told us that Dr Hillar had unplugged the ventilator in an effort to kill a patient, well, I talked with the other nurse that was working that day. This nurse was working in another patient room with Dr Hillar, this nurse had left the room and was looking in the room with the patient that was on the ventilator and she saw Betty unplug the ventilator. Betty got up and saw her, so she tried to make it look like she did not see anything. After Dr Hillar was fired on the spot, that nurse quit, she said if Betty was willing to kill a patient to prove her point, then it was too dangerous there to work. Here are a sample of the nursing scheduling sheets to verify this information."

"We have 3 physicians that have been here for more than one year. The rest have only been here for around 6 months. There has been 27 full time physicians during the last two years. Mercy is known State wide as a "Shark Tank." A Shark Tank is a place where the nurses are running the ER and not the physicians. Shark Tanks are known for bad medical care, mediocre management and lots of problems. In order to fill last minute shifts that have been caused by one of the gruesome four, Mercy has had to pay time and half or double time for 108 days during the last two years. It has cost Mercy well over \$500,000.00 annually for the past two years to keep these four nurses employed. Here are some of the physician schedule sheets to verify this information," continuing on, I handed out the sheets of paper to the board members.

"When talking with the staff about the Emergency Department Staff meetings, the ER physicians were not allowed to participate. The staff was encouraged and even forced sometimes to give private information on the ER physicians, on other staff and to incriminate these people so that Betty could use this information for her own personal purposes of power. If the staff ever complained about another staff member or a physician to Betty, then Betty would use that information to back stab the physician or staff member. Anyone that would not play ball, was eliminated, here is a list of the staff members that left or were eliminated in some

fashion or another," again handing the papers out to the board members.

"Here is a stack of incident reports that were written by the physicians that quit or were fired due to Betty's undermining methods. These reports were hidden and never taken to the proper committee or copies of "lost reports" that I obtained from these physicians. These are reports of the gruesome 4 giving patients medicines without orders, reports of when the physician requested one of the gruesome four to give a medicine and/or to do some testing, the nurse would counter the order in front of the patient saying that this was bad medicine and incompetence, when in fact, it was modern medicine and the best option for the patient. Can you imagine being a patient and when the doctor tells the nurse to do a task and the nurse argues with the doctor, telling the doctor that it is bad medicine or incompetent medical care, just what is that patient to think?" querying my audience.

"No matter what the situation, should there be any disagreement, it should NEVER occur in the room with a patient. For medicine of excellence, the patient NEEDS to believe that the physician and the nurse are working together as a team. Any disagreement should occur out of range of the patient," I clarified.

"Because the gruesome four had learned medical therapies from years ago and they had learned them from memorization instead of from understanding of physiology, anatomy, pathology and pharmacology, they did not have the necessary education nor background to understand the newer therapies, thus, when a new physician would come in and write an order for a modern evidence based therapy, the gruesome four were not up to date, as they did not take yearly continuing medical education courses and thus they thought that they knew more about it because they had been giving patients medicines for years, yet there was never a real understanding of the science behind it, it was just repeating what they were told from years gone by. Then, when the newer physicians would come in and order the newer evidence based therapies, these up to date physicians would be written up and discarded inappropriately, and given reputations as incompetent, which was far from the truth," I went on.

"Additionally, when looking at some of these incident reports that were conveniently lost by Betty, there are many incidents of repeated insubordination, incidents of when all of these 4 nurses at different times did not like a patient because of the way they smelled or their clothes or because the patient is a

frequent Emergency Department patient and reports of malicious patient care, trying to hurt the patient because the patient is not cooperative in their manner of cooperation, calling the patients' malicious and insulting names while at the nursing station, and intimidating the other nursing staff when they do not participate in these childish games, all which are very unprofessional and have the potential to create patient morbidity and mortality," I added, when giving copies of these incident reports to each of the board members.

"In looking at patient throughput, these 4 nurses have been the bottleneck in all time flow studies. As they do not like the numerous patients, these 4 staffers undermined the process and purposely made patients wait, and in my opinion, needlessly. These 4 nurses want the old days, when the patient flow was much slower. They have not been able to make the change and adjust to the increasing patient volume, so they have instead, thrown a wrench into the gears in an effort to destroy the hospital. Instead of being a solution for patient care at Sisters of Mercy, they have created throughput problems and slowed patient care for their own benefit," handing out copies of the process flow time studies with the results showing that the problems are always associated with the shifts that these 4 nurses work and not on any of the other shifts," I had laid out.

"While many people look at these 4 nurses as giving their life to the Hospital, we need to take a good look at the statistics and the facts. The high turnover rate of nurses is clearly a nursing management problem of which these 4 nurses have created and maintained. They like the over time but it is more of a pathologic personality trait than a solution for the hospital and patient care. Their attitude is disruptive to patient care of excellence and anytime a physician uses modern methods they are written up as incompetent medical care, yet it is just the opposite. As it is not in the Hospital bylaws or the Hospital procedures, how did these 4 nurses get a carte blanc to judge emergency department physicians in terms of the physicians ability to give quality medical care? These nurses are not physicians, they are not on any quality assurance committee, they are not following any set of Hospital procedures or bylaws. How can these nurses get the power to get physicians fired or black balled or removed from the schedules? These 4 nurses have no medical degree, they have no list of continuing medical education courses giving them knowledge in modern emergency medical care, and they have no training in quality assurance nor quality medical care. These 4 nurses are being praised as being solutions to problems of which they themselves created. These 4

nurses have created crisis after crisis after crisis. They have literally cost this hospital millions of dollars, and somehow and somehow, they have been praised and rewarded for this vicious immature and unprofessional behavior. My question is why am I the one bringing this to the board, as this should of been observed and discovered years ago," I had said continuing on with more facts to base every comment.

"Department supplies and inventories is my last comment. In looking at the supplies that are coming and going into the ER and the supplies that we are keeping track of as being assigned to patients, there is a big discrepancy. In the two years that I have been looking at, nearly 50% of the supplies are unaccounted for. This task of whom is supposed to be keeping track of these supplies and how they are to be assigned to each of the patients has never been very clear since I have started here a few months ago. It is my opinion that we should know where each and every supply goes and which patients they are used on. Should there be a problem with a medicine or some supply, it is just good medical care to be able to track this information through time. To my knowledge, there has never been a good supply management method implemented, and as I have no idea of what is really coming and going, I am unable to give a good report on our supplies and what we use them for. In the future, I plan to develop a method with the ER team to keep track of all of these supplies. Thank-you for allowing me to go over the problems in detail and to get the necessary documentation to you so that you too will fully understand our dilemma in fulfilling our goal of medical care of excellence," I ended.

I had planned to not even bring up Ms Winter, even though she should of known what was going on in her hospital, I figured I would give her the benefit of the doubt. Though in remembering the management seminar by Dr Elegean, if there is a problem, the management is to blame. There was no doubt in my mind that Ms Winter blew it big time, and she just didn't take care of business. During my short few months at Mercy, I noticed that Ms Winter does her hospital management from her office. She rarely takes the short walks to each department to see for her own eyes what is going on in each department. She only knew the names of the department heads. And I noticed she never came to the hospital except between 8 and 5, she never made a night visit nor came to see what the night shift was doing. Ms Winter's management method was management from the control center. The only information she got was from the department heads, the chosen few. No

other information was utilized or obtained. If the department head gave Ms Winters bad information, then it was that bad information that was used for decision making. Ms Winters never bothered to check to see if the information was accurate, she apparently never heard the quotation "Trust but Verify."

During the quality management seminar I had taken with Dr Elegean, he repeatedly said "any administrator that does not spend time in each department and during each shift, talking with the staff and getting first hand knowledge of the operations, even helping out with the scut work, doesn't deserve to be administrator and should be fired on the spot by the board once this poor behavior has been identified."

I had copies of each of the accusations with supporting material, there was no doubt, Betty, Carol, Jane and Donna would never be coming back, they had committed numerous felonies and they acted way out of line. I hadn't heard anything from them since we kicked them out on that day back in August. The staff had all supported me and since then we had been having a very stable situation. I do not know if the Board had heard from the gruesome four or not, as they did not share any of this information with me.

"Dr Zenran," Mr Felding said, "your presentation was very thorough and there is clearly enough supporting documents to support your decision and the path you took. As this was covered so well, we most likely will support your decision, but of course we must all go through the information in detail, for that is our job. Thank you so much for joining us tonight. We value you as a excellent team member and we can see from your work so far, that you are helping our hospital aim toward medical care of excellence, just as you said you would do. Please excuse us now so that we can attend to our other business and again thank you so much for doing such a complete and thorough job."

"Thank you," I responded, got up, packed up my computer, projector and left the room.

I walked out of the Country Club, to the parking lot, got in my car and drove home. Sarah, my wife, asked me how the interrogation went. I was surprised that it went so well, though there were still thoughts of what happened to Ms Winter during the meeting. Plus we never got around to talking about the new paramedic

and nursing arrangements which was turning out astoundingly excellent and was being well received by the patients.

As I did my investigation of the gruesome four, I realized that our goal was to give patient care of excellence. Whether it was nurses, paramedics, doctors, mid-levels, or whatever, my goal was to give patient care of excellence, that was what I was hired to do and that is what we were starting to do, it was working. Just like Dr Elegean had told me at the seminar and through our phone conversations over these last few months.

Remembering back after firing the gruesome four, our new rough start in September, our struggle with PRN nurses, and then trying out a paramedic model which turned out to be incredible and tops in giving excellent care. The nursing turf battle was really difficult and I wondered if we could get through. I thought and thought and thought, what type of arrangement would give medical care of excellence within Sisters of Mercy Medical Center. There was no need to solve the problems of the world, of the State's hospitals, or the hospital across town, the goal was to solve the problem right here at Sisters of Mercy.

So, though there were some "Nursing Turf" Laws on State Books for Hospital care, I was determined to give our patients medical care of excellence and to find a way around these "TURF Laws" so that we could start giving patients health care of excellence, instead of following the laws and forcing patients into accepting mediocre health care. "Turf Laws" are laws that allow a profession to keep others out of the geographical area for reasons of money and power. There is always claims of quality, but in the emergency department, I found through time, over and over again that using Paramedics instead of Nurses actually improved the medical care and not by a little but by a lot. This actually made the "Turf Laws" counter productive, in fact these laws requiring nurses in the ED promoted poor quality patient care and health care of mediocracy. The nurses have done some very good lobbying to keep any people except nurses within the hospitals. The physicians too, have many turf laws, but it is my belief that patients should come first and any law that puts a patient as second rate in comparison to the money and power, is a bad law. I was ready to make the fight, but for the sake of everyone involved, I would try to work within the system and the laws so as not to cause any hospital liability.

In a physician office, a physician can appoint any person to assist the physician in their job of patient care, including giving parenteral medicines (shots), oral medicines, durable goods application and any medical care that the physician deems appropriate. There has been arguments about this along with some examples both supportive and counter-supportive.

In a hospital, the nursing associations have implemented State laws to enforce that hospitals are run by nurses. However, with intense scrutiny, we found that we could get around this. In spite of these turf laws, we could still give patient care of excellence, even though the lawmakers did everything they could to undermine the patient and to force us into giving mediocre health care. Believing that the patient should be given health care of excellence apparently was not on the minds of our law makers.

The team decided to have one nurse on at all times, and that nurse would managed the operations of the ER. This nurse keep track of all of the comings and goings of the patients. This one nurse would stay at the desk, and review the patient orders, get the medicines prepared, and then get them ready for the paramedics to administer. It really worked well. There were no med errors since we started this program. The nurse manager stayed in a small area and managed all the activities, while the paramedics were the ones that would go and see the patients and deliver the therapies. Though it was just in trial, it would later turn out to be a real solution and a great leap in patient care of excellence. As we got busier, our department needed a board approach, thus the nurse stayed at the main desk and also then managed the board, keeping track of all of the patients, their ancillary service requests, the staff and their whereabouts.

We set up the following schedule.

Nurse 7a-7p

Paramedic 8a-8p

Paramedic 10a-10p

Paramedic 12-12

Paramedic 3p-3a

Paramedic 8p-8a

Nurse 7p-7a

There was one nurse working at all times. This nurse could be used for front line

patient care, but it was only when an ambulance came in, and there were no available rooms.

The main job of the nurse was to manage the patient flow. This included getting the chart from the triage paramedic, order all of the ancillary services that followed the chief complaint protocols and keep the board up to date. After the physician saw the patient, if more ancillary services, medicines or durable goods were needed for therapy, the nurse would order these test, get the medicines ready and give them to the paramedics for disposition on the patient, and/or get the durable goods and then give them to the paramedic for administration. This simple set up also allowed us to keep track of all supplies, because one person, this one nurse, saw every patient chart and could keep track of each situation along with the supplies.

The paramedics would triage the patient and assign the original ancillary tests if on protocol and assign a color of red, yellow or green to the patient. Red meant high priority, yellow was medium priority and green was low priority. Reds were taken back into a patient room immediately. Yellows were given a yellow number and greens were given a green number. In the waiting room we had a board with three labels, Red, Yellow and Green. Below each label was an electronic number which the staff could operate from inside. This let the patients know where they stood in terms of being seen. There was an explanation board that all Reds were seen first, then all Yellows and then the Greens. The clerk managed this sign.

After this, the paramedic would take the patient to the room and get the patient in the proper gown for physician exam. Getting the patient into the proper attire has always been a downfall of nursing. Emergency Department Nurses are notorious for not getting the patient into the proper exam attire. Patients that were brought in by ambulance, never a problem, but patients that are ambulatory, always a problem. Getting the patient into the exam gown makes for a very quality physical exam. Getting this across to the paramedics was not an issue, during the orientation process, I personally informed them that the body site of problem needed complete exposure at least one joint above and one joint below. The paramedics in turned took this information very seriously and took the time necessary to explain it to the patient and how it was important to have the anatomical site exposed for the best medical exam possible. In our survey's we found that requiring all patients to get into an exam gown, even helping them into

it on many occasions, was acknowledged by the patients as "an emergency department that always gives a thorough and complete examination." With the paramedics' explanation and enthusiasm, the patients' obliged without problem. We additionally had a small poster in each room that said, "Get A Proper Exam, Get Into A Gown."

After the patient was put into their room, the physician was notified that the patient was available, via the non verbal communication box board. Which turned out to a very important device.

In remembering Dr Elegean's course, the lecture on non-verbal communication methods was very important in building our communication box. The box board we designed structured the emergency Department into three sections, with 4 exam rooms per section. Each paramedic was assigned a section (1, 2 or 3)(ZONE), when there were three available. So, their first duty was to the patients in their section. Should they be on hold, then their next duty was to help with the other sections. The nurse would manage this tool and would also put in a hand for a few minutes here and there. But the nurse's job was to manage the patient flow, to observe where the staff was, to identify situations that needed immediate problem solving, and to redirect staff when they had the time.

There are 3 kinds of nursing/paramedic patient care within the Emergency Department. One on One, Sequence, and Zone. One on One nursing / paramedic care is when one care giver gives care to one patient. Sequence nursing / paramedic care is when the care giver picks up the next order and gives the care to which ever patient is on the next order. Zone is when a nurse or paramedic takes care of a zone or an area in an emergency department. There may be one or more staff assigned to a zone in a busy emergency department. We settled on Zone patient care with some hybridization of sequence patient care when some of the staff was busy and others were not.

With the initial physician patient visit, if more ancillary services, medicines or durable goods were requested, the chart was put into the nurse slot, where the nurse would then figure out the request, get it done and then place the chart into the appropriate slot.

With the four nurses gone, four others quit within the next two weeks out of fear.

Apparently they were badgered by the gruesome four by phone calls. That left us six nurses, and with our new plan of switching over to paramedics and having one nurse on, six nurses was all we needed. At first everyone was very worried, so we hired some "PRN Nurses" but in 4 weeks, the cost was overwhelming and even Ms Winter suggested another solution.

As there were plenty of paramedics in the area needing work, it worked out really well. Paramedics have a much different attitude and approach than nurses. The results were phenomenal. At first the nurses were offended, as our nurses felt that they deserved more respect and more recognition, this was how they felt, I am not certain that it is justified, but that was the reality. Anyway, as we only had one nurse on duty at any given time, the nurses job was to act more as a manager of the activities and believe it or not, it suited our nurses. They liked the idea that the paramedics had to come to them for orders and it allowed them the recognition that they felt they needed. The paramedics did not have that strong need to be needed, as they just liked having a job in health care and being able to use their skills to their full ability. The paramedics and nurses had different attitudes and personalities in which this model transformed these people into a team of excellence, something that I had never seen in a nurse only emergency department.

OUR NON-VERBAL COMMUNICATION CENTER.

Doctors Orders Paramedics End Process

1	7	Red	1	7	Zone 1
2	8	Yel	2	8	Zone 2
3	9	Green	3	9	Zone 3
4	10		4	10	Middle
5	11	n s	5	11	
6	12	u e	6	12	Doctor
		r			

Our non-verbal communication center was made of wood. It was a matrix of 6 main columns with 7 rows which we mounted to the wall in an easy to get at place for the staff, out in the open, with lots of room. Column one and two each had six slots, one for each of the 12 patient rooms. These were the physician boxes. When a patient was to be seen by the physician, the chart would be in this box. The middle column had four slots, a small one for the RED patients in the lobby, a little bit larger one for the YELLOW patients in the lobby, the biggest one for the GREEN patients in the lobby, and the bottom one was for the nurse. Any chart that needed ancillary services, meds, durable goods, whatever, first went to the nurse. From here the nurse could make the order, get the accounting sheets filled out and put the chart into the proper slot for either the paramedic or the physician to see next. The last two columns each had 6 slots, again for the 12 exam rooms. These 12 room slots also had three little tags that came out from the side. The tags had 00, 20, and 40 on them, meaning that the vitals or the patient needed a recheck on the hour, at 20 after the hour or at 40 after the hour, as we all decided that the patients should all be looked at every 20 minutes. All of the ancillary service reports came to the nurse. This way, nothing was over looked. The nurse would then get the reports, such as the lab reports, determine if the whole set came back or if there was a problem, and if the reports were completed or there was a problem that needed immediate attention, then the nurse would put the chart with the reports into the physician side of the board. And in this way, the physician could see even from across the room the task waiting.

When a patient was discharged, the paramedic would put the discharged patient chart into the nurse box. The nurse would then select a patient from the RED,

YELLOW or lastly GREEN box, and then put the chart into the paramedic exam room slot. Then when ready, the paramedic would go and get the patient and bring them back. After room assignment was done, the nurse would then go through the chart get the billing checked off, scan the chart for deficiencies. If there were physician deficiencies then the nurse would put the chart into the physician deficiency box in the bottom of the 6th column. When the physician was done, then the physician would put the chart into the 6th column middle slot, where the nurse would then recheck it. If there were paramedic deficiencies then the nurse would put these into the paramedic deficiency slot by zones. As each paramedic would be assigned a zone, then they would just check their zone for deficient charts. Though some of the other paramedics would help in other rooms and zones in busy times, it was still the responsibility of the paramedic assigned to that zone to get the charting done for that patient.

When one physician was working, only eight of the exam rooms would be used. When two physicians were working, we used all twelve rooms with each doctor taking 6 apiece. We studied this phenomena of patients per physician and room turn around time. Eight rooms is maximum for a single physician, having more than eight rooms actually increased the patient in department time, it cut the volume of potential patients seen within a 24 hour period and it cut the efficiency of the whole staff. Eight rooms turned out to be the most efficient for a single physician. Additionally, with multiple physicians, 6 rooms per physician turned out to be the most efficient in terms of patient turn around, patients per room per 24 hour period, staff management, and staff efficiency. During our study we found that an 8 room emergency department with one physician could turn over more than 100 patients in 24 hours (though difficult). Yet, we found a 21 patient room emergency department with one physician could barely see 50 patients within a 24 hours period. More rooms actually hinders the process, because it is just to many people to mentally keep track of, the physician has to spend additional time going over the chart multiple times because the information gets mixed up within their minds. Thus, anytime a patient needs to be seen two times or more, the physician commonly had to redo the interview and exam because it is difficult to remember the details which are required for medical care of excellence. With two physicians, a 12 patient room emergency department could turnover close to 200 patients in a 24 hour period, yet two physicians in a 24 patient room emergency department could only turn over a little more than 80 patients.

Process flow models and process management concepts are difficult to understand. There is this overwhelming belief by administrators that the more exam rooms there are, the faster the patient throughput. Patient turn around and throughput has a lot to do with the number of rooms, that is the right number of rooms, not the amount of rooms. System efficiency, facility layout and organization, re-round time, and process flow management are the other variables that need to be evaluated and defined along with the right number of rooms.

"Dr Zenran," Ms Winter said knocking on my office door in the Emergency Department.

"Yes, come on in," I said getting myself back to October 16 after mentally thinking of how far we had come in these short few months.

"Your presentation was very well done last night," Ms Winter started, "I really appreciate that you clearly went out of your way to leave me out of the story. However, the board felt that I should of been aware of these problems, as I have been here for the last 6 years. They ended up giving me a vote of 'no confidence.' As I was sitting there listening to your talk, I thought back and it just never really occurred to me that this was going on. I had been listening to Betty tell me about all of these bad nurses and bad physicians and it just never occurred to me that Betty was the problem. Betty was always there, she would work overtime, she would work anytime, always available, always johnny on the spot. When you showed me the information about Betty and the other three nurses back in August, I saw that there would be no alternative but to let them go. However, I was afraid, as the Emergency Department has had so much trouble getting staff that I thought with firing the 4 best nurses I had, that we would end up putting ourselves in a worse jam. Actually, I was hoping that you would fail and bring this hospital down with you. Now that it is October, and I see the changes that you have made, it is the first time that we have had a steady 6 weeks, no absences, no problems, no bad doctors that had to be removed, no bad nurses that quit, and though 6 weeks is really not that long, this emergency department has never not had a crisis in that short amount of time of 6 weeks. Here you have the schedule made out all the way to the end of the year, the staff is very happy and they like coming to work, I have to admit, I completely analyzed the problem wrong," Ms Winter commented. "Though I wanted to see you fail, so I could get back to my life as usual, I now realize that it was me, I missed an opportunity, I really failed in my job."

"My best move is to resign, so I told the board I would resign in 4 weeks and help them to get a new administrator," Ms Winter added. They said that they would give me 6 months severance pay, and they want you to be very influential in hiring the new administrator. The Board requested that I keep you informed on all of the steps of this process. Dr Zenran, you made this emergency department into an emergency department of excellence and you did it in under 4 months. The Board is very impressed and so am I, I just wish I had seen the writing on the wall," Ms Winter solemnly said.

"I don't know what to say," I replied, "it is wise to resign, as it would be very difficult to stay on in this situation. I would say that by recognizing your errors, the next job will be that much better. If I can write a letter or give you a reference, I think you can use this experience to be an administrator of excellence in your next opportunity."

Ms Winter left. Through the next month, there was a real change in her, she started visiting each department, getting to know the staff, and really made an effort to learn the concepts of a administrator of excellence.

The next week, I started talking with the physicians, nurses, paramedics and the clerks about meetings and how to communicate our situations without a specific meeting. Everyone seemed to value their off time and no one really liked coming in for a meeting if they were not already working. We decided to try a meeting board. A bulletin board was put up in the break room. On this bulletin board as the ER Director, I put up the topics that needed discussion and needed communication. Each bit of information or discussion paper had a list of everyone's name on the front. After each person read it, they checked their name off. If comments were required, we had a sheet on the back where comments were written. We discussed these concepts at work during our in-between times. I personally got people to talk about topics in quality assurance, in auditing, in patient records, in protocols, in transfers and anything else of which the whole department needed everyone to know. For three months we did this, and it worked very well. As I was the director, I had to go out of my way to talk with each person in small groups or individually, but it turned out to be a much better method and things got thoroughly discussed and thoroughly understood. After three months, I went to the hospital staff meeting and made this method of a department meeting, that is a bulletin board meeting, into a legal and hospital

acceptable meeting, it was now on the books, our on the job meetings were now official, as a formal part of the hospital policies and bylaws.

It was now the first week in November. We had made it for two months without hiring any PRN nurses or Locum Tenens physicians.

Places that have excellent management are fun to work at. The staff enjoys their work and the comradery makes life worth living. Any facility that needs PRN nurses and/or Locum Tenens physicians on a regular basis has management problems and that is all there is to it. To deny it, is just lying to oneself. If there are lots of temporary staff, then the administrator is probably managing by sitting in their office and only talking with the department managers.

There is so much business in health care for temporary nurses and physicians that it sticks out like a sore thumb. With all of this temporary work available and this high turnover of staff, this is clearly indicative of some very serious management disorders.

In looking over our Emergency Department Physicians, we have Dr Miller, Dr Kampe, Dr Wyatt, Dr George, Dr Woods and Dr Cinde.

In looking at the numerous emergency departments across the USA, as a general rule (of which there are many exceptions) the larger emergency departments take less amounts of clinical decision making skills, with more management skills, while the smaller facilities take more clinical decision making skills and the less management skills. There will be arguments about this statement, and there will be a lot of emotional flaring because of it. However, the larger emergency departments have a tendency to utilize many specialists whom can be eager for work, while in the rural emergency departments, the emergency department physician has to manage the patients for longer periods of time.

Large volume emergency departments are at large hospital centers. Large hospital centers have lots of specialists and sub-specialists. Thus, these physician specialists and sub-specialists want to get the patients that have diagnoses within their specialty and make themselves available. The job of the emergency department physician is more of taking care of the outpatients and then initial identification and stabilization of the potential inpatient for consult and admission

to the specialist or sub-specialist. The large volume emergency department physicians spend a lot of time in communication methodologies with the admitting and consulting physicians.

In the low volume emergency departments, there may only be two physicians in town, there may be more or their may be none. Because of this, the emergency department physician is required to solve more problems and be more resourceful in nature. In the smallest emergency departments the emergency department physician may also be the hospitalist, and thus when a patient needs to be admitted, they will just do it. If the patient needs a surgeon, the general surgeon may come in and say lets take this patient to surgery and may request the assistance of the emergency department physician, because it may take two people to do the job.

The moderate volume emergency departments are a hybrid of the two extremes. When an emergency department is growing, there comes a point of growing pains at each of the different stages of growth. Not enough volume to hire more people, but clearly enough volume to become more efficient. These growing changes typically will need change within communication methods. Non-verbal communication methodologies need to be understood and one selected for implementation. Then, as the patient volume increases through time, the non-verbal communication methods will also need changing.

Facility layout concepts for efficiency need to be evaluated and re-evaluated through the growing patient volume times. It is important to realize that the emergency department needs to be one area. If add-ons are done, making joined sections, one can count on efficiency problems, and a slow down in throughput. This is an inherent problem with "patched" layouts. Always keep in mind 6-8 rooms per physician depending upon the ancillary service throughput times.

The Emergency Medicine societies have done a very successful sales job on getting control of the larger and highest paying emergency department jobs. However, the residency trained emergency medicine physicians have never been found to be the best physicians within any emergency department in any of the studies. What has been found to give the best quality of care and medical care of excellence is to have physicians from emergency medicine training, family

practice training, internal medicine training and surgical training, when an emergency department has at least one from each of these training backgrounds, this gives the best chance of obtaining excellence. If the goal of the hospital administration is to achieve health care of excellence, the administration will secure a team of physicians from the multiple disciplines and training background.

Dr Miller is a internist by training. He is very analytical, as internists are. He orders more tests than the rest of the group, but he has the highest definitive diagnostic successes, and even for the zebras (zebra is a term used within usa medicine for rare diseases). Dr Miller is particular, he is our slowest physician, but he is learning the methodology to speed up. Dr Miller is the one that approves all of our protocols, just prior to the committee meeting, because he is vigilant in staying up to date on the literature. He has some eccentric behavior, but he never takes things personal. Once the nurses understood this, everything ran smooth. When Dr Miller wants something, he asks for it. This initially was not clear to the staff, for they were used to physicians that are aggressive. For example, if Dr Miller wants a suture set up in a patient room, Dr Miller would say, "I am thinking about suturing up the patient in room 5." Really he means, "Nurse, go and get all of the necessary equipment for suturing up a laceration in room 5 and do it pronto." But that is not Dr Miller's way. So, it took some training for the nurses to understand Dr Miller's mild mannered approach. This approach was initially evaluated by the nursing team to mean an incompetent physician. There was concern on their part about Dr Miller. Through time, when the nurses and paramedics saw that all of the other physicians would ask Dr Miller medical questions, they eventually saw that they just misinterpreted mild mannerism with incompetence, which was clearly not the case at all. Dr Miller is the best diagnostician we have, he is just not aggressive. This is where I learned that in many cases, nurses view physicians with aggressive personalities as competent, and physicians with mild personalities with incompetence. This is a big mistake.

Dr Kampe is a general surgeon. Dr Kampe is a surgeon through and through. He ended up getting hepatitis from a surgical case, and was lucky enough to take the interferon therapy and get a cure. He now does emergency medicine full time. He enjoys procedures and is very skilled at them, as he has done many. Like most surgeons he is abrupt and to the point. He is commanding and that is clear. Dr Kampe does not ask, he tells. The nurses were used to this type of physician. However they did not know that Dr Kampe was a very compassionate person, that

took years to come out. For the patients really loved Dr Kampe, and the staff viewed Dr Kampe as gruff and abrupt.

Dr Wyatt is a board certified family practitioner. Dr Wyatt has been working in emergency departments for more than 20 years. He has also worked as a hospitalist, an office physician and has been on many surgical assists. One thing that becomes clear when working with FPs within the emergency department is that they have the best all round knowledge of health care and all of its processes. The FP knows all of the interactions that the patient will be going through during their health care process. Dr Wyatt sees the most patients per hour in our group.

Dr George is a residency trained board certified emergency medicine physician. I say that because of the politics of the emergency medicine societies. We have a policy at our emergency department to write the admitting orders. Dr George has been very resistant to this action, giving us the emergency medicine society literature on malpractice and the writing of orders. Dr George is a good caring physician and takes pride in his work. His training did not prepare him for a rural moderate volume emergency department. Here, we are expected to solve a lot of health care problems of which in a bigger emergency department would just be sent over to a specialist or sub-specialist. So, Dr George has had to learn a lot of things, but he is well liked, intelligent and above all a team player.

Dr Woods is a grandfathered in board certified emergency medicine physician. Dr Woods is from the old school. He worked as an office physician, a hospitalist and assisted in many surgeries through his career. He tells everyone he is a "board certified emergency medicine physician," but to the other physician team members, he tells us that he is really just a "general practitioner." He has a vast knowledge of many of the older therapies, which still come in handy.

Dr Cinde has two years in general surgery and grandfathered into family practice. Dr Cinde's father was a general surgeon and her uncle was a thoracic surgeon. So she lived within medicine throughout her whole life. She is a fighter by nature, and has a demanding and aggressive personality. However, she has a very strong nurturing side, and when with patients, she shows this side exclusively. The surgery residency just took too much out of her, as it is very rigorous, and one is trained by intimidation, which takes a very leathery personality.

