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EDITORIAL

The COVID Effect: Making a Case for Uniform Accreditation among Healthcare Leadership

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The COVID pandemic has revealed much that we as a medical community did not know about a strain of the virus. More revealing, however, is what the COVID pandemic has revealed about the blueprint of our medical community and our society at large. Much was spoken and written in recent months about the failures of leadership at the international and state levels. Interestingly, online medical bulletins have also detailed the financial windfall for for-profit health systems such as HCA [1] as well as the staffing shortages and union challenges in other systems such as Tenet [2]. C-Suite leaders have shuffled from one facility to the next in the face of consolidation and a reset of organizational priorities. What is lacking from much of this debate and discussion, is hard and objective, accountability for the effects of the pandemic on hospital staff. As physicians on the front line of the worst pandemic in a century, doctors are still required to maintain active medical licenses, board certification, high-quality care, as well as an extremely high level of professionalism at work and outside. As a Cardiothoracic Surgeon, I would not perform heart or lung surgery without the necessary surgical equipment or supplies, such as suture, gauze, forceps. Why then during the height of the pandemic were providers forced to re-use masks, hats, and face shields? Why did the use of PAPR respirators require letters of appeal and training after the pandemic had already begun? While the lack of physical beds and ventilators along with poor staffing levels is also contributory, it is management's lack of empathy and frontline presence which has led to widespread resignations as a result of depressed morale and burnout [3]. This can easily be chalked up to a "Tsunami"-like a phenomenon that nobody could have expected and, thus, nobody was prepared for. However, as a surgeon on call, there is a reasonable expectation that at some point, one will get a phone call for an emergency, and thus, should be prepared. Granted, the frequency of those emergencies will likely affect the desired consistency of the response, but there is an assurance of some form of response. Ultimately, the medical staff and hospital employees are the individuals that drive a hospital's success and highlight those who maintain a high level of quality for both patients and staff. COVID mortality has not been publicly compared yet from hospital to hospital in our state, nor should it be done until we understand what drives differences in outcomes. We do know from recent reports that those from impoverished neighborhoods who had less access to care and those of African-American or Hispanic background fared worse during the pandemic [4, 5]. What we do not know is how many lives could have been saved if health systems were better managed and prepared? We have landed at this juncture because of doubt and a lack of trust in our leadership. This lack of trust has come from a departure from objective data and logical scientific processes. In healthcare, the medical community has relied on leaders in the financial, insurance, and legal industries to manage hospitals. The fundamental change at the healthcare level that is required to restore trust is to empower those in the medical community to lead organizations [6]. This informed leadership will help build the trust and collaboration needed from those on the frontlines to collectively steer through the pandemic and in the future. Just as physicians are required to be licensed and certified, so too must be hospital administrators. There should be a robust debate about the creation of a medical specialty or board that legitimizes the leadership of a hospital executive. Being a hospital executive should require a heightened sense of leadership and moral authority, just as physicians are bound by the Hippocratic Oath- "First, do no harm" [7]. Many administrators do perform internships and begin their careers in comparable fields such as healthcare devices, marketing and sales, *etc*. Others pursue certification in Lean, Six Sigma [8], as well as a Fellowship in the American College of Healthcare Executives [8]. However, to date, no such standard board exists that requires testing of competency, proficiency, or evaluation of skills needed to lead an organization. This lack of regulation results in a varied leadership response and creates confusion and deficits in

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perception. We have been well-acquainted with the concept of a high-reliability organization or HRO. An HRO relies on standardization, consistency, and improved communication to affect a high-quality result. However, imagine if the participants in one branch of the HRO had different educational qualifications; for example, some nurses did 2 years of post-Baccalaureate clinical training, whereas others had an online certificate. The result would be a disorganized service line characterized either by adjustments by the highly-trained nurses to accommodate the deficiencies of the other less well-trained colleagues or conflict. In the same light, administrators must possess the most basic certifications and training to lead an organization. A recent article on this topic of accountability in healthcare focused on several stages of behavior a leader exhibits when faced with a crisis [9]. The stages are characterized by behavior that ranged from "unaccountable-reactive" to "accountable-proactive". To explain this further, we can use an analogy from the medical field, such as lung cancer, *i.e*., a patient may be diagnosed incidentally with a lung mass [imaging done for another reason that shows an unexpected and unconnected pathology]. The patient may be completely asymptomatic and unaware of such lung mass. Early treatment, when the mass has not spread, results in good long-term survival when treated with surgery as the primary modality. However, if the provider incorrectly treats the patient based on symptoms alone and waits to treat when the patient exhibits shortness of breath or cough as a result of this lung mass, the patient may be in an advanced stage of cancer and miss out on an opportunity for long-term cure. Likewise, an aortic aneurysm, when diagnosed early, can be successfully treated with a stent or surgery, but if left untreated, providers may have to react to an emergency that entails treating a ruptured aneurysm that can potentially be fatal [and more costly]. Administrators will have a higher likelihood of exhibiting accountability when they [like physicians] have the necessary competencies and experiences to lead through crises [10]. Those who do not have the required skills and values will be perpetually faced with reacting to high stakes circumstances and be ill-prepared for the constant change that healthcare mandates for organizational sustainability. The public deserves better. Hospital administrators should be accredited or certified by a common entity. Executives should hold MHA [Master's in Healthcare Administration] or its equivalent degree and be certified by an entity such as the Commission on Accreditation of Healthcare Management Education [11]. Perhaps, administrators should be trained physicians who would empathize with front-line workers. Future health education models can include hospital-leadership training to better equip tomorrow's healthcare CEO. Today's leaders should have several years of experience in a hospital setting prior to holding an executive position of leadership or authority. Just as surgeons are committed to public reporting of statistics, so too should administrators be required to report associated quality and metrics, which would include Leapfrog scores, patient satisfaction scores, as well as evaluations by Human Resources. In the interim, it may be prudent for hospitals to form crisis advisory councils which would consist of physicians, nurses, EMT's, *etc*., that would directly impact the timely decisions of health administrators. Ultimately, it is incumbent on those of us in the healthcare industry to raise the ceiling and provide the best for our fellow citizens.

CONCLUSION

In order to raise the ceiling, however, we must first raise the floor. Advocating for higher standards of leadership will restore trust in medicine and science. Restoration of trust will lead to confidence in leadership during a crisis and will provide humanity with a stable rock to step on during the storm.

CONFLICT OF INTEREST

The author declares no conflict of interest, financial or otherwise.

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Declared none.

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