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Hospital Governance in a Crisis: Governance of Ontario Hospitals during SARS

by Lynne Golding and George Glover

The Ontario hospital system and, in particular, its management have been lauded for the manner in which they responded to the SARS epidemic that struck Ontario last Spring. Generally, the administrators of Ontario's hospitals – both administrators of hospitals that treated SARS patients and those that did not – are considered to have been quick in responding to the crisis, diligent in implementing applicable protocols, creative and scientifically sound in developing internal procedures where required and dedicated, beyond all conceivable expectations, to the support and safety of their patients and staff.

Dozens of articles and papers have explored the performance of Ontario's hospital system in the face of the SARS epidemic. The purpose of this article is to consider whether the generally stellar conduct of Ontario's senior hospital administrators and boards during the crisis was in keeping with the best principles of good corporate governance.

Many readers will surely ask whether it is reasonable to expect senior hospital administrators to be concerned with matters of governance in a time of crisis. Is it a luxury that can be afforded at that time? On the contrary, we would reply that it is not a luxury at all but rather a necessity, given all that is at stake to a hospital in a time of crisis.

For example, a decision to admit SARS patients to a hospital meant potentially exposing other patients and

staff to the life-threatening virus. A decision to cancel elective and other surgical procedures meant potentially putting at risk the health of hundreds of others, threatening the financial stability of the hospital and jeopardizing its ability to meet short-range and potential long-range plans, all matters that are at the heart of corporate governance. While ultimately government directives took away the power of many hospital boards and administrators to make decisions about a number of these matters, we will see in this article that some senior hospital administrators made related decisions before – or without ever – being mandated to do so.

In their four-part series entitled "Issues in the Governance of Canadian Hospitals,"* published in *Hospital Quarterly*, Mark Hundert, Robert Crawford and Adam Topp described the principles of good corporate governance of hospitals under four headings:

- Effective and Efficient Board Structures and Processes
- Long-Range Planning
- Financial Oversight
- Quality Oversight

The principles set out in their articles were drawn from

In future issues

- Insurance standards for evidence based care
- Healthcare insurance reform

experiences gained in operational reviews of hospitals across Canada and were summarized in a number of principles that should be followed by hospitals seeking to implement best practices in corporate governance. This article will consider some of those principles and will assess the extent to which each was followed by senior administrators and boards of four Ontario hospitals, each differently affected by SARS.

The four hospitals that are the subject of this article are:

- West Park Healthcare Centre, a 479-bed rehabilitation, complex continuing care and long-term care facility located in northwest Toronto. A former tuberculosis centre, West Park was the first hospital requested by the Ministry of Health and Long-Term Care to admit as patients infected healthcare workers including physicians and nurses from Scarborough Grace Hospital, the epicentre of the SARS outbreak in Ontario.
- Sunnybrook and Women's College Health Sciences Centre, a 1,200-bed health sciences centre with sites in central and north Toronto. In addition to treating 94 SARS patients between March and August 2003, Sunnybrook also established the province's only SARS screening clinic at its Women's College site in central Toronto.
- Southlake Regional Health Centre, a 300-bed community hospital located in Newmarket, north of Toronto. Over 50 patients presented themselves to Southlake's emergency department for SARS testing. Eight were admitted and treated: six as probable SARS patients; two as suspect patients.
- Toronto Rehabilitation Institute, a 500-bed rehabilitation and complex continuing care hospital with five sites located throughout Toronto. Like most Ontario hospitals, Toronto Rehab did not treat any SARS patients but operated in the crisis environment, at one point having over 100 employees in working quarantine due to their exposure to another employee determined to be a probable SARS case.

Hospital Planning

Hundert and Crawford speak of the necessity of planning in hospital governance and management. They describe the importance of establishing a Strategic Plan comprising a mission and/or vision statement, a set of core values; a list of communities and health needs to be served; a description of programs and services to be offered; and plans for achieving program and service

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goals. The Strategic Plan and its components are matters that should primarily be the responsibility of the board, developed with the input and assistance of management. Once it is adopted, management has a responsibility to develop an Operational Plan that translates the board's Strategic Plan into specific tactics and activities to be initiated in the next fiscal year. The Operational Plan should similarly be approved by the board (through its approval of the budget or otherwise) and then left to management to implement, with management's implicit ability to vary it in such minor ways as are necessary without the board's approval. However, major deviations from the implementation of the Operational Plan will require board consultation or approval.

In Spring 2003, all four of the subject hospitals had Strategic and Operational Plans of one sort or another. The Strategic Plan for Sunnybrook and Women's Hospital identified the treatment of acutely ill patients within its community as a key service offering. Southlake's Strategic Plan addressed acute care services for its primary catchment area but also focused on the development and provisions of regional tertiary services. The Strategic Plan for West Park identified the treatment of respiratory patients as a key service offering. But, similarly, all referred to the provision of numerous other specific programs and medical procedures (many of which had to be cancelled because of SARS); all spoke to desired fiscal outcomes; all spoke to the need to ensure the safety of patients and staff. None identified a protocol in the event that meeting one goal meant that another could not be met for a short, intermediate or long period. In the absence of such a hierarchy, should management of the subject hospitals have sought specific direction from their respective boards before admitting SARS patients or taking other steps relating to SARS that would cause other objectives not to be met? None of the management of the subject hospitals did, although all did a thorough job of keeping their boards apprised of their actions.

To be fair, not all of the consequences of treating SARS patients and of cancelling non-emergency procedures were the result of decisions by management of the subject hospitals. While ultimately the government did ask Sunnybrook and Women's to play a leading role in managing SARS in the province, the initial SARS patient admitted there came in the way of most patients – through a physician-to-physician referral. No management decision was involved. Similarly, the first probable case admitted to Southlake came in, without warning, through Southlake's emergency department, one day before the first directive was issued. Again,

management was not involved in the decision to admit the patient. (The extent to which Strategic and Operational Plans of boards and management can be compromised as a result of admissions to a hospital is a subject worthy of a separate article.)

Furthermore, once the directives were issued by the Ministry of Health, the hospitals to which they were directed were compelled to implement them – even though implementation would, by necessity, have an adverse effect on their Operational Plans and their balance sheets. None of the subject hospitals sought board approval to implement the directives. For two reasons, we agree that board consent was not required. The first reason, which we actually think is the weaker, is that the hospitals were required by law to implement the directives. It could be argued, therefore, that aside from interpretation of the directives, there was no decision to be made by the hospital or its board.

■ ■ ■ some contemporary writers on governance take a different ... view, [that] a hospital and its board are accountable directly to ... the Ministry of Health and, indirectly, to the community. ... [Thus,] there is no reason for management to seek the board's consent ... : the implementation of an edict issued by the entity to which the hospital is directly accountable is, in and of itself, an exercise of good governance.

The second reason relates to the fundamental issue of governance: to whom is a hospital or a hospital board accountable? Traditionalists might argue that a hospital and its board are accountable directly to the hospital's members (if it has any) and to the community it serves. In the traditionalists' view, then, a government edict – with or without the force of law – should be referred by management to the board before being implemented.

However, some contemporary writers on governance take a different view. In their view, a hospital and its board are accountable directly to the hospital's primary funder and regulator, the Ministry of Health and, indirectly, to the community. This view, which in some ways equates the government's role to that of a private sector shareholder, is bolstered by the Ministry's ability to replace a hospital's board with a supervisor – similar to the ultimate right of shareholders. These contemporary writers, then, would conclude that there is no reason for management to seek the board's consent to the implementation of the directives: the implementation

of an edict issued by the entity to which the hospital is directly accountable is, in and of itself, an exercise of good governance.

But some decisions were consciously made by management. West Park was the first of the subject hospitals asked by the Ministry of Health to set up a separate SARS unit. Dan Coghlan, Vice-President, Corporate and Support Services, and the manager on call on Sunday, March 23, received a telephone call from Marnie Weber, Toronto Regional Director for the Ministry of Health, at 2:00 that afternoon. Scarborough Grace had eight nurses with a then unknown, but apparently contagious, respiratory infection, who needed to be admitted to a hospital for observation – preferably a hospital with a separately ventilated area. West Park had a vacant unit and infectious disease expertise. Could West Park set up that empty unit and admit these nurses that day?

“The board put the management in place here. They charged the management to develop emergency plans. When the emergency arrived, it was management’s job to implement the plans. That is what we did. Had the directors not previously paid attention to governance matters ... , then governance would have failed prior to the crisis.”

Coghlan immediately called West Park’s CEO, Barry Monaghan. “We activated our code orange [external disaster code] and by 5:00 p.m. that Sunday we had the entire senior administration team assembled at the hospital and by 7:30 p.m. the Ruddy Building stocked and ready to receive patients. The first eight patients were admitted by 1:00 a.m. I didn’t consult the board chair about taking on these patients – I saw it as part of our mission, although I must say, at that time we weren’t entirely sure what we were dealing with.” Monaghan did communicate with Michael Ennis, his board chair that day, thus starting a two-month, initially daily and ultimately bi-weekly routine of written reports to the board relating to SARS.

Leo Steven, the CEO of Sunnybrook and Women’s, had an equally conscious decision to make when he was asked by the Ministry of Health to set up the Ontario SARS screening centre. He consulted with Nancy Malcolm and her management team at the Women’s College Hospital site. While the operation of the centre would obviously pose some risk to staff and volunteers,

they clearly saw it within their mission and mandate to provide this necessary service. The operation of the centre was not only agreed to but embraced by the management at the Women’s College site. Over 970 patients were assessed at that centre, which was operated by both paid staff and volunteers. Again, although Steven discussed the initiative with Martin Barkin, his board chair, no approval was sought from him or the board more generally.

Mark Rochon, the CEO of Toronto Rehab, also had a decision to make. At 7:00 p.m. on March 27, following a board meeting, he returned to his office to find a Ministry of Health directive issued to acute care providers. This directive – the first of many to be received by Ontario hospitals relating to the actions and procedures they were to take during the crisis – applied only to hospitals with emergency departments. It required those hospitals to cancel all non-emergency surgeries. Toronto Rehab does not have an emergency department and so the directive did not apply to it. But with frequent patient transfers and employees working in other organizations, some of which were acute care, Rochon and his team concluded that their patients and staff were also at risk. Without being directed to do so, Toronto Rehab immediately cancelled all out-patient programs and told all non-essential staff to stay at home. Did Rochon seek board approval of these actions? No. “I clearly saw it to be a matter involving the health and safety of Toronto Rehab’s patients and staff and well within my mandate,” he said. Like the other hospitals within the subject group, he immediately advised Ron Meredith-Jones, his board chair, of these steps and kept him apprised of their actions throughout the crisis.

Structure and Process

In Part I of their four-part series, Hundert and Crawford describe the structure and process of the board, its desired composition and size, the committee structures and processes and the information to be provided to board members; all with a view to permitting boards to achieve their primary function: to make good decisions. Consistent with most contemporary descriptions of good governance, Hundert and Crawford allude to the strategic, policy and big-picture decisions in which boards are to be involved. We can take it as an axiom that boards should not be directly involved in the day-to-day operation of the hospitals that they govern.

The boards of all four subject hospitals appear to have properly understood this role. All four CEOs spoke of the support they received from their board chairs

during the crisis, offered of necessity by phone, fax or email, never with any suggestion of interference on their part. Virginia McLaughlin, currently the chair of the Sunnybrook and Women's board, then a vice-chair, reflects on that time with mixed emotions. "The hospital is such a big part of all of our lives. When we knew it was in crisis, that our patients were at risk, and that our staff was working day and night and becoming burned out, we naturally wanted to run in, roll up our sleeves and help out. But we knew we couldn't – that that would only complicate matters. And, of course, we knew that the hospital was in the very capable hands of the leadership we had carefully selected." Mark Rochon agrees. "The board put the management in place here. They charged the management to develop emergency plans. When the emergency arrived, it was management's job to implement the plans. That is what we did. Had the directors not previously paid attention to governance matters (selecting and evaluating leaders, ensuring that those leaders put in place systems, structures and processes to deal with its operations including crises), then governance would have failed prior to the crisis."

Financial Oversight

In Part III of the series, Hundert speaks to the need for hospital boards to take a more active role in ensuring the fiscal integrity and long-term solvency of their hospitals. The article chiefly focuses on the steps that should be taken by boards in the approval of annual budgets; the types of information and reports that the boards should regularly receive in order to monitor the financial health of the hospital and management's adherence to approved budgets; and the action that should be taken by the board in response to indications of deterioration in the hospital's financial position. Again, while the article does not say so, it is a well-established principle of good governance that management should not knowingly enter into transactions or arrangements that will result in a material deterioration of the hospital's financial situation without the consent of the board.

Of course, none of the budgets prepared by management for the subject hospitals for the 2002–2003 or the 2003–2004 fiscal years (the SARS crisis affected both years) contemplated the significant incidental costs and lost revenue that would result from the cancellation of medical procedures and other steps adopted by the subject hospitals to deal with SARS. In November 2003, Sunnybrook and Women's estimated those costs to be \$45 million for that hospital alone. We know from the text above that none of the boards of the subject hospitals was asked ahead of time to approve the steps that would cause these costs to be incurred. However, at

least in the case of the two hospitals that were asked to take on special roles and responsibilities relating to the treatment of the SARS patients (West Park and Sunnybrook and Women's), their CEOs sought and received assurances from the Ministry of Health on the direct costs of providing the requested services prior to doing so.

Arranging for and Monitoring the Effectiveness of the Hospital's Management

In the final article in the series, Mark Hundert and Adam Topp describe the importance of monitoring and ensuring the quality of hospital services. They recommend that each board satisfy itself that quality of care within its hospital is being monitored by its medical advisory committee and by hospital management. In the case of a crisis of the nature of SARS, in which so much is directed by senior leadership teams (most often in the form of "central command" or "emergency response" teams), it is important that the role and actions taken by these individuals also be evaluated. In this way, the experiences of management as well as those of clinical staff can be learned from and reflected in updated policies on emergency situations and other day-to-day arrangements. Because the senior leadership team is in part the subject of the study, it is clearly advisable that the review be conducted and a report prepared by the board itself, a committee of the board or an independent third party, not management, or at least not management alone.

■ ■ ■ these hospitals ... displayed exemplary leadership ... but ... deviated significantly from their Operating Plans and ... their approved budgets, all with the knowledge but without the express approval of their boards.

All four of the subject hospitals have undertaken an assessment of their operations during the crisis; however, in all four cases the report was prepared by management (in one case – West Park's – with the assistance of an outside consultant). Nonetheless, in all four cases, the boards have been the recipients of the reports produced and have taken action on their recommendations. Dan Carriere, the CEO of Southlake, confirms: "The report to the Southlake board has resulted in changes being made to the functional plan for the new wing we are building. It also led to a very exciting initiative being undertaken by all hospitals in York to develop a regional infection control centre. We take

every opportunity to learn from our experiences and to improve the services we offer to our community.”

Having identified the failure of the provincial directives to address the circumstances of rehabilitation and complex continuing care hospitals, Toronto Rehab and six other rehab hospitals have agreed to work together to develop their own infection control processes.

Conclusion

What can we conclude about the management of these hospitals, which clearly displayed exemplary leadership and communications skills during and after the SARS crisis but did not follow to a T the strictures of good governance during it? Under their direction and leadership, their hospitals deviated significantly from their Operating Plans and wildly from their approved budgets, all with the knowledge but without the express approval of their boards. Under their direction and leadership, Ontario’s most serious healthcare crisis in many years was confined to their doors and was not unleashed on the community.

We think we can say, especially in the case of the four subject hospitals, that it all worked out well – or as well as could be expected in the circumstances. The boards of all four subject hospitals had chosen their management well; the CEOs and their board chairs had good, communicative relationships and the governance-level decisions the CEOs made were obviously in line with those that their boards would have made had they been asked.

But in other circumstances, it may not have happened that way.

Note

*See “Issues in the Governance of Canadian Hospitals, Part I: Structure and Process” by Mark Hundert and Robert Crawford, *Hospital Quarterly*, Fall 2002; “Issues in the Governance of Canadian Hospitals, Part II: Hospital Planning” by Mark Hundert and Robert Crawford, *Hospital Quarterly*, Winter 2002/2003; “Issues in the Governance of Canadian Hospitals, Part III: Financial Oversight” by Mark Hundert, *Hospital Quarterly*, Spring 2003; “Issues in the Governance of Canadian Hospitals, Part IV: Quality of Hospital Care” by Mark Hundert and Adam Topp, *Hospital Quarterly*, Vol. 6, No. 4, 2003.

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Newsworthy

Landmark study on adverse events coming this winter!

US studies estimate that between 44,000 and 98,000 deaths and more than one million injuries each year are related to hospital adverse events. Many of these are preventable. British and Australian studies have come up with similar findings, suggesting that from 5 to 15% of hospital admissions are associated with adverse events, a third of which lead to disability or death, and a half of which are preventable.

A study led by Principal Investigators Ross Baker at the University of Toronto and Peter Norton at the University of Calgary, funded by the Canadian Institute for Health Information (CIHI) and the Canadian Institutes of Health Research (CIHR), will shortly provide the first national assessment of the numbers of adverse events (defined as unintended injuries or complications that result in disability, death or prolonged hospital stay and are caused by healthcare management) in Canadian hospitals. Working with researchers in five other Universities (University of British Columbia, University of Alberta, McGill University, University of Montreal and Dalhousie University), the research team has carried out a detailed review of charts from 20 hospitals in five provinces, including large teaching hospitals as well as those in smaller urban and rural areas.

This study has been designed as a first step to help inform improvements in Canada's healthcare system, making it more effective and safe. It is hoped that the study's results will provide an impetus for action to address quality-of-care issues. However, reducing adverse events in Canada will be a daunting task given the complexity of healthcare delivery.

The study will appear in the Canadian Medical Association Journal in early 2004, following peer review. For more information, including a briefing presentation on the study, visit the adverse events section of the CIHI website (www.cihi.ca).

Ontario's commitment to Medicare act under review

Ontario legislature's Standing Committee on Justice and Social Policy has begun a two-week, five-city tour to hear presentations about the government's Commitment to the Future of Medicare Act.

The bill has three components according to Health and Long-Term Care Minister George Smitherman: it establishes a new Ontario Health Quality Council to report on the performance of the health system; it closes legislative loopholes allowing two-tier medicine; and, it entrenches accountability as a central principle in Ontario's health system.

The legislation, designated Bill 8, is not without controversy and concerns are focused on the bill's accountability provisions.

Doctors fear they could be liable for fines of as much as \$25,000 for providing uninsured services. Hospital executives worry that CEOs will be answerable to both government and hospital boards of directors through separate performance contracts. Unions are concerned that the bill gives the government the power to rip up collective agreements. (*Source: Health Edition, Volume 8 Issue 7*)

Health sector drives job growth in 2003

The health and social assistance sector registered the largest job gains in Canada last year, according to the December 2003 Labour Force Survey from Statistics Canada. The agency said the health and social assistance sector added 77,000 jobs, an increase of 4.7%. These jobs accounted for over 28% of all new employment created in 2003, which was down overall from 2002 because of job losses in the manufacturing sector. Seven provinces had job increases in 2003, and health and social assistance employment figured prominently in gains made in Ontario, Quebec and, to a somewhat lesser extent, in Alberta, British Columbia and Nova Scotia.

Insurers test-drive 'no-frills' coverage in N.B.

New Brunswick drivers, who have complained bitterly at the ballot box about high car-insurance premiums, would be the first in Canada to try out a "no-frills" coverage option that could save them about \$200 a year under a system proposed by the Insurance Bureau of Canada.

The organization representing private insurance companies unveiled its proposed system to allow drivers to choose reduced coverage in exchange for lower premiums of about \$750 a year.

But critics say the no-frills option is simply a desperate attempt by the industry to placate drivers and prevent major reforms to the insurance system by offering greatly reduced coverage in exchange for lower premiums. (*Source: Globe and Mail, February 25, 2004*)

Patient's bill of rights

B.C. nurses have proposed a patients' bill of rights. The 26-point list of rights covers access to hospital services, community services, seniors' care, and information (including patients' right to information about their medical records). The bill of rights, which can be accessed at www.bcnu.org, says patients have a right to agreed upon maximum wait times for treatment. (*Source: Health Edition, Volume 8 Issue 7*)

Abstracts

Issues in the Governance of Canadian Hospitals, Part I: Structure and Process

by Mark Hundert and Robert Crawford

Despite the myriad changes in the healthcare system over the past decade, many hospital and health system boards have concentrated on advocating on behalf of their organizations with not enough attention being paid to rethinking and restructuring hospital governance to better meet the challenges of change. This article elaborates on the nature of governance, the responsibilities of governance and some of the issues related to its structure and process. www.longwoods.com/hl/art.php?view=1&ID=77

Issues in the Governance of Canadian Hospitals, Part II: Hospital Planning

by Mark Hundert and Robert Crawford

The healthcare industry has clearly recognized the importance for hospitals to develop coherent sets of objectives and plans. Planning is recognized as a critical component of hospital governance and management. Hospitals should develop plans in response to the needs of the community and other healthcare and social service agencies. This article explores the role of the board of trustees in defining the purposes, principles and objectives of the hospital. www.longwoods.com/hl/art.php?view=1&ID=76

Issues in the Governance of Canadian Hospitals III: Financial Oversight

by Mark Hundert

This is the third in a series of articles examining governance in Canadian hospitals. This article draws upon experiences gained from operational reviews of hospitals across Canada to suggest approaches to building more effective hospital governance. Find out the role of the board of trustees in overseeing and directing the financial performance of the hospital so as to ensure its fiscal integrity and long-term future. www.longwoods.com/hl/art.php?view=1&ID=74

Issues in the Governance of Canadian Hospitals IV: Quality of Hospital Care

by Mark Hundert and Adam Topp

The quality of hospital services is a fundamental responsibility of governance. This responsibility can be thought of in terms of three components: monitoring the quality of services; ensuring that management processes are in place to measure, monitor and maintain quality of services; and ensuring quality in all aspects of hospital operations. www.longwoods.com/hl/art.php?view=1&ID=71

The Health Council of Canada: A Speculation on a Constructive Agenda

by Michael Decter

Mr. Romanow and Senator Kirby each devoted several years and intense effort to studying the Canadian healthcare system. They both came to the view that a national health council is a good idea. Their shared hope was that a health council could bring evidence and reason to bear on health problems that are often buried in the rhetorical avalanche of intergovernmental combat. One suspects that most Canadians prefer light to heat in health matters. But, exactly how can a health council help us achieve our goals, and what role does it have to play in improving the health of Canadians? www.longwoods.com/hl/art.php?view=1&ID=79

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