**Chapter 14
Political realities for the medical director**

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**Introduction**

The emergence and maturation of the specialty of emergency medicine has spawned and nurtured the development of EMS. In turn, EMS has become a subspecialty of its own, attracting a subset of emergency and acute care physicians whose focus of technical expertise and clinical acumen has been directed to the provision of care from the moment of system access to the arrival of the patient at the emergency department [1]. The original EMS medical directors were those individuals fascinated by the possibility of extending “sophisticated” methodology to the patient at the scene. Equally intriguing to them was the opportunity to provide this technical sophistication using individuals operating under the broad-based concept of “extension” of the physician. Not surprisingly, and by the very nature of EMS itself, those physicians attracted to this subspecialty of emergency medicine were captivated by the eclectic and unique attributes of medical practice in this complex arena.

They were soon faced, however, with daunting challenges concerning their own creativity in an equally complex arena, the political one. The multiple interfaces required of the medical director, within and outside the medical community, have created an especially challenging section of emergency medicine practice, where technical expertise by itself proved insufficient in creating a workable system. While the magnitude of this challenge is attractive for some physicians, the emotional energy required and the intense, continuous interaction in the political arena may cause an abbreviated career for even the most innately passionate physicians. As with most areas of medicine, if not life itself, an “apprenticeship” is the means of conveying a “practice” from veteran to neophyte. The growth and development of training programs in emergency medicine, while initially tentative in developing “fellowships” in EMS, have now witnessed substantive progress. In turn, this has hastened the exposure of young physicians to the political realities incident to EMS system development and sustenance.

While there are numerous structures within which the medical director may work (full-time academic; full-time public safety with academic affiliation; part-time volunteer), none guarantees success. The skillful political behavior of the physician in his or her role ultimately determines the success of system function, and may even alter the administrative structure within which the physician resides.

Politics and economics are omnipresent forces with which the medical director must work as he or she attempts to craft and manage an EMS system. These “forces” are usually not familiar, understood, nor embraced by individuals who originally entered the field of medicine in pursuit of the satisfaction derived from patient care. Many opportunities for frustration and disappointment thus await the unwary and idealistic physician who fails to acknowledge these forces, or is unable to master their elements. Similarly, those physicians who appreciate the “leverage” to be gained from an understanding of politics and economics will be rewarded by the growth and development of their systems. Some thoughts and perspectives are herein shared with the interested reader to enable a means of creatively employing these forces for the ultimate benefit of the patient, and the community.

For most physicians, the difficulty, indeed the resistance to comprehending the political climate in which EMS activities are crafted is deeply seated. How many physicians entered medicine because of a love of politics and economics? These are not motivating factors frequently identified by anyone in medicine. In addition, few individuals can provide an apprenticeship for the aspiring medical director that addresses the political realities requiring mastery.

Residency programs are now committed to providing a formalized experience in EMS. Still, the attempted metamorphosis of the clinician into a political “statesperson” is far more complex and arduous than the acquisition of technical expertise in the field. Further, the frequently misperceived position of physicians as “superior” to other members of the health care team seduces them into behaving as such with non-medical individuals, with predictable and disastrous results. Political acumen, if not prowess, must be forged slowly, over time, and with a mentor (an “Obi-Wan Kenobi” of sorts) who nurtures the individual physician.

The disaffection for politics found inherently in most health care providers arises perhaps from the physician’s affiliation with the precepts of the “craftsman.” As one of four “corporate types” defined by Maccoby in his seminal book, *The Gamesman* [2], the craftsman experiences perhaps the greatest disparity between the reality and the ideal. It is most difficult for this individual to juxtapose the desired medical goals of a “perfect” EMS system with the political realities found in any community. Friction between value systems surfaces. For most, the emotional cost produced by this paradigm discordance is high, and for some it is too great to sustain a career of permanence in this aspect of practice of emergency medicine. In the pursuit of quality, however, the craftsperson is handicapped by the lack of a definition easily communicated to the political veterans in the community. Quality, as with style, class, poise, and pornography, tend to be attributes of human behavior which are recognizable but poorly articulated. Political awareness is not usually found embedded in the “genetic code” of the health care practitioner. At most, it remains a dormant gene which needs to be “turned on.”

While many definitions of politics abound, it is based, practically speaking, on an attempt to engender, gather, manufacture, or express consensus. The relationship to the technically “ideal” system, at best, is viewed as oblique, from the perspective of the scientifically forged physician.

The genesis of EMS systems is not founded on logic and rationality. These attributes are not legal tender in the political community. He who possesses the power or the money, and who “sleeps” with whom, are more often the determining factors.

While the medical director may desire an arena devoid of political influences, this is as impossible to achieve as eliminating the vagaries of human behavior itself.

**Case studies**

Examples of the influence of politics in medicine are ubiquitous but often subtle. Even in the most academic aspects of EMS, such as the creation of medical protocols for providers (e.g. ACLS), the political process is operative. Most obviously, legislation to enact seat belt, helmet, and drunk driving laws must of necessity enlist widespread public support in the very citadel of the political process, the statehouse. Between these two extremes, political processes are operative to varying degrees. Examples include:

* determination of hospital destination policy for ambulances
* trauma center designation
* creation of a combined (unified) communications center
* participation of a hospital in an emergency medicine residency, helicopter program, etc.

Specific examples of the use of the political process abound, but are difficult to scrutinize from a distance. They are known only by those involved in the creation of a specific program, and shared infrequently and usually in confidence. Yet it is only through the process of sharing case studies that the “apprenticeship” process is actualized. Clearly, forums to achieve this are necessary, on a local and national scale.

As an example, the unification of the Denver EMS system in 1979 lacked the formalized participation of the fire department. A plan was drawn up to achieve such formalized control, and assure the competence of the firefighters, serving in their capacity as first responders. When presented to the fire chief, it was found unacceptable for a variety of reasons, not the least of which was the perception of power ceding to physicians at Denver General Hospital (now Denver Health). This medical director then donned firefighter’s clothes and, after direct observation and participation with firefighters in the provision of emergency medical care, designed a curriculum for first responders. This was joined with the course of the same title by the Department of Transportation, and gained acceptance within the fire service. More importantly, the educational process and the creation of a more formal involvement of the fire service were embraced by a sufficient number of city officials to encourage a “reevaluation” of the position taken by the fire chief. Ultimately, a document prepared by the physician emergency medicine staff, and acceptable to the fire service, was issued as an executive order by the mayor. The process took 2 years. While the process was cumbersome, the outcome has proven durable.

The emplacement of paramedic presence at Stapleton International Airport, and subsequently at Denver International Airport, provides another example of the political process in EMS systems design [3]. The growth of the population in Denver at the periphery of the city (the social epiphyseal plates of the community) produced an area of increasing demand for EMS services. As response time increased, complaints were heard from members of the city council whose constituents populated these areas. The support of council members was obtained through a citizen oversight council, to enable funding of a paramedic response unit on a golf cart at the airport. The latter site was chosen because of its identified volume of calls (approximately 5% of system total at the time), and the large number which were fraudulent, cancelled, or refused. By providing paramedic presence at the airport, triage could now be accomplished by system paramedics, redirecting ambulance-based paramedics to those who were both ill and willing to be transported. By encouraging the airport to financially support the endeavor, a public relations benefit could be realized, and overall system performance improved without additional cost to the fiscally strapped municipal hospital.

The citizen oversight council and the City Council were publicly praised for their insightful and creative address of a technically complex, operationally driven solution to the problem. The paramedic presence has been increased over the years, consonant with growth of the new airport facility (Denver International Airport). By avoiding the obvious solution of increasing the number of ambulances serving the entire system, the overall number of paramedics remained small (maximizing individual experience rate) and increased efficiency was gained. City ambulances were now available for more calls, as a delegated, dedicated, and focused solution for the airport population had been created. A byproduct of the new system was the more rapid availability of Advanced Life Support care at the airport to passengers and employees. Were this the *initial* objective of the project, it is highly unlikely that the Stapleton International Airport Mobile Paramedic Unit (SIAMPER) would have been emplaced, simply because most passengers at the airport do not vote in the councilmanic districts of Denver, since they are from out of state.

**Power blocs, vectors, and pressure points**

The approach of the medical director who is new to a community must be one of openness and great caution. While espousing an “ideal” system, it is well for the physician to identify the power blocs. Typically, they consist of a bouillabaisse of the following.

* Mayor/council/manager
* Chief administrator for EMS (fire chief, EMS chief, etc.)
* Line firefighters
* EMS providers
* Patients
* Taxpayers
* EMS attorneys
* Regional EMS council
* State health department or EMS office

Fundamental to appreciating the appropriate evolution of a system is the need for the physician to understand the pressure points within it. This requires patience, a willingness to invest time with each of the above principals, and an ability to discern the history of the present situation. A pivotal mission for the physician advisor is to reframe, refocus, and redefine the agendas of others. Clearly, he or she must become intimate with the capabilities and desires of each of the provider groups and the position of government leaders, before attempting to choreograph a new system of EMS for the community.

If one visualizes the aforementioned “power blocs” as “political vectors” with magnitude (force) and direction, the objective becomes the exertion of pressure in such a way as to realign the vectors as parallel as possible toward the desired EMS agenda of the system.

**Philosophy, perspective, and bias**

Five political senses require mastery.

1. **A sense of mission** (yours, that of the specialty, and that of the institution) should first be defined, then amalgamated and articulated. It is also helpful to frame the efforts of the medical director not only as a practice champion and political choreographer, but as a genetic engineer as well. Indeed, the manipulation of the system is analogous to skillfully revising the “genetic code” of the EMS system of the community. While the object is to create a “superior high-performance species” of system, more resistant to the onslaught of political viruses, one never knows what will crawl out of the petri dish 5 years from now. The mission of the medical director is also that of a “steward” of the system. It is in this role as a “trustee,” with a fundamental medical fiduciary responsibility to the patient, that the physician must speak most directly.
2. **A sense of tradition**: the history of the community and the service within it should be studied. This provides guidance in maneuvering around the political obstacles which have erected barriers toward development.
3. **A sense of position**: the position of the medical director within the organization and the community, and the position of the service agency, should be acknowledged. In addition, EMS may be “positioned” technically within the practice of emergency medicine (if not critical care), operationally within public safety, and philosophically within public health. The ability of the medical director to articulate this categorization, and relate to each of the individuals who inhabit these three worlds, is important in determining overall success.
4. **Humor**: invaluable, and to be perfected during the entire professional lifespan of the individual.
5. **Timing**: the introduction of new ideas and programs should take advantage of other changes being introduced into the institution, community, or agency.

**Preparing yourself**

Goals of the organization, and the individual, require the achievement of excellence in five spheres: academic, operational, administrative, clinical, and community relations. The target audience of the medical director should be defined in the broadest possible context: that of other health care providers, citizens, and every other “customer” whom the medical director and his or her agency touch.

Understand the concept of “political Darwinism”: the political and economic topography define “reality.” As the topography changes, you must adapt or perish; in other words, “mutate or die.” The individual who can seize upon innovative management and communication styles, and who is alert to changes in the “big picture,” is able to adapt the needs of his/her agency to the vicissitudes of politics. Always keep reality squarely in your sights. Sadly, Darwinism is not pretty.

Distinguish between a politician and one who is “political.” A politician is loyal to his constituency. A medical director is free to be loyal to the principles of sound clinical practice. The director’s demonstrated “awareness” of the political climate in which he must work does not impugn his motives, however; nor should he be an apologist for his insight.

Systems evolve. The goal of system excellence will be well served, and the sanity of the medical director preserved, if she appreciates the glacial time frame within which change is accomplished. Perhaps the most for which any one individual can hope is to refine the system, in preparation for her successor to refine it still further. Yet another analogy is the “river” concept of individual efforts. Acute diversion of a river in one direction may beget spontaneous directional changes downstream for miles to come. Many, if not most of these distant changes are unforeseen.

Nurture your colleagues. Patients and issues come and go. Long after your colleagues have forgotten the reason for your anger, they will recall the unpleasantness of the interaction. Expressed alternatively, friends may come and go, but enemies accumulate. Your colleagues outlast the issues and should be respected. Technical errors are more easily forgiven than those which are normative or behavioral. Strive to develop an ethical, emotional, and behavioral gyroscope within you. Like its physical counterpart in navigation, a similarly stable operational perspective will allow you to weather the buffeting vicissitudes of system change with constancy of purpose, enabling accurate tracking toward the goal you and our colleagues have identified.

Attempt to create win-win solutions to problems. When this is impossible, ensure that both sides appreciate compromise.

Be the source, and you become the force. Too often, the goal of the medical director is to become the power broker in the community. By striving to become the “source” (i.e. the consultative resource to whom people turn for guidance and problem resolution), the medical director soon becomes the force for change.

Define quality in meaningful terms. Since the definition of “quality” is so elusive, choose those measurement parameters which are meaningful to the intended audience.

Every transport of a patient is a political statement.

Choose realistic mentors. Mentors who are great and flawed are more likely to be emulated than those who are perceived as great and perfect. The former are seen as “human,” the latter “god-like.” We see some hope of improving upon the former, but are never able to reach the standard of the latter. Expressed alternatively, prescience is wisdom, omniscience is delusional. Choose mentors with the former skill.

Observe why others fail. To be effective, you must have a good engine (innate talent), a good transmission (personality and communication skills), plenty of fuel in the tank (endurance), with a good set of windshield wipers to see where you’re going. It also helps if you’re on the most appropriate road. It’s quite a waste to place a Ferrari on a jeep trail, and quite dangerous to run the jeep on the autobahn. When colleagues fail, observe the reasons.

Develop a shared paradigm for your staff. Stress the provision of agency services with competence, compassion, class, creativity, credibility, connectivity, and collegiality.

Strive to develop a demeanor and countenance which reflects an academic, intellectual, and collegial approach to solving problems.

A special note of caution about bureaucracies is in order. Often, an adversary will remain camouflaged, if not silent and stealthy. While the remonstrative opponent is easy to identify if not to outmaneuver, the bureaucrat has proven more lethal to great ideas and system reform, if for no other reason than his resistance, persistence, and longevity. The bureaucracy will consume enormous amounts of energy on the part of the medical director. More reforms have been defeated in an attempt to navigate a bureaucratic quagmire than the withering verbal artillery of individual or collective opponents. Bureaucrats fundamentally perceive themselves as underappreciated, if not powerless. A bureaucrat, if provoked, can erect enormous obstacles, and subvert and condemn the most noble and meritorious ideas of the medical director, if only to demonstrate his power over the physician. Respect, acknowledgment, and interaction with the bureaucracy may not provide a dramatic victory but it will pave the way for one.

**Principles of action**

Unlike the provision of police or fire suppression services, EMS is inextricably tethered to hospital health care politics and economics. Every transport of a patient is thus a political and an economic statement. Institutional paranoia dictates that whoever controls ambulances controls the patients, and the revenue. Economically, ambulances thus become charged particles, to be gathered by some institutions and repelled by others, depending on their fiscal “force fields.” Thus, stereotypically the trauma center may desire critically injured patients, regardless of insurance status (or despite the absence of third-party coverage), while the suburban community hospital may seek to avoid these patients in favor of the medically ill and third-party reimbursed clientele. Into this economic maelstrom is placed the medical director, for whom none of this fiscal agenda is inherently germane, but in which the service he is to provide exists. Is it any wonder that such an individual perceives the political and economic topography as foreign, if not hostile? To steer an academically neutral course becomes an ordeal that has daunted many. No wonder the physician advisor feels like a swash-buckling and heroic Harrison Ford slashing his way through the political and economic vegetation!

To be effective in an arena which is inherently unfamiliar to the physician, a number of principles of action are herewith submitted.

* An understanding, if not a mastery of political judo is encouraged. As with its physical counterpart, the politically diminutive physician must understand the simple but effective maneuvers necessary to tumble opponents in the desired direction. The political agility of the medical director accrues from her allegiance to principles of medicine, and not to a political constituency or the egomaniacal forces of her opponent. With regard to adversaries, it is more effective to exploit their psychopathology than to perseverate about it.
* Before pushing the first domino, know where the last one falls. Do not be tempted by the seductively easy “win,” unless you are aware of all the political connections of your opponents. Better to be one who sets up the dominoes than the one who pushes them. Natural political forces will cause one to fall eventually. The wise medical director will have spent years establishing the desired direction in which they should fall, content that fate or circumstance will eventually tumble the first one.
* The movements of the chess game are instructive. The pawn, slowly moving ahead, can become as effective as any other “chess piece.” At any moment in time, the chessboard can be upset, moving all the pieces in different and unpredictable directions. For example, the regulatory bureaucracy may increase innovative torment for all or a new mayor may be elected. Public officials rapidly acquire a global perspective of each piece on the chessboard, as well. Like the professional tournament athlete, consistent performance over time will usually create substantial success.
* Covet identified problems. Complaints may be seen as “opportunities in drag.” They permit creative manipulation of the system, and insight into behavioral issues which must be addressed. The medical director is a “problem solver,” as much as any other single role he plays.
* Identify the relationships among people. The EMS system within the community is a complex political ecosystem, with myriad political connections among even the most far-flung members. A movement or alteration of the power at any end of the “pond” will move the "lily pads” at the other by virtue of its “ripple effect.”
* Become dispensable, but not openly so. As a wise physician administrator once demonstrated, place your finger in the middle of a glass of water. The finger represents your presence within the system or institution. Remove your finger. Notice the hole that is left.
* Learn to swim with the sharks [4].
	+ If bitten, do not bleed.
	+ Before recognizing another individual as a non-shark, ensure that you have witnessed docile behavior on more than one occasion.
	+ Rescue an injured swimmer with due regard for the external and internal reasons for his incapacity, lest you succumb during the effort.
	+ Periodically give a known shark a forceful punch in the nose to remind him that you have some power.
* Stage a crisis on your own terms. When a crisis looms, ensure that you orchestrate it to occur at such time that it will be optimal for you. For example, when funding for a poison center in the community was threatened by legislative inaction, the administrator notified the press that this clinical facility was about to lose an “800” line. This was timed for release shortly before Christmas, and coincident with public safety messages to parents concerning the potentially poisonous nature of Christmas foliage. The legislature quickly authorized the funding before recessing for the holidays for fear of constituent retribution at the next election.
* Be a political chameleon. It’s helpful to have a full set of costumes to enable you to project a panoply of images, appropriate to the political moment.
* Identify all the stakeholders. Too frequently, only the patient is identified as the customer. Within any organization, however, internal and external customers must be satisfied. They are not necessarily direct supervisors of the medical director. Every individual within the system who must be satisfied, or at least acknowledged, should be identified, and never ignored.
* As expressed in the hallmark work *In Search of Excellence* [5], understand the business with which you are really engaged. The medical director is a choreographer of care. The challenge is to rise above the technical image of the physician as a provider of care to only a single patient. In providing the choreography for the entire system, one cares for thousands of people, and influences the well-being of people far beyond the limits of a single individual. This becomes one of the strongest motivating factors for the craftsman to continue the quest for system improvement.
* Project academic passion with political neutrality. In other words, craft the system to enable acknowledgment of and allegiance to medical imperatives while achieving political equanimity.
* Visible power is vulnerable power. The final decision maker enjoys the most ego gratification and the least potential for long-term survival. The individual who is invisible and informal in the use of power is most insulated from assault, but will not enjoy the adoration of the public or recognition from same. Strive for a position between these two extremes, to enable a “low profile” but with a somewhat formalized power base.
* Never satisfy a bureaucratic need completely. To do so will cause bureaucrats to forget you. Partial solutions enable an occasional reminder to the bureaucracy of your importance as a problem solver, and your inadequate funding.
* Control the key factors, but not all. For example, the medical director must retain the power to sign off the eligibility of each paramedic to sit for recertification. The power to “hire and fire” is thus focused into an clinical arena, rather than a political one.
* Avoid the use of fear, embarrassment, anger, frustration, intimidation, and guilt. They are transparent and managerially myopic means of motivating behavior. They are also antiacademic, antiintellectual, and anticollegial.
* Survival alone defines a certain success of design, and merits your respect. Individuals who have existed within a system for some time have evolved successful forms of political adaptation. Do not ignore what may appear to be conservative postures or clever camouflage.
* Remain vigilant, but not suspicious. The latter is an emotionally draining posture with which to confront life.
* Subject projects to the OREO analysis.
	+ Identify Opportunities
	+ Identify Resources
	+ Identify Expectations
	+ Identify Obstructions
* Linguistics are important. Develop and refine your language skills with the goal of achieving precision, brevity, and elegance. In particular, avoid public expressions of profanity at all costs (a recommendation of the Stoic philosopher Epictetus which remains as valuable as ever).
* There is nothing more compelling than genius presented with style, grace, and class. Cultivate this vision of self throughout your career.

**Sustaining the drive**

It is said in physics that all energy is devoted to overcoming friction and gravity. This is true of human behavior as well. The energy of the EMS system medical director is expended on overcoming the resistance (friction) of the status quo in order to move the system to higher performance and greater accountability. The gravitational forces of tradition and bureaucracy exert a profound influence to restrain new ideas. While there is no substitute for having the raw strength of merit, it is frequently, by itself, insufficient. Innovative tactics and strategies, coupled with endurance, prove more effective in the long term.

It is perilously easy to impugn the motivations of adversaries. More durable is to approach each individual or group with a respect for their position and an understanding of why a particular position is held (we all have religion, but we worship at different altars).

Publicity should be used advisedly, deliberately, and with due regard for the law of unintended consequences. The use of the media is worth mastering. As often as possible, give credit to others for the success of the system. Always strive to achieve medical imperatives with political equanimity.

History belongs to the person of letters, the student of language, but most of all to the master of the synthesis. The individual who can amalgamate the various resources of the community, and weave a tapestry involving many threads, will be the individual who contributes the most to any system. Remember that institutions, professions, and communities are platforms for your creativity. Respect them, and ensure that they are used wisely.

Each medical director must consider his or her own personal evolution. The goal should be to leverage your creativity at every opportunity. Assist not a limited population of patients, but an entire community. In the process, contribute to the knowledge base of the specialty and assist an entire nation. Key to this personal evolution is the need to become “more than a physician.”

To this end, medical directors should consider acquiring knowledge, skills, and abilities from other professions such as teaching and business, to augment their own innate talents. Such education may be acquired by either informal (apprenticeship) or formal (MBA acquisition) methods. Borrowing from other professions to augment the persuasive talents of the physician can be extremely powerful. Likewise, adding non-medical literature, such as the *Harvard Business Review* and the *Wall Street Journal*, will suggest a multitude of approaches which are effective in the non-medical venue of business and government, in which the medical director must forge her vision of the high-performance EMS system.

System development and maturation are non-linear and anything but smooth. They do not follow the measured, predictable tempo of a Strauss waltz as much as that of a reggae rhythm.

The EMS medical director must be a seasoned clinician (practice champion) who is able to move beyond the bedside and choreograph the system. It is important to appreciate that the choreographer need not be the best dancer, but must recognize those who are gifted with superior talent.

Always have an exit strategy for yourself. The frustration of system choreography over the years may be lessened by identifying the myriad other venues in which your creativity can be expressed.

Be substantive. Figureheads soon become hood ornaments, and the first to be sacrificed when the system crashes.

**Conclusion**

Though politics and economics may appear abrasive to the physician, they act as sand within the oyster, which produces the pearl.

Remain professionally satisfied by performing meaningful work, identifying and placing yourself proximate to role models to emulate, keeping things eclectic and capturing a childhood fantasy on a daily basis. Most of all, identify your own vision of the medical director to enable each of the above. Finally, know when your effectiveness has waned, and your tenure is drawing to a close. A timely, gracious, and dignified exit will nullify the harshest critics, and establish your accomplishments in the institutional memory of EMS.

**References**

1. [www.abem.org/public/subspecialty-certification/emergency-medical-services/ems-announcement](http://www.abem.org/public/subspecialty-certification/emergency-medical-services/ems-announcement)
2. Maccoby M. *The Gamesman: The New Corporate Leaders*. New York: Simon and Schuster, 1976.
3. Cwinn AA, Dinerman N, Pons PT. Prehospital care at a major international airport. *Ann Emerg Med* 1988;17:1042–8.
4. Cousteau V. How to swim with sharks: a primer. *Perspect Biol Med* 1973;16(4):525–8.
5. Peters TJ, Waterman RH Jr. *In Search of Excellence: Lessons from America's Best Run Companies*. New York: Harper Collins, 1982.