



ACPE White Paper



The Value of Physician Leadership

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In this article...

An extensive review of the literature, followed by dozens of interviews with health care leaders, confirms that matured physician leadership will be essential for health care to continue moving toward higher quality, consistent safety, streamlined efficiency and becoming value-based.

The health care industry has entered an era marked by seismic change and disruption of the status quo, and one area that is experiencing high demand and explosive growth is physician leadership.

Today, approximately 5 percent of hospital leaders are physicians, and that number is expected to increase rapidly as the health system moves toward value-based care.¹

“The decade we’re in is probably going to lead to the greatest amount of change that’s been experienced for the last hundred years in health care,” said Dean Gruner, MD, president and CEO of ThedaCare Inc., and a board member of the ThedaCare Center for Healthcare Value in Appleton, WI.²

Considering the rising rates of chronic disease, the growing physician and nurse shortages, and the aging of our population, the current environment presents outstanding opportunities for physicians to develop lasting improvements in care delivery. Overall, this represents a period of extraordinary opportunities for physicians to provide leadership.

A constellation of forces place physicians at the center of this stage:

- The shift from a volume-based to a value-based system.
- The public health-oriented focus on the management of populations toward wellness.
- The fundamental redesign of clinical care models in several settings.

- The financial payment models that have begun rewarding health care organizations for clinical excellence and coordinated care at reduced cost.
- The emerging shared risk, capitation and bundled payment strategies.

The fact that growing numbers of physicians are pursuing leadership positions bodes well for health care, according to Maureen Bisognano, president and CEO of the Institute for Healthcare Improvement in Cambridge, MA.

“It’s a wonderful sign that physicians are expanding from clinical care to include learning what it takes to be a good leader,” Bisognano said. “When you can marry the leadership skills and the clinical background, you have an opportunity to lead in a very distinct and different way. When you get someone who knows what quality looks like, and pair that with a curiosity about new ways to think about leading, you end up with people who are able to produce dramatic innovations in the field.”

For several reasons, health care organizations need the distinctive perspective of physicians among their leadership. Because of increased constraints on revenue and heightened review by payers, health system leaders of today are now more often in the position of making administrative decisions that ultimately affect clinical care.

The American College of Physician Executives (ACPE), the nation’s oldest and largest leadership education and career support organization for all types of physicians, champions the view that physicians are best suited to lead clinical efforts to achieve true patient-centered care. It is well-recognized that, at some level, all physicians are regarded by our society as leaders.

ACPE includes physician leadership as one of its nine essential elements required to provide optimal patient-centered care. The organization believes that, in order to succeed, health care must be: quality-centered, safe, streamlined, measured, evidence-based, value-driven, innovative, fair and equitable, and physician-led.



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Maureen Bisognano
Institute for Healthcare Improvement



Why physicians?

Since passage and implementation of the Affordable Care Act, ACPE has recognized a rapid rise in organizations seeking to employ physicians and educate physician leaders.

According to a survey by the Medical Group Management Association, there has been a 75 per-

cent increase in the number of active physicians employed by hospitals since 2000.

Merritt Hawkins reports that the share of physician searches for positions with hospitals hit 64 percent in 2013, up from 45 percent in 2012 and 19 percent five years ago.

The American Hospital

Association states that between 2001 and 2011, the number of physicians and dentists employed by U.S. hospitals grew by more than 40 percent.

Evidence suggests that organizations and patients benefit when physicians take on leadership roles. Physician leaders play critical roles in providing high-quality patient care. The 2013 *U.S. News and World Report* rankings for hospitals include an “Honor Roll” that lists 18 institutions. The top five are led by physicians, and 10 of the 18 are physician-led.³

Another study, *Physician leaders and hospital performance: Is there an association?*,⁴ indicated that “the best-performing hospitals are led disproportionately by physicians.” In each of three specialty areas—cancer, digestive disorders, and heart and

Physicians as Hospital Leaders

Rank	Organization	State	Name of CEO/President	Physician?
1	Johns Hopkins Hospital	MD	Paul B. Rothman	Yes
2	Massachusetts General Hospital	MA	Peter Slavin	Yes
3	Mayo Clinic	MN	John H. Noseworthy	Yes
4	Cleveland Clinic	OH	Delos M. Cosgrove	Yes
5	UCLA Medical Center	CA	David T. Feinberg	Yes
6	Northwestern Memorial Hospital	IL	Dean M. Harrison	No
7	New York-Presbyterian University Hospital of Columbia and Cornell	NY	Steven J. Corwin	Yes
8	UCSF Medical Center	CA	Mark R. Laret	No
9	Brigham and Women's Hospital	MA	Elizabeth G. Nabel	Yes
10	UPMC-University of Pittsburgh Medical Center	PA	Jeffrey A. Romoff	No
11	Hospital of the University of Pennsylvania	PA	Ralph W. Muller	No
12	Duke University Medical Center	NC	Victor J. Dzau	Yes
13	Cedars-Sinai Medical Center	CA	Thomas M. Priselac	No
14	NYU Langone Medical Center	NY	Robert I. Grossman	Yes
15	Barnes-Jewish Hospital/Washington University	MO	Richard Liekweg	No
16	IU Health Academic Center	IN	Dan Evans	No
17	Thomas Jefferson University Hospital	PA	Stephen K. Klasko	Yes
18	University Hospitals Case Medical Center	OH	Thomas F. Zenty III	No

U.S. News Best Hospitals 2013-14: the Honor Roll



You can't scrimp on patient care or on morale and commitment to physicians and the rest of the health care team to make one more dollar. That's where the physician executive helps to bridge that gap in understanding.

Cathy Wilkinson, MD, FAAP
Pediatric Associates Inc. PS



heart surgery—"the better a hospital's performance, the more likely it is that its CEO is a physician and not a manager," the study found.

Specifically, the study found that overall hospital quality scores are 25 percent higher when doctors run hospitals. For cancer care, physician-run hospitals posted scores 33 percent higher than those run by nonphysicians.

A more recent investigation by the same author regarding business leadership in a highly competitive field outside medicine reached a similar conclusion: "Teams led by leaders with extensive knowledge of their core business perform better than others."⁵

Consultants with McKinsey & Co. conducted a study of factors associated with health care productivity. The researchers found an association between higher organizational scores on several management dimensions, with reduced rates of hospital-acquired infection and hospital readmission, greater patient satisfaction, and improved financial margins.⁶

The study revealed stronger physician leadership to be a key contributor to this organizational performance. The hospitals with greater degrees of physician leadership involvement scored higher, on average, in performance management and Lean management, and produced higher average overall management scores.

Physician leadership gives organizations "a competitive differential" and "a definite edge over a hospital that does not have it," noted Rick Guarino, MD, vice president of medi-

cal affairs of Wilson Medical Center in Wilson, NC, (then senior vice president and chief medical officer of Nash Health Care in Rocky Mount, NC) in *American Medical News*.⁷

Interface professionals

Physician leaders provide that competitive differential because they have extensive knowledge about the "core business" of caring for human beings. They have learned, lived and breathed patient care.



"Having had that direct experience as a deliverer of care positions me to understand why, in my past medical practice, I may not have

been as careful with attention to detail as I should have been," said Gerald B. Hickson, MD, senior vice president of quality, safety and risk prevention at Vanderbilt University Medical Center in Nashville, TN. "From a leadership standpoint, I experientially 'get it.' And that helps me collaborate with others to think about how we can encourage right delivery of care every time."

Physician leaders have been described as "interface professionals" who bridge medicine and management.⁸ At the edge between other physicians and managers, physician leaders can be the catalyst that every successful organization needs, connecting the organization's so-called sharp end (the front lines of care) with the blunt end (related management, leadership and governance).^{9, 10}

To foster that connection, Rutland Regional Medical Center (RRMC) in Rutland, VT, embraced a dyad model that pairs physicians and nonphysician administrators as co-leaders of services and programs. Several other health care organizations across the country have taken this approach as well.



According to Baxter C. Holland, MD, vice president of medical affairs at RRMC, "physicians are critical to the overall success of any

health care organization, so to leave them out of significant leadership roles, you've basically tied one hand behind your back. You've also set yourself up for a 'we-they' dynamic if they are not part of the discussion. You can't really take them out of the equation and expect to achieve the improvements you are looking for."

ACPE believes that, with the right physician or physicians on the executive leadership team, the organization will be able to relate to non-physician managers as well as clinicians of several disciplines. Through the orders they place and the management they provide for patient care, physicians remain the primary drivers of care. For this reason, it's natural for physicians to be in key leadership roles shaping the decisions around what's best for patients and the organization as a whole.

The soul of the business

This, however, does not necessarily mean that physicians need to only be in titled leadership positions. Physicians of all types and in a variety of roles still provide leadership—albeit informal leadership. It is natural that formal and informal clinician leaders tend to have attributes that are especially useful for health care leadership, including the belief fundamental to the art of medicine being "first, do no

harm,”—an appreciation for the value of solid data and a receptiveness to evidence-based decision-making and an inclination to do “what’s best for the patient.”¹²



According to Cathy Wilkinson, MD, FAAP, chief personnel officer of Pediatric Associates Inc. PS, an 84-member practice headquarter-

ed in Bellevue, WA, that inclination helps physician leaders “understand the balance between the business reality and the reality of taking care of patients.”

A nonphysician executive is more likely to be focused on the organization’s financial success, she said. “At what cost do you do that? You can’t scrimp on patient care or on morale and commitment to physicians and the rest of the health care team to make one more dollar. That’s where the physician executive helps to bridge that gap in understanding.”



Because they speak the same language and share common histories with most types of clinicians, physician leaders are more likely

to empathize with the demands of their colleagues’ clinical responsibilities and to make decisions sensitive to their needs, said Glen Lux, MD, MBA, CEO of Pediatric Associates. “We understand the soul of the business because we’ve done it,” he said.

According to Lux, the soul of their business means always putting the needs of patients first, and doing so with consideration for the professional and personal lives of the clinical staff. “If we wanted just to be financially successful, we would have more doctors than we have now working weekends, we would have people working all night—and we would burn out our doctors,” he said.

Skillsets for Reform

In 2011, the American Hospital Association (AHA) asked its regional policy boards, governing councils and committees to identify the skills they felt physicians needed to practice and lead in a reformed environment. The results were published by the AHA’s Physician Leadership Forum in *Lifelong Learning: Physician Competency Development*.²⁸ They cited the following:

- Leadership training
- Systems theory and analysis
- Use of information technology
- Cross-disciplinary training/multidisciplinary teams
- Understanding and respecting the skills of other practitioners
- Additional education around:
 - Population health management
 - Palliative care/end-of-life
 - Resource management/medical economics
 - Health policy and regulation
- Interpersonal and communication skills:
 - Less “captain of the ship” and more “member/leader of the team”
 - Time management
 - Empathy/customer service
 - Conflict management/performance feedback
 - Understanding of cultural and economic diversity
 - Emotional intelligence





A lot of the strategy and integration that has to occur is on the front load between the physicians. It takes an orthopedic surgeon leading the way to say ‘let’s get together and choose the two [knee implants] that give the best cost and value.

Bradley Lembcke, MD
Baylor University Medical Center



Lux believes the practice’s physician leadership, which also includes a chief operations officer who is an MD, as well as a chief medical officer and a medical director at each of eight clinics, helps set the tone for a culture of respect, which in turn breeds satisfaction among the clinical staff and ultimately improves professional and financial performance.

“It’s hard to give someone feedback if you don’t know what they really do. That feedback is much more accepted from a physician than from a nonphysician who doesn’t ‘get it,’” he said. “When we ask our physicians to do something that’s a little bit out of the ordinary, they know that we understand what that means to them and that we wouldn’t ask unless it was important.”



Having medical colleagues in administrative leadership positions helps to ensure that a medical practice remains focused on

what is best for patients rather than primarily what is best financially, said Josephine L. Young, MD, MPH, chief operations officer for Pediatric Associates.

A physician is certainly not needed in every leadership role—the practice’s CIO and CFO are not medical, she said. In fact, “there is value in having your senior leadership team come from a nonclinical perspective as well.”

That blend of clinical and non-clinical backgrounds, including specialized expertise in information technology and finance, “allows you to treat the business side like a business and to draw from the best of both worlds,” she said.

However, “because we’re a medical practice, everything we do is ultimately related to the medical aspect. Having physician administrators takes that into account for decisions at every level. It’s just inherently there,” Young said. A nonclinician leader, even one with extensive health care knowledge, would not offer that same depth of understanding, she said.

For example, Young’s knowledge of medicine contributed to the success of a recent operational discussion regarding complaints by some physicians about the schedulers’ handling of bookings for consults. She drew on her clinical knowledge to present examples to facilitate the discussion, such as: Should a 15-year-old girl with a history of depression and chronic abdominal pain be scheduled as a consult or a sick visit?

“It was a split decision—the point being that you can’t fault your schedulers for making the appointment, because you’ve got to do what the patient needs,” she said. “It was a conversation stopper when I posed the question: ‘If your best answer is ‘It depends,’ how is the scheduler supposed to make the decision? I played up the nuances to get my point

across because I speak a common language.”

When the H1N1 virus surfaced as a public health threat a few years back, Young’s clinical knowledge enabled her to make key decisions more readily than if she had been a nonclinician.

“So many operational decisions needed to be made that hinged on information coming out of the Centers for Disease Control and Prevention regarding who should be vaccinated, who should get treatment, what clinical protocols to use and universal precautions. I was able to read through the health department recommendations, absorb the information and render a decision,” she said.



Similarly, Heather Smith, MD, medical director of the hospitalist service at Rutland Regional Medical Center, uses

her clinical knowledge and experience to support the hospital’s corporate action plan to reduce length of stay and inpatient costs. To help achieve its objectives in these areas, the medical center has embedded clinical decision support in the electronic health record—an “added level of refinement” that provides physicians and nurses with access to a database of best practices, Smith said.

As a member of a multidisciplinary committee of medical directors and nonphysician leaders, including the chief financial officer, “What I bring to the table is the knowledge of how a physician uses this support and whether something will work. If you have these meetings in isolation, it takes so long to circle the wagons that by the time you get there, the best practices have already changed. It’s much more efficient this way because it brings the clinical perspectives to the fore. My role is to identify the diagnoses we should tease out to be refined, and where we should put the

links to our order sets” to make sure best practices are applied, she said.

Matters of trust

A shared history and a common language give physician leaders the credibility among their colleagues and other providers needed to garner critical support for clinical integration. This allows driving the value agenda for initiatives such as reducing variations in care, reducing readmissions, developing a patient-centered medical home, implementing best practices and other value-driven initiatives.

“If you have physician leaders, you are more likely to have the medical staff follow the organization’s direction,” Holland said. “They’re much more likely to follow other physicians than they are administrators.”

And it’s not just doctors listening to other doctors. Nurses, surgical technicians, nurse practitioners, physician assistants and all members of the direct health care team respect the physician’s point of view and are more likely to buy into organizational changes led by the physician leader.



Physicians trust physicians and appreciate knowing that someone has walked in their shoes, said Bradley Lembcke, MD, chief

medical officer of Baylor University Medical Center in Dallas. “It’s an advantage for getting things started. It gets your foot in the door,” said Lembcke, who also serves as a board member of the Baylor Quality Alliance (BQA) and chairs its Best Care Clinical Integration Committee.

Recognition of that advantage by executive leadership served Baylor Health Care System (now Baylor Scott & White Health after a merger with Scott & White Healthcare in 2013) well in the formation of the BQA, the system’s 2,600-member accountable care organization. Practitioners

might have felt less confident about joining the organization had the hospital approached them directly, Lembcke said.

“The hospital helps supply the capital and resources, but a lot of the strategy and integration that has to occur is on the front load between the physicians,” he said. “It takes an orthopedic surgeon leading the way to say ‘let’s get together and choose the two [knee implants] that give the best cost and value.’”

As the BQA continues with clinical integration and markets itself to the community, it will take a physician to lead the discussions on how the physicians will be reimbursed. “You can’t have the administration leading that discussion,” Lembcke said.

To make sure physicians feel their voices are being heard, the leaders made a deliberate decision to create an organization whose board of managers consists primarily of physician leaders. This physician-led organization has begun to implement improvements to further the system’s transition to accountable care.

The Best Care Clinical Integration Committee and 20 subcommittees representing specialties and subspecialties have so far developed 80 best practice protocols and processes with accompanying metrics.

A protocol for the treatment of uncomplicated low back pain was among the first chosen because it offered a relatively uncontroversial condition around which a multidis-

Leadership and Professional Self-Regulation

Gerald B. Hickson, MD, of Vanderbilt University Medical Center in Nashville, cited the following attributes as core competencies for physician leaders:

- Humility
- The ability to treat all team members fairly and with respect
- A willingness to engage thought leaders throughout the practice or health system in seeking best ideas
- Toughness and the tenacity to follow through with difficult decisions
- An absolute unwillingness to blink when an individual physician asserts special status

Hickson stressed the importance of sustaining a focus on professional self-regulation. A physician cannot lead effectively without that commitment, he said. “When physicians perform poorly and data begin to accumulate that they are, who lets them know? The answer is almost always silence, because we, as a profession, have not done a very good job in peer review,” he said.

For this reason, professional self-regulation must also be a thrust of physician leadership training, Hickson said. “You are going to have someone who comes in and just doesn’t get it. There cannot be anyone who is so influential based on the volume that they deliver or their specialty that they are exempt.”



These are clinical issues, so you need clinical leadership to help guide the programs and implement the practices that will get you improved outcomes.

John R. Combes, MD
American Hospital Association



ciplinary task force representing neurology, neurosurgery, physical medicine, pain, trauma medicine and rehabilitation could join forces. According to Lembcke, the Best Care Committee's next major task is making sure the data for the protocols are "well-scrubbed" so they can be presented to the physician members.

Respected change agents

The respect and authority traditionally conferred on physicians helps them win support for change, both within their organizations and from the communities they serve. "Large-scale organizational changes . . . require strong leaders and a cultural context in which they can lead. For obvious reasons, such leaders gain additional leverage if they are physicians," said Thomas Lee, MD, former president of Partners HealthCare System in Boston, in *Harvard Business Review*.¹³

In an example of influence, the additional leverage provided by a physician leader enabled Rutland Regional Medical Center to win legislative and community support for the creation of a new six-bed acute care psychiatric unit. The unit has helped fill the significant services gap for individuals with severe mental illness, created when floodwaters from Hurricane Irene destroyed the 52-bed Vermont State Psychiatric Hospital in Waterbury in 2011.

The leadership of W. Gordon Frankle, MD, chief of psychiatry, helped the medical center obtain state resources to convert a portion of its

inpatient psychiatric unit into a psychiatric ICU to care for some of the state's most seriously ill patients. The unit is one of a handful opened across the state to improve geographic access to short-term psychiatric care.

According to RRMCC's Baxter Holland, Frankle served as an articulate and convincing spokesman for the hospital and advocate for effective treatment for people with mental illness. His professional standing as a psychiatrist and knowledge of the medical needs of individuals with severe psychiatric conditions gave the medical center an entrée and a degree of credibility among legislators, community members and other stakeholders that a nonphysician may not have had, he said. "People will listen when a doctor talks. They might not when someone else talks."

The credibility and trust engendered by a physician-led board and extensive physician committee structure have enabled the HealthTexas Provider Network to drive quality improvement since the multispecialty group's data-driven work in this area began in 1999.



The network of 633 employed physicians practicing in 211 sites throughout North Texas "has learned to trust the metrics once they are filtered by the physician committees and physician leaders," said F. David Winter, MD, MSc, MACP, president and chairman.

Initially, physicians received blinded data on their performance relative to their peers. The network has gradually increased data transparency as a strategy to drive adherence with quality and safety core measures.

Today, unblinded data that ranks physicians according to quality metrics are shared transparently throughout the organization. "It took some time for the physicians to accept the data and to understand that change was coming," Winter said. "Now, we show them the data and they change. We have credible metrics. There's a lot of opportunity for improvement, but I think we're on top of getting the physicians to change as rapidly as possible to improve health care."

This physician influence can also be harnessed internally by involving peers in helping their fellow physicians reflect on feedback from patients and co-workers about problems and perceptions regarding their performance and professionalism.

A validated, tiered-intervention tool, the Patient Advocacy Reporting System®, developed by Hickson and his colleagues at Vanderbilt University Medical System, has reduced the institution's malpractice claims and losses by 80 percent in the past 15 years.

The reporting system, which has also been used by other hospitals and health systems, identifies disruptive behavior and uses data-informed peer interventions to improve self-regulation by at-risk physicians.

"Research shows that the best way to do this is to have a physician [peer] who is actively engaged in helping other individuals change their own practices," Hickson said. "The goal is not to debate the merits of the data, but to ask the physician to reflect on why his or her performance is not where it should be. The good news is that the vast majority of people who get this feedback show improvement."¹⁴

Transitional hurdles

The need for physicians to serve as team builders, motivators, communicators and change agents has grown exponentially in a system that now recognizes health care organizations more for their medical performance than their operational acumen.

“As the complexities of health care reform take shape, more physicians will be called upon to lead the change. Who better to address challenges faced by health care organizations today than those with experience on the front lines?” said John R. Combes, MD, senior vice president of the American Hospital Association and president and chief operating officer of the AHA’s Center for Healthcare Governance.¹⁵

Although hospitals and health systems are scrambling to recruit talented candidates from the outside and to groom physician leaders internally with on-site courses, experiential learning opportunities, and certificate and advanced degree programs with universities and colleges, they have work to do in bringing physicians into the leadership fold.

According to a survey cited in the 2014 *American Hospital Association Environmental Scan*, 66 percent of health system CEOs report that physicians constitute only about one-tenth of their senior leadership teams. Only 52 percent of CEOs have a formal chief medical officer involved in strategic planning.¹⁶

“These are clinical issues, so you need clinical leadership to help guide the programs and implement the practices that will get you improved outcomes,” Combes said.¹⁷

But physicians can’t do it alone. They must work with professional clinical teams in a complex environment.

Multidisciplinary teams

Until recently, health care was primarily physician-centric and disease-focused. This focus has driven not only care delivery but

also a majority of the business practices within the industry. A shift to team-based approaches and population health and wellness is occurring quickly. Those trains have clearly left the station, and physicians need to recognize these shifts.

Several health care organizations are already grappling with what this actually means and how to successfully implement team-based clinical care. There are a variety of initiatives around the country and the world aimed at moving the industry toward multiprofessional and interprofessional team-based education.

A new horizon is slowly approaching. Pride in being a physician who is passionate about quality patient care is a professional expectation grounded in centuries of behavior. The pride and passion for the physician “team” will not be easily displaced—nor should it.

Yet the world is rapidly changing, and the physician workforce must continue to change as well. Other clinical disciplines and non-clinical professionals also have pride and passion for their respective disciplines. They, too, want to work at the “top of their license.”

Although ACPE has a legacy of promoting physician-led care and physician-led teams, the organization recognizes the importance of the changing environment and highly respects each of the nonphysician disciplines active in health care delivery.

Specifically, ACPE has active initiatives or is in serious discussions with several nonphysician disciplines, including nursing, pharmacists, financial managers, nonclinical administrators, the legal community, health care researchers and information management professionals, to emphasize a team-based approach to care.

The entire health care industry is ultimately about patient-centered care. This is one common factor for which every discipline has true pride and passion. Health care profession-

als are all playing on the same team for patients, regardless of which discipline or model of care delivery they support.

For a variety of reasons, many physicians have a tendency toward autonomy and independence. However, it is important to recognize that this behavior can create misperceptions and impediments, directly and indirectly, to successful patient care outcomes. It also can create barriers to forming, leading or participating in successful teams.

It is critical that physicians develop deeper insights into how this behavior might have become engrained in their attitudes and how it could be modulated and channeled in a positive fashion—without losing their pride and passion.

ACPE believes it will take some time for formal medical education programs to foster different behaviors in the student and resident population, but those changes are occurring. It also will, therefore, take time for the current physician workforce to gradually adjust to initiating and promoting collaboration and partnering.

In the interim, ACPE supports the idea that balanced physician leadership behaviors could and should begin to emerge that will promulgate a transition from command-and-control behaviors to an atmosphere of collaboration and success for all members of a team or organization.

New intelligence needed

Physicians still have work to do. They must acquire a new set of competencies, including team-building and communication skills, and the business intelligence in finance, marketing, strategy formulation, information technology, law and other areas required to steer health care organizations of all sizes over the bumps and pitfalls of a complex system in flux.



Independent problem solving may serve physicians well during surgery, but it does not necessarily deliver as a leadership tactic.

Stephanie Sloan, PhD, and Rod Fralicx, PhD
Hay Group



As James L. Reinertsen, MD, of the Reinertsen Group, Alta, WY, said, “Physician leadership roles are powerful

potential leverage points for improvement of the health care system. As citizens in the health care system, physicians have an obligation to learn as much as possible about effective leadership so that when an opportunity to lead comes, they will make optimal use of it.”¹⁸

Among other things, physician leaders need financial literacy “to link the quality of care with the financial resources they’re expending to produce that quality,” noted Bisognano of the IHI. They must be able to speak the language of and connect fluently with boards of trustees, insurers, senior executives, clinical chairs and chiefs, patients, and staff. “The same person needs a sense of each culture,” she said.



To prepare for these expanded roles, Richard J. Gilfillan, MD, president and CEO of CHE Trinity Health, headquartered

in Livonia, MI, and former director of the federal Center for Medicare and Medicaid Innovation, urged physicians to “learn as much as you can about the nonclinical areas,” such as finance, operations and IT, “and how the pieces come together. I believe that exposing yourself to as much of the organizational activity as possible makes you a richer contributor to the

leadership team.” This deeper understanding produces leaders who can “think synergistically with the other disciplines about how to optimize across multiple dimensions,” he said.

Toward that end, the physician leadership development program at CHE Trinity Health focuses on enabling physicians to “broaden their framework for thinking about health care” by learning about the other key disciplines, such as marketing, strategic planning and law, said Donald Bignotti, MD, senior vice president and chief medical officer.

The program challenges physicians to “absorb the nonclinical side of the world and then come back and think about how it fits into the world of delivering health care,” he said. That experience prepares physicians to serve as part of a larger team.

Adjusting to ambiguity

There is no dearth of leadership potential within the physician talent pool. Physicians come to the table with multiple finely tuned skills and strengths.

Noted Jason Petros of Witt/Kieffer in Oakbrook, IL, physicians are “intrinsically fast learners, are extremely outcome-driven, have high expectations and an unparalleled work ethic. They are comfortable with responsibility and decision making. In other words, they already have executive leadership skills. These attributes have made them successful in solo practices or small team environments, and can be leveraged for success in the executive suite.”¹⁹

Despite these assets, physicians often encounter obstacles in making the transition from clinical to leadership responsibilities. The two worlds differ significantly.

Much of the difficulty stems from the autonomous problem-solving and authoritative decision-making abilities drummed into physicians during medical school and residency training. That training does not lend itself to the large-picture, vision-oriented, collaborative approach required to develop strategy, instigate clinical integration, and motivate teams, hospitals and systems to produce sustainable improvement.

“As a result, when physicians transition to a leadership role, they sometimes try to take the same approach to management problems that they took to medical problems,” said Stephanie Sloan, PhD, and Rod Fralicx, PhD, of Hay Group in *H&HN Daily*.

“Rather than coaching and helping others solve problems, they might try to jump in and fix those problems themselves. If their team is not performing as well as they would like, some physician leaders respond by doubling their own efforts to model the type of behavior they would like their fellow physicians to emulate. Independent problem solving may serve physicians well during surgery, but it does not necessarily deliver as a leadership tactic.”²⁰

That prescribing, fix-it-now tendency can stifle the cultural momentum needed for transformation. There is cultural value and power in learning when to step back, said Hickson of Vanderbilt.

“People come to me, and I might know what they need to do, but if I allow them to reflect and come to their own opinion, it is their success, and it sustains the effort,” he said. “When medical leaders go out and try to fix other people, and they don’t get fixed, they provide a ‘push back’: ‘But I just did what you told me to do.’ This is the downside of physicians who haven’t

changed the way they approach problems.”

An individual with an episodic, problem-solving mindset does not always adjust easily to the ambiguity and delayed gratification that are virtually inevitable aspects of hospital and health system leadership. And it may actually take years for a physician to unlearn their historical behaviors as they attempt to adopt newer behaviors that are better appreciated in nonclinical environments.

“We [physicians] don’t always spend the time needed to understand all of the nuances of the problems of a complex health care organization—problems that can be even more challenging, in their own way, than the human body,” James E. LaBelle, MD, corporate senior vice president and chief medical officer of Scripps Health in San Diego, observed in *Healthcare Executive*.²¹

Noted Hickson, “The hardest thing I have had to do in my career is to learn that I cannot fix every single human’s problem. I have to create a system that allows them to reflect, develop insight and solve their own problems. A significant issue with some medical leaders is that they can never make that transition.”

Management is not leadership

Gilfillan made that transition by cultivating a “servant leader” leadership style that emphasizes the modeling of honesty and integrity and helping others find their own way to become more effective. Those supportive behaviors “lead to a culture that people get excited about and perform their best in,” he said.

It can be done, but the leap between worlds requires mental gymnastics. Delos Cosgrove, MD,

president and CEO of Cleveland Clinic, noted in *Business Insider* that losing the immediacy of quickly knowing the impact of a decision he had made in the operating room was the biggest change he faced when he became a physician leader. As an executive, “You make a decision and you may find out two years later,” he said.²²



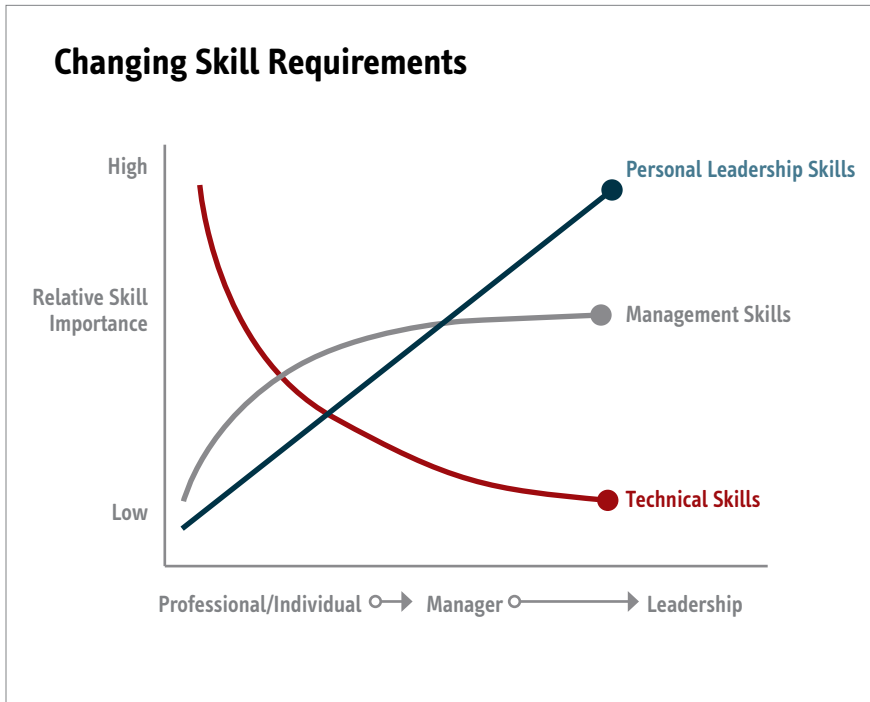
The proclivity to act and to do can predispose physicians to confuse management with leadership and to emphasize the acquisition and use of management skills at the expense of developing a unifying and inspiring sense of purpose, according to Joseph S. Bujak, MD, co-author of *Leading Transformational Change: The Physician-Executive Partnership*²³ and author of *Inside the Physician Mind: Finding Common Ground With Doctors*.²⁴

Medicine vs. Leadership



The Nature of Medicine	The Nature of Leadership
Prescribe and expect compliance	Lead, influence and collaborate
Immediate and short-term focus and results	Short-, medium- and long-term focus and results
Procedures/episodes	Complex processes over time
Relatively well-defined problems	Ill-defined, messy problems
Individual or small-team focus	Larger groups crossing many boundaries, integrated approach
Being the expert and carrying the responsibility	Being one of many experts and sharing the responsibility
Receiving lots of thanks	Encountering lots of resistance
Respect and trust of colleagues	Suspicion of being a "suit"

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Although physician leaders need proficiency in both realms, they also need to understand the differences between the two. “Martin Luther King, Jr. had an ‘I have a dream’ speech, not an ‘I have a plan’ speech,” Bujak said. “The ‘plan’ is management. The dream without the plan gets you nowhere. But the plan without the dream becomes about what you do, and people don’t care about what you do. They care about why you do it. Leadership is about why you do it. What aligns people is that sense of commitment to shared purpose, and what binds them together is the covenant that says this is how we will behave and hold each other accountable.”

Many physicians also make the mistake of assuming clinical skill translates into leadership ability, Bisognano said. The two do not always go hand in hand. “Clinical skills are certainly a requirement, but they are not enough. It’s about vision and strategy and moving a system culturally toward the Triple Aim” of better health, better care and lower cost.

“That’s very different from solving problems one at a time. It requires

a different tempo of decision-making, a different scope of work and a different set of skills,” she said.

In *Executive Insight*, consultant James A. Rice, PhD, FACHE, of Management Sciences for Health in Medford, MA, encouraged physician leaders to focus more time and energy on developing those skills. This involves a shift in focus from hard skills, such as technical competence and clinical expertise, to soft skills, such as building relationships and emotional intelligence.

The change can pose challenges for professionals who receive “little, if any, exposure to formal assessment and training in establishing effective interpersonal skills” and whose careers have “focused on functioning in an independent, decisive and dictatorial manner,” he said.²⁵

A qualitative analysis of physician leadership behavior at eight primary care practices underscored the interpersonal skills challenges physicians may face. The study zeroed in on the attribute of inclusiveness.

“Some physicians may intellectually understand what it means to practice leadership inclusiveness,

and even believe that they are doing so, when in fact, they may actually be undermining the collaboration they are aiming to support,” observed Jenna Howard, PhD, and her colleagues at the Robert Wood Johnson Medical School, New Brunswick, NJ.

They noted that inclusive leadership requires both an invitation to others to participate and an expression of appreciation for that participation with a positive and constructive response. “It may not be enough for professional organizations and researchers to simply encourage physician leaders to practice leadership inclusiveness. Rather, such an approach likely needs to be explicitly taught and supported.”²⁶

ACPE has recently developed a new assessment tool (the only one on the market) that is specifically focused on providing these types of assessments for the physician personality. These assessments can be highly valuable for individuals looking to improve their approaches, while also being valuable for organizations as they assess how best to utilize physicians for formal and informal leadership roles.

Recognizing the need to facilitate these transitions for the physician workforce, ACPE also has a variety of other career support initiatives that range from simple counselling to mentoring to full coaching, resume support and job-placement assistance.

Innovations in education

Medical educators and health care organizations have begun working to help physicians address these and other shortfalls. Recognizing that a dictatorial manner can hinder patient safety by inhibiting important information-sharing and discussions with nurses and other members of the patient care team, WellStar Health System in Marietta, GA, includes mandatory physician training in inclusive leadership as part of a comprehensive patient safety program.

Launched in 2008, the physician-led training is designed to help physicians understand how their behavior as care team leaders impacts patient safety. The program has helped achieve an aggregate 80 percent reduction in high-level safety events across the system and improve scores on the Patient Safety Culture Surveys of the Agency for Healthcare Research and Quality and the Gallup Employee Engagement survey.

In addition to providing training in safety science, the program heightens physicians' sensitivity to behavioral cues and signals that can help or hinder free and open communication among members of the care team.



“The physician has an important role in promoting an environment that leads to high-performance teams and allows

members to feel comfortable about asking questions and raising concerns,” said Marcia L. Delk, MD, senior vice president of safety and quality and chief quality officer.

Toward this end, for example, physicians learn to encourage team members to communicate their observations and concerns and to respond in an accepting and inclusive manner when those concerns are raised. “Intimidating or demeaning a person who asks a question sends the wrong signal and can lead to oversights and errors that jeopardize patient safety,” Delk said. “The goal is to embed these skills in the culture and have physicians hard-wire awareness of these behavioral cues in their leadership skill set.”

Similarly, the American College of Osteopathic Internists has developed a training program, the Phoenix Physician, to help primary care residents and practicing physicians develop skill in delivering high-quality care with respect for patients as members of the care team.

The Power of Influence

When it comes to winning support and accomplishing goals, influence trumps authority, according to Irving D. Prengler, MD, MBA, vice president of medical staff affairs for Baylor University Medical Center in Dallas.

“I often joke that I don’t have a great deal of authority in my position, but I do have a great deal of influence,” Prengler said. The use of influence — presenting a position and the evidence to support it while listening carefully to the other points of view — ultimately achieves more sustainable results, he said.

The strategy served BUMC well several years ago as leaders began working to obtain buy-in from the medical staff for the use of best practices to increase compliance with core measures.

The approach was, “I can’t argue with your sense of loss of autonomy. But is it reasonable to give a person with myocardial infarction an aspirin? Does anyone have evidence that refutes this? Wouldn’t you rather lead the way, since you are going to have to do it regardless?” Prengler said.

“Our core measures are stellar, but it took a while to learn that culture,” he said. “You work through the emotions to get to the evidence and what is best for the patient, because physicians want to take good care of their patients all of the time.”



In addition to training physicians in using performance metrics and information technology to measure and improve care, the program incorporates leadership and communication skills training and helps physicians develop an appreciation for the contributions of all team members.²⁷

These organizations are moving in the direction today’s health care environment requires. For its part, ACPE has been educating physicians through an extensive array of leadership and management courses. ACPE has taught more than 100,000 physicians and lists nearly 120 different courses, hosts four live educational conferences a year, conducts thousands of online courses for individual physicians each year, teaches nearly

200 on-site leadership programs in hospitals, group practices and health systems each year, provides certification for physician executives, offers a growing array of other certificates and partners with four universities to provide opportunities to earn master’s degrees in health care leadership and management. Additionally, ACPE has recommitted to provide only the best with leading-edge adult education approaches combined with leading-edge technical delivery platforms with its education initiatives.

The organization’s efforts have impacted physicians and health care in various ways.

“Doctors must recognize the unique skills required to be effective physician leaders and the necessity

for continuous adult learning. ACPE is an essential ingredient in the journey to becoming a successful physician executive,” said Scott Ransom, DO, MBA, MPH, FACOG, FACHE, CPE, FACPE, of Fort Worth, TX.

“A CMO must possess many tools. To ensure my role as a successful physician leader, I have learned that additional training is no longer an option—it’s a prerequisite,” agreed Robert Bratton, MD, CPE, FAAFP, CMO of Lexington, KY.

To involve physicians very early in their training in teamwork and communication around projects that lead to real and sustained outcomes improvement, the Texas A&M Health Science Center College of Medicine has formed a House Staff Quality and Patient Safety Council for interns and residents who are completing their clinical training through a joint program with Baylor University Medical Center.



The recently formed council, whose purpose is to function as a liaison between the house staff, the Graduate Medical Education

Committee and the institution as a whole, is expected to provide “a proving ground for leadership,” said Cristie Columbus, MD, vice dean of the program and assistant director of medical education at BUMC.

“All of our residents receive training in teamwork and communication, but the House Staff Council will be the most well-developed avenue by which resident leaders will emerge and participate in the life of the institution.”

Likewise, ACPE reaches thousands of medical students and residents with its LeadDoc e-zine that focuses on the leadership and management skills important for those with an interest in medical management. ACPE also provides educational sessions at the American Medical Student

Association meetings, and is developing other initiatives designed to assist younger doctors interested in the administrative side of medicine.

“The interest we see on the part of medical students and residents is less about curiosity and more about recognition of what will be required of them,” said Rebekah Apple, senior manager of physician services and support at ACPE.

“As soon as they get into any sort of clinical setting, they see the need for decision-making skills that begin at the bedside, but ripple throughout the whole building.”

Apple has seen a marked increase in leadership activity among residents. “They are leading quality initiatives in their institutions, being relied upon to manage major projects. By the time their residencies are complete, they will have demonstrated their ability to create cohesion and lead others to where their organization needs to go.”

Core competencies for leadership excellence

What qualities, skills and attributes do physicians need to lead well? Leadership models and lists of core competencies abound.

The Healthcare Leadership Alliance, a six-member, multiprofessional collaborative consisting of ACPE and five other professional advocacy groups (the American College of Healthcare Executives, the American Organization of Nurse Executives, the Healthcare Financial Management Association, the Healthcare Information and Management Systems Society, and the Medical Group Management Association), has created a list of 300 competencies required for effective health care leaders.

The 300 competencies are grouped into five primary competency areas:

1. Knowledge of the health care environment—The understanding

of the health care system and the environment in which health care managers and providers function.

- 2. Professionalism**—The ability to align personal and organizational conduct with ethical and professional standards that include a responsibility to the patient and community, a service orientation, and a commitment to lifelong learning and improvement.
- 3. Communication and relationship management**—The ability to communicate clearly and concisely with internal and external customers, establish and maintain relationships, and facilitate constructive interactions with individuals and groups.
- 4. Business skills and knowledge**—The ability to apply business principles, including systems thinking, to the health care environment.
- 5. Leadership**—The ability to inspire individual and organizational excellence, create and attain a shared vision, and successfully manage change to attain the organization’s strategic ends and successful performance.

Likewise, in *Exceptional Leadership, 16 Critical Competencies for Healthcare Executives*,²⁹ Carson F. Dye, MBA, FACHE, of Witt/Kieffer, and Andrew N. Garman, PsyD, MS, of Rush University in Chicago, put forward a similar list of the core qualities and attributes that most commonly distinguish the highest-performing health care leaders.

With findings based on an extensive literature review, a review of competency lists prepared by boards and executives for executive searches, and surveys and interviews with health care executives and search consultants, Dye and Garman organize the 16 competencies into four cornerstones:



What aligns people is that sense of commitment to shared purpose, and what binds them together is the covenant that says this is how we will behave and hold each other accountable.

Joseph S. Bujak, MD



- **Well-cultivated self-awareness:** An understanding of one’s strengths, limitations, hot buttons and blind spots.
- **Compelling vision:** The capacity to create effective plans for an organization’s future.
- **Real way with people:** Skill in listening, giving feedback, mentoring, developing champion teams and energizing staff.
- **Masterful style of execution:** The ability to generate informal power, build consensus, make decisions, drive results, stimulate creativity and cultivate adaptability.

The most effective leadership development training takes place by doing and by learning under some type of pressure, according to Dye. He advocated a three-pronged approach to leadership development that stresses a 70-20-10 blend of challenging assignments, relationships, networking and feedback from mentors and peers, and formal training.²⁹

The “crucible” experiences that involve obstacles and pressure force leaders “to examine who they are, what matters to them and what they can learn from success and failure,” he said.

A framework for change

In a 2013 white paper, *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*,³⁰ the Institute for Healthcare Improvement presented a three-pronged model for health

care leaders at all levels to support the transition from volume-based to value-based care. The model encompasses the following dimensions:

- Individuals and families are partners in their care.
- Compete on value, with continuous reduction in operating cost.
- Reorganize services to align with new payment systems.
- Everyone is an improver: Everyone in the organization should see themselves as having two jobs: to do their work and to improve their work.

High-impact leadership behaviors:

- **Person-centeredness:** Be consistently person-centered in word and deed.
- **Front line engagement:** Be a regular, authentic presence at the front line and a visible champion of improvement.
- **Relentless focus:** Remain focused on the vision and strategy.
- **Transparency:** Require transparency about results, progress, aims, and defects.
- **Boundarylessness:** Encourage and practice systems thinking and collaboration across boundaries.

ACPE’s Meta-Leadership courses and certificate target many of those specific behaviors. People who are able to work across systems to engage people and get them working together

— Meta-Leaders — are much more effective within their organizations and from career perspectives.

Meta-Leadership, developed by Leonard Marcus and Barry Dorn, is an overarching leadership framework and problem-solving methodology. Meta-Leaders look at every problem that is multidimensional, examine the various components, understand who is involved and put them together to accomplish a successful outcome.

Meta-Leadership is composed of five dimensions that define outstanding leadership:

- **The person of the Meta-Leader:** Ability to understand one’s own emotional intelligence, weaknesses, biases and strengths so that one can lead with balance, discipline and direction.
- **Situational awareness:** Ability to accurately comprehend the situation or problem—even when full information is unavailable.
- **Leading the silo:** Ability to empower co-workers to achieve maximum effectiveness.
- **Leading up:** Ability to educate and help superiors understand what is happening so they can make good decisions.
- **Leading across:** Ability to connect and inspire disparate stakeholders, departments/silos and other organizations to work together to accomplish a mission.

Conclusion

Clearly, the need for physician leaders is great, and the value they bring to health care organizations is significant. One recent example comes from reports from the Centers for Medicare and Medicaid Services (CMS) where it reported on the first year of experience with accountable care organizations (ACOs) and how physician leadership made a positive impact.



The philosophy . . . is to involve physicians very early in their training in teamwork and communication around projects that lead to real and sustained outcomes improvement.

Cristie Columbus, MD
Texas A & M Health Science Center
College of Medicine



According to the CMS data:

- Of the original 114 ACOs from the program's first year, only 54 were able to successfully attain their targets.
- Of those 54, 29 ACOs successfully received their added bonuses.
- 21 of those 29 ACOs that received bonuses were physician-led.
- And 29 percent of physician-led ACOs achieved savings greater than their minimum savings rate, versus 20 percent of the remaining participants (mainly hospital-sponsored).

Overall, physician-led ACOs tend to be more nimble in execution of their programs than hospitals—e.g., improvements in care coordination, chronic disease management and prevention.

Other examples are notable from a variety of settings, but clearly physicians, with their deep clinical understanding and desire to provide the best care for patients, are well-placed to help bring about the redesign of care that is the bedrock of health reform. Matured physician leaders are able to further leverage their skills and provide even deeper levels of expertise to the evolving health care industry's reform processes.

“Nobody went to medical school, nursing school or business school to deliver fragmented, unaffordable care. Everybody went because they wanted to do great things for patients, families and communities,”

said Gilfillan of CHE Trinity Health.

Physician leadership is critical to shepherd health care into the future, creating a delivery system grounded in better health and better health care at lower costs.



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