Too Important to Leave to Doctors?

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In this article...

Experienced physician leaders make the case for physicians taking full-time leadership roles as health care grows more complex—putting an end to the days of "symbolic," part-time physician leaders.

Driven by dramatic shifts in payment arrangements, the health care delivery system is undergoing the most rapid transformation of any industry in U.S. history. Success of traditional provider organizations will be predicated upon their ability to be redesigned as more efficient and effective population-based care models delivering higher quality and lower overall costs.

Never has there been a stronger calling for physician engagement and leadership. This is particularly true at the C-suite level, where the physician leaders with the capability and the accountability to lead and manage complex organizations day-to-day and through a period of change are in high demand.

Physicians have been historically viewed as inadequate to the task of C-suite leadership. This has been attributed to either not having the required skill sets or as hesitation to take on the broader levels of responsibility and accountability. This view was characterized in *Fortune Magazine* in 1970: "The time had come for radical change. ...The management of medical care has become too important to leave to doctors, who, after all, are not managers to begin with."

Although the credibility of that point of view can be retrospectively challenged by the national and international success of well-known physician-led organizations, the sentiment has been pervasive, particularly among hospital organizations.

Historically, the lack of formal physician leadership and management training and experience were seen as barriers to these roles. Additionally, the clinical role often was juxtaposed as contrasting with good management skills, classically distinguishing the clinician from the manager with such categorizations as:

- Doer versus designer.
- Reactive versus proactive.
- Autonomous decision-maker versus collaborator.
- Empathetic versus objective.
- Immediate tangible results versus delayed gratification.[1]

These objections are no longer valid, as the past two decades have been marked by an increasing proportion of physicians acquiring these skills through formal leadership/management education and experiential learning. Although there may be some lingering bias by the more traditional health care leaders, search firms are increasingly being requested by community boards to bring forward qualified physician CEO candidates.

Yet there still exists a lack of proportional representation of physician leaders at the highest levels of leadership. There may be many reasons for this; however, the reason, in part, may actually lie within the traditional belief systems of the physician community itself.

Management bias

Historically, the management bias toward physicians was not unilateral. Physicians maintained their own countervailing bias often with an adversarial view of "administration." This originates from a long history of different perspectives, misaligned incentives, and a mixed environment of cooperation and collaboration. Arguably, no one has suffered more than our patients who endure fragmented variable care.

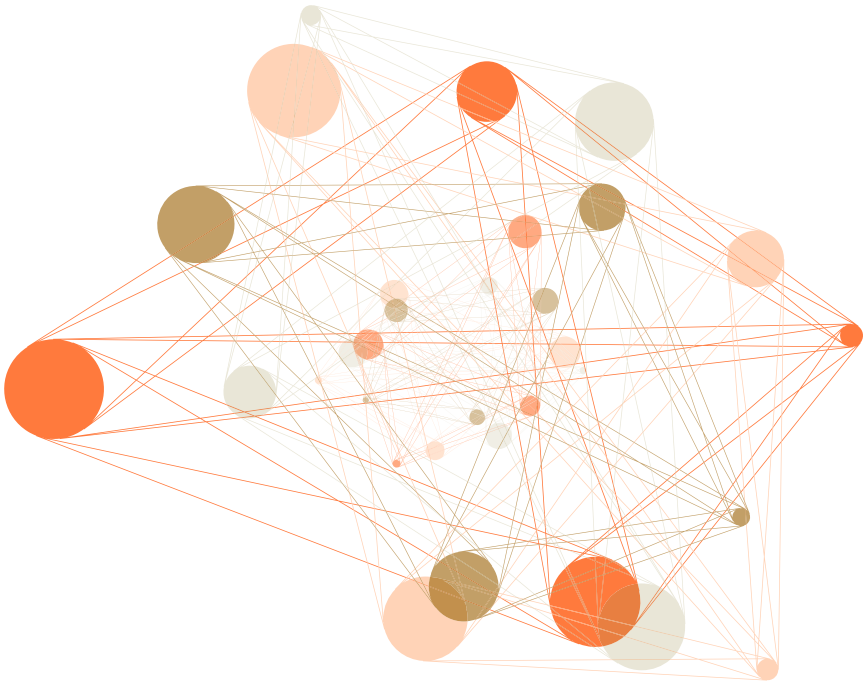
Regardless of the underlying reasons and perspectives, this strained relationship and bias had been routinely transferred by practicing physicians to those physicians who enter into administrative roles. Physicians taking on management responsibilities have often been described by their

clinician colleagues as "going over to the dark side" or "becoming a suit."

This characterization may have been perpetuated by the limited administrative roles of physicians, their lack of adequate leadership training and the way they were selected (e.g., "friendly" to administration, nearing the end of career).

The modern physician leader is of a different nature. Often he or she is not a retiring or burned out aging clinician but rather an energized clinician, who values direct patient care, but who also has the vision and the drive to have a greater impact on the health care delivery system and larger populations.

He or she embarks on a journey of formal education, often earning an advanced degree (e.g., MMM, MBA, MHA) and seeks to develop skills through experiential learning of increasingly larger and complex scale and scope. He or she expects to earn the position by proving capability as well as demonstrating a sense of responsibility and accountability.



The practice of competent clinical care has become increasingly complex with the explosion of knowledge, technology and regulatory oversight.

Modern physician leadership

The modern physician leader is focused on the future for our patients, our providers and our organizations. This transition from clinician to an effective leader/manager is not an easy one and takes many hours of study and engagement beyond clinical office hours.

Although most practicing physicians would be quick to express a desire to have more physician influence in organizational leadership and decision-making, the same physicians often inadvertently create obstacles for this to become reality.

Many health care organizations, particularly physician organizations such as medical groups, have held onto a rule that all physicians in management must maintain clinical responsibilities. The underlying belief system tends to follow two rationales:

- An individual cannot lead practicing physicians unless they are an actively practicing physician (i.e., street credibility).
- A physician leader must personally feel the downstream impact of every decision at the bedside to be effective.

There are physician leadership roles in which this line of reasoning makes sense, particularly roles with proximity to patient care. This may include service line directors, medical directors and department chairs who work with their administrative counterparts to maximize quality and efficiency in their area of expertise.

However, there are other roles of such magnitude of scale and scope (e.g., CEO) that maintaining the dual roles of clinician and leader/manager may create an untenable situation in which a physician is never entirely successful in either role. The conflicting demands on time may result in a lack of full attendance in the clinic or at important meetings, less attentiveness to important management functions, and inability to keep up on clinical and leadership knowledge and skills.

Subsequently, these highly capable physician leaders become less effective in both roles. It is a false premise that practicing physicians make better leaders or conversely that great leaders are only those that still practice medicine.

Mandating physician leaders to serve in a symbolic role as a clinician is not necessarily in the best interests of our patients, our providers or our organizations. Sadly, what may be holding physicians back from optimizing their performance as physician leaders are the expectations that other physicians often impose upon them to maintain a dual role of clinician and manager, or to disparage their professional legitimacy within the management role.

There may have been a time when the concept of the clinician as

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organization leader was more practical—a time when clinical care and management were less complex. This is no longer the case.

The practice of competent clinical care has become increasingly complex with the explosion of knowledge, technology and regulatory oversight. Since 1985, approximately 2,500 new drugs have been approved, not to mention the explosion in medical knowledge, technology and procedures. At the same time, there has been an explosion in the research and understanding of management as it relates to effective leadership skills, change management, strategy, innovation, science of quality, human interaction and successful business drivers. This is coupled with an increasingly complex and changing health care delivery system most recently disrupted by the Patient Protection and Affordable Care Act of 2010. There is another practical aspect to consider and address. Traditionally, physicians have worked under a transactional fee-for-service minus expenses model. Market-based compensation for well-trained, capable physician executives is not inexpensive. Practicing physicians have often viewed this as "overhead" without fully appreciating the overall organizational value. Physician leaders should be evaluated based on their performance and their value to the organization. This must be independent of whether they continue in a clinical role.

An additional issue to be considered is the development of our future physician leaders. The pressure put upon high-potential, aspiring physician leaders to maintain a full-time clinical practice ignores the reality that becoming a senior physician executive takes time for education and experience. Just as a busy physician earns her reputation by being available for patients and delivering high-quality performance, the evolving physician leader requires experience in administrative and leadership roles to demonstrate the ability to deliver high-quality performance.

If the physician leaders are not available for meetings, for additional projects and roles, or for personal development they will not progress in their executive tracks. This time commitment requires that practicing physicians have respect for the role of the physician leader. This allotment of time for development should be paced and managed appropriately, and reserved only for those with high potential.

Health care is in the midst of major change. If physicians are going to be effective leaders in health care delivery transformation, we need to fully embrace the complete spectrum of the evolving physician role, within the context of the clinical role and the management role. Good leadership takes people to a better place, a place where people would not have gone on their own without that leadership.

Capable physician leaders can deliver this main organizational value. Physician leadership may require the application of clinical acumen within complex organizations and teams, but it is not contingent on the clinical role. Some physicians may continue to focus some of their professional time in clinical roles, while others may transition to entirely administrative roles.

Competency will be required in both roles. Instead of clinging to old belief systems and principles, would it not be better to ask what is it that we need to be successful in this actively unfolding ambiguous environment? Would we not want highly capable physician leaders who had experienced medical school, residency training and the demands of good patient care to be proportionally represented at the decision-making table?

Do we want physician leaders to look out for the best interests of our patients, our peers and our organization on a full-time basis or part-time? Why would we not adopt the principle that physician leaders should be held accountable for performance instead of an old principle that physician leaders must show up in the clinic to see patients?

In order for physicians to provide leadership in the rapidly evolving health care environment, physician respect for those colleagues taking on nonclinical roles must not be diminished by a professional decision to do so. Otherwise, we might as well buy in to the 1970s mindset of *Fortune* magazine.

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Reference

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