HSG | PHYSICIAN LEADERSHIP

IDENTIFICATION AND DEVELOPMENT

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INTRODUCTION

Physician leadership is recognized as one of the eight intertwined, interdependent key elements essential for employed physician network success (shown in the accompanying graphic) – along with Strategy, Management Infrastructure, Quality, Culture, Brand/Identity, Aligned Compensation, and Financial Sustainability.[1] Incorporating proficient physician leadership into the employed network operating structure is likewise vital for propelling the network along the growth and maturation curve to becoming a High Performing organization[2,3] and crucial for successfully navigating the journey to value-based care.

To be successful, organizations must identify and cultivate key physician leaders who understand clinical, market, and economic issues; who are committed to improving quality; who are willing to model and drive desired culture; and who are willing and able to hold peers accountable. These individuals must embrace the role of rallying peers and colleagues to accept the challenges associated with the evolving healthcare environment and actively leading positive change.

Physician leaders must represent a philosophy that balances individual autonomy with system expectations; advocates for both the patient and the system; adeptly promotes team participation; and leads by example. They help to establish direction, buoy the vision, and align, motivate, and inspire others to follow. These tenets apply to all levels of physician leadership.

Achieving the desired echelon of physician leadership requires identifying and actively developing physicians through evolving roles as they mature to fulfill their ultimate potential.

LEVELS OF PHYSICIAN LEADERSHIP

Physician leadership exists on three basic, progressive levels of a continuum – from front line leadership to middle management to senior management.

FRONT LINE LEADERSHIP

While spending most of their time in the trenches of direct patient care wherever it is delivered, all practicing physicians have a role in working within and leading a care delivery team that is aligned with organizational objectives and driven to achieve the safest, highest quality, most efficient and effective patient care. This form of leadership is key to organizational success and should not be abdicated or abrogated.

To be truly successful at this level, physician leaders must embrace the evolving expectations of simultaneously being a leader with being an active team member – and embrace changing leadership roles that vary according to circumstances. This characterization is emblematic of the type of team function and the varying team member roles advocated in the TeamSTEPPS[4] approach. This level of functioning is crucial to many of the concepts inherent in clinical practice transformation and team-based care delivery model adoption.

MIDDLE MANAGEMENT

These roles depend on system size and can vary from positions such as office-based physician leads, divisional medical directors, or service line medical directors and clinical department chairs. These individuals assume some level of management activity related to their area of responsibility.

SENIOR MANAGEMENT

Encompassed by physician executive roles, from Chief Medical Officer or Medical Director to CEO or Executive Director, these positions represent the highest level of physician leadership and the greatest degree of management activities.

Successful progression along the physician leadership continuum does not happen by chance or through magic transformation. It must be cultivated. Formal didactic programs, self-learning adjuncts, and active mentoring all contribute to individual skill enhancement to effectively plan, organize, empower, and problem-solve. These deliberate interventions are augmented experiential learning – the value of which should not be underestimated. Progress depends on developing and expanding both leadership and management skills.

LEADERSHIP VERSUS MANAGEMENT

There are definitional and perceptual distinctions between leadership and management that become somewhat blurred when applied to the concept of physician leadership. As physicians progress in the leadership continuum outlined above, they must acquire and exhibit progressive management skills to complement their progressive leadership skills.

Leadership generally involves creating change, producing movement, and leading individuals to progressively work toward a common goal.[5] It implies the ability to inspire and motivate others to accomplish an end. Leadership can be abstract and may be formal or informal. In fact, identifying and engaging informal leaders is often a pillar to successful goal achievement. Dwight D. Eisenhower reportedly defined leadership as "… the art of getting someone else to do something you want done because he wants to do it."[5]

Management, on the other hand, generally involves the actual planning, organizing, coordinating, and/or controlling resources to accomplish a goal.[5] The focus tends to be on processes – and secondarily on people (though managers need good "people skills" to be effective). Management tends to be formally designated and have associated well-defined responsibilities.

The following table contrasts these two attributes:[6,7,8]

LEADERSHIP	MANAGEMENT
About coping with change	About coping with complexity
Creating value	Counting value
Circles of influence	Circles of power
Leading people	Managing work
Aligning	Organizing and staffing
Developing a vision & executing strategies to achieve a vision	Planning, budgeting, and allocating resources
Leading between paradigms	Managing within paradigms
Motivating and inspiring	Controlling and problem solving
Strategic Thinking	Planning
Determining the right thing to do	Determining how to do things right
Satisfying basic human needs for achievement, a sense of belonging, recognition and self-esteem	Helping normal people who behave in normal ways to complete routine jobs successfully day after day
Inspiring people to want to do what needs to be done	Getting people to do what needs to be done
Pull	Push

While some of these characteristics seem to be diametrically opposed, the two categories are not, and should not be, mutually exclusive. One aspect should not be coveted over the other. Both are necessary to effectively progress in the physician leadership continuum. John P. Kotter, author and professor at Harvard Business School, is attributed with the philosophy that strong leadership needs strong management[6] – implying that the skill sets are mutually supportive…especially as physician leaders rise through the more formal functional levels.

CHARACTERISTICS OF PHYSICIAN LEADERS

Let's first address some commonly held perceptions.

- **"Leaders are born, not made."** This axiom is not absolute by any means. While some characteristics are – or at least seem to be – innate, all can be developed. And while charisma can be a distinct asset, it is not the be all and end all for effective leadership…and can be quite shallow if not supported by a proficient skill set. In fact, some feel that introverts make better leaders than extroverts because they listen more than they talk, they are not impulsive so they process their thoughts before offering them, and they always come prepared.[9]

- **The best clinicians make the best leaders.** This can be the case, but definitely not always. While the medical decision-making process provides a solid foundation for critical thinking processes, some clinicians are not able to translate those skills into an administrative or executive environment.[10] A crucial issue is the relative inability to expeditiously move forward once the critical thinking process determines a preferred course of action. Functioning in the administrative and executive environment involves building coalitions and facing competing priorities from multiple directions. Shared decision-making in the administrative environment is much more challenging than in the clinical environment – which can be quite frustrating for clinicians. Acknowledging these caveats, clinical expertise and respect are foundational elements that predict success, as depicted in the following image.

THE SWEET SPOT FOR PHYSICIAN LEADERSHIP

In addition to the critical thinking and exceptional interpersonal skills depicted in the graphic above, a number of traits and skill sets are indispensable at any level of physician leadership. These include:

- Demonstrating excellent communication skills – including active listening
- Being a visionary who sees and understands the "big picture"[15]
- Being a "Doer" who is motivated and actively involved in positive change
- Being decisive, but in a data driven manner
- Being adaptable[11] to changing circumstances, which implies being flexible
- Exhibiting humility[12]
- Accepting accountability
- Being collaborative that predict success, as depicted in the image above.

CHARACTERISTICS OF PHYSICIAN LEADERS (CONTINUED)

Another approach to defining desirable traits and skills is to define undesirable and detrimental traits and approaches that should be avoided. These include:

- Being egocentric and narcissistic
- Being abrasive
- Being narrow-minded
- Being indecisive
- Being directive, autocratic (not to be confused with effective delegation)
- Taking a "hands off" approach
- Exclusively focusing on details – unable to rise above the "trees"

In addition to these general attributes, characteristics of good physician leaders vary as an individual progresses through the leadership continuum. Skills such as the following must be developed to permit advancement:[13,14]

- Understanding organizational structure and function – and the ability to assimilate within it
- Business, marketing, and legal/regulatory intelligence
- Mentoring and coaching skills to advise and develop other physician leaders
- Change management techniques
- Ability to effect and develop a cohesive, positive culture
- Understanding and creating alignment
- Consensus building
- Transparency without undue or untimely disclosure

NOTE: Several of these skills are best acquired through didactic endeavors.

Since hiring executives of all kinds is notoriously a risky undertaking (up to 70% of newly hired executive fail within 18 months of being hired or promoted[10]), how can decisions to place physicians in the leadership hierarchy be made more objectively – notwithstanding impressions cultivated through direct observation combined with a gut sense or "hunch?" Leadership potential can be measured through tools designed to help with that assessment.

PHYSICIAN LEADERSHIP DEVELOPMENT

Once physicians are identified who exhibit leadership potential based on traits, skill sets, and track record, the process of leadership development can be undertaken. The process often parallels clinical training concepts emphasizing progressive interventions based on a combination of didactic learning versus practical experiences and formal versus informal mechanisms. Examples include formal didactic opportunities (such as courses and conferences), informal didactic opportunities (such as self-study and independent reading), formal practical opportunities (such as formal mentoring or coaching programs and assigned leadership positions), and informal practical opportunities (such as informal mentoring and coaching from other leaders and committee membership allowing role model exposure).

Physician leadership development does not imply nor depend on an individual's desire to scale the entire leadership pyramid. Leadership development pays dividends for all physicians through greater alignment and administrative efficiencies, even for those without aspirations of advancing through progressive levels of leadership. Development options best targeted for a specific individual will depend on the level of individual development that has already occurred, the individual's future aspirations, and past experience/performance. The general phases of development can be practically divided into three broad categories: early, middle, and advanced.

THE EARLY PHASE

This phase tends to be relatively informal. The training emphasis is primarily on receiving experiential learning, mentoring, and coaching. Early development can be advanced through select formal didactic opportunities that are directly linked to their current or desired situation (a tenet of adult learning effectiveness), which the individual will often augment with self-learning opportunities. At this juncture, introduction to the larger organizational picture and to the responsibilities of representing, interfacing with, and communicating with colleagues and peers is foundational.

Potential roles to reinforce early development concepts promoting active leadership of informally changing teams, such as those involved in patient care delivery, with augmentation by more formal education about associated tenets, such as the TeamSTEPPS[4] program materials, should be emphasized. More formal positions include membership on the Leadership (Advisory) Council (or its committees) and membership on project teams, particularly those focused on clinical quality and patient safety improvement.

THE MIDDLE PHASE

Building on the Early Phase, the Middle Phase introduces additional formal didactic opportunities directly linked to anticipated roles and responsibilities. Individuals in this phase also tend to increase the pace of their self-study efforts to match their progressive involvement in organizational activities. They continue to receive mentoring and coaching while beginning to assume a primary mentorship role with more junior peers.

Multiple educational options exist for these efforts including the American Association for Physician Leadership (AAPL), the AHA Physician Leadership Forum, the American College of Healthcare Executives, and other similar organizations; graduate school courses (varying Master's Degree programs); and health system sponsored programs.

At this juncture, the individual assumes progressive formal leadership opportunities with progressively less supervision and assistance. Potential roles include assuming the practice's lead physician role and associate level then full service line leadership and/or department chair positions.

THE ADVANCED PHASE

The advanced phase includes only those individuals with aspirations for the highest pillars of physician leadership. These individuals are highly motivated to advance their knowledge and seek higher levels of responsibility. To achieve these ends, many physicians decide to obtain an advanced degree in Business Administration, Medical Management, Health Administration, Public Health, Law, or other related area.

Mentoring continues – both as a recipient and as a primary mentor. This is also an opportune time to explore leadership roles outside of the organization, such as a voluntary position on a local not-for-profit organization's board.

CONCLUSION

Investing in developing and involving physician leadership at all levels and aspects of the organization will reap broad benefits, including more efficient and effective organizational function, enhanced positioning for value-based care delivery, and accelerated progress toward becoming a high performing network.

Encouraging potential future leaders to pursue tailored developmental options consistent with individual needs and desires is key to maximizing successful individual progress and catalyzing interest in further advancement.

Investing in physician leadership development is investing in future organizational success.

CITED REFERENCES

1. 8 Keys to Building a High-Performing Employed Physician Network. HSG https://hsgadvisors.com/thought-leadership/articles/8-keys-building-high-performing-employed-physician-network/
2. Physician Network Growth Phases – Accelerating the Performance of Your Network. HSG https://hsgadvisors.com/thought-leadership/white-paper/physician-network-growth-phases/
3. Physician leadership: A Key to Organizational Success. HSG
4. https://www.ahrq.gov/teamstepps/index.html
5. J. Bridges, Leadership vs. Management, What's the Difference? Oct 8, 2018 https://www.projectmanager.com/training/leadership-vs-management
6. D. Benson, Building the Mental Model for Leadership. Physician Leadership Journal, January/February, 2016.
7. V. Nayar, Three Differences Between Managers and Leaders. Harvard Business Review, AUGUST 02, 2013. https://hbr.org/2013/08/tests-of-a-leadership-transiti
8. Dye, Sokolov, Building Physician Leadership. 2013 ACHE Congress on Healthcare Leadership, 05145
9. S. Bailey, Why Introverts Are More Effective Leaders Than Extroverts. Cincinnati Business Courier, Aug 18, 2014. Cites Dr. Jennifer Kahnweiler's book "The Introverted Leader."
10. J. Blanchard, From Clinician to Leader, the Road to a Better Fit. August 17, 2018. https://www.physicianleaders.org/news/clinician-leader-road-better-fit
11. E. Sabol, Seven Characteristics That Define a Physician Leader. April 26, 2018. https://www.physicianleader.org/news/seven-characteristics-that-define-a-physician-leader
12. C. Stith-Flood, It's Not Hard to be Humble: The Role of Humility in Leadership. Family Practice Management, May/June, 2018.
13. M. Sonnenberg, Changing Roles and Skill Sets for Chief Medical Officers. June 19, 2018. https://www.physicianleaders.org/news/changing-roles-skill-sets-chief-medical-officers
14. J. Paskert, A Seasoned CMO Offers His 'Ten Commandment' for Physician Leaders. August 10, 2018. https://www.physicianleaders.org/news/seasoned-cmo-offers-ten-commandments-for-physician-leaders

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Before joining HSG's consulting team in November, 2013, Dr. Terrence R. McWilliams, a Family Physician, spent a decade as the Vice President of Medical Affairs and Chief Medical Officer at Newport Hospital, an acute care community hospital in Rhode Island. During his tenure as CMO, he supervised the Medical Staff Services Office; was responsible for quality of care/patient safety/risk management, clinical information systems, medical staff services, physician recruitment and clinical service line development. He was intimately involved in numerous system-wide initiatives, including creating system-wide Medical Staff Bylaws, spearheading various clinical IT projects, and contributing to broad-based performance improvement efforts.

A University of Pittsburgh School of Medicine graduate, he retired from the US Navy after a career spanning more than 20 years working as a family physician and clinical administrator in a variety of practice environments, including leading multi-specialty clinical operations and physician-hospital alignment. Dr. McWilliams completed a Master of Science in Jurisprudence (MSJ) focused on Hospital and Health Law from Seton Hall University School of Law in August 2015.

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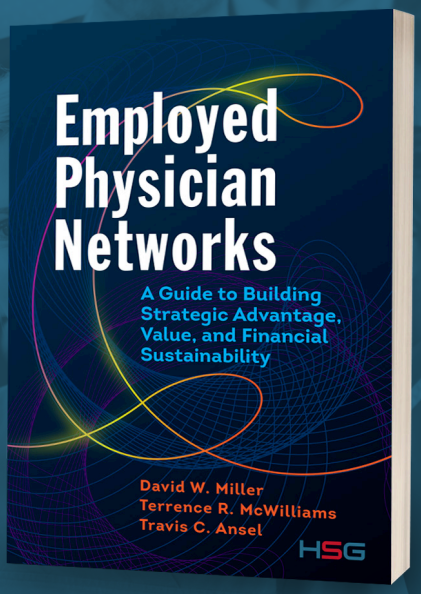

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