

## Physician Leadership: Where, Why and How\*

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### INTRODUCTION

The topic of physician leadership seems to be a popular subject, especially over the last several years. This probably should be no surprise since physicians have such a major vested interest in healthcare, and since healthcare worldwide is in an ever-changing state. However, what seems to be different about discussions involving physician leadership in recent times is that the domain of consideration is stretching far beyond the traditional doctor-patient relationship and into much broader arenas.

It is in this context that I would like to dedicate the next several minutes to how doctors may play a role in providing leadership at a more holistic level and how, in many cases, they may not only be invited to do so but also expected to do so. What I would like to do is drill down in three major areas where physician leadership seems to be emerging:

1. In crafting healthcare policy for the broad population
2. In local institutional governance
3. In selected areas of healthcare institutional management

### PHYSICIAN LEADERSHIP IN NATIONAL HEALTHCARE POLICY

Top level input and direction in creating national healthcare policy is not only a privilege of the medical profession, but also a distinct responsibility. Physicians are expected to address the needs of the broad population as well as the individual patient. In fact, physician professionalism extends beyond the expectation that doctors will function not only as the

individual patient's advocate, but also as advocates for public health issues — the broad population. At times, these roles may present conflict and this is where physician input is so critical in helping craft policy. It serves the greater good, yet allows the flexibility to meet the special needs of the individual patient who may not be served adequately by broad policy.

So, how does the individual doctor provide this leadership and prepare for the role? I would like to suggest that the pathways for doing so are multiple.

1. The first step, and perhaps the most important step, is for all physicians to dedicate a certain amount of their busy schedules to becoming informed in an objective, rather than prejudicial manner regarding the pressing national issues. These, of course, will vary among societies and cultures but there are some common themes that seem to be of contemporary importance for virtually all advanced societies. These include:
  - i) Spiralling healthcare costs
  - ii) Poor quality
  - iii) Ignorance or disregard for evidence-based practice standards
  - iv) Appropriate incorporation of new technology and scientific discoveries
  - v) Motivating and training the next generation of healthcare providers
2. Active participation in the policy arm of organised medical societies. There is little question that national policy is made chiefly by elected and appointed officials. They are concerned with many other public issues besides healthcare and very few have the background and expertise to draft policy on the basis of their own experience and expertise.

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Thus they need, and responsible public officials actually seek, informed input.

The largest and broadest organisations — physicians, hospitals, chronic care facilities, and health plans — are the natural source for most, if not all, such policy makers. Too often, at least in the United States, this input is fractionated and parochialised by sub-units — medical specialty societies, individual institutions and vocal visible individuals who often are guilty of promoting personal or small-segment agendas. In the long run, this implodes the impact those of us closest to the patient can have on benefiting our holistic societies and, perhaps equally devastating, the professionalism of medicine.

When it comes to public policy, it is essential that the voice at the podium not be that of a geriatrician, a paediatrician, a surgeon or a radiologist, but rather that of a physician who recognises that he or she represents all physicians and that this work can have maximal benefit only in a cooperative and mutually beneficial relationship with hospitals, nurses, allied health professionals and chronic care institutions.

3. The third way leadership can influence national healthcare policy may be a path that does not come to all physicians, but it does come to a good number, often when least expected, and that is in the form of leadership invitations and appointments. I would dare say there is only a miniscule number of medical school matriculates who enter the profession with any other reason than to practice medicine. It is this to which virtually all of us physicians dedicated our lives.

However, some, due to timing, personal relationships or serendipity, will be asked to abbreviate their medical practice responsibilities to assume a more bureaucratic role. I would encourage those who find themselves in this position to view it not as an odious distraction from the practice of medicine, but as an opportunity to promote the ideals of the profession and an opportunity to serve the best interest of their patients and medical colleagues. Most such appointments are of a temporary nature and, when well served, make one's return to the practice of medicine all the more fulfilling.

In the final analysis, if physicians themselves do not get personally involved with national healthcare policy formulation, our patients, who depend on us as protectors and advocates, might

well find themselves the victims of cycling national priorities, budgets and even cultural prejudicial actions, all of which run counter to the oath of Hippocrates.

## **PHYSICIAN LEADERSHIP IN LOCAL INSTITUTIONAL GOVERNANCE**

Now let me turn from the role of physician leadership in the realm of national policy to those issues closer to our day-to-day work — that is, our involvement with the governance of the institutions within which we work daily. I imagine there are few people here today who have not had some experience in this regard.

At the highest level, it may take the form of membership on the Board of Directors, but more broadly involves participation in various institutional policy-related committees, task forces or work groups. These activities are not only crucial to the effective governance of a healthcare organisation, but they also can be a very effective means of training physicians in leadership skills, regardless of how remote the task at hand might seem to one's individual medical specialty or interests. It is through physician participation in these activities that doctors can truly appreciate the wide range of activities, skill sets and stakeholders that contribute to a well-run and visionary hospital or health system.

Although at Mayo Clinic we may complain occasionally about the cumbersome nature and large number of committees involved in our governance, we do value the learning lab role of these committees and work groups. Just to give some idea in this regard, there are over 100 named committees or subcommittees at Mayo beyond the infrastructure of individual departments or divisions that involve participation of virtually 100 percent of our medical staff for at least some significant portion of their career. It is in this role that many doctors become acquainted with significant institutional challenges or opportunities that they otherwise would be unaware of, and for many it is a vivid lesson in the give and take that consensus government requires.

In most cases, physician participation in the realm of governance, which for purposes of this discussion I will define as oversight and policy determination, does not mandate a high degree of prior management experience. However, it does require a general appreciation of the value and breadth of management skills, and it is essential that governance responsibilities not be confused with management responsibilities. Governance is setting the direction through policy formulation, long-range strategy development and

monitoring accountability of management. Management, on the other hand, is actually getting the job done — execution of that policy and planning.

At Mayo, the most important element for ensuring the smooth coexistence and success of the complementary functions of governance and management is a high degree of mutual respect. It requires the administrative professional, that is, the physician leader, to work in concert with the professional administrator and to recognise and respect the important skills taught in schools of business administration and hospital administration, as well as in our nursing, technical and other health-related schools.

The aspiring physician leader who assumes a domineering posture or who approaches his or her relationship with administrative colleagues with an attitude of superiority is assured of less than full cooperation and support and is unlikely to be successful as an institutional leader over the long run.

### **PHYSICIAN LEADERSHIP IN SELECTED AREAS OF HEALTHCARE INSTITUTIONAL MANAGEMENT**

The third area of physician leadership is where the tire is actually in contact with the pavement, that is, actually running a healthcare institution — the management side of things. It is at this level where we sometimes experience more heat than light. Physician leadership at this level, or even the thought of physician leadership in the management of the healthcare institution, is a definite expanse of foreign territory for most organisations and actually is a relatively recent phenomenon brought on by the trends over the last two decades to more effectively integrate the healthcare delivery process.

Prior to the mid-1980s, in most developed countries, doctors did their thing, hospitals did their thing and healthcare payers (whether private or government) did, for the most part, whatever doctors and hospitals told them they had to do. Some have referred to this arrangement as “the golden age”, but for most advanced societies it may be more accurately referred to as the “thinly coated gold-plated age.” This is because problems related to uncoordinated, duplicative and sometimes conflicting care have accelerated spiralling healthcare costs and undermined quality, leading to delamination of the gold plating.

As a result, the “integration of the full spectrum of healthcare” has become a goal for many advanced systems. Indeed, who can argue with the wisdom of ensuring full and complete continuity of care from the

doctor’s office to and through the acute care hospital and then back to home or an appropriate chronic care or rehabilitation facility? And as the idea of integrated care has become embraced, the idea of integrated healthcare systems has become for many a restructuring goal. At least this has been true for Mayo Clinic.

Prior to 1986, Mayo Clinic was simply an outpatient medical group practice. It was comprised, as most independent group practices, of a collection of physicians and scientists with some elected leaders among them and a few non-physicians to provide support chiefly in the areas of business management and technical administration. There was, at the same time, two large independent hospitals, both restricting staff privileges to Mayo Clinic physicians only, with their own leadership that was composed chiefly of trained hospital administrators, business administrators, nursing and support staff. This arrangement, while it worked well for decades past, led to duplication of expensive facilities and at times, internecine conflict as a result of competition for the limited healthcare dollar and rational allocation of who provided the high-profit service or the money-losing service.

Thus, in 1986, with Mayo Clinic and the two Rochester hospitals facing unprecedented economic pressures, Mayo Clinic merged with the two hospitals to form a single organisation under a single management and governance. This model is basically how most integrated healthcare systems have come together — a hospital with an established leadership, administration and culture coming together with an organised group of physicians who also have an established leadership, administration and culture — and then trying to work out what the leadership, administration and culture will be in the newly formed entity. Indeed, this situation is so common that it has developed its own lexicon of “the white coats versus the dark suits” to describe the struggle between the doctor and the professional administrator for management leadership and control.

But does it have to be this way? Do physicians and healthcare administrators have opposite goals and values? I would like to answer that with an emphatic “no, not at all”. But it does take a special breed of both physician and administrator. For both, it takes a high level of mutual respect — an individual able and willing to recognise the special skills and talents of the other — and the ability to sublimate one’s personal ego and ambition for the greater good of the collective — the integrated system.

When approaching the subject of physician leadership in managing an institution, two questions often arise. The first is, “Why is physician leadership in management needed at all? Why not let non-physicians run the institution and let doctors practice medicine?”. There are several reasons why physician participation at the leadership level is important, particularly in the 21<sup>st</sup> century, and in the integrated delivery system. Let me comment on just a few.

The first is that there are no delivery systems that I know of that can afford to have the physicians and the other half to two-thirds of the provide side — that is, hospitals and nurses — competing with each other. There are simply too many ways that the physician staff can help improve hospital efficiency and too many ways that hospitals can improve physician efficiencies to ignore this as a necessary and mutually beneficial partnership. And all are concerned, at the end of the day, with one fundamental objective – what is best for the patients served?

The second is that, especially within the integrated delivery network, intimate physician involvement is key to the quality of patient care. The physician-patient relationship accounts for 50 percent (give or take 25 percent) of a patient’s outcome, satisfaction and ultimate experience. If management ignores this fact, physicians feel estranged and it translates at supersonic speed to the patient.

The third reason why physician leadership is of importance today is the economic realities of the cost of healthcare. All healthcare systems are facing oppressive financial pressures that require the consideration and protection of multiple stakeholders. Professional administrators are charged with the holistic responsibility of preserving the health of the institution, whether a hospital or system of healthcare institutions. This role is essential, since no one survives if the ship goes down in shark-infested seas. The physician, on the other hand, is trained to focus responsibility on the individual patient. The leadership orientation is essential at both levels, institutional and individual, and the blending of these two advocacies is a key element of the successful integrated delivery system.

### **INCLINATION, ATTRIBUTES AND SKILLS**

If we agree that physician leadership at some level of institutional management is desirable, how then do we determine who should step up to the task? It certainly is not a role for every physician and some of the finest doctors I know have turned down opportunities in leadership. Moreover, one must be wary of the fact that there are physicians out there only too eager to be

appointed to leadership roles but who may not be the best choices. For most physicians, a senior level role in managing a healthcare institution is not a natural evolution. Most of us with a medical degree have dedicated virtually our entire education to diagnosis and treatment of illness. Our responsibility is focused on the individual patient and sometimes even an individual organ or disease. Such terms as operating margin, internal rate of return, human resources, investment allocation balance and “the care and feeding” of the Board of Trustees are relatively foreign and meaningless to most practicing physicians.

How then, does one gain an equivalent level of confidence and comfort in the executive office as in the operating room, medical clinic or radiology suite? I don’t know of any failsafe prescription for selecting and developing physician leaders, but let me say a few words about inclination, attributes and skills.

#### ***Inclination***

The successful physician leader doesn’t have to be overly eager, but he or she can’t be reluctant for long. They must share a professional commitment that physician leadership within the organisation is important and perhaps, beyond that, a critical success factor. I believe it is important also that aspiring physician leaders view their role as incremental additions to their overall responsibility rather than in lieu of patient care. It is essential that physician leaders maintain credibility as doctors and members of the medical profession with their colleagues, even if this is as little as a few hours per week in a medical capacity.

#### ***Attributes***

A number of attributes have been cited as useful for developing a leadership profile for physicians. No one candidate will be “best in class” for all of these, but let me comment on several characteristics that I believe are important.

1. First, it is key that an individual leader be respected as a professional, that is, regarded as an excellent physician or scientist. Even the most charismatic individual on the podium will lose momentum rapidly among physician peers if they consider him or her mediocre in the area of patient care or is labelled as one who has lost interest in his profession.
2. The second important attribute is integrity, and this holds true for all leaders whether physicians or not. Their words must be rock solid and always aligned to the institution’s good rather than a personal agenda.

3. The physician leader must, at all times, reflect the institution's values in thought, word and deed. Those values must go beyond mere rhetoric and must be a strong point of cohesion for all members of the staff. Leaders are expected to not only promote the institution's values, but also be staunch defenders of them.
4. The individual leader must be selfless and collaborative. Personal ego, though a strong driving force within human nature, has only a short half-life in most institutions. Colleagues usually can see through self-promoting versus self-effacing activity.
5. An effective leader is very much helped by possessing an open and sincere communication style. Professional level followers want to be able to see, hear and touch their leaders.
6. The physician leader must possess the energy to not only accomplish the managerial and executive functions, but also add that to some level of professional responsibilities. And a word of caution along these lines. Many physician leaders may be suspected by their peers of choosing a managerial or executive route in order to avoid patient care. If in fact this is true, authority, confidence and credibility amongst one's peers unavoidably become undermined. On the other hand, a physician leader who is also seen at the clinical or scientific workbench tends to garner admiration and cannot be accused of losing touch with the challenges of the practice of medicine.
7. Amongst doctors, it seems as though most effective leaders spend much more time in the listening mode than the talking mode. They certainly listen before speaking and when they do speak they are careful to do so without excess.
8. The physician leader will be required in this era of rapid change in the healthcare landscape to be a "change agent" for the organisation. However, at the same time, as I mentioned previously, they will need to be staunch defenders of institutional values. Therefore, they must be willing to embrace change in all areas except the values and in that regard maintain a constant course.
9. No institution will sail smooth waters for very long. Thus, it is inevitable that the physician leader will from time to time, and with some individuals, have waning popularity. A willingness to be unpopular and to take unpopular positions, while no fun, is unavoidable.
10. The role of the physician leader certainly is not that of the dogmatic autocrat. Rather, it is of a coach and consensus builder willing to help groups make decisions, even if that decision might represent a variation or modification of the leader's thoughts.
11. However, at the same time, ultimately, decision-making is important and if groups cannot make decisions, that leader must be willing to make a decision him or herself and deal with the consequences, whether favourable or unfavourable.
12. Finally, physician leaders must minimise personalising issues. It is very tempting to associate a contrary point of view with a face and name rather another way of thinking about issues.

### ***Skills***

Now we move from some attributes of effective leaders to talk about the required skills for the management role of physician leaders. I am sure there will be some who would argue with me, but I believe this is less important than inclination and the list of personal attributes we just discussed.

The physician leader should make every attempt to understand the vernacular of management and to appreciate the role of human resources, strategic planning, finance, treasury services, philanthropy, information services, internal audit, and so on. But the most essential management skill is to establish an optimal working relationship with trained administrative experts in these fields so that they are providing the institution with their expertise in an unimpeded manner.

Clearly, when administrative professionals with the required skills are not available, it may fall to the physician leader to fill in the gap or appoint someone to do so. It is pure folly, however, to think that the full range of management skills can or should be acquired by the physician leader, or by any single individual for that matter.

I frequently have been asked, does a physician turned CEO need to get an MBA to fulfill the duties of the office? My answer to that is stolen from a former chief administrative officer of Mayo and that is, "Combining an MD with an MBA runs the risk of wasting two good degrees." I believe it is often far more effective for the physician leader and the administrative leader to bring their unique management skill sets to the table and for each to learn how best to amplify the skills of the other.

## **CONCLUSION**

Let me conclude by suggesting again that the time has arrived for physicians to step forward to assume leadership roles in any one or all three of the levels discussed above:

1. National health policy
2. Local institutional governance
3. Local institutional management

Physician input to some degree at all three levels is important, but what is required for effectiveness at any of these three levels differs. An underlying message is

that there is no one person who can do it all. It is the partnership between and amongst physician administrators and professional administrators that leads to a logarithmic return on investment. At the same time, physician leadership in crafting the future model of healthcare is as much a responsibility of our profession as ensuring that the medical needs of a patient under our care are fulfilled. If we as physicians do not provide the leadership and direction to create the healthcare environment for the next generation, we may find this landscape crafted by macro-level thinkers, a level or two removed from the needs of individual patients. We as physicians must provide this leadership.