Transitioning physician leaders

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Lily J. Henson
is the chief medical officer at Piedmont Henry Hospital in Stockbridge, GA, after serving as the Piedmont Healthcare chief of neurology and interim chief medical officer for Piedmont Fayette Hospital. Prior to that, she served as the vice president of medical affairs at Swedish Ballard Hospital in Seattle, WA. She was the inaugural chief of staff of the Swedish Issaquah Hospital in Issaquah, WA. In addition to having a large clinical practice with a focus on multiple sclerosis, she was the site principal investigator for many clinical trials in multiple sclerosis. She was also a clinical associate professor of neurology at the University of Washington. She is a graduate of the Honors Program in Medical Education at Northwestern University in Chicago, IL, where she earned her medical degree and completed her internship in internal medicine. She completed her residency in neurology at University of Washington Medical School. She later earned her master's degree in medical management (MMM) from Tulane University School of Public Health and Tropical Medicine. She is a fellow of the American Academy of Neurology (AAN) and previously served as the chair of the AAN's BrainPAC and advocacy editor of the AAN's website. She served on the national board of directors of the National Multiple Sclerosis Society (NMSS) and the board of managers of the NMSS's Fast Forward. She is a former Thomas C. Dolan's Executive Diversity Program scholar of the American College of Healthcare Executives (ACHE), of which she is a fellow, and is currently a Regent-at-Large for ACHE.

Piedmont Henry Hospital, Administration, 1133 Eagles Landing Parkway, Stockbridge, GA 30281, USA
Tel: +1 678 604 5404
E-mail: Lily.Henson@piedmont.org

Abstract The successful transition of physicians from clinicians to leaders of healthcare organisations is important to the overall success of these organisations. The journey involves formal education as well as professional mentoring and support of individuals who are team players and able to flex to the different skills needed to be effective physician leaders.

KEYWORDS: physician, leader, development, education

The value of physician leadership in healthcare organisations is well established and increasingly accepted. From the traditional department chairs and chiefs of staff, to the chief medical officer positions of hospitals and health systems, to the more senior roles in corporations that provide physician and healthcare services, the physician leader is recognised and desired. This is reflected in the growth of professional organisations like the American Association for Physician Leadership (AAPL), which has educated 250,000 physicians since its charter and claims 3,300 physicians with a certified physician executive designation.[1] In addition, physician membership in the American College of Healthcare Executives (ACHE) is one of the fastest-growing segments of that organisation, with over 3,000 members, and 400 participating in the Physician Executive Forum.[2] At the state level, physician leaders are also becoming more active. For example, in the Georgia Association of Healthcare Executives (GAHE), the Georgia chapter of ACHE, the Physician Executive Group has 70 members and is very active in networking activities and in promotion of physician advancement to the FACHE (Fellow of the American College of Healthcare Executives).[3] Physician leaders who join these professional groups describe the value of networking opportunities, leadership education and development, technical education, achievement of board certification

in healthcare management, and mentoring opportunities.

The importance of preparing physician leaders for their non-clinical role is critical. The training of physicians, from pre-medical studies, four years of medical school, three to seven years of residency and up to three years of fellowship, is fully based on a clinical science-heavy curriculum and has little focus on leadership thinking or health economics. Physicians are clinically oriented but have no depth in these non-scientific areas.

How, then, are most physician leaders identified, let alone prepared? At baseline, they are successful clinicians with busy practices, satisfied patients and excellent outcomes. They become involved in committee work, usually starting at a department level, and then become introduced to system committees such as peer review, credentialling or other medical staff governance activities. As they learn more about the healthcare organisation outside of their own clinical world, they also begin to understand what makes organisations run. They begin working more with non-physician leaders in nursing, diagnostic ancillaries, pharmacy and other operational departments. At that point, the clinical expertise of being in a particular specialty becomes less relevant, and the need for further training in leadership becomes apparent.

To learn more about other non-clinical aspects of healthcare, physicians seek out organisations like AAPL, which offer courses in quality, ethics, health law, finance and performance management. These introductory courses can be followed by a Certificate in Medical Management, which builds upon the preliminary coursework with a capstone project. ACHE has a Physician Executive Boot Camp, which is offered at its annual meeting and is designed for physician leaders looking for the fundamentals of healthcare leadership. More specialised organisations like HortySpringer[4] and Greeley[5] offer programmes training new physician leaders on areas such as credentialling, peer review and medical staff governance.

Larger, more forward-thinking healthcare organisations also have physician leadership development programmes in which potential physician leaders are chosen to engage in courses such as the R. Timothy Stack Piedmont Leadership Academy.[6] In addition, specialty organisations may offer leadership training for their members.[7] For many physicians, this is the first time they learn about non-clinical leadership skills, such as active listening, getting buy-in despite disparate opinions, understanding different perspectives and deepening self-understanding.

There are also a number of graduate-level programmes available for physician executives. Traditionally, most hospital administrators enrol in a MHA (master's in hospital administration) programme. Many physicians get a master's in medical management through the AAPL.[8] It is also very common for physicians to enrol in an MBA (master's of business administration) programme, where they get a more expanded view of the business world that is not limited to healthcare. The importance of obtaining this graduate-level training cannot be overemphasised. Most organisations look for physician leaders who have been exposed to these development programmes, and many look for a Master's degree. It shows the physician's investment of time and dedication to expanding their expertise beyond the practice of medicine.

Board certification in healthcare management, whether it be as a fellow of the ACHE or a certified physician executive as designated by AAPL, lends a level of gravitas, which emphasises the focused transition of physicians into non-clinical roles and gives them credibility, particularly among non-physician leaders. Similarly to specialty board certification for physicians, certification sets a bar for expertise, in this case, in healthcare management. Particularly for physicians who are at the mid or senior level, this

certification adds value by acknowledging the dedication of these physicians to attaining the expertise needed to be successful in their executive roles.

The differences between what makes a physician successful as a clinician and as a healthcare executive have been well described (Table 1). Physicians are used to being the captain of the clinical team and bearing the responsibility for the decisions and the outcomes of their patients. They are used to being proscriptive and expecting compliance. They are short-term problem focused and results oriented. They are accustomed to being thanked for their expertise and being trusted and respected. Therefore, it is not surprising that physicians entering leadership roles may find themselves frustrated about being one of many experts where their individual opinion may not drive decisions. They have to learn to be part of a team where frequently they are not the leader. They have to learn to influence others rather than telling them what the course of action should be. They need to grasp that processes are complex, and as they come up with solutions, these lead to consequences that may not be anticipated or desired.

One of the hardest things for physician leaders to grasp is that while they may advocate for a particular patient issue, they must also recognise the consequences of their actions for a larger patient population with respect to the finite amount of resources available. The ability to flex in this new role is not for all, and many physician leaders find their administrative career paths limited by their inability to make this transition.

It is also common for physician leaders to be treated by their clinical colleagues as betraying the medical profession, because the new leader now sees the many facets of a problem — and must balance these aspects, unlike the limited prior perspective. This can create discomfort for inexperienced physician leaders, who may find themselves isolated both from their former physician colleagues and from the administrative leaders with whom they work. For their continued success, physician leaders may have to distance themselves from the skills that made them valuable as clinicians and focus on traits that lead them to add value in their new roles. Knowing how to be part of a team and understanding that their perspective is one of several when issues are weighed, are basic insights that create successful physician leaders (Figure 1).

It is also critical that they are able to speak the language of their non-clinical leader partners, such as recognising the importance of return on investment, the processes

Table 1: Medicine versus 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'

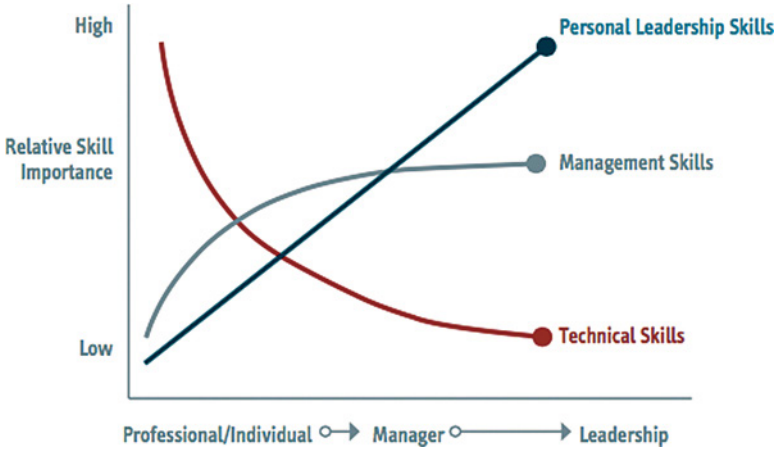

Figure 1: Changing skill requirements

in place for staff discipline, or following regulatory requirements that may not inherently have value to a clinician. Physician leaders also have to show their value to their non-physician colleagues by being able to bridge the power differentials inherent in medicine. They do this best by understanding the perspectives of both sides and facilitating a position that results in all parties feeling as though their concerns have been heard and they have been treated fairly.

A common example of this is when a physician is reported for disruptive behaviour. It takes a balanced investigation to understand why the physician behaved in the way he or she did, and to help all sides recognise the opportunities they missed and can improve on in the future. It also requires that the physician leader has the trust and respect of both parties. Full-time clinicians have to be confident that their physician leader has not gone over to what is sometimes called 'the dark side', and non-physicians have to trust that the physician leader would not simply take the side of physicians regardless of the issue at hand. Physician leaders also have to bring to the executive table unique skills and experiences that other leaders will not have. That includes expertise in traditional physician areas, whether they are clinical or medical staff governance related.

The dyad model in which a physician leader is paired with a non-clinical leader also serves as a synergistic relationship in which the strengths of each individual are enhanced by the other. The physician leader's clinical perspective adds depth and nuance to the work of the operator. Physicians often complain when they encounter barriers to their ability to provide care to their patients. The physician leader is able to bridge the gap between the care-givers and those departments perceived as creating the difficulties, and provide solutions that satisfy the clinician's concerns and accommodate the departmental processes and functions.

Witt/Kieffer and Hogan Assessment Systems studied a large healthcare organisation's physician leaders to identify core leadership competencies.[9] They found that top-performing physician leaders tended to be more resilient, even-tempered and motivated by sharing success compared with good performers. Successful physician leaders tended to focus on learning and remaining current with changes in the medical field, and less focused on financial success compared with other healthcare leaders. They tended to be data-driven decision-makers.

All physician leaders would benefit from mentoring. Just as many physicians had clinical colleagues who were instrumental in guiding their careers, physician leaders also

find value in being led by senior colleagues, whether physician or not, who can help them in their leadership journey. The author has been fortunate enough to have had many mentors during the course of her career. Early on, when she was a young clinician, several well-respected physician leaders in her organisation took an interest in her and suggested taking paths that opened many doors for her into leadership roles. Perhaps if she had not encountered these individuals, her interest in physician leadership might never have germinated. These individuals provided a safe haven to share fears and frustrations and were always available to dust her off when she failed, and share sage advice to help her move on and grow. She has also had non-physician leaders who served as trusted advisers. Although physicians may naturally gravitate towards other physicians as mentors, non-physician leaders offer very valuable perspectives that can help their physician mentees expand beyond their clinical experiences.

Networking for physician leaders is crucial. National organisations like AAPL and ACHE, and its state chapter organisations like the GAHE, not only create opportunities for physician leaders to meet others in similar roles, but also expand the horizon of experiences in which they may find themselves interested. Particularly for many less experienced physicians, being able to develop a cohort of others in similar situations provides a safe place to learn and develop their leadership skills.

Physician leaders are important to the success of healthcare organisations. The physician's metamorphosis from clinician to leader requires high-functioning individuals with focused training and support. These leaders provide a much-needed perspective to healthcare organisations that will enable their success in the changing healthcare market.

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