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Physician Leadership in Hospitals and Health Systems:

Advancing a 21st-Century Framework

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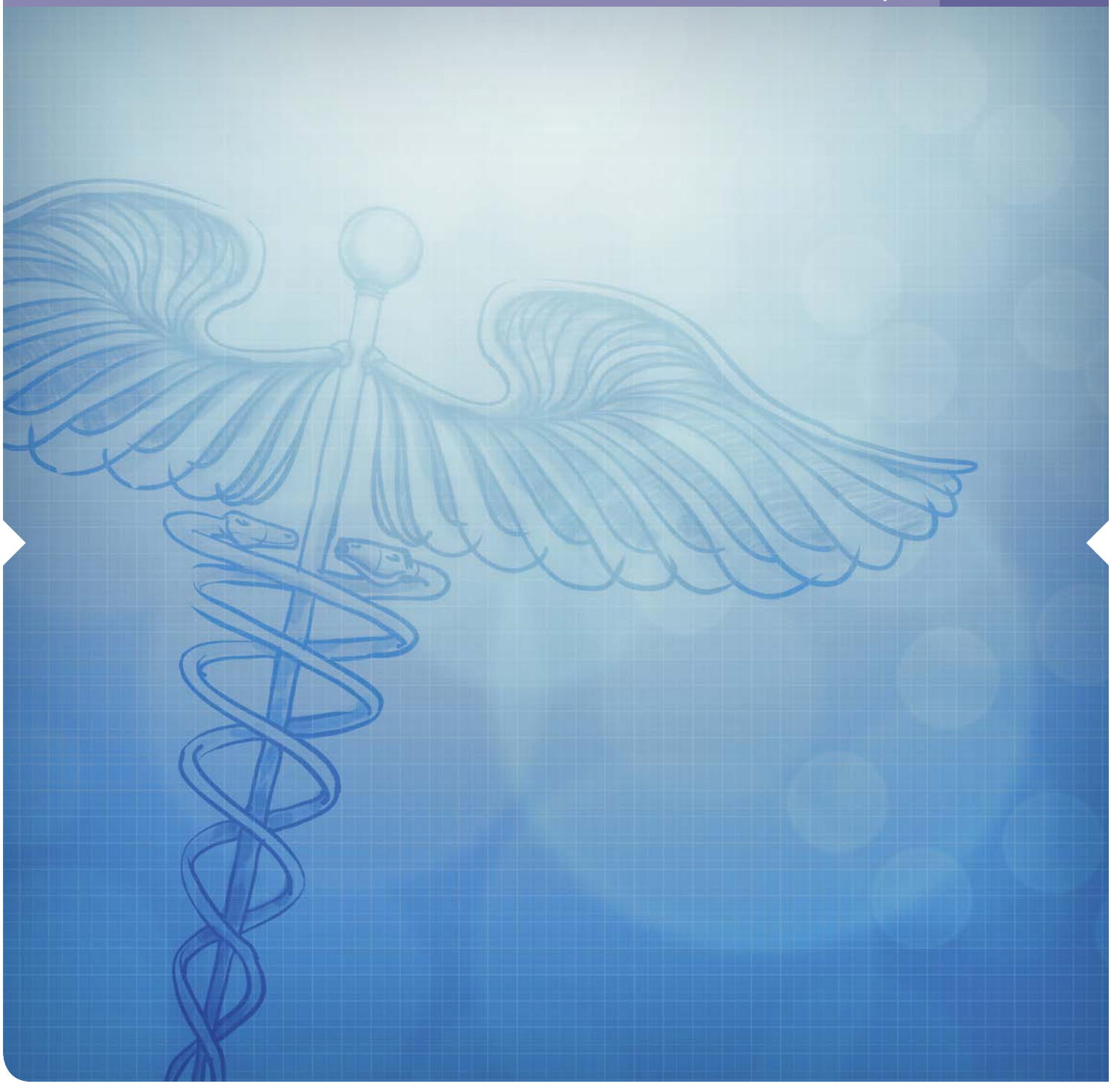

About the Author

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Executive Summary

The critical utility of doctors to hospitals and health systems has never been disputed. Despite their importance to hospital success, since the mid-20th century, physicians have played a minor leadership role in these increasingly complex entities. Only recently has this reality begun to change as increasing recognition emerges that the future long-term viability of many healthcare institutions will hinge on providing leadership development opportunities and significant leadership roles for physicians.

TRACKING THE COMPLEX GYRATIONS and challenges roiling healthcare today is a daunting task for many board members. The roles played by clinical leaders are expanding and becoming more critical to organizational success. It has therefore become imperative for the hospital or health system board to assure that physician leadership development is considered a strategic priority at its institution.

It is the premise of this white paper that governing boards that fail to attend to the adequacy of physician leadership will put the mission and long-term sustainability of their enterprises at risk, as organizations face increasing pressure from the public, payers, regulators, employers, and politicians to provide greater value as they pursue their missions. Improvements in quality and safety, cost efficiency, and patient-centered orientation have been slow in coming to most hospitals and health systems. Furthermore, many hospital-affiliated practitioner communities are plagued by burnout, growing physician turnover, and challenges to the recruitment of new doctors. Increasingly, missing physician leadership is being perceived as a vital tool for addressing these issues.

Challenges

The significant employment of physicians by hospitals has led many to develop an internal leadership structure to forge these doctors into potent, multi-specialty group practices. Such practices may develop their own board or executive committee of physician leaders, hire or appoint a group practice physician executive, or encourage their employed doctors to provide leadership in working committees and task forces. Physician leadership facilitates the creation of a culture of excellence and collegiality among employed doctors and engages them meaningfully in care transformation.

The advent of accountable care organizations (ACOs) and clinically integrated networks (CINs) has created yet additional structures that function best when they have significant physician leadership. ACOs that are physician-driven have demonstrated some of the best financial and quality results in our early experience with these new healthcare entities.

However, the rapid expansion of leadership roles has created its own problems in many facilities. Too little care in the creation of clear job descriptions and the assignment of accountabilities has left many hospital players confused about which physician leader has responsibility when a particular problem manifests.

Expanded physician leadership is undermined in many institutions because these facilities lack adequate integration of strategic and operational command. Too many health systems behave like federations of entities that have been acquired or developed, and they maintain leadership in convenient silos, limiting overall efficacy. There is an urgent need in such institutions to rationalize the totality of physician leadership structures so that the enterprise reaps maximal value from its investments.

Various healthcare trends have only exacerbated these challenges. Over the past 15 years, the locus of physician practice moved inexorably out of the hospital footprint. Earlier times saw doctors voluntarily engaging in the performance of medical staff duties in exchange for access to the hospital "workshop." In recent years, as doctors find less and less need for the hospital, they have balked at providing the time needed to participate in these activities. Participation in staff and department meetings has been diminishing almost everywhere.

Despite several decades of stormy hospital–doctor relationships, the tide has been turning in recent years. A growing doctor shortage has made hospitals much more cognizant of the need to become physician friendly. Hospital boards increasingly value administrators who can bridge gaps with the physician community and form strong bonds with key clinical stakeholders. Competition between physicians and hospitals has become less of a

flashpoint as many physician outpatient enterprises have failed and closed and others have been sold to local hospitals. Hospitals today are as much outpatient enterprises as inpatient businesses and they are less threatened by technology that moves hospital-based services into the outpatient arena. Many physicians who have been veterans of past battles with hospitals have recently retired or will be doing so soon. They are being replaced by a younger generation that approaches their professional lives with a more collaborative orientation. The rapid implosion of private practice medicine in recent years has left the majority of doctors employed by hospitals. This creates a natural alignment of interests and makes it important to both hospitals and doctors to maintain good working relationships.

Physician leaders' primary roles in the past have been to serve as advocates for the interests of their fellow doctors. In today's volatile healthcare environment, what is needed is less focus on such advocacy and more leadership focused on sponsoring change and improvement of care for patients.

Hospitals have tried to offset the inherent weaknesses of the medical staff model by creating physician leadership positions in management. Historically this has been the position of the vice president of medical affairs (VPMA). Many hospitals employed VPMAs as hospital–physician tensions became prevalent in the 1980s and 1990s. Hospitals often hired a doctor who had a long tenure on the medical staff and who was nearing retirement and looking for a way to comfortably segue from clinical practice. Hospital CEOs figured that such an individual could serve as an interface between management and doctors and would be more likely to engage physicians in needed tasks (e.g., compliance with medical record requirements or utilization expectations) than would exhortations from administrators. The growing investment in VPMAs and CMOs was an early sign that, as hospitals approached the end of the 20th century, they were seeing a need for increased physician leadership.

There has also been a paucity of physician participation in governance over the preceding six decades. In the 20th century, the only physician on many hospital boards was the medical staff president or chief of staff. However, in recent years, boards have begun to invite more doctors into governance in recognition of the valuable perspective and insights they can bring. This has provided a new platform for physicians to exert leadership, but few doctors have a clear understanding of the fiduciary responsibilities of hospital board members. Many doctors appointed to boards see themselves as representatives of and advocates for the physician community. This has undermined their ability to provide the institutional leadership required of those in governance. For this and other reasons, the numbers of physicians serving in hospital governance has remained relatively small at most hospitals and health systems.

The deteriorating state of the organized medical staff has led many organizations to undertake a concerted effort to rethink approaches to medical staff structure and functioning. One significant goal of this work is to make physician leadership on the medical staff more impactful and therefore more attractive to potential leadership candidates.

There is a sea change occurring in hospital and health system commitment to physician leadership. Today a clear business case exists for this increased commitment and it is starting to transform hospital executive suites in many communities.

The Business Case for Enhanced Physician Leadership in Hospitals and Health Systems

The need to make a financial investment in physician leadership is becoming clearer, with many experts concluding that a strong emphasis on clinical leadership is essential rather than a passing fad.

The value of physician leadership in today's healthcare environment rests on multiple benefits. To strengthen a health system's quality and safety performance, doctor's must be guided to carry out their tasks in ways different from the direction they received in their training. Doctors are often characterized as poor "followers," but they are certainly more responsive to their peers. Under value-based reimbursement arrangements, hospital and health system revenue streams will be significantly impaired if physicians cannot be led to adopt behaviors that reduce costs, promote high quality, and achieve better patient satisfaction.

The efforts at many health systems to change physician behavior through financial incentives have not been particularly effective. There is growing recognition that the missing ingredient in these change management efforts is effective physician leadership. Another benefit of enhanced physician leadership is the ability of such leaders to create a satisfying professional home for their colleagues.

When doctors are strongly engaged in maintaining and enhancing organizational performance, better clinical and financial outcomes result. A growing number of studies support this conclusion as does a wealth of anecdotal evidence from leading healthcare institutions. If these perceptions are accurate, then advocacy for enhanced physician leadership clearly supports institutional goals relating to both margin and mission.

The Expansion of Physician Leadership Roles: A 21st-Century Phenomenon

It is now widely recognized that successful transformation of healthcare in the 21st century requires greater physician input. This recognition has generated an explosion of new leadership positions. These range from new physician executive titles and functions to key posts in emerging healthcare structures like ACOs, CINs, and employed physician groups. Summarized descriptions of many of these new physician roles are below; see the full white paper for more complete information.

Physician Executives

The roles of VPMA and CMO have become more substantial and ubiquitous since the 1990s, but growth in physician executive positions has only recently reached an inflection point, with a rapid rise in both numbers and in the variety of physician leadership positions. The drive toward clinical quality outcomes and patient engagement has been giving rise to the position of chief clinical officer (CCO). Today it is also becoming common to see health systems with physicians serving in a range of additional executive positions including chief quality officers, chief medical informatics officers, chief transformation officers, chief integration officers, or other creative new positions. The greatest recognition of the importance of physician executive leadership comes from organizations that have determined to fill the position of CEO with a doctor.

Physician Directors of Service Lines and Centers of Excellence

There is considerable diversity in health systems in the service lines they choose to develop, in their number and in their key characteristics. But almost all have a physician medical director with considerably more responsibilities than those historically held by a medical staff department chair. In many organizations, this medical director is paired with an administrative partner in a working dyad relationship.

Physician Leaders in Hospital-Employed Physician Groups

When the employed physicians are organized into an operational entity or incorporated as a group practice, it is common to find a physician CEO, president, or director. Often there is some type of governance for these doctors—either a formal board or an executive committee. These are typically populated by employed physicians who must now learn how to perform in a governance capacity. In large employed groups, there may be working sub-committees that typically require physician chairs. Examples include a quality committee, an operations committee, a culture and recruitment committee, and/or a compensation committee.

Physician Leaders in Accountable Care Organizations and Clinically Integrated Networks

Both ACOs and CINs are required to have leadership that involves doctors and they must undertake practitioner credentialing and quality oversight functions. The governing boards of these entities frequently include more physicians than are found on the typical hospital board. This reflects the strong emphasis on clinical results necessary for these entities to succeed. It is not uncommon for ACOs and CINs to have a physician as president or CEO or serving as the organization's medical director. Physicians are often heavily involved in the leadership of working committees to help facilitate clinical transformation that can deliver high-quality results at lower cost.

Physician Leaders Fulfilling Academic Responsibilities

Teaching hospitals require physicians to fill faculty roles and to take on leadership in the oversight of academic programs. Examples of leadership roles include:

- Residency program directors
- Fellowship directors
- Chairs of academic departments that perform both teaching and research
- Directors of graduate medical education

To help academic physicians to better appreciate the challenges for which they must prepare students, some hospitals are involving academic faculty leaders in more of the institution's strategic planning discussions.

Physician Leaders on the Front Line

These physician leaders are working at the pointy or sharp end of the spear where actual care is delivered. This is where day to day problems are most likely to occur and where the immediate guidance of trained physician leader can make substantial differences in the efficiency and quality of care. Physician leaders at this level can help:

- Advance physician engagement
- Compliance with best practices
- Team building
- Practitioner resiliency

Making Medical Staff Leadership More Effective: The Push for Medical Staff Redesign

One of the most significant forms of medical staff redesign in the past two years has been the unification of medical staffs across different hospital campuses within a multi-hospital health system. Maintaining multiple medical staffs is a drain on the time and talent of the limited resource of physician leadership in a health system. Valuable clinical standardization can be harder to achieve across multiple medical staffs and clinical redesign efforts slowed. Furthermore, the financial resources needed to staff and support multiple medical staffs can be substantial as is the organizational strain of enduring multiple accreditation reviews.

While the reasons to unify medical staffs are compelling, there are also challenges and potential downsides. Unification may be impractical if large distances geographically separate a system's hospitals. Another obstacle may occur when a particular hospital in a system has a unique and strong culture which it

does not wish to see attenuated. In some institutions, local physicians may feel threatened if they perceive a merger of medical staffs will result in a dilution of their input and influence with management. Sometimes opposition to medical staff unification can come from local hospital administrators, who may believe it will be harder to manage physician affairs on their campus if multiple medical staffs are consolidated.

While it is necessary to garner the support of physicians, the need to have management and board support should not be overlooked. Until these entities are clearly supportive, no effort at unification should be initiated. It is also important to be clear with medical staff professionals how their future will be affected. When new bylaws are being adopted to create a single medical staff, it can also be wise to create a transition plan to smooth the path forward.

Leadership Training: How Hospitals Are Preparing a New Generation of Physician Leaders

Physician leaders today need broad skills ranging from analytic and strategic capabilities and the capacity to embrace change, to the ability to build teams, resolve conflicts, and motivate colleagues. It will be necessary for most health systems to help develop these and other important skills in those doctors they want to lead.

Leadership succession planning requires self-conscious efforts to identify talent within the ranks of employed and private practice physicians in the community and find the enticements to bring these individuals into the ranks of leadership. For most organizations, it will also necessitate developing relationships with recruiters to identify talent that can be hired from outside the community to supplement locally available resources and to inoculate the institution with new viewpoints and knowledge.

The following are recommended tools for physician leadership development:

- Onsite or offsite "boot camps" that target a defined set of skills such as those needed for newly elected medical staff leaders
- Episodic onsite leadership development programs (e.g., grand rounds or retreats)
- Onsite physician leadership curriculums or "academies" with longitudinal training that may take place at quarterly or monthly intervals.
- Offsite participation in national physician leadership programs sponsored regularly by both commercial and professional organizations
- Enrollment in certificate programs such as the AAPL coursework leading to recognition as a Certified Physician Executive (CPE)
- Enrollment in healthcare oriented M.B.A., M.H.A., or M.P.H. programs
- Onsite mentoring and coaching initiatives

Hospital and Health System Board Responsibility for the Promotion of Effective Physician Leadership

A CEO might consider the development of physician leaders to be solely a management issue, rather than a matter of governance, but as physician leadership is essential to the success of an integrated delivery system, it affects, and should be part of, the strategic plan. Boards should place the matter of physician leadership and its effectiveness periodically on its meeting agenda for assessment and deliberation.

Introduction

The critical utility of doctors to hospitals and health systems has never been disputed. Physicians are a major source of patient referrals to such institutions and they are the prime managers of care for patients both within and outside hospital walls.

ONE PUNDIT SUCCINCTLY SUMMED UP HOSPITAL DEPENdency on doctors when he noted, "A hospital without doctors is just a hotel with bad food!" Despite their importance to hospital success, since the mid-20th century, physicians have played a minor leadership role in these increasingly complex entities. Only recently has this reality begun to change as increasing recognition emerges that the future long-term viability of many healthcare institutions will hinge on providing leadership development opportunities and significant leadership roles for physicians.

Tracking the complex gyrations and challenges roiling healthcare today is a daunting task for many board members. The roles played by clinical leaders are expanding and becoming more critical to organizational success. It has therefore become imperative for the hospital or health system board to assure that physician leadership development is considered a strategic priority at its institution. This white paper is written to help those in governance appreciate the significant changes in physician leadership that are occurring in hospitals across the nation. It serves as an aid for understanding why the importance of physician leaders has grown, provides a roadmap to the expanding number of leadership roles being undertaken by doctors in healthcare organizations, assesses the adequacy of the historic organized medical staff as a leadership platform, provides understanding of leadership development initiatives that hospitals sponsor, and suggests ways to improve the efficiency and effectiveness of emerging physician leadership roles. It is the premise of this white paper that governing boards that fail to attend to the adequacy of physician leadership will put the mission and long-term sustainability of their enterprises at risk.

Historical Context

The working relationships between doctors and hospitals has a varied history. Initially a synergistic partnership that strongly benefited both parties, the marriage has gone through many stormy patches over the decades. Physician leadership in hospitals has historically existed in the structure of the organized medical staff, which required minimal time, effort, and skill on the part of doctors. Physicians typically took on medical staff roles with little training or orientation and the time devoted to this work was voluntarily offered once the doctor's clinical responsibilities were met. Through most of the 20th century, medical staffs were fairly homogenous in their make-up and the needs of medical staff members were generally straight-forward. As a result, it was typically understood that anyone on the staff could stand in as a medical staff leader. During this period, leaders in the hospital could truly be characterized as amateurs. Despite their good intentions and the varied energy and commitment individuals brought to the work, most medical staff leaders met the Merriam-Webster definitions of "amateur"—"one who engages in a pursuit…as a pastime rather than a profession" or "one lacking in experience and competence in an art or science."

The onset of managed care in the 1980s and 1990s created new demands and opportunities for physician leadership. Hospitals engaged in numerous tactics to attempt to accommodate that era's new reimbursement models. These included the establishment of physician–hospital organizations (PHOs), the purchase of primary care physician practices, and various joint ventures with independent practice associations (IPAs), insurers, and others to experiment taking on financial risk. Most of these endeavors created increased tension between hospitals and doctors. One result was that hospitals began to create new physician executive roles to help their institutions "herd the cats." In these years, it became more common to find a vice president of medical affairs (VPMA) in the ranks of hospital management and larger organizations were often creating new opportunities for a chief medical officer (CMO).

In its early years, managed care organizations (MCOs) also attracted many idealistic physicians into their leadership ranks. These doctors hoped to promote the broad reformist agenda promised by managed care (e.g., more inclusive care coverage, improved care access, strong focus on preventative care and community based health services, and greater cost effectiveness). Many of these highly motivated new physician leaders became discouraged or burned out as for-profit insurers came to dominate the managed care world and brought with them their overarching focus on managing costs and enhancing profits. The public backlash against managed care convinced many doctors that they should concentrate on clinical practice and leave the politics of healthcare leadership to others. Nevertheless, in the last years of the 20th century and early years of the 21st, there emerged a cohort of entrepreneurial physicians with innate leadership skills who devoted themselves to the development of enterprises such as diagnostic, surgical, and ambulatory care centers; the expansion of aggressive multi-specialty group practices; or the development of single-specialty organizations to contract with multiple hospitals in areas such as emergency room coverage, hospitalist medicine, anesthesia, and radiology.

What Is Different Now?

Today there is a clear resurgence of interest in physician leadership in hospitals and health systems across the nation. The prime mover of this interest has been the incessant drumbeat from the public, payers, regulators, employers, and politicians for hospitals to provide greater value as they pursue their missions. Improvements in quality and safety, cost efficiency, and patient-centered orientation have been slow in coming in most hospitals and health systems. Furthermore, many hospital-affiliated practitioner communities are plagued by burnout, growing physician turnover, and challenges to the recruitment of new doctors. Increasingly, missing physician leadership is being perceived as a vital tool for addressing these issues.

Hospital and health system boards and management teams have responded in a variety of ways. Many have invested, to varying degrees, in physician leadership development programs. These range from minor efforts (e.g., an annual leadership "boot camp") to the creation of elaborate physician leadership academies and institutes. There has also been an explosion of new leadership roles for doctors in the institutions with which they are affiliated. Physician executive positions have proliferated and more and more physicians have infiltrated the ranks of hospital senior management. Today we find hospitals and health systems that may have a CMO, chief clinical officer, chief integration officer, chief quality officer, chief medical information officer, chief transformation officer, and/or campus-specific VPMAs.

As hospitals increasingly organize around clinical service lines, these structures require medical directors who are often assigned an expansive range of administrative responsibilities. These new physician leaders are often paired in dyad relationships with an administrative co-manager.

The significant employment of physicians by hospitals has led many to develop an internal leadership structure to forge these doctors into potent, multi-specialty group practices. Such practices may develop their own board or executive committee of physician leaders, hire or appoint a group practice physician executive, or encourage their employed doctors to provide leadership in working committees and task forces. Physician leadership facilitates the creation of a culture of excellence and collegiality among employed doctors and engages them meaningfully in care transformation.

The advent of accountable care organizations (ACOs) and clinically integrated networks (CINs) has created yet additional structures that function best when they have significant physician leadership. ACOs that are physician-driven have demonstrated some of the best financial and quality results in our early experience with these new healthcare entities.

Challenges

In all the clamor to develop new physician leadership positions, many hospitals are suddenly realizing that they have neglected training for doctors undertaking traditional medical staff leadership roles. While organized medical staff has become an increasingly anachronistic vehicle for physician leadership, it still retains responsibility for two critically important hospital functions: credentialing and peer review. Both are a source of growing liability for hospitals and health systems. Plaintiff lawyers have increasingly sued hospitals with claims of corporate negligence for inadequate vetting or oversight of medical staff members who are accused of malpractice. Furthermore, when a hospital takes an action to restrict or terminate the clinical privileges of a poorly performing medical staff member, it may find itself sued by that physician. If medical staff leaders perform their duties well, these suits typically go nowhere. However, medical staff leaders who are inadequately trained for their duties can make mistakes that can lead to multi-million-dollar judgments and incalculable harm to institutional reputation.

When creating new physician leadership roles, hospitals and health systems also need to consider leadership development efforts that go beyond "just-in-time" training for medical staff leaders. Across the nation, organizations are investing in physician leadership academies, sending doctors to offsite educational programs, encouraging leaders to enroll in certification and graduate degree programs (e.g., M.B.A.s and M.H.A.s), or implementing mentoring and coaching programs.

Growing a cadre of well-trained physician leaders to take on a broad range of new responsibilities is underway in hospital and health systems from coast to coast. There is good reason to be optimistic that this activity will lead to improved results for these institutions and for the general public health. However, the rapid expansion of leadership roles has created its own problems in many facilities. Too little care in the creation of clear job descriptions and the assignment of accountabilities has left many hospital players confused about which physician leader has responsibility when a particular problem manifests.

Physician Leadership Challenges

- Neglected training for doctors undertaking traditional medical staff leadership roles
- Need for leadership development efforts that go beyond "just-in-time" training for medical staff leaders
- Lack of clear job descriptions and the assignment of accountabilities, causing confusion regarding which physician leader should respond to a particular problem, and duplication of effort
- Expanded physician leadership in health systems may operate in a fragmented fashion within multiple silos, limiting overall efficacy

For example, in a complex health system or hospital, which physician leader should address a poorly performing colleague? This problem physician may be manifesting poor clinical competency or exhibiting unprofessional conduct in relationships with colleagues, staff, or patients. Historically this individual might be approached and "managed" by an officer of the medical staff or a medical staff department chair. However, in

many hospitals a more experienced physician executive (e.g., CMO) might be a more effective choice. But if the doctor is a member of the hospital-employed physician practice, perhaps the leadership of this group practice should intervene? Of course, the problem doctor probably practices within one of the hospital's clinical service lines and it has a medical director who is responsible for the quality of service line care, the smooth operation of its activities, and the high level of team work of its clinical participants. Clearly this physician leader should have strong interest in addressing a problematic physician who can undermine these results! And yet, this poor actor is also performing much of his problematic work in the outpatient setting and is a member of the hospital's affiliated ACO and/or CIN. The success of the ACO or CIN is strongly tied to its quality and financial performance metrics, as well as patient satisfaction scores. Physician leaders in the ACO/CIN will certainly feel pressure to address unsatisfactory performance on the part of a colleague—indeed, that is one of the rationales for such leadership in the first place.

At this point it should be clear that a proliferation of roles can have downsides as well as positive effects. In the example above, it is likely that there will be duplication of effort, which will be inefficient at best and ineffective at worst. The problem physician may be bombarded with conflicting input and suggested remedies. Alternatively, if every leader assumes someone else is addressing the problem, no one at all may address the troubling colleague. When this happens, the hospital has made significant investments in leadership that simply aren't paying dividends.

Expanded physician leadership is undermined in many institutions because these facilities lack adequate integration of strategic and operational command. Too many health systems behave like federations of entities that have been acquired or developed, and they maintain leadership in convenient silos. Because such systems act more like holding companies than tightly integrated delivery systems, physician leaders are often frustrated in their efforts to redesign care and achieve the goals of the Triple Aim.[1] Equally significant, many physician leaders are limited to strategic planning, input, and management within a particular health system silo, whether the ACO, a service line, the medical staff's executive committee, or the employed physician group. Because the expanded physician leadership operates in a fragmented fashion within these multiple silos, its overall efficacy is limited. There is an urgent need in such institutions to rationalize the totality of physician leadership structures so that the enterprise reaps maximal value from its investments.

In the sections that follow, this white paper will look further in depth at the history of physician leadership in hospitals and its future trajectory. In doing so, its goal is to help board members, physicians, and management teams develop perspective on hospital–physician working relationships and to appreciate the fulcrum that physician leadership can provide in moving forward the agenda of the 21st-century healthcare organization.

1 The Institute for Healthcare Improvement's Triple Aim is to "simultaneously improve the health of the population, enhance the experience and outcomes of the patient, and reduce per capita cost of care for the benefit of the communities." To read more, visit www.ihi.org/Topics/TripleAim/Pages/default.aspx.

A Short History of Hospital–Physician Working Relationships

Doctors and hospitals have always needed each other—especially since the early 20th century when the possibility of benefiting from a hospital stay rose above the breakeven point. At that point, advances in anesthesia and in antiseptic technique made the hospital less a place to die and more a place of hope for cure and recuperation.

AS THE SOPHISTICATION AND EFFICACY OF HOSPITALS GREW, they became essential workshops for physicians. The doctor brought to the facility patients and medical expertise, and the hospital provided beds and equipment, nurses, and technical personnel. This was a synergistic relationship that served both parties well.

The hospital became the most visible symbol of the dramatic scientific advance of 20th-century medicine, and physicians enjoyed the prestige that accompanied affiliation with a reputable institution. In the early years of the 20th century, hospitals were often led by physicians who played an outsized role in their establishment and sustenance. But as hospitals became ever more complex, institutional leadership migrated to a cadre of executives trained in corporate management and prepared to deal with the many non-medical aspects of running a multifaceted organization. Physician leadership was relegated to oversight of the "organized medical staff" and physicians, mainly interested in caring for their patients, acquiesced in this compartmentalization of responsibilities.

The middle years of the 20th century were a time of smooth working relationships between doctors and hospitals. The explosion of medical specialties after World War II anchored the position of the hospital at the center of the medical practice community. The rapid development of expensive medical technologies required that new cohorts of specialized physicians maximize time close to their new tools located within hospital walls. Dramatic advances in medical science caused more and more patients to seek care in hospitals and their growing intensive care facilities. The then dominant model of cost-based reimbursement tended to promote long hospital lengths of stay. Doctors spent increasing amounts of time in the hospital caring for a growing hospitalized patient population. When hospitals thrived, so did doctors. The reverse was also true. Little was expected of physicians in the way of leadership and most doctors were content to let hospital management drive institutional decisions and direction. Management rarely balked at physician requests for new equipment or technology as most hospitals were in a continual mode of growth. The rapid post-war expansion of medical schools kept the supply of doctors plentiful and these physicians were readily welcomed into the ranks of hospital medical staffs. Challenges to an applicant's credentials were rare and, once on a staff, physicians were largely given *carte blanche* to practice as they deemed appropriate. Administrators from the 1950s through the 1980s seldom had need to challenge physicians and they largely deferred to their professional authority.

DRGs introduced a significant fault line between doctors and hospitals and the latter responded by seeking to enlist physician leadership to serve their needs.

The inflation in medical costs that followed the initiation of the federal Medicare program disrupted the equilibrium of these peaceful years. In 1983, to rein in runaway healthcare expenses, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA). This legislation ushered in a new prospective payment model for hospitals that was built around the use of "diagnosis related groups." Known as DRGs, many CFOs were known to characterize this acronym as "**d**e **r**evenue **g**one." To incent hospitals to control costs, DRGs fixed reimbursement for a given episode of illness. However, TEFRA did not change the reimbursement methodology for doctors, who continued to be paid on a fee-for-service basis. Suddenly doctors and hospitals were not seamlessly aligned: doctors benefited financially from longer patient hospital stays, while the hospital was financially disadvantaged when stays could not be kept short. DRGs introduced a significant fault line between doctors and hospitals and the latter responded by seeking to enlist physician leadership to serve their needs. Hospitals pressured many medical staffs to develop utilization review committees, while others appointed individual doctors as utilization review directors to intervene with colleagues who had patients with long inpatient stays. Most doctors were uncomfortable in these new roles and the positions in utilization management were hard to fill. Physicians had little experience managing one another and doctors resisted any imposition by colleagues on their clinical autonomy. In response, hospitals ramped up utilization departments and trained nurses to monitor hospital stays. Hallway meetings between administrators and doctors became increasingly tense as the former,

seeking to staunch financial losses, began to intrude more and more on physician decision making.

As the 20th century moved further into its final decades, events further alienated doctors and hospitals. The challenging economic climate for hospitals forced many to abandon their history as charitable enterprises and join for-profit hospital chains. Comfortable relationships between doctors and local management teams sometimes evaporated as new and distant corporate management asserted itself in these takeovers. Not all of these transitions were rocky, but they invariably heightened physicians' concerns that economics would trump their patient care decisions. Paranoia regarding "economic credentialing" spread across the professional community and motivated many organized medical groups to rail against hospital efforts to manage costs. Doctors worried that for-profit hospitals would be run to maximize shareholder return on investment, attenuating any commitment to invest in hospital infrastructure sought by physicians. One result was that some doctors began to feel less loyal to the hospital with which they had affiliated and formerly had considered their professional home. Such feelings became even more common when hospitals were bought and sold multiple times to successive investor-owners.

While most hospitals continued to function as not-for-profit entities, all were affected by the emergence of managed care as the economic model du jour in the century's last decades. Many physicians rapidly adapted their medical practices to the realities of capitated payment systems. However, hospitals were not as agile in making changes and struggled to cope with the new model of payment and care delivery. To ensure they received an adequate number of covered lives to keep their beds full, hospitals began to link themselves with physicians using a variety of mechanisms. These included the purchase of physician practices, the development of physician–hospital organizations (PHOs), and the establishment of physician practice management companies.

In most cases, hospital efforts in these endeavors exacerbated tensions with the physician community. Hospitals and physicians rarely saw eye-to-eye regarding the distribution of capitated funds and most PHOs were either failures at managing financial risk or never got out the door with their efforts. Hospital administrators had difficulty collaborating with physicians, who usually lacked formal management training and who were shaped by a "culture of the expert" whose tenets were very different from those taught to management personnel. The features of physician culture, including its emphasis on personal autonomy and self-reliance, is well articulated in various publications.[2] It was during this time that administrators began to refer to managing doctors as "herding cats." For their part, physicians observed with derision the failure of most hospitals to manage newly purchased physician practices. It quickly became apparent to doctors that hospital managers had no clue how to run an outpatient physician business and hospital financial losses on practice acquisitions quickly mounted. This experience led many hospitals to divest themselves of purchased practices and left many boards very wary of such investments. (Ironically, in only a few short years most of these institutions found themselves, reluctantly, once again in the practice acquisition business.)

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Their experience during the stormy 1990s convinced many physicians that hospital administrators were incompetent. Based on failure to adequately manage doctor practices, many physicians came to believe that most administrators were also incompetent in the performance of their hospital management responsibilities. For similar reasons, many administrators entered the 21st century perceiving physicians as adversaries and major obstacles to the achievement of their organizational goals.

Various healthcare trends have only exacerbated these biases. Over the past 15 years, the locus of physician practice moved inexorably out of the hospital footprint. Changes in practice patterns and technology allowed many physicians to focus on the outpatient practice of medicine and minimize their time in the hospital. Primary care doctors stopped doing hospital work, finding it more convenient and economical to concentrate on their office practices. Many specialists also discovered that lucrative procedures could now be performed in their offices and their time in the hospital was more limited.

2 For examples, see Joseph Bujak, *Inside the Physician Mind: Finding Common Ground with Doctors,* Health Administration Press, 2012.

Clearly, the hospital had become less and less important to an ever-larger circle of physicians. Furthermore, many doctors discovered they could directly compete with their hospitals in areas lucrative to both. Physicians began to invest in outpatient surgi-centers and freestanding diagnostic facilities. Advances in technology also allowed doctors to perform studies ranging from echocardiograms to colonoscopies in office settings, when once these had been exclusively hospital-based procedures. Hospitals fought back in a variety of ways from advocacy of certificate of need laws to efforts to exclude competing physicians from medical staff membership. The animosity that bloomed between doctors and hospitals as a result was palpable in many communities. In cases where hospitals and doctors joint-ventured on an outpatient enterprise, the collaboration was, nevertheless, often a contentious one.

The 21st century has seen a decline in the historic social compact implicitly understood by 20th-century medical staffs and hospitals. Earlier times saw doctors voluntarily engaging in the performance of medical staff duties in exchange for access to the hospital "workshop." In recent years, as doctors find less and less need for the hospital, they have balked at providing these institutions the time needed to participate in these activities. Medical staff member participation in staff and department meetings has been diminishing almost everywhere.

An area of considerable contention in the recent past has been physician participation in hospital call coverage. The historic compact had doctors voluntarily taking emergency department call as an obligation of medical staff membership. But in the early years of this century, doctors began to demand payment for this service. As some hospitals acceded to these demands, they found physicians continually upping the ante by demanding stipends in ever greater amounts. For their part, doctors saw the large revenues reflected in their hospital's income statements and came to believe that these "deep-pocketed" institutions were being unreasonably stingy in their negotiations over pay-for-call. What eventually became apparent is that large numbers of doctors no longer see any reason to take hospital call at all and simply don't want to do it at any price. The struggles around call have been extremely bitter in many communities, leaving doctors and administrators with a wider gulf to bridge than ever. Administrators and hospital boards have sometimes emerged from these battles seeing physicians as disloyal to the institution, self-serving, and lacking in a sense of professional responsibility. Doctors have often left these conflicts feeling abused and taken advantage of by hospitals that have failed to appreciate the impact call coverage has on their personal and professional lives. Many doctors perceived hospital administrators as cavalierly augmenting this burden by implementing tactics to increase emergency room volumes without any consideration for increased burden placed on members of the medical staff.

Turning the Tide

Despite several decades of stormy hospital–doctor relationships, the tide has been turning in recent years. A growing doctor shortage has made hospitals much more cognizant of the need to become physician friendly. Hospital boards increasingly value administrators who can bridge gaps with the physician community and form strong bonds with key clinical stakeholders. Competition between physicians and hospitals has become less of a flashpoint as many physician outpatient enterprises have failed and closed and others have been sold to local hospitals. Hospitals today are as much outpatient enterprises as inpatient businesses and they are less threatened by technology that moves hospital-based services into the outpatient arena. Many physicians who have been veterans of past battles with hospitals have recently retired or will be doing so soon. They are being replaced by a younger generation that approaches their professional lives with a more collaborative orientation. The rapid implosion of private practice medicine in recent years has left the majority of doctors on many medical staffs employed by the hospital. This creates a natural alignment of interests and makes it important to both hospitals and doctors to maintain good working relationships.

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This background is important to appreciate as doctors, board members, and administrators consider the evolving role of physician leadership in health systems. Some physician leaders have been shaped by their personal experiences living through previous decades of difficult hospital–doctor relationships. All physician leaders must deal to some degree with the legacies of the contentious times described. The reactions today's physician leaders face from board members, administrators, and colleagues is often molded by individual experiences forged in the ups and downs of these past decades. Certainly, there is a wealth of lessons for current physician leaders in reviewing the leadership failures of the past.

Factors Affecting the Evolution of Hospital–Physician Relationships: 1950s to Present

The 1950s to 1980s: The "Golden" Years of Hospital–Physician Synergy

- Physician workforce expansion
- Dramatic medical science triumphs
- Proliferation of new medical specialties
- Success of the "workshop model" of hospital–physician collaboration
- Cost-based reimbursement

The 1980s to Century-End: Growing Hospital–Physician Tensions

- Emergence of DRGs and utilization management in response to healthcare inflation
- Growth in regulations (e.g., accreditation requirements)
- The turmoil of managed care
- Growth in competition ("co-opetition")
  - » Doctors vs. hospitals battles over ambulatory surgery and diagnostic centers, physician specialty hospitals, increased deployment of hospital outpatient services
- Decreasing interest of physicians in the organized medical staff and its obligations
  - » Battles over hospital call coverage

21st Century: The Era of Accountable Care and Increased Hospital–Physician Collaboration

- Rapid move to hospital employment of physicians
- Growing physician workforce shortages
- New value-based reimbursement models (e.g., accountable care)
- Hospital transformation into "health systems" with large outpatient focus
- Growing retirement of physicians raised in private practice environment

A Perspective on the History of Physician Leadership in the United States

Healthcare delivery in the U.S. is a largely dysfunctional enterprise. Despite expenditures on healthcare that dwarf those of any other nation, America has tens of millions of citizens with inadequate access to medical services vital to their well-being.

THE NATION'S HEALTH DELIVERY APPARATUS IS FRAGmented and poorly coordinated, lags behind other nations in overall quality and safety, has an inadequate primary care foundation, and the most threadbare public health infrastructure. It drives many Americans into bankruptcy or financial extremis, and has created many markedly unhappy practitioners and patients. This has been a worsening state of affairs for nearly a century; throughout this period, physicians have largely been absent from the leadership arena. The major platform for physician leadership—the American Medical Association—has generally been viewed as an interest group for the self-serving (mostly financial) needs of physicians. Few third-party observers would characterize this entity as a consistent force for constructive change to address the systemic deficits described above. While a powerful lobby in the political arena, its influence has historically been used to block substantive delivery system change and to support efforts to maintain a status quo that preserves the autonomy and financial status of doctors. Many physicians see this as failed leadership and it is one contributory factor to the steady decline in membership experienced by both the AMA and its affiliated state medical associations. While specialty professional societies are more popular with their constituencies, they have mostly focused narrowly on specialty development. Historically they have not been a platform for significant physician leadership on broader issues of healthcare improvement.

Physician leaders' primary roles in the past have been to serve as advocates for the interests of their fellow doctors. In today's volatile healthcare environment, what is needed is less focus on such advocacy and more leadership focused on sponsoring systemic change and demonstrable improvement in the quality and safety of care provided to patients.

At the level of hospitals (and more recently health systems), physician leadership has mostly been provided through the organized medical staff. However, in most hospitals, medical staff leadership positions have largely been an amateur affair. These leaders volunteer or are often conscripted into roles that usually have short terms and regular turnover. Such leaders are rarely trained for these positions and are just as rarely oriented to the roles they assume. Most medical staff leaders pass the baton on to a successor just as they are beginning to understand the attendant responsibilities of their positions and developing some facility with the tasks involved. It is no wonder that the organized medical staff has been a mostly ineffectual vehicle for driving high-quality, safe, and efficient care at the typical hospital.

Hospitals have tried to offset the inherent weaknesses of the medical staff model by creating physician leadership positions in management. Historically this has been the position of the vice president of medical affairs (VPMA). Many hospitals employed VPMAs as hospital–physician tensions became prevalent in the 1980s and 1990s. Hospitals often hired a doctor who had a long tenure on the medical staff and who was nearing retirement and looking for a way to comfortably segue from clinical practice. Hospital CEOs figured that such an individual could serve as an interface between management and doctors and would be more likely to engage physicians in needed tasks (e.g., compliance with medical record requirements or utilization expectations) than would exhortations from administrators.

Most VPMAs were part time, had little or no formal management training, and relied heavily on professional courtesy and individual social skills to bring along their colleagues. In larger health systems, a VPMA might report to a CMO who had a similar trajectory from respected and/or well-liked colleagues to hospital administrator. There is no uniformity in how these titles have been assigned or have evolved at institutions across the healthcare landscape. However, the growing investment in VPMAs and CMOs was an early sign that, as hospitals approached the end of the 20th century, they were seeing a need for increased physician leadership. Nevertheless, the effort was a minimal one.

Contrast this history to the typical hospital's approach to leadership for nurses. Most hospitals have long had very robust leadership infrastructures for nurses. From the unit level on up to the chief nursing officer, a hospital may have dozens of nurses in management roles. These individuals usually have extensive preparation for their positions and most hospitals provide ongoing support in the form of in-house training and continuing management education. Yet until recently, most hospitals invested at most in one full- or part-time physician

executive (the VPMA or CMO), who has been expected to lead a professional staff of possibly hundreds of physicians (who are notoriously poor followers).

There has also been a paucity of physician participation in governance over the preceding six decades. In the 20th century, the only physician on many hospital boards was the medical staff president or chief of staff. However, in recent years, boards have begun to invite more doctors into governance in recognition of the valuable perspective and insights they can bring.[3] This has provided a new platform for physicians to exert leadership, but few doctors have a clear understanding of the fiduciary responsibilities of hospital board members. Many doctors appointed to boards see themselves as representatives of and advocates for the physician community. This has undermined their ability to provide the institutional leadership required of those in governance. For this and other reasons, the numbers of physicians serving in hospital governance has remained relatively small at most hospitals and health systems.

The Decline and Resurrection of the Organized Medical Staff

The main platform for physician leadership in the hospital setting for nearly half a century has been the organized medical staff. The concept of a hospital "organized medical staff" emerged from concerns about the corporate practice of medicine (CPOM). The late 1800s and early 1900s saw the widespread hiring of physicians by corporate employers for the care of their employees. Much of the public and many physicians were appalled by employer abuses of this system. The American Medical Association (AMA) issued prohibitions against the CPOM in an effort to create new public policy in support of the professionalism of doctors and the attendant need for their independence from lay control and interference. The proffered justification for bans on corporate employment of doctors was to allow physicians to act in the best interests of their patients. Most states adopted bans on the CPOM in the late 19th and early 20th century. If the growing number of hospitals could not employ doctors to meet their needs, then there needed to be some vehicle through which hospital management and the board could engage with doctors in private practice to collaborate on the delivery of care. To fill the void, the concept of a "voluntary, self-governing organized medical staff" was promoted and quickly became established in American hospitals. This entity was later cemented in place when Medicare was created and its Conditions of Participation made an organized medical staff mandatory for hospitals. In these early years of the 21st century there has been significant erosion in the influence of CPOM laws. However, the concept that a hospital must have a medical staff to influence the safety and quality of patient care has endured.

In 2017, federal and state regulatory requirements require a hospital governing body to work collaboratively with the "organized" medical staff in carrying out its legal mandate to oversee the quality of the professional care and services rendered in the hospital. For example, Medicare's Conditions of Participation (COPs) §482.22 state: *The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.* This requirement creates a three-way relationship between a hospital's governing body, management team, and the "organized" medical staff.

Medical staffs have had mixed results in carrying out their delegated duties. Credentialing scandals in the 1980s and 1990s[4] led to heightened medical staff credentialing standards and better orientation and training for medical staff leaders engaged in this important activity. In 1999, the Institute of Medicine published its seminal report, *To Err is Human*, which revealed the magnitude of preventable deaths occurring in the nation's hospitals. This report suggested that as many as 98,000 deaths a year occur in the country's hospitals because of preventable errors. A wealth of data has emerged over the subsequent fifteen years revealing the egregious extent of quality and safety problems plaguing hospitals everywhere. It is clear that the efforts of the organized medical staff have not been sufficient to assure safe and high-quality hospital care. The medical staff's main efforts in this regard have traditionally been focused on credentialing and peer review. The latter has been a labor-intensive activity which historically has engaged physicians in the review of hundreds of thousands of medical charts. This approach is increasingly being replaced by contemporary best practices in peer review that emphasize the tracking and trending of aggregated practitioner performance data. Nevertheless, the view from 2017 makes it abundantly clear that hospitals cannot solely rely on the organized medical staff and its leadership to drive high-quality and safe care.

Physicians in many communities no longer see the organized medical staff as relevant to their practice lives and they limit their participation in its activities. Attendance at general medical staff meetings and clinical department meetings has dropped off significantly at most hospitals. It has become ever more difficult to recruit doctors to take on the leadership responsibilities of the organized medical staff. It is often observed that a department chair is someone who did not attend the meeting where the election took place. Nomination committees often struggle to find candidates willing to serve as medical staff officers. Fewer and fewer physicians spend significant time in the hospital as medical practice moves increasingly into the outpatient setting. This makes it harder for them to participate in medical staff meetings on the hospital campus and further diminishes their interest in the hospital-centric issues discussed at such meetings. These

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3 For more on physician presence on hospital boards, see: Todd Sagin, "Boards Benefit from the Expertise of Physician Members," *E-Briefings,* Vol. 10, No. 1, The Governance Institute, January 2013; and Todd Sagin, "Doctors on Board: Should Physician Participation on Health System Boards Be Expanded?" *Boards* (official publication of the Governance Center of Excellence), Issue 12, September 2015, p. 18.

4 James B. Stewart, *Blind Eye: The Terrifying Story of a Doctor Who Got Away With Murder,* Simon and Schuster, 2000.

trends have been observed for several decades now as the nature of medical practice has evolved.

For doctors in private practice, the business imperatives of keeping a small business afloat make it difficult to justify a diversion of time to medical staff responsibilities. Most hospitals still expect doctors to volunteer their time to undertake medical staff work. However, more and more are paying stipends in recognition of the burden this work imposes on doctors. Nevertheless, few pay stipends in amounts commensurate with the dollars a physician loses by being away from his or her practice.

The historic understanding between doctors and hospitals was an implicit compact that the latter would provide doctors a workshop to ply their trade (i.e., hospital beds, advanced medical technology, ORs, nurses) and the former would contribute service to the hospital in the form of medical staff participation. Today, most doctors do not need the hospital as they used to and so do not see a reason to volunteer their time to help it meet its institutional needs. Furthermore, a shift in the professional culture of doctors now favors a better balance of work/life needs. One of the easier ways to add to desirable "home time" is to subtract it from the time that would otherwise go to hospital medical staff involvement. The growth in hospital employment of physicians has had little impact on these trends. Since most hospitals pay employed doctors under a productivity formula, time away from clinical practice to attend medical staff meetings reduces physician compensation. Furthermore, many physicians choose employment to assure more regular work hours than they could economically justify in private practice. Devoting significant time to medical staff work simply elevates their work load in a way they may have been trying to avoid by becoming employed. Younger physicians in particular often see no point in contributing to medical staff work and are often put off by excessive medical staff bureaucracy, meetings, and inefficiency.

At the same time physicians have seen declining interest in their ranks for medical staff work, accreditation requirements for medical staffs have proliferated. Of the several accrediting organizations with deemed status from CMS to review hospitals, this is most true for the Joint Commission. The Joint Commission today accredits the majority of the nation's hospitals and its medical staff requirements have been heavily influenced by elements of the AMA that cling to 20th-century paradigms of healthcare practice. This has put hospitals in the difficult position of needing to comply with ever more rigorous requirements that their physicians see as burdensome and unnecessary micromanagement.

The changing nature of the practitioner community has also taken a toll on a medical staff organization built for a time when doctors were a more homogenous group. The typical medical staff today is more diverse than ever in terms of generation, gender, employment status, ethnicity, specialty, and geography. Fewer doctors practice in or ever come to the hospital and a new group of telemedicine practitioners has often joined the staff. Furthermore, the current hospital professional community includes a rapidly growing number of non-physician practitioners. These demographic factors have contributed to the diminished viability of a medical staff structure ossified in place since the middle of the last century.

The deteriorating state of the organized medical staff has led many organizations to undertake a concerted effort to rethink approaches to medical staff structure and functioning. One significant goal of this work is to make physician leadership on the medical staff more impactful and therefore more attractive to potential leadership candidates.

As we shall see in the sections that follow, there is a sea change occurring in hospital and health system commitment to physician leadership. Today a clear business case exists for this increased commitment and it is starting to transform hospital executive suites in many communities.

The Business Case for Enhanced Physician Leadership in Hospitals and Health Systems

Contemporary healthcare organizations throughout the country are heavily engaged in transformational change. Calls for greater physician leadership arise within the context of competing (and expensive) hospital and health system needs.

DOES IT MAKE SENSE TO FINANCE EXPANSIONS IN PHYSICIAN leadership in the face of the enormous costs of electronic health record implementation, needs to purchase the latest medical technology or enlarge or refurbish physical plants, maintain margins to buoy bond ratings, and so forth? Many hospitals and health systems are expending considerable financial resources in the employment of physicians. Indeed, in the short run, the return on this investment at many institutions has yet to be forthcoming.[5] Nevertheless, it has become clear to hospital strategic planners on boards and management teams that the continued employment of physicians needs to remain an institutional imperative. The need to make a financial investment in physician leadership is likewise becoming clearer, with many experts concluding that a strong emphasis on clinical leadership is essential rather than a passing fad.

Why Do We Need Physician Leaders?

Why is physician leadership necessary as opposed to leadership proffered by other professionals trained in management? The answer lies in the nature of the physician community. From their matriculation into medical school until the culmination of their postgraduate education, physicians are trained to personally embrace the responsibility of making life and death decisions. Regardless of the many changes in medical practice or what specialty a physician chooses, this fundamental responsibility defines what being a doctor means. Physicians are inclined, as a result of the subtle process of acculturation into medicine, to be suspicious of collective decisions, to focus on the needs of individual patients rather than the group needs of a population, and to assume that traditional business algorithms are unlikely to be relevant to their clinical work. These beliefs and behaviors set the stage for physicians to be skeptical at best and disdainful at worst towards non-physician leadership. For these reasons, physicians resist accepting the authority of leaders unless they too are physicians. This reality makes physician leadership essential for healthcare organizations.

Expanding physician leadership in most hospitals is not a small investment. Physician executives command compensation considerably higher than the typical administrator without a medical degree. Physician leaders who continue to practice often want compensation commensurate with the clinical income they relinquish. Furthermore, marketplace competition for experienced physician leaders has heated up as there is a relative shortage of such individuals. In addition to compensation packages, many physicians also need their employer to invest in considerable training and professional development to help them achieve their full leadership potential. What then justifies the hospital and health system financial investment in an expansion of physician leadership?

The value of physician leadership in today's healthcare environment rests on multiple benefits. To strengthen a health system's quality and safety performance, doctor's must be guided to carry out their tasks in ways different from the direction they received in their medical school and residency training. Providing care as it has always been rendered has clearly not worked to adequately reduce medical errors or to raise the bar for healthcare quality. Layering on safety protocols (e.g., checklists or operating room "timeouts") to historic practice patterns has not been

5 Moody's Investor Service's *Physician Employment FY 2014 Medians* report shows that facilities with very high rates of physician employment had stronger revenue growth but lower profitability than those with lower employment rates. The report predicted that this dynamic will persist for several years at hospitals continuing to employ significant numbers of doctors.

shown to dramatically or consistently change clinical results in a positive direction. Such tactics can be helpful, but are clearly not sufficient to make the advances we seek. Similarly, leaving in place traditional approaches to clinical care has not been successful at significantly reducing the costs of care.

> Physicians resist accepting the authority of leaders unless they too are physicians. This reality makes physician leadership essential for healthcare organizations.

This state of affairs is consistent with the insightful reflection, often attributed to Einstein, that "insanity is doing the same thing over and over again and expecting different results." Physicians, however, tend to resist change, and especially so when it is promoted by non-physicians. Doctors are often characterized as poor "followers," but they are certainly more responsive to their peers. Under value-based reimbursement arrangements, hospital and health system revenue streams will be significantly impaired if physicians cannot be led to adopt behaviors that reduce costs, promote high quality, and achieve better patient satisfaction. Health system reputations will also suffer as hospital performance data becomes more transparent to the public.

The efforts at many health systems to change physician behavior through financial incentives have not been particularly effective. There is growing recognition that the missing ingredient in these change management efforts is effective physician leadership. Some of the healthcare institutions most admired for their high quality and cost-efficient results are those that have been physician led, such as Cleveland Clinic, Mayo Clinic, and Geisinger Health, which all feature strong physician leadership presence at all levels of the organization.

Benefits of Enhanced Physician Leadership

- A more effective mechanism to change physician behaviors to those that reduce costs, promote high quality, and achieve better patient satisfaction
- Ability to create a satisfying professional home for their colleagues (reducing expensive physician turnover and enhancing physician engagement)
- Greater responsiveness to the concerns of employed physicians and promotion of physician engagement
- Minimizes costly legal liability
- Professional expertise in needed clinical transformation
- When doctors are strongly engaged in maintaining and enhancing organizational performance (e.g., via strong physician leadership), better clinical and financial outcomes result

Another benefit of enhanced physician leadership is the ability of such leaders to create a satisfying professional home for their colleagues. Many hospitals incur significant expense from physician turnover. It has been estimated by the American Group Management Association (AMGA) that recruitment of a new physician to employment averages $270,000. The total cost of replacing a physician averages $1.2 million since it usually takes time for a new physician to ramp up patient volume. (These numbers do not include the diminished revenue that might be seen if there is loss of patient market share because the departing doctor was well-liked.) According to 2016 data published by Fierce Health, the average length of time doctors stay at one institution shows a clear predilection for mobility:

Average length of time doctors stay at one institution:

1–2 years	5.7%
3–4 years	23.6%
5–6 years	18.9%
7+ years	51.9%

Organizations with strong physician leadership tend to be more responsive to the concerns of employed doctors. Equally important, they provide physicians with a greater sense of control over their professional lives. These factors promote physician engagement in the health system, can reduce practitioner dissatisfaction and burnout, and lessen rates of physician turnover. It is important to note that some recent surveys have indicated rates of physician burnout approaching or exceeding 50 percent. Physicians so afflicted tend to perform poorly in the care of patients, frustrate fellow team members, discourage new applicants from joining the organization, demonstrate reduced productivity, and diminish patient satisfaction. There are significant institutional costs to all of these consequences. As hospitals ramp up efforts to fight burnout, physician leadership is being seen as an essential tool to create a more supportive environment for a demoralized community.

Strong physician leadership can also minimize costly legal liability that is a drain on the fiscal health of some healthcare institutions. There has been an exponential rise in the number of corporate negligence claims filed against hospitals. Such claims have long been common in selected regions of the nation, but in recent years the majority of states have recognized negligent credentialing as a valid legal cause of action. If physician leaders fail to properly vet the clinical abilities of a medical staff member, recommend the board grant clinical privileges when such action is questionable, inadequately monitor the clinical performance of their peers, or do not intervene sufficiently when a colleague becomes problematic, the consequence can be a costly legal judgement against the hospital if a patient is injured. Conversely, when medical staff leaders undertake to limit or terminate the privileges of a staff member, that doctor can win huge damages against the hospital if physician leaders do not meticulously follow proper due process. Well informed and trained physician leaders will not make mistakes that lead to these forms of potentially significant financial loss.

In today's highly volatile healthcare environment, more and more experts have come to believe that when doctors are strongly engaged in maintaining and enhancing organizational performance, better clinical and financial outcomes result. A growing number of studies support this conclusion as does a wealth of anecdotal evidence from leading healthcare institutions. If these perceptions are accurate, then advocacy for enhanced physician leadership clearly supports institutional goals relating to both margin and mission.

Tasks for a New Cadre of Hospital/ Health System Physician Leaders

- Clinical care redesign
  - » Delivery of more efficient/cost effective/high-value care
  - » Delivery of care that is more patient-centered
  - » Improved quality and patient safety
- Leadership in the development of population health management
- Team leadership in an era of increasing integration and enhanced care coordination
- Creation of vision and values for new clinical structures (PHOs, ACOs, employed group practices, comprehensive service lines, hybrid insurance models, patient-centered medical homes, etc.)
- Promotion of physician satisfaction in a time of increasing burnout and increasing rates of physician turnover in hospitals
- Growing market share in consolidating marketplaces

The Expansion of Physician Leadership Roles: A 21st-Century Phenomenon

It is now widely recognized that successful transformation of healthcare in the 21st century requires greater physician input. This recognition has generated an explosion of new leadership positions. These range from new physician executive titles and functions to key posts in emerging healthcare structures like ACOs, CINs, and employed physician groups. Descriptions of many of these new physician roles are enumerated below.

Physician Executives

Academic institutions, typically organized around deans, department chairs, and practice plan directors, have long had a tradition of physician leadership. In the typical community hospital, there was little professional physician leadership of large health organizations until the 1980s. As noted elsewhere, the elected officers of the medical staff provided what leadership they could without formal training and with limited authority. Through the 1980s, the increasing complexity of healthcare institutions strained hospital–physician relationships and hospitals created a new leadership role to help: the vice president for medical affairs (VPMA). This physician was often a respected member of the medical staff, an individual nearing retirement, and viewed as politically neutral, whom the hospital could count on to conduct "shuttle diplomacy" when conflicts arose. This VPMA typically had little formal training in management or leadership, and often unclear authority and accountability within the executive team.

Over the 1980s and 1990s, the role of the VPMA became increasingly complex, and educational opportunities for physicians in administrative roles became more readily available. Over the past 25 years, an ever-growing cohort of physicians have become interested in pursuing healthcare management in a more or less full-time capacity. Many of these doctors have obtained M.B.A.s or M.H.A.s (Master's of Health Administration), or done extensive coursework through organizations like the American Association of Physician Leadership (previously known as the American College of Physician Executives). As a result, today's physician executives are more likely to be tasked with real operational responsibilities and to be better prepared to carry out these tasks because of supervised development experiences, formal educational programs, and advanced degrees.

The roles of the VPMA and CMO have become more substantial and ubiquitous since the 1990s, but growth in physician executive positions has only recently reached an inflection point, with a rapid rise in both numbers and in the variety of physician leadership positions. For example, the executive search firm Witt/Kieffer recently reported that the drive toward clinical quality outcomes and patient engagement has been giving rise to the position of chief clinical officer (CCO). The characteristics looked for in a CCO are somewhat different from that of the historic VPMA. Many hospitals seek a tech-savvy consensus builder who is comfortable living in a world of relative ambiguity. A CCO might be expected to understand tactics like Lean management, Six Sigma, crew resource management, and other approaches to building high reliability in pursuit of high-quality care. Sought-after skills include the ability to engage in systems thinking and the capacity to integrate quality data and process improvement measures. Perhaps most important is an ability to empower and motivate colleagues to achieve the goals of the Triple Aim. The employment of emotional intelligence is a highly-valued characteristic of such physician leaders.

The Role of the Chief Clinical Officer

Experience

- Lean management
- Six Sigma
- Crew resource management
- Building highly reliable systems and processes

Skills

- Ability to engage in systems thinking
- Capacity to integrate quality data and process improvement
- Facility with empowering and motivating colleagues to achieve big goals such as the Triple Aim
- Emotional intelligence

Today it is also becoming common to see health systems with physicians serving in a range of additional executive positions. These include chief quality officers, chief medical informatics officers, chief transformation officers, chief integration officers, or other creative new positions. While many organizations have well-defined job descriptions and goals for these new physician leaders, others have kept them flexible in recognition of the high

volatility in today's healthcare environment. These latter hospitals have determined a need for high-level physician leadership, but are not yet certain of the best way to deploy it. Unfortunately, this circumstance sometimes sets new physician leaders up for frustration and failure.

The greatest recognition of the importance of physician executive leadership comes from organizations that have determined to fill the position of CEO with a doctor. The number of physician CEOs across the nation is still relatively small, but the absolute numbers have been creeping up steadily.[6] Conventional wisdom has suggested that physicians should focus on clinical care while managers with business or administrative backgrounds command a hospital's daily operations. Those hospital boards making a choice to have a doctor as CEO have rejected this historical assumption as outdated and fundamentally flawed. In a time when hospitals need to be focused on greater coordination of care, population health management, and quality metrics, these boards have concluded that individuals who see the world through a clinical lens may be in the best position to create needed vision and transformation in their organization. Many boards also recognize that physicians are strong decision makers by virtue of their training, and the ability to take critical actions promptly in fast changing times can be a competitive advantage for their organizations.

While many organizations have well-defined job descriptions and goals for these new physician leaders, others have kept them flexible in recognition of the high volatility in today's healthcare environment. These latter hospitals have determined a need for high-level physician leadership, but are not yet certain of the best way to deploy it. Unfortunately, this circumstance sometimes sets new physician leaders up for frustration and failure.

Growing Ranks of Hospital Physician Leaders:

- Medical staff officers, department and committee chairs
- Physician executives (CMOs, VPMAs, CQO, CIO, etc.)
- Physician leaders of hospital affiliated ACOs and CINs
- Medical directors of service lines, centers of excellence
- Physician leaders of hospital employed and contracted group practices
- Physician leaders in academic affairs
- Physician leaders in patient centered medical homes (PCMHs), perioperative surgical homes, PACE programs (**P**rograms of **A**ll-Inclusive **C**are for the **E**lderly), etc.

Physician Directors of Service Lines and Centers of Excellence

The traditional medical staff clinical department serves little utility in a modern hospital. To better serve their needs, many hospitals have developed clinical service lines as operational units. These characteristically bring together practitioners from multiple disciplines in a product line model that follows the patient's path through the care process. Examples of such service lines include women's health services, cancer services, cardiovascular services, neurosciences, and so forth. These service lines tend to provide care in both the inpatient and outpatient realm, highlight accessibility and a patient centric focus, are often team driven and usually multidisciplinary, and emphasize delivery of high-quality and cost effective care.

There is considerable diversity in health systems in the service lines they choose to develop, in their number and in their key characteristics. But almost all have a physician medical director with considerably more responsibilities than those historically held by a medical staff department chair. In many organizations, this medical director is paired with an administrative partner in a working dyad relationship. This works best when both of these individuals own full accountability for the operational success of the service line. Each brings unique training and experience to their joint responsibility, and together they model the teamwork that should characterize working relationships throughout the service line. Unlike a traditional medical staff department chair, the service line medical director typically has a critical role in oversight of operations, budget, personnel management, strategic planning, marketing, and performance metrics. Clearly such medical directors require much more extensive administrative training than has historically been expected of physicians in various hospital directorships.

6 In 2014, the American College of Physician Executives determined that about 5 percent of hospitals had a physician CEO; the 2015 Governance Institute biennial survey indicated 7.4 percent of respondents (a sample size of 355 and representative of the nationwide hospital population) had a physician CEO, and 12 percent indicated a nurse CEO or other clinical background.

Typical Leadership Responsibilities for Service Line Physician Directors

- Oversight of operations
- Budget
- Personnel management
- Strategic planning
- Marketing
- Performance metrics

Physician Leaders in Hospital-Employed Physician Groups

Most hospitals in 2017 are directly employing physicians. The numbers vary by hospital but across the nation, the shift of physicians into employment relationships has been a startling 21st-century phenomenon. Fewer than one-third of practicing doctors remain in traditional private practice mode. Hospitals with significant numbers of employed physicians often find it prudent to provide these employees with a certain degree of self-governance to facilitate their evolution into an effective multi-specialty group practice. These institutions find that they are more likely to get excellent clinical results, better productivity and cost effectiveness, and heightened provider satisfaction when physicians feel like they have some control over their activities. When employed physicians forge a true group practice they are more likely to create a rewarding professional home for doctors and to develop a culture that supports excellence and collegiality.[7] This in turn can make it easier for the hospital to recruit and retain physicians in a time of increased competition for clinicians. Some hospitals have created corporate subsidiaries for their employed physicians. Others simply operate the employed physician enterprise as an operational unit of the health system.

When the employed physicians are organized into an operational entity or incorporated as a group practice, it is common to find a physician CEO, president, or director. Often there is some type of governance for these doctors—either a formal board or an executive committee. These are typically populated by employed physicians who must now learn how to perform in a governance capacity. In large employed groups, there may be working sub-committees that typically require physician chairs. Examples include a quality committee, an operations committee, a culture and recruitment committee, and/or a compensation committee. In these cases, physicians need to assume new leadership roles for which they usually have received little by way of training and preparation. Nevertheless, in many hospitals, these roles are providing a leadership training ground for those with the potential to assume future positions as a physician executive.

Reporting Relationships of Employed Physician Groups within a Hospital/Health System

- Employed physician groups may be a legal corporate subsidiary of the health system or an operational unit of the hospital.
- Strong employed physician groups typically have a board (if incorporated) or an executive committee.
- If a corporate subsidiary, the employed physician group board will typically report to the hospital/health system board.
- Physician leaders managing an employed group practice (e.g., group president or medical director) usually report to hospital/health system management.

Physician Leaders in Accountable Care Organizations and Clinically Integrated Networks

Various experiments are underway across the U.S. to find the best way to deliver care under value-based reimbursement programs. Both Medicare and private insurers are promoting ACOs as a vehicle through which doctors and hospitals can coordinate high-quality, lower-cost care. The Federal Trade Commission also allows private doctors and hospitals to collaborate in selling their services without incurring penalties for anti-competitive behavior if they meet criteria for demonstrating adequate integration of their activities. This is accomplished by forming a clinically integrated network (CIN). Many hospitals and health systems sponsor ACOs or CINs, but they can also be organized by physician groups or other healthcare entities.

Both ACOs and CINs are required to have leadership that involves doctors and they must undertake practitioner credentialing and quality oversight functions. The governing boards of these entities frequently include more physicians than are found on the typical hospital board. This reflects the strong emphasis on clinical results necessary for these entities to succeed. It is not uncommon for ACOs and CINs to have a physician as president or CEO or serving as the organization's medical director. An important task for such leaders is to develop strong relationships with doctors in private practice, often including community practitioners who are not members of the hospital's medical staff. The success of an ACO or CIN may hinge on physician leadership that has the ability to attract the participation of a large number of such community providers.

Physicians are often heavily involved in the leadership of ACO/CIN working committees to help facilitate clinical transformation that can deliver high-quality results at lower cost. Early experience with ACOs suggests that those that are physician-organized have demonstrated greater success in lowering costs and improving quality. This may be a reflection on greater physician leadership in these entities.

7 See Todd Sagin and Eric Lister, *Creating the Hospital Group Practice: The Advantages of Employing or Affiliating with Physicians,* Health Administration Press, 2009.

Physician Leadership in ACOs/CINs

Strong physician engagement is essential for the success of these new models of healthcare delivery and payment. Physician leadership in these entities often consists of:

- **President/medical director/CEO:** often a physician with strong business skills and the ability to encourage broad participation of community practitioners in the integrated delivery model.
- **Board membership:** the governance bodies of the typical ACO/CIN has greater physician membership than do most hospital boards.
- **Committee chairs:** physician chairs tend to be more effective at driving clinical transformation (e.g., leading a quality committee) or winning physician "buy-in" (e.g., methodology for distribution of ACO revenue).

Physician Leaders Fulfilling Academic Responsibilities

Teaching hospitals require physicians to fill faculty roles and to take on leadership in the oversight of academic programs. Examples of leadership roles include:

- Residency program directors
- Fellowship directors
- Chairs of academic departments that perform both teaching and research
- Directors of graduate medical education

In the past, these leaders have tended to work in separate silos from colleagues who provided leadership on the medical staff.[8] Recently physicians providing oversight for academic programming have been exhorted to include curricular time that includes the teaching of leadership skills. To help academic physicians to better appreciate the challenges for which they must prepare students, some hospitals are involving academic faculty leaders in more of the institution's strategic planning discussions. Physicians in academia are often more open to new ideas and innovation than those in the general practice community who may be more fearful of change. For this reason, many hospitals are finding it valuable to have academic doctors participate on hospital, medical staff, employed group practice, and ACO/CIN working committees. These physicians may have also been faculty for residents who graduated from their programs and now practice in the community. As such, they are sometimes seen as role models and are held in high regard by colleagues. In these cases, an academic leader may be a good choice for other hospital leadership positions.

Physician leaders at many teaching hospitals are also feeling growing pressure to induce graduating residents to become employees of the hospital or otherwise remain affiliated with the organization (e.g., through its CIN). In a time of growing physician shortages and increasingly difficult physician recruitment, physician leadership in the academic world is taking on new value.

Physician Leaders on the Front Line

Doctors on the front lines of care delivery are often managed by administrators when they work in institutional settings or programs managed by hospitals. However, physicians often perform better in these settings when they have supervision that comes from a peer. Physician leaders are increasingly being identified as the directors of hospital owned ambulatory sites and practices such as primary care patient-centered medical homes (PCMHs). Designated physician practice leaders may also be found in medical office buildings which house hospital employed physicians across multiple specialties or in programs such as PACE (**P**rograms of **A**ll-Inclusive **C**are for the **E**lderly). In the lingo of health policy pundits, these physician leaders are working at the pointy or sharp end of the spear where actual care is delivered. This is where day to day problems are most likely to occur and where the immediate guidance of trained physician leaders can make substantial differences in the efficiency and quality of care.

Physician leaders at this level can help:

- Advance physician engagement
- Drive compliance with best practices
- Promote team building
- Encourage innovation through practice redesign
- Facilitate practitioner resiliency

> Many healthcare organizations concentrate on developing physician leadership at the 60,000-foot level and overlook the value of fostering leadership in the front ranks of practicing doctors.

Recruitment and Compensation Issues When Expanding Physician Leadership

Most physicians have received little or no training in competent leadership skills. Some have natural leadership talent, but most physicians will need to deliberately develop their core administrative and leadership competencies. The rapid development of new leadership opportunities for doctors is hampered by a lack of currently qualified candidates. As discussed elsewhere in this white paper, this shortage makes it imperative for most hospitals and health systems to create leadership development programs and training opportunities. However, until an expanded pipeline of trained physician leaders yields more candidates, hospitals will continue to experience the present fierce competition for

8 An exception to this description would be the university/medical school teaching hospital where the full-time faculty tend to be employees and the academic department chairs often are also wearing the hat of hospital department chair and medical director of the clinical operations in his or her specialty.

experienced physician leaders. This reality is likely to get worse before it gets better.

Physician executives with proven track records are in great demand and many value employment mobility as they move to advance their careers. Many hospitals must decide whether to promote an in-house candidate who needs extensive on-the-job training, or wait to fill a position until they can snare a qualified external candidate. The former may be the right move if adequate support in the form of mentoring and coaching can be put in place and chances of recruiting a qualified external candidate are low. If an external candidate can be landed, a hospital or health system can benefit significantly by that individual's fresh perspective and familiarity with practices used in other markets.

When physicians fail as leaders they can reinforce biases in hospital management teams that doctors should stick to seeing patients. If an inadequate physician leader is terminated or otherwise loses support from the executive suite, practicing colleagues will sometimes circle the wagons in defense or see the action as a sign that administration is not genuinely interested in meeting the needs of doctors. Obviously, there are many reasons to get recruitment right in the first place.

Compensation is often a sticking point in the recruitment process. In the past, many hospitals paid administrative stipends to specialists to manage some set of management tasks relevant to the doctor's specialty. These medical directors were often not held to any performance standards and the underlying motivation for the administrative appointment was to bump up payments to a specialist the hospital wished to keep on staff. In these cases, the hospital is at risk for poor administrative results as well as scrutiny for possible fraud and abuse violations. Today, hospitals are much more meticulous in demanding that physician leaders actually perform commensurate with their compensation. But what should that compensation be? If a neurosurgeon wishes to take on a position as a physician executive she may demand a salary equivalent to the income she made in clinical practice. Whether such a high compensation can be justified as fair market value is an issue with which hospital counsel should feel comfortable. Of course, if a pediatrician is doing the same administrative work, is it appropriate to pay him the going rate for a pediatric practitioner? What if he feels his work as an executive is comparable to that being turned out by the neurosurgeon and he wants similar recompense?

The fair market value of compensation for physician executives is further complicated by the competition for experienced players. Salaries and benefits can become subjects of intense negotiation when a health system has its eye on an individual who has multiple employment options. Of course, hospitals are used to these compensation challenges. They are not unique to physician executives and similar issues are present when recruiting other senior management personnel. Furthermore, hospitals have always had to deal with the compensation demands of high-paid specialists when they are seeking to build clinical services in areas like orthopedics, oncology, and neurosurgery. However, when expanding the physician leadership cohort in a health system, board members and executive team members should not lose sight of the compensation challenges that might arise.

Rationalizing a Menagerie of New Physician Leaders in the Modern Healthcare Organization

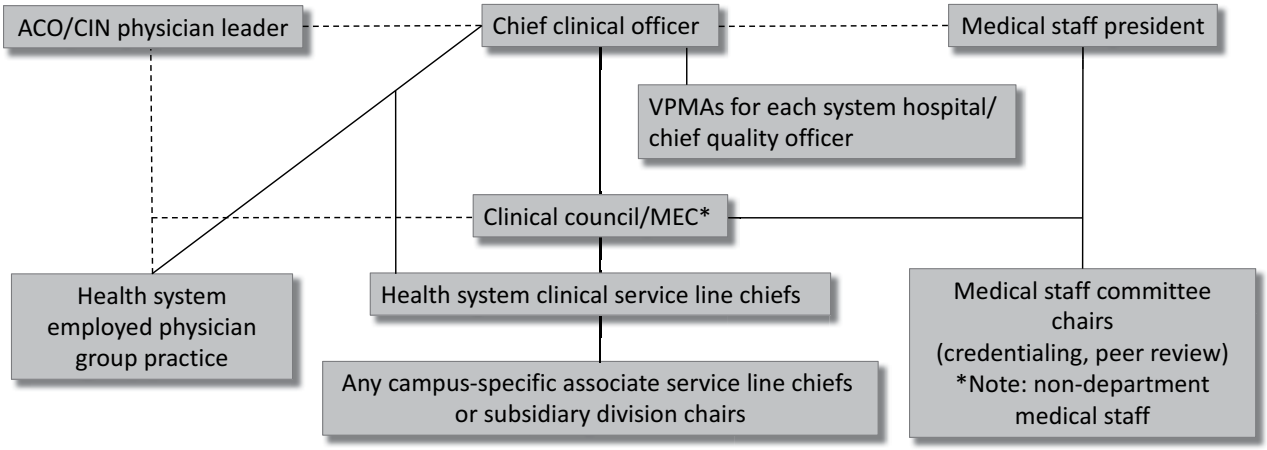
The growth of physician leaders brings tremendous new potential to a health system. This is especially true if these leaders are carefully selected, trained, mentored, and coached. However, this potential is blunted when careful thought is not given to how various physician leaders will relate to one another, how their scopes of responsibility can be made complementary and avoid unwanted overlap, and how lines of authority are drawn and communicated. This is true whether new positions are being created or added or whether old positions (e.g., the role of medical staff leaders) are changing in scope and importance.

SOME EXAMPLES WILL BE HELPFUL IN ILLUSTRATING THE downside of rapid growth in physician leadership without care to "rationalize" the accountabilities of the various players. Imagine Dr. Smith who was recently recruited by the Brilling Hospital to fill a need for an additional ob-gyn practitioner. Part of a multi-campus system, the hospital has recently developed multiple layers of physician leaders. Dr. Smith is employed by the hospital in its large hospital-owned group practice and he delivers both inpatient and outpatient care in its women's health service line. Although he was recruited mainly to the system's flagship hospital (Brilling), he also exercises privileges at one other health system facility. After being on the job for six months, complaints start to arise with regularity from both patients and nurses. These complaints are related to episodes of rude interactions with staff, brusque manner with patients, and some concerns by nurses that his rushed clinical encounters sometimes fail to address all the clinical concerns that need attention.

In a smaller health system with only a few physician leaders, these concerns might have been funneled to a VPMA and then passed on to medical staff leaders. In the past, most hospitals left any intervention with a problematic physician, such as Dr. Smith, to the relevant medical staff department chair. That might still be the approach most likely to be taken at Brilling, but multiple options exist. Now that Brilling has physician executives who have experience in dealing with colleagues manifesting unprofessional conduct, it might make sense to have the CMO, VPMA, or chief quality officer undertake a collegial intervention with Dr. Smith. On the other hand, medical staff officers might feel that it is their job to take the initiative and process the matter through established medical staff peer review protocols. Since Dr. Smith's behavior is negatively impacting the performance metrics and reputation of the women's health service line it is reasonable that the service line medical director sees it as his or her responsibility to address Dr. Smith. Of course, Dr. Smith is a member of the health system's employed physician group practice and this group is proud of its ongoing efforts to develop a culture of excellence and collegiality. The president of the medical group would like a first crack at helping Dr. Smith meet the group's expectations for conduct and quality of care. Furthermore, he or she feels that handling the concerns regarding Dr. Smith as an employment matter will be more expeditious and successful than addressing them through the more cumbersome medical staff mechanisms. However, in this health system there is yet another physician leader who feels a need to step in at this point. As a member of the employed physician group, Dr. Smith is enrolled as a provider in the hospital-sponsored CIN. Several physicians on the CIN board have been reviewing performance dashboards and see that Dr. Smith is pulling down the CIN's patient satisfaction ratings. They want the CIN medical director to address this promptly since it has potential to affect the economic distributions the CIN can make to its member providers. This medical director is anxious to demonstrate to doctors that physicians participating in the CIN can reap financial benefits, and he or she is determined to address the poor performance being manifested by Dr. Smith.

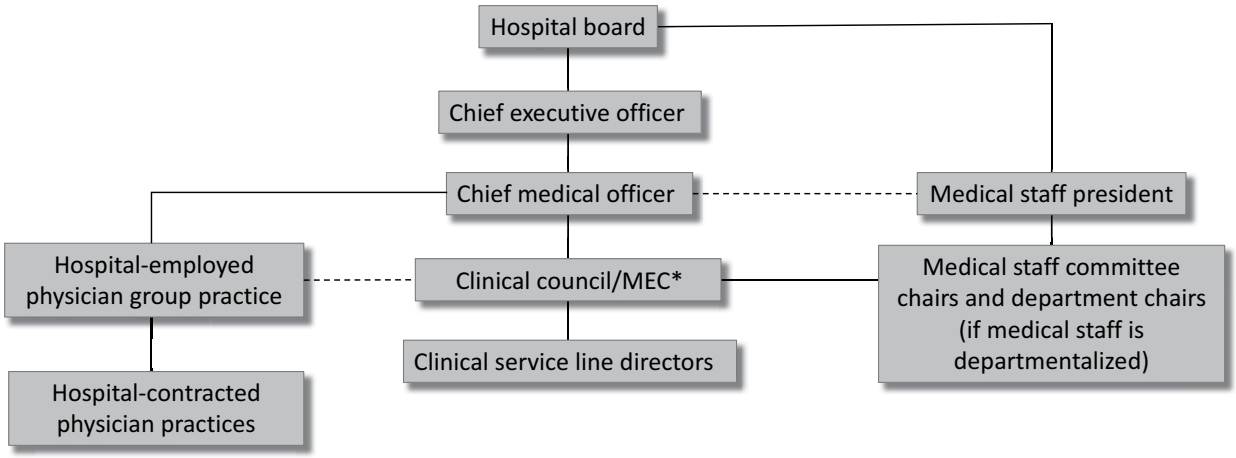
It is easy to see the problem in the above scenario. While Brilling Hospital and its health system are fortunate to have an abundance of physician leadership, the ownership of responsibilities has not been clearly delineated. Furthermore, the system

Sample Organization Chart: Health System Physician Leadership



*The clinical council serves as the physician leadership body in discussions with management concerning health system strategies and operations. At alternate meetings it acts as the medical staff executive committee for a portion of the meeting agenda. Composition may include the chief clinical officer, selected health system service line chiefs, president of the medical staff, and president of the employed physician group(s). Other physician executives may be added or invited as appropriate.

Sample Organization Chart: Hospital Physician Leadership



* Clinical council meets weekly to discuss matters of clinical and strategic importance to the hospital. Every other week, part of its meeting functions as the medical staff executive committee to address credentialing, peer review, and other medical staff issues. Composition may include the CMO, president of the employed physician group(s), key service line medical directors, and medical staff officers.

has no established forum or other communication routines that would facilitate a coordinated approach to addressing the problem posed by Dr. Smith. Brilling is not atypical in having insufficient job descriptions for its physician leaders, which must be continually reviewed to see that they maintain usefulness in a constantly evolving health system. It has not created a leadership organization chart that clearly delineates the flow of authority among these physician leaders so that accountability can be maintained. Nor has this health system adopted protocols that define the preferred tactics for approaching the management of problematic doctors on its staff, in its employment, or affiliated with its CIN.

Another example will show how the proliferation of physician leaders can sometimes delay and degrade the ability to

make important decisions unless careful planning goes into the overarching physician leadership framework within a health system. Centerville Health Network is a multi-hospital system with an extensive number of doctors in leadership roles. Like Brilling, it has multiple physician executives, several medical staffs, a large number of clinical service lines, employed doctors in a group practice organized as a corporate subsidiary of the health system, and an affiliated ACO. Recently the system CMO had to handle an issue with an elderly staff doctor who was manifesting early signs of cognitive impairment while making clinical rounds. After a mandated physical assessment, this doctor was found to be significantly impaired and his staff membership and employment were terminated. The CMO would like to see a policy implemented in the health system to screen older physicians periodically for cognitive or physical limitations which might affect their ability to practice safely. He raises this with the medical executive committee at one of the system hospitals where the mean age of medical staff members is late 50s. The MEC leadership quickly dismisses such a policy as something that would never be approved by the general membership. The CMO also raises the issue at a second health system hospital and the reception from MEC leaders is very positive and a change to their hospital credentials policy is promptly adopted. When the CMO reports this at a meeting of the health system executive team, hospital counsel raises strong objections, declaring such a policy will put the health system at risk of age discrimination lawsuits. Meanwhile the president of the employed medical group was shocked to find one of the group's members was practicing with unidentified early dementia. The group's executive committee votes to require members over the age of 65 to have an annual cognitive screen. Several doctors object and consternation ripples through the physician community at Centerville Health System.

Some of the system's service line leaders feel sandbagged by the matter when the issue is raised at meetings of their service line's doctors. They had no idea policies were being considered to screen aging physicians, so in several service lines, *ad hoc* task forces are developed to consider the matter. At the annual meeting of physicians in the ACO, a community doctor speaks from the floor and demands to know if the ACO leaders are planning to shut out older doctors in the community.

It is easy to see the rapid spreading dysfunction being generated in this health system over consideration of one policy. Physician leadership is fragmented and most matters are given consideration in multiple silos. If the CMO wanted to develop and implement a common policy for consistency across the system, the effort could easily take many months as drafts circulate to the various appropriate parties, feedback is provided, revisions and follow up drafts are circulated, and so forth. While health systems should be working diligently to integrate their activities and forge heightened coordination across their many parts, the growth of physician leadership in most hospitals has occurred without conscious effort to achieve these aims.

Rationalization of Physician Leadership

What might "rationalization" of physician leadership look like? If Centerville's multiple medical staffs are in reasonable geographic proximity, unifying them into a single staff has many advantages.[9] In particular, a single medical executive committee could be comprised of the health system's major physician leaders: the medical directors of its most significant clinical service lines, the president of its employed physician group, and its key physician executives. This group of doctors comprise the major physician leadership for Centerville Health System and they might meet weekly, with the following meeting agenda structure as an example:

Weekly (at every meeting):

- Discuss clinical and business strategies and major policy considerations
- Discussion of matters brought forth by the system CEO and executive team
- ACO physician director attends and discusses matters relevant to successful practice under risk contracting

Bi-weekly (every other meeting):

- Act as the unified MEC and address credentialing and peer review matters

9 See section below describing the option of medical staff unification in some depth. Also informative are: Todd Sagin, "Unification of Medical Staffs in Health Systems: The Time is Now," *Hospitals and Health Systems Rx,* American Health Lawyers Association, Vol. 18, Issue 3, November 2016; Todd Sagin, "After the Merger: To Combine Medical Staffs—Or Not?" *Healthcare Executive,* Vol. 30, No. 4, July/Aug 2015, pp. 62-63; Todd Sagin, "Unifying the Medical Staff: A Critical Look at New CMS Conditions of Participation," *Boardroom Press,* Vol. 25, No. 5, October 2014, The Governance Institute.

There is no single best practice for such an organizational scheme, but the goal is to allow critical matters of concern to physician leadership to be discussed once with all relevant leaders present. In this way, all of these leaders are on the same page at more or less the same time, communication and collaboration are facilitated, strategies are unified rather than unique in different parts of the organization, and decisions can be reached rapidly since the key players are around the table at the same time.

There are other tactics health systems can employ to foster mutual understanding of issues and consistency in solution implementation among physician leaders. Examples include:

- Periodic retreats in which all physician leaders participate
- Leadership development classes or programs, which all physician leaders attend and where specific health system challenges are discussed
- Technical tools such as listservs and password-protected Web portals to facilitate dialogue within the leadership cohort

Another approach is to employ a common coach to assist physician leaders. This individual would work with all of the system's physician leadership team, and could readily identify occurrences of miscommunication, leaders working at cross-purposes, or matters that need to be brought up for group consideration.

Avoiding Fragmented Physician Leadership

- Create job descriptions for all positions that clearly articulate the scope of responsibility, relevant reporting relationships, and accountabilities
- Have an organizational chart for physician leadership that demonstrates how such leaders relate to one another
- Create forums that bring all appropriate physician leaders together to discuss and develop common understanding of health system strategic plans and to address issues that have system impact and should be standardized
- Assign the same group of key physician leaders to serve on committees such as a unified MEC, a health system clinical council, a common credentials committee, and so forth
- Where multiple medical staffs exist, consider partial or full unification in order to reduce the number of silos in which physician-relevant decisions are being considered
- Maximize the use of communication tools like listservs and dedicated Web portal sites
- Utilize periodic retreats to assure adequate time to align physician leaders regarding major health system issues
- Consider ongoing leadership development classes attended by all senior physician leaders so that learning can be applied to real health system challenges and common understanding and solutions considered

Making Medical Staff Leadership More Effective: The Push for Medical Staff Redesign

Most medical staffs today are structured and function as they were designed 50 years ago for a very different healthcare environment. The basic template upon which many medical staffs are built was formulated in the 1970s when The Joint Commission (formerly the Joint Commission for the Accreditation of Healthcare Organizations or JACHO) and the American Medical Associations promulgated model medical staff bylaws.

MANY ASPECTS OF THE TRADITIONAL ORGANIZED MEDICAL staff, as structured at the typical community hospital, undermine its efficiency and effectiveness. Recent years have seen many medical staffs undertake a self-assessment to determine better ways to carry out their delegated and assigned responsibilities. While the concept of an organized medical staff is seen by many as an anachronism in the healthcare world of 2017, it continues to be mandated by the Medicare CoPs and many long-standing state hospital regulations. However, within current regulations, many medical staffs are finding latitude to become more adapted to current times.

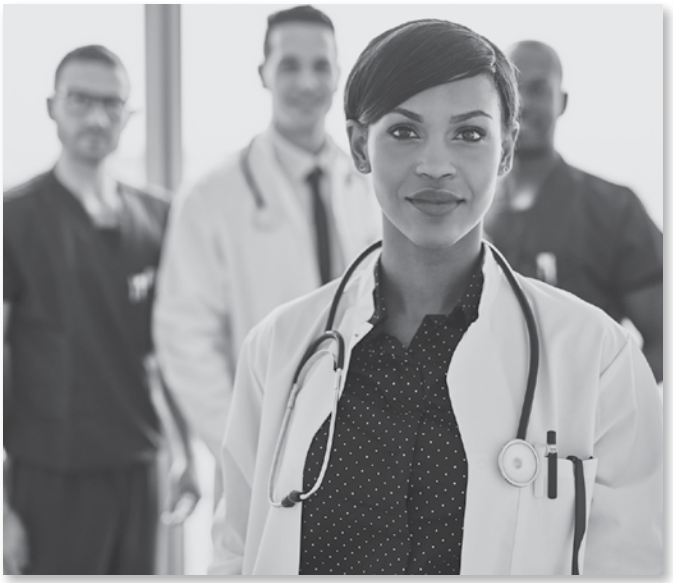
Leaders of medical staffs often identify the following as problematic features of their organizations:

- Leadership positions are often held by poorly prepared individuals who assumed their roles reluctantly and who pass them on to someone else before they can gain solid familiarity with or experience in the role.
- Leadership positions have become increasingly demanding of physician time, but typically are volunteer roles or supported with only a token stipend.
- Some leadership positions no longer have a clear purpose or rationale for existence (e.g., the historic officer role of secretary/treasurer).[10]

- Eligibility criteria for leadership positions often are non-existent or minimal, and in many organizations candidates can nominate themselves from the floor at the time a vote is being held.
- The MECs at many hospitals are excessively large and unwieldy, resembling small parliaments rather than efficient executive bodies.
- Many medical staffs have seen a proliferation of committees that sap physician time, experience poor attendance, and address issues that do not command the interest and attention of physician committee members.
- The bureaucratic infrastructures of many medical staffs have become unnecessarily extensive, with many clinical departments and standing committees that require staff support and physician commitment.
- Medical staff categories have become excessive and confusing at many institutions, allowing practitioners to play a "category shell game" to avoid responsibilities tied to specific categories (e.g., emergency department call).
- There is lack of clarity regarding how the organized medical staff, designed when most practitioners were in independent private practice, should address the performance issues of doctors who are employees of the hospital or one of its subsidiaries.

Compounding these concerns are governing documents (e.g., bylaws, rules, regulations) that are poorly written, outdated, contain contradictory or confusing passages, are excessive in length or legal verbiage, and provide poor guidance regarding the contemporary challenges facing current medical staff leaders. Many medical staff bylaws are resting on a foundation of language drafted decades ago and which is only slightly revised year after year.

10 Today, management of medical staff finances and minute taking are tasks almost universally performed by a medical staff professional and not by a medical staff officer.



When medical staffs decide to strengthen physician leadership through redesign, the following are some of the most typical changes being implemented:

- Lengthening terms of office for key physician leaders and allowing unlimited successive terms in cases where these leaders are doing a good job and continue to have the confidence of their peers
- Creation of enumerated qualifications for key leadership roles, including requirements for education and training relevant to the position to be assumed
- Reduction in the number of medical staff officers where more than two have historically existed
- Simplification of medical staff categories and uncoupling them from problematic medical staff requirements such as emergency call responsibilities
- Downsizing of the MEC to a more functional number (roughly 5–12 members)
- Elimination of medical staff clinical departments
- Elimination of many standing medical staff committees
- Addition to bylaws of clearly enumerated physician rights so that physicians understand how medical staff membership provides them something of personal value
- Reduction of in-person meeting requirements to reduce burdens on physician time and allowing greater use of virtual meeting participation
- Restructuring of peer review so it is an interdisciplinary process that stresses collegiality and abolishes historic cultures of shame and blame
- Creating clear descriptions of how the medical staff will collaborate with hospital departments that address human resources, risk management, patient safety, and the recruitment and onboarding of employed physicians

The above list is certainly not exhaustive, but the dialogue that accompanies redesign discussions at medical staffs causes many to be quite thoughtful and creative about how they carry out important responsibilities. The changes being implemented at many institutions have reinvigorated interest in medical staff leadership or have helped to highlight new opportunities for meaningful physician leadership in the health system. Flexibility in the redesign of medical staff work has also been facilitated by the growth in the number of organizations which have "deemed status" from CMS to accredit hospitals. Some of these newer organizations are much less prescriptive in their requirements for medical staffs than the historic market leader.

Unification of Medical Staffs in Multi-Hospital Systems to Strengthen Leadership and Reduce Burdens

Today, health systems typically provide considerable amounts of care in the outpatient setting, an arena in which medical staffs have traditionally exerted little oversight of credentialing or quality of care. Similarly, many health systems are moving to embrace population health strategies, which the organized medical staff was not designed to address.

One of the most significant forms of medical staff redesign in the past two years has been the unification of medical staffs across different hospital campuses within a multi-hospital health system. The existence of multiple medical staff organizations in a single health system creates numerous liabilities, legal and otherwise. For example, when various medical staffs within a health system adopt divergent policies, privileging criteria, bylaws, and other documents, a health system can be accused of maintaining conflicting standards of care. When these same medical staffs reach different decisions about a practitioner's credentials or medical staff status, which an inattentive health system board let stand, the potential for health system liability is high. There is rarely any justifiable explanation as to why a practitioner can be considered competent and safe to practice in one part of the health system but not in another.

Maintaining multiple medical staffs is a drain on the time and talent of the limited resource of physician leadership in a health system. Valuable clinical standardization can be harder to achieve across multiple medical staffs and clinical redesign efforts slowed. Furthermore, the financial resources needed to staff and support multiple medical staffs can be substantial as is the organizational strain of enduring multiple accreditation reviews.

In the spring of 2014, Medicare's hospital CoPs were modified as part of a CMS effort to reduce the regulatory burden on healthcare providers. In its final rule published on May 12, 2014,[11] CMS changed its regulations to allow multi-hospital health systems to utilize a single, consolidated medical staff model. To take advantage of this new latitude, a health system must first confirm that this structure is permissible under state law. It is also required

11 Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (79 Fed. Reg. 27106), May 12, 2014.

that each constituent hospital's medical staff decide voluntarily to merge into a unified medical staff entity. The final rule spells out four conditions that must be met if unification is to occur:

1. The medical staff of each hospital must have voted by majority in accordance with its bylaws to join, or to opt out of, the unified medical staff.
2. The unified medical staff must have bylaws, rules, and requirements describing its processes for self-governance, credentialing, peer review, and due process, which shall include advising each medical staff of its rights under (1) above.
3. The unified medical staff must be established in a manner that takes into account each hospital's unique circumstances with respect to any significant differences in patient populations and hospital services.
4. The unified medical staff must operate in a way that gives due consideration to the needs and concerns of all members of the medical staff, regardless of their practice or location, to ensure that localized issues applicable to particular hospitals are duly considered and addressed.

In the wake of the modified CoPs described, health systems across the country have begun to explore whether the time is right to merge medical staffs. Others have already completed the process or are in the middle of efforts to create greater medical staff consolidation.

Upsides to the Unification of Multiple Medical Staffs

The potential advantages of creating a single medical staff within a multi-hospital system are multi-fold. Some of the most significant benefits are derived when medical staff committees are consolidated:

- Efficiency is gained by **reducing duplicative medical staff committees**. For example, in a three-hospital system that historically maintained three pharmacy and therapeutics committees, the work can be done by one.[12] Fewer committee meetings means less time physicians spend away from valuable clinical work or other administrative tasks. The unification of such committees also facilitates standardization of work product.
- The **physician leadership talent** available to manage medical staff committees is increased as it can be pooled from multiple medical staffs. This makes more highly qualified individuals available to assume important leadership positions. In addition, there is less potential to overwork a limited pool of leaders where bench strength is limited.
- Fewer medical staff committees and meetings means less work for support staff and can **produce financial savings** as staffing is reduced or redirected to other important work. It also conserves the time of medical staff leaders so they can focus on important health system priorities.

- It becomes **easier to adopt standardized policies and clinical protocols** since the work product of one committee doesn't have to journey from institution to institution for review by multiple groups, reconciliation of differences, and ultimate approval. This results in health systems that can respond more facilely to growing demands for improvement.

Unified medical staffs are inherently more "user-friendly." There are fewer meetings for physicians to attend and the medical staff communications they receive tend to be reduced and primarily come from one source. Physicians who work at multiple facilities within a health system no longer must apply and reapply for membership and privileges at each hospital. This saves doctors from the work and aggravation connected with the biannual credentialing requirement. Board time is also conserved since this body will no longer have to review and approve as many credential applications. The opportunities for flaws in the credentialing process are reduced, which in turn reduces the potential for liability from negligent credentialing litigation. Where problematic physicians exercise privileges at more than one institution in a health system, burdensome tasks like fair hearings do not have to be repeated at each hospital.

Health systems that have consolidated medical staffs sometimes find they experience increased flexibility in cross-coverage of employed clinical practices throughout the system and an enhanced ability to coordinate specialty call coverage for their emergency departments. Additional benefits include a reduction in accreditation surveys of medical staff affairs, the ability to build stronger consolidated medical staff support teams, and less opportunity for the emergence of dysfunctional medical staff politics.

12 It should be noted that medical staffs can merge working committees without complete unification of their medical staffs. Indeed, doing so is sometimes a helpful intermediate step toward complete merger of such staffs.

Challenges to Medical Staff Mergers

While the reasons to unify medical staffs are compelling, there are also challenges and potential downsides. Unification may be impractical if large distances geographically separate a system's hospitals. Much of the current experience with consolidated medical staffs has been where a system's hospitals are aggregated in a single urban area or single region. Where systems cross state lines, local regulations must be consulted to assure there are no state regulatory obstacles to medical staff mergers.

Another obstacle may occur when a particular hospital in a system has a unique and strong culture which it does not wish to see attenuated. If one hospital in a system has created an exemplary culture of excellence among its practitioners or has adopted highly effective medical staff practices, it would be foolish to undermine these attributes with a thoughtless approach to medical staff mergers. For example, if one medical staff within a system has an excellent track record of highly effective peer review, this activity should be preserved locally even within a unified medical staff structure. Indeed, the hope for unification is to facilitate the rapid spread of such best practices.

In some institutions, local physicians may feel threatened if they perceive a merger of medical staffs will result in a dilution of their input and influence with management. This can be especially true for private practice physicians who often express fear of a creeping corporatization of healthcare. Such doctors sometimes seek to maintain multiple medical staffs to provide as many platforms as possible from which to raise their objections to change.

Sometimes opposition to medical staff unification can come from local hospital administrators, who may believe it will be harder to manage physician affairs on their campus if multiple medical staffs are consolidated. These senior executives often believe that the loss of their local medical staff will make it more difficult to achieve hospital performance measures for which the administrative team is being held accountable.

An important challenge to the effective functioning of unified medical staffs is the increased demand for better communication across the combined entity. Health systems must be prepared to invest more resources into communication tools and better training in the facilitation of virtual meetings. It is not reasonable to expect physician leaders to travel significant distances to attend meetings with any regularity. Even short geographic distances can be a significant barrier to participation and unified medical staffs that master the art of virtual meetings will fare better than those that do not.

Considerations in Implementing Medical Staff Mergers

It is of critical importance to achieve the buy-in of key physician stakeholders in any effort to unify medical staffs. In most medical staffs this is not a difficult task since there is widespread indifference to medical staff affairs among doctors. Nevertheless, even where a very small group voices opposition, physicians can be quick to circle the wagons around the status quo. The merger endeavor should be guided by a task force of physicians carefully chosen for the value of their input and their ability to rally support for the necessary bylaws amendments at each medical staff. The rationale for mergers should be pitched at individual meetings, open forums, presentations to current medical staff committees, and formal medical staff meetings. The operational details of the new unified medical staff should be modified in accordance with the feedback received through these interactions.

While it is necessary to garner the support of physicians, the need to have management and board support should not be overlooked. Until these entities are clearly supportive, no effort at unification should be initiated. It is also important to be clear with medical staff professionals how their future will be affected. If they fear the changes may leave them without a future in the organization, passive-aggressive behaviors may emerge which will undermine forward progress.

The following are examples of design options that must be decided upon before a unification plan can be completed:

- Should the medical staffs at all hospitals in a health system be merged, or just some?
- What should be the size of a unified MEC?
- How should the new MEC be comprised? (Should members be elected or appointed? Should each campus be represented and

if so, based on size or should there be equal representation? Should there be *ex officio* members?)
- What officers should exist for the unified medical staff? How should they be selected?
- What mechanisms will be created to address local campus issues?
- What standing committees should exist in the unified medical staff?
- How will privileges be held (by campus or system-wide)?
- Should the unified staff be non-departmentalized, have departments based at each campus, or have unified clinical departments across campuses?
- Should peer review be kept a local activity at each campus, or should this critical medical staff activity be centralized?

Sometimes politics will demand that movement toward unification of medical staffs move through intermediate steps. For example, cooperation across medical staffs can be initiated by starting with a combined credentials committee. This is often a compelling place to first undertake shared decision-making because of the liability posed when disparate decisions are reached concerning the same practitioner privileged at multiple hospitals within a health system. Over time other committees can be consolidated and, at some point, joint MEC meetings might be held. Once these steps are accepted, it is not a great stretch to move to full unification under a single set of bylaws.

The final step in any effort to unify medical staffs is to create compatible bylaws language. This can mean adoption of an entirely new set of bylaws or modification of a current set from one of the existing medical staffs. Care should be taken not to let this open the door to a host of other issues physicians may wish to address through bylaws changes. If the bylaws modifications are kept focused on the structural redesign of the medical staff organization, the process of unification is less likely to become derailed by side issues.

When new bylaws are being adopted to create a single medical staff, it can also be wise to create a transition plan to smooth the path forward. For example, many medical staff officers are elected to two year terms. It may be prudent to let current leaders ride out their elected time of service rather than truncate that time abruptly in a move to unification. Under a transition plan, in its first year of operation a unified MEC might be comprised of existing medical staff officers from each hospital. Then, on a scheduled timetable, the composition could move to a new constellation of members for the long-term.

Example: Efficient Medical Staff Organization

Two Officers
1. President or chief of staff
2. Vice president or vice chief of staff

Two Medical Staff Categories for Members
1. Active: voting and eligible to hold office
2. Associate: non-voting and not eligible to hold office

Three Committees
1. Executive committee (MEC) (seven members)
   - Two officers
   - Three members elected at-large
   - Chair, credentials committee
   - Chair, peer review committee
2. Credentials committee
3. Multi-disciplinary peer review committee

Non-Departmentalized Medical Staff
Elimination of "rules and regulations": all matters outside of medical staff bylaws are addressed in medical staff policies and procedures.

Note: in a multi-hospital health system, there would be a unified medical staff. In this case, the MEC composition would be different and a local/campus specific physician leadership council would be established to address hospital-specific matters.

Clearly there are many paths to achieve the merger of medical staffs and the right course for any health system will depend on numerous variables. However, this trend is gaining momentum and we will continue to see in the years ahead many health systems taking advantage of CMS' new flexibility. The unification of medical staffs is a natural accompaniment to the increasing integration of care delivery systems and has great potential to strengthen organizations in an era of value-based reimbursement and population health. Equally important, it can strengthen physician leadership in an organization in several ways. One is by making medical staff leadership roles more attractive and effective. But often overlooked is that by simplifying medical staff bureaucracy and eliminating unnecessary medical staff leadership positions, it makes it easier to create a seamless overarching physician leadership organization chart for the organization that reduces overlap and redundancy of positions.

Leadership Training: How Hospitals Are Preparing a New Generation of Physician Leaders

The need for physician leaders is becoming more self-evident and growing. An insufficient number of doctors are prepared to engage and succeed in leadership roles.

SOME OLDER PHYSICIANS, BURNED OUT FROM CLINICAL practice, see respite in the assumption of an administrative role. These individuals are often poorly suited to physician leadership.

Their motivations are generally self-serving, they typically lack any history of formal leadership training, and they are often rooted in a 20th-century perspective on the nature of healthcare delivery. However, health systems often turn to these individuals for leadership based upon their longevity with the organization, their clinical experience, and their familiarity with peers in the physician community. As has been noted elsewhere, until recently physician advancement into positions of leadership has been largely based on credentials, seniority, clinical competency, and political standing.[13]

Physician leaders today need broad skills ranging from analytic and strategic capabilities and the capacity to embrace change, to the ability to build teams, resolve conflicts, and motivate colleagues. It will be necessary for most health systems to help develop these and other important skills in those doctors they want to lead. Many administrators and older physicians are dismissive of younger physicians, who they perceive as having inadequate work ethic and a lack of interest in medical staff service and citizenship. However, numerous studies of the millennial generation have corroborated many reasons to target these doctors for induction into leadership training and positions. Millennials tend to be tech adept (and reliant) in an age where medicine is becoming increasing buffeted by technological change; they are not generally driven by money but rather by meaningful work; they are team oriented and value collaboration and sharing of ideas; they like coaching and direct feedback; and they are comfortable in multicultural and diverse environments. Many of these characteristics are valuable attributes for a contemporary physician leader. On the other hand, millennials tend to prefer democratic, non-hierarchical workplaces and often feel stifled by traditional, rigid workplace practices. Enticing them into traditional medical staff roles may be an uphill battle. However, the opportunity to help reshape and guide a transforming health system and practice environment may be just what excites a young doctor with leadership potential.

Leadership succession planning requires self-conscious efforts to identify talent within the ranks of employed and private practice physicians in the community and find the enticements to bring these individuals into the ranks of leadership. For most organizations, it will also necessitate developing relationships with recruiters to identify talent that can be hired from outside the community to supplement locally available resources and to inoculate the institution with new viewpoints and knowledge.

21st-Century Physician Leadership Skills

However a hospital or health system goes about stimulating interest in leadership opportunities, there will also be a need for efforts to cultivate, further, and refine leadership skills. Many of the skills required of physician executives are generic, common to any leadership position in any business, including:

- The ability to work on a team
- Effective communication
- Understanding of business planning and business finance
- Change management
- Conflict negotiation
- Delivery of performance reviews
- Empower and engage others
- Accountability management
- Emotional intelligence

In addition to these fundamental skills, physician leaders need to be knowledgeable about areas specific to the medical enterprise. These include:

- Quality and patient safety
- Healthcare financing and reimbursement
- Clinical workflow design
- Proper use of clinical protocols and guidelines
- Health information technology
- Physician compensation
- Patient engagement and patient experience considerations
- Practitioner credentialing and peer review
- Familiarity with health law
- Aspects of public health and population health management

Of particular concern today is a physician leader's skills to motivate and mobilize their colleagues, who often feel beleaguered and alienated from the very institutions to which they are more tied at the hip than ever before.

13 J.K. Stoller, "Commentary: Recommendations and Remaining Questions for Healthcare Leadership Training Programs," *Academic Medicine,* Vol. 88, No. 1, January 2013.

Physician Leadership Education and Development

Health systems can develop education and skill building capacity by establishing their own internal physician leadership courses, retreats, and ongoing academies. There are several benefits of onsite programing. It can be more cost effective to run a leadership education program by making use of internal resources readily found at the hospital or by utilizing individuals from the nearby community. These might include current physician leaders and health system executives, hospital finance and human resources personnel, and/or relevant faculty from nearby academic institutions. It is also possible to train more individuals at less cost when the education is held on or near the hospital campus. At the same time, it is also a more efficient use of physician time and less detrimental to physician productivity to perform training locally rather than have doctors incur time away from clinical practice when traveling to distant educational programs.

Hospitals vary greatly in the nature of onsite programs. Some just sponsor periodic "boot camps" for newly elected or appointed medical staff leaders. These provide "just-in-time" training for medical staff officers, department chairs, and committee chairs. They are generally held every few years and they focus on skills necessary to carry out basic medical staff work. Topics typically include introduction to credentialing, peer review, running effective meetings, accreditation requirements, and intervening with problematic colleagues.

Many hospitals and health systems run more extensive programs that require significant physician commitment ranging from a few hours each quarter to a full day each month. Such programs are intended to not only strengthen the skills of existing physician leaders, but also to develop future leaders. The curriculums in these ongoing programs usually address topics such as change management, conflict management, introduction to basic finance skills and business planning, and so forth. Some hospitals will have tiered programs that allow the "graduates" from one year to enroll in a more advanced set of sessions the following year. Enrollment in these programs is sometimes by invitation only so that attendees understand that they are being given a unique opportunity. Attendance and participation is expected and the education provided is sometimes considered a mandatory qualification to hold a leadership position in the institution.

There are limitations to onsite physician development programs. It can often be helpful to get physicians away from the distractions of the hospital environment and the urgent pull of their clinical practices. Once offsite, many physicians are better able to concentrate on the educational material presented. Time offsite can also provide an occasion to bond with fellow colleagues attending the same program. Such programs typically expose attendees to other professionals from various parts of the country and help doctors who have spent most of their career in one place to shed parochial perspectives. Valuable networking can take place providing attendees with resources that extend well beyond those found in their local community. Furthermore, offsite programs often utilize faculty with national reputations and extensive experience in training physician leaders. These faculty members frequently bring the material alive and keep it relevant with illuminating case studies based on their work at large numbers of facilities.

Many physicians interested in physician leadership choose to pursue advanced degrees. Most commonly these are Master's degrees in business (M.B.A.s) or health administration (M.H.A.s). However, some physicians see utility in obtaining their Master's degree in public health (M.P.H.), doctorate in law (J.D.), or a degree in medical informatics. There are also certificate programs run by educational institutions or entities like AAPL, which offers certification as a physician executive (CPE). While there is no doubt that physician leaders benefit from the knowledge gleaned in such training, it is not clear how well most of these educational pursuits deliver skills honed for the hospital setting. While a healthcare institution can shape an internally sponsored physician development curriculum, it has no influence on the content of standard academic degree programs. While some of these college or university programs have a healthcare orientation, many are taught by professors who lack intimate knowledge of daily practice in hospitals and health systems. While few health systems subsidize the costs of such graduate education for potential leaders, some have accommodated flexible scheduling to allow a physician to attend classes or participate in an *executive* M.B.A.

Often missing in hospital physician development efforts are the establishment of significant mentoring and coaching programs. Long recognized as a valuable tool in the executive suites of Fortune 500 companies, coaching is seldom utilized to strengthen the abilities of physician leaders. This is unfortunate as coaching is a powerful tool for helping a physician take classroom education and apply it successfully to everyday challenges. Organizations that resist the use of coaches because of the associated expense are being predictably "penny-wise and pound foolish."[14]

14 For an excellent article on the use of coaching for physicians, see Atul Gawande, "Personal Best: Top Athletes and Singers Have Coaches. Should You?" *The New Yorker,* October 3, 2011.

Tools for Physician Leadership Development

- Onsite or offsite "boot camps" that target a defined set of skills such as those needed for newly elected medical staff leaders
- Episodic onsite leadership development programs (e.g., grand rounds or retreats)
- Onsite physician leadership curriculums or "academies" with longitudinal training that may take place at quarterly or monthly intervals
- Offsite participation in national physician leadership programs sponsored regularly by both commercial and professional organizations
- Enrollment in certificate programs such as the AAPL coursework leading to recognition as a Certified Physician Executive (CPE)
- Enrollment in healthcare oriented M.B.A., M.H.A., or M.P.H. programs
- Onsite mentoring and coaching initiatives

Determining the best way to develop current and future physician leaders for a hospital requires a good understanding of the organization's goals and needs. Most health systems serious about such leadership development embrace a mix of the approaches described above. In doing so the institution not only creates more capable leaders, but it also sends a strong message of the value it places on physician leadership. Such a message fosters confidence in the medical community that doctors can have some influence over the direction of healthcare and their professional future. This confidence in turn empowers doctors to achieve goals that will benefit the hospital as well as its clinical practitioners.

Hospital and Health System Board Responsibility for the Promotion of Effective Physician Leadership

It is important for hospital and health system governing boards to periodically assess the effectiveness of physician leadership in their organizations.

WHEN SUCH LEADERSHIP IS WEAK, INADEQUATE, OR POORLY organized, both the short-term and long-term success and sustainability of a health system can be jeopardized. As noted previously, many of the nation's most successful and durable healthcare organizations have a long history of strong physician leadership.

A governing board should place the matter of physician leadership periodically on its meeting agenda for assessment and deliberation. It is important for board leadership to be proactive in this regard, because in some organizations senior management may feel threatened by board attention to physician leadership. A CEO might consider the development of physician leaders to be solely a management issue, rather than a matter of governance. Because there may have been historic tension between management and doctors (see the section on the history of hospital–physician relationships above), a health system's senior executive(s) may see doctors as inappropriate for high-level administrative leadership and prefer to treat doctors only as a "commodity" important to the institution's success. In these cases, top management may give lip service to the importance of physician leadership, but in practice they resist the encroachment of doctors into their administrative decision-making space. While this kind of resistance from management is not the norm, when present, board agendas may be steered away from forthright discussions about the nature and extent of physician leadership in the institution.

How should a board go about assessing physician leadership effectiveness? This question will be answered differently in each organization based on that entity's goals and priorities. For example, some hospitals rely heavily on physician engagement surveys to provide an indication of successful alignment with the medical community. If the results of such surveys suggest low engagement, it *may* reflect inadequate physician leadership. The board may ask management to survey current leaders periodically and ask if these individuals are satisfied with their leadership development opportunities. A board might request periodic audits of important medical staff functions like credentialing and peer review to understand the adequacy of physician leadership in these essential activities. At a minimum, the board should be periodically informed of the investments the organization is making in physician leadership development. If a hospital spends large sums of money on a yearly social event for all of its doctors but comparatively little on specific leadership education initiatives, a board should question whether budget priorities are appropriate.

A governing board assessing physician leadership should ask multiple questions:

- How effective is current physician leadership? What metrics are we using to define and track such effectiveness?
- Do we have sufficient physician leadership to drive the health system performance we seek?
- How well trained and prepared are our physician leaders?
- Do we have an adequate leadership develop program in place?
- Are we engaging younger (future) generations of physician leaders through deliberative succession planning?
- Is there a clear organizational chart for the hospital/health system's physician leadership?
- Do physician leaders have detailed job descriptions that make clear their responsibilities, accountabilities, and reporting relationships?
- Has physician leadership in the organization become overly fragmented and siloed? How would we know and evaluate this concern?
- Has the medical staff recently assessed its structure, processes, and bylaws to make sure they represent contemporary best practices?
- If we have multiple medical staffs, should they move toward part or partial unification so there is combined leadership?
- Are there adequate venues, forums, and organizational structures to allow physician leaders to come together regularly to deliberate on clinical strategy, standardized protocols and policies, and common approaches to physician engagement and the promotion of physician resiliency? If not, what should be considered?
- Are we compensating physician leaders properly to maximize value and to avoid any potential compensation related liability?

Perhaps the most important time for a board to consider the state of physician leadership in the organization is when it undertakes strategic planning. The fundamental premise of this white paper is that physician leadership is essential to the success of an integrated delivery system. This is particularly true when an organization takes the long view and focuses on the ability to sustain itself in a continually changing healthcare environment. Boards that neglect the state of physician leadership in their hospitals, outpatient facilities, employed physician ranks, service lines, clinically integrated networks, and in operations on the front lines everywhere the system delivers care, do so at their peril.

Conclusion

As demonstrated in this publication, there is a clear resurgence of interest in physician leadership in hospitals and health systems across the nation due to the continued and increasing pressure from all stakeholders for hospitals to provide greater value as they pursue their missions. Increasingly, physician leadership is a vital tool for addressing improvements in quality and safety, cost efficiency, and patient-centered care delivery, as well as growing physician burnout, turnover, and challenges in recruiting new doctors. Advocacy for enhanced physician leadership clearly supports institutional goals relating to both margin and mission.

PHYSICIAN LEADERSHIP HAS MOSTLY EXISTED AT THE LEVEL of the organized medical staff, with "amateur" leaders who volunteer or are often conscripted into roles that usually have short terms and regular turnover. Such leaders are rarely trained for these positions and are just as rarely oriented to the roles they assume. Most medical staff leaders pass the baton on to a successor just as they are beginning to understand the attendant responsibilities of their positions and developing some facility with the tasks involved. As this white paper has demonstrated, the organized medical staff has been a mostly ineffectual vehicle for driving high-quality, safe, and efficient care at the typical hospital.

The deteriorating state of the organized medical staff has led many organizations to undertake a concerted effort to rethink approaches to medical staff structure and functioning. One significant goal of this work is to make physician leadership on the medical staff more impactful and therefore more attractive to potential leadership candidates. Many hospitals are streamlining medical staff bureaucracy, strengthening medical staff bylaws, better preparing medical staff leaders for their positions, and unifying disparate medical staffs when they exist in multi-hospital health systems.

Recently there has been a significant increase in the physician leadership roles in hospitals. It has become common to see a growing cadre of physician executives, ranging from VPMAs and CMOs to chief clinical officers and chief integration officers. It has also become common to see physician leaders as directors of clinical service lines, leading employed physician groups, and playing major administrative roles in accountable care organizations and clinically integrated networks. While this growth in physician leadership harbors great potential, it is too often developed within health systems that have not given enough thought to its organization and development.

Expansive growth in physician leadership positions has occurred in many institutions without adequate job descriptions, well-defined reporting relationships, and clearly articulated accountabilities. Physician leaders often operate in silos with poor coordination of their activities and responsibilities. However, thoughtful organizations are not just designing a contemporary medical staff model, but also rationalizing the overarching framework of physician leadership across the hospital or health system. The result can be a clear and highly efficient physician leadership org-chart which creates maximum value from an investment in enhanced physician leadership.

While there is growing recognition of the value of doctors in administrative positions, few have been trained to do the work well. Physician leaders today need broad skills ranging from analytic and strategic capabilities and the capacity to embrace change, to the ability to build teams, resolve conflicts, and motivate colleagues. It will be necessary for hospitals and health systems to help develop these and other important skills in the doctors they want to place in leadership roles. Determining the best way to develop current and future physician leaders for a hospital requires a good understanding of the organization's goals and needs. In doing so the institution not only creates more capable leaders, but it also sends a strong message of the value it places on physician leadership. Such a message fosters confidence in the medical community that doctors can have some influence over the direction of healthcare and their professional future. This confidence in turn empowers doctors to achieve goals that will benefit the hospital as well as its clinical practitioners.

Board members, physicians, and management teams who appreciate the fortification physician leadership can provide, and who implement a strategically effective physician leadership structure with supportive training and development, have the power to place their organizations in the best position possible to forward the agenda of the 21st-century healthcare organization.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