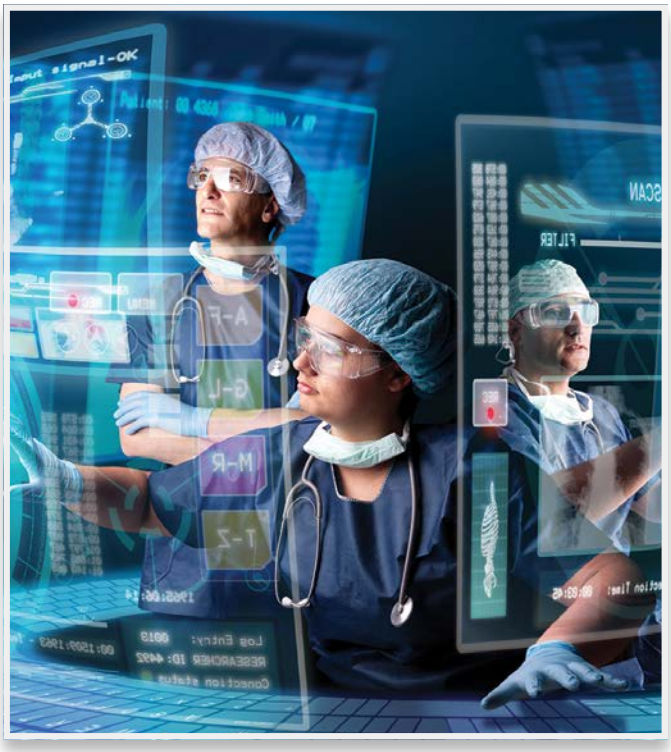
Restructuring Physician Leadership in Evolving Health Systems

BY TODD SAGIN, M.D., J.D., SAGIN HEALTHCARE CONSULTING, LLC

Board members have been hearing a lot lately about the importance of physician leadership to the future success of their organizations. Such leadership is essential if physician talent and engagement is going to drive needed redesign in clinical care.

It is hoped that these new approaches in turn will deliver higher quality results with greater patient satisfaction and lower cost. Doctors need to pay more attention to strategic planning, the efficacy of operations, the nuances of data interpretation, adherence to evidence-based medicine, and the growing challenge of population health management, all while sustaining their primary focus on the immediate needs of patients under their care. To achieve these changes in focus, many policy experts assert that durable health systems will need to be increasingly "physician led and professionally managed."

In recent years, a plethora of new physician leadership positions has emerged in response to an evolving 21st century healthcare business model. Not surprisingly, in many hospitals this growing cadre of leaders often find they have conflicting roles, unclear accountabilities, duplicative responsibilities, and competing constituencies. This article will first describe the expanding physician leadership roles in our health systems. It will conclude by addressing ways to rationalize the deployment of these proliferating leadership positions.



A Growing Number of Physician Leadership Roles

For decades, most hospitals have relied heavily on the elected representatives of the organized medical staff to provide physician leadership. The doctors who step forward to serve as medical staff officers, department chiefs, and committee chairs are usually well intentioned but poorly trained for these roles. Though their skills may mature during the course of their tenure, most serve limited terms and pass the baton on to the next cohort of leaders in relatively short order. This often results in what might be characterized as "amateur" leadership rather than professional leadership. Furthermore, in the highly competitive and volatile healthcare marketplace that has characterized recent years, many hospitals have experienced periods dealing with medical staff leaders who are not fully aligned with institutional needs.

To bring a higher degree of expertise to the leadership of doctors, many hospitals employ a physician executive as a vice president of medical affairs or chief medical officer. As the only physician in the senior management team of most hospitals, this individual often has an overwhelming set of expectations laid at his or her feet. Fortunately, there is a growing cadre of doctors who have trained to be physician executives and who bring growing confidence and skill to these positions. Some hospitals have tapped into this growing cohort to create additional executive roles such as a chief medical

information officer (CMIO) to facilitate physician adoption of electronic health records or a chief quality officer to spur improved quality and safety metrics. Some larger systems have deployed physician executives with titles such as chief innovation officer or transformation officer to promote the dramatic new approaches in tactics and culture needed to succeed in our evolving healthcare environment.

Another inescapable trend at hospitals across the country has been growth in the employment of doctors by hospitals. As hospitals see their number of employed doctors grow many have organized them into carefully structured multi-specialty group practices. This in turn requires a subset of employed physicians to step forward and assume group practice leadership roles. These employed groups typically have their own governing board or executive committee whose members are drawn from the ranks of the group practice. They often develop working committees with physician chairs and most will have a physician medical director or CEO. In many cases, physicians who have not previously held leadership roles on the organized medical staff fill these roles. Often the responsibilities of these leaders are focused less on inpatient care in the hospital than on the outpatient settings where the majority of

employed physicians spend their time in office practice.

Hospitals have adopted many approaches to succeed in turbulent times and an increasingly common tactic has been the development of service lines to effectively deliver targeted care. Originally, service lines were primarily marketing tactics to increase revenue by raising a hospital's public profile in a particular service area. Today, service lines are a tool for delivering highly coordinated care across the inpatient and outpatient continuum. They require a high level of physician leadership to achieve their quality, cost, and service targets. A popular leadership arrangement has been to pair a physician medical director with an administrator and hold these professionals jointly accountable for all the performance expectations of their service line. These important new roles for physicians have further augmented the ranks of doctors in leadership positions.

Some pundits refer to our current times as the era of "accountable care." In recent years, hundreds of accountable care organizations (ACOs) have been developed around the nation. Whether developed by doctor groups or hospitals, these ACOs require boards and executive teams with significant physician participation. In addition, in recent times we have seen a resurgence of traditional structures such as physician–hospital organizations (PHOs) and independent practice associations (IPAs) in an effort to take advantage of new payer contracting arrangements. Here again, physician leadership positions abound. Yet additional roles for doctor managers are springing up in newly organized primary care networks built around developing concepts of the patient-centered medical home (PCMH).

New Challenges

The potential upside to greater physician leadership participation in healthcare redesign and delivery is undeniable. However, the rapid expansion in leadership roles for doctors also creates new challenges. Many hospitals have only a limited number of physicians on their medical staff with significant leadership training or experience. When untrained and inexperienced doctors are given authority and responsibilities they are not prepared to execute there can be multiple downsides. Not only can specific management needs remain unmet, but frustrated senior administrators may decide to usurp decisions they otherwise would have delegated to physician leaders. This, in turn, reinforces the belief by some doctors that management never intended physicians to have meaningful authority in the first place. This can cause a destructive circle of distrust to emerge that can have a long-term negative impact on the organization.

A Growing Constellation of Physician Leaders

- Officers of the organized medical staff
- Executive committee members of the organized medical staff
- Committee chairs of the organized medical staff
- Department chairs of the organized medical staff
- Vice president of medical affairs/chief medical officer
- Chief medical information officer/chief quality officer
- Chief innovation or transformation officer
- Medical directors of clinical service lines
- Medical directors of hospital clinical departments (e.g., ED, pathology)
- Members of board or executive committee of hospital employed physician group and chairs of working committees
- Medical director of hospital employed group practice
- Medical director of PHO/IPA/ACO
- Physician board members of PHO/IPA/ACO
- Medical directors of primary care networks and patient-centered medical homes

More physician leadership positions in hospitals can also lead to damaging role confusion. The responsibilities of new service line medical directors are often seen as an intrusion on the duties of historic medical staff department chairs. For example, is an ob-gyn concern the responsibility of the ob-gyn department chair or the medical director of the women and children's service line? If a medical staff member misbehaves, should this conduct be addressed by a department chair, service line medical director, medical staff officer, or the CMO? Do hospital contracting issues regarding clinical services require the involvement of medical staff leaders, ACO and/or PHO leaders, service line chiefs, or other doctors in management roles? As physician management roles have proliferated, many hospitals have not spent time clarifying who should have ownership of which issues. This can result in duplicative effort, lack of clear direction to subordinates, and delays in implementation. In addition, often the old adage that "when everyone is accountable, no one is accountable" becomes manifest.

Expansion of physician leadership roles can also tax the ranks of physicians who feel compelled to fill the leadership void. Many hospitals have invested little in physician leadership development over the years. Those that have put forth some effort often do not go beyond an occasional education retreat or a series of lectures comprising a "leadership academy." It is unusual to see fully developed programs that include management "internships," creation of mentorship relationships, and

opportunities for ongoing coaching. When the ranks of effective physician leaders are small, talented individuals are often pressured to wear multiple hats. A doctor having just completed multiple terms in medical staff leadership may be tapped to serve on an ACO board, be asked to step up as a service line chief, or requested to chair various *ad hoc* task forces. The hospital's goal is to take full advantage of a valuable physician resource, but the result may well be burn out that frequently occurs when physicians with busy clinical practices are also expected to participate in significant management activity.

Organizing and Developing Physician Leaders

How can hospitals and health systems maximize the upside and minimize the downside of expanding physician leadership positions? First, every hospital should have a game plan for physician leadership development and succession planning. Without skillful physician leaders it doesn't matter what positions exist or how well they are thought out and coordinated. Fortunately, there is an abundance of resources to assist hospitals with such education. Second, it can be enormously valuable for management to sit down with current influential physicians and define the leadership positions they believe will be necessary for a successful future. This can take the form of a focused retreat where new roles can be defined and consensus can be reached on current positions that should be retired. For example, as many health systems create medical directors to lead expanding service lines they are simultaneously downsizing traditional medical staff clinical departments (e.g., departments of ENT, pulmonology, or gastroenterology). Indeed, some staffs become totally non-departmentalized in recognition that historic medical staff specialty silos are no longer very functional in an age of integration. (This lack of relevance is reflected by the meager attendance seen at many medical staff department meetings.)[1] Many medical staffs are also downsizing the number of committees they maintain, thereby reducing the meeting burden on doctors and the number of chair positions they must fill.

Retreats such as described have been used to clarify anticipated conflicts such as how a problematic employed physician will be handled. Will this be a matter for medical staff officers to take up through collegial peer review and/or corrective action? Or will such doctors be handled as a personnel matter by physician leaders of a hospital employed physician group? Also addressed are questions like whether the leadership infrastructures of the traditional

organized medical staff, an employed physician group, a primary care network, and/or an ACO can be partly merged in order to minimize the total required leadership roles and to diminish duplicative activity? Retreats to address such issues have been creative in devising new approaches and creating opportunities for increased efficiency and effectiveness. Subsequent to such brainstorming sessions, job descriptions can be customized to provide clear accountabilities and prevent confusion in assigned responsibilities.

Finally, through thoughtful identification of the physician positions it wants for its future, a hospital can assess its talent pool and its ability to fill those positions. Ongoing leadership development and succession planning can be oriented to address the specific needs of those positions that will be maintained. The result will be a clear roadmap for strong physician leadership and engagement to drive transforming strategies and their effective implementation in the brave new world of healthcare delivery.

The Governance Institute thanks Todd Sagin, M.D., J.D., president and national medical director of Sagin Healthcare Consulting, LLC, for contributing this article. He can be reached at tsagin@saginhealthcare.com.

1 Note that The Joint Commission does not require medical staffs to have departments. Medical staffs can simplify structures by getting all of their important work done through a few key committees.