E-Briefings

Volume 16, No. 5 • September 2019

New research and expert opinions in the area of hospital and health system governance.

Rethinking Physician Leadership

By Larry McEvoy, M.D., Founder, Epidemic Leadership

For quite a while, healthcare boards and senior leaders have heard (or said) these words: "We need physician leadership." Over the last two decades, they have seen the emergence of increasing numbers of formal positions, the proliferation of internal and external physician leadership programs, and large numbers of physicians pouring into physician leadership efforts. Today those clinicians, who now include PAs and NPs, have their own questions and concerns: "Where do I go now—where are they going to put all of us?" "It feels like people only want us to lead so much." "We can't do it without them," as they nod toward the administrative suite.

Healthcare organizations have more clinician CEOs, board members, CMOs, and dyad structures. There are more physician leaders than ever at every level, yet we still need more and better physician leadership, everywhere. Hospitals and health systems still struggle to control costs, solidify quality in any comprehensive way, and energize clinical work environments while responding effectively to the population-level challenges of health. Perhaps most tellingly, the tribal divide between "administration" and "clinician" is as wide as ever. Organizations are moving too slowly and people are redlined—we can do great things in healthcare, but we still have a sick system.

Key Board Takeaways

What boards can do:

- Emphasize high-capacity leadership and scaling collective intelligence as a strategic foundation for systemic function; learn how leading-edge adaptive organizations are leveraging systems thinking in their leadership development approaches.
- Ask for a "leadership capacity" audit from the organization and match its attributes and design against requisites of developing high-capacity leaders and effective scaling of new thought and action patterns.
- Create ongoing dialogue from both developers and participants about how the organization is scaling capacity and creating intended and surprising effects.
- Ask how your executives and physician leaders are creating leadership capacity around, and how they themselves are understanding, the changing role of leaders in true systems.

What CEOs and leadership development personnel can do:

- Emphasize learning together, across boundaries, both "in the classroom" and in practical settings; understand physicians have much to learn *and* much to teach.
- Integrate experiential learning with practical "on-the-job stretch-and-learn" beyond comfort zones and outside of boundaries. (This doesn't mean dermatologists should do heart surgery; it *does* mean asking people to lead topics and processes that are out of their—and your—comfort zone.)

Amid all the tools, programs, certifications, and roles, something's missing. It's time to rethink physician/clinician leadership development—not to throw out all the good things that are happening, but to move to a new level of impact and energy. If we really want a system of health, we're going to have to focus on the health of our system. I suggest we make two shifts: from competency to capacity and from skill to scale.

Moving beyond Competency and Skill

Both increasing capacity and the ability to scale are characteristics of sustainable systems, but healthcare organizations are not yet modeling physician leadership development around these key dimensions. Most leadership programs are aimed at individual skills and competencies (to be plied in settings of varying sizes

from one-on-one conversations to large multi-disciplinary processes). These are helpful adjuncts to leadership, but its highest use is to amplify the performance, learning, and vitality of the organization in every nook and cranny. Skills and competencies help us deal with the component parts of leading an organization, but they don't necessarily help us move entire systems where patterns of thought, interaction, and action define performance and behavior of the organization as a whole.

The fundamental challenge of leadership is shifting these patterns across numbers of people and processes in the face of innumerable known and *unknown* challenges. Focus too much on skills and competencies, and you risk a confining, rule-based organization that eliminates variability. (Eliminating variability is good, of course, when the variability itself is a risk for harm or error; eliminating variability is a disaster when that variability is the seed of improvement or innovation.)

Capacity is not the opposite of competency, but rather the ability to leverage competency (one's own and that of others) to successfully think and act on unconventional and emerging challenges. If competency equips us to respond as leaders with "we have seen this before and we know what to do," capacity equips us with the ability to think and act at multiple levels and from multiple angles *when we don't know what to do*. High-capacity leaders certainly have skills, but their capability to understand and interact with wider varieties of people, challenges, and dynamics with a wider and more flexible set of mindsets and approaches makes them quantum contributors. Competency is the currency in a static and predictable world; capacity is the currency of a complex and unpredictable one—and healthcare is the poster child for complexity and unpredictability with all of its changing and moving parts.

> There are more physician leaders than ever at every level, yet we still need more and better physician leadership, everywhere.

Think of capacity this way: a skilled and competent carpenter may have many skills and be competent with a large complement of tools, but he/she can only build one way. The high-capacity carpenter has the same skills and tools, perhaps more (or even fewer), but he/she can build in a wider number of ways, in different architectural styles, on different terrain, and with a wider array of materials. Two leaders may have the same emotional intelligence scores and be equally competent at having a performance conversation, but the one that can think and respond at multiple levels can leverage emotional intelligence and performance conversations to a far deeper degree. Research by Anderson and Adams has shown that individuals with deeper thinking and emotional capability have a greater reservoir for understanding challenges and responding with a wider array of creative approaches—and create higher organizational results and performance.[1]

The potential limitation of the high-capacity individual is the reality that there are hundreds and thousands of particles known as free-thinking humans orbiting nearby—each who can have a positive or negative influence on the performance of a healthcare organization. The highest leverage of capacity is to multiply it in and across large numbers of people to go from high-capacity leader to high-capacity system. We tend to think of scaling as a directive phenomenon ("roll out," "push down," send the memo), but it's far more participative and organic than that. Swarm intelligence (heavily studied by the military), cloud computing, and the design of AI all emanate from the same awareness that needs to mobilize leadership development in healthcare: the highest level of leadership is the summoning of collective intelligence in any and all settings so that performance is both predictable in stable circumstances and responsive to new realities.

Conclusion

High-capacity and participative approaches to scaling are essential attributes of systemic leaders, but to get there we have to move beyond an obsession with competencies as the measure of leaders. Both capacity and approaches to scale are developable in leaders as part of a systems approach to leadership. Such approaches incorporate various skills and competencies and have the benefit of simplicity—they gain their power from encouraging leaders to dig deeper into how they think, how they generate deeper awareness, and how they can facilitate diffusion of new patterns of thought, interaction, and action beyond themselves by inviting others to participate, not to comply. Such an approach can increase precision but requires the

1 Robert Anderson and William Adams, *Mastering Leadership: An Integrated Framework for Breakthrough Performance and Extraordinary Business Results*, Hoboken, New Jersey: John Wiley & Sons, 2015; Robert Anderson and William Adams, *Scaling Leadership: Building Organizational Capability and Capacity to Create Outcomes that Matter Most*, Hoboken, New Jersey: John Wiley & Sons, 2019.

relinquishment of control; it can escalate commitment but requires participation over direction; and it requires leaders to discard the ego of expertise and telling for the humility of learning and listening. Our times are telling us that if we want to function as a system, we're going to have to learn and lead "as a system." If a system is more than the sum of its parts, we're currently focusing too much on the parts.

The Governance Institute thanks Larry McEvoy, M.D., past-CEO of Memorial Health System and the President and CEO of Epidemic Leadership, for contributing this article. He can be reached at larry@epidemicleadership.com.