Physician Leadership: Are the Right Number of Chefs in the Kitchen?

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Key Board Takeaways

- Ensure the hospital has a strong physician community to support its activities and sustain its future.
- Understand the critical role of adequate physician leadership in promoting engaged practitioners who can transform care in support of hospital objectives.
- Challenge management to explain its physician leadership strategy. This includes what new roles are being created and how they are being coordinated to ensure clear lines of accountability.
- Explore whether adequate funding is being directed to physician leaders at all levels of the organization. Also, be sure management has created a strategy for the training and development of new physician leaders.
- Ask the medical staff to reduce its physician leadership ranks where they create problematic redundancies, such as when historic medical staff department chair roles overlap with new service line medical directorships.

Successful hospitals and health systems need strong medical staffs to attract patients, deliver high-quality care, promote institutional reputation, and ensure a steady revenue stream. However, a growing physician shortage is making it harder to recruit clinicians, doctors have become more mobile and are spending less time at any single hospital, the prevalence of practitioner burnout is creating a less engaged clinical workforce, and an explosion of physician employment by non-hospital entities (e.g., private equity-sponsored groups and insurers) is weakening traditional doctor–hospital bonds.

To counter these trends and meet multiple other needs, hospitals and health systems have invested more and more heavily in physician leadership. For most of the 20th century, hospitals turned to the organized medical staff for such leadership. In the 21st century, the organized medical staff is an anachronistic model, poorly suited to our rapidly evolving healthcare world. Medical staff leaders are usually transient in their roles, often inexperienced in leadership, poorly trained in management tasks, not always aligned with institutional goals and needs, and constrained in the time they can give to what are largely volunteer roles. For these reasons, new physician leadership roles have been proliferating in hospitals. This article looks at the growth in physician leadership roles and how boards can help promote effective physician leadership in their organizations.

A Growing Group of Physician Leaders

The board should take an interest in the new ranks of physician administrators. Historically, the organized medical staff has been a direct report to the board through its elected leaders. When the board needed to take the pulse of the physician community or hold someone accountable for critical delegated duties, such as credentialing or quality monitoring of practitioners, it could dialogue directly with medical staff officers. However, the growing cadre of new physician leaders (e.g., Chief Medical Officers, Vice Presidents of Medical Staff Affairs, and Chief Quality Officers) are considered hospital management and are directly accountable to the CEO rather than the board.

The benefit of adding more physician leaders into the hospital environment should be obvious. Where hospital nursing has always had an extensive management infrastructure, the hospital's physician community is just starting to achieve something similar. However, the creation of additional leadership jobs with new titles is too often being done without sufficient thought by hospital executives. Often, new physician leadership roles come with poorly defined job parameters, inadequately delineated accountabilities, and unclear authority to make needed decisions. Responsibilities are frequently overlapping, and it is common to find confusion regarding the role of medical staff leaders versus that of hospital-employed physician leaders.

A good example of this occurs in hospitals where the board and management have promoted the creation of multidisciplinary service lines. When such service lines are instituted, the historic role of a medical staff specialty department chair becomes unclear or unnecessary. Yet too few hospitals eliminate medical staff departments as they ramp up service lines. Service line medical directors and medical staff department chiefs often end up perplexed about which of them is accountable for managing challenging colleagues when they manifest quality or conduct concerns. If neither addresses the concern or it is managed inadequately, the problem colleague can end up requiring the board to consider the painful task of imposing a restriction on privileges or termination of membership.

Adding physician leadership is an expensive proposition and should be carefully considered. In the past, it was often believed that such leaders needed to stay in part-time practice to retain credibility with colleagues. More recently, the demanding portfolios of physician leaders and the extensive management training required to master these roles has led to the prevalence of the full-time "physician executive." While high-level physician executives are necessary, commonly missing are clearly defined physician leadership roles on the front lines of clinical care. These should be part-time positions for doctors heavily engaged in the care of patients. But such practitioners should receive adequate time and training to be able to provide daily, "in the trenches" guidance, coaching, instruction, and mentoring to their colleagues. Such leaders are critical to transforming outdated modes of care delivery.

Senior management is usually under pressure to control expenditures and adding additional physician leaders in clinical offices, employed specialty groups, and specialized inpatient units may be seen as fiscally impractical. Board members should challenge such assumptions and carefully weigh the cost–benefit balance to further growth in the ranks of physician leaders. This is especially true in the ranks of primary care practitioners who, if effectively led, are critical linchpins in any effort to reorganize clinical care to yield superior results across the care continuum.

Reallocation of a relatively small amount of dollars can reap tremendous rewards in a stronger primary care backbone for most health systems.

Promoting Effective Physician Leadership

It is important for board members to understand how physician leadership is organized in their hospital. The board should periodically ask senior management to explain how it has rationalized the existing cohort of physician leaders to promote role clarity and accountability. As physician leadership roles proliferate, the board needs to press to understand whether only more silos, bureaucracy, and fragmentation have been created.

Board members should also inquire whether new cohorts of physician leaders have received adequate training to perform optimally. For example, many service line medical directors have been put into these new roles without fully understanding or mastering the tools at their disposal for optimizing service line functioning. Newly elected medical staff leaders often assume their roles without the knowledge to perform challenging responsibilities for credentialing and peer review. Most hospitals do not have well-developed internal professional development resources for physicians and the common practice of sending doctors to outside programs for leadership education has waned during the COVID-19 pandemic.

Board Dialogue with Physician Leadership

Most boards include one or more medical staff officers as voting or non-voting members who give reports at most board meetings. However, it is important for board members to hear about physician matters that go beyond the medical staff's responsibility for credentialing and peer review. In recent years, it has become customary for the Chief Medical Officer, if this position exists, to attend board meetings as a member of senior management. While this individual is often expected to channel the input of the entire cohort of hospital physician leaders, the board should consider more direct communication from time to time. For example, many hospitals employ a significant percentage of medical staff members and often have a physician leader at the head of the employed physician group. A direct report from this doctor on a periodic basis can allow board members a better understanding of how well the hospital is tending to the concerns of this critical group of doctors. In a similar fashion, hearing directly from a physician Chief Quality Officer can give board members greater insight into the hurdles hindering overall improvement in physician performance. Alternatively, directors could dialogue directly with a broader range of physician leaders through various working committees of the board. Contact with the board will help energize and empower physician leaders who often feel insufficiently heard by the hospital's non-physician administrative staff.

Successful hospitals and health systems build strong physician communities that are attractive to new practitioners and retain current doctors by creating stimulating, engaging, and supportive professional environments. An essential element is well-prepared physician leaders who are deployed throughout the organization in thoughtful roles. The board owns the ultimate responsibility for ensuring its hospital has such leadership.

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