Key leadership Traits of Physician Executives

A comparative review and analysis of the literature

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Abstract

Integrated delivery models of health care in the new era of accountability, demand leadership from not only executives, but from physician leaders as well. It is evident that the physician vision is imperative in provider based business structures. Common definitions of physician leadership have placed emphasis on the unique personal vision and intellectual capabilities that are inherent to those pursuing a career in medicine. Physicians in an executive and/or leadership role in the health care setting is not a new premise. Most health system executives would find these same traits to be critical to the individuals leading their physician enterprises, there has been a significant number of "disconnects" between health system leaders and the physicians designated to lead their affiliated enterprise. The findings of this research sought through the current body of literature to highlight areas of commonality as well as distinguish the differences between the traits sought by CEOs and the leadership features of their designated physician executives. This work lends itself to helping bridge those gaps in expectation and subsequent performance as it relates to each party's mutual traits.

Introduction

Integrated delivery models of healthcare in the new era of accountability, demand leadership from multiple sectors. Prompted by the passage of the Patient Protection and Affordable Care Act (PPACA or ACA); health system CEOs, who are often successful in leading and managing their facilities are now engaged in new initiatives outside their normal scope. These new programs range from assuming health insurance risks to an increased presence of employed physicians seeking shelter from disruptive change through health system employment. Because of the evolving business models, health system executives are soliciting a skill set that will allow them to navigate these unique business models. However, often the skills they seek in themselves and their subordinates may not always be the attributes that best serve these new models, most notably with physicians.

McAlearney and Chaudry (2005, 2008) contend that the need for a physician vision is increasingly important in these new integrated healthcare structures. The model of the disengaged "employed" physician, reporting through a hierarchy of non-clinical leaders

demonstrates itself as an increasingly ineffectual method of creating the necessary metrics for success, inclusive of quality, efficiency and access (Deane, J., D'Eredita, A., 2010). Common definitions of leadership have placed emphasis on the unique personal vision and intellectual capabilities that are inherent to those pursuing a career in medicine (Warden 1999, Kotter 2012). Physicians are intelligent individuals whose long-term persistence sustained them through years of difficult education. However, years of intensive education do not always create the training to be the best leader. There is growing evidence that what health systems are asking from their physician leadership is "less management" e.g. finance, operations and "more clarity of vision" i.e. communication to peers and/or augmentation of strategic plan. (Stoller, 2008, The Advisory Board Company Policy Paper,Innovations in Physician Leadership, 2012)

Physicians in executive and/or leadership roles in the healthcare setting are not a new role, and as healthcare historians have noted many of the great institutions of medical care were physician created, led and managed. (Starr, 1983, Falcone, 2008) There are a number of executives with MDs/DOs after their name with little clinical activity associated with their title (Hoff, 1999). What is evolving is that the former concept of physician "executive" as a dedicated administrator is falling out of favor (Stoller, 2009, Advisory Board Policy Paper, 2012). These new types of physician leaders are increasingly more likely to have a clinical component to their leadership or management roles.

Physician leadership is an increasingly covered research topic in recent years (Dine, 2011, Barnhart, 2010), as the need for a substantive discussion on leadership and management efficacy continues to rise. Past findings from research of physician leadership traits demonstrate a desire for business knowledge or "core competencies", as well as clinical behaviors. (McKenna, 2004). The nine core competencies defined by McKenna are:

- interpersonal and communication skills;
- clinical excellence;
- financial acumen and resource management;
- professional ethics and social responsibility;
- continuous learning and improvement;
- ability to build coalitions of support for change;
- ability to convey a clear, compelling vision;
- system-based decision-making and problem-solving;
- ability to address multiple stakeholders' needs.

Many health system executives would consider these traits essential in any key executive, whether physician or business-based. However, there have been a significant number of "disconnects" between health system leaders and the physicians designated to lead their affiliated enterprise (Xirasagar, 2008, Duberman, 2011).

The recent and growing integration of physician groups into the complex array of facilities and services within health systems has been the source of increased research and case studies with examples of both successful and failed initiatives (Xirasagar,

2008, Falcone, 2008). The prevailing message of many of these analyses, regardless of the outcome, is the efficacy of physician leadership (Gunderman, 2009, Stoller, 2011). The capacity to find the right person, at the right time, with the effective skills of vision and communication, often determines the outcome of the physician group transformation. The personality traits of the physician and the cultural conditions around the prospective leader will often foretell the outcome of the integration effort. It is imperative that health systems not only seek the physician who is the right "fit" complemented with the appropriate training, but also set the proper cultural stage for a successful executive-physician partnership. The subsequent outcome may rely on whether the person selected to lead is the right person to create the right conditions for transformation.

There are new leadership programs at Duke and The Cleveland Clinic Foundation meant to guide physicians and their business peers to a higher level of leadership capacity than more traditional training environments (McAlearney, 2008, 2010, Taylor, 2009). Additionally, there is also an underlying potential difference in the outcome of leadership training and results between the physicians who seek leadership roles and their administrative counterparts.

Duberman (2013) describes in her research that physicians may struggle in the current healthcare model without proper training and preparation. Her findings conclude that traditional, business-centric health system conditions can create obstructions or "derailers" for physician leadership, more so than their business peers, which may include:

- Being risk averse.
- Limiting self-awareness.
- Inability to manage change.
- Being inflexible and/or impatient.
- Being too self-involved and individualistic.
- Being naïve about the importance of politics.
- Inability to persuade groups towards a common goal.
- Allowing the tactical to take the place of more strategic work.
- Unwilling to give up instant gratification for longer term success.
- Unclear role expectations for self.

As any of these derailers apply to non-physician leadership, many of them accentuate the prevailing stereotype around physician leadership experiences. However, upon reflection of the traditional medical school/residency pathway many of these behaviors can be accentuated as positive traits in a patient care setting such as risk aversion.

Whether related to healthcare or to any business model, it is important to distinguish the difference between management and leadership, as they are not one in the same (Kotter, 1995, 2012); or tightly interwoven in their requirements (Steinbruegge, 2011). Although there is a

strong need for both skill-sets in the physician environment, this research will focus on leadership traits by conducting a systematic review of relevant research found in the literature.

The authors compared and contrasted the key characteristics distinguished in the literature that reflect physician leadership attributes against the leadership traits in the non-physician executive and administrative leaders within healthcare systems. This research seeks to address the question of whether or not there are relevant and discernible differences in the leadership traits in physicians as a class of professionals versus their administrative peers in similar health systems.

The analysis of the literature searchconcentrated on research that examines health systems including academic medical centers (AMC), faith-based organizations, and integrated hospital systems, all have employed physicians and some form of physician-represented governance models. As these organizations must deal with the changing healthcare landscape, the strategy and tactics of integration is often consistent in design with the immediate hurdles these organizations face. As the crisis of leadership impresses itself over an organization that seeks change, it is difficult to re-engineer the culture and take corrective actions. In other words, if physicians were not leading in good business times, how can they be expected to lead when things are difficult and/or disruptive?

The authors conducted an extensive literature review that validates that physician outcomes must move beyond revenue production and measure a broader spectrum of care delivery. The proposed measurement model for this physician group, referred to as a “trilogy” model. This model includes measures of cost, quality, and service (or access). These measures separately examined, however, the author states that it is imperative to understand how these metrics integrate to determine the organization's competitive advantage. The authors suggest that recommended measurements for the physician group must be consistent with the overall organizational goals.

The paper projects that the long-term impact will be better utilization of resources. These efforts subsequently will result in the most cost effective, quality care for the healthcare consumer. This narrative review of the literature is insightful as it reflects in 1998 many key assumptions that are part of modern accountable care strategies and the need for physician leadership as part of the “buy-in” to a changing environment.

Gary Barnhart and Michael O'Brien are well-known physician leadership consultants. In their recent white paper, “Overcoming Physician Leadership Limbo” (2012), the authors reinforce the notion that the emerging health system environment requires far more physician leaders than has been necessary in the past. The article suggests that when physicians move from a clinical to a leadership role, they have a tendency to “straddle both worlds” at the same time and often not effective. This environment can be tension filled as physicians seek to differentiate between the practice of medicine and the trials of leadership. These disruptions in the healthcare setting are often a major barrier to the performance of physicians who are stepping into new leadership roles. The key to minimizing distress of practicing both medicine and management is to support physicians in the process of leadership development

Methods

The Agency for Healthcare Research and Quality (AHRQ) defines a systematic review of the literature as “a critical assessment and evaluation of all research studies that address a

particular clinical issue. The researchers use an organized method of locating, assembling, and evaluating a body of literature on a particular topic using a set of specific criteria. A systematic review typically includes a description of the findings of the collection of research studies. The systematic review may also include a quantitative pooling of data, called a meta-analysis". The mechanisms of a systematic review of qualitative research can take on many variations from formal grounded theory to cross-case analysis. The researcherschose to use meta-ethnography supplemented by base organizational tools of meta-analysis as defined by the Cochrane Collaboration.

Table 1. Keyword Theme Synthesis from Literature Search

General Definition	Management-Focused Literature n=16	Physician/Clinically-Focused Literature n=16
Employed: Give work to (someone) and pay them for it.	Physician working for hospital. Either academic or staff/resident	Clinical Staff, often support team around care provider or administrative support
Executive/CEO: Executive responsible for a firm's overall operations and performance	Head of Hospital or Health System; occasionally large physician group	Rarely defined in the Physician-based literature; common conceptual separation between "leader" and "executive"
Health System: Structured and interrelated set of all actors and institutions contributing to health improvement	Consistently defined in the Management Research Literature when Described	Consistently defined in the Physician Research Literature when Described
Hospital System: Group of hospitals that work together to coordinate and deliver a broad spectrum of services to their community	Not often defined, but when defined, is consistent with general definition of hospitals organized to deliver services to associated area	Not consistent within Physician Literature and is often not defined in physician generated or physician leadership training research
Leadership/Leader: The action of leading a group of people or an organization	Consistent in Administrator and Vendor Literature	Inconsistent or more specific definitions of Leadership; Physicians are more clinically focused
Physician: person qualified to practice medicine	Same as General Definition	Same as Healthcare Definition
Transformation: A thorough or dramatic change in form or appearance	Consistent in the Vendor and Administrator Literature. Interpretations are more broad and strategic	Inconsistent between educators and physician literature. Physicians are more clinically focused or patient-centric
	Keyword Synthesis Agrees	

We used a systematic review of the relevant literature and then organized the selected research literature around key words, metaphors and idioms (described as Keyword Themes) using meta-synthesis and its specific subset, meta-ethnography to determine each researcher's perceptions of physician leadership traits. After the assessment and translation of each article's Keyword Themes, the collective (or expressed theme) does (or does not) convey specific leadership traits unique to physicians.

The importance of leadership in today's healthcare organization prompts the question about whether physicians as leaders are effective in leading the medical staff or other aspects of the healthcare organization. The research method is indicative of the search for leadership traits of physicians in key positions compared to the traits exhibited by non-physician leaders in similar healthcare organizations. These insights lead to the question as to whether or not there are clear and discernible differences, if any, between physicians in leadership roles in hospital or health systems and non-physician executives in comparable roles and organizations. If there are clear and convincing traits, how can these attributes be incorporated into the roles and responsibilities of health system functionality and provide assistance with the objectives around cost, quality, access and safety.

Table 2. Keyword Theme Expression from Literature Search

Expression Theme General	Management-Focused Literature n=16	Physician-Focused Literature n=16
Employed: Give work to (someone) and pay them for it.	The understanding of employment is more traditional and directly applicable to the researcher and/or the publication audience	Physician perception of employment is viewed as second or third party distinction as opposed to first person reality even in academic literature
Executive/CEO: Executive responsible for a firm's overall operations and performance	Expressed more a goal/achievement of leadership process as opposed to unique and separate entity	Not commonly recognized as goal/achievement in leadership (exception Falcone) where leader is evident; executive is not
Hospital System: Group of hospitals that work together to coordinate and deliver a broad spectrum of services to their community	Clearly defined as setting where leadership is conveyed and a natural environment for leadership	Perceived as more of a hurdle than setting. Almost unnatural work place that a physician has to navigate
Leadership/Leader: The action of leading a group of people or an organization	Consistent definition with Executive/CEO and there is a natural interaction between the two Keyword Themes	There is not a consistent link of leader/leadership to executive/CEO. Leadership is often described in clinical, educational, or peer management terms

Thirty-two (32) articles were selected that reflect the prevalence of the key word drivers (physician, leadership) and the presence of keywords intended to define the parameters of physicians and leadership. The 32 selected articles were then further assessed (second order) for consistency of Keyword Themes that solicit the research question of whether or not there are clear and discernible differences, if any, between physicians in leadership roles in health systems and non-physician executives in comparable roles and organizations.

Further synthesis of Keyword Themes found concurrence/agreement around Health System and Physician. The synthesis of Keyword Themes confirmed ambiguity with themes Employed, Executive, Leadership, and Transformation. The lack of clear dissonance over Keyword Themes reflects the synthesized researchers convey a general understanding of the key words used to define physician leadership but begin to provide subtle but alternative meanings when applied to specific understandings of key words and subsequent themes.

Conclusion and Recommendations

The research study question of whether or not there are clear and discernible differences, if any, between physicians in leadership roles in hospital or health systems and non-physician executives in comparable roles and organizations has been answered in the negative with significant considerations to the contrary. Although the meta-ethnography did not distinguish clear and convincing evidence of unique traits in physician leaders, it did reflect key factors or elements that appear to highlight physicians in leadership settings.

A systematic review of the defined literature using a qualitative meta-synthesis model of research indicates unique attributes in physician leadership elements but not clear and convincing traits. The intensive education and training of the modern physician is not conducive to classic examples of leadership that involve risk taking or conveying a distant and/or convergingvision. However, other attributes of the physician learning process are very facilitative to leadership qualities most notably, the requirement of a sense of urgency and decision-making, taking charge in a group environment, and learning empirically from past decisions to take corrective actions to ensure different, more effective outcomes.

Many healthcare leaders have been presumptuous in their thinking that if a physician, who may have some qualities of communication skills, organizational skills, and is outfitted with an medical degree; that with a little bit of basic training in budgets and capital planning, will be a formula that is “good enough” to lead sophisticated physician models within complex systems. This is often a misuse of a key asset of the healthcare organization. Instead of making a physician emulate a traditional business/administrative role of leadership, health system executives may be better served if they can accentuate the unique elements of physician leadership to achieve system goals.

The second part of the research question, if there are unique attributes of physicians as leaders, how does the healthcare business model make accommodations to facilitate a better outcome from the physician components of these integrated models?, was also answered by this research. The findings convey the need for strong collaborative efforts between business and clinical leaders within health systems to maximize the return on the physician leadership asset. Leadership training programs, many of them recently deployed over the last decade, need to focus their efforts to accommodate the training and vantage points of the future graduates,

specifically physicians, who seek a broader positive transformation. To paraphrase Albert Einstein, you cannot solve problems with the same thinking that was used to create them.

The importance of leadership in today's healthcare organization prompts the question about whether physicians as leaders are effective in leading the medical staff or other aspects of the healthcare organization. The research is partially indicative that leadership factors in physicians are distinguishable when compared to the behaviors exhibited by non-physician leaders in similar healthcare organizations. The data do not distinguish which leadership attribute is better for the healthcare system. However, it does speakto when and where these key factors can better serve the needs of the organization.

There are additional opportunities for complimentary research along this theme including a quantitative study on key physician traits to empirically determine what those elements and expectations are in hospital and health system settings. Although physician-centric systems such as The Cleveland Clinic Foundation or Geisinger Health System have had robust physician leadership training, these programs are still in their infancy across most health systems around the United States. Many of the physician leadership programs at health systems that the authors have observed often have a generic syllabus, borrowed from a leading institution, with no viable correlation with current system goals and objectives. There appears to be a recognition of the need for physician leadership training programs, just not a clear vision on what to do with the resulting graduates. A goal for physician leadership training needs to determine where their aspiring thought leaders are best placed in the general scheme of a complex health system. Whether the organizational focus is on strategy or operations, designing the methods of management and engagement and having a clear vision of final expectations is essential to health system viability.

Health systems and academic medical centers that recognize the need of physician leaders at many levels of the delivery, must decide how best to integrate the training and mentorship with the goals of the whole organization. If the core strategic objectives are set to improve clinical quality, reduce risks, increase access to care, and all the while achieve these goals in a more efficient manner, then the key question is, how does the health system get physicians to recognize, respond, and then lead these initiatives, as they won't occur otherwise. The basis for this research should help educators not only create more robust leadership training programs, but help health systems executives bridge communication gaps between their interpretation of "transformation" and their physician peers.

There are significant academic opportunities for leadership research in healthcare. The dynamic between converging physician and hospital cultures are creating both opportunity and discourse around questions of what are the goals and critical metrics of why health systems are going through integration of providers, facilities, and risk transfer, one more time. That question on its own requires further study as the anecdotal answers have ranged from "market share", to "population health", to "efficiency of care delivery". There are significant outstanding questions.

Lastly, this research provokes additional and deeper questions along the same theme. Whether profound traits or subtle elements, there are traits and behaviors that physician leaders need to maximize to continue to improve healthcare delivery. Questions around how best to incorporate physicians into complex models and beyond traditional patient care remain to be answered.

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