Development of Physician Leaders

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• Physician • Leadership • Medical education • Diversity

KEY POINTS

- Physician leadership in health care.
- Physician leadership training.
- Physician culture.
- Leadership principles.

INTRODUCTION

Health care today is rapidly evolving and so too must health care leadership. Many external forces, including the implementation of the Affordable Care Act, have resulted in a transition of health care systems away from the traditional fee-for-service (FFS) models and toward value-based care. This has led to increasing pressures on the system to improve access, affordability, and quality.[1] These external forces are also impacting the physician workforce resulting in high physician burnout and attrition. Added to this is a rapidly changing health care environment with new technologies and treatments continuously becoming available and an aging population with increased complex care needs. Together these factors have resulted in a need for new care delivery models that emphasize team-based care. Change requires the engagement and cooperation of many different stake holders including physicians. Health care leaders must be equipped to work in this complex and rapidly evolving environment. Currently, most health systems are run by nonphysician hospital administrators. Given the significant challenges facing health care today strong and expert leadership is needed. Physicians, naturally viewed as leaders, are especially suited to this role for their expertise clinically and their credibility with other physicians. This is also true of independent medical practices. Although larger single-specialty and multispecialty groups may have the economic ability to retain business executives as managers, for many smaller groups, particularly those facing economic challenges, this burden typically falls on a practicing physician. Traditional physician leaders lack the formal training in many of the skills that are required for our current leaders, yet they have many of the necessary skills required to be successful. Growing our physician leader workforce requires formal training of existing physician leaders and a modification of the current medical school curriculum to ensure that there are qualified physician leaders in the pipeline ready and able to continue this work going forward.

WHY PHYSICIAN LEADERS

Historically, hospitals were run primarily by physicians. This practice has decreased over the past 80 years such that now only about 5% of US hospitals are run by chief executive officers (CEOs) with a medical degree.[2] Recent evidence suggests that hospitals with strong physician leadership may perform better in terms of quality of care, physician engagement, and cost efficiency. In 2019, greater than half of the 21 US News and

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World Report "Best Hospitals" were managed by physician CEOs.[2,3] Further analysis demonstrated that quality scores in physician-run hospitals were 25% higher than in nonphysician-led hospitals.[2] In the United Kingdom, hospitals with more physicians in management roles scored 20% higher on financial and clinical quality scores.[2] According to the Centers for Medicare and Medicaid services, in 2018, physician-led accountable care organizations led the Medicare Shared Savings Program in net savings per capita compared with nonphysician-led accountable care organizations.[4] Although the data are suggestive only, it does provide support for the move toward increasing the presence of physician leaders in health care.

Physician leadership may be important for the quality and financial success of health systems, but it may also be critical for hospitals and independent practices struggling with physician burnout. Hospital CEOs recognize burnout as one of the most significant factors affecting health care today.[5] In 2014, 54% of physicians had one symptom of burnout, which is two times the general US population.[6] Burnout has been shown to lead to an increase in the rate of medical errors, poorer clinical outcomes, decreased productivity, and lower patient satisfaction.[6] Burnout ultimately results in physicians leaving the workforce before retirement age contributing to a national growing physician shortage. In urology, burnout is especially high with 54% of urologists reporting burnout compared with 42% of physicians overall.[7] Many of the factors that give rise to physician burnout including increased administrative burdens and the use of an electronic health record are out of the control of administrators and leaders. Engagement, however, which is viewed as the opposite of burnout, is one factor that leaders may have some influence over.[8] In 2016, according to Gallop, 33% of employees on average were engaged at work.[9] Engaged employees are less likely to suffer burnout and less likely to leave the job.[10]

Research has shown that supervisors who have expertise in the field are linked to increased company performance and employee satisfaction across industries including sports, education, and medicine.[11] Increasing the presence of physician leaders can improve physician engagement. In medicine, physicians respect the voice of other physicians as someone who has "walked the walk" and has knowledge of what occurs on the front lines. Thus, physician leaders, with their deep understanding of the core business, have the advantage of having greater credibility with other physicians and ultimately improving engagement.[12,13] Physician leadership is important for addressing burnout and critical to the future of health care.

LEADERSHIP AND DIVERSITY

Promotion and growth of a physician leader workforce must include promotion and growth of diversity within this workforce. Diverse leadership teams are associated with improved medical quality, reduced health care disparities, and improved financial outcomes.[14,15] It is estimated that by 2043, most of the population will be comprised of racial and ethnic minorities. This is currently reflected in the increasing diversity of the patient population. As these demographics change, it will be important to ensure diversity at all levels of the workforce including in leadership and board composition.[16] Today, minorities make up 32% of the patient population while holding only 11% of executive leadership roles.[2,17] In fact, more than 90% of all hospital CEOs are White (non-Hispanic, or Latino).[18] Additionally, women who make up slightly more than 50% of the population, half of the workforce, and hold 50% of the doctoral degrees are also scarce in leadership roles. In fact, only 18% of health care CEOs are women and only 3% of the C-suite roles are held by minority women.[18,19] Even with evidence to suggest the benefits of women leaders on financial performance, risk, social responsiveness, and firm value, women still advance to leadership roles at a much lower rate than men.[19] Today roughly 50% of medical students are women yet only 38% of full-time medical school faculty are women, 21% full professors, 15% department chairs, and 16% deans.[20,21] In urology 30% of incoming residents are women, yet only 3.3% of department chairs are women verses 14% of department chairs across all specialties.[21] A focused effort to address diversity and equity in the workplace is important if we want to decrease the disparities seen in minority patient care, improve the quality of life of the workforce, and increase profitability.[22,23]

CHANGING HEALTH CARE ENVIRONMENT

Since the enactment of the Affordable Care Act in March 2010, health care organizations have found themselves in the midst of significant external pressures. Hospital systems are now being rewarded for delivering high-quality, patient-centered, coordinated care at reduced costs. There is a shift from FFS to value-based care. There is an increased emphasis on public health and the wellness of populations. This is being driven through shared risk arrangements, capitation, and bundled payment strategies requiring

significant redesign of clinical care models.[24,25] Hospitals and health systems have had to build the information technology infrastructure to comply with meaningful use, which promotes the electronic exchange of health information. Quality public reporting brings transparency to hospital outcomes but requires a significant investment in data infrastructure and quality-improvement efforts. Patients are increasingly more informed and empowered as consumers of health care driving changes in practices around access, cost, and choice of care. Reimbursements continue to decrease and there is increasing competition for these limited dollars in the market.[25] The population is aging and requires more complex health care in the face of a projected shortfall of up to 139,000 physicians by 2033.[26] Currently, a large proportion of the physician workforce is reaching retirement age, and this may be accelerated because of effects of burnout and the COVID-19 pandemic. All of these changes in the health care industry require fundamental changes in the way health systems interact with physicians.[27] Strong leaders are needed to drive these changes in health care delivery and to lead the physicians through this change.

Physicians are facing similar challenges and external pressures as health care systems including the need to adapt to new payment models, decreasing reimbursements, the costs of implementing an electronic health record, and building the infrastructure to meet the quality reporting requirements. These external forces are driving physicians to join larger groups or become employed by hospital systems. In 2018, 47% of practicing physicians in the United States were employed, whereas 45.9% owned their practices. This was the first time that the number of employed physicians exceeded the number who owned their practices. The number of physicians who worked directly for a hospital or work in hospital-owned practices was 34.7%, up from 29% in 2012.[28] As physicians transition from self-employment to employed status they struggle with a loss of autonomy, which is a fundamental aspect of the physician culture. Physicians also face increasing administrative burdens. This includes the growing need for prior authorizations by insurance companies, increasing documentation requirements, increased burden of pay for performance initiatives, increasing maintenance of certification requirements, and increased consumerism of medicine with no obvious connection to improved patient outcomes. This along with the recent COVID-19 pandemic is resulting in increased physician burnout and may ultimately drive many physicians to an early retirement at a time when there is an increasing demand for providers to care for an aging and complex population.[29]

The cumulative results of these external pressures on the health care system is meant to drive change from the traditional FFS system to a value-based system. Significant change must occur over the next decade to fully implement value-based care. This current environment presents an important opportunity for physician leaders to combine their clinical background with leadership skills. In this way, physician leaders can help other practitioners understand novel payment models in a distinct and different way at a time when strong “expert” leadership is needed.[30] The American College of Physician Executives includes physician leadership as one of its nine essential elements required to provide optimal patient-centered care. The organization believes that, to succeed, health care must be quality-centered, safe, streamlined, measured, evidence-based, value-driven, innovative, fair and equitable, and physician-led.[31]

PHYSICIAN LEADERS

Traditional physician leaders were chosen based on their credentials, seniority, clinical competency, and political standing.[1] One’s individual legacy as a clinician, educator, and researcher was valued above all else when selecting a physician leader. This practice begins with the intense socialization process of physician training. The health profession is founded on a rigorous scientific discipline that values autonomous decision making, personal achievement, and the importance of improving one’s own performance rather than that of an institution.[1,27] Medical schools value and encourage individuals who look to self, not others, for answers. Consequently, physicians are often put into leadership roles based on their standing as a respected physician in their field. This model was successful when physician leaders were expected to be advocates for resources and liaisons between administrators and other physicians.[27] As we continue to evolve, the skills required to be a successful physician leader are changing and may not now be the same skills required to be an effective physician. To address the gap in skills between traditional physician leaders and more formally trained physician leaders, health systems often pair physicians with an administrator. The dyad leadership model has been important for the growth of traditional physician leaders but can also hinder physician leaders when administrators step in to fill the skill gaps verses mentoring and ultimately empowering

the physicians to acquire these skills themselves. Furthermore, although institutional and larger independent providers may have the resources to support this model, this is much more complicated for smaller groups. The current climate calls for strong physician leaders with high emotional intelligence, knowledge of the business of health care, formal leadership training, and team building skills in addition to their clinical acumen and professional standing.[17]

This transformation may be particularly challenging for independent groups. In urology, as increasing numbers of physicians are institutionally employed, a simultaneous trend is the formation of large urology-centric groups; by 2016, such groups provided more than a third of the nation's urologic care.[32] These groups typically coalesce around individual physicians who use a charismatic model of leadership; this model relies on "their ability to communicate in a moving, emotionally charged way. By expressing their visions with power and inspiring trust, they influence those they lead and persuade them into action."[33] Once formed, effecting change may require completely different skills than that required to actuate formation of the group[34]; engagement of different stakeholders and delegating authority may be a challenge for physicians accustomed to a more top-down leadership structure. The anthropologic concept of liminality, which describes an intermediate state in a rite of passage, appropriately describes the transition between clinician and administrator.[35] Physicians in this liminal state face challenges in which their leadership roles and needs of the institution may not be completely consistent with their historical personal goals; understanding how to modify their historical individual use of power to a more distributed model is key to this transition.[36]

Transitioning from a physician to a physician leader is challenging in other ways. As physicians move into administrative positions they work more closely with administrative leaders. Historically, there has been a large cultural divide between physicians and administrators resulting in distrust between the two.[37] Physicians come from an expert culture in which its members are cohesive and have a highly developed personal identity. The culture is based on biomedical sciences and the scientific method. Physicians rely on hard facts and are suspect of soft data. They typically have minimal exposure to the business side of health care. Their focus is on the individual patient with physicians viewing themselves as the champions of patient care. They assume that resources are unlimited and should be available to all to maximize quality. They work autonomously and are experts at problem solving, working under pressure, and rapid decision making.[38]

The administrative culture, however, is one built on social and management sciences. It has a collective focus with the group valued over the individual. Administrators use soft qualitative data and have a loose professional identity. They embrace organizational values, missions, and visions. Decision making is usually team based. Most have minimal exposure to health care professionals or front-line clinical care. They focus on populations verses the individual patients. They view themselves as the protector of the hospital where resources are limited and so allocated appropriately.[38]

As physicians move into leadership roles, it is important to understand the cultural differences along with the new skill requirements that one needs, which is a source of frustration in the new role. The transition from physician to physician leader requires a shift from technical competence and clinical expertise to more soft skills, such as team building and relationship building. Physician leaders must leave the command and control methods behind in favor of a more collaborative style.[30] They must move from acting to visioning and strategizing. The pace of change at the system level is often much slower than with clinical care. Challenges are often not clearly defined, and without an obvious solution. There is a need to approach problems in a team-based manner, which can lead to anxiety around the dependance on others. There may be a loss or changes in old relationships with colleagues and peers and challenges in forming new ones. As the physician transitions into the administrative role they can often be viewed by their colleagues as "going to the dark side" or becoming a suit. Administrators are also often weary of physicians, viewing them as the reason for the high costs of care. This can lead to a questioning of one's professional identity. There may be a lack of self-confidence in the new role as they begin the transition.[37] It is important for health systems to be aware of these challenges and provide continued support for these physicians as they move into their leadership roles.

Physicians inherently have many of the qualities needed in leaders. They are fast learners, outcome driven, comfortable with responsibility and decision making, have high expectations, and an unparalleled work ethic.[30] That being said, they often need to modify the way they approach things and at the same time acquire new skills. Professional organizations, including the American Association for Physician Leadership, formerly the American College of Physician Executives, have created a list of some 300 competencies needed

in a physician leader. They grouped them into five primary areas: (1) knowledge of the health care environment, (2) professionalism, (3) communication and relationship management, (4) business skills and management, and (5) leadership.[2,30]

TRAINING PHYSICIAN LEADERS

Urologic leaders, like urologic surgeons, are not born. They are made by years of training. However, traditionally there has been little leadership training in medical school, residency, or throughout most urologic careers. In addition, there are physicians in practice who are moving into leadership roles and thus, we must be able to provide education at all points in one's career. Current medical school curricula are beginning to incorporate basic leadership training, but it is not universal, and the methodology varies from institution to institution. There is no consensus or data to determine the best method for teaching leadership, the areas to be taught, or the timing of the coursework. Most of the courses are taught by clinical faculty, and most are taught in an isolated fashion, not longitudinal over time.[39] Medical school curricula are often already impacted and some programs are even shortening the training to 3 years making it even more difficult to incorporate a formal leadership program. It is recognized, however, that even early in one's training there is a need for trainees to work collaboratively across disciplines, lead teams, and train and mentor those in junior positions.[39] Medical schools should consider selecting medical students with the desired leadership qualities by putting more emphasis on the human and interpersonal skills on the Medical College Admission Tests and entrance criteria. They need to be encouraged to offer leadership modules, at least as electives, in the last year of medical school, which can then be continued throughout training and beyond. During residency, there should be lectures on the elements of leadership and required reading assignments. Three skills that all physician leaders require are (1) to speak well, (2) to write well, and (3) basic business acumen. Residency program directors need to provide opportunities throughout training for residents to acquire these skills. In the same manner that residents receive feedback on their surgical and clinical skills, there should be formal feedback on their leadership development.

Leadership training should not cease at the time of residency graduation. The American Urological Association offers a well-structured and valuable leadership program that is available to American Urological Association members; Large Urology Group Practice Association and the American Association of Colleges & Universities offer topic-specific programs to enhance physician management skills knowledge base. Many universities offer truncated executive business training programs and some individuals may opt to enroll in formal master's in business administration or master's in public health programs.

Currently, there are some programs that offer an MD and a formal master's in business administration degree together.[12,37] Some professional organizations offer postgraduate opportunities, such as the American Association for Physician Leadership and American College of Healthcare Executives, and many institutions, such as Mayo Clinic and the Cleveland Clinic, offer their own in-house programs.[2,39] The most successful programs incorporate a formal curriculum on the business of health care and leadership skill with mentorship and coaching by role models in addition to experiential learning in progressive leadership roles.

LEADERSHIP ROLES FOR UROLOGISTS

Urologic leadership takes on many roles. It is not limited to roles within the medical profession. Although within academic urology obvious leadership positions include chairpersons and program directorships, in private practice urology leaders are needed as managing directors. Other urologists will serve as chief medical officers, CEOs, or, in some cases, deans. Other leadership opportunities include editorial positions and serving on hospital and medical school committees.

In addition to the formal positions outlined previously, urologists use leadership training every day in practice. When a urologist is in the operating room or in clinic, he or she is leading a team where leadership training has tangible applications.

Finally, physicians are respected leaders in their community and their fellow citizens often look to them for guidance on a variety of topics. It is not unusual to observe urologists on school boards and town councils or as authors on op-ed and other newspaper articles. Urologists should be aware that leadership has many faces. Nowhere has the opportunity for civic leadership been more apparent than in the recent COVID-19 crisis.

WHAT MAKES A GOOD LEADER?

Although leadership styles differ, there are seven traits that are common to leaders.[40]

1. *Integrity*. Integrity is the most important leadership quality. Former Wyoming senator, Alan K. Simpson summed it up best, "If you have

integrity, nothing else matters. If you don't have integrity, nothing else matters."

2. *Vision*. In the rapidly changing field of urology, vision is a quality that is essential for a leader. Vision facilitates the establishment of priorities, allocation of resources, and strategic planning.
3. *Be a Good Listener*. Beware of those who interrupt. Not only do good listeners show respect for their colleagues, they learn by listening. Good listeners are good students. The corollary to being a good listener is being a good observer. Tom Peters, the Stanford management guru said, "You can learn a lot by just walking around."[41]
4. *Humility*. Many surgeons do not like to use the words, "I don't know." Not only are these important words for a surgeon, they are particularly important for a surgical leader. Humility, rather than a weakness, actually empowers the leader. Hubris is not a leadership quality. Those who consider themselves the smartest person in the room are invariably not.
5. *Persuasion Not Power*. The surgical world engenders ad hoc pronouncements. Although, at times, the leader must mandate a policy, often arbitrary, the effective leader looks at the long game. If policies and decisions are arrived at by persuasion, by consensus, that leader banks future credibility and trust, which is invaluable.
6. *Avoid Isolation*. Many leaders, either by position or temperament, become isolated. This is a dangerous circumstance for a leader. A good leader should encourage a coterie of close advisors who he or she can trust. A leader needs to have someone who will say directly, "I think you are wrong." In her book, *Team of Rivals*,[42] the presidential historian Doris Kearns Goodwin emphasized that one of the qualities that made Abraham Lincoln such a great leader was his ability to value the opinions of those who disagreed with him.
7. *Arrogate Not, Be Unselfish*. It is easy for those in power to unfairly take credit for accomplishments that were not their own. Most academic urologists have observed senior faculty arrogating the accomplishments of junior faculty or residents. When this occurs, it severely undermines morale and any spirit of teamwork and unselfishness, which are critical components of good leadership.

HOW ARE UROLOGIC LEADERS SELECTED?

The short answer to this question is in too many cases, the selection is arbitrary and not thoughtful. An individual with a lengthy curriculum vitae or a robust grant history may be given a leadership position without either the temperament or experience to function as an effective leader. The same traits that contributed to the publication and research accomplishments do not necessarily translate into leadership skills. The chairperson or professor who continues to be primarily focused on their own ongoing achievements, often neglects the time and energy required to lead and mentor others. Mature leaders realize before accepting a leadership position that it is necessary to put many of their own goals on hold. A hallmark of a good leader is one who is amplified by the accomplishments of their colleagues, rather than be threatened by them. Too often that is not the case.

One of the strengths of our profession has been the emerging role of women and minorities. This presents our specialty with a challenge and an opportunity. Leadership training needs to be modified to train a more diverse constituency. Women, in particular, have already made enormous contributions to the world outside of medicine. Of 195 countries, 70 have had women leaders and females occupy almost 20% of Congressional seats.[43] Medical schools and health systems must invest in flexibility policies (job sharing, part-time work) and faculty development and mentoring.[20] Organizations must make a concerted effort to hire women and minorities.

To continue to be leaders in health care delivery and advance urology, the talent pool needs to be expanded beyond White men. Diversity has the potential to be urology's greatest strength. The increasing influence of female urologists and the greater representation of diverse ethnicities and cultures serve to better populate leadership resources and to better serve the multicultural population of the United States.

EMOTIONAL INTELLIGENCE, THE UNDERPINNING OF LEADERSHIP

In 1995, Goleman[44] published his landmark book, *Emotional Intelligence*, which has been part of most business school curricula ever since. In it, he argues that emotional intelligence is as important as IQ for success. He identifies the elements of emotional intelligence as self-awareness, self-regulation, motivation, empathy, and social skills.[44] These characteristics are the underpinning of leadership. As urologists, it should be our goal to develop these qualities in ourselves and in those who we identify as our future leaders. The mantra for urologic leaders was captured by Bill Gates when he said, "As we look ahead into the next century, leaders will be those who empower others."

CLINICS CARE POINTS

- The rapidly evolving health care environment is resulting in an increased need for leaders with clinical expertise and strong business acumen. This is driving many health care systems to hire and develop physician leaders with formal business training.
- Increasing diversity at all levels of the health care workforce is needed to decrease health care disparities. Additionally, increased diversity within leadership has been shown to improve medical quality and financial outcomes.
- The transition from a physician to a physician leader often requires that the physician acquire a strong business knowledge of health care, and develop their leadership skills with an emphasis on emotional intelligence and team building.
- Physician leadership training should begin in medical school and continue throughout their training and into their careers.
- Physicians are often viewed as natural leaders. Building on this with formal training in the business aspects of health care, urologists can and should take on leadership roles within their practice or health system and within their community.

DISCLOSURE

The authors have nothing to disclose.

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