Physicians in health care management: 1. Physicians as managers: roles and future challenges

Peggy Leatt, PhD

Physicians are increasingly expected to assume responsibility for the management of human and financial resources in health care, particularly in hospitals. Juggling their new management responsibilities with clinical care, teaching and research can lead to conflicting roles. However, their presence in management is crucial to shaping the future health care system. They bring to management positions important skills and values such as observation, problem-solving, analysis and ethical judgement. To improve their management skills physicians can benefit from management education programs such as those offered by the Physician-Manager Institute and several Canadian universities. To manage in the future environment they must increase their knowledge and skills in policy and political processes, financial strategies and management, human resources management, systems and program quality improvement and organizational design.

On attend de plus en plus des médecins qu'ils se chargent de la gestion des ressources humaines et financières dans le domaine des soins de santé, et particulièrement dans les hôpitaux. Ceux qui doivent établir un équilibre entre ces nouvelles responsabilités administratives, les soins cliniques, l'enseignement et la recherche peuvent se retrouver dans des rôles contradictoires. Or, leur présence dans le domaine de la gestion joue un rôle crucial dans l'orientation de l'avenir du système de santé. Ils contribuent au processus de gestion des compétences et des valeurs importantes : observation, solution de problèmes, analyse et jugement éthique. Afin d'améliorer leurs compétences de gestion, les médecins peuvent tirer parti de programmes de formation en gestion comme ceux qu'offrent l'Institut de gestion médicale et plusieurs universités canadiennes. Afin de savoir gérer dans l'environnement de l'avenir, ils doivent améliorer leurs connaissances et leurs compétences dans des domaines comme les politiques et le processus politique, les stratégies et la gestion financières, la gestion des ressources humaines, l'amélioration de la qualité des systèmes et des programmes et la conception de l'organisation.

This article is the first in a series on the increasing involvement of physicians in managing the health care system. This article delineates the various managerial roles physicians can assume and challenges they will face; subsequent articles in the series will emphasize the knowledge and skills necessary for effective health care management.

Patterns of medical practice in Canada are changing for many important reasons: growing government concern about rising health care costs, pressure from the medical profession to ensure cost-effectiveness in practice and changes in the need for medical professionals. Physicians are accordingly expected to expand the variety of roles they assume in health care organiza-

Dr. Leatt is professor and chair, Department of Health Administration, University of Toronto, Toronto, Ont.

Reprint requests to: Dr. Peggy Leatt, Department of Health Administration, 2nd floor, McMurrich Building, 12 Queen's Park Cres. W, Toronto, ON M5S 1A8

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tions (hospitals and other organizations providing health care services).[1] For example, physicians now provide not only care and treatment for patients but also expert opinion for other physicians and health care providers, teachers and researchers.

Physicians have historically had a leadership role in health care delivery; however, in the past decade they have increasingly assumed major managerial responsibilities (beyond management of solo or group practices) in the health care system. Physicians from a broad range of specialties advise federal, provincial and local governments on policies concerning medical practice, appropriateness of care and organization of the health care system.[2]

The greatest increase in physicians' involvement in managerial decision making, however, is taking place in hospitals. Physicians, hospital administrators and managers, and trustees are recognizing the advantages of working together to make appropriate decisions, with patients' interests at the forefront.[3] Hospitals' traditional "dual hierarchy," in which the medical staff forms a second line of authority beside the administrative staff, clearly no longer works. Canadian hospitals are trying various mechanisms to integrate physicians into the decision-making processes, including appointing physicians to boards of trustees, board committees and senior management committees. Physicians are now routinely involved in issues affecting the entire hospital — strategic planning, capital and operating budgets, information systems design and quality improvement.[4-6] They are also asked to become salaried line managers, assuming such positions as vice-president or chief of a department or service, and to manage decentralized clinical programs. Appointing more physicians as managers is a trend not only in Canada but also in the United States (where administrative medicine has been described as a new medical specialty),[7-9] the Netherlands[10] and Britain.[11,12] The introduction in hospitals of new organizational designs that decentralize decision making to clinical programs or strategic business units reinforces the critical need for physicians to take on managerial roles.[13,14] Shortell[7] welcomed this integration of administrative and clinical decision making as a way to bring clinical expertise to bear on managerial issues and provide physicians with a legitimate organizational role.

Roles of physician managers

For physicians taking on managerial responsibilities the most important change is that they are now accountable not only for their own actions but for the work of others — a traditional line-management role. In health care organizations, because decision making is complex and involves a wide variety of health care professionals, there are many modifications of this managerial role. The following, adapted from Elliot Jaques,[15] describes some examples of such roles (also illustrated in Fig. 1).

- Managerial role: A managerial role is represented by a direct line relationship between two staff members in which one staff member is fully accountable for the work of the other. The manager is expected to be responsible for the selection of the other staff member, providing him or her with orientation to the role, assigning work, evaluating performance and providing training. The manager also has the authority to modify the staff member's duties as necessary and arrange transfer or dismissal if required. This relationship is a classic line-management role, like that recently assumed by physicians-in-chief who are accountable for the work of residents and interns. Because of the level of professional autonomy enjoyed by physicians, there were no true managerial roles in medicine until recent years.
- Staff role: Organizations frequently create staff positions when a manager needs assistance in managing his or her subordinates. A staff role usually involves formulating policies and seeing that they are implemented. The staff person requires authority from the manager to issue selected instructions to the subordinates. These subordinates cannot ignore the instructions, but if they disagree they can take the problem to the manager. Staff positions are often created to provide education; for example, a clinical instructor or educational specialist who is asked to explain new clinical procedures to other physicians is taking a staff role.
- Collateral role: This type of relationship exists when two people, subject to the authority of a common manager, need to work together and adjust to each other to complete a task — for example, two physicians from different specialties treating the same patient. When colleagues in a collateral role disagree, the common manager must resolve the dispute. In the example of two specialists, this manager is the physician most responsible for the patient's care. Alternatively, in the hospital hierarchy, it could be the medical director or vice-president in charge of medical affairs.
- Monitoring role: A monitoring role is commonly assigned in health care organizations when it is necessary to ensure that another professional conforms to organizational or professional standards but a line-management relationship is inappropriate. For example, when a new surgeon is taken on staff, his or her work in the operating room may be monitored during a probationary period.
- Representative role: Physicians are sometimes elected or appointed to represent a particular group on a committee, board or task force. It is often unclear to what extent these representatives may express their own views instead of the views of the group they represent. In a truly representative role the person expresses the consensus of, and is accountable to, the group. Such representatives must, however, have some discretion in negotiating with others. In hospitals in some provinces the president of the medical staff association is a voting member of the board of trustees and must represent the medical staff as a whole on the board.

• Coordinator role: It is frequently necessary to appoint one person to coordinate the work of several others when a managerial relationship is inappropriate. The coordinator may propose actions, new strategies and programs but has no direct line authority. Disagreements between staff members must be resolved by higher authorities. A recent trend for health care organizations to appoint clinical program managers with limited line authority is an example of creating a coordinator role.

• Secondment role: When a staff member is transferred to a new position for a limited period, the original manager retains official accountability for him or her. It is particularly important that the original manager still have long-term responsibilities for the staff member's performance appraisal and career development. The secondment manager's role is to supervise and appraise the staff member's work on the short-term assignment.

Potential for role conflict

Physicians must be responsible to their health care organization and at the same time act as unreserved advocates for their patients.[16] Thus, taking on organizational responsibilities for cost containment and rationalization of services or programs can be particularly challenging.[17]

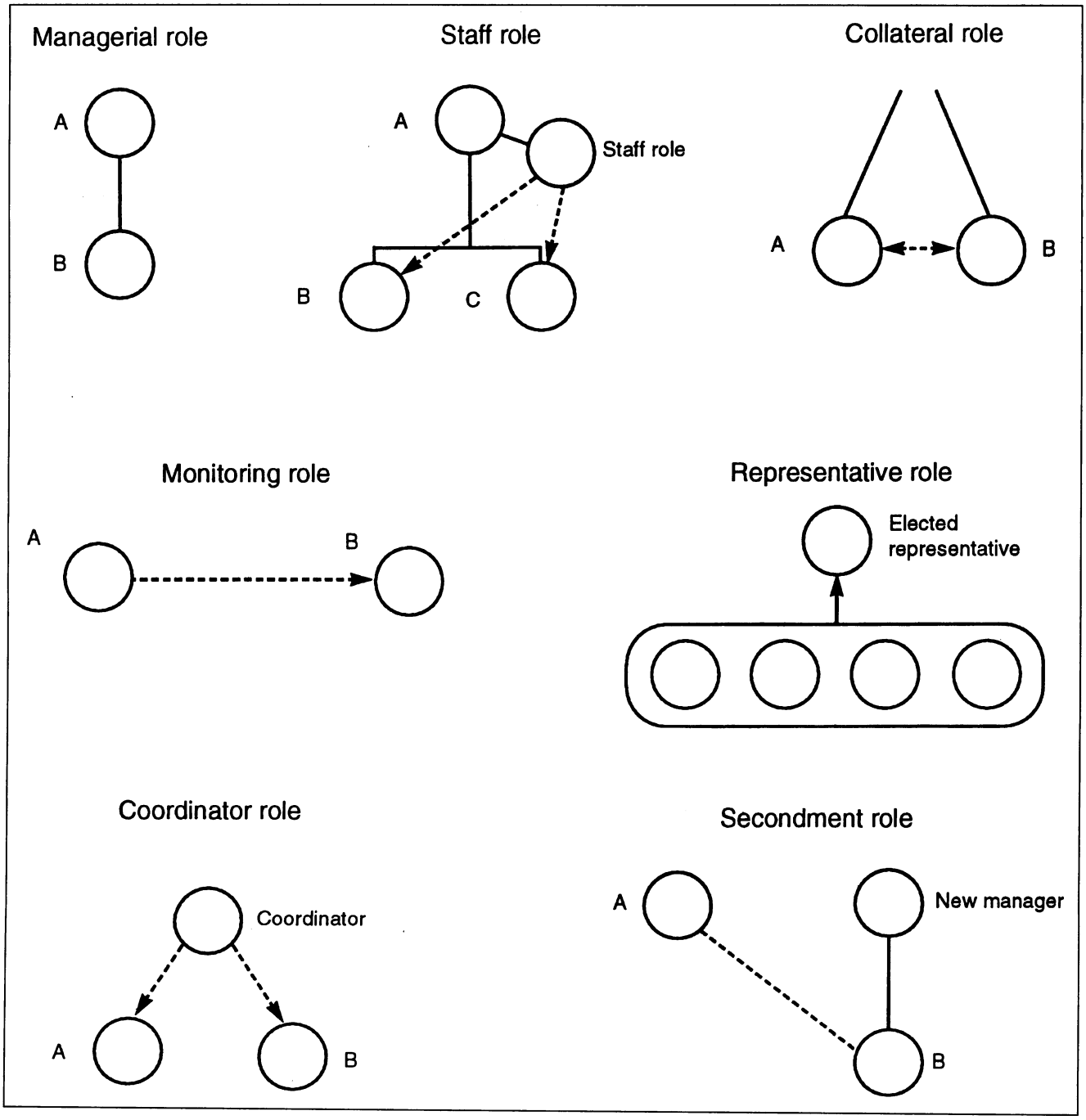

Fig. 1: Types of roles assumed by physician managers.

Physician managers function as part of a network of professional positions critical to their activities, called a "role set." The role set includes subordinates, supervisors and peers as well as positions outside the organization. Patients or clients may also be considered important members of a physician's role set. Members of the role set may have expectations of the physician manager that are incompatible. Role conflict occurs when the expectations of the person in a particular role differ from those of members of the role set. Situations with the potential for role conflict include the following.

- The members of the role set believe that the physician manager is spending too much time participating in hospital activities away from his or her clinical work.
- Teaching and research responsibilities, especially in academic medical centres, are incompatible with hospital expectations.
- Organizational decisions about program priorities have implications for patient care.[18]

Hospital administrators and boards of trustees have traditionally decided the priority of clinical and rationing programs. Greater involvement of physicians in hospital-wide decisions is good because clinical factors will be considered when setting priorities. However, the potential for physicians to be caught in ethical dilemmas has led to considerable discussion. It is not yet clear whether taking on managerial roles helps physicians to perceive and resolve such dilemmas.[17]

Changing career paths

Much has been written about professionalism in medicine and medicine's place at the top of a hierarchy of health professions.[19,20] Physicians occupy this position because society has granted them considerable autonomy in deciding patient care and treatment. The medical profession has the authority to control the content of physicians' professional work and the formal organization of medical practice. These key characteristics must be retained; however, there are indications that traditional professional autonomy is changing under pressures from outside the profession to control costs. Examples of changing patterns in the United States, many of which are gradually emerging in Canada as well, include changes in hospital and medical reimbursement systems for diagnosis-related groups, hospital resource allocation based on the use of Case Mix Groups and Resource Intensity Weights, the growth of comprehensive health organizations (prepaid group practices) and alternative payment plans (health maintenance organizations) that limit physicians' independent authority, the development of medical practice guidelines from "appropriateness-of-care" research, and a variety of other regulations to control costs.[21,22] Some observers are concerned that physicians' greater involvement in managerial activities may lead to further erosion of medical autonomy.

I believe that physician-manager roles are crucial as the tension between health care as a social good and as an economic good increases. Several US studies have shown that US physicians are assuming a broad range of management functions (beyond medical management) and that many young physicians are assuming part-time managerial responsibilities.[23] More recently, a survey conducted in the United States has shown that older physicians are spending even larger proportions of their time on management issues and that top physician executives may spend 10% or less of their time on clinical activities.[24]

Early in their careers, physicians with a particular interest in management may serve on committees and boards or work on special projects with organization-wide implications. Physicians' first managerial experience is often obtained in position with a medical staff association at a hospital, or as chief of service or staff. These positions tend to be temporary, and it is assumed that the physicians will return to full-time clinical careers. More recently, we have begun to see more physicians considering dramatic career changes to top management positions in hospitals or provincial ministries of health. These positions require full-time devotion to management or leadership; thus, reversion to clinical practice is unlikely.

Physician managers possess important built-in skills and values derived from their clinical roles. During medical and residency training, physicians learn to observe and solve problems through a meticulous, analytic approach to diagnosis and treatment and to weigh the ethical considerations required for making optimal decisions. Physician managers must have these skills and values as well, but they must change the level of analysis. Physicians' clinical decisions focus on the interests of the patient; physician managers' decisions are made in a broader context and must take into account such interests as those of a program, a department, a hospital or a system. To help physicians achieve management expertise various organizations have designed diverse educational programs, ranging from excellent short courses offered by the Physician-Manager Institute[25] to 2-year graduate university programs in health administration.[26,27] Physicians seeking management education should match their learning style with the available programs.[28]

The future environment

As governments exert greater control over health care organizations and practitioners in order to contain costs, the medical profession will have to become involved in policy formation and management of the health care system at all levels.

It will be a question not of whether physicians should participate in decisions about the health care system but, rather, how to foster their participation. Many physicians will face important choices in balanc-

ing clinical, teaching, research and management roles.

To participate fully in creating the future health care system physician managers must increase their knowledge and skills in a number of critical areas.[29]

• Policy and political processes: Physicians must learn how health policy is formed and influenced, and develop strategies to influence it effectively. This means they must engage in meaningful dialogue with all levels of government. Physicians must also know the economic conditions affecting the health care system and the range of financial options for paying physicians and funding hospitals; they must explore the implications of these options for their practice and the health care system.

• Client- or patient-focused approaches: Physician managers must understand population-based approaches to health care services and their implications for medical practice and service management. Techniques for conducting community needs assessments and market analyses will become fundamental to all managers. Mechanisms to allow communities and clients to participate fully in health care system decisions will be essential.

• Decisions based on data: As information technologies become more sophisticated, an almost unlimited amount of data about costs, quality and outcomes will become available. Physician managers will be expected to use these data in their decisions and to help other managers interpret and respond to this information.

• Program definition and management: As many hospitals and other health care organizations are compelled to reconsider their mission, they are defining their program priorities more clearly. Physicians must participate in and sometimes manage all phases of individual programs — planning, budgeting, evaluation and outcome.

• Strategic alliance building : Most hospitals are redefining their role as part of a network of organizations providing services to common customers. There is an increasing trend to provide programs and services through shared arrangements, joint ventures, contracts, consortia and mergers. There will likely be an increase in the number of regional program arrangements that cut across traditional hospital or institutional boundaries.[30,31]

• Systems-level quality improvement: Although several Canadian hospitals have started organization-wide strategies for quality improvement, these strategies are expected to expand to the whole health care system. Wide-scale quality improvement will require more sophisticated information about costs and quality indicators. Physician managers will be integral not only in identifying clinical processes that can be improved but also in implementing quality-improvement recommendations.

• Human resources management: As management paradigms shift to greater empowerment of individual workers and to team or collaborative approaches, physician managers are expected to provide leadership for many groups. It will be essential that they understand how to provide leadership without having line managerial authority and that they play a major part in all human resource activities including performance appraisal and team building. We can expect to see a greater emphasis on new positions filled by multiskilled workers who come from different disciplines and who have overlapping roles. Physician managers will require expertise in handling conflict and in negotiating among various interest groups because many of the new, evolving organizational designs make physician managers more accountable for both cost and quality.

Physicians who assume management responsibilities will have a major function in shaping the future of the health care system. They will be expected to play a leadership role with other health managers in creating the organizational cultures needed to help health care organizations respond to this future environment.

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Conferences
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Apr. 24, 1994: Association of Canadian Medical Colleges 6th Conference on Physician Manpower
Vancouver
Eva Ryten, Association of Canadian Medical Colleges, 1006–151 Slater St., Ottawa, ON K1P 5N1; fax (613) 594-3364

Le 24 avr. 1994 : Association des facultés de médecine du Canada 6e conférence sur la main-d'oeuvre médicale canadienne
Vancouver
Eva Ryten, l'Association des facultés de médecine du Canada, 1006–151, rue Slater, Ottawa, ON K1P 5N1; fax (613) 594-3364

Apr. 25–26, 1994: Canadian Pharmacoepidemiology Forum
Toronto
Abstract deadline: Feb. 1, 1994
Dr. C. Ineke Neutel, Health Protection Branch, Health Canada, 3rd floor E, Sir F.G. Banting Research Centre, Tunney's Pasture, Ottawa, ON K1A 0L2; tel (613) 954-6745, fax (613) 966-8774

Apr. 25–26, 1994: International Symposium on Inherited Epidermolysis Bullosa (cosponsored by the Office of Continuing Medical Education, University of North Carolina School of Medicine, and by the National Epidermolysis Bullosa Registry; precedes the annual meetings of the Society for Investigative Dermatology and the American Federation for Clinical Research)
Chapel Hill, NC
Dr. Jo-David Fine, Department of Dermatology, University of North Carolina at Chapel Hill, 137 NCMH, CB 7600, Chapel Hill, NC 27514; tel (919) 966-3321

May 8–11, 1994: Canadian Long Term Care Association Annual National Conference (cosponsored by the Newfoundland Hospital and Nursing Home Association)
St. John's
Canadian Long Term Care Association, 302–260 St. Patrick St., Ottawa, ON K1N 5K5; tel (613) 237-9837, fax (613) 237-6592

May 12–14, 1994: Cardiovascular Technology Symposium
Ottawa
Abstract deadline: Feb. 28, 1994
Susan Menzies, University of Ottawa Heart Institute, 201–1053 Carling Ave., Ottawa, ON K1Y 4E9; tel (613) 761-4794, fax (613) 761-5323

May 19–20, 1994: Centre for Health Economics and Policy Analysis 7th Annual Health Policy Conference — Rethinking Primary Care
Alliston, Ont.
Lynda Marsh, Centre for Health Economics and Policy Analysis, Department of Cinical Epidemiology and Biostatistics, McMaster University, 1200 Main St. W, Hamilton, ON L8N 3Z5; tel (905) 525-9140, ext. 22135; fax (905) 546-5211

May 25–28, 1994: 10th Canadian Heart Health Network Meeting — Women and Families: the Heart of the Matter
Saint John, NB
Abstract deadline: Apr. 8, 1994
Sharon Elliott, Secretariat, Canadian Heart Health Network, 200–160 George St., Ottawa, ON K1N 9M2; tel (613) 241-4361, ext. 317

May 31–June 2, 1994: Centre for Studies of Children at Risk Inaugural Symposium — Improving the Life Quality of Children: Options and Evidence
Hamilton, Ont.
Peggy McAlpine, Department of Psychiatry, Chedoke–McMaster Hospitals, PO Box 2000, Stn. A, Hamilton, ON L8N 3Z5; tel (905) 521-2100, ext. 7358; fax (905) 574-6665

June 22–26, 1994: International Congress for Lung Cancer
Athens, Greece
Abstract deadline: Jan. 31, 1994
Official languages: English and Greek
Olympic Sun S.A., 7, Voulis St., 10562 Athens, Greece; tel 011-30-1-323-0083 or 322-6646 or 324-5979 or 322-3739 or 325-5248, fax 011-30-1-322-9149 or 322-5428

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