PERSPECTIVES

Developing Physician-Leaders: A Call to Action

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BACKGROUND: The many challenges in health care today create a special need for great leadership. However, traditional criteria for physicians' advancement to leadership positions often regard academic and/or clinical accomplishments rather than the distinctive competencies needed to lead. Furthermore, physicians' training can handicap their developing leadership skills. In this context, an emerging trend is for health-care institutions to offer physician-leadership programs.

METHODS AND RESULTS: This paper reviews the rationale for developing physician-leaders. Factors that underscore this need include: (1) physicians may lack inclinations to collaborate and to follow, (2) health-care organizations pose challenging environments in which to lead (e.g., because of silo-based structures, etc.), (3) traditional criteria for advancement in medicine regard clinical and/or academic skills rather than leadership competencies, and (4) little attention is currently given to training physicians regarding leadership competencies.

CONCLUSION: Definition of these competencies of ideal physician-leaders will inform the curricula and format of emerging physician leadership development programs.

KEY WORDS: leadership; physician-leader; competencies; organizational development.
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INTRODUCTION

Because great leadership is a characteristic of successful organizations, developing a pipeline of leaders is a priority of frontrunner organizations. As Kotter states, "Successful corporations don't wait for leaders to come along. They actively seek out people with leadership potential and expose them to career experiences designed to develop that potential."[1]

Another important characteristic of successful organizations and their leaders is the ability to embrace change.[1–3] Indeed, ample evidence supports the relationship between being change-avid and business success.[4–6] For example, in a study of 160 companies across 40 industries, Joyce et al.[6] reported that businesses with performance-oriented cultures and fast, flexible structures outperformed competitors over a 10-year period. Also, Collins and Porras[5] searched for companies with enduring qualities that made them industry leaders. Such so-called "visionary companies" showed that $1 invested in such companies would have grown to $6,356, >15-fold higher than the general market.

Though developing great leaders and embracing change are well-established characteristics of frontrunner organizations in many industry sectors, health-care institutions have generally lagged behind and are just recently awakening to the importance of developing physician-leaders.[7] This perspective addresses the rationale and need for developing physician-leaders.

THE RATIONALE FOR DEVELOPING PHYSICIAN-LEADERS

Health-care organizations pose special leadership challenges for several reasons. First, health-care organizations are complex, usually characterized by many professional work forces and silos or "fiefdoms."[8–10] Second, characteristics of physicians and of their training conspire against their having "reflexes" for collaboration or followership,[9–11] traits that are needed for effective teamwork that leaders must harness for positive organizational change. Third, the demands of training and, in academic settings, of developing academic skills and performance, often compete for physicians' attention to mastering leadership competencies, thereby potentially handicapping physicians' leadership skills. Finally, health care today faces a number of pressing challenges regarding access, affordability, and quality.[12] These challenges call for and, in fact, demand great leadership from within health care.

Beyond the challenges of the hospital environment, Leatt and Porter offer a systems view that cites features of the health-care environment that pose special challenges for leadership, including that:[13]

1. the external environment (e.g., insurance, reimbursement, regulation) is very complex and dynamic,
2. new technologies are continuously evolving and the evidence about their effectiveness may be incomplete,
3. the professional workforce is difficult to manage, and
4. the goals of service delivery are multiple and potentially competing, e.g., the tension between expense, clinical care, and patient quality.

Compounding the complexity of the health-care system are the characteristics of physicians, who value autonomy and, outside of structured interactions (like the operating room or intensive care unit), may be disinclined to collaborate or to

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follow.[10–11,14–15] In assessing why organizational development had not worked in hospitals, Weisbord[9] stated that "science-based professional work differs markedly from product-based work. Health professionals learn rigorous scientific discipline as the 'content' of their training. The 'process' inculcates a value for autonomous decision-making, personal achievement, and the importance of improving their *own* performance, rather than that of any institution." Also, Kornacki and Silversin[10] point out that "physicians do not typically see themselves as followers; therefore, they do not readily acknowledge leaders to have any more authority than that required to call meetings or to represent physicians' interests. Effective leadership among physicians calls for…recognition on physicians' part of leaders' authority." Finally, Stoller[11] has suggested four features of physicians and of their training that may conspire against their having instincts or "reflexes" to collaborate, i.e., physicians: (1) experience long and hierarchical training, often with extended subordination, (2) are extensively evaluated, usually based on individual performance (e.g., board certifications, competition for training slots, etc.) rather than on group or team-based performance (which many suggest is more relevant to achieving excellent clinical outcomes[5,14,15]), (3) may experience "extrapolated leadership," in which they extend the clinical authority that is conferred to them by patients to settings for which it is irrelevant (e.g., driving on the highway, getting on an elevator, etc.), and (4) are "deficit-based thinkers;" specifically, because differential diagnostic thinking encourages physicians to identify problems (deficits) and because clinical skill reinforces the value of problem-solving, physicians may be hampered in their ability to adopt an "appreciative" type of thinking that is felt better suited to solving organizational challenges.[16] As an example of appreciative thinking, appreciative inquiry[16] is an approach to organizational change and opportunity that builds momentum for change based on images of "the best of what could be" rather than the shortcomings of the present state. Because of the strong reflex for deficit-based thinking, physician-leaders must learn to switch nimbly between different reasoning and thinking processes—one that is "deficit-based," narrowly focused, and well-adapted for clinical practice and another that is more divergent or "appreciative" for thinking about organizational or system issues and challenges.[11,16]

Furthermore, interviews of ten academic internal medicine chairs identified several critical leadership success factors,[17] including mastery of visioning, communication, change management, "emotional intelligence" (EI),[18–19] team building, business skills, personnel management, and systems thinking. Emphasizing the importance of EI, which consists of competencies regarding self-awareness, self-management, social awareness, and relationship management,[18–19] these chairs "stated that this ability was fundamental to their success and its absence the cause of their failures."[17] To the extent that the current selection of academic leaders may place greater priority on traditional academic and clinical success than on leadership readiness or skill, a gap and opportunity are identified. As one chair stated, "The fact is that the majority of chairs are chosen for skill sets that have little to do with the skill sets they are going to need to use." In this gap between current practice and actual need lies the rationale and energy to develop physician-leaders.

Though the evidence that great physician-leadership confers clinical and organizational benefit is sparse and demands greater study,[17] early findings support the value of excellent leadership. For example, Xirasagar et al.[20] have reported that physician-leaders' "transformational leadership"—which reflects four elements (idealized influence, inspirational motivation, intellectual stimulation of those led, and individualized communication)—was significantly associated with perceived leadership effectiveness (R^2=0.687, $p<0.0001$) and, in a sample of community health centers, with the achievement of clinical goals (e.g., hemoglobin A1C levels in diabetics, functional status scores in geriatric patients, etc.). Still, more research is needed to further examine the deliverable benefits of great leadership in health care.

Going beyond the leadership deficits of traditional medical training, the healing mission and ethical imperative of medicine further underscores the importance of optimizing physician-leaders' skills. Congruence with a healing mission requires that physician-leaders possess and model the traits of compassion and hopefulness, traits that inform "resonant leadership."[19]

Finally, there is a clamor for leadership development among current trainees, who identify important deficits and needs for leadership training. For example, in a survey of 23 Baylor surgical residents,[22] >75% identified a deficit in their knowledge of leadership theory and in specific traits (e.g., conflict resolution); over half reported at most average competence in other traits (e.g., challenging the status quo, inspiring others, helping others optimize performance, etc.).

Taken together, the current challenges facing health care,[12] organizational challenges of health-care organizations,[8–9] the features of physicians and their training that conspire against collaboration and followership,[10–11] the perceived needs of trainees,[22] and the extra mandate for resonant leadership in health care[19] underscore the need for developing excellent physician-leaders. As health-care organizations better appreciate this need, programs are emerging and being offered to physicians to foster their development.[7,22–25] Such programs include offerings by health-care executive associations (e.g., the American College of Physician Executives, the American College of Healthcare Executives, the American Medical Group Association, and the Medical Group Management Association),[24,26] specialty societies, and health-care organizations (e.g., the Cleveland Clinic,[23,28–29] the Mayo Clinic,[22] the University of Kentucky,[7] Aucra Health,[30] and the Medical College of Wisconsin[31]).[26] At the same time, questions that require further attention include: (1) What are the competencies that characterize the optimal physician-leader and (2) what are the features (e.g., format, curriculum) of the ideal program to train physician-leaders?

Though a review of the answers to these questions goes beyond the scope of this perspective piece, an emerging literature is addressing the needed competencies[7,25–26] of effective physician-leaders using different methods for harvesting answers. For example, polling its large constituency of member organizations and their members, the Healthcare Leadership Alliance[24] has assembled and proposed an exhaustive list of 300 needed competencies for health-care leaders. Also, in an interview-based study with established and aspiring physician-leaders, Taylor et al.[25] have proposed four general competencies deemed needed by effective physician-leaders: knowledge, emotional intelligence, vision, and organizational altruism (i.e., dedication to organizational success even at personal sacrifice). The latter aligns with the

concepts of "level 5 leadership"[32] (i.e., the co-occurrence of personal humility and an unwavering commitment to produce great, long-term results) and of "servant leadership."[33] Finally, in a systematic review of available reports, Stoller[26] has suggested six domains of needed competencies as those that characterize effective physician-leadership, including: technical knowledge (i.e., of operations, finance and accounting, information technology and systems, human resources (including diversity), strategic planning, legal issues in health care, and public policy), knowledge of health care (i.e., of reimbursement strategies, legislation and regulation, quality assessment and management), problem-solving prowess (i.e., around organizational strategy and project management), emotional intelligence (i.e., the ability to evaluate self and others and to manage oneself in the context of a group), communication (i.e., in leading change in groups and in individual encounters, such as in negotiation and conflict resolution), and a commitment to lifelong learning.

As pointed out in these and other available reports,[22–26] even with significant initial efforts to clarify the needed competencies and to offer programs that attempt to cultivate these skills among emerging physician-leaders,[7,22–23,26] several basic, pressing questions remain that mandate this call to action. For example, what is the evidence that acquiring these competencies ties to better organizational and/or personal performance? What are the best strategies and learning formats in which to cultivate these competencies in emerging physician-leaders? Also, at what point in one's training are the competencies best developed (e.g., in medical school, during training,[28] or after further clinical maturation)? As pointed out by Lobas,[17] developing answers to these questions should prompt enthusiasm and funding for research regarding organizational development in health care, a novel but important area for study. In the end, those institutions that develop the answers and implement the solutions to these questions will design the future of health care.

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