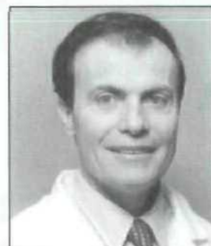
Becoming a Physician Executive

To Be Effective Leaders, Clinicians Must First Adopt a New Mind-Set

BY RICHARD B. BIRRER, MD



Dr. Birrer is senior vice president for medical affairs and chief medical officer, St. Joseph's Regional Medical Center, Paterson, NJ. This is Part 2 of a two-part article; Part 1 appeared in the November-December 2002 Health Progress.

"There is nothing more difficult to take in hand, more perilous to conduct or more uncertain in its success, than to take the lead in the introduction of a new order of things."

—Machiavelli[1]

Physicians are moving into a variety of executive roles in hospitals and such hospital-affiliated organizations as health maintenance organizations, independent practice associations, management service organizations, and physician service organizations. Although new attitudes, skills, and knowledge are necessary for success in these fields, a strong sense of self, a willingness to take risks, a sense of humor, optimism, and an enduring work ethic constitute the essential foundation. In *CEOs in 2000,* a national study of health care, Witt Kieffer found that 53 percent of the responding chief executive officers represented hospitals; the remainder represented health care systems.[2] The executives ranked their key strengths as follows:

1. Aligning physician incentives and systems
2. Developing, implementing, and monitoring "best practices" for the clinical enterprise
3. Effectively advising the board, other senior executives, and the medical staff
4. Creating and nurturing strong bonds between administration and physicians to enhance quality and monitor utilization outcomes
5. Focusing clearly on the interests of the organization and patients

Some Statistical Data

In the early 1950s, 33 percent of hospital CEOs were physicians. By 1982 only 202 were physicians, a decline of 89 percent. Of *Modern Healthcare's* recent list of top 100 U.S. hospitals, only 5 percent are led by physician executives.[3] No physician CEOs are among the leaders of the 34 health care systems with hospitals on the list. Even so, membership in the American College of Physician Executives (ACPE) has increased by an average of 10 percent each year in the last two decades.[4] Over the same period, the number of physicians in administration has increased by 50 percent.

According to the ACPE study, the median age of such physicians is 48 years; their median annual compensation is $210,000 (ranging from $300,000 for practice management companies to $150,000 for government-related positions); their median annual rate of bonus pay ranges from 10 percent to 40 percent; their median amount of management experience is eight years.

On average, these physicians have held three previous administrative positions. In those positions, they have worked an average 50 hours a week. Ninety-eight percent are board certified in a specialty, most commonly internal medicine (44 percent); family practice (20 percent); and infectious disease, psychiatry, and pediatrics (10 percent). Forty-four percent do not currently practice medicine; those who do still practice spend 25 percent of their time in clinical work. About 20 percent of respondents have an additional postgraduate degree (e.g., MPH, MPA, MBA, PhD, JD). Fifteen percent are women, a number that has grown slowly since 1980, when it was 10 percent.

Why Become a Physician Executive?

Those physicians who are positive, optimistic, and proactive are most likely to pursue a management role. Almost half of the physicians who chose to become executives did so because they wanted to help solve the nation's health care problems. A third did so because they were inter-

ested in management and leadership challenges. And approximately a fifth had other reasons (e.g., the frustrations of private practice; the curtailment of medical careers by health problems; a dwindling interest in medical challenges; or a search for a shorter working day, a more predictable work schedule, or post-retirement opportunities).

What's in a Title?

The range of physician executive roles is reflected in their various titles (see **Box**), of which at least 30 are in existence. A "medical director" tends to have varied, sometimes nebulous, responsibilities. A "vice president for medical affairs" traditionally manages the medical staff and monitors quality. The bearer of newest title on the management scene, a "chief medical officer" (CMO), establishes senior management presence in a manner similar to a chief operations officer and finance officer. The CMO title enables the organization's lead physician to participate in governance, strategic planning, and business operation decisions. The CMO position can serve as a springboard to the CEO role—the true test of stature in a senior management group. Outside physician-dominated cultures, however, movement from CMO positions to CEO ones has been slow.

Specific Responsibilities

A physician executive can be a source of independent clinical expertise and impartial judgment with respect to quality-related information. For example, data from the Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration) is best interpreted by a physician leader, who can answer questions such as the following:

- Are the data (concerning, for example, mortality, length of stay, utilization rates) good indicators of quality? Why or why not?
- If data are significantly above the norm or higher than a previous year's, have the reasons for that been sought? What are they? Are the data valid? Why or why not?

Because they can interpret raw data, physician executives can be especially useful to boards of trustees. Whereas the science of quality measurement is improving, the straightforward quality indicators sought by boards remain crude, requiring careful interpretation by medical professionals. A physician executive can turn the data into meaningful information and put it in a context, whereupon the board can apply it to decision making and policy setting. Physician executives can help the board establish clinical resource management and risk-management policies and procedures (e.g., sentinel events, malpractice experience).

The physician executive's role vis a vis the board should be shaped in a way that provides the board access to the information it needs without, however, subverting the CEO's position, on one hand, or compromising the physician executive's responsibility for patient protection, on the other. For instance, a CEO's authority could be significantly weakened and the medical staff's relationships polarized if the chairman of the board were to use the physician executive as an inside source on hospital quality. Conversely, a CEO can, by keeping tight control of quality-related information, deny the board a valuable and credible source of education and interpretation.

The physician executive must be familiar with various local, regional, and national regulatory and accreditation requirements: the Licensure Committee of Graduate Medical Education, Accreditation Committee of Graduate Medical Education, Joint Commission on the Accreditation of Healthcare Organizations, U.S. Department of Health and Human Services, Federal Drug Administration, and the Institutional Review Board pertaining to the organization's clinical, research, and educational programs. Involving the physician executive in his or her organization's strategic planning process is a critical step in forging an enduring physician-administration partnership. Encouraging his or her participation in negotiations with managed care organizations and with the institution's practice groups will foster visibility and credibility at a time when these parties are often polarized. Finally, a physician executive can provide leadership to the structure and function of the clinical enterprise.

Knowledge

A competent physician executive must be versatile in a panoply of areas (see **Box**, p. 31). His or her knowledge and skill sets will in some ways be similar to the general management training usually found in MBA programs. However, because of

NOMENCLATURE OF PHYSICIAN EXECUTIVES

Physician leaders wear a variety of titles in health care organizations. According to G. E. Linney and B. J. Linney, the authors of *Physician Executives: What, Why, How* (American College of Physician Executives, Tampa, FL, 2000), 40 percent of such people are called "senior vice presidents for medical affairs," 25 percent are called "chief medical officers," and 15 percent are called "medical directors." In other organizations, physician leaders are "vice presidents for medical management," "physicians in chief," and "chiefs of staff."

health care's unique nature, the differences exceed the similarities. Because of the increasing depth and breadth of the role, few people agree on which areas of knowledge the aspiring physician executive should be adept in. However, quality management, physician management, finance, and organizational issues are considered core requirements.

CHALLENGES

Aspiring physician executives are sure to face several challenges.

Position Realities At present, the average length of time a chief medical officer remains in his or her position is 18 to 24 months. Market change, corporate politics, and the harsh reality of health care economics are usually responsible for the brevity of the stay. Performance alone is rarely a factor in termination. Chief medical officers who want to keep their jobs should:

- Develop "multitasking" (generalist and specialist) expertise (technology and informatics)
- Accept a mid-range salary (people drawing high salaries tend to become expendable when corporate finances are tight)
- Generate revenue (health care executives tend to see physicians as a cash-flow drain)
- Be willing to work long hours when necessary
- Be willing to relocate (refusal can jeopardize one's career)
- Maintain a good relationship with the boss (one should communicate with the boss frequently, not only by telephone and e-mail but also through regular face-to-face meetings, perhaps over a meal)

Burnout Compulsive behavior resulting from doubt or from an exaggerated sense of responsibility and guilt (combined with a sense of perfectionism) frequently contribute to job burnout. Physician executives often need to realign their expectations for success because their typically strong egos need tremendous reinforcement. Physician executives who want to avoid burnout should take care to maintain their physical health, set achievable steps toward their goals, stay focused on those goals, have hobbies, and manage their time intelligently.

A physician's transition from clinician to executive will certainly involve endings and losses. He or she will leave behind the gratitude of patients, a professional support structure, a familiar sense of competency and respect, all of which he or she will need to acknowledge. By maintaining a sense of creativity and flexibility, rebuilding a support structure, strengthening continuities, participating in community activities, and just plain staying in the loop, the new physician executive can maximize job satisfaction and minimize the sense of loss.

The "Glass Ceiling" Whereas physicians who are either female or members of an ethnic minority frequently have difficulty (because of discrimination or sexual harassment) reaching the upper levels of medical school faculties, physicians as a class are frequently denied executive management positions, primarily because they haven't been trained for them. The fundamental difference between a physician clinician and a physician executive is focus: the former usually focuses on a single patient whereas the latter focuses on a team, department, or organization. Clinicians are, moreover, accustomed to the autonomous, "go-it-alone," "lone ranger" mind-set appropriate for a crisis mode—a mind-set considered undesirable from a managerial perspective.

Successful physician executives find ways to balance the individual, quick-management result with the longer term, insured-lives perspective. For them, long-term strategies supplant the quick result. Positioning and patience, always grounded in a degree of uncertainty and ambiguity, are typical of health care management positions. The physician executive must be intimately familiar with resource management, capital budgeting, and similar functions. Because many clinicians view resources as unlimited, resource allocation is perhaps the greatest single challenge facing a physician executive. Although "the good old boy" network is pervasive in medicine, physicians who exchange a clinician's white coat for an executive's pinstripe suit often find themselves in a

REQUIRED EXPERTISE

To perform effectively, physician executives must be familiar with:

- Management of medical staff relations (including conflict resolution, the issuing of credentials and privileges, network management, and recruitment and retention
- Efficiency practices (including those involved in informatics, staff performance and compensation, and managed care/insurance)
- Quality management (including quality assurance, clinical benchmarking, outcomes and disease management, resource utilization, risk management)
- Legal and regulatory issues
- Liaison functions (including mergers/affiliations and operations)
- Cost management (including finances, cost accounting, cost containment, profit/loss statements)
- Technology assessment
- Decision making in uncertain situations
- Clinical medicine
- Organizational issues (including sales/marketing analysis, negotiation of contracts, strategic planning, governance)

kind of "no man's land." An aspiring physician executive may find himself or herself socially isolated, avoided by both former physician colleagues and nonphysicians competing for the same job.

For physicians to bridge the clinical/managerial divide, breaking through the "glass ceiling," they must acquire skills that will bring them in line with their nonmedical counterparts. They must be board certified with business training and credentials, have a mentor, recognize the importance of economic as well as clinical objectives in the organization, and understand the personality and cultural differences between clinicians and managers.

HABITS OF HIGHLY EFFECTIVE EXECUTIVES

- Communicate
- Be accountable
- Enhance information technology
- Develop mission and vision
- Work with committees
- Lead, don't manage
- Mentor and model

SUGGESTIONS

Autonomy—the essence of professional status—actually works against physicians seeking to turn themselves into effective leaders. Physician clinicians who want to become physician executives should:

- Create relationships based on shared principles and purposes.
- Commit to measured accountability.
- Learn to work differently. The fact that an executive has a title and power will not, in itself, compel others to respect and willingly follow him or her.
- Don't try to please everyone. Go with those who buy into the program early on.
- Think systemically.

Physicians aspiring to be executives should first discuss it with their families. Because leadership positions require a tremendous amount of sacrifice, aspirants should consider leaving their current organizations, especially if they feel "stale" in their present positions. For example, the aspiring physician might need to become a chief operations officer in another organization as a stepping-stone to a CEO title. Academic degrees such as master's of business administration, master's of medical management, or master's of hospital administration can give aspirants a significant edge over other candidates for the job, especially those who lack similar postgraduate training.

Aspiring executives should pay attention to those likely to succeed them, because it is easier to promote a person with a clear line of succession. Aspirants should also develop negotiation strategies; develop team-building, communication, and leadership skills; cultivate both patience and tolerance for change and upheaval; groom a reliable support network; and hone those abilities (in creating resumes and responding to interview questions, for example) that will help them prepare for the CEO role. A clinician seeking to become an executive might begin by negotiating a title change signifying that his or her duties are not limited to medical affairs alone. Such a person should also let others know that he or she is preparing to take an executive role and would appreciate assistance and advice.

EDUCATION AND TRAINING

Successful physician executives recognize the need for specific management and leadership training for both themselves and the teams they lead. The best leaders know it is difficult for people to change rapidly and that ongoing training is necessary if a collective goal is to be realized. People are not born physician leaders, but such leaders can be created and nurtured through a wide variety of formal and informal management and leadership programs adapted to the needs of the executive-to-be. Organizations such as the American College of Physician Executives, American College of Healthcare Executives, Medical Group Management, and Governance Institute—as well as numerous business schools and medical and specialty societies—offer these programs.

MENTORSHIP

Successful physician executives usually have mentors who are themselves often physician executives. From these mentors they get coaching, feedback, encouragement and support, guidance in making decisions, and personal and professional advice. Mentors serve as models of executive behavior and leadership for aspiring physician leaders; they also make them aware of opportunities for further learning and professional growth. Physicians who want to become executives in the chaotic world of today's health care can also profit from reading Stephen R. Covey's *7 Habits of Highly Effective People*[5] (see **Box**). From Covey's book they will learn that immersing oneself in the organization's inner workings, asking the tough "why?" questions, and cultivating positive relationships with the staff at all levels are critical to success. Covey explains how action steps for achieving each "habit" can be developed and implemented.

NETWORKING

To be successful, an aspiring physician executive must also build and maintain a resource group of colleagues. The members of this group will serve the new executive as mentors, sounding boards,

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and contacts in an industry that is constantly and rapidly changing. Networking is an area of development that is often ignored or postponed by the busy physician leader whose mind-set often remains that of a lone ranger. Indeed, the importance of having a support network may not become clear until the new physician executive confronts a major workplace dilemma or—worse—is fired. The aspiring physician executive will find that keeping a file of the names, addresses, phone numbers, and personal data of trusted colleagues—and periodically reaching out to them—will probably be more valuable over the long term than socializing at meetings and conferences.

AN AWESOME CHALLENGE

It is not enough for physician executives to be competent clinicians. They must also possess and demonstrate outstanding communication and managerial skills. They must effectively blend administrative and medical acumen into a seamless package—an awesome challenge that requires adaptability, good judgment, and a talent for taking action in the face of uncertainty, unfamiliarity, and the negative thinking of some colleagues. But effective physician executives lead *beyond* the bottom line; they create environments that encourage teamwork, innovation, and necessary change. □

NOTES

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REMOVING BIAS FROM HEALTH CARE

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> For Catholic health care providers today, the challenge of discerning the proper course of action is all the more exacting because of the nature of the activity and the values inherent in a religious organization. . . . Good quality care is the essential and tangible reflection of a provider's intent to honor the dignity and promote the well-being of the person. Moreover, although all providers are expected to go beyond corporal concerns and attend to patients' emotional and spiritual needs, faith-based providers have an expressed accountability to patients and families to provide the necessary services that address these needs.[16]

Those who provide health care in a faith-based setting should take care to align care delivery with their organization's stated mission and values. For Catholic organizations, such alignment clearly requires a demonstrated commitment to the dignity of every person, to social justice, and to advancement of the common good.

Catholic organizations should engage in a formal process of self-reflection, reviewing their clinical and administrative practices in light of these values and mandating improvement where those values are not being honored in day-to-day practice. In cases where racial, cultural, or gender bias is found to interfere with care delivery or treatment, a truly values-based organization will take prompt and compassionate action to see that such interference comes to an end. □

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