Leadership

Setting Physician Leaders Up for Success

By Lory A. Fischler

In this article...

Find out what kind of training works—and what doesn't work—when it comes to teaching medical staff leaders.

Despite a shift toward in-house physician leadership, the traditional medical staff, made up of community practitioners who pay dues, maintain privileges to practice in the hospital, and refer their sick patients, still elects a chief of staff or president to represent them in the hospital.

In many hospitals, community physicians lead departments and oversee quality improvement. (Although it is a voluntary job, most chief of staffs are paid a generous stipend to serve in the role—mostly to offset their time away from patients.) Often, they serve a two-year stint as vice president before their two-year term as chief. When the term ends, the next in line fills the slot.

Despite very little (if any) training for the role, hospitals have to rely on medical staff leaders to champion efforts to improve the quality of patient care among the medical staff as well as reduce costs from unnecessary tests and procedures.

Medical staff leaders bridge the communication gap between administration and the medical community and play a critical role in dealing with behavioral and quality issues of physicians who jeopardize quality of care. Failure to do so can lead to adverse patient outcomes and costly malpractice suits, and brings down the quality and reputation of the hospital and its medical staff.

How are these physicians chosen for this important role? Are they selected by the hospital administration after a thorough vetting? No. Do they get elected based on a track record of success leading others? Sometimes, but not always. Many step up because it is "their turn," and many serve in the role for years, usually maintaining the status quo until a new administration comes into place.

Challenges

Historically, medical staffs and hospital administrators butt heads as to who makes key decisions about patient care. Here are some of the challenges medical staff leaders often face:

- One hospital, in needing to cut costs, looked to consolidate purchasing power by buying one kind of suture material for the operating room rather than the six different types preferred by its surgeons on staff. No one wanted to give up their favorite, and some were even receiving remuneration for its use.
- A hospital administrator feels pressure to satisfy his top physicians based on financial performance and make decisions that favor them. This adds tension among the other members of the medical staff.
- Medical staff leaders can find themselves in a conflict of interest. When a local internist came before peer review for abusive treatment of nurses, the chief of staff—a community cardiologist who received referrals from the offending physician—felt put on the spot. He feared losing important patient referrals if he was too hard on his colleague.
- A chief of staff had to conduct a peer review meeting involving a physician who was a member of a competing practice. The physician's attorney accused the leader of conducting a self-serving vendetta to drive the physician out of competition.

No one relishes telling a colleague they aren't competent or capable. Informing a physician that their standard of care is below par and they no longer have privileges in the hospital can be career ending, and should not be done lightly. Physician leaders can be threatened with lawsuits at the hint of interference with physicians' livelihoods. These are among the many challenges that medical staff leaders face, with little or no training for the role.

Physician leadership training

Hospitals, for their part, invest generous resources to help elected medical staff leaders learn to be more effective in their role. Annual retreats, workshops and attendance at national meetings provide opportunities for leaders to grow in their role.

Given the level of financial investment, it is useful to determine what works and what doesn't. We interviewed a number of physicians: elected medical staff leaders who have served in the role and chief medical officers, responsible for physician leadership training. Our interviews, analysis and personal experience with training physicians reveal six key strategies that make training of non-employed medical staff leaders more effective.

1. Create a physician community. When physicians learn together they build a community of support. Being able to draw on each leader's experience and point of view builds confidence and competence. One hospital CMO created a physician learning community by offering a year-long leadership curriculum. By invitation only, he recruited 60 high-potential, high-impact physicians to participate. His approach conferred a kind of elite status, and membership was highly prized. He hired a leadership consultant with extensive experience working with medical staff to help design, develop and facilitate engaging monthly sessions with little drop-out or absenteeism. What doesn't work as well? Mingling the community with nonphysician administrators seems to dilute the engagement. Physician leaders are less forthcoming and open when non physicians are learning alongside them. Although collaboration helps build bridges, it also seems to disenfranchise doctors.

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Recommended strategy: Keep physician training separate from other hospital leadership training and customized to their specific needs.

2. Be practical.

A new medical staff leader had to tell a surgeon on the medical staff that his outcomes were consistently below acceptable standards and that his privileges to practice at the hospital were under review. Understandably, the leader was extremely uncomfortable having to face this task. Leadership training to address specific skills relevant to the role includes: managing conflict, conducting difficult conversations, negotiating agreements with administration and using vision to build consensus. These are practical skills that medical staff leaders will use.

Recommended strategy: Focus on the practical application of training models. Physicians have little patience for theory. They want to know what to do and how to do it. Demonstrations and providing time to experiment with new skills in real world situations is good use of training time. You will maintain their attention and build skills simultaneously. Use role-plays. Getting physicians to pair with colleagues and work through issues together strengthens the communal learning and encourages accountability for performance.

Practical Leadership Skills Needed by Medical Staff Leaders
Creating a shared vision
Managing conflict
Negotiating agreements
Leading effective meetings
Holding difficult conversation

3. Focus on clinical excellence.

The major role of physician leaders is to champion quality patient care. According to CMO John Hensing, MD, Banner Healthcare medical staff retreats of the past used to spend too much time presenting information to physician leaders that the administration thought was important: strategic direction, hospital budgets and development initiatives. Not surprisingly, there was little physician engagement. Banner began to focus medical staff leadership retreats on topics that related directly to patient care and raising the bar on clinical excellence in the hospital. Hensing saw better results when they reduced emphasis on what leaders should know, and emphasized what leaders should do.

Recommended strategy: Physicians care deeply about their patients and ensuring quality of their care. Physicians who provide less-than-optimum care impact the reputation of the hospital and every physician who shares privileges at that hospital. Engage physician leaders in the work of raising the quality of care in the hospital by working collaboratively to identify key targets for improvement. Tracking results builds success.

4. Use data.

Physicians are trained to use objective-based data to make treatment decisions. The same is true in dealing with patient care issues. Data are the critical ammunition physician leaders need to deal effectively with a low-performing peer. The data help the focus remain on the bigger picture, which is to raise the bar on clinical excellence. A substandard comparison with the rest of the medical community is a hard pill for any doctor to swallow. It is too easy without data to defend oneself by protesting favoritism or bias. The data are much harder to refute or ignore. Physicians have more credibility and confidence entering these difficult discussions when the focus is on charts and graphs, not personal opinion, allegation or rumor.

Recommended strategy: Collect data related to quality targets identified by medical staff leaders. Educate medical staff leaders in how to interpret and use data to advance patient care.

5. Provide coaching.

There are many areas where coaching can play an important role in supporting and developing volunteer physician leaders. Most doctors in our surveys conveyed significant discomfort at having to confront their peers. Even Hensing acknowledges that his doctors did not do well in shaping the behaviors of their colleagues. Many felt unprepared for managing conflict in meetings. Although training helps, coaching provides more customized, just-in-time support. Coaches boost confidence along with performance that promotes early, more frequent communication and more effective feedback. Problems are more likely to be addressed before they become more pronounced. Good coaches help their clients become good listeners. They model facilitated conversation that engages others and draws out their point of view. A coach works individually and confidentially with leaders who can feel more comfortable addressing their own leadership gaps in a safe space.

Recommended strategy: Raise the confidence and competence level of physician leaders through individualized coaching to address personal leadership challenges. It will encourage more timely and effective interactions that produce more effective results.

6. Use mentors.

One surgeon at a medical staff retreat acknowledged that the reason he has signed up for a second term is that, “I just finally figured out what I am doing.” Mentoring is an effective way to support the new leader, fast-

tracking their learning and providing a friendly, now wiser ear to bounce ideas off of. Mentoring is not cloning, or the "sage on the stage," but rather a "guide on the side," providing encouragement, support and a friendly check in, especially in the beginning of a new leader's term. A good mentoring relationship reduces the stress level of the new leader and contributes significantly to their quick onboarding and long-term effectiveness. Mentors aren't necessarily the immediate past leader, but they should have experience and a track record of success.

Recommended strategy: Build in a mentoring support system designed to help the new leader in their role. Use clear job descriptions of the role and how to interface with the incoming leader to ensure more effective interactions.

Setting physician leaders up for success can make a big difference in the quality of patient care. Hospitals provide a unique leadership opportunity for physicians. By applying these strategies, those responsible for creating, delivering and/or sponsoring medical staff leadership training are more likely see long-lasting results.

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