Practice Management

Bridging the Management Divide: Understanding Physician Leadership

Urgent message: Physicians are trained for clinical care; administrators are trained for business management. These differences can create conflict regarding how healthcare is (and should be) managed. So what happens when the physician *is* the administrator?

Trevor Rohm, MD, MS

Introduction

There is a philosophical division between physicians and healthcare management/administration. There are a variety of causes for this great divide, but understanding how physicians think, act, listen, and learn can provide invaluable insight into how to best involve them in leadership positions, which leadership styles work best for this unique group, and how to improve healthcare management through physician leadership.

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The urgent care physician, typically, plays many roles in the course of a day: clinician, counselor, mentor, educator, employee, boss, partner, friend, and teacher. When the worlds of clinical medicine and business management and healthcare collide, however, some of these roles come into conflict with each other—to the point that we might add "combatant of the healthcare management and administration."

Our clinical training prepared us to care for patients, not dollars. As medical practitioners, we seek improved patient care, not improved profits. I want the clinic to run smoothly, my staff to be happy, and patients to be satisfied. Most of us are accustomed to others making sure that the business end of things works well.

We want to get paid, of course, with a raise and maybe a bonus, but we have not been directly involved in making sure those things happen. We have not been involved in the fine details.

The standard relationship between clinician and administration through the ages might be characterized thusly: "I need your help to succeed, and you need my

services for your employment and the profits. You can't tell me what to do because I have specific training for what I do as a doctor, and I can't tell you what to do because you are my boss, you are the administration."

The entrepreneurial nature of urgent care often casts us in the role of clinician and administrator, however. We are in the position of mandating from on high, seeking profits, and dictating policy.

Healthcare Management

There are two fundamental divisions of medicine: the clinical aspect of medicine and the business of medicine. All physicians are clinicians; this is what our training encompassed. We have learned through experience that there is a fundamental lack of understanding of how a physician trains, learns, and practices, as evidenced by "the mismatch between what doctors were trained for and what they are required to do."[1]

Medical training is based on principles, not specific job tasks. Physicians are trained for clinical practice, but our job requires understanding of the business of medicine, which is not taught. Physicians deal with individuals; our focus is not dealing with organizations.[2] Medical school is not business school.

Clinical expertise and experiences are a manifestation of the time and the volume of patients seen and evaluated throughout the course of clinical care. All medical training is focused on the clinical aspect of medicine (meaning how to render and make complex medical decisions) and how it affects, and effects, patient care.

Prestige, respect, and time all provide a clinician with the mantle of leadership in a clinical setting. The clinical setting is not, however, a business setting. In the business world, experience is important, but not always an indicator for good leadership.[3] Experience counts, though it is not everything as pertaining to the clinical setting. Time does not equal experience. There is a great need for new training in order to produce physician leaders.[4]

There have been four key components identified that explain the need for the development of physician *leaders*:[5]

1. Healthcare organizations are complex, and physicians already know how to manage such organizations.
2. Physicians are already leaders in the clinical setting; they are not blind followers.
3. Physician leaders are currently chosen based on experience, not necessarily leadership qualities.
4. Physician training programs are not managerial-based, but clinically focused.

By using resources already available[6] and incorporating the clinical leaders into traditional management roles, by educating them with leadership theories, qualities, and training, the goal is to improve the overall healthcare administration by using those individuals who already understand the system and all its complexities.

Leadership Theories

A variety of leadership theories apply to physician leaders. Each is unique and offers an array of tools that can be used to improve the use of physician leadership in healthcare management and administration.

- Employee-oriented behavior theory is a leadership model that focuses on relationships between "managers" and employees.[3] This leadership model seems a natural for physician leaders who spend their whole lives developing relationships. The goal of this model is to build relationships so that you can ultimately improve productivity in your employees (such as other physicians and staff) and increase employee job satisfaction. Employee-oriented behavior theory is a natural fit for physician leaders.
- Transformational leadership is a leadership process which inspires employees to focus on the goals of the organization, rather than self-serving purposes.[7] Physicians and physician leaders understand that patient care is the only important clinical outcome, which is in the best interest of any healthcare organization.

  This leadership model is consistent with physician goals for clinical care and should adapt easily for physician leaders. Evidence supports the theory that by focusing on the needs of the "follower," relationships can grow and help to produce effective leaders.[8]
- The Fielder contingency model of leadership is another tool that physicians can use to lead and guide their colleagues. The Fielder model attempts to match a leader's style with the leadership situation.[3]

  The Fielder model is based on three basic principles:

  1. Identify leadership style to match the type of situation. Leadership styles are task-oriented or relationship-oriented. Physician leaders understand clinical care and can adapt easily to this model because they are already relationship-oriented.
  2. Evaluate and define the desired situation based on the following contingency factors: leader-employee relationships, the degree of task structure, and the influence and power the leader yields. Most clinical care is very structured in the clinical

setting, so physician leaders can be expected to lead efficiently.

3. Improve leader effectiveness to find a leader to fit a situation or change the situation to fit the current leadership style. Physician leaders understand the complexities of modern medicine, which makes most situations static and can help physician leaders qualified to adapt to each situation.

Physician Leadership

Each leadership theory is unique and may not apply to every piece of clinical work. As previously explored, there are a number of unique attributes and skills that physicians possess, and while not always recognized as leaders by administration, they are indeed leaders.[9] Physicians guide, lead, and coordinate the complex task of clinical care. We manage patients, sometimes numbering in the thousands, and help each patient with his or her own unique medical problems. While these skills do not always translate into managerial business fortunes, they have similarities.

There is an unwritten code in medicine. I hesitate to share it, for fear of breaking the code, but it must be spoken and understood: clinical expertise equals leadership in the clinical settings. The whole of medical education is based on it; the long nights, tedious hours, and experience of endless patient care add up to what we call residency training. All physicians must endure this hardship, must learn what needs to be learned, must cross the proverbial bridge from bookwork to clinical application, and must receive their mantle of clinical care.

This is how physician leaders are made: by walking the path that has been walked before, by crossing the bridges that all physicians have crossed. In the clinical world, experience equals leadership. But this leadership is clinical, not managerial.

In the course of clinical events, however, managerial tasks are encountered. Physicians learn what makes nurses and staff members irate; we know the frustrations of inadequate scheduling, and understand the headaches in the current healthcare system. We run, maneuver, guide, manage, and manipulate the system for each patient we encounter. We understand not only the complexities of clinical care, but also the complexities that are in the healthcare system. While spreadsheets and profit margins are not in the daily clinical routine, patients' lives hanging in the balance are more important than profit margins. Managerial skills are gained through time and experience—which, combined with personal attributes, can make great physician leaders, even in the administrative realm.

Data suggest that physician leaders must exhibit some common characteristics in order to be successful leaders:[10]

1. Knowledge
2. People skills
3. Emotional intelligence
4. Vision
5. Organizational orientation

Most of these characteristics are incorporated by many physicians, but not all. However, these skills are also necessary to care for patients, which may explain why physicians can easily become administrative leaders.

Conclusion

There is a great need for physicians to cross the divide and become leaders in the managerial and administrative services of healthcare. They alone, with their patients, know the frustrations and barriers that pre-empt quality patient care. By learning the goals and unwritten rules of administration, by gaining and understanding the business of medicine, physicians can become the leaders that healthcare has been lacking. Physician leaders understand what cruel restrictions are placed on them and their partners by decrees, sent from above, mandated from on high, with little to no knowledge of how the patient care system actually works.

Many physicians *are* crossing the divide to become leaders; this is, after all, much easier than it is for an administrator to get accepted into medical school and become a physician.

Crossing the divide is not always easy, and may not even be desirous, but it is necessary to improve our administrative services and overcome any and all suspicions between physicians and administrators.[11]

By applying formal leadership theories, physicians can be trained to apply their knowledge, experience, and expertise to healthcare administration. ■

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