

Turning Great Doctors into Great Leaders

How healthcare organizations
are boosting performance
by building a pipeline
of physician leaders.

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E X E C U T I V E S U M M A R Y

With all the upheaval and uncertainty in the healthcare industry, strong leadership has never been more important – especially leaders who are also physicians. In fact, several studies have shown that physicians with leadership and management skills can be better suited to lead healthcare organizations than business professionals.

Unfortunately, there's an acute lack of physicians with the right skills, experiences and mindsets to take on those roles. They can grow into leaders but the transition is fraught with barriers.

In this paper, we examine the forces that have made it essential for healthcare institutions to employ many more physicians in key leadership positions. We then explain three common leadership deficits of physicians who are put in place to manage complex businesses or large numbers of people, and how those deficits can be turned into strengths:

- **Inability to manage and develop other leaders.** Specific skill-building and developmental feedback can help doctors learn about management responsibilities such as delegating and managing others.
- **Poor relationship management skills.** Personality typing tools and 360° assessments are powerful ways to show leaders how their actions and behaviors affect others.
- **Lack of strategic perspective.** Some companies create specialized programs to expose promising physicians to more complex aspects of running a business.

Finally, we show how several healthcare organizations have built development pipelines that move physicians through five levels of leadership. Among others, they include Sound Physicians and Benevis (a provider of services to dental practices across the U.S.), and how these leadership development programs have helped their institutions generate strong performance in an uncertain and highly competitive healthcare marketplace.

The healthcare industry is undergoing a dramatic transformation, and needs highly effective physician leaders who can pull their organizations through it. Now more than ever, hospitals and other healthcare services enterprises need seasoned doctors who also have the well-honed managerial and leadership skills to run a business. Several studies show that clinicians with the right leadership skills are much better suited to direct enterprises providing high-quality yet cost-effective care than are administrative and business professionals. One of them, an analysis of the top 100 U.S. hospitals, found “the best-performing hospitals are led disproportionately by physicians.”¹

Yet the industry has an acute shortage of physicians with the experience, skills, and capacity to lead effectively. Why has the industry failed in this respect, and how must it change the way it develops physician leaders? From 30 years of working with executives across industries – the majority from within healthcare – we have seen both the power of effective leadership and the costs of poor leadership. Those experiences have shown us what physicians need to become great leaders.

Let’s start with looking at what’s fueling the demand.

THE ACUTE NEED FOR PHYSICIAN LEADERS

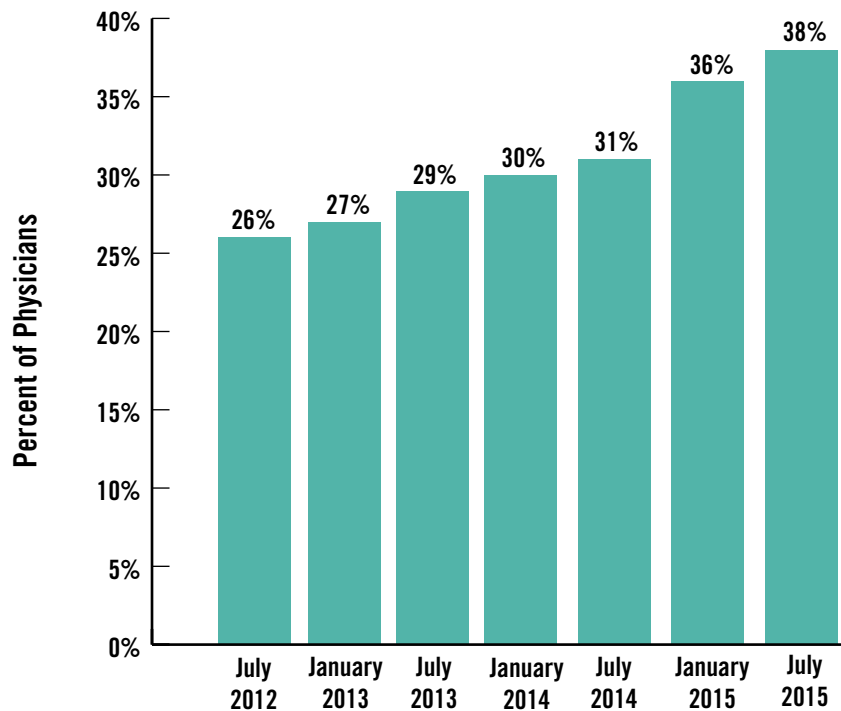
Far-reaching change and consolidation in the U.S. healthcare industry over the past decade has placed severe pressures on how healthcare organizations are led. Several sectors have merged (hospitals or insurance companies buying physician groups or non-acute services, for instance) into larger, more complex organizations. And new businesses have aggregated large numbers of providers such as multi-specialty groups or hospitalists, physicians dedicated to exclusively treating hospital patients. The result is a once-highly fragmented industry that now has sizable organizations composed largely of physicians. According to SK&A, each of the top 50 U.S. medical groups has more than 500 physicians, with Kaiser Permanente Medical Group (more than 10,000 physicians), Cleveland Clinic (more than 3,000) and Mayo Clinic (more than 2,500) leading the pack. Many of these medical groups are integrated into hospital systems or academic medical centers, while others are large independent providers or service companies like TeamHealth (with more than 1,000 physicians and almost 20,000 clinicians). The net effect: A much higher percentage of physicians are employed by hospitals – 38% in 2015, compared with only 26% in 2012.²

1. Amanda H. Goodall, Social Science & Medicines, “Physician-leaders and hospital performance: Is there an association?” August 2011. <http://ftp.iza.org/dp5830.pdf>

2. Physicians Advocacy Institute presentation, September 2016, cited the Avalere data. <http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Physician-Employment-Study.pdf>

Change in Employment of Physicians

Percent of Hospital-Employed Physicians



- In 2012, One in four physicians was employed by a hospital.
- By 2015, 38 percent of physicians were employed by hospitals.

This structure differs dramatically from the historical one, in which physicians worked independently in private practice or small groups, or served on hospital medical staffs as independent providers.

Why does this matter? Physicians will tell you they prefer to be led by other physicians. The reason, said Dr. Toby Cosgrove, CEO of Cleveland Clinic, in a recent *Harvard Business Review* article is the credibility that a fellow physician brings as a leader – someone who has walked in their shoes and understands the demands placed on practicing physicians.³

The inclination to work for someone with a similar background is particularly pronounced with physicians, but it is not limited to the medical profession. Research has shown that, in general, people are happier if their boss is capable of doing their job. Several studies also back up Cosgrove's assertion.⁴ A 2016 study by Athena Health found that four times as many physicians in physician-led organizations were engaged in their work vs. physicians in non-physician-led organizations.⁵

3. *Harvard Business Review*, "Why The Best Hospitals are Managed by Doctors," Dec. 27, 2016. <https://hbr.org/2016/12/why-the-best-hospitals-are-managed-by-doctors>

4. *Harvard Business Review*, "If Your Boss Could Do Your Job, You're More Likely to Be Happy at Work," Dec. 29, 2016. <https://hbr.org/2016/12/if-your-boss-could-do-your-job-youre-more-likely-to-be-happy-at-work>

5. AthenaHealth website, "Can strong leadership boost engagement?" July 11, 2016. 32% of 2,011 U.S. physicians surveyed in physician-led organizations were engaged in their work vs. only 8% in non-physician-led institutions. <https://insight.athenahealth.com/strong-physician-leaders-key-tackling-change>

One national dental service organization we worked with, Benevis (which operates Kool Smiles dental clinics with more than 500 dentists), reorganized its entire leadership structure to address this issue. It replaced business leaders with dentist leaders, saying it was a critical factor in proving industry credibility and attracting and retaining dentists. Many other organizations have created what is known as a “dyad” structure, where a physician and a non-clinical business leader share leadership oversight of a market or an entire business enterprise.

The dyad model is designed to ensure both strong clinical and business expertise are at the top of a healthcare organization. Indeed, many are using the model with good results. But it can also limit the leadership potential of physicians and create inefficiencies and conflicts. (See the Sidebar, “Why the Dyad Model Is Not the Optimal Solution.”)

In addition to making a strong internal case for physician leaders, healthcare organizations have strong external reasons for so doing. It promotes consumer confidence that the organization puts quality of care over profits. We spoke with Jim Tait, VP of human resources at TeamHealth, one of the largest suppliers of healthcare professional staff in the country. He told us physician leadership has become an important factor in new business development. The hospitals that TeamHealth works with prefer having a clinical leader at the helm, he said, partially because of patient perceptions.

Benevis leaders also cite perception as an important driver in making the transition to a dentist-led organization. Lisa Mikkelsen, the company’s chief operating officer, points to its organizational structure as a point of differentiation with “dentist owners and other dentist leaders actively engaged in the business and leading the dental practices.”

Why the *Dyad Model* Is Not the Optimal Solution

As one answer to the problem of an inadequate supply of fully qualified physician leaders, many healthcare organizations have put into place a “dyad” model. It pairs clinical and administrative leaders, either as co-leaders or with one reporting to the other, to run a market or business segment. Some organizations use duplicate management structures — one to oversee the clinical enterprise and another to oversee the business and operations that support the clinical enterprise.

While the model has worked relatively well for some organizations, it can create inefficiencies and other challenges. At its worst, it allows physicians to abdicate learning about the business or gaining critical financial, operational and manage-



ment skills, thus limiting their future leadership potential. Common challenges include power struggles, dysfunctional behavior between two executives with different priorities, and conflicting messages to the parts of the organization they lead. To be successful, the dyad structure requires role clarity and strong communication and collaboration skills — skills that are often

lacking in physician leaders.

In the long term, would it be more economically sustainable for healthcare organizations to have a single effective physician running the business, holding both clinical and administrative responsibilities, rather than bifurcating them? Why invest in and pay for two leadership positions when one could do the job.

On Leadership Issues, Doctors Have More Confidence in Other Doctors

Issue	% with very high or high confidence in PHYSICIAN LEADERS to manage the issue	% with very high or high confidence in NON-PHYSICIAN LEADERS to manage the issue
Rising healthcare costs	59%	19%
Improving physician satisfaction with the profession	58%	11%
Reducing unnecessary care that is not evidence-based	64%	14%
Increasing patient adherence to treatments	55%	17%
Increased transparency about quality	70%	29%
Shortage of primary care providers	45%	14%

Source: American Association of Physician Leadership and the Navigant Center for Healthcare Research and Policy Analysis

Another factor driving demand for physician leaders is the increasing complexity and changing reimbursement structure in the industry. To stem the high and rising cost of care, reimbursement is shifting toward a value-based model. Healthcare providers are paid increasingly based on quality outcomes or a fixed monthly rate for a patient population's care, rather than being paid based on how many services or procedures they deliver. As such, clinical and operational efficiency have become intricately tied together.

With their deep knowledge of clinical care, physicians are uniquely qualified to make value-based decisions that balance cost and quality. In fact, studies have shown that hospital quality scores are higher in physician-led hospitals.⁶ In addition, a McKinsey study showed physician leadership contributed to better organizational performance, including such outcomes as lower infection rates, higher employee engagement scores, and healthier financial margins. After changing the organization structure, Benevis observed the clinics experienced improved clinical performance and productivity, in part due to the additional touchpoints, attention and oversight of local dentist leadership.

Physician leaders themselves endorse the value of clinical leadership. In a 2015 survey

6. Peter Angood, MD, FRCS(C), FACS, FCCM, and Susan Birk, "The Value of Physician Leadership," *Physician Executive Journal PEJ*, May/June 2014; and Mountford J, Webb C., "When clinicians lead." *The McKinsey Quarterly*. McKinsey & Company, London. 2009.

of nearly 2,400 U.S. physician leaders, 59% had strong confidence in their peers to manage rising healthcare costs, compared with only 19% who had such confidence in non-physician leaders. Both groups ranked managing costs as the industry's most important issue.⁷

All these factors have created an unprecedented demand for more physician leaders – not just business administrators – to lead healthcare organizations. But the problem is that most doctors are not prepared for these leadership roles and lack deep experience in leading others. According to Dr. James K. Stoller, chair of Cleveland Clinic's Education Institute, physician advancement into leadership roles has historically been largely based on credentials, seniority, clinical competency, and political standing.⁸ These qualities do not necessarily make for an effective leader.

WHAT MAKES A GREAT LEADER

Any physician leader needs basic business and management skills such as planning and directing work, giving performance feedback, financial planning, and mentoring and developing others. Because these skills are not taught at medical schools, doctors often don't have them when they come to the job. Fortunately, to some degree, these skills can be taught.

Many healthcare institutions believe that creating good leaders equates to sending physicians off to an MBA program or a two-day or two-month leadership training course. Yet powerful leadership requires more than acquiring knowledge and frameworks. It demands experience and people skills. Experience comes from leading others in a variety of situations over time. It comes with practice and immersion. Newly minted physicians have spent years studying and focusing on data and outcomes, and less time on the relational skills required of a leader. But over time, and with the right experiences, they can develop these people skills too.

Indeed, putting a doctor into a senior leadership role without business and leadership experience would be akin to sending a new doctor into full practice without a residency. Yet that's precisely what many healthcare companies do: promote individuals directly from clinical work into administrative positions.

There's another factor that we believe makes for a great leader – in any field, not just medicine: having failed at something. Failure helps leaders develop empathy, humility, and persistence, along with some self-awareness. They learn something about their own skills and limitations, and begin to see the need to rely on others.

In fact, some of the best healthcare leaders we've met come out of the emergency room or the trauma field, where their best efforts don't always yield positive outcomes. They've had experience with trying different things, some of which don't work, dealing with complexity and multiple disciplines, and having to rely on others often under significant time pressure.

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7. 2015 survey by the American Association for Physician Leadership and the Navigant Center for Healthcare Research and Policy Analysis. As cited in Becker's Hospital Review, Sept. 28, 2015. <http://www.beckershospitalreview.com/hospital-physician-relationships/physician-leaders-lack-confidence-in-nonphysician-leaders-on-6-top-of-mind-issues.html>

8. Dr. Stoller's remarks at an AHA Physician Leadership Forum. Recommendations and remaining questions for health care leadership training programs. Academic Medicine. Jan 2013;88(1), 12-5



Failure can also provide physician leaders with insight on areas for further personal growth. The most effective leaders intimately understand their strengths, weaknesses, and habits. Such personal awareness enables them to recognize when to seek input or delegate, when they should invite other perspectives, or when to pause before reacting strongly to something. It also allows them to access their best qualities and demonstrate authenticity, which in our opinion is an important characteristic of a great leader.

FAILING OUR PHYSICIANS – A SHORTAGE OF PHYSICIAN LEADERS

Unfortunately, the medical profession and healthcare industry historically have not been structured to develop physicians into strong leaders. Physicians have been largely trained to manage symptoms and care, not people. Medical school, and the path to it, trains primarily for an individual contributor role, not for a team effort (although that is changing). Students are taught to compete on individual performance.

On the job, physicians' focus is often on “knowing” the right answer whether it comes from research or clinical practice – not on developing the muscles associated with ambiguity and interpersonal relations. With people's lives on the line, there's often little room for indecision or delay. And medical settings prize individual heroics.

All of this leaves many physicians ill-prepared for situations where there is no “right” answer, and where collaboration and humility are needed. Indeed, in a 2014 survey of more than 20,000 U.S. physicians, only 22% said interacting with colleagues was one of the top two most satisfying elements of practicing medicine. That was less than half the percentage (56%) who said that in 2008. One of our clients spoke at a recent physician leader forum of the difficulty associated with “letting go of being the expert – of being the one with the answers” and instead being the one posing the questions, a critical leadership skill.

What's more, the shift from practicing medicine to leading a medical organization forces doctors to make the leap from self-management to team and functional management; from managing episodic procedures to overseeing projects and processes over extended periods; from diagnosing symptoms to dealing with people and organizational issues; and from getting minute details right to creating a bigger vision.

FEW ON THE JOB OPPORTUNITIES TO LEARN LEADERSHIP

Doctors also have little opportunity for leadership development or the on-the-job learning experiences that business executives routinely encounter. Business executives are typically groomed through career-path experiences, with gradually increasing responsibility and spans of control. In contrast, so they can focus on clinical quality, physicians historically tend to specialize and have been shielded from the business and administrative aspects of the organizations in which they work.

Even doctors who get promoted through the ranks and have leadership roles often get stuck, whether by choice or circumstance, operating in individual contributor roles. And many physicians don't want to deal with the administrative aspects of the business, preferring to focus on patient care.

We believe the healthcare industry has also failed its physicians by not consistently holding them accountable for how they interact with others. Many excellent physicians have been rewarded for delivering outstanding clinical outcomes. However, because many possess a reputation or expertise that brings in business, some organizations have been reluctant to hold physicians accountable for their behavior. How they treat other staff, handle inter-colleague rivalry, and communicate and collaborate with others – or their willingness to put organizational needs above their own – are often largely ignored.

We've heard endless stories from clients of "challenging yet critically strategic" physicians and the destructive wake they leave. Examples range from chief surgeons bullying staff in the operating room when not handed the right instrument to physician leaders sending subordinates withering emails criticizing their performance. Of course, there are many highly qualified and empathetic clinical leaders who promote teamwork and communicate with respect. However, failure to institutionalize and hold physician leaders to behavioral standards or values can wreck staff morale, increase turnover of physicians and nurses, and create toxic working environments.

A wealth of research on communication and patient safety documents the importance of this issue. A 2012 article, for instance, quotes Lucian Leape, professor of health policy at the Harvard School of Public Health, as asserting that "a substantial barrier to progress in patient safety is a dysfunctional culture rooted in widespread disrespect."⁹ He noted that such a culture "inhibits collegiality and co-operation essential to teamwork, cuts off communication, undermines morale, and inhibits compliance with and implementation of new practices."

Historically, however, many healthcare organizations have not provided or required physicians to participate in 360°-degree feedback or performance reviews. This reinforces physicians' lack of self-awareness and responsibility for their impact on others in the workplace. Whether they have a formal leadership position or not, all physicians are viewed as leaders among those they work with by virtue of their position. As a result, they influence those around them.

In short, the qualities of a great doctor do not necessarily equate to those of a great leader, and a physician's traditional career path does not mold strong leaders. This situation is fast becoming untenable at many healthcare organizations. Tighter insurance reimbursement models have fueled an acute demand for highly effective physician leaders who can control costs and keep quality high – and not improve one at the expense of the other.

We have found that leadership ability can be developed in doctors. (And it's certainly more cost-effective to offer management training and leadership development opportunities to doctors than it is to send MBAs through medical school.) With the right set of experiences, and an intentional approach to leader development, healthcare organizations can create the same type of physician leader pipeline that well-run businesses use to train the next generation of leaders.

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⁹ Aeon, by Ilana Yurkiewicz, "Medical disrespect," Jan. 29, 2014. <https://aeon.co/essays/bullying-junior-medical-staff-is-one-way-to-harm-patients>

THE PHYSICIAN LEADERSHIP PIPELINE

In their book, *The Leadership Pipeline*, business consultant Ram Charan and his two co-authors laid out seven levels of leadership in an organizational hierarchy.¹⁰ Each level represents more complex work and major changes in job requirements, skills, time, and focus.

As leaders take on greater responsibility, they move up the pipeline and gain experience and skills critical to being effective at the next level. Over time, they develop a longer-term and more holistic view of the organization's needs. Charan argues that organizations are better served by not allowing leaders to skip steps in the pipeline. Indeed, the skills and values that drive success at one level are not the same that drive success at the next level of leadership. Although the book and model is directed to all industries, Charan specifically identifies healthcare as “desperately in need of better leadership models” and offers this model as a resource to healthcare leaders.

Based on our healthcare industry work, we have adapted Charan's model to outline a typical physician leadership path. It's one we've seen a number of health care organizations institute. It features five levels of leadership (see the exhibit below):



Five Levels of Physician Leadership

Enterprise MD Leader	CEO or other roles for the whole organization
Group MD Leader	Leading a group of businesses
Market MD Leader	Leading a business segment or region
MD Leader	Leading a medical group program or academic medical division
Individual Practitioner	Practicing physician (whether in solo or group practice)

¹⁰ Ram Charan, Stephen Drotter and Jim Noel, “The Leadership Pipeline: How to Build the Leadership-Powered Company,” (Jossey Bass, 2011). <http://www.ram-charan.com/books/the-leadership-pipeline/>

1. **Individual Practitioner** — Practicing physician as part of a practice, group, or healthcare organization, focused primarily on patient care and treatment. Technical proficiency is valued in this individual contributor role.
2. **MD Leader** — Leadership role in a medical group, hospital, or an academic medical center (AMC) division (such as medical director of a service line or group of MDs; leadership of clinic or residents/fellow program in AMC) with management of other physicians or a program. Leaders learn to oversee and delegate work, and develop and coach others. Emotional intelligence comes into greater focus.
3. **Market MD Leader** — A leadership role responsible for a business segment or region overseeing other MD leaders or broader scope of clinical/MD staff (such as regional or market physician leader or chief of an AMC faculty division). This is where you often see dyad models emerge with business leader counterparts or support. The role still largely involves clinical oversight, with some business responsibilities. The leader must learn to understand and manage financials, develop a longer-term view and build some knowledge of strategy. Communication and collaboration skills are paramount.
4. **Group MD Leader** — Leadership role over a group of businesses, with responsibility often expanded over clinical and business outcomes (such as group president or chief medical officer for a corporation or chair of an AMC faculty department). Here the leader must be proficient in evaluating strategy, portfolio assessment, and factoring in the complexities of both internal and external requirements, in addition to skills gained in prior roles.
5. **Enterprise MD Leader** — A top leadership role (such as CEO) responsible for an entire enterprise, including strategic direction and overall organizational results. Leaders at this level are more focused on values than on skills, with emphasis on visionary thinking, external trends, strategic positioning and mission-critical priorities.

There are variations of this pipeline, depending on whether you are looking at an academic medical center, health system or a large private health service delivery business. For the purposes of this paper, we will refer to leaders' roles using the descriptors in the pipeline above.

To build a solid leadership bench, it is important to identify leadership candidates early and draw them through this pipeline by providing growth assignments at the appropriate level, building adequate experience in each role and offering candid feedback and coaching along the way.

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BREAKDOWNS IN THE PHYSICIAN LEADERSHIP PIPELINE

Leadership development needs to be a strategic endeavor, not a one-off course. Turning even the most esteemed clinicians into outstanding leaders requires a comprehensive, systemic set of actions. These actions should be implemented over multiple years and involve increasing levels of responsibility. Each level involves a shift in values, skills, time horizons and spans of control – working and advancing up through the physician leadership pipeline described above. Further, physician leaders must build emotional intelligence (e.g., adequate self-awareness, social skills) and the ability to lead and inspire others to greatness.

Ideally, organizations will develop a strategy for developing physicians as leaders early in their career, and supporting each transition in the pipeline. Absent that, key intervention points present opportunities to build physician leadership.

Each step in the leadership path poses new challenges for a leader. But in our experience, physician leadership effectiveness breaks down most often during two key transitions in the pipeline:

- Moving from individual practitioner to MD leader who manages others, or
- Moving from managing a business or division to managing a large, complex enterprise, in a role such as CEO.

Moving from individual practitioner to MD leader requires leaders to expand their focus – from their own technical expertise to being accountable for others' performance. It involves a new balancing act – learning how and when to delegate, and how to support other people's growth. Superstar physicians often suffer a sense of loss as they hand over some responsibility for patient care.

Physician Leader Skill Requirements:

Clinical:

Delivery of patient care, including coordinating care and bedside manner/relational aspects of care delivery (vs. business or operations management).

Relational:

Managing and developing others, including interpersonal skills, collaboration and emotional intelligence/behaviors.

Business:

Business management and administrative/operations (financial, operations, etc.).

Strategic:

Setting goals, long term direction, managing complexity.

Physician Leader Pipeline – Skill Requirements

Enterprise MD Leader	Relational	Business	Strategic	
Group MD Leader	Clinical	Relational	Business	Strategic
Market MD Leader	Clinical	Relational	Business	Strategic
MD Leader	Clinical	Relational	Business	
Individual Practitioner	Clinical	Relational		

Moving from a group MD leader to an enterprise CEO entails stepping into a role with significant responsibility for a large organization, which can be a difficult adjustment for any leader. At this point, working directly with patients is essentially out of the picture. Some physician leaders try to keep their hands in clinical care to a very small extent, but the demands of the role don't always allow for it.

In developing physician leaders, these transitions often uncover key leadership deficits, three of which can be costly and glaring:

- **Inability to effectively manage and develop other leaders;**
- **Poor relationship management skills; and**
- **Lack of strategic perspective.**

These gaps represent three high-cost but (when corrected) high returns on leadership investments.

FMG Leading's experience and research further support these findings. Our database of 360° leadership behavioral assessments is based on a proprietary 360° evaluation tool that evaluates leaders on 10 categories of leadership capacity (through 65 items about specific skills and behaviors). It includes feedback from more than a thousand supervisors, peers or direct reports of physician leaders.

As you would expect, feedback shows that physician leaders are most recognized for their expertise, knowledge and commitment. Many physicians go into healthcare due to a strong desire to heal and help others, wanting to make a difference in the lives of others. Physicians are also learners by nature and training, with a desire to gain knowledge and understanding, and to often share that with others. Another common characteristic is commitment – to excellence, to continuous improvement, to achieving goals – which all show up with frequency in the top leadership behaviors among physician leaders. Dr. Rob Bessler, CEO of Sound Physicians, one of the nation's largest physician groups focused on the acute episode of care from Emergency department to transitional care, aptly uses the word “resilience” when describing this characteristic. Bessler defines resilience as the unique ability found in successful entrepreneurs and effective leaders to adapt, persevere, and push past any obstacle while staying focused on the task at hand.

Top areas for development that we commonly see among physician leaders and show up in the lowest rated behaviors include self-awareness, conflict management and developing and delegating to others – all critical leadership and people skills.

Addressing the three critical gaps described above – managing and developing leadership skills in others, developing robust relationship management skills, and taking a strategic perspective – can greatly improve a physician leader's effectiveness. And it boosts workplace culture and patient outcomes. Let's explore each skill gap and ways to address them:

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Managing and Developing Others.

As we've noted, many practicing physicians don't gain traditional management experience such as increasing levels of control over budgets or ever-larger teams. They often get directly promoted into leadership roles to manage a group of others or oversee a business unit – in essence, skipping levels in the leadership pipeline, from an Individual Practitioner in the Physician Leadership Pipeline to a Market MD Leader or Group MD Leader. As such, they're dropped into a role that requires skills that perhaps they haven't developed. Leading at this level requires the ability to plan one's own work and the work of others, delegate effectively, and make time to coach others. It also demands taking on the management work of leading the business: understanding business operations, financials, and so on. Succeeding in the business manager role requires a more collaborative style and the ability to take the enterprise view – balancing short and long-term concerns. The traditional command and control environment that physicians have grown up in does not model or foster these skills.

This transition to managing and leading others is especially challenging for physician leaders who continue to deliver clinical care at some limited level (often to maintain their clinical skills and credibility). It puts additional strain on the time they have to plan, delegate and lead others. Many physician leaders prioritize clinical work over the “leading others” part of their new role. This tends to dissolve into micromanagement and work bottlenecks, reactive decisions, and turnover resulting from a lack of mentoring, feedback, or support of their direct reports. We have heard more than one physician leader say, “I just don't have time for that,” when asked how much time they plan, delegate and direct the work of others, and give feedback and mentoring.

There are a number of ways to build leadership aptitude to manage and develop others. These include specific skill-building through training, working with an executive coach, providing developmental feedback and/or investing in the hard and important work of carefully clarifying roles, responsibilities and deliverables of each member of the leader's team.

For example, consider a medical school faculty leader we coached who was making a move from an MD Leader to a Market MD Leader – a high-level position. He was an outstanding clinician brought in to lead a complex medical business on the East Coast. But he struggled to separate his self-interest from the strategic priorities of the organization. He micromanaged every decision, rather than providing direction and allowing others to take ownership. His leadership style paralyzed the organization.

In his 360° feedback, we found that people working with him respected his clinical expertise but were frustrated by his lack of clarity on priorities and his inability to fully delegate. That and his moodiness under stress negatively affected those around him. He had many ideas but reacted negatively when people did not agree with him. That, in turn, filled him with doubt and lessened his impact as a leader.

Our coaching of this leader focused on improving his self-awareness, specifically his reactions and tendencies when stressed or challenged. We also helped him develop a more realistic understanding of his role. We worked with him to design the systems and

structures he needed to build a team he could trust, delegate to and hold accountable (and who could hold him accountable as well), and expand beyond his own personal needs. In essence, we helped him build his capacity as a leader.

The results were powerful. He formed his team with clear intention. He put in place meeting and accountability structures that allowed him to seek other perspectives and delegate key aspects of work to members of his team. He recognized and appreciated how much more he and his team achieved. And he was excited about how much progress the team made on key strategic initiatives – all because he narrowed his role instead of trying to do all the work himself or over-direct others to do it.

This also freed him to focus on critical aspects of his new job, such as recruiting talent and growing the clinical enterprise. Under his leadership, the program became the health system's fastest-growing business.

Although individual coaching is a solid approach to building competence in one physician leader, sometimes an organization needs to build leader capacity among a broader group. In those instances, tailoring a leadership skills course can be a better (and more economically sustainable) solution than providing one-on-one coaching to many physicians.

This is what Sound Physicians found out. When we first met Dr. Rob Bessler, its CEO and founder, his organization had been through three COOs in five years. Dr. Bessler was looking to create more stability and faster growth. He also had a vision for building the next generation of physician leaders, in essence to be “the GE of healthcare leadership.” A critical success factor in his plans was increasing the leadership capacity of Sound Physicians' top-tier physician leaders, and building a strong leadership pipeline for others. However, internal research indicated that engagement levels were low because those leaders did not, in fact, have adequate leadership skills to lead growth or develop their own staff effectively. Their morale, as well as the morale of their direct reports, was suffering. Physician turnover was too high.

Sound Physicians identified the key leadership competencies (the behaviors, beliefs and knowledge) its physician leaders needed to support its values and direction. The organization then created a foundational leadership course that covered an array of management and leadership topics – for instance, handling conflict and providing effective feedback. The course brought together cohorts of physician leaders from each region. The structure allowed them to learn from one another, and was tailored to their organization's unique roles, culture, and challenges. Dr. Bessler had tried using “off the shelf” leadership programs with limited success, noting the irreplaceable power of “peer to peer” training, bringing together leaders facing similar challenges to make the training relevant and actionable to the work at Sound Physicians.

This company-specific learning approach provided significant value well beyond what could have been achieved through generic training, or outsourcing physician leader development to an outside program or course. A follow-up survey a year later showed a 5% increase in confidence in physician leadership skills among team members, and an 18% increase in engagement among physician leaders themselves. Bessler notes that although the specific skill development was valuable, the program provided something even greater: “getting the leaders aligned, inspired, and motivated,” which enabled them to better inspire, lead and develop others. Today, all incoming physicians to Sound Physicians participate in the leadership de-

Building leader capacity to manage and develop others also requires a sober assessment of current leadership and management skills, through tools like a 360 leadership assessment.

velopment program, which includes both basic and advanced components. This leadership program is just one of many components that Sound has instituted in building its own physician leadership pipeline to attract, retain and grow strong physician leaders.

To succeed, the CEO or other senior executive must own and champion such an effort; they can't assign it solely to the HR or organizational development functions. When developing physicians' leadership skills, organizations must provide a variety of management experiences and project leadership opportunities. They also need to deliver incisive feedback on performance.

When *Executive Coaching* is **Not** the Solution

Executive coaching can be a very effective way to develop clinical leaders, especially when it is provided to a physician leader at a critical point in time (such as when promoted to a new role on the physician leader pipeline, requiring an adjustment in focus and skills). It can also be effective because it focuses on the specific needs and learning style of the physician, and delivered at times that work around his/her schedule. It also helps to have such coaching delivered over an adequate time period so that it can be tailored to specific organization situations.

At the same time, coaching entails a significant investment and can be risky if certain factors are present. In particular, there are **four situations** that have the potential to doom the success of coaching:

1. The Leader Isn't Ready

When coaching is pushed on a person who doesn't want it, the odds of success decline dramatically. Forced development almost never succeeds. Straight feedback, compassionately delivered on outcomes and behaviors, is a precursor to readiness. Unless you've been candid and compassionate with the physician leader about issues and possibilities, don't throw a coach his or her way. "When the student is ready, the teacher will appear."

2. No Time to Pause

By job title and description, physicians are busy. Layer on administrative and leadership responsibilities to a leader trying to maintain a high degree of clinical excellence and eminence, and you risk reaching a point of over-saturation. If the cup can't

take one more drop of water, don't waste a precious commodity. Successful coaching can't be an "add on" to an already brimming cup or a calendar with no spaces. Instead, for the duration of the coaching work (and it is work to develop, improve and change), find ways for the leader to temporarily clear extraneous meetings, conferences and assignments. Create "slack in the system" to allow this to work.

3. No Time to Breathe, Reflect

Similar to #2, successful leader development through coaching often requires a "pattern interrupt" — that is, a process of becoming aware of a habit or behavior, deeply understanding its consequences (both positive and negative), and learning to make better, more effective choices. That's hard work, and in our experience, is seldom successful when one's focus is consumed by the day to day without space to pause and reflect.

4. Unwilling to "Not Know" or Look Weak

Growth as a leader (and as a person) requires a certain type of vulnerability, a willingness to be uncomfortable in "not knowing." Developing leaders need to try on new behaviors and approaches. They won't master them quickly. They will make mistakes and won't have all the answers, all of which (to their thinking) makes them appear weak.

Overcoming this fear is central to successful behavior change, whether it be for a new golf swing or a new approach to handling difficult conversations. The key is getting a leader to make a sincere effort (whether polished or not) until he/she masters proficiency in a new behavior. They must also be willing to

Building leader capacity to manage and develop others also requires a sober assessment of current leadership and management skills, through tools like a 360° leadership assessment. Once the skills and behaviors are evaluated, key gaps can be identified and addressed individually or collectively.

As part of its commitment to developing its physician leaders, Benevis engaged all of its market dentist leaders, called Area Dental Directors (ADDs), in a 360° assessment and coaching process. The results were stunning. It was the first time that many of these leaders, even some who were mid-career, had received any formal feedback. Dave King, senior vice president of human resources, noted how difficult and eye-opening the process was for many of the dental leaders. One of them had been told his whole life that he was a “rock star,” even in his current role. When he was informed that he had areas of opportunities to improve as a leader, he was devastated and required interventions to help restore his confidence.

Other ADDs embraced the process and made significant strides. One of them, who initially took the coaching feedback poorly, later fully engaged in the process and became one of the company’s strongest leaders. What was the difference? According to King, “doctors by nature are learners, so many of them loved learning about themselves and how to develop and practice the skills provided to make them better at what they do.”

Common gaps identified from the assessment were knowledge of basic business skills and language, as well as people skills, especially communication and delivering feedback to others. Targeted coaching and mentoring was provided to individual ADDs to address gaps and further enhance leadership skills, as well as the provision of group leader development at annual leadership meetings and follow-on programs, such as e-learning.

King also noted the benefit of having colleagues going through the same process with a common language for leadership, and the strong commitment and support from senior executives. “Ultimately, they appreciated the investment in their development.” Benevis saw higher engagement scores as a result, with clinical leadership having the highest scores among the different employee groups within the organization a year later.

Developing Robust Relationship Management Skills.

Leading other people is a “person-centric” job. Patient care is too, to an extent. However, interactions with patients tend to be episodic and individually focused, with the power dynamic putting the doctor clearly in charge.

Indeed, many physicians start out as researchers, where relationship management skills are not necessarily critical for success. Physicians have also typically been trained to keep emotion out of the job, and are not comfortable showing vulnerability in the workplace. Doctors have largely been evaluated on clinical skills, not on collaboration. Being the “hero” for many means they haven’t gained the self-awareness or accountability for their behavior and its impact on others, as noted previously.

Indeed, many studies on physician leadership have noted the importance of social awareness, social skills and relationship aspects of leadership. Dr. Stoller, who leads the Cleveland Clinic’s leadership program, believes emotional intelligence (which he defines as “the ability

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The Physician Leader's *Blind Spots*

One of our clients, Ned Schwing, who has worked extensively and successfully in launching and scaling physician-based companies, likes to tell the story of “Tim,” (not his real name) illustrating common blind spots of physician leaders. In his words:

“A stereotypical overachiever, Tim got into the ‘right’ college, aced a double major, finished early, and went on to medical school, where he graduated at the top of his class. He is a brilliant cardiologist, a physician you want on your team if you have a heart attack. But while he may know everything there is to know about left ventricle hypertrophy, he doesn’t know a thing about effectively relating to the nursing staff or his partners. He doesn’t show empathy or compassion, and seems annoyed by people’s questions. He looks at his colleagues as a necessary evil.

“What Tim doesn’t understand is that at people’s worst moments, he needs to be at his best. Unfortunately, there are many ‘Tims’ who are serving as physician leaders, yet lack key skills needed to build an engaged workforce, guide strategic growth or drive a thriving business.

“We all know a Tim. And like it or not, the medical profession is filled with Tims. Why? That, as they say, is above my pay grade. Some suggest an overdeveloped IQ and an underdeveloped EQ, while others argue that the medical community itself breeds a culture of arrogance and entitlement. Perhaps it’s a mixture of both.

“As a businessman and an entrepreneur who has partnered with over 1,000 physicians, including orthopedists, cardiologists and neurosurgeons for the past three decades, I have seen my fair share of Tims. But I have also seen the antidote – the un-Tim – the doctor who is empathetic, humble and selfless: the physician leader.

“I have seen him listen and learn, collaborate and cooperate. I have seen him work incredibly long hours, come home



and pore over the latest medical journals because he knows that education doesn’t stop after graduation. I have seen him keep his composure under the most stressful, gut-wrenching situations. I have seen him make mistakes and take responsibility for them because he knows that no human being is perfect, and sometimes, the best we can do is learn from our missteps. In my view, the physician leader is marked by four foundational elements: his character, competence, humility and passion. Everything he does, and all that he is, are rooted in these traits. His head, heart and hands work seamlessly together, and he leads by example.”

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to understand and manage oneself and to be aware of and manage relationships”) is the most important differentiating factor for a physician leader.¹¹

Our research and experience supports the notion that self-awareness and relationship management are critical components of effective leading, and are often lacking in physician leaders. Weak relationship skills often show up as conflict avoidance, poor emotion management, a lack of collaboration, and communication issues.

Reluctance to give performance feedback, especially with physician colleagues, is a common gap among physician leaders. “We see two sides to this coin among our doctors,” says Dave King of Benevis. Leaders are reluctant to have difficult conversations or give feedback, while others have no problem sharing feedback but do so bluntly with no filter, which can also be problematic.” And the cost of these gaps increases as the leadership level rises, since the physician leader has an impact on a growing number of people and areas of the business, with their behavior directly influencing the culture of the organization.

Consider a physician leader we’ll call Dr. Jeff, who was recruited to lead a clinical business unit in a large medical center whose clinical and business outcomes were suffering. He was hired based on his strong research and clinical success. However, he had weak relationship skills and couldn’t build the cohesive team of nurses and physicians necessary to improve outcomes. When he arrived, he immediately highlighted the need to improve clinical outcomes and introduced new practices without adequately educating or engaging the nursing staff, or bringing medical staff together to support the changes. In fact, he didn’t hold a medical staff meeting the first year of his tenure.

When challenged, he became emotional. The rest of the clinical staff revolted, and physician turnover shot up. When we conducted an employee engagement survey, the score for senior leadership was less than 3.0 on a scale of one to five, one of the lowest scores we’ve ever seen. It reflected the lack of communication and trust in leadership. Even though the opportunity to improve clinical care was there, as a leader Dr. Jeff failed to value collaboration and inquiry. He couldn’t regulate his emotions or build relationships and a collective commitment to change. He lost his leadership job over this, and ultimately left the organization.

Such stories aren’t unusual. Today, physicians are increasingly encouraged to focus on patient satisfaction and improve their “bedside manner.” (See the sidebar, “The Physician Leader’s Blind Spots.”) Yet many don’t recognize the importance of their “deskside manner” – the way they interact and relate to their co-workers and colleagues. Effective leadership requires leading with both the head and the heart – showing authentic presence, demonstrating emotions and caring in a positive way.

We have found several ways to help physicians gain insight to their blind spots and build relationship management skills and higher EQ. Utilizing personality or style typing tools, often referred to as psychometric testing or assessments, can be a powerful method of providing awareness and appreciation for differing styles. Performance feedback through a 360° assessment is also a valuable tool in building self-awareness and insights into a person’s

Reluctance to give performance feedback, especially with physician colleagues, is a common gap among physician leaders.

11 American Hospital Association, Physician Leadership Education, report from 2014 Physician Leadership Forum meeting.



behavior and how it affects others. A 360° assessment, including quantitative and qualitative feedback on key management and leadership skills, provides an objective snapshot and specific examples on how a leader is viewed, and their impact on their staff. Physicians, by nature and training, love data. We have seen many clients use the 360° feedback to gain insight and commit to changing themselves.

A recent review of physician leadership programs across the industry shows that 84% use 360° assessments and some type of personality tool, such as the Enneagram or Emergenetics, to provide personal insight and feedback on leadership, and 92% offered executive coaching.¹²

Take the case of the physician leader of the Emergency Services Department at a major medical center. Dr. James, as we'll call him, had been identified as successor to an incumbent, who had held the leader role for almost two decades. He was appointed as the emergency physician practice leader with solid experience and credibility, but was immediately faced with a mandate to improve quality, efficiency, and morale.

His new role required him to work in new ways with nursing leadership and other clinical departments that interacted with the Emergency Department. He faced a culture of silos and a fair amount of finger pointing, rather than aligned or collaborative behavior. Dr. James had already developed solid business and leadership skills, to add to his good leadership instincts. To navigate the leadership transition, he needed to work on his influence skills, broaden his strategic perspective and deepen his ability to lead change.

With the benefit of 360 degree leadership feedback, Dr. James was able to focus precisely on improving interactions with his direct reports. It helped him identify elements of his leadership style that had previously been effective, but were no longer serving him well. In particular, his strong bias for action, when applied to his new role, came across as a tendency to move too quickly to action before sharing the big picture or rationale for key decisions.

He was making great progress, but wanted to better engage the rest of the department with him in the journey. Through working with an executive coach, Dr. James recognized his need to build relationships with key stakeholders. He also realized the importance of having a core team of nurse and physician leaders to help him guide the path for change in the department.

Through his coaching and commitment to new ways of engaging, he turned a fractious relationship with the nursing leadership into a cohesive and collaborative team, dedicated to a shared future vision and culture. One of his key stakeholders commented that it was the first time in 30 years that the leader of the department had actually asked for feedback on how to enhance the relationship and coordination of patient care between the two departments.

Dr. James initiated a number of cross-functional efforts to redesign how physicians and nursing staff worked together, seeking input and being open to other's ideas. For example, he brought together senior nursing staff and physician leaders to articulate a shared vision for culture and quality within and across two hospital Emergency Department locations. The group continued to meet weekly to plan for quality, operations, and strategic oppor-

¹² Physician Leadership Development Programs: Best Practices in Healthcare Organizations 2014, National Center for Healthcare Leadership

tunities. Another physician-nurse leader group launched a weekly meeting to identify workflow issues, address hot topics facing the unit and improve cross-functional communications.

As important, he worked on managing how he reacted to others, developed communication skills and made himself more accessible to staff. With dedication and practice, he became viewed as a strong leader and built an engaged and united leadership team. He also brought back pride and cohesion to the Emergency Department. Key performance metrics and physician/staff engagement survey results also improved in the first year of his tenure.

Leaders need to be attentive to both the “doing” and the “being” aspects of leadership, noted above, balancing their focus on business results while inspiring others through authentic and purpose-filled leadership. Self-awareness and executive coaching are two ways to find and develop that balance.

Taking a Strategic Perspective.

Managing complexity in business has never been more important, especially in healthcare. When physician leaders are promoted to lead an entire enterprise or a business segment (level four or five on our physician leader pipeline), many lack the experience in managing and blending functional and business strategies, portfolio assessment, factoring in short- and long-term tradeoffs, and taking a longer-term strategic approach to decisions. This gap can directly affect leader effectiveness and success of the business. The risks are high, given the degree of change in the competitive and regulatory landscape.

Take the case of Dr. Ronald DePinho, who resigned in March 2017 as CEO of MD Anderson Cancer Center in Houston. As he wrote in his resignation letter, his admitted inability to navigate “the tectonic changes in health-care delivery and economics” led to his departure.¹³

On the other hand, take Dr. Kevin Tabb, CEO of Beth Israel Deaconess, a renowned hospital in Boston. He is known for his ability to think strategically, always examining industry trends and calculating how to adapt. He recently was instrumental in forging a merger with Lahey Health, another large Northeastern system, to take on New England giant Partners HealthCare. Those who know or have worked with Tabb say “his varied experience, communication skills, sharp focus on data and results, and ability to navigate changes in the health care industry have prepared him for the task.”¹⁴ He’s a leader who has effectively navigated the leadership pipeline, gaining experience through a variety of roles with increasing responsibility and scope, first at General Electric’s healthcare technology business and then at Stanford Hospital and Clinics, where he moved up the ranks to Chief Medical Officer before becoming CEO at Beth Israel Deaconess.

One doctor we worked with, a top executive of a large physician organization, is a great example of how on-the-job learning can help a physician gain strategic skills. Dr. Mark, as we’ll call him, was promoted from a division group president to president of a portfolio of businesses (moving from the Group MD Leader level to the Enterprise MD Leader level).

Leaders need to be attentive to both the “doing” and the “being” aspects of leadership, balancing their focus on business results while inspiring others through authentic and purpose-filled leadership.

¹³ “DePinho resigns from top post at MD Anderson Cancer Center,” Modern Healthcare, March 8, 2017. <http://www.modernhealthcare.com/article/20170308/NEWS/170309897>

¹⁴ Boston Globe, “Is this the guy to take on Partners HealthCare?” March 8, 2017. <http://www.bostonglobe.com/business/2017/03/08/this-guy-take-partners->



To transition effectively, he needed to make two significant adjustments simultaneously. The first was to let go of his clinical involvement and shift to a more strategic role. The second was that, as a market president, he had to become much more deeply involved in the business, as he was ultimately responsible for many significant client relationships.

Honing his business chops for the next level required that he see himself as a capacity creator – coaching a half-dozen physician leaders further down in the organization to solve client problems for themselves. Indeed, for Dr. Mark, developing, mentoring and grading his team was a critical focus area. He needed to assess the players and select his team, as well as develop a strategic narrative for the business to tell a story about where it was headed.

While he struggled to let go of his clinical identity, Dr. Mark ultimately decided to give up his clinical rotations and focus exclusively on growing the business. He visited each of the geographic groups for which he was responsible and listened intently to assess the capabilities of his teams. In six months, it was clear to him where he had strong performers, and where he had to replace leaders. In addition, he was given many opportunities to attend board meetings and present a strategic narrative about the health and trajectory of this business. While preparing these kinds of presentations can be stressful for a newly promoted leader, they are extremely effective development tools.

DEVELOPING A ROBUST PIPELINE OF PHYSICIAN LEADERS

To build an adequate pipeline of physician leaders for the future, a healthcare organization's talent management strategy and culture must provide a career path for younger physicians with leadership potential and aspirations. To date, these opportunities have largely been opportunistic but are more effective when they are targeted and intentional.

For example, Kaiser Permanente in Colorado was struggling in the late 1990s, its financial performance and clinical outcomes declining. Many top-notch doctors were exiting. A new medical director revamped Kaiser Permanente's physician leadership development programs. Part of the change was identifying potential leaders and putting them through the pipeline. In five years, the system became one of the best in Kaiser's system in clinical outcomes. What's more, patient satisfaction increased significantly, staff turnover plunged, and financial performance improved greatly: annual net profit rose from zero to \$87 million.¹⁵

Jim Tait of TeamHealth is one who advocates for integrating more concepts of management and leadership in residency programs and medical schools, providing earlier exposure and skills to physicians as part of the curriculum and training process. The company now offers a medical scribe position (a person to take medical notes for physicians as they see patients) to 1st and 2nd year medical students and some medical residents, to expose them

[healthcare/kUbvQHPrTgaFapE6ymxl1J/story.html?s_campaign=8315](https://www.healthcare/kUbvQHPrTgaFapE6ymxl1J/story.html?s_campaign=8315)

¹⁵ CNN Money, "Changing minds," May 22, 2007.

earlier to certain capabilities and experiences, as well as give them the chance to observe and learn from effective physicians. It has served as an effective recruiting tool, as well as providing experience and knowledge of TeamHealth during this program.

Similarly, Sound Physicians has started a program they call Compass program. It is available to physicians in their last year of training/residency who have demonstrated leadership interest and potential, i.e. chief resident. Applicants are subject to a rigorous selection process, and those selected are provided a small stipend, the opportunity to attend Sound Physicians leadership conferences, participate in a monthly development call with peers and receive some training. Sound Physicians has found this to be an effective recruiting tool for aspiring physician leaders, and the program has been in high demand with more applicants than available slots.

Our client Benevis had that objective of providing a career path for physician leaders in mind when it created the senior associate role for aspiring and high potential dentist leaders. Its goal is to have at least 25% of associate doctors meet the criteria for eligibility. Criteria include demonstrated examples of leadership at work, excellence in serving patients, and commitment to involvement in the local community. Dentists can apply annually to be considered. Benefits include having access to additional selected company leadership development resources and activities, as well as a dedicated bonus program based on clinic performance, which also serves to develop financial and business knowledge. “It is just one way we aim to invest in and recognize top talent,” says COO Lisa Mikkelsen.

There are, of course, many physicians who are already advanced in their career and won’t be able to fully benefit from an early career development approach. Nonetheless, we have found that executive coaching and strategic advising can help them build key strategic and enterprise leader skills. It can accelerate their ability to lead an enterprise and improve its performance. They can also benefit from real-time learning experiences that come with a promotion – if they are open to learning new ways of working.

Despite the strong demand for physician leaders, not all physicians are suited to leadership roles, nor do all wish to make the transition. For one final example, consider a physician leader at a large healthcare system. He had the opportunity to move from a Market MD Leader to a Group MD Leader in the last several years of his career. The health system had done a nice job of providing him experiential opportunities to prepare for a larger leadership role. He served on system wide committees, taking leadership on key strategic initiatives, collaborating with other parts of the organization, and so forth. He had strong interpersonal skills, good strategic sense, and an aptitude for developing others. He was assigned an executive coach to further develop his leadership skills.

The coaching process required him to give some deep thought about what an executive role would entail. He used his coach as a sounding board to play out various scenarios. But the deeper he explored the role, the more he found the “committee work” he was being groomed for to be somewhat distasteful and unfulfilling. He had almost decided that he didn’t want the bigger job, when the CEO role of his medical group unexpectedly became

Despite the strong demand for physician leaders, not all physicians are suited to leadership roles, nor do all wish to make the transition.

available. The work he'd done exploring a "next level move" made it easy for him to see this CEO role as ideal for him. It allowed the organization to tap his leadership skills but also keep his hands in the clinical practice, providing patient care while still leading at a more focused level.

THE TIME TO START BUILDING THE PIPELINE IS NOW

The need and call for physician leaders today is at a critical level. In the face of increasing demand, the industry is falling short in its attention, approach, and level of investment needed to deliver an adequate supply of highly effective physician leaders.

Building a solid pipeline of physician leaders at all levels takes time, resources and great attention. It cannot be done in a matter of months. However, if healthcare organizations want a steady stream of physicians who can run key parts of their business with great skill, they need to make the commitment now or risk seeing key jobs led by executives who aren't ready for prime time.

Long term, the answer is an integrated talent management strategy and development of a tailored physician leadership pipeline. In the interim, clinical organizations must focus on building leader capacity, relationship management skills, and strategic perspective in their current and future physician leaders. Those that do will be prepared to drive strong and successful companies in meeting the growing healthcare needs of our country. ■

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FMG Leading is a human capital strategy firm that partners with visionary leaders and investors who are committed to transforming the healthcare industry in America. Working at the intersection of humanity and high performance, the advisors at FMG Leading partner with clients to design integrated development strategies that accelerate growth, build enterprise value, and create industry-leading results.

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