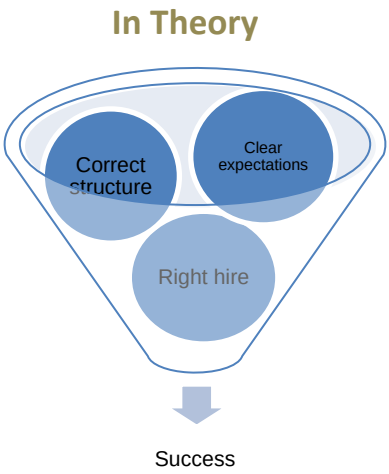
TEN WAY PHYSICIAN LEADERS GET TORPEDOED

Theories always look good on paper. That holds for the structures organizations put in place to support physician leaders. But there's a wide divide between theory and practice. And more often than not, it's the execution – not the theory – that breaks down. We make it very, very difficult for medical leaders to be successful sometimes. In fact, we put a number of key obstacles in the way.



What are the top 10 organizational missteps that can torpedo medical leaders? A summary list follows and at the end of this article, a link to an enlightening Webinar with a more detailed discussion. Note that the list is in two parts: five more obvious gaffes that are easier to spot and avoid, and five more nuanced blunders that are harder to ferret out and therefore tackle. Each list counts down to the number one hurdle.

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5 Obvious Mistake #5: *Hire a Soloist When You Need a Conductor*

Back in the day, hiring was all about a physician's curriculum vitae. How many published papers? How many prestigious grants? Today's medicine is team-based. Physician leaders must be able to juggle many responsibilities that hinge on interpersonal relationships. They need to bring out the best in their people by helping them achieve and succeed. Hiring a soloist focused solely on his or her own career is counterproductive to organizational success.

4 Obvious Mistake #4: *Create an Org Structure that Looks Good on Paper*

Organizations may put medical leaders in the C-suite but in reality, there's no seat at the table. The administrative team works well together but doesn't really understand how physician leaders contribute. Dual reporting relationships in health care's matrix structure pose interesting challenges. We expect physician leaders to balance sites, services, specialties and departments, and in the ACO environment, manage both employed and private practitioners. To be successful, organizations must be clear about where the buck stops so physician leaders can work effectively from within to facilitate change.

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Obvious Mistake #3: *Value Management Over Governance*

It's instinctive: when placed in a position of authority, people tend to manage down and tell others what to do. But that's not the best approach to take with physicians. Medical leaders must learn to orchestrate, not dictate, medical staff and practice success through leadership, governance and stewardship. They need to provide clinical, operational and financial oversight to ensure the affordable delivery of quality health care services. It's about advancing the organization's vision and mission by giving people the tools, skills and support necessary to do the job.

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Obvious Mistake #2: *Demand a Jack-of-All-Trades*

Job descriptions are jammed with too many archaic and technical tasks. Organizations need leaders who can focus on clinical quality and direction, and care delivery models, especially with the hybrid, reimbursement mechanisms at work in the market today. Relationship building is also key, with the medical staff, hospital team and the community. Physician leaders should not be expected to execute financial obligations, dive into IT issues, or deploy marketing tactics. Yes, they need analytics to monitor and dashboard their organization, but they shouldn't get lost in the weeds.

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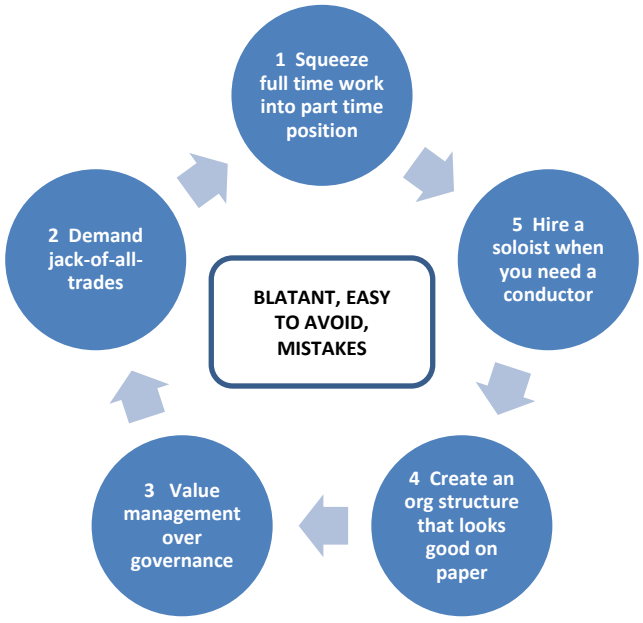
And the #1 Obvious Mistake: Squeeze Full-Time Work into a Part-Time Position

It's natural to expect more from ourselves and others. But squeezing full-time work into part-time positions, or pieces of positions, upends organizations and frazzles the people working there. Physician leaders who are asked to do more than what's possible in the time allotted burn out. And burnout is directly linked to lower patient satisfaction and care quality, higher medical error rates and malpractice risk, higher physician and staff turnover, and physician substance abuse, addiction and suicide. Organizations must calculate the actual time that's required to be successful, and then allot that time and honor it.



More Nuanced Mistakes Are Even Tougher

What about those subtle slipups – organizational faux pas that are so hard to discern they surreptitiously hopple or topple physician leaders? Those mistakes follow, again counting back to the most egregious offense.

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5 Nuanced Mistake #5: *Failure to Define Success*

Organizations create job descriptions that are just too vague. Leaders need to see quantitative measures of success. "Make the medical staff get along" should read instead, "attain a 5 percent increase in physician engagement scores." Not "achieve clinical integration" but rather, "ensure 80 percent of the medical staff are ACO members." Vague expectations lead to dissatisfaction and wheel-spinning. Specific targets, with assigned due dates, generate workable strategies and realistic action plans for success.

NOT THIS	THAT
make our medical staff get along better	attain a 5% increase in physician engagement scores
improve the patient experience	improve our "likelihood to recommend" score by 7%
achieve clinical integration	ensure 80% of the medical staff are ACO members

4 Nuanced Mistake #4: *Skimping on Support Resources*

Organizations do not always provide the resources necessary for physician leaders to achieve these clearly articulated success measures. The resources most often required include project management support, analytical support to measure metrics and assess outcomes, and content knowledge so people understand how to move forward and improve outcomes.

3 Nuanced Mistake #3: *Not Holding Physician Leaders Accountable*

This mistake is rampant. Organizations, by and large, do not hold physician leaders accountable. Commonly overlooked accountabilities include performance improvement, team building and personal skill building.

Common personal skill building needs:

- Clinical integration, IT
- ACO funds flow
- Patient experience
- Presentation
- Conflict resolution, advocacy, negotiation
- Vision, strategy, end-game articulation

Team building accountabilities include:

- Build high functioning, cohesive teams
- Work with & through others
- Learned behavior, not instinctual
- Tendency to power through – use brain not brawn

Performance improvement requirements include:

- Quantitative operational & clinical outcomes
- Written!
- All levels:
  - Team-based
  - Medical staff/practice based
  - Individual

2 Nuanced Mistake #2: *Failure to Manage the Victim Mentality*

Victim mentality can fester in a rapidly changing healthcare environment, where there are no underpinnings. Whether it's a newly introduced electronic health record or a newly formed ACO, or some other change, it's too easy to say: someone did this to me (the administration, IT and/or the hospital), I'm not the cause of the existing problem(s), and it's your fault. As medicine evolves from a doctor-centric to a consumer-based model, many physicians feel loss, which can breed anger and disengagement. The antidote is to shift the discussion from victim mentality to serving patients: I am accountable for the clinical environment that delivers care excellence; although I can't control all of the variables, the ones I can control will deliver great care every time. And I may have multiple missions, but when I'm in my clinic, I'm there for my patients with excellent access and care. Physician leaders must espouse and promote patient-centered change as an opportunity for new programs, therapies, academic initiatives and research advances.

1 *And the #1 Nuanced Mistake: Not Coaching or Supervising*

Too many CEOs toss their medical leaders into the fray, without enough guidance or supervision. Many are in senior positions for the first time and need formal leadership and business training. They need to understand how to orchestrate and not just give orders. And they need help in managing the residual distrust of administration. While administrators and physicians are better at working together, coaching and mentorship can help put lingering doubts to bed and solidify partnerships.

Link Here for More

Our physician staffs are beleaguered. They're overworked and sometimes under-supported. Helping physician leaders move to a place of empowerment benefits individuals, teams and ultimately the organization itself.

To expand and continue the discussion on what mistakes to avoid and how to spot issues before they explode, download the slides and Webinar recording, featuring Jayne Oliva, MBA, and John Schreiber, MD, President of Baystate Medical Practices; Chief Physician Executive, Baystate Health; Regional Executive Dean, UMass Medical School.

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