



Physician Leadership Education

Physicians are being called upon to bring their expertise to bear on the management of the clinical enterprise in collaboration with other hospital leaders. How do they ensure they are prepared?



INTRODUCTION

With health care delivery on a fast pace toward transformation, strong partnerships between physicians and hospitals are more essential than ever. Strong environmental forces are pushing the separate clinical and operational management models of today's hospitals to find new ways to collaborate and create a clinical management structure that addresses the efficient use of scarce resources while maintaining strong clinical quality and patient focus. As integration continues, physicians are being called upon to bring their expertise to bear on the management of the clinical enterprise in collaboration with other hospital leaders. At the same time, physician preferences are shifting to allow increased work/life balance reflecting the changes in physician demographics. The days of individual practices dominating the health care landscape are fading as more physicians seek employment.¹

As physicians continue to assume leadership roles in hospitals and health systems and serve as drivers of the future health care organizations, they will need to move beyond their clinical expertise and think long term, understand and be able to see the larger issues, and work collaboratively as team players.²

Approximately 5 percent of hospital leaders are physicians, and that number is expected to increase as health care delivery moves to a value-based system. Arguably, clinically trained health care leaders can offer significant insight into patient care, quality, and safety issues based on their experience and training, which some data bears out with one study indicating that hospitals with physician leaders scored higher on certain quality measures.³ In addition, when physician leaders are partners with the hospital they can help drive better coordination across the continuum.⁴ However, until recently, a pathway for physicians to

gain business and management insight to lead a transformed delivery system was not entirely clear. However, hospitals, health systems and educational groups have begun to recognize the need to provide leadership training to physicians. Physicians, in turn, are seeking out these opportunities as more look to effect delivery system reform.

The American Hospital Association's (AHA) Physician Leadership Forum, as part of its focus to foster strong physician-hospital relations, has sought to identify and encourage leadership development opportunities for physicians. This report highlights the case for developing physician leaders, identifies characteristics to consider for leadership education programs, and concludes with the proceedings from the Physician Leadership Forum's educational summit in conjunction with the American College of Physician Executives, *Physician Leadership: The Implications for a Transformed Delivery System*.

The Case for Physician Leaders

As Lee Igel, PhD, writes, physician leadership is not new. Physicians have always led the way in the performance of health care. But during the past 50 years, those who aspired to a leadership position were told to “think like businesspeople” rather than trained to become true leaders.⁵ The most effective physician leaders are those who demonstrate superior responsibility and performance. It is those physicians who should be developed – not appointed – as leaders.

According to Dr. Alan Kaplan, navigating the rapidly changing health care landscape takes engaged physician leaders who can take charge of initiatives such as medical home development, care coordination, chronic disease management, practice management, information systems implementation and strategic planning. “We know the end game, increased quality at lower cost, but we need innovators to help define what that looks like in the face of the current uncertainty. Leading into ambiguity requires committed, capable leadership,” Kaplan wrote.⁶

intelligence, empower and motivate their workers, and help team members strike a balance between work and home.⁷ According to Dr. Richard Schwartz and colleagues, these new leadership skills have traditionally not been a part physician training. “While many physicians believe the skills learned in medical school, residency and practice in the health care environment will ensure their success as physician leaders, we believe that the vast majority of the administrative and organizational skills necessary for physician leaders are, in fact, not among those skills typically developed in the medical education process.”⁸ It is, however, crucial that physicians understand these leadership concepts and the skills they will need to thrive as leaders in hospitals and health systems. Dr. James Stoller says there are four factors driving the need for physician leaders:

...navigating the rapidly changing health care landscape takes engaged physician leaders who can take charge of initiatives...

Traditional leadership is morphing from a top-down approach to one that is more matrixed and collaborative.

Where traditional leadership was more paternalistic, with leaders crafting a vision, delineating specific perfor-

mance goals, and focusing the team on the work arena, leaders of today work to inspire performance, employ emotional

1) The complexity of health care organizations and the current health care climate.

Challenges faced by health care organizations today are best addressed by those with experience on the front lines of delivering care. Reform will require strong leaders from within health care, and who better to lead this



than physicians, who have firsthand knowledge on pressing issues like access, quality and safety improvement, and patient care.

2) Physicians' disinclination to followership and collaboration.

Physician training is individualistic in nature, but to meet the care needs of the increasing population with a decreasing physician supply will require that all clinicians work together in teams to provide the best care to patients across the continuum. Those physicians who are able to embrace a culture of collaboration will be better situated to succeed.

3) The traditional practice of promoting physicians to leadership positions based on clinical and/or academic skills and accomplishments rather than leadership competencies.

Clinical and academic skills are no guarantee of leadership success. With increasing practice demands, physicians

have little time to develop leadership or management skills and today's fast-paced health care environment leaves little room for on-the-job training.

4) General inattention to training physicians in leadership competencies.⁹

Physicians transitioning into leadership roles must recognize the need for a different skill set to succeed as a leader.

Leadership Training — Finding the Opportunity

Physician advancement into positions of leadership has been largely based on credentials, seniority, clinical competency, and political standing.¹⁰ These traits, however, do not necessarily make a strong leader. On the journey from medical training to practice and leadership, physician leaders often receive little, if any, formal training in leadership or management skills.¹¹ In part, the tight medical school curriculum schedule and its focus on clinical skills and science education have not left room for leadership training, and the selection process for applicants has not focused on leadership criteria.¹² However, some medical schools have begun to reshape their admissions processes to select for attributes beyond basic sciences knowledge and look for those traits exemplified by physician leaders.¹³

A study conducted by the AHA's Physician Leadership Forum recommended several ways medical schools could do a better job preparing the next generation of clinical leaders by expanding candidate search criteria to include non-traditional aspects, such as emotional intelligence. The study also recommended several ways to decompress the educational load of medical school through broader modes of education, moving foundational science courses to the undergraduate level and expanding the curriculum to include more education around the science of teamwork, quality improvement, and potential leadership development. Finally, the report suggests looking to Masters of Health Administration and Business Administration programs for additional insight and methods for ingraining teamwork approaches.¹⁴

Indeed, it's rare to find business courses interspersed in the medical school curricula, although some schools have begun offering introductory business courses on medical

organizations and economics.¹⁵ Dr. David Fairchild and colleagues agree, saying, "Strategic planning, finance, leadership, negotiation, and other management skills are often necessary in these [leadership] positions, but represent skills not taught at most medical school or postgraduate residency programs."¹⁶

Residency training, when exposure to collaboration, teamwork and the administrative and organizational functions of an institution begins, would present an opportune time for leadership training to begin, yet little is currently documented in the literature.¹⁷ Medical training has traditionally focused on individual responsibility with less emphasis on collaboration and teamwork, which can hamper development of interpersonal and communication skills critical for leadership. "Not only have studies revealed that management training in residency is desired yet inadequate, many believe, as we do, that residents are far enough in their training to provide both clinical support and critical

managerial energy and productivity that can be tapped in a structural program.”¹⁸ Some,

...include more education around the science of teamwork, quality improvement, and potential leadership development.

like Dr. Michael Tibbitts, believe the medical school curriculum needs to be altered to include more medical-related business topics, such as the future of health care, marketing, quality assurance, and stress reduction.¹⁹

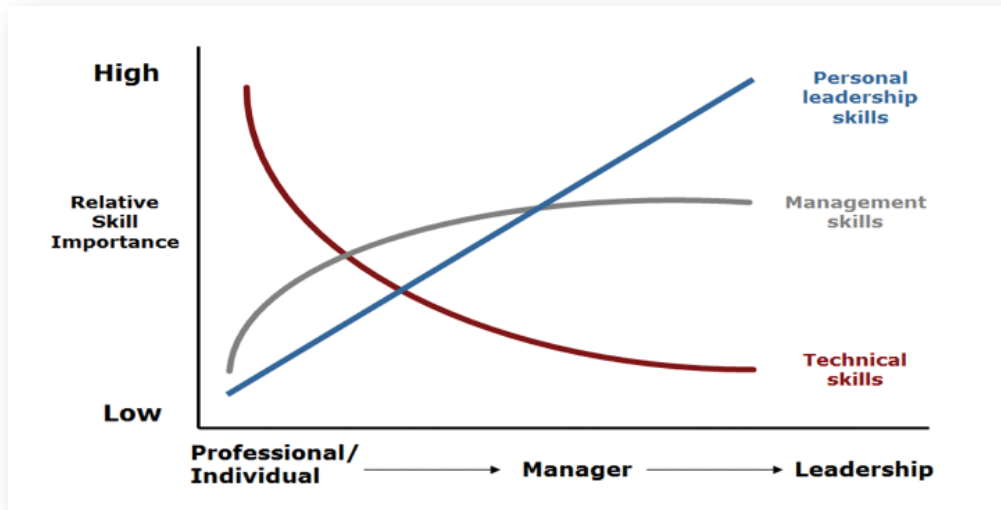
Studies have shown there are gaps between skills learned in medical school and those required for residency and practice, particularly around communication and professionalism. Medical school graduates may be prepared for the clinical tasks they face in residency, but non-clinical knowledge is often lacking.²⁰ To help ease the transitions across training and into practice, numerous programs have been developed to address some of the knowledge gaps inherent in the transitions. There are short programs designed for the move from classroom study to the clinical learning environment which include an overall orientation to the clinical setting, introductions to experiential learning, team environments, and practical knowledge of the workings of a hospital. Most use simulation, shadowing, and role playing to increase student comfort with the new environment.^{21, 22, 23}

Another area of study is the use of the fourth year of medical school for more intensive uptake of the competencies and skills needed for residency. Instead of having fourth year medical students spend time on a number of different rotations, medical schools, in partnership with a local

university, could offer elective teamwork, management or leadership courses.²⁴ The fourth year also provides an opportunity to construct electives addressing effective communication skills, health policy and regulation, palliative care, or population health management, all topics with limited exposure in the curriculum.²⁵ One recent survey of program directors indicated professionalism, communication skills, and patient care were areas ripe for focus in the fourth year to improve the transition to residency.²⁶

The transition from residency to practice has primarily focused on adjusting to different clinical work environments, practice management, and career mentoring. Many of the programs emphasize increased autonomy and skills building in the final year of residency to prepare graduates to practice independently, lead/participate on a team, and understand and use the resources of the health care team in patient management. Add-on retreat programs are found in some specialties to focus on practice management and include instruction on the economic aspects of health care.^{27, 28} As physicians progress along the leadership pathway, the need for increasing clinical skills gives way to developing personal leadership and management skills (Figure 1).

Figure 1: Changing Skill Requirements for Physicians



Source: *Changing Demographics, Competencies and Physician Leadership*. P. Angood, MD presentation, July 27, 2013.

Some medical schools and health care delivery systems are recognizing the need for physician leadership education and training. In the late 1990s, the University of California at Irvine became one of the first medical schools to offer a joint MD/Masters of Business Administration (MBA) program and now more than 50 percent of medical schools offer this joint degree.²⁹ In addition to a joint MD/MBA, another popular joint degree offered is an MD/Master’s in Public Health (MPH) degree.³⁰ According to the Association of American Medical Colleges (AAMC), more than 80 medical schools offer a joint public health degree. Medical students are recognizing the need for business and public health training earlier in their careers, and universities are meeting this need with physician leadership education programs.³¹ Examples include:

- The University of Kentucky offers a certificate of medical management, which consists of 12 courses in full-day sessions and covers such topics as health care delivery systems and introductory accounting.³²
- The University of Tennessee offers a Physician Executive MBA through its School of Business.³³
- The Medical College of Wisconsin offers a nine-day course, in three, three-day segments over five months with topics including managing people, marketing, and leadership.³⁴
- Duke University School of Medicine, in collaboration with the Duke University Health System, offers a Management and Leadership Pathway for Residents program. This program includes opportunities for management and clinical training during the five year residency program.³⁵

Health care organizations also are recognizing the need for physician leadership education. Organizations that offer training include:

- Cleveland Clinic offers its physicians the Leading in Healthcare program, which consists of 10 full weekday sessions covering institutional history, business and accounting, and team-work.³⁶
- Massachusetts General Hospital's physicians group created the Physician Leadership Development Program, which includes courses on organizational

and financial leadership, business management, and health care-specific topics such as quality and patient safety.³⁷

- Sharp HealthCare, a not-for-profit organization with hospitals in the San Diego area, has partnered with the University of California at Irvine to offer a Physician Executive Leadership Program consisting of 11, eight-hour seminars dealing with topics of health care management.³⁸



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Physician Leadership Characteristics

The need for physician leaders is great, and many feel that having expertise in managing people, finances, and quality and safety will be crucial.³⁹ Dr. Stoller lists six key competencies for physician leaders including technical knowledge and skills, knowledge of health care, problem-solving prowess, emotional intelligence, communication, and a commitment to lifelong learning.⁴⁰ Dr. Stoller believes emotional intelligence, which he defines as “the ability to understand and manage oneself and to be aware of and manage relationships,” is the most important differentiating factor for a physician leader.⁴¹ Victoria Stagg Elliott feels physicians should possess a number of characteristics if they want to be leaders, including seeing the big picture beyond the patient at hand, collaborating with people at all levels of the health system, thinking long term, and being comfortable making some people unhappy.⁴²

Cherry, Davis and Thorndyke identify a number of competencies that physician leaders must possess, including the ability to think analytically, embrace change and take initiative. In addition, these leaders must be skilled in delegation, team building and conflict resolution.⁴³

Richard Hansen with MGMA Consulting Group lists 10 characteristics of physician leadership:

As the need for physician leaders increases, educational programs that address physician leadership competencies are essential.

- 1) Clarity of purpose -** Physicians interested in leadership roles should examine their commitment and drive to make changes in health care.
- 2) Sustaining the focus of others on a vision -** Physician leaders must be able to articulate a vision for the future and help others understand and work toward attaining it.
- 3) Building trust and credibility -** The effective leader must be trusted and understanding of current clinical issues is crucial.
- 4) Persistence when challenged by obstacles -** The physician leader must pursue goals, chipping away at them slowly and steadfastly.



- 5) **Political savvy** - Physician leaders need to develop a strong base of influence and maintain strong negotiation and persuasion skills.
 - 6) **Working with and through others with an attitude of service** - Physician leaders need to relinquish controlling behaviors and position themselves as team builders, drawing others into leadership. The effective physician leader demonstrates a high regard for diversity of opinions and the ability to bridge differences to build consensus.
 - 7) **Freely giving praise and recognition** - Leaders who infuse their organizations with abundant recognition of others are more likely to maintain a high level of enthusiasm and commitment among followers.
 - 8) **Keen self-awareness** - Physician leaders pursue self-knowledge through continual introspection and self-assessment.
 - 9) **Having a mentor** - Physician leaders with mentoring relationships derive high levels of learning as well as a personal support system.
 - 10) **More formal education with an emphasis on the human side of leadership** - Education tailored to the role of physician leadership is desirable.⁴⁴
- Be it through formal medical education and training, or programs in addition, those physicians seeking leadership roles will need to acquire these competencies in order to be able to effectively lead the health care enterprise of the future.

Leadership Education Core Elements

As the need for physician leaders increases, educational programs that address physician leadership competencies are essential. Whether the education and training occurs in medical school, as part of residency, or during practice, physician leaders need a strong mix of skills in order to be successful. For those programs based at health care organizations, Dr. Stoller calls for a three-pronged approach: didactic and curricular teaching, mentorship and coaching, and experiential leadership. He suggests that current leaders nominate strong candidates and that participants receive continuing medical education credit or be offered credit toward graduate degrees. In Dr. Stoller's experience, benefits include a ready pipeline of leaders, enhanced participant satisfaction, increased collaboration, and a brainstorming opportunity for the organization.⁴⁵

In addition to having strong clinical judgment and expertise, physician leaders also need to possess a combination of applied management, analytic, and strategic capabilities in order to effectively tackle the clinical needs of the organization. Progression through management to leadership follows the path outlined in the chart below (Figure 2), with initial training of applied management of both a team and workforce to understanding change management, economic aspects of health care, and process improvement science. Finally, strategic thinking skills and knowledge of the health care organization's direction, the system of care and the impact of the environment, fully round out the development of a leader.

Each line of the chart below shows areas that should be included in leadership development, starting with cultivating and promoting teamwork, managing a workforce, self-awareness and emotional

intelligence to the need for lifelong learning. As leaders continue to develop they move into clinical management, understanding financial responsibility and leadership, and process/change management until finally entering the strategic level where knowledge of enterprise management, visioning and initiatives to drive change are honed.

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Figure 2: Skills from Management to Leadership

Applied Management	Analytical	Strategic
Managing a team <ul style="list-style-type: none"> • Trust building/credibility • Coaching/development • Consensus building • Evaluation • Conflict resolution • Delegating 	Clinical ability <ul style="list-style-type: none"> • Skillful practitioner • Versed in clinical processes • Intuitive • Strong clinical judgment • Lead a care team 	Environmental awareness <ul style="list-style-type: none"> • Reading trends • External forces • External relations • New business development • Political savvy
Managing a workforce <ul style="list-style-type: none"> • Influence/negotiation • Performance management • Communications • Change management • Team building/development • Situational leadership 	Financial leadership <ul style="list-style-type: none"> • Budgeting and forecasting • Compensation models • Reimbursement • Allocation of finite resources 	Visioning <ul style="list-style-type: none"> • Forecasting • Goal setting • Project planning • Change management • Ability to sustain the focus of others on vision
Emotional intelligence <ul style="list-style-type: none"> • Self-awareness • Self-management • Social awareness • Relationship management 	Process/systems management <ul style="list-style-type: none"> • Knowledge of health care regulation • Evaluation of existing systems • Acquiring meaningful data and using for change/benchmarking 	Oriented to the environment (specific hospital needs)
Commitment to lifelong learning	Problem-solving <ul style="list-style-type: none"> • Project management • Team management • Use qualitative and quantitative skills 	Initiative and recognition of the need to change

Developed from the following sources:

Cherry, RA, Davis, DC, and Thorndyke, L. Transforming culture through physician leadership development. *Physician Executive*. May-June 2010; 36(3):38-44.

Crites GE, Ebert JR, and Shuster RJ. Beyond the dual degree: development of a five-year program in leadership for medical undergraduates. *Academic Medicine*. 2008;83(1):52-8.

Gagliano NJ, Ferris T, Colton D, Dubitzky A, Hefferman J, Torchiana D. A physician leadership development program at an academic medical center. *Q Manage Health Care*. 2010;19(3);231-8.

Maggi, JD, Stergiopoulos, V, and Sockalingam, S. Implementing a new physician manager curriculum into a psychiatry residency training program: the change process, barriers and facilitators. *Psychiatric Quarterly*. Mar. 2008; 79(1):21-31.

Stoller JK. Developing physician-leaders: key competencies and available programs. *The Journal of Health Administration Education*. 2008; 307-28.

Building a Leadership Program

As outlined in the following proceedings from *Physician Leadership: The Implications for a Transformed Delivery System*, evaluating and developing an appropriate leadership program requires a good understanding of each organization's goals and needs. Building and sustaining a strong physician leadership pathway requires a thorough assessment of the organizational aims, commitment from the hospital or health system leadership, and strong involvement from physicians. It is essential that any leadership education program fit with the organization's culture and values.

Programs also need to grow and adapt to the changing needs of the organization. Metrics to evaluate and refine program offerings as well as gap analyses to understand where future programs should focus are both required. Physician involvement in this process can help drive “buy-in” and ensure it is relevant to their interests as well as meeting the goals of the organization. The case examples highlighted in the following proceedings also emphasize the need to address social aspects of training and importance of building opportunities for mentoring and networking among and between cohorts as another strong development tool.

Combining these factors with the areas outlined in the chart above can assist in designing a program that both creates a depth of physician leadership within the organization and at the same time addresses specific performance improvement areas around front-line management, clinical management and organizational leadership.

Conclusion

As the complexities of health care reform take shape, more physicians will be called upon to lead the change in partnership with hospital and health system executives and other clinicians. It is imperative leaders have a common language and the necessary skills and training. Competencies in change management, a strong understanding of the economics of health care, team building and communication skills will be in high demand for all leaders and will comprise many physician leadership educational programs.

Medical schools should consider incorporating elective classes in these areas so students are exposed to these skills earlier in their careers. However, tight schedules may leave little time to acquire the skills needed to lead an organization so hospitals and health systems should contribute to the educational opportunities to help create leaders within their systems.

Although varied, the literature on physician leadership coalesces around the need for



business, management, and finance training, as well as enhanced communication skills and emotional intelligence. Organizations will be charged with identifying potential physician leaders and providing the tools and resources needed for success.

together to ensure resources and training for physician leadership and growth are employed. Physicians who possess the right mix of leadership competencies will continue to be in high demand for the foreseeable future and are effective partners with hospitals and health systems to move toward a more accountable and efficient health delivery system. The end result will be health care that is higher quality, more affordable and safer for everyone.

...evaluating and developing an appropriate leadership program requires a good understanding of each organization's goals and needs.

The current variation in costs and outcomes are two areas targeted by reform efforts. Transformed care delivery will require increased physician involvement in the leadership of health care organizations to provide the vital clinical perspective

as the field continues to move toward a quality-based, patient-centered system. It is imperative physicians and hospitals work

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PROCEEDINGS from

Physician Leadership: The Implications for a Transformed Delivery System

In July 2013, the AHA's Physician Leadership Forum held, in conjunction with the American College of Physician Executives, a one-day educational session on physician leadership and the implications for a transformed delivery system. Participants heard from leading edge experts on the changing landscape and the leadership competencies physicians will need to be effective partners with hospitals and health systems to move toward a more accountable and efficient health delivery system. They also heard from a panel of experienced physician executives on different successful leadership education modes and methods.

The Physician Leadership Imperative



Peter B. Angood, MD

Peter B. Angood, MD, FRCS(C), FACS, FCCM, chief executive officer, American College of Physician Executives (ACPE), and Ana Pujols McKee, MD, chief medical officer, The Joint Commission, delivered the keynote addresses. In his presentation on physician leadership, Dr. Angood spoke

about the competencies required to lead a transformed organization and the education and training opportunities currently being developed. Dr. McKee focused her remarks on the skills physicians need today and in the future to lead health care.

According to Dr. Angood, the number of practicing physicians employed by hospitals has increased by 75 percent since 2000. Traditional models of physician employment will continue to change as more physicians become employed by hospitals or health care organizations. Hospitals, in turn, will have to understand how to move from employment of physicians to integrating them into the fabric of the organization. This closer connection will require effective leadership from both hospitals and physicians to ensure that both are focused on the same goals around improving care and communities.

In addition to increased employment, physicians will need to lead the way for innovative practice methods to address concerns about physician shortages and increasing care needs. Currently, there are nearly 900,000 licensed physicians in the United States, yet the AAMC predicts a shortfall of 130,000 physicians over the next 10 years. Couple this with an estimated 25 million people expected to have access

to insurance coverage through the *Patient Protection and Affordable Care Act* (ACA), it is essential physicians be prepared with the necessary skills to lead. More patients combined with a shortage of physicians will put a greater onus on care teams to manage patient care across the continuum.

Dr. Angood indicated it is vital physicians continue to grow professionally while being given the necessary tools and resources to be change leaders. For clinical integration to work, physicians need to collaborate, be in tune with an organization's vision and values, and unified with leadership on the organization's direction. To stress his point, Dr. Angood highlighted Regina Herzlinger's work on the divide between academia and business and how it relates to the divide between health care management and medicine. Organizations have always faced challenges in managing and nurturing talent and in health care that challenge is exacerbated by the very different training paths for leaders from clinical and business backgrounds. Many business-focused leaders feel academia focuses on skills that are not as valuable in leading an organization, such as change management, and

...physicians will need to lead the way for innovative practice methods to address concerns about physician shortages and increasing care needs.

often look for those skill sets from the business world. Academia, on the other hand, may view business leaders as more narrowly focused and less knowledgeable about larger policy issues. Dr. Angood emphasized that hospitals and health systems of the future will need leaders with a combination of both business and clinical management skills. Leaders of the future will need to understand the global view, the full continuum of care, employ critical business thinking and be able to mentor the next generation.

Dr. Angood used the work of James Mountford and Caroline Webb to highlight the three distinct types of clinical leaders: frontline, service, and institutional (Figure 3). Most clinical leaders are front-line leaders focusing on delivering excellent patient care, are passionate about clinical work, and understand quality improvement techniques and their importance in improving the system of care. They are close

to patients and can spot opportunities for improvement that may be missed by those not in constant contact with patients. As leaders progress through their careers, some move to the next level of service leader. These leaders are equally passionate about both their clinical scope and service, but feel a sense of responsibility not only for the clinical, but the financial performance of the whole organization. Their interest and strength as leaders lie at the clinical management level, looking at strategies and development for their service line. The third level of clinical leader is an institutional leader, who serves as a steward for the resources of the organization. They are viewed as a credible leader and clinician by peers but their focus is not on clinical patient care, rather on sharing and developing a common vision and culture across all clinical areas and the whole organization. Strategic thinking and political acumen provide support to their well-developed change management skills.⁴⁶

Figure 3: Three Distinct Types of Clinical Leaders

Three ways to lead Research suggests that at least three distinct types of clinical leaders exist

	Overall Identity	Sources of power	Selected leadership skills and knowledge required
Few Institutional leader	<ul style="list-style-type: none"> Clinician executive acting as steward of whole organization Little direct contact with patients 	<ul style="list-style-type: none"> Highly credible to colleagues as clinician and leader; able to communicate vision 	<ul style="list-style-type: none"> Corporate-level strategic thinking, talent management, success on planning Political savvy; strong skills in negotiation and influence
Service leader	<ul style="list-style-type: none"> Passionate advocate for own service, feels responsible for clinical and financial performance Moderate level of direct contact with patients 	<ul style="list-style-type: none"> Highly credible to colleagues, primarily as clinician; well connected, can tap into centers of excellence Innovative, willing to take risks 	<ul style="list-style-type: none"> Fluent service-management skills – eg, strategy/people development, budgeting Detailed knowledge of evidence-based medicine in own clinical area
Many Frontline leader	<ul style="list-style-type: none"> Great frontline clinician who focuses on delivering and improving excellent patient care High level of direct contact with patients 	<ul style="list-style-type: none"> Passionate about clinical work, credible to colleagues Close to patients and frontline realities; can see opportunities for improvement 	<ul style="list-style-type: none"> Understanding of systems- and quality-improvement techniques – eg, process mapping, operational improvement Self-starter, able to work well in teams

Source: *Changing Demographics, Competencies and Physician Leadership*. P. Angood, MD presentation, July 27, 2013.

Figure 4: The Nature of Medicine vs. Leadership

Medicine vs. Leadership

The Nature of Medicine	The Nature of Leadership
Prescribe and expect compliance	Lead, influence and collaborate
Immediate and short-term focus and results	Short-, medium- and long-term focus and results
Procedures/episodes	Complex processes over time
Relatively well-defined problems	Ill-defined, messy problems
Individual or small-team focus	Larger groups crossing many boundaries, integrated approach
Being the expert and carrying the responsibility	Being one of many experts and sharing the responsibility
Receiving lots of thanks	Encountering lots of resistance
Respect and trust of colleagues	Suspicion of being a “suit”

Source: Changing Demographics, Competencies and Physician Leadership. P. Angood, MD presentation, July 27, 2013.

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Dr. Angood laid out a pathway for physicians interested in acquiring the skills for leadership. He felt physicians need to approach leadership development as a process, understanding the importance of guidance and structure. He recommended physicians look for structured ways to assess their potential and chart a path for moving forward, and once on the path of leadership development, continuous feedback and assessment are essential. Dr. Angood did underscore the differences in the nature of medicine and the nature of leadership, and the challenge in moving from a more structured, episodic, individually focused mindset to one of influence, complexity, and integrated work (Figure 4).

While physicians should seek out opportunities for structured learning and education, health care organizations can support this development by integrating and engaging physicians in the organization. Physicians may not arrive at the hospital with the business or management training to lead, but organizations should offer leadership development to the betterment of the organization. Health care reform mandates a close partnership between physicians and health care organizations.

Dr. Angood cited the work of Dr. Daniel Kearns showing that hospitals and health systems led by physicians show improvement in some areas. These include a better understanding of clinical challenges, an ability to align the differing values of

clinical staff, and an unwillingness to compromise on quality and safety. Some have shown greater coordination and less duplication and an ability to anticipate clinical change in health care. Clinicians' dedication to quality and patient safety as they move into positions of leadership can help drive the health care field forward to stronger models of care delivery.

Dr. Angood said the success of physician integration will hinge on how well organizations engage physicians. For this to work, organizations will need to create buy-in, share a common vision and goals, build confidence and trust, create a strong performance leadership structure, measure and assess performance, and develop a physician code of conduct. All of these need to be done in partnership with physicians. Supporting physician development of a leadership structure through a trust-based structure that uses objective measures and an agreed upon code of conduct will support a strong integration and partnership.

At the same time, physicians need to be willing to support and engage in a collaborative organizational culture, ensure their practice is consistent with the vision and values of the organization, and work in partnership with the administration to move the organization forward.⁴⁷ This shift to a team-based approach will require strong leadership attuned to the clinical and business-related challenges facing the organization and awareness that different organizations place emphasis on different areas. As a potential physician leader, one must first define his own values and goals and then align with an organization that shares them.

Physician Leadership Skills and Overcoming Knowledge Gaps



Ana Pujols McKee, MD

Dr. McKee shared her perspective on the skills physician leaders need today and in the future to partner effectively with hospital leaders to move the health care delivery system forward. She focused on the knowledge gaps

among physicians moving into leadership positions, including a lack of skills in improvement science, developing a culture of safety, and understanding change management. She also found a lack of knowledge of accreditation and regulatory issues, which significantly impacts all aspects of the organization. Without these essential skills, not only would physician leaders find managing and leading change frustrating and unrewarding, their efforts would result in suboptimal involvement of the physician community they are attempting to engage.

Dr. McKee shared vignettes, some gleaned from her personal learning curve and others from her work with health care organizations, to illustrate the importance of leadership skills. In one scenario, she described how the absence of physician leadership in reviewing a poor surgical outcome contributed to a second similar event that could have been avoided had physicians and physician leaders been involved. She next related a board meeting, where a chief quality officer shared a lengthy report with volumes of data supporting an important position the board should have taken action on. While the

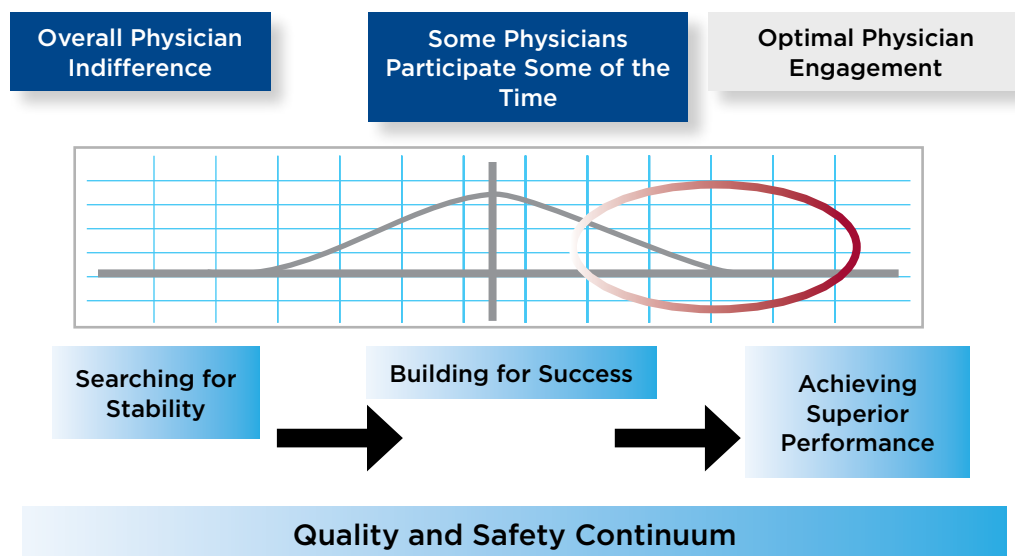
report was highly detailed and technical, not a single board member asked questions. For the next meeting, in lieu of a presentation, the officer was asked to submit a written executive summary. The physician leader's lack of skill and understanding about engaging board members in crucial discussions on quality turned into a lost opportunity to garner champions at the board level.

Lastly, Dr. McKee recalled an effort she undertook earlier in her career to present a new patient safety initiative to the medical executive committee for their support and approval. The initiative was rejected, not because it was without merit, but primarily because she had failed to get key stakeholders on board in advance and engage them in lending their support.

In each instance, a knowledge gap led to a poor outcome. Physician leaders need to understand the importance of these skills, identify their knowledge gaps, and proac-

tively seek out opportunities to gain these skills. As clinicians and leaders, they will be essential in partnering with the hospital to move the delivery system toward safer and more efficient care. Dr. McKee said physician leaders need to engage their c-suite colleagues to address the gaps and work with the full health care delivery team to foster a culture of safety and accountability (Figure 5). Dr. McKee shared a common observation: highly engaged physicians and physician leaders in high performing organizations are instrumental in advancing the quality agenda with the board and transforming the board to an environment of learning about quality and safety. With the changes brought about by the ACA, there will be financial consequences for poor outcomes and low performance in quality and safety. Physician leaders need to work strategically to drive change within organizations. Dr. McKee stressed the difference physicians can make when they are engaged and committed to transforming

Figure 5: Achieving Optimal Physician Engagement



Source: PowerPoint presentation at PLF Leadership Session by Dr. Ana Pujols McKee, July 27, 2013.

their delivery systems to provide the best possible outcomes.

Dr. McKee discussed several strategies physician leaders can employ to improve outcomes at their organization. In engaging the hospital board, Dr. McKee encouraged physician leaders to champion goal setting by identifying risk and opportunities for improvement. Goals set by the board should be clearly articulated throughout the organization. She also emphasized the need not only for a top-down approach, but also bottom-up to promote front-line support and accountability. Without the full leadership team on the same page and without board support, progress will be difficult. Specifically, she emphasized the need for focusing the board's attention on quality and patient safety, by having the clinical teams present their work in reducing risk and improve outcomes. Staff should share patient stories that demonstrate the human impact and the importance of their work.

Dr. McKee underlined the need for change management training and ability to lead a team to achieve sustainable positive results. As scientists, physicians are comfortable relying on data. The combination of skills in change management and evidence-based performance improvement methodologies such as LEAN and Six Sigma, are powerful skill sets for a physician leader to obtain. It will be up to an organization's leadership, she said, to provide the structure and resources. She also spoke of strategies physician leaders can employ in order to get senior leaders attuned to the front-line issues in their organizations. She encouraged organizations to adopt daily briefings, where senior leaders typically spend 15 minutes in a session where they review any event of harm that has occurred in the past 24 hours and identify any potential risk that

Dr. McKee underlined the need for change management training and ability to lead a team to achieve sustainable positive results.

could occur in the next 24 hours and take action to mitigate it. She also suggested an "adopt a unit" program for executive leaders to engage and become closely familiar with the services and safety and efficiency concerns unit staff deal with on a daily basis. Each of these approaches allows leaders to learn more about the challenges the front-line faces and opportunities to identify potential harm before it occurs. These strategies also have a great impact in driving the culture of safety throughout the organization.

Dr. McKee has seen dramatic results when organizations restructure their quality improvement organization into clinical-based unit leadership teams, typically co-led by a nurse manager and a designated physician leader. These teams work collaboratively with infection control, and receive support from data analysts and quality assurance and other disciplines. Dr. McKee reported The Joint Commission is developing new programs and performance improvement tools to support physician leaders in reaching or exceeding their organization's performance improvement and patient safety goals. She encouraged organizations to dedicate resources to training physician leaders to allow them to attain the skills and tools they need to be effective.

Sharing Leadership Education – Successful Models and Methods

During the second half of the session, four health care leaders shared their experiences on developing and executing formal physician leadership training programs. With unique geographies, from multi-state systems spanning rural and urban settings, to an urban academic medical center, to a metropolitan hospital association, each presenter described the challenges faced in creating a meaningful leadership development opportunity, what drove them to succeed, and lessons learned along the way. Each had to craft an approach to engage physicians in their respective communities that outlined the value proposition for the hospital and the physician. In addition, each highlighted their work evaluating and continually improving program offerings through input from program participants, the hospital, and the community.

Metropolitan Chicago Healthcare Council

Founded: 1935

Location:
Chicago and surrounding areas

Comprised of more than 170 hospitals and health care organizations

Trish Anen, RN, MBA, NEA-BC, vice president, clinical services, Metropolitan Chicago Healthcare Council (MCHC), spoke about how MCHC, a hospital association of more than 170 health care organizations in the Chicago area, partnered with ACPE to create an education track targeting primarily new medical staff leaders. The decision to create a regional learning collaborative grew from the association's Chief Medical Officer (CMO) forum, which began in 2009 to facilitate networking and thought leadership among Chicago CMOs. With 40 active members representing more than 80 hospitals, the forum discussed the need to further develop physician leadership opportunities beyond those currently available in the region. While the CMO forum had a history of providing engaging programs during their two-hour quarterly meetings, the group felt partnering with an experienced education provider, such as ACPE, to craft an educational program specifically for new medical staff leaders was the best course of action.



MCHC
Metropolitan Chicago
Healthcare Council

Courses taught include *Breakthrough Thinking*, *Finance in Health Care Organizations*, and *Conflict Management & Negotiating Skills*. Program topics also feature managing physician performance, marketing and strategic planning, understanding quality and change management, and improving communication skills. Since the partnership began in 2011, 290 physicians from 68 organizations have participated in 10 sessions. To date, they've provided a combined 4,585 continuing medical education (CME) hours.

Evaluations for all sessions have been extremely positive and comments were glowing for programs held thus far.

As a result of the education, many physicians have expressed interest in gaining certification as a Physician Executive (CPE) or continuing on for master's level degrees. In addition, participants have an increased understanding of MCHC and its services and the resources available through the association. Finally, the programs have helped to build strong relationships and a community of physician leaders to drive future collaboration and improvement across Chicago area health care systems.

“This was an excellent session. You can tell if a physician-targeted session is any good on Saturday if there are as many participants at the end as there were at the beginning. I don’t believe a soul left!”

As with all new ventures, MCHC learned a few lessons along the way. Moving forward, they intend to gain commitments from participants earlier in program planning to allow for budgeting and accommodating all interested participants more efficiently. Ms. Anen underscored the need for a contact management system to track participants and better communicate with physician leaders both about current programming and future events.

For future programs, MCHC hopes to encourage more non-physician leaders to participate, particularly in conjunction with their physician leaders to help develop strategy and build teamwork. Finally, developing a clear method to conduct an impact analysis of the educational programs would provide data needed for future course development. While evaluations provide improvement to existing programs, developing more quantitative methods to analyze the needs in the market would provide strong information for future development.

NYU Langone Medical Center

Founded: 1841

Location:
New York City

1,069 beds

2,166 attending
physicians

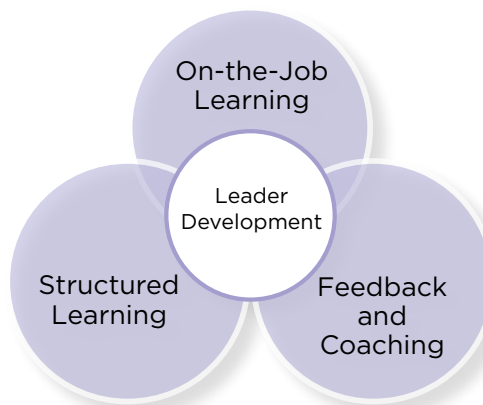
38,911 patient
admissions

Donald E. Casey, MD, MPH, MBA, FACP, FAHA, chief medical officer of the NYUPN Clinically Integrated Network, New York University Langone Medical Center (NYULMC), New York, NY, spoke about the Leadership Academy at NYULMC. All physicians are members of the network and the NYU clinical faculty, including both the faculty group practice and voluntary physicians. With more than 1,600 employed and voluntary physicians in the network, it serves as a single contracting entity to improve quality and efficiency of care through alternative payment methods.

Within the underlying structure of an academic medical center, NYULMC developed a framework to evaluate how best to develop physician leadership. They felt that understanding the level of system integration, physician involvement, presence of medical education, the degree of insurance risk, and the culture of quality and patient safety improvement would all factor strongly into the best methods to approach physician leadership development.

NYULMC launched the Leadership Academy to ensure current leaders and managers at the medical center were prepared to lead in academic medicine, develop a leadership pipeline for their organization, and leadership capacity for the future. The academy combines on-the-job learning, feedback and coaching and a structured learning approach in equal measures to drive leadership development. Specifically, a competency-based curriculum is mandatory for all new leaders starting with basic leadership skills and moving through the skills essential for management of the delivery system with an underpinning of demonstrating value through high-quality, low-cost care. The curriculum provides formal coaching, includes electives, and allows participants flexible delivery and access (Figure 6). The academy is overseen by an executive steering committee in partnership with curriculum advisory councils, and faculty are drawn from both internal and external experts. The academy includes dedicated organizational development staff and uses a robust database to track results and improvements. A number of metrics are used to measure success including performance, physician retention and advancement, successful promotion, and skill improvement.

Figure 6: NYULMC Leadership Academy Philosophy



Source: PowerPoint presentation at PLF Leadership Session by Donald Casey, MD, July 27, 2013.

The Leadership Academy development embraced the critical success factors highlighted by The Joint Commission for an effective organizational performance improvement program including physician involvement and accountability, strong administrative leadership, effective oversight structure, board and staff involvement, a strong communication strategy, and the use of data for decision making.

The academy's growth trajectory started with a focus on leadership education for new potential leaders and developing the faculty/staff leadership ranks

with the benchmark of a 100 percent increase in leadership activities. The second threshold in the trajectory involved aligning the leadership curriculum with the overall system strategy, mandating a leadership curriculum, developing a succession pipeline and developing strong metrics and incentives for the program, all with the goal of 25 percent of leadership positions filled by internal candidates. Finally, the third phase involved developing an enterprise-wide succession program, involvement in the academy by all levels of the organization, and best-in-class leader retention rates. The goal of the third phase was to have 50 percent of all mission-critical positions filled by internal candidates.

Dr. Casey described some of the lessons learned in the process of creating the academy including the need to find and develop the best people. He noted that establishing trust and leadership by example was key to success. He summed up his comments with a quote from Floyd Loop, MD, past CEO of Cleveland Clinic, who said, “To maintain good relations (with physicians), don’t try to force clinical protocols or evidence-based medicine on doctors too quickly . . . These systems could be wonderful if medicine were a powerful science with a clear understanding of what causes and cures illnesses and disabilities, but currently it’s more an art than a science. Dictating protocols to doctors is as meaningless as forcing artists to paint by numbers. Peer influence from good clinical data is a far more effective method of management.”⁴⁸

UnityPoint Health

Founded: 1993

Location: Based in Des Moines, Iowa; includes 29 hospitals in nine regions covering Iowa and Illinois

3,026 beds

900+ employed physicians

127,812 patient admissions



Alan S. Kaplan, MD, MMM, CPE, FACHE, FACPE, senior vice president/ chief clinical officer, UnityPoint Health, West Des Moines, IA, told participants about its Physician Leadership Academy, which was born out of UnityPoint’s journey to become an accountable care organization (ACO). The system leadership understood that without physician leadership working in partnership with administration leaders and a joint vision of the organization’s direction, the ACO could not move forward. UnityPoint felt strongly that the ACO should be a physician-driven system, led by physicians, able to align the 900 employed clinicians and develop a clinically integrated network.

Dr. Kaplan underscored the importance of aligning with the independent community-based physicians within their service areas and involving them in the network to provide seamless care across the continuum. The academy is a formal master’s level program designed for physicians who show leadership potential. Through the application process, interested physicians commit to participate in the program through more than 100 hours of education. The courses are designed to be physician-schedule friendly with online and on-site offerings and projects that are strategically aligned with the work of the

hospitals and practices. The goal of the academy is to equip physician leaders with the skills required to lead their health care delivery system.

The program offers a mix of courses, such as Implementing Innovative Quality Systems and Understanding Integrated Health Systems. Participants can earn CME and graduate degree credit if they are interested in pursuing further studies. A formal graduation ceremony marking the end of the program is held to celebrate the milestone and recognize accomplishments. To date the program has graduated 75 participants with another 25 currently enrolled. Graduates have assumed roles ranging from CMOs to medical directors to full-time clinicians, all with a greater knowledge of the leadership skills needed to drive improvement and change the delivery system.

Mountain States Health Alliance

Founded: 1998

Location: Johnson City, Tennessee; includes 14 hospitals located in Tennessee and Virginia, and a service area including Kentucky and North Carolina
1,220 physicians

Morris H. Seligman, MD, MBA, CPE, FACP, FACHE, CHCQM, senior vice president and chief medical officer, Mountain States Health Alliance (MSHA), Johnson City, TN, discussed the alliance's Physician Leadership Academy. MSHA is the largest regional integrated delivery system serving 29 counties across four states with 14 hospitals. As mentioned by others, the driving factors for creating a leadership academy included developing future physician executives and leaders across their medical staff to help drive the vision and mission of the organization. MSHA also hoped to drive evidence-based practice, better educate physicians on current health care issues, involve physicians in the system's population health management strategy, foster collaboration and communication across the system, and help with deployment of information technology.

Hospital CEOs and CMOs nominate participants for a commitment of seven to eight courses over a two-year period. The courses include in-person presentations with online makeup options available. In addition to physician leaders, the health system's executives all attend sessions to help drive teamwork and common understanding. MSHA also opens the Leadership Academy not only to employed physicians, but to independent community physicians and faculty from East Tennessee State University Medical School.

Dr. Seligman underscored the importance of including past participants in the program through alumni events to maintain their connections to each other and the program. The academy sponsors several social and networking events involving past participants to help strengthen the bonds among physicians and executives across the system, as well as board involvement and support throughout the program. He also emphasized the importance of a formal graduation ceremony, with system executive and board participation, to celebrate this milestone and recognize accomplishments. The academy also includes a dedicated website to share information and data.



Since its inception, five graduates have become physician executives at MSHA including four CMOs and one medical director for quality and patient safety. The program has led to greater physician engagement, a better understanding of health care challenges faced by the system, and the development of a large group of physician champions to draw upon for various organization initiatives. In addition, the physicians who have participated from across the system have developed new connections to colleagues in other hospitals and communities, creating stronger linkages for mentoring, and future leadership.

As with all of the programs, there are always areas for improvement. MSHA determined more interactive presentations and discussions provide better learning for the group. In addition, increased involvement by executives and all past and present cohorts is key to driving strong camaraderie. Thus far, the program has had increased participation in each cohort and evaluations from participants have been strong. In the future, MSHA anticipates forming a curriculum development committee to further evaluate future needs, shorten the length of the program to offer more opportunities, explore the use of online options, and look specifically at developing project work around LEAN activities already underway.

Common Themes Among Leadership Education Models

Among the four programs, several common themes emerged:

- Physicians need to be involved in the planning and creation of the program in order to drive buy-in.
- Classes need to be accommodating in both time and location for participants with multiple options for receiving education. Ideally, this would involve a mix of in-person and online classes, either at night or on weekends.
- Consider offering credits toward graduate degrees or CME credit, giving physicians even more incentive to participate. Many programs found that once there was physician buy-in and full understanding of the value of the education and the connections to their colleagues, most physicians were eager for additional education and team-building opportunities. Presenters spoke of finding creative ways to increase involvement of past participants and to forge connections between the cohorts.
- Establish good evaluation methods and metrics in order to improve offerings. Health care is constantly changing and so too should the goals of each program.
- Offer graduation ceremonies for participants with recognition of the importance of physician leadership and the program from both the board and executive leadership.

Creating Physician Leadership Programs

John R. Combes, MD, senior vice president, AHA, moderated a discussion session with the day's speakers on next steps for moving physician leadership forward. Dr. Combes began the session sharing with the participants the work of the AHA's Physician Leadership Forum, which seeks to engage physicians who work closely with hospitals to improve the quality, safety, and efficiency of care delivery. Through educational sessions like this one, webinars, resource materials and the Physician Leadership Forum website (www.ahaphysicianforum.org) the AHA hopes to help physicians and hospitals move towards a reformed delivery system. Developing strong physician leaders working in concert with hospital and health system executives is essential to moving to the next level of health care delivery.

The first question posed to the group was how to evaluate the characteristics that should be in physician leadership development programs. In addition to many of the points made previously, panelists underscored the importance of assessing local needs and goals. Adapting existing programs is a viable option as long as it is a good fit for the culture and can be scaled to meet specific needs. Several panelists highlighted the number of organizations, associations, and universities with available programs and partnership options that present a broad array of modes, levels, and quantities of courses so each organization can choose what works best. Organizations also need to evaluate the resources available for leadership development to choose the most appropriate path.

All panelists stressed the importance of developing metrics and measures for success early in the process and feedback

mechanisms to evaluate and adapt program development to the organization's needs. Several panelists highlighted the role played by program champions in their success and urged participants to seek out physicians interested in leadership development and involve them early in the process to create local champions. Panelists found it imperative that physicians be engaged not only in the development and initial design of the courses, but also throughout the whole process. They also emphasized the need for program candidates to share a common vision and goals with the sponsoring organization. For these programs to be successful, all agreed long-term mentoring, as well as adjusting course offerings and providing ample opportunity for interaction among participants are crucial. It's not enough just to offer a static program. It must adapt to meet the changing needs of the organization.

Another question posed to the group dealt with candidate selection. Panelists indicated it is critically important for an organization

Transformed care delivery will require more physician leaders at the helm. Therefore, it is imperative physicians and hospitals work together to ensure resources and training for physician leadership and growth are employed.

to assess a person's skills and evaluate if they should be pursued as a leader. While many leadership characteristics can be learned, interest and shared values with the organization will drive success. Others agreed, adding that understanding how to motivate and inspire a team can be taught and is a

critical skill for any leader. One participant added that their program looks at three areas – a match between candidate and health system values, the candidate's ability to evaluate complex situations, and finally, their appetite for the work and commitment involved. All felt that nominations by senior

leaders and interest expressed by potential candidates, along with a clear understanding and commitment, were lessons learned from their programs' development.

Closing

The four organizations highlighted above are providing their physicians with the tools and opportunities needed to lead a transformed delivery system. Each was able to create physician buy-in by involving physicians in the planning and creation of the programs. In addition, each program is sensitive to the time pressures for practicing clinicians, offering accommodations in both time and location, and credit toward graduate degrees or CME.

Transformed care delivery will require more physician leaders at the helm. Therefore, it is imperative physicians and hospitals work together to ensure resources and training for physician leadership and growth are employed. Physicians who possess the right mix of leadership competencies will continue to be in high demand for the foreseeable future and are effective partners with hospitals and health systems to move toward a more accountable and efficient health delivery system.

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