



Physician Leadership Interviews and Action Plan

I. Executive Summary

The VMS Foundation conducted structured interviews with Vermont physician leaders and hospital CEOs in order to learn their views about physician leadership:

- Who are physician leaders? What are their key skills and attributes?
- What is expected of them? What happens in the absence of physician leadership?
- What resources are needed develop and support current and future physician leaders?

The stimulus for the effort is concern within the physician and hospital community about diminishing physician involvement in leadership roles and its deleterious impact on the quality of care in the state. An additional concern is the impact on retention and recruitment of the state's physician workforce. Both these issues were highlighted in a previous VMS Foundation effort, [2011 Physician Needs Assessment](#)

Seventeen Vermont physicians and three hospital CEO's were interviewed. The effort was supported by a grant from The Physicians Foundation¹. The output of the effort will guide the development of leadership resources for physicians in Vermont.

Leadership within Provider Organizations

The interviews were very informative, and the reader is encouraged to explore the richness of the responses in the main body of the report. From the perspective from within a provider organization (hospital, clinic, private practice) physician leaders were characterized as competent clinicians, but equally important, leaders need to have a sense of professional responsibility extending to the broader community, not just their patients. Leaders need to be good listeners and appreciative of the viewpoints of others. Leaders need vision and be able to motivate others towards achievement. Leaders need to be team builders, but also have the self confidence and sense of professional responsibility to challenge their peers when they see unprofessional conduct.

Leadership in State Policy Decisions

Many responses were directed at the need for physician leadership at the state policy level – especially in light of the Vermont legislature and Governor having initiated aggressive health care reform with the passage of Act 48 in 2011.

“If they have the goods, physicians are potentially the most appropriate leadership choices for the future; they are the closest to the knowledge needed to make a value-based system of care work.”²

¹ <http://www.physiciansfoundations.org/>

“Physicians have a professional responsibility to fix the delivery system.... to fight for sensible and just allocation of resources during upcoming state and federal reform efforts.”

“Physicians should own clinical issues.....break down existing silos in the delivery system.”

Leadership Support and Resources

The interviews were structured to elicit comments about content and logistics of potential new resources for physicians in the state. Though respondents differed on educational strategy, they did not differ on the ultimate expectations and roles of physician leaders. The difference was about where on the educational spectrum to start a support effort for physicians - skills focused on navigating change versus skills focused on managing complexity.

“Leadership is different from management. Leadership is about pointing the way to a realistic goal, motivating all and ensuring success. Management is more about paying attention to the details and the fine print”.

The chief determinant of where to start seemed to be determined by the everyday demands of the interviewee. If their responsibilities included management deliverables, they put more value at the managerial end of the educational and training spectrum and topics such as regulatory environment, marketing, finances and managing the complexities of modern healthcare organizations. If the context of their professional work was more about strategic planning, organizational development and quality improvement, they were more interested in self awareness and interpersonal competencies needed to motivate and manage change such as emotional intelligence assessments, change management, communication and other core leadership skills.

All but one responder stated that educational programs had to be accessible from their own place of work and not require travel, and that content needed to be immediately relevant to current work demands.

“Didactic programs can drift off into useless non specificity. Programs that are immediately adaptable to one’s own context are most useful.”

Next Steps

Based on the interview responses, the VMS Foundation is proposing to support two types of support resources for physician leaders in the state. The major resource will be the creation of four physician leadership communities –three of which will have state-

² All quotes in the document are from interviews. After each interview, a summary was written by VMS Foundation staff and sent to the interviewee. The interviewee was asked to review the summary and edit as needed. The ground rules for the interviews were that specific comments would not be attributed to individuals. Additional salient responses to the interview questions are included in the body of the text.

wide membership; one will be community focused. Additionally, the VMS Foundation will host an annual leadership conference to allow the separate leadership communities to interact as well as serve as a forum to bring in expert presenters.

Step One – Four Pilot Physician Leadership Communities

The VMS Foundation assessed that a “one size fits all in one place” approach to offering leadership development and support is not what physicians want or need. The best solution would be to deploy resources to teach and mentor leaders in the context that makes the learning and support valuable to them – their place of work.

“The best expenditure of VMS Foundation resources would be to bring resources to leaders as near and as relevant to their context as possible, rather than generic resources removed from their context.”

Four Physician Leadership Communities are being supported in response to specific requests for interviewees:

- 1. Vermont Hospitalists;**
- 2. Physician Recommendations for the Management of Chronic Pain in Vermont;**
- 3. Vermont Physician Executives; and**
- 4. Rutland Regional Medical Center Physician Leadership Program**

Detail about the Leadership Communities can be found in the body of the document.

Step Two – Annual State-Wide Leadership Learning Session

Several interviewees opined that “an annual statewide event where leaders can meet, share and generate new knowledge could be very powerful.” The conference will bring in out-of-state experts as well as act as a Leadership Bootcamp offering break-out sessions focused on core leadership and management topics.

“There is core leadership learning appropriate for physicians with different interests and responsibilities; however, after an introductory plenary curriculum, meaningful education and support has to be specific to the leadership challenges specific to the leader.”

Finally, an annual leadership conference will allow the VMS Foundation to continue to hear from Vermont physicians on their needs to continue to strive for the highest levels of professionalism.

“Give them forums to speak from. Ask them questions. Actually seek their advice, and then follow it.”

II. Responses to Interview Questions

Responses are grouped by unifying themes, such as the role of physician leaders within their organizations or in relation to state or federal policy. These themes do not track exactly with the seven specific questions used to elicit the responses.

The interview questions were as follows:

- 1) How do they lead? What are their key skills? What is their key knowledge?
- 2) Are there key opportunities for leadership? Where and when do physicians lead?
- 3) Why is it important to have physician leaders? What happens when there is no physician leadership?
- 4) What resources/supports do leaders need to be successful?
- 5) What are the key attributes of a physician Leader? Who is a “physician Leader”?
- 6) What is a physician leader accountable for? What are the deliverables?
- 7) Interviewees were asked to comment on both the content and the logistics of a distance learning curriculum for physicians being offered in rural Washington state and a program offered by the Cleveland Clinic.

What are the Key Skills and Knowledge of Physician Leaders?

A) Vision and the Ability to Motivate Others

The vast majority of responses to interview questions about core skills and knowledge of leaders focused on having vision and being about to motivate others to work towards goals:

- “Leadership is about vision; it is not about getting ‘deep in the weeds’ in management:”
- “Leadership is about being able to see goals in the future, articulate their importance and motivate others to strive to achieve these goals;”
- “Inspire people to work together and get tough things done;”
- “Leaders are able to see the big picture, have a sense of overarching policy and its influence on everyday practice.”

B) Informed about State and Federal Policy and Regulation

Several responses mentioned the need for physician leaders to be informed about policy and regulation given the ever increasing complexity of health care law and oversight. “(Leaders need an) appreciation for how larger health system functions; how policy is determined and how it affects operations; an appreciation of health system economics and the financial aspects of the delivery system – but they must always be cognizant of the clinical implications of organizational decisions.”

C) Articulate Communicators in Public Settings

Related to requisite knowledge about state and federal policy and regulations, responders felt that physician leaders must be able to articulate in public venues like the legislature and in the media the extent of medical science while at the same time advocate for patients and overall public good. Physician leaders must be:

- “Knowledgeable about the issue, the other constituents and be ready to broker acceptable outcomes;”

- “Able to articulate the essence of the clinician/patient relationship to non-clinicians and advocate for it in management and leadership venues in the organization;”
- “Able to sponsor change necessary to address the new face of reality being presented to them by federal and state reform efforts;”
- “Able to tell clinical stories about actual practice experience is very powerful to both professional and non-professional audiences.”

D) Listen, Listen and Listen Some More

During the interviews underlying this report, the single most mentioned characteristic of physician leaders was the capacity to listen and hear what others were saying. The capacity to listen typically was accompanied by comments about the need to be an effective communicator and a team builder. Physician leaders need the ability to:

- “Think and act like a team player; ability to get their peers to buy in to being a team player;”
- “Bridge the gap between the physicians and the other care givers in the organization; foster mutual understanding among all health professionals....Build trust among peers and co-workers;”
- Be flexible in how decisions are made; tailor the decision-making process to the context and specific needs of a situation or group;”
- “Understand how non-clinical leaders think and how to have difficult respectful conversations with them.”

Physician leaders need to be team builders. They need to be able to:

- “Navigate conflict successfully and productively;”
- “Prioritize... fathom the possible versus the impossible... get to the heart of the question – to define what is the issue;”
- “Follow up on their vision with the tactical skills to put in place the key elements needed to reach the envisioned goal, e.g. team building, ability to set reasonable expectation.”

A few comments from physicians about teams were pointedly directed at their peers:

- “Physicians are expert in having crucial conversations with patients, but not with each other; expertise in initiating successful, difficult conversations between peers is essential;”
- “Motivating their peers to generate and endorse change needed to address the inevitable shifts in the health care delivery industry.”

Consequences of Inadequate Physician Leadership

Many responses to this question were directed at the effects of insufficient leadership contributions to state health care policy discussions:

- “Decisions that impact clinical issues may not be rational, as non-physicians may not understand various complexities;”
- “Without physician leadership there is potential for the business aspects of the delivery system to dominate decisions at the expense of quality, safety and patient needs and expectations;”
- “If there is no physician leadership, third-party financial interests win at the expense of patient care;”
- “If there is no physician leadership, bureaucracy and political ambition win;”
- “Control of practice and quality of care will leave the profession, with deleterious effects on patient care; control doesn’t have to be absolute, but shared;”
- “Ill crafted, poorly informed regulation and accreditation;”
- “Policy and rule making occur void of insight into patient needs and the realities of practice.”

Another group of responses focused on the effects of insufficient leadership at the organizational level:

- “Fiscal and operational responsibilities always trump clinical considerations in an organization not led by physicians;”
- “A physician leader can bring quality, safety and clinical reliability concerns into the board room and debates on finances and operations;”
- “Non-clinical leaders always default to what they’re comfortable with which is not typically patient-centered care and best practices;”
- “Without physician leadership organizations slip backwards or at least stagnate;”
- “Viable organizations rely on collaborative relationships among all employees including physicians;”
- “If the organizational culture is one of everyone for themselves, nothing works, everyone loses; current health care is too complex for going it alone;”
- “In order to get the puck in the net, it takes team work.”

Challenges and Opportunities in Today’s Complex Environment

A) Opportunities in State Policy and Health Care Reform

- “If they have the goods, physicians are potentially the most appropriate leadership choices for the future; they are the closest to knowledge needed to make a value-based system of care work;”
- “Physicians need to be involved in the policy making conversations and decisions if they want the profession and high quality care to survive in the state; “
- “Physicians should own clinical issues;”
- “Break down existing silos in the delivery system;”
- “Because of state and federal reform efforts, there is an enormous need and opportunity for physician leadership;”
- “Extremely important to have physician input on policy concerning the measurement of care, particularly in the future if value-based purchasing becomes a reality;”

- “Uncertain prospects of state health care reform are scary for many physicians and having a deleterious effect on retention and recruiting;”
- “Physicians are “responsible for the overall health of the general population...responsible for the efficiency, effectiveness and safety of the delivery system;”
- “Physicians must sponsor change necessary to address the new face of reality being presented to them by federal and state reform efforts.”

B) Opportunities in the Organizational Context

- “The most difficult challenge for leadership accountability is recruiting peers to understand the inter dependency of their own financial performance and that of the larger organization;”
- “As physicians become employed there is a need to nurture a mature and mutually satisfying relationship between the professionals and their new employers;”
- “Physicians are being forced to be part of larger systems against their will and natural tendencies;”
- “Key opportunity exists now for leaders to bridge the transition from professional independence to mutually dependent relationships with the larger organization;”
- “Administrators are as unprepared as the physicians for a new relationship; at times it’s easier for administrators and unemployed physicians to work together, than it is for the two groups to work together when they are co-employed;”
- “Physicians do not align themselves with organizations easily or naturally; they are by nature, by nurture through training and practice experience, single-handed sailors;”
- “Leadership is needed to bring physicians together.”

C) Challenges

- “The biggest issue is time to commit to either leadership responsibilities or formal education and training on leadership topics;”
- “For young physicians it is difficult to find leaders; there is no map leading to their door;”
- “Leadership skills and training opportunities should be early and often during residency years;”
- “Physician leaders must succeed in one of the most complex industries in the economy;”
- “Both generational and isolating nature of the current fragmented delivery system need to be addressed;”
- “PCPs and specialty physicians have little opportunity to interact anymore because of the partitioning of inpatient and outpatient services.”

Personal Attributes of Physician Leaders

A common opinion was that much of leadership is something that comes naturally - not all individuals are effective leaders, and leaders have varying effectiveness across

different circumstances. Leaders “have a sense of themselves – what are their personal strengths and limitations.”

Additional comments about physician leaders mentioned that they:

- “demonstrate trustworthiness, integrity and reliability;”
- “see beyond own their immediate motivations and appreciates what is driving others”, “are considerate of all people, peers, co workers and patients;”
- “are self confident enough not to be threatened by criticism and act as a role model for their peers in this ability;”
- “have a willingness to learn and to be flexible about incorporating current best practices;” “exhibit behavior congruent with organizational culture and reinforcing core values.”

Additional common comments about personal attributes of physician leaders were their ability to:

- Listen and communicate effectively and get other’s buy-in for change;
- Navigate conflict successfully and productively;
- Build trust among peers and co workers; and
- Build networks – someone who can bridge the gaps between the ever more fragmented physician and care giver community.

That being said, all interviewees also expressed the opinion that everyone including natural leaders can benefit from education and training:

- “There is much that is transferable from other businesses and industries; much of what is offered by business and management schools is applicable to medicine;”
- “Those that do come by leadership naturally can have their skills and knowledge increased by education and mentoring... They need time, training and support in the processes of quality improvement;”
- “We need resources and experienced mentors in rapid cycle improvement process”

Professional Attributes

“A sine qua non for credibility among peers is experience in clinical practice; they must be respected for their clinical competency.”

Additionally, leaders must:

- “understand what the patient experiences as they navigate the system;”
- “advocate for all of the team particularly the patients;”
- “have a ‘sense of professional responsibility extending to the larger community, not just their patients;”
- “be actively engaged in and supportive of performance improvement and clinical metrics... Quality and safety must be paramount in their vision of professional responsibility”

What is a physician leader accountable for in their community and to the overall population of the state?

Quite likely because of interest and concern about health care reform, many of the responses about what physician leaders are accountable for were directed at the role of physicians in health care policy and particularly the opportunity presented by both federal and state reform efforts. One repeated view was that given the trust the public has bestowed on the profession in terms of legal and economic privilege, physicians are expected to always put patient need ahead of physician need, and that physician leaders are accountable for both setting the tone for expected professional conduct and calling out peers that are in violation of public expectations:

- “Ensure that their peers optimize the quality of patient care for each patient and for the community as a whole;”
- “Lead peers away from squabbling over distracting side issues and get them to focus on the big picture;”
- “Parochial physician advocacy for their own patients can impede overall system reform for the betterment of all patients.”

Physician leaders are seen by their peers to be accountable for partnering with other leaders to ensure the:

- “overall health of the general population;” and
- “Efficiency, effectiveness and safety of the delivery system.”

A few interviewees challenged their peers:

- “Fix the delivery system, huge opportunity to do so in light of federal and state reform....Fight for sensible and just allocation of resources in state and federal reform efforts.”
- “Physicians are to a large part responsible for the distortions in reimbursement between procedural interventions and cognitive practices, and they must be in the lead towards solving the challenges of the current delivery system.”

What is a physician leader accountable for within their organization and in terms of Medical Education?

The majority of responses pertaining to the role of physician leaders within provider organization had to do with setting examples for appropriate professional behavior and being a motivator and team builder.

- “Setting a course at whatever level of the organization at which they operate;”
- “Getting the buy-in from other key staff”
- “Serve as an example for collaboration to offset the predominant individualistic and counterproductive nature of physicians;”
- “Close open issues; physicians are exceptionally poor at bringing an issue to closure and making commitments to strategic and operational decisions”

A few responses focused on financial and managerial deliverables:

- “Ensure the financial viability and success of their organization;”
- “Ensure patient and professional satisfaction, positioning the organization to be able to retain and recruit the best professionals;”
- “Be responsible for the successful integration of mid-level care providers into the practice.”

Interviewees involved with medical education and graduate medical education either as teachers or trainees remarked the physician leaders are accountable for: “Mentoring and coaching younger physicians to eventually lead.” “The hierarchical nature of medical training doesn’t nurture leadership skills.” “Undergraduate medical and residency training needs to include dimensions that prepares trainees for future leadership roles.”

III. Next Steps Based on the Interviews

The VMS Foundation is proposing to support two types of support resources for physician leaders in the state. The major resource will be support for four physician leadership communities –three of which will have state-wide membership; one will be community focused.

Additionally, the VMS Foundation will host an annual leadership conference to allow the separate leadership communities to interact as well as serve as a forum to raise awareness and promote physician leadership concepts across the state and region.

A) Pilot Physician Leadership Communities

Based on the interviews, the VMS Foundation assessed that a “one size fits all in one place” approach to offering leadership development and support is not what physicians want. A solution more in-line with physician preferences would be to deploy resources to teach and mentor leaders in the context that makes the learning and support valuable to them – their place of work.

“The best expenditure of VMS Foundation resources would be to bring resources to leaders as near and as relevant to their context as possible, rather than generic resources removed from their context.”

The VMS Foundation has chosen to support four pilot efforts. All pilots were suggested by interviewed physicians and CEO’s. Physician Leadership Communities will be organized around a similar logistical construct. It is expected that the initial logistics will undergo changes as the needs of the Communities become more specific. Change and improvement in community organization and operations will be encouraged. The pilot design is an attempt to build initiatives that will develop and support physician leaders while focusing on real-time, real-world issues that matter to the participants and requiring only a tolerated amount of travel.

The fourth effort in Rutland is already in its early stages; the VMS Foundation will be assisting with development and maturation of the effort as well as developing the capacity within the state for organizations with interest to network with those involved in the RRMC effort and other emerging efforts.

1. Vermont Hospitalists Leadership Community

All but one Vermont hospital has a hospitalist service. There is currently no forum for hospitalists to network within the state or region. The concept for this pilot was first suggested during a leadership discovery interview with a physician who has volunteered to champion the effort. Initial outreach to other hospitalists has been greeted positively. Time to meet has been identified as the key obstacle. The VMS Foundation is presently working with a subset of the physicians to explore internet-based solutions to support the effort.

2. Recommendations for Management of Chronic Pain in Vermont

The management of chronic pain and the related abuse of prescription drugs is an enormous problem in the state. Though physician-led, this pilot community will include key non-physician community leaders as well. This pilot was conceived as a result of conversations between the VMS Foundation, key physician leaders, hospital senior management, and community and public health leaders. Chronic pain/prescription drug abuse has been identified as one of the top three health care system issues in this community along with primary care access and obesity.

3. Vermont Physician Executives Leadership Community

This pilot was promoted by a primary care physician who has administrative responsibilities in a critical access hospital. As is the case for hospitalists, there is no formal forum for physicians with executive responsibilities at Vermont hospitals to learn from each other or have access to leadership and management support. The physician who suggested this pilot has volunteered to champion the effort and is working with the VMS Foundation to recruit members. Initial response has been enthusiastic. The current discussion is focused on membership; should it be just rural hospitals? Should it be hospitals that share the same geographic location? In contrast to most of the other physician and CEO input, this group is most interested in support that starts on the “management” end of the skills and knowledge spectrum as opposed to the “leadership” end of the spectrum.

4. Rutland Regional Medical Center Physician Leadership Program

This community health care association has recently embarked on developing a physician leadership curriculum for their institution. The organizational CEO and the trio of physicians leading the effort invited the VMS Foundation to help with the development of the initiative. Their organizational strategy is for physicians to lead clinical practice in collaboration with management and administration. Physician leaders are responsible for the content and knowledge base of clinical practice in the institution. The administration believes that without effective physician leadership the organization will fail to meet their mission. The CEO sees physician leaders stimulating change through

motivation of others and alignment of individuals with the organizational mission. The CEO and lead physician are enthusiastic about partnering with the VMS Foundation to identify the best approach for leadership development, identification of training/teaching resources from outside their community and facilitating networking among emerging like efforts.

Pilot Logistics

Initially the first three pilots will be similarly organized. The membership of each community will share similar professional responsibilities in their organizations with the exception of the Chronic Pain Community which will include non-physician community leaders. Homogeneity of membership facilitates consensus on priority topics. Each community will have a physician champion whose role is both to be a content expert and motivating influence encouraging bringing the group together initially, helping the membership reach consensus on a meaningful purpose and motivating the group towards meeting their goals. The physician champion will have the support of five staff roles: 1) a group process facilitator; 2) information technology support; 3) administrative duties; 4) quality improvement expert; and 5) leadership development expert. Depending on the capabilities of the assisting staff, individuals may assume more than one staff role.

The RRMC effort already is underway and has a slightly different organizational structure though it is principally a physician-led effort with dedicated administrative support. The VMS Foundation role will be supportive rather than acting as a catalyst.

B) Annual Statewide Plenary Conference

Several interviewees opined that “an annual statewide event where leaders can meet, share and generate new knowledge could be very powerful.” The conference would also serve as a venue to bring in out-of-state experts to present information on topics of interest to the physician leaders in the audience.

The annual leadership conference will allow the VMS Foundation to continue to hear from Vermont physicians on their needs to continue to strive for the highest levels of professionalism. “Give them forums to speak from. Ask them questions. Actually seek their advice, and then follow it.”

IV. Methodology

Interviewees

Approximately 40 requests for interviews were sent out via email to:

- VMS Foundation board members;
- VMS Council members;
- Current presidents of all Vermont hospital medical staffs; and
- Selected Vermont hospital CEOs.

Twenty individuals were interviewed. The characteristics of the interviewees were:

- 4 hospital CEO's (one physician CEO)
- 6 hospital or clinic chief medical officers
- 2 College of Medicine Deans/Departmental Chairs
- 1 fourth year resident physician
- 4 self employed specialty and primary care physicians
- 2 employed specialty physicians
- 1 employed primary care physician

County location: 8 Chittenden; 1 Franklin; 2 Washington; 2 Caledonia; 1 Windsor; 2 Rutland; 2 Orleans; 1 Lamoille; 1 Orange.

Four of the interviewees were hospital CEOs, one of whom was a physician. Their responses were not different from the physicians interviewed; though they were more interested in efforts that were community specific rather than efforts that focused on problems shared across communities. Only one of the CEOs held the minority opinion that physician leaders need more management skills and training in order to promote more corporate efficiency and more corporate awareness among its physician members. The other respondents who thought that managerial training was paramount were employed physicians with management responsibilities. Not all of the physicians with management responsibilities shared this view.

The CEOs were among the most passionate about the need for physician leaders. Their two principal concerns were: 1) their organizations needed its physicians to be active if not in charge of envisioning what health care services and resources would best meet its community's needs; and 2) a growing number of physicians are becoming more disengaged from the hospital, other physicians and their community.

The CEOs were very passionate and articulate about the need for physician leaders to be enthusiastic creators of a vision for the delivery system in their organization and community and to motivate others to join in the efforts to achieve this vision. They stressed the need for physician leaders to be able to step up to the tasks of building and leading effective improvement teams, to deal with their peers who were being unprofessional or disruptive and negotiate effectively in the face of disagreements.