No Longer a Solo Practice: How Physician Leaders Lead

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ABSTRACT

The authors conducted a national study to determine the factors associated with the success of physician leaders. They utilized the Leadership Practices Inventory (LPI) and a demographic survey followed by individual interviews with respondents. Data analysis revealed several implications for the selection, training, management, and career development of physician leaders. The results suggest that:

- ***Physician leadership training should have a strong focus on the "human side" of management, including negotiation, organizational "politics," conflict resolution, team building, and motivation.***
- ***Data management and finance should be a focus represented in the curriculum.***
- ***Mentoring relationships should be developed as an aspiring physician leader pursues a career shift.***
- ***Self assessment, including an analysis of style, strengths, best potential organizational fit, and specific areas of strength and weakness should be an integral part of the development of an aspiring physician leader.***
- ***Screening mechanisms to ascertain a physician's motivation to move toward a full-time leadership role should be developed to ensure appropriate intent. To facilitate this implication, more effective assessment tools need to be developed.***

Health care reform is being driven by market forces that have propelled consolidations throughout the health care delivery system. Physician practices are being consolidated, combined into single and multispecialty group practices, or purchased. Hospitals are pursuing physician-hospital organizations, management service bureaus, merged hospital systems, or integration with insurers and physicians. Devers *et al.* have identified that physician integration into these systems is predictive of clinical integration and some measures of financial performance for the entity.[1] With critical reforms emerging in the '90s, health care organizations are changing at lightning speed. Hospitals, private practices, HMOs, and insurers are aligning to increase their odds of survival in an era of restrained resources and intense competition. Physicians are propelled to shift from solo, autonomous, and self-regulated practices to collective, collaborative, and externally managed ones. Who is leading these changes? Historically, health care leaders have come predominantly from nonclinical backgrounds. But, looking around today, we see yet another change: the increasingly strong presence of physicians as leaders of health care reform.

Who are these physician leaders and how do they approach their leadership roles? What would they say are critical success factors for physician leaders in these turbulent times? Studies have identified practices of successful leadership, but none of them specifically focus on the physician leader.[2-8] If queried, would physician leaders report similar practices to leaders in other industries? In order to answer these questions, the authors undertook a study.

Methodology

The authors randomly selected 150 of 350 Fellows of the American College of

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Table 1. Demographic Profile of Physician Leaders

Categories	Percentage Reporting
Current Position Title	
Medical Director	25.6%
V.P., Medical Affairs	24.5
CEO	10.6
Program Director	7.4
Consultant	7.4
Other	24.5
Years in Current Position	
1 year	10.6
2 years	18.1
3 years	9.6
4 years	7.4
5 years	14.8
6+ years	39.5
Current Setting	
Hospital	35.1
HMO	19.1
Private Practice	8.5
Insurance	6.4
Academic	6.4
Nonhealth Care	3.2
Other	21.3
Average Years in Clinical Practice before Becoming Leader:	10.02
Time Spent	
80% or more in leadership	50
20% or less in clinical practice	8.5
20% or less in research	100
20% or less in teaching	93.8

Categories	Percentage Reporting
Medical Specialty	
Internal Medicine	21.3
Cardiology	14.9
Ob/Gyn	9.6
Family Practice	8.5
Surgery	5.3
Pathology	5.3
Psychiatry	4.3
Pediatrics	4.3
Other	21.5
Gender	
Male	95
Female	1
Missing Data	4
Education in Leadership	
Degree	34
Working on Degree	1
Continuing Education	53.2
Diplomate, ABMM	50
Mentored	21.3
How Selected for Current Position	
Formal Application	38.3
Election	9.6
Default	1.1
Developed/Prepared	24.5
Other	32

Physician Executives. To attain Fellow status, a physician must:

- Be an ACPE member in good standing.
- Be a Diplomate of the American Board of Medical Management or have achieved stature in medical management.
- Be recognized among his or her peers and submit two letters of nomination from Fellows or Distinguished Fellows of ACPE and one letter of recommendation from the chief executive or governing board of the candidate's employing organization.
- Have contributed to the profession of medical management as demonstrated by participation in ACPE activities recognized as showing commitment and contribution to medical management.

The authors worked under the assumption that achievement of the Fellow title implied at least some level of success as a physician leader.

To profile these physician leaders, the researchers used three methods of data collection: the Leadership Practices Inventory (LPI)[6]; a demographic survey; and individual, one-hour, structured interviews of 20 physician leaders who participated in the study and volunteered to be interviewed. These interviews were conducted at the ACPE national conference in Washington, D.C., in May 1994 and by phone.

Leadership Practices Inventory. LPI comprises 30 behaviorally based statements about leadership and uses a five-point Likert scale. In developing the instrument, Kouzes and Posner utilized case study analysis of more than 1,100 managers and in-depth interviews of 38 middle-to-senior-level managers, In addition, more than 3,000 managers and their direct reports received the LPI. The analyses demonstrated patterns of critical leadership actions in five categories, defined as[6]:

- *Challenging the Process.* "Searching out challenging opportunities to change, grow, innovate, and improve, and experimenting, taking risks, and learning from the accompanying mistakes." (p. 5)
- *Inspiring a Shared Vision.* "Envisioning an uplifting and ennobling future, and enlisting others in a common vision by appealing to their values, interests, hopes, and dreams." (p. 6)
- *Enabling Others to Act:.* "Fostering collaboration by promoting cooperative goals and building trust, and strengthening people by sharing information and power and increasing their discretion and visibility." (p. 6)
- *Modeling the Way.* "Setting the example for others by behaving in ways that are consistent with their stated values, and planning small wins that promote consistent progress and build commitment." (p. 7)
- *Encouraging the Heart.* "Recognizing individual contributions to the success of every project, and celebrating team accomplishments regularly." (p. 7)

Demographic Survey. The authors designed a demographic survey to accompany the LPI, including questions regarding positions previously held, current work setting, percentage of time devoted to leadership practice, medical specialty, gender, age, education, and selection process for the current position. The demographic survey and the LPI, along with a cover letter, were reviewed by experts and piloted with 25 physician leaders participating in a 13-week seminar conducted at the Center for Health and Medical Affairs, University of St. Thomas, Minneapolis, which funded this study.

To obtain a sample of respondents for individual interviews with the authors, the demographic survey included a solicitation for volunteers willing to be interviewed by phone or at the ACPE Conference and a coding procedure, ensuring confidentiality and anonymity, but still allowing for the tracking of respondents. Two weeks following the initial survey distribution, the authors redistributed the survey to nonrespondents. To increase the survey's return rate, the authors offered an opportunity for two respondents to win American Express gift certificates. To encourage respondents to volunteer for the interviews, the researchers offered an additional incentive of an American Express gift certificate to each interviewee.

Interviews. The authors conducted interviews with 20 volunteers. The interview questions focused on:

- A description of their current responsibilities.
- The selection process used for their current positions.
- Their perception of variables associated with leadership success and failure.
- Their core philosophy regarding leadership.
- Their handling of obstacles/failures.
- Ways to reduce an upcoming physician leader's "learning curve."
- Ideas for the preparation of physician leaders.
- Their advice for potential physician leaders.

Statistical Procedures. The authors used analysis of variance to assess differences in the LPI indices and variables in the demographic survey and used the Pearson product moment correlation coefficient to assess statistical significance among years in practice, years in current position, and the LPI variables. The authors selected a 95 percent confidence level for statistical significance.

Results

Demographics. The authors received 94 responses, a response rate of 63 percent. The majority of respondents were medical directors, vice presidents for medical affairs, and CEOs who practiced in hospitals, HMOs, or private practice. On the average, they had been in their current positions almost six years and had spent 10 years in clinical practice, with approximately one third of the respondents practicing in internal medicine or cardiology before assuming a formal leadership role. They spent the majority of their time in their leadership role, with very little time, on the average, devoted to research or teaching. All but one of the respondents were male, and approximately 65 percent did not have a degree in leadership/management, but more than 50 percent were involved in some type of continuing education. Slightly over one third of the respondents had been selected for their current positions through a formal application process, while another 25 percent had been developed and moved into the position through a more "political process" (see table 1, page 12).

Table 2. Comparison of Respondents' Leadership Practices Inventory Scores with Normative Population

LPI Practice	Norm	Respondents	Percentile Ranking of Respondents
Challenging	22.38	24.92	75
Inspiring Vision	20.44	24.38	85
Enabling	23.90	27.25	80
Modeling	22.12	24.42	80
Encouraging	21.96	24.64	80

Leadership Practices Inventory. Table 2, above, compares physician leaders in our study with the norms of the LPI. Physician leaders in our study reported more frequent use of all five leadership practices than did the population from which the norms for the LPI instrument were developed. Analysis of variance indicated that the older the physician leader, the more frequently he or she reported using "modeling the way" behavior. Physician leaders from academic institutions reported less frequent use of "challenging the process" behavior than physician leaders in other settings. Respondents from hospital settings reported more frequent use of "modeling the way" behavior than physician leaders in other settings. And the more years physician leaders were in clinical practice before they became leaders, the more "inspiring a shared vision" and "modeling the way" behavior they reported. Medical specialty, gender, selection process, training in leadership, and time in current position made no significant difference in reported frequency of use of leadership practices.

Individual Interviews. An analysis of the interview findings unfolded the following characteristics attributable to physician leadership success:

- *Clarity of Purpose.* Physicians who desire to move into leadership roles should carefully examine their motives, respondents said. The impetus must come from a commitment and drive to make change in the health care arena, not from a personal need to escape practice. The physician leaders we studied spoke of having clarity about their mission that served as their primary motivation in seeking a leadership role.
- *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. Often this entails aligning individual goals with the needs of the organization to gain commitment. The effective leader is able to determine what's in it for others to commit to the direction the leader is proposing. How the vision is developed may vary. Some of the leaders we interviewed spoke of creating the vision with others; some appeared to create it more independently. Whatever the case, without the sustained commitment and focus of others needed to enact the vision, the physician leader cannot succeed. This requires the leader to pave the way for others to achieve the vision by removing obstacles, sharing information freely, and calling upon their unique talents.
- *Building Trust and Credibility.* The effective physician leader must be trusted by those he or she leads. Our interviewees talked of the importance of the

professional background of the leader in gaining credibility, especially with other physicians. Success in clinical practice and understanding of current clinical issues are crucial in building that trust and credibility. Without proven clinical competence and attention to current issues in medical practice, our interviewees reported, most physician "followers" would not easily give credence to the ideas proposed by the physician leader. In addition, personal integrity and honesty were described often as characteristics that contributed to the credibility of the physician leader in the eyes of followers.

- *Persistence when Challenged by Obstacles.* When asked about differences between successful and unsuccessful physician leaders, our interviewees talked about the importance of perseverance when obstacles appear along the path to a leader's vision. The physician leader who gives up too soon often fails, while the leader who relentlessly pursues goals, chipping away at them slowly and steadfastly, is more likely to succeed. The drive to persist, again, must come from a strong commitment to the leader's articulated vision and goals.
- *Political Savvy.* Interviewees pointed to the need for physician leaders to develop a strong base of influence within the organization as well as within the community. Understanding the needs of each faction within an organization and building coalitions among them to achieve goals were described as crucial to the leader's success. Often this included being more than a representative of physicians alone, embracing the needs of other groups and integrating solutions to satisfy all interested parties. To do this, the successful physician leader must employ high levels of skill in negotiation and persuasion.
- *Working with and through Others with an Attitude of Service.* Interviewees spoke of the need to let go of autocratic, controlling behaviors and position oneself as a team builder, drawing others into the leadership act. By listening, inspiring, coaching, delegating, and guiding, the physician leader can transfer the vision and goals from "mine" to "ours." The effective physician leader demonstrates a high regard for diversity of opinions and the ability to bridge differences to build consensus. Interviewees spoke of arrogant, ego-involved, self-centered leadership behaviors as a sure formula for failure. Approaching their roles with humility and high regard for others, interviewees spoke of the need to subjugate their personal needs and agendas to the needs of others.
- *Freely Giving Praise and Recognition.* A sure sign of impending leadership failure, interviewees said, was neglecting to give enough credit to others who contribute to accomplishing the established goals. Leaders who infuse their organizations with abundant recognition of others are more likely to maintain a high level of enthusiasm and commitment among followers.
- *Keen Self-Awareness.* Interviewees recounted their pursuit of self knowledge through continual introspection and self-assessment. They talked of the need to know their personal strengths and weaknesses—accept them and even develop a sense of humor about them—and to surround themselves with others who provide the skills and abilities the leader may not have. Also, an effective leader must be attuned to the type of organization that is the best fit for his or her talents.

We went further to ask the physicians in our study what more would have helped them in their career development to more quickly learn the skills they view as critical to their effectiveness. Two key themes emerged from their responses:

- *Having a Mentor.* Finding someone along the way who could show an aspiring leader "the ropes" could accelerate the speed of the journey, interviewees noted. Those who had found mentoring relationships reported high levels of learning from the interaction as well as a personal support system.
- *More Formal Education with an Emphasis on the Human Side of Leadership.* While the physician leaders we studied varied in the type of formal education they recommended, nearly all agreed more formal education, tailored to the role of physician leadership, was desirable. Some spoke of master's degree programs designed for physician leaders and leading to a specific credential, while others believed leadership education should be part of medical school curricula. The focus of the curriculum should address real-life situations that focus on human interaction, the guts of the leadership role. In addition, data management and finance were noted as critical areas of study.

Conclusions

The responses of the physician leaders in this study were generally congruent with those reported by leaders from other industries in other research studies. However, the leaders in our study appeared to report even stronger than average utilization of behaviors associated with effectiveness by the Leadership Practices Inventory. This may reflect the senior level of our respondent group as compared to the population from which the LPI norms were derived. Additionally, the physician leaders we studied placed more emphasis than leaders in other studies in two key areas. First, they focused on the importance of having clinical competence and experience as a key path to building trust and credibility, especially with other physicians. Second, they talked extensively of the need to work collegially, as partners, putting aside personal needs and focusing on service to others. This seems to imply that the physician leader comes at his or her role as a peer to "followers," rather than from the traditional top-down positioning.

Implications

The results of this study have several implications for the selection, training, and development of physician leaders, as well as for further research.

- Our results suggest physician leadership training should have a strong focus on the "human side" of management, including negotiation, organizational "politics," conflict resolution, team building, and motivation. Data management and finance should also be represented in the curriculum.
- Mentoring relationships should be developed as an aspiring physician leader pursues a career shift.
- Self assessment, including an analysis of style, strengths, best potential organizational fit, and specific areas of strength and weakness, should be an integral part of the development of an aspiring physician leader.
- Screening mechanisms to ascertain a physician's motivation to move toward a full-time leadership role should be

developed to ensure appropriate intent. To facilitate this implication, more effective assessment tools need to be developed.

As a follow-up to this study, additional research would be helpful in two areas. First, a study of individuals reporting to physician leaders would help to confirm the congruency of our respondents' self-perceptions with those of his or her staff members. Second, a comparative study of the LPI responses of the physician leaders we studied with other leaders in similar positions in other industries would help further understand similarities and differences. ■

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