CHEST

Developing Physician Leaders

A Perspective on Rationale, Current Experience, and Needs

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Health care is beset by paradox and challenges today—and these challenges demand great leadership. The paradox regards the gap between the need for teamwork in health care and physicians' traditional training as "heroic lone healers." The challenges regard the needs to pivot from volume-based care to value-based care and in doing so, to satisfy the goals of the "triple aim"—enhanced population health, experience of care (including quality and safety), and lower per capita cost. In the context that effective leadership is needed to navigate these challenges, this perspective discusses the rationale for developing physician leaders, current experience with physician leadership development, and remaining questions regarding impact. Special attention is given to the leadership development needs and opportunities for physicians-in-training and for those who are early in their careers.

The Leadership Paradox in Health Care

To further frame the aforementioned paradox, on the one hand, there is robust evidence that teamwork among caregivers drives the excellent clinical outcomes to which physicians aspire for their patients. As just a few examples of this evidence, surgical mortality is lower among teams trained in teamwork than among untrained control groups. Mortality rates correlate favorably and significantly with the effectiveness of teamwork in the ICU. Precision in determining the etiology of interstitial lung disease increases progressively as pulmonologists, radiologists, and pathologists interact with one another rather than thinking alone. Accuracy in diagnosing rounded atelectasis increases when the pulmonologist and chest radiologist review films together rather than when each assesses the films separately. Finally, Gittel et al have shown that "relational coordination," when present, is a powerful correlate of high quality, high reliability health care delivery. They define relational coordination as the coordination of work through relationships of shared goals, shared knowledge, and mutual respect among colleagues.

Just as compelling as the evidence that teamwork matters is the observation that patients judge their experience of health care based on their perception of the teamwork among their caregivers. Specifically, concordant data from Press Ganey and from Gallup show that the strongest correlate of "most likely to recommend the institution," "highest overall rating," and of favorable HCAHPS scores was the perception that "caregivers worked together as a team to care for you."

The paradox, then, is that although teamwork is critical to achieving the highest quality and patient experience in health care, physicians have traditionally been selected and trained as "heroic lone healers" or as "cowboys." While "heroic lone healing" persists and may even prevail in health care today—at least among traditionally trained physicians—this observation about physicians is hardly a new one. Writing in 1978 in a paper entitled "Why hasn't organizational development worked (so far) in medical centers," Weisbord noted that "Science-based professional work differs markedly from product-based work. Health professionals learn rigorous scientific discipline as the 'content' of their training. The 'process' inculcates a value for autonomous decision-making, personal achievement, and the importance of improving their *own* performance, rather than that of any institution." Simply put, the paradox is that although teamwork

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matters immensely, physicians are neither selected nor trained to be team players.

Four factors contribute to the lack of team behaviors among physicians: (1) Physicians are selected for medical school and trained on individual performance; consider board exams, in-service training exams, and the myriad of assessments that physicians receive on clinical rotations through a training career—all are individual assessments. (2) Medical training is long and hierarchical, creating a sense of being "king of the hill" on completing training that can undermine the inclination to collaborate, (3) Clinical reasoning and generating differential diagnoses is a powerful example of so-called "deficit-based thinking," which is perfectly suited to physicians' roles as clinical healers, but which is antithetical to the "appreciative thinking" that creates organizational possibility and collaboration, and (4) Physicians are at risk for "extrapolated authority." Consider the seasoned pulmonologist whose dyspneic patients confer to him the authority he deserves as an expert in dyspnea but who, on leaving clinic, becomes incensed at waiting in line at a restaurant because, after all, he is an expert in dyspnea. The extrapolation of clinical authority to unrelated contexts can create an aura of entitlement to which at least some physicians fall victim.

Leadership Competencies in Health Care

These challenges in health care cry out for effective leadership and underscore the need to develop health care leaders. We need to fundamentally rethink how we select and train physicians and we must teach and cultivate leadership skills in medical curricula through the continuum of training. Several questions follow: First, what are the leadership competencies that are needed for physicians? Second, what is the available experience with developing physician leaders and especially for trainees and early career physicians? Third, what are the gaps in current understanding that need to be answered through continued inquiry? Let's briefly consider each of these questions.

Generic leadership competencies have been amply studied and articulated and many leadership models have been espoused. While different in taxonomy and parlance, in this author's view, all these constructs converge like good statistical models on certain core leadership competencies, perhaps especially clearly articulated by Kouzes and Posner in their five "leadership commitments." According to these authors, great leaders must "challenge the process, inspire a shared vision, enable others to act, model the way, and encourage the heart."

Leadership competencies for health care have also received much attention. For example, the National Center for Healthcare Leadership model bundles 26 individual competencies into 3 rubrics: transformation, execution, and people. At the Cleveland Clinic, the leadership model and curriculum is organized around 4 pillars—leading change, developing self and others, fostering teamwork, and demonstrating character and integrity. Emotional intelligence (EI) figures prominently in developing these leadership attributes. The EI model of Goleman et al has been broadly embraced and subsumes 18 competencies within 4 quadrants: self-awareness, self-management, social awareness, and relationship management (Fig 1). Indeed, ample evidence suggests that emotional intelligence is a critical leadership competency for health care providers. For example, in surveying ICU caregivers regarding the determinants of the best bedside clinician in the ICU, Dine et al reported that the essential characteristics included teambuilding with a participatory style; vision by creating and modeling enthusiasm; communication in articulating the clinical plan and identifying any obstacles to execution; and humility, integrity, being encouraging, and being respectful—all core features of emotional intelligence. In surveying chairs of academic departments of psychiatry regarding the characteristics associated with role success, Keith et al reported the following traits, again all elements of emotional intelligence: good interpersonal communication, the ability to inspire and lead by example, integrity and honesty, altruism, tolerance, and perseverance. In interviewing 10 chairs of academic departments of internal medicine regarding success factors in their roles, Lobas noted that "Emotional

Figure 1 – *The Emotional Intelligence Model (After Suggested Reading 4).*

intelligence and its concomitant skills are the most essential competencies for leaders to succeed in academic institutions. The 10 chairs emphatically stated that this ability was fundamental to their success and its absence the cause of their failures. They suggested that the absence of emotional intelligence often resulted in the demise of chairs and contributed to the high turnover among colleagues." Finally, in a 10-year follow-up of participants of a physician leadership program at Cleveland Clinic called "Leading in Health Care," 43% of participants were promoted to an organizational leadership role in the decade following the course. The emotional intelligence attributes that were significantly associated with leadership promotion (all $P < .05$) included being a change catalyst, achievement orientation, and self-confidence. For the 18% of participants who experienced at least 2 leadership promotions in the decade following the course, 10 of the 18 EI competences were significantly associated with promotion.

The emphasis on developing EI as a critical leadership competency for health care is buttressed by the observation that EI can be taught and that enhancements in one's emotional intelligence are sustainable long-term.

Best Practices and Available Experience in Leadership Development in Health Care

In the context of these leadership competencies and their impact to frame a curriculum for developing physician leaders, what are the best practices in leadership development programs and what is the available experience in health care? Rabin has articulated three elements of developing leaders, that is, offering: (1) Curriculum around the competencies; (2) Developmental relationships, often through supportive coaching and mentoring; and (3) Progressive and challenging leadership opportunities, or so-called "experiential" leadership learning. Day and Halpin have articulated the best practices in leadership development programs, which include: (1) Having an influential champion—the higher placed in the organization, the better (ideally CEO); (2) A shared vision that leadership is needed throughout the organization, not only by a select few (leadership capacity is everywhere); (3) Tying the development program to a current business imperative (eg, globalization, growth, etc); (4) Integrating the program as a part of an over-arching strategy, not as standalone activities; (5) Offering the program at an offsite location and ideally having a dedicated facility for developing leaders (eg, Crotonville for General Electric) to demonstrate the organization's commitment to the process; and (6) Patience by organizational leadership, that is, acknowledging that the organizational return on such programs may take a long time to be fully realized.

In the context of these best practices, what is the available experience of leadership development in health care organizations and what programs are specifically targeted to trainees and early career physicians? Despite the fact that effective leadership development programs are signature features of the world's most successful corporations, health care organizations—with some notable exceptions—have generally been slow to implement such programs. Interest and activity does seem to be growing. In a 2012 survey of leaders of health care organizations, Davidson et al reported that 57% of responding institutions reported offering no leadership development programs and only 14% offered fully intramural programs, with the remaining minority offering external vendor-delivered or hybrid internal-external programs. Still, premier programs to help develop physician leaders are now being developed and are offered through different organizations, for example, by medical societies (including the American College of Chest Physicians with its 1-day annual post-graduate course [also directed to fellows and early career physicians], and the longstanding CHEST Leadership Development Program which pairs emerging with senior CHEST leaders; the American Thoracic Society with its "Emerging Leaders Program" [which was launched for early career, high potential emerging leaders]; and the American Association for Physician Leadership), by business schools (including Wharton and its collaboration with DeLoitte, Harvard Business School, etc), and health care organizations (like Cleveland Clinic, Mayo Clinic, Virginia Mason, Hartford HealthCare, McLeod Health, and the Drexel University College of Medicine). At the Cleveland Clinic, leadership development programs are available throughout the spectrum of medical training, from a full-day leadership workshop for Cleveland Clinic Lerner College of Medicine students, to a longstanding annual Leadership Workshop for Chief Residents—now in its eighth year, to a 13-year history of offering an interdisciplinary leadership program to established caregivers called Leading in Health Care. Such leadership development programs for trainees are similarly emerging in other institutions.

As a snapshot of the impact of these programs on trainees, medical students valued the workshop highly with key takeaways being the importance of adapting one's leading style to the specific context (ie, situational leadership), the importance of aligning one's leadership values to the organizational culture, and the value of building a toolbox of different leadership styles. Results of a survey of the 105 chief residents who attended the first 5 annual offerings of the Cleveland Clinic Chief Residents Leadership Workshop indicated that pre-workshop awareness and proficiency in the needed leadership competencies were generally low and that following the workshop, attendees were uniformly more familiar with these leadership competencies. Finally, outcomes of the Leading in Health Care course included its serving as an innovation and leadership incubator for the organization. The majority of business plan proposals that were developed as a course deliverable were impactful and 43% of course alumni were promoted to a leadership role over the decade following course completion.

In the context of Rabin's construct of 3 elements of an optimal leadership development program, several practical recommendations emerge for early career physicians who seek to advance their leadership skills and opportunities: First, find and undertake a curriculum in leadership training. Various pathways exist from curricula offered by one's own or by other health care organizations, by professional societies, or by universities (both in certificate and in formal degree-granting programs). The primary goal of such training is to gain awareness and a vocabulary of leadership competencies that will set the stage for deliberate practice in pursuit of mastery. One's learning style preferences and practical considerations in the context of already busy lives (eg, geographic proximity, convenience, and cost) should dictate program choice. Those who desire structured and accountable learning environments may elect formal degree-granting programs (eg, Masters of Business Administration, Masters of Organizational Development, Masters in Health Administration, etc).

The second recommendation is to recognize the difference between coaching (ie, enhancing self-awareness through inquiry) and mentoring (ie, advising) and to seek and cultivate both coaching and mentoring relationships with colleagues around leadership. In choosing such leadership coaches and mentors, recognize that these individuals may be different from those who serve as mentors or coaches for your academic work, your work-life balance issues, and so on.

Finally, and perhaps most importantly, seek progressive opportunities to lead and to demonstrate your leadership prowess. Early opportunities may include service on search or review committees or on task forces that are convened. Because success begets success, favorable performance in these early opportunities will likely foster additional opportunities for leadership, with progressive levels of responsibility and leadership scope. Recall also that the timing of such invitations to lead and serve never come at ideal or even opportune times. One's trajectory in leadership is a balance between intentionality—the planned, methodical intent to assume a leadership role—and serendipity—the reality that these opportunities often present through unplanned and seemingly random events. Every senior leader with whom I have spoken can tell an impassioned story about how they assumed their current leadership roles through interactions with beloved coaches and mentors and through unplanned circumstances and opportunities that presented to them. Assuming leadership roles truly embodies Pasteur's quote that "chance favors the prepared mind." Preparation comes from studying and embracing leadership competencies, developing and cultivating trusting, meaningful, and supportive relationships, and by seeking opportunities to lead.

The Impact of Leadership Development in Health Care and Remaining Questions

Notwithstanding these reported impacts, evidence supporting the implementation and impact of physician leadership development programs remains generally sparse. Specifically, using a Kirkpatrick impact scale (where level 1 impact reflects the learners' subjective rating of the teaching, level 2 reflects knowledge gained from the teaching, level 3 regards evidence that behavior changed as a result of the gained knowledge, and level 4 indicates systems-level performance impacts of the training [eg, financial impact, leadership promotion, etc]), the weight of available evidence regarding the impact of physician leadership development programs supports favorable level 1 results, with less evidence regarding higher levels. In a systematic review of 45 eligible reports regarding such programs, Frich et al reported that only 6 (7.5%) assessed system-level impact (eg, quality of care process measures, promotion to leadership of course participants, improved clinical quality metrics in specific diseases, and patient satisfaction).

So, recognizing the importance of leadership development for trainees and early career physicians, important questions about the impact of physician leadership development persist. For example, what impact do graduates of physician leadership programs exert in their organizations? Are such leadership development programs cost-effective? What is the optimal method to deliver physician leadership development? Recognizing that such training should likely begin early in medical training, what is the ideal "spiral curriculum" and when are the optimal times during a career in medicine to offer such training?

Notwithstanding these unanswered questions, the power of and the need for effective leadership to meet the challenges of health care will propel physician leadership development forward. Early career physicians are encouraged to seek such training and to create an appetite for such programs to which their organizations should surely respond.

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