

Success Factors for Physician Leaders

Thriving in today's practice environment part of Midwest Clinical Conference program

By Susan Reynolds, MD, PhD

PAYMENT REFORM is well underway, causing a major upheaval in the health care industry. The new paradigm bases payment on clinical outcomes and accountability rather than the traditional fee-for-service model.

Physicians must continually adjust to new rules and regulations in order to maintain their previous compensation levels. They have to learn about value-based purchasing, readmission non-payment, bundled payment, accountable care organizations, population health management, meaningful use, and more. Today's payment mechanisms require sophisticated IT systems to collect outcomes data that demonstrate quality care. Many physicians are struggling to become IT savvy, so they can use these computer systems efficiently.

Quite a few medical practices have been forced to merge in order to acquire computer systems. And many physicians have decided not to go it alone anymore, instead preferring to become employees of a hospital, health system, or large medical group so they can survive the tsunami of change.

Physicians and Hospitals Need Each Other

In this challenging environment, how can physicians succeed, and how can physicians and hospitals collaborate for mutual success? What new knowledge, skills, and strategies are needed to survive?

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Today we see hospitals developing a regional approach to care delivery wherever possible in order to maximize reimbursement. The more lives they cover, the more outcomes they can report. And by collaborating with physicians, many hope that clinical outcomes will show excellent results, which in turn will generate better reimbursement.

Hospitals must work with physicians to develop

financial and clinical integration models using complex computer systems. Physicians can help them by developing disease management systems that ensure consistent care delivery, utilize best practices and evidence-based medicine, and maximize clinical outcomes. They can also participate in IT system design and help analyze the outcomes data collected through those IT systems.

Physicians need to align with hospitals in some way so they have access to reportable outcomes data they can use to maximize their own reimbursement. Physicians, also, need sophisticated IT systems, and must learn how to use them effectively. They also need education about care management, best practices and protocols, and evidence-based medicine in order to demonstrate excellent outcomes.

With the new payment model focused on quality reporting, physician oversight is needed now more than ever. Hospital boards today have more practicing physicians on them so that all board members can understand the latest treatments available for hospitalized patients and ensure that they are being used. ACO models also need physicians in management and governance.

How Physicians View Themselves

Physician leadership is now an imperative if the new payment system is to work. And so the next question becomes, “What is effective physician leadership?” A corollary is, “What are the success factors for effective physician leadership?”

We often ask physician audiences, “Why do people follow you?” Here are some unusual responses:

- “We all got 800s on our College Boards.” (Medical Society President)
- “Because they have to.” (Orthopedic Surgeon)
- “Most billable hours.” (Medical Malpractice Defense Attorney)
- “Nobody else wanted the job.” (Chief of Staff)

Better answers have included:

- Task competence
- Knowledge
- Experience
- Work hard
- Trustworthy
- Good communicator/listener

- Courage
- Vision

And sometimes we hear:

- Get the job done/get results
- Approachable
- Charismatic
- ... and even instill fear (not usually a long-term motivator)

Vision is frequently not at the top of the list. In fact it was listed as the #10 success factor in a UCLA Anderson School of Management study. Motivating others was listed as #9. “Trust” came in at #1 and “Communicating one-on-one” and “Teamwork” came in at #2 and #3, respectively. Physician CEOs did rank “Vision” as their #1 success factor, followed by “Communication,” then “Teamwork and Creativity,” and “Management Experience.”

In the same study, Senior VPs said “Clinical Background” was most important, followed by “Communication,” “Teamwork,” and “Information Management.” In other words, these physician leaders had to be excellent clinicians, up-to-date on clinical care guidelines, able to collaborate, and know how to use IT systems to handle clinical outcomes data.

For Chiefs of Staff and Department Chiefs, “Trust” was the #1 success factor, followed by “Communication Skills,” “Vision,” and “Creating Buy-in” [for the vision]. Their top functional skills mirrored those in the overall study and included knowledge of “Health Policy,” “Health Economics,” “Information Management,” and “Data Analysis.”

Building trust is key for any physician leader since they must meet with administrators on a regular basis to collaborate. However, in doing so, they may be viewed by their clinical colleagues as “going over to the dark side.” Administrators need physician input as they build quality and patient safety programs, but they may have different goals and objectives and even different communication styles, so the doctor may not fit in easily.

Qualities of Successful Leaders

The most successful physician leaders, according to the UCLA study, maintain strong relationships with their clinical colleagues while building strong new relationships with administrators. Ideally, physician leaders have conflict resolution skills to bring both sides closer together. The most successful ones can create and communicate a vision. Along with these qualities, leaders must inspire a team to make the vision a reality. Successful leaders help others to learn and grow.

In the new health care paradigm, physicians need to rely on tools like motivation and communication as they collaborate on teams. Many individuals they work with are not under their direct authority, and so physicians must be able to



build rapport, listen to others, delegate effectively, understand millennials, and give timely and appropriate rewards. It is difficult to motivate others when people have been assigned to a team they have no interest in. Team members function best when their roles match their individual strengths, and others on the team cover their weaknesses.

Allowing others to participate in solving problems rather than just assigning specific tasks to be accomplished is also helpful. Team members function better when they have ownership in the project. Recognition, even as simple as a “Thank You,” can be very important. People may give their all once, but if unrecognized, they may not put in as much effort in future projects.

Obstacles to Good Leadership

When a leader seems too demanding, micromanages, or seems to criticize unfairly, team members will become far less motivated and perform less well. Leaders must avoid seeming autocratic. No one wakes up in the morning and says, “I think I’ll be arrogant today.” That just doesn’t happen. However, white coats, clipboards, and the over-usage of “medicalese,” can distance physicians from others, making them seem arrogant even though it was not intended. It is important that physicians get feedback from a close colleague or staff person about whether anyone perceives them to be arrogant or condescending.

In our medical training, we physicians learned to be autocratic when giving orders. We write an order for 10 units of regular insulin and do not want the nurse to give 25 units. We write an order for a PA and lateral chest x-ray and do not expect that we will get three views of the ankle instead.

Sometimes physician leaders are perceived as too autocratic in management settings. They arrive at a management meeting and give orders just as they would on the clinical floor or in the OR. Managers do not take kindly to this approach, and there can be “tissue rejection.” In other words,

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leaders who communicate this way do not fit in.

This type of leadership in which the leader gives an order and the follower obeys is called “transactional leadership.” It is fine to use this style in key medical situations such as when running a Code Blue, while in the operating room when in need of an instrument or a sponge, or when writing medical orders. However, management schools now teach “transformational leadership,” which is more participative and inclusive. Transformational leadership invites team members to give input before the leader makes the final decision.

Being a poor listener is another obstacle. Physicians are trained to ask a litany of questions when doing the history and physical. We usually hope the patient doesn’t give long answers, since we have so many questions to get through in an ever-shorter timeframe. We may talk 90% of the time with our patients, and listen 10% of the time.

A study at LDS Hospital (Salt Lake City, Utah) of family practice residents revealed that male residents interrupted their patients every 18 seconds; female residents interrupted every 23 seconds. That study found that if residents were quiet, patients would tell them why they were really there, beyond their chief complaint, within two minutes. But what doctor has two minutes per question? Becoming an effective leader requires talking less than 40% of the time and listening at least 60% of the time. It’s important to listen first. We are more persuasive if we have first heard what the other person is thinking and adjust our comments and questions accordingly.

Having poor rapport or no rapport with one’s followers is a recipe for disaster. To motivate followers, leaders must be able to connect with them and understand them, which means they must build rapport and also listen to them. Strong rapport helps in many situations. Studies show that physicians who have good rapport with their patients are much less likely to be sued and patients are much more likely to follow their instructions.

Physicians also need good rapport with their colleagues, with administrators, with legislators when urging that a bill be voted for or against, and when recruiting a potential new member to their medical group. They must be able to connect with their audience when giving a presentation, and with the jury, if they have been sued, or are appearing as an expert witness.

Rapport Building


Almost all physicians know and utilize basic rapport building skills, such as having a pleasant facial expression and warmly greeting someone, focusing their attention, being enthusiastic, and giving an early honest compliment. If the physician does not know the person, the physician can say something like, “Thank you for meeting with me today,” so the other person feels welcome. If it is a patient, the physician can start with, “What can I do for you today?” or “What seems to be the problem?” The goal is to set the patient at ease as much as possible.

NLP (Neurolinguistic Programming) identifies three basic communication modes: visual, auditory, and kinesthetic. The most effective leaders use all three in appropriate settings. More than 80% of Americans are visual learners and communicators. Yet over 50% of physicians are kinesthetic learners and communicators, preferentially learning through tactile function.

We doctors palpate, percuss, lay on hands, and even put our hands inside other people’s bodies. These kinesthetic activities are not the norm for most Americans, putting physicians at a disadvantage when trying to build rapport with people who use different communication modes. To maximize rapport, physicians must mirror back the communication mode of others.

Managing Stress, Preventing Burnout

In today’s health care environment, team collaboration requires knowledge and mastery of leadership skills. Developing methods to reduce stress is essential for physicians who lead these teams toward a shared goal. Burnout is the enemy of effective leadership. It is a tall order to fill, and that is why we are working with the Chicago Medical Society to offer physician leadership programs.

Susan Reynolds, MD, PhD, is President and CEO, The Institute for Medical Leadership. The Institute for Medical Leadership has conducted 32 Chief of Staff Boot Camps, teaching skills to over 2,500 physician leaders since 2003, conducting hundreds of onsite leadership programs for hospitals and health systems as well as medical societies. For a list of references, please contact esidney@cmsdocs.org. 



Rapport Building at MCC

ADVANCED RAPPORT building skills are part of what Susan Reynolds, MD, PhD, will be teaching at the Chicago Medical Society’s Midwest Clinical Conference on May 20-21. Participants will learn about body language, matching and mirroring, and neurolinguistic programming as methods to build rapport quickly in various situations and have the opportunity to practice with a colleague. Register online at www.cmsdocs.org/events/69thMCC; or contact Rachel at rburns@cmsdocs.org; or call 312-670-2550, ext. 338.