CHAPTER 21

Physician Leadership Development and Competencies

The two most senior physician executives of St. Nicholas Health System, Dr. Howard James, Senior Vice President Medical Affairs, and Dr. Dr. Bob Borman, President of the St. Nicholas Medical Group, were discussing the critical need for their organization to develop a physician leadership development program. "With our system growth the past two years and the anticipated expansion we are seeing in our western suburbs, we really need to get more physicians into leadership roles," said James. Borman replied, "Of course. And with health reform, we have to get more physicians involved at the helm. We both need a lot of additional physician leaders to help us do the heavy lifting. But it seems like we have been getting nowhere with the leadership development programs we have been offering from the two outside companies we have used. Their programs are really just outside speakers teaching seminars and that seems to be falling short. I think we need a novel approach to the younger physicians that we have identified as our key up and comers." James responded, "I think that the new programs using the leadership competencies that Jim Batten, our HR guy, has introduced, could be the answer for us." Borman asked, "How so?" James replied, "First of all, if you look at the competencies, they are all about what we need to be able to do. Second, when Jim teaches to them, he does it in a realistic and practical way. He's not a 'death by powerpoint' instructor. He will provide at most a ten minute introduction, and the participants spend the rest of the time actively discussing or solving problems. What's more, Jim uses cases based on the real problems we are actually facing. The way I see it, we could build a large part of our physician development program around applying each of these competencies. Each one could be a course by itself. Let's get with Jim and see what he can do for us."

Two weeks later as the three executives met to discuss the program, Batten explained, "I have heard from several of the physician leaders that they have not really liked the seminar approach the outside firms are using. They want something that is more applicable to us. Also, I know that physicians are not that patient with learning the softer side of management. As scientists, they work mostly with data and view leadership education as subjective and something that is just not that useful. I know they find the theory part not applicable to day-to-day matters. However, I think they will find that using specific leadership competencies will provide a more objective way to define and describe leadership skills and actions. I also think they will be quick to get the idea of needing to practice these behaviors and get feedback on them. Working together, I believe we can come up with some very practical examples for them to work on that will illustrate each of the competencies nicely, and give them the initial practice they need to be more effective using them."

The two physicians looked at each other and smiled. Then James responded, "This sounds like exactly what we were looking for. Let's get started!"

WHY A SEPARATE CHAPTER ON PHYSICIAN LEADERSHIP?

At the time of this writing, the health care world is being upended. The passage of the Affordable Care Act; the movement of public and private payors into value-based reimbursement; clinical integration; population health management; and provider shortages have all coalesced to create a climate of volatile change. Most of the changes in the industry the next few years will require significant increases in physician leadership. Physician impact upon quality and cost is indisputable. Moreover, consumer interest in quality outcomes has risen. Improving clinical quality as well as the patient experience has taken a much higher level of emphasis than it has in the past. Dr. Frank Byrne comments, "There is no way forward without integration and collaboration with physicians, and coordination of quality care and improvement efforts across the continuum of care." Expert and system-oriented physician leadership will be essential for addressing all of these issues.

While there has been a significant uptick in the focus on physician leadership and how to develop physician leaders, many organizations are still struggling with it. Carl Couch, MD, of the Baylor Quality Alliance, recently remarked, "Doctors are a highly educated group of people. But their education and career is mostly technical and clinical. The whole subject of physician leadership training has only received attention in the last 10-15 years."

The first edition of this book has had considerable response from the physician executive community. Many physicians have expressed appreciation for the articulation of leadership competencies, which have helped many of them see how leadership could actually be more definable and understandable. The concept of leadership competencies also fits well with the scientific nature of physicians. As scientists, physicians are quantitative and prefer to deal with objective data. While leadership does not fully lend itself to quantitative measure (for example, it is misleading to believe that assessment can declare that Leader A is an 83.4 leader while Leader B is a 96.5 leader), the use of competencies does move the understanding of leadership toward a more objective view.

Another factor that makes the development of physician leaders unique is the age that physicians typically move into leadership positions. While many nurses take their first lead roles at age 24 or 25 and business-track executives in health care have had 15-20 years of leadership experience by their early 40's. As a result, management and leadership can be confounding. The understanding of leadership competencies can help physician leaders up to speed quicker.

Are physician leaders different in terms of what they do as leaders? In a word, no. Certainly they bring a different perspective to management and leadership than their counterparts without clinical training. But the functions and practices of leadership are the same. And it should be noted that just because they are physicians does not mean that they are qualified to be leaders. It is absolutely essential that physicians receive management and leadership training just as other non-physician leaders do. Regarding this, Dr. Frank Byrne commented, "The breakthrough

moment for many physician leaders is attending their first leadership course, wherever it may be, and realizing that, similar to our clinical domain, there is a science to leadership and specific skills that can be acquired to increase the probability of achievement of desired outcomes.That was our motivation for sending a cohort of 30 key physician leaders through a 10 month custom leadership curriculum developed with a local business school. In addition to the faculty, we had health system leaders attend each session, to assure relevance and to provide examples of deployment in our system of the skills being taught."

What does differentiate them is their clinical background. The fact that they have the perspective of knowing what is done in the care process can give physician leaders a significant edge as they move to shape strategy and implement change in health care organizations.

Most would agree that having a greater number of physicians engaged in leadership activities, both part-and full-time, will enhance the outcome of both patient care and wellness initiatives. A recent McKinsey Quarterly reported that "hospitals with the greatest clinician participation in management scored about 50 percent higher on important drivers of performance than hospitals with low levels of clinical leadership did." (Mountford and Webb, 2009, p. 2).

Finally, it must be said that for too long the management and leadership of health care organizations has been the domain of professional managers without clinical backgrounds; physicians and other clinicians have often been viewed as separate and distinct - "Us and Them" in a sense. If management and leadership become too separated from those who are working with the patients, the ability to work collaboratively and sustain an agenda of change will be impaired.

CONTRASTING PHYSICIANS WITH EXECUTIVE LEADERS

"Physicians as leaders are often like fish out of water" wrote Dr. Charles Saunders and Bonnie Hagemann. To be certain, there are significant differences between physicians and professional managers. It is important when considering leadership competencies to keep in mind the background and nature of physicians. Dye and Sokolov (2013) present a contrast between physician and administrators as shown in Exhibit 22-1.

INSERT Exhibit 22- 1

PHYSICIANS	ADMINISTRATORS
Science-oriented	Business-oriented
1-on-1 interactions	Group interactions
Value autonomy	Value collaboration
Focus on patients	Focus on organization
Identify with profession	Identify with organization

Independent	Collaborative
Solo thinkers	Group thinkers

(Exhibit from Dye, C., and Sokolov, J. *Developing Physician Leaders for Successful Clinical Integration,*" Health Administration Press, 2013. Page 9)

Although much has been written about these differences, several points have a direct bearing on leadership competencies and bear a closer look.

Science orientation. To begin with, physicians are scientists. They are quantitative by nature; they seek to solve problems through clearly definable and measurable factors, and avoid basing decisions on hunch or intuition. In contrast, while executives typically use some science and quantitative skills in their work, much of the time their decisions are driven by "good enough" analysis. Deciding on a strategic course for an organization often has as much subjective feeling involved as it does objective analysis. As much as strategic planners wish to bring analytics into their work, there is always some degree of intuition involved in setting strategy. And when dealing with people issues, the complexity of humans makes it impossible to make this type of leadership entirely scientific.

The competencies, "Developing and Communicating Vision," "Mindful Decision-making," "Driving Results," and "Stimulating Creativity" are all rooted in science and physician leaders can often be exemplary in them. These competencies will also be critical ones as enormous changes in how medicine is practiced occur over the next several years.

Time perspective. In their clinical work, physicians have "encounters" in which they interact with patients usually in a short time duration of as little as 5-15 minutes. During this brief time period, the physician moves through a process of assessment, diagnosis, outcome identification, planning, and follow-up. One physician was heard at a board strategic planning retreat, "Look, I do all of my work in ten to fifteen minute increments all day long. Trying to determine strategy for this organization for the next three years does not fit on my radar screen." Administrative activity rarely is achievable in such a short time span. Because much of the work of leaders is done through collaborative efforts and coordinating the work of many people, the time span often bridges days, weeks, and months. It is easy to see how physicians can be frustrated by this. Also of note is the emphasis on productivity within many health systems as they work with their employed cadre of physicians ("see more patients; generate more productivity").

Dr. John Byrnes notes that physicians have been trained with a reactive mindset. "We see one patient at a time, respond to their needs, and move on to the next patient visit. We react to whatever situation or patient need presents itself. We weren't trained to be proactive, to plan, to proactively manage large-scale projects, or to project strategy over several years. This proactive mindset is very foreign to the average physician and must be deliberately learned for physicians to be successful in administrative roles."

The competencies, “Developing High Performing Teams,” “Energizing Staff,” “Generating Informal Power,” “Building True Consensus,” and “Driving Results” have significant time elements to them. For many hopeful physician leaders, these are competencies that are among the most difficult to develop and use effectively.

Personal vs. organizational accountability. Another major difference between physicians and administrators is that physicians are held more *personally* accountable for their actions. With the issuance of an individual license to practice medicine, the physician is held to specific personal standards *as an individual*. While administrators also have personal accountability for their actions, their accountability and authority are more organizationally assigned. Moreover, physicians are accountable to the medical standards practiced within a community and those standards are based upon a preponderance of clinical practice within that community. Conversely, administrators are accountable to either a higher administrator, or in the case of the CEO, to a board of trustees, and the standards are applied differently.

When considering accountability, the competencies “Leading With Conviction,” Using Emotional Intelligence,” and “Earning Trust and Loyalty” most closely support this principle within organizational life.

Time urgency of decision-making. Physician decision-making is typically immediate while administrators often deliberate for long periods of time and require input from many sources which adds to the time needed to take action. Particularly true of surgeons, emergency medicine physicians, or physicians faced with critical life-saving judgments, physicians have to be able to make quick decisions. One physician remarked, “one thing that drives me crazy is the amount of time it takes for these administrators to make decisions. If I took that kind of time, my patients would die.”

Because of the manner in which physicians make decisions in clinical settings, the competencies, “Listening Like You Mean It,” Giving Great Feedback,” Developing High Performing Teams,” “Building True Consensus,” and “Mindful Decision-making” are often challenging for physicians as they enter leadership roles.

However, a final point should be made. Physicians are often criticized inappropriately and maligned by business leaders when they fail to follow administrative procedures. Readers are warned to be mindful that this unfair criticism can be dangerously divisive. Dr. Ginger Williams comments on this theme, “Administrators and others far too often make the mistake of thinking that maladaptive behaviors like not completing your budget on time, not keeping people in the loop, etc., are intentional and something you just have to put up with because "that's the price we have to pay to have physician leaders". While that's sometimes true I think it's more often the case that these things simply are not axiomatic to the physician leader like they are to the non-physician executive.”

We sum this up by saying "Don't Always Blame the Physicians." There is a tendency in some organizations to point the finger at the physicians and say as one CEO did, "they just are not capable of learning this." Dr. Kathleen Forbes sums this up quite effectively, "It is great to have physician leaders at the table. With the appropriate training they can be quite impactful on strategy development and execution of organizational strategies. But the misstep that can happen is when physicians are brought to the table as key leaders and then not held accountable for the performance of their areas of responsibility. While they attend the necessary meetings, they may not be fully contributing to the effort since they feel they hold a figurehead role only. Digging deeper into this you will find this to be multifactorial: physician leaders may feel that their input doesn't matter since the strategy was developed without their input; the physician leaders are not held accountable to actively participate in key discussions regarding the strategy; the physician leaders may not be invited to the key meetings in which the true planning or execution is accomplished; organizations often assume a lack of business skills by physician leaders and hire a number of support leaders who work "around" the physician executives to keep efforts moving forward. "Bottom line – bring physicians to the table and engage them. Strong physician alignment is critical in the post ACA healthcare delivery system but it is not enough. You must have true physician engagement." "This is a big investment and one that needs to be maximized by the organization. Do not underestimate what a well-trained physician leader brings to the table."

WHERE PHYSICIANS TYPICALLY MISS THE MARK WITH LEADERSHIP COMPETENCIES

In their chapter on managerial derailment, Dye and Sokolov (2013) suggested there is often a very high cost involved when physician leaders have to be terminated. Derailment is the common term describing situations in which individuals who have had great success suddenly find themselves failing (or "derailing" as it is labeled in management and leadership literature). They wrote that many of these failures are caused by the "inability of physician executives to detect common derailment factors." Many of the reasons for derailment are the results of failures in many of the sixteen competencies. Ready (2005) suggested several causes for derailment including the inability to manage teams and others, flawed execution of strategy, failure to engage employees and to inspire them, poor listening, and failing to fit with the company's values. Clearly, mastering several of the sixteen competencies would help avoid these career stoppers.

We suggest an in-depth reading of some of the derailment literature. Two of our favorites are Sydney Finkelstein's (2004) *Why Smart Executives Fail: And What You Can Learn from Their Mistakes* and Jeffrey Sonnenfeld and Andrew Ward's (2007) *Firing Back: How Great Leaders Rebound After Career Disasters.* We also suggest Inyang's (2013) article, "Exploring the Concept of Leadership Derailment: Defining New Research" in the *International Journal of Business and Management.*

Based upon much of the derailment research and also by anecdotal observation by the authors, there are several specific areas where physicians have considerable problems with the sixteen leadership competencies. A note to the reader is important here. While this next section presents suggestions of shortcomings among physicians aspiring to work in leadership positions, it is not intended to suggest that physicians cannot make highly effective leaders. In fact, the opposite is true – physicians skilled in the 16 competencies can be extraordinarily successful leaders. However, it is helpful to examine leadership from a competency perspective and consider the challenges physicians in particular often face in developing fully as leaders.

Applying the Competencies in Practice Begins With Deep Self Reflection. Because of the nature of their work and because of the way they are trained, physicians often are less reflective of themselves. During the time of life (late teens and through the 20's) when most business oriented leaders are gaining insights from early mentors and learning how to navigate the difficult politics of organizational life, physicians are focused almost exclusively on the rigorous academic study of medicine. Saunders and Hagemann (2009) describe the problems that physicians often have in socialization, stating, "An issue that is not often discussed is that many physicians have personality or character issues due to a prolonged period as a student. Many do not start their careers until their early 30s. They work long hours and study in their off-hours. They have little time to develop social skills. Their social skills often stop developing when they enter medical school. By the time they are asked by the healthcare organization to take a leadership role, they will have bridged some of the social skill gap, but it is very likely that there are still some socialization skills that are significantly lagging." It should be no surprise that physicians focus almost exclusively on growth in clinical knowledge and skills in the first years of their careers. There is not the time to learn or explore business and leadership concepts.

Dr. Dike Drummond (2012) also noted, "What we do pick up automatically in our clinical training is a dysfunctional leadership style based on 'giving orders.' The clinical actions of diagnosis and treatment are simply adopted as our default leadership style. When faced with any practice challenge, we assume we must be the one who comes up with the answers (diagnose) and then tell everyone on the team what to do (treat)."

Dr. Akram Boutros commented, "Physicians are used to being trusted by virtue of the job. Patients either go through a discernment process in choosing a physician and therefore have committed to trust their physician, or they are in dire need of emergency treatment and instinctually give their trust to those caring for them. Being trusted by others, therefore, has become an expectation for physicians. To ignite trust by team members in non-clinical situations, physicians have to exhibit vulnerability. For physicians, showing vulnerability is antithetical to how they were trained, that is to project strength and confidence in every situation."

In Exhibit 22-2, the sixteen competencies are listed showing those in which physicians often lack expertise. Note that many of the ones listed in the far right column, entitled, "Often a challenge to master," pertain directly to interpersonal leadership competencies. Deficiencies in these are often derailing factors in leadership jobs.

INSERT

Exhibit 22-2

Cornerstone/Competency	*Often a strength among physicians*	*Usually not well developed among physicians*	*Often a challenge to master*
Well-cultivated Self Awareness/ Leading with conviction	**X**		
Well-cultivated Self Awareness/ Using emotional intelligence			**X**
Compelling Vision/ Developing vision			**X**
Compelling Vision / Communicating vision			**X**
Compelling Vision / Earning trust and loyalty		**X**	
Real Way With People/ Listening like you mean it	**X** (pediatricians, family medicine, psychiatrists)		**X** (most other physician specialties)
Real Way With People/ Giving great feedback		**X**	
Real Way With People/ Mentoring others			**X**
Real Way With People/ Developing high performing teams			**X**
Real Way With People/ Energizing staff			**X**
Masterful Execution/ Generating			**X**

informal power			
Masterful Execution/ Building true consensus			**X**
Masterful Execution/ Mindful decision-making	**X**		
Masterful Execution/ Driving results	**X**		
Masterful Execution/ Stimulating creativity			**X**
Masterful Execution Cultivating adaptability			**X**

The reasoning behind Exhibit 22-2 follows.

Well-cultivated Self Awareness. If one of the meanings of conviction is "a firmly held belief," physicians certainly possess this characteristic. We see this competency as requiring strong drive and being very confident in actions. It is the rare physician who does not possess this. However, when it pertains to emotional intelligence, many physicians fall short in this competency - often as the result of the relative inattention to socialization described earlier. Moreover, as they begin clinical practice, they rarely receive direct feedback on their interpersonal practices.

Compelling Vision. Because of the shorter term nature of their work, physicians often have difficulty developing longer-term vision. Strategic planning can be very frustrating. Dan Beckham (2010) wrote, "for physicians, strategic planning is a bureaucratic and amorphous undertaking run out of a hospital administrator's office. There is usually a flurry of interviews, some retreats and then lofty commitments. Physicians rightly ask, "What has that got to do with me?" And, too often, the answer may be, "Very little." The experience of many physicians is that they are invited to strategic planning retreats (which may be held every three years or so), asked for their input, and then sent "back to the clinical factory" while over the next several years, the executives of the organization make changes to that strategy or in many cases, reverse course – all without any further consultation or touching base with those same physicians who participated in the original planning retreat. A better understanding of this factor is expressed by Dr. Frank Byrne, "In our clinical careers, we generally work linearly, from one patient to the next, attempting to solve problems on the spot, alone, or in small groups. Administratively, we balance a number of projects, goals, and priorities, some of which need to be addressed by noon today, and others are multi-year complex endeavors involving scores of people and multiple disciplines to achieve the desired outcome."

Real Way With People. Dr. John Gartland (2009) states it well: "A frequent criticism of physicians expressed by patients is that the rigorous scientific training required for their medical educations depersonalizes some of them to the extent that effective medical technicians are

produced who, upon entering the clinical practice of medicine, have fewer communication and interpersonal skills than they had upon entering medical school." Although this observation was made regarding interactions with patients, that the same deficiencies often present themselves in other workplace interactions as well.

One differentiation in the competency, "Listening Like You Mean It" is made here between specialties. Specialties that require intensive listening to patients such as pediatricians, family medicine and psychiatrists, often transfer those effective skills into leadership positions. Dr. Frank Byrne drives this point further, "Virtually every problem that I've either caused or had to adjudicate, in both my clinical and administrative careers, has had a communication component to its root cause. It concerns and mystifies me that we don't provide specific communication training every step of the way in physicians' clinical and administrative training."

There is a growing recognition within the medical education and practicing clinician communities that teaching medical students, residents, and new physicians team skills is critical. In his commencement address to the Harvard Medical School, Atul Gawande (2011) described a "skill that you must have but haven't been taught—the ability to implement at scale, the ability to get colleagues along the entire chain of care functioning like pit crews for patients." While Gawande speaks to the need to have this skill for those who are working directly with patients, the same holds true for those physician leaders who work with leadership teams running today's healthcare organizations. An interesting observation along these lines was made by Dr. Frank Byrne, "I had the benefit of practicing in a clinical setting where the ICU nurses I worked with made it clear that our shared work was a team sport. I carried that into my executive leadership roles, and also had the benefit of working with non-physician executives and board members who both valued my unique perspective, and helped me develop my leadership skills".

Masterful Execution. Similar to their stance on strategic planning, physicians are not accustomed to practices such as generating informal power, creativity, adaptability, and consensus building. They come from a more controlled environment where they are the expert and their orders are "final." Execution for physicians means following the orders of the clinician in charge. Orders are to be carried out – and usually not questioned. Physicians can be viewed as being very decisive and because of this, their orders are immediately carried out. However, this "command and control" culture does not lend itself to contemporary approaches to decision-making.

Despite these shortcomings in many of the sixteen leadership competencies, physicians are often quick to see their gaps when it comes to them. In an unpublished paper written for his doctoral in management thesis, Dr. Michael Deegan (2002) wrote, "As a consequence of the way American physicians have been selected, educated, and socialized during their training many are highly competitive, relatively independent practitioners. They often eschew teamwork and collaboration and other affiliative behaviors. Their education and socialization fosters pacesetting or commanding leadership styles that may be appropriate in certain clinical circumstances, e.g., a busy emergency department or a critical care unit, but could be counter-productive when used in other care settings."

Finally, Dr. Darrell Kirch (2011), CEO of the Association of American Medical Colleges, discussed the importance of teamwork and being able to relate to patients: "When I entered medical school, it was all about being an individual expert. Now it's all about applying that expertise to team-based patient care."

How Can Physicians Develop Further in Each Competency

Physicians are typically very quick learners. Using the sixteen competencies as a guide, they can learn and practice leadership quite effectively. Below are suggestions for physicians to develop their leadership skills as they contemplate moving into either part- or full-time leadership and management positions. Dr. Frank Byrne reflected, "During a previous wave of disruptive, transformational change in healthcare in the mid-1990's, it became fashionable to place physicians in executive roles. I was one of them. Unlike many physicians at that time, I had support and a development plan to assist my transition. It was tragic that we burned through a significant percentage of that generation of physician leaders by placing them in complex leadership roles without providing the support and training they needed to be successful."

Organizations need to lay some groundwork to ensure that physicians successfully grow as leaders. Some of this involves structure while some of it involves the willingness of other senior leaders to personally take a stand in helping physician leaders develop. Dr. David James summarizes this quite effectively, Dr. David James stated, "I think there are two compelling organizational circumstances that substantially enhance the successful integration of physician leadership into the organizational matrix: The first is a servant leadership style on the part of those to whom the physician leaders report. Physicians often initially find that the maze of bureaucracy built into large scale corporate systems is extraordinarily difficult to navigate and the servant leader can help assure success by helping remove obstacles, facilitating and navigating heavily matrixed environments until the physician executive has assimilated the corporate acumen. The second lies in implementing a "dyad" leadership model pairing strong clinical leaders with strong business leaders into one functional leadership unit. This can serve as a quick way to fill competency gaps in either while speeding the skill acquisition for competencies in both."

Gain adequate assessment and feedback. Physician leaders often have great difficulty in getting effective feedback. We believe this is for several reasons. First, because most physician leaders are much older when they begin, there is more hesitancy by others to provide input on their leadership or interpersonal behaviors. And physician leaders often move into very high levels of positions as their first roles. In these settings, which could be board rooms or senior management conference rooms, discussion is more often focused on organizational matters and rarely on specific personal styles and approaches to leadership. Also, physicians typically hold the "captain of the ship" position and are not challenged as much as a result. The Sixteen Competency Model is very adaptable for 360 degree type feedback (see chapter 20), which can be a very effective approach to overcoming these feedback barriers. However, to reach the level

of exceptional leadership, it is essential that physician leaders listen, understand, internalize, and appropriately act upon the feedback they receive.

Dr John Byrnes adds, "It's critical that physicians actively reflect, internalize, and study the results of feedback and link this information directly to a formal plan of study to gain needed competencies. I remember my training on the surgical side of the house – it was a very combative and aggressive environment and I quickly learned the behaviors needed to succeed. However, in my first management role, I quickly found that the behaviors that served me well in the OR were the exact opposite of what I needed as an administrator. The bottom line: I needed to "unlearn" most of my surgical behaviors and consciously replace them with the 16 Competencies described in the Exceptional Leadership book. Yearly feedback has become an invaluable tool in this journey."

Learn by doing. Leadership is best learned by doing – and doing while something is riding on the outcome. Dye and Sokolov (2013) discuss the importance of crucible experiences in learning leadership, where the learning takes place when the situation or problem encountered is a real world one and not a classroom example or case study. While classroom time is important, it is most powerful when used as a supplement to applied work, rather than the other way around. Dr. Greg Taylor considers this when he thinks about the impact of experience on physicians, "Those missed diagnoses, whether it's a heart attack, or cancer, are the cases physicians carry to their graves. But those are mistakes physicians rarely repeat, and in fact, they frequently become laser-focused experts in those areas. Likewise, leadership mistakes, such as failure to communicate, provide the opportunity to dissect and analyze, setting the stage for future competency and strength."

As Dr. Ginger Williams stated, "The most productive and effective educational experience of my life was getting my Master's in Medical Management. When I started the program I had been in my first administrative position (CMO) for six months; I understood by that point that I knew nothing about executive leadership. During my master's program I was learning in class what I was expected to do at work, and doing at work what I was learning in class. It was ideal!"

Use an executive coach. Leadership coaching, as described in more detail in Chapter 18, is being used with increasing frequency by physician leaders. One reason an outside coach can be so effective is that by the time physicians come into leadership positions, they are often old enough that feedback and input on matters such as leadership competencies are not common. Caution should be used though to ensure that the coaches selected have prior first-hand experience in relevant settings and, ideally, with physician clients. Dr. Frank Byrne commented, "When I hire a physician for a complex leadership role, I include mandatory provision of a coach in their job offer, and we work together to find a coach with appropriate background and experience to help them succeed." Dr. Greg Taylor added, "After 11 years of practicing medicine, and 17 years in a Chief Medical Officer role, when I took over the Chief Operating Officer position, I found it invaluable to secure an Executive Coach, who was experienced with

physician executives. We focused on communicating vision (Compelling Vision) and energizing staff (Real Way with People). Assistance in articulating and communicating my vision and creating energy with our staff was the key to a successful start in the new role."

Avoid overconfidence. Physicians train and work in a culture where confidence is paramount. It is often viewed as a sign of weakness to not know something or to be unable to do something. Highly effective leaders, in contrast, recognize that they can only know and do so much themselves, so they surround themselves with strong and highly capable individuals and much of their work is to coordinate the work of those individuals. Physicians in leadership positions need to recognize that they do not have to have all the answers to every problem and that it is acceptable to allow others to take the lead. For a deeper understanding of the risks of overconfidence as well as other derailment risks, we recommend *Why CEO's Fail: The 11 Behaviors That Can Derail Your Climb to the Top and How to Manage Them* by David Dotlich and Peter Cairo (2003). The website of Hogan Assessment Systems (www.hoganassessments.com), a leading provider of personality-based leadership assessments, also provides excellent insights into behaviors that can harm the ability of any leader to enhance and improve leadership skills.

SUMMARY

Dr. Lawrence Dyche captured it well when he wrote, "An understanding physician must be able to tolerate ambiguity because science's clear solutions often do not match people's lives." Leadership is exceedingly complex, but a good competency model can provide a helpful roadmap to the terrain. As more physicians move into the leadership ranks of health care organizations, they will be doing well by themselves and their organizations to learn and adopt a competency based approach to leadership.

The essence of this chapter is summarized well by Dr. Lee Hammerling, "The challenges healthcare faces today are best addressed by physicians who have not only mastered the clinical aspects of patient care but also have a deep understanding and training in management. These physician executives will be the industries best opportunity to implement the changes necessary to achieve a sustainable high quality cost effective health care model for the US."

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