Inspired Physician Leadership

Creating influence and impact

By Charles R. Stoner and Jason S. Stoner

Sample Preview Chapter

An American Association for Physician Leadership® publication
Contemporary health care organizations are engaged in unprecedented transformational change. Although clarity is masked, the future will yield new and challenging models of practice and delivery. Like all transformational changes, disruption abounds as traditional assumptions and approaches bend to the winds of powerful economic, social, political and demographic pressures.

While the future of health care remains problematic, experts agree that physician leaders must be at the table, engaged as principal players among those who will define and shape tomorrow’s health care strategies. Beyond the considerations of broad strategy and policy, a range of fundamental and immediate factors demand attention. As such, the call for physician leadership arises within a context of competing needs — expanding health care demands, systemwide motives for efficiency and questions about our capacity to respond while maintaining patient-centrality with sound clinical outcomes.

The gravity and complexity of these overlapping needs lead experts to conclude that the emphasis on clinical leadership is an essential reality rather than the latest passing fancy. Increasingly, expert voices declare that “the leadership needed to transform the performance of hospitals and health care systems must come primarily from doctors and other clinicians.”

The Need for Physician Leadership

The need for physician leadership has never been more critical. We begin by considering three reasons. The first, drawn from the insightful work of
Harvard professor Richard Bohmer, resonates deeply with clinicians.

Bohmer argues that as health care reform intensifies, physician leaders help assure that patient well-being will not become a subservient concern in the face of politically charged issues of cost containment and revised delivery models. Physician leaders appear to be our best choice for ensuring that these complicated decisions will be firmly grounded in health care’s central mission of patient care and outcomes.

There is no escaping bottom-line reality. Health care organizations face far-reaching challenges that demand “increasingly difficult tradeoffs … (that) balance the allocation of scarce resources to individual patient care and the care of communities and populations.” Medical leaders are best suited to understand and make these tradeoffs. Expanding this theme, experts argue that physicians, with their training and practice, bring a mindset of clinical realism that is fundamental when grappling with these tough choices. In short, physician leaders possess “a deep intuitive knowledge about the core business … that helps with decision-making and institutional strategy.”

The second reason physician leadership is needed is more nuanced — imbued with deep behavioral themes. Physician leaders, because of their acquired levels of expertise and credibility, are poised to be key mediators between practicing physicians and the organization’s non-clinical leadership. As potential conduits of understanding, physician leaders can influence an array of interdependent constituencies who may have difficulty envisioning perspectives beyond their own. Of course, this potential is achieved only when physician leaders successfully navigate the tricky maze of interpersonal and politically charged dynamics that make impactful leadership so challenging.

The third reason has been the subject of extensive and spirited debated. A growing array of experts, however, believes that when doctors are engaged in maintaining and enhancing organizational performance, better financial and clinical outcomes occur.

In one of the few empirical investigations of its type, Amanda Goodall examined hospital performance outcomes according to CEO classification — either physician leaders or non-physician leaders. Data were collected from 100 U.S. hospitals (each with top-level rankings) and included 300 CEOs. Quality outcomes were assessed in three specialty areas: cancer, digestive disorders and heart surgery. The study found a strong positive association between physician leadership and hospital quality rankings.
Notwithstanding some obvious methodological constraints inherent in such data, at least three important conclusions can be drawn. First, as noted earlier, physician leaders may experience a success differential because they have a deeper understanding of core clinical dynamics than their non-clinical counterparts do. Second, physician leaders have developed strong connections with the medical staff that should yield important advantages — an understanding ear and informed voice, competency-based trust and clinical credibility. Third, physician credibility pays dividends in many tangential areas, including the likelihood of attracting talented medical professionals to their organizations.¹¹

In the face of such powerful rationale, the call for physician leadership places us squarely on the horns of a dilemma. While the need for physician leaders is apparent and growing, an insufficient number are poised to engage and succeed in leadership roles. Physicians stepping into new roles as organizational leaders are often underprepared to thrive in this new context. Although medical schools are increasingly adding some leadership components to their courses of study, there remains little in the physicians’ formal training that prepares them for positions of leadership.¹² In fact, a recent report drew the dramatic conclusion that “despite evidence supporting the link between leadership and improved clinical outcomes, a significant frontline leadership gap exists in health care.”¹³

Any discussion of the rationale for physician leadership must address an additional complication: Experts predict a national shortage of an estimated 90,000 physicians by 2020 and 130,000 by 2025.¹⁴ Jeff Cain, MD, president of the American Academy of Family Physicians, noted a confluence of factors that have dramatically affected the demand for services. Our population is growing and aging — two factors that signal increased health care needs. Against this demographic backdrop, add the impact of the Affordable Care Act, which could account for 30 million newly insured individuals seeking primary care.¹⁵

There is a further complication. The number of new physicians entering the workforce each year has not grown appreciably in the past 20 years. Compounding this depletion, evidence indicates that practicing doctors are likely to retire earlier than previously anticipated. In fact, the Association of American Medical Colleges has estimated that nearly one-third of all physicians — approximately 250,000 — will retire by 2020.¹⁶
In general, physicians have been reluctant or ambivalent about assuming formal leadership roles. Scholars have suggested at least three reasons for this hesitancy: financial disincentives, status disincentives and training and skill deficiencies. Regarding the latter point, some observers have boldly asserted that “there is nothing in a physician’s education and training that qualifies him (or her) to be a leader.”

What does all this mean for our purposes? As in any situation where demand for services significantly outstrips the supply of talent, we must be careful in the deployment of our talent resources or risk exacerbating the problem. Leadership roles reduce a physician’s time in direct clinical care. As such, we must identify physicians who appear to possess both clinical expertise and strong potential for leadership success. Further, we must help this cadre of promising physician leaders develop the perspectives, mindset and skills (the bulk of which can broadly be classified as interpersonal in nature) to meet the challenges of leadership with insight, authenticity, confidence and impact.

Arguably, the selection and development of high-potential physician leaders may be one of the most critical challenges facing our health care organizations. Drawing from leadership pioneer Jim Collins, part of this challenge will be making sure that we get the right people in the right spots.

Accepting the mantle of leadership, one encounters a landscape that is familiar in nature but strange in complexity. As we will discuss in the next few chapters, the transition from clinician to clinician leader is behaviorally nuanced and interpersonally intense. And evidence suggests that many physician leaders recognize a formidable gap between the well-honed expertise they possess and the toolkit needed for leadership success. The focus of this book is to close that gap. Importantly, we accept that leadership is “an observable, understandable, learnable set of skills and practices” — an arena capable of enhancement and development. Before progressing, however, a deeper understanding of the nature of contemporary leadership is in order.

The Nature of Leadership

In a recent review of clinical leadership, researchers suggested that the “widespread fascination with leadership may be because it is such a mysterious process.” Echoing this thought, leadership pioneer Bernard Bass has noted...
that “there are almost as many different definitions of leadership as there are persons who have attempted to define the concept.” Indeed. Rather than offer an easily forgotten, all-encompassing sweep, we have chosen to target just a few of the more powerful explanatory attempts.

In refreshingly succinct fashion, best-selling scholar Peter Senge suggested that leaders “inspire” others. There is deep insight and significance to this perspective. Consider the etymology of the word inspire, suggesting that one who inspires “breathes life into” others. Daniel Goleman, Richard Boyatzis and Annie McKee extended this framing, indicating that “Great leaders ... ignite our passions and inspire the best in us.”

Apparent in these two definitions is the realization that leadership plays an “expansive role” when it is successful. Indeed, effective leaders have the capacity to bring out the best in others. In our phrasing, impactful leaders “unleash the talent in others so their full potential can be realized.”

Have you ever been to a Bruce Springsteen concert? Whether you are a diehard fan or a take-it-or-leave-it observer, there is no escaping the power of the event. For nearly four hours, the drumbeat never stops and Springsteen never leaves the stage as the E Street Band pours every ounce of raw emotion and energy into the performance. Now here is the key. Members of the E Street Band, each distinguished musicians in their own right, will tell you the same thing. They perform at their very best when they are with Springsteen. That is the image and tone of leadership that is needed — engaging the talent around us so others can perform and contribute at the top of their game.

There is a second key theme. Leaders create and exert influence. This concept of influence is both intentional and directed. In essence, leaders create influence that “touches the feelings, emotions, thinking and actions of others so that goals and visions are realized.” The idea that leadership encapsulates the capacity to create intentional influence is a multilayered process that we will refine in later chapters.

Let’s add another timely perspective. In a classic work, Harvard professor John Kotter argued that leaders “cope with change.” In this regard, he emphasized three fundamental functions of leadership: establishing direction, aligning people and motivating and inspiring. This forward-looking approach is relevant for all competitive organizations, and speaks to the turbulent re-shaping that frames our contemporary health care environment.

Yet Kotter’s version of leadership is often misunderstood. A colleague
once opined, with only minimal sarcasm, that “administrators manage chaos, and leaders create it.” The latter phrase is dangerously repugnant. In fact, the finesse of leadership comes in the capacity to move people, teams and organizations to embrace change precisely without the experience of chaos. The ways to achieve this intricately balanced outcome serve as the foundations of this book.

Finally, we encourage you to consider a broad view of leadership. We are long past the days when leadership was compartmentalized, the purview of a select few perched at the top of an organization’s hierarchy. Leaders, some with formal designations and some without (informal leaders), are scattered throughout our organizations. When formal leaders misunderstand or minimize the influence that is wielded by their informal counterparts, both efficiencies and effectiveness are at risk.

Many of you, drawing from the credibility of your clinical backgrounds and the strength of your personalities, wield influence that belies any formal position or title. At times, informal leadership allows one the freedom and flexibility to behave in ways that may be blocked to those holding formal positions that require stricter adherence to the “company line.” While this book focuses on the challenges of formal leadership, the concepts we present have merit for those of you who seek to expand your influence through more informal means.

The Differential Impact of Leadership

Transparency demands that we address a question that philosophically frames all that follows. It is the question of leader impact — a question that has spawned years of debate and pointed controversy. The controversy is not whether leadership matters but the extent. In short, how much does leadership really matter? What is the differential impact of leadership?

As with most complex issues, experts fail to display complete agreement. Some scholars cynically opine that even our most talented leaders have minimal impact on overall organizational performance. Instead, these critics argue, key external or environmental factors — such as spikes and declines in the economy, shifting patterns of client and market expectations, industry transitions and sociopolitical trends — are far more critical drivers of performance than leadership acumen. 29
Despite these arguments, the preponderance of evidence over the last two
decades has presented a different view. Researchers, scholars and thought
leaders have argued that leadership plays a significant role in performance,
as well as a range of other positive organizational outcomes (such as trust,
culture and the overall interpersonal dynamics of the workplace).\textsuperscript{30}

For example, consider a specialty clinic that in the past two years has seen
three of its heavily recruited and brightest young stars leave the practice.
Such turnover is not only costly but ripples throughout the clinic, affecting
colleagues, staff and patients, as well as the overall image of the clinic. While
we certainly do not know all the factors rumbling behind this turnover, we
can comfortably argue that our immediate leaders have a dramatic impact
on the way we experience and feel about our work.

The Physician Leader

Physician leadership or clinical leadership is a broad term, largely be-
cause of the range of roles that may be included and the array of paths that
may be pursued. Leadership in the clinical realm is certainly among the most
idiosyncratic of any industry. Broad generalizations diminish the complexity
of roles that physician leaders hold. Further, physician leadership usually in-
volves a mix of clinically based and administratively based roles. With this in
mind, researchers have identified three types of clinical leaders: institutional
leaders, service leaders — such as department chairs or research directors
— and frontline leaders, those who are serve as a key point of contact with
direct patient care and are responsible for clinical outcomes.\textsuperscript{31}

Although intensity varies with each of these roles, a shift is apparent.
While our clinical activities focus on decision-making at the individual phy-
sician/patient level, “leadership necessarily involves stepping away from the
individual physician/patient relationship and examining problems at a sys-
tems level, requiring the ability to view issues broadly and systematically.”\textsuperscript{32}

Physician leaders are people like Matthew Gorman, who spends part
of his time devoted to his private practice in internal medicine, work that
highlights the excitement and meaning of direct patient care. Referring to
his practice, Gorman’s words echo what many of you no doubt believe: “This
is why I became a doctor in the first place.”

Increasingly, however, Gorman has been asked to assume leadership
roles within his health care organization. Currently, he serves as director of informatics. He works with an assortment of high-profile project teams — often as the sole physician — to address critical quality and patient service initiatives. These systemwide leadership activities put Gorman at the cutting edge, helping to shape the future.

Physician leaders are also people like Ronald Lander, chairman of the department of neurosurgery at a major university. A respected neurosurgeon, Lander finds energy and excitement in a range of leadership roles. Armed with an MBA, he can address both business and clinical exchanges with insight and perspective. He enjoys working on important, difference-making initiatives because he knows that he possesses unique skills that help “move the needle forward.” He also mentors younger physicians and helps to create and maintain a world-class department. Further, Lander’s blend of experience and perspective has led to his inclusion in key professional associations, as well as community and service activities, bringing his leadership into a broader social arena.

Moving into physician leadership requires that you embrace a “leadership mindset,” which is different from the traditional “clinical mindset.” We view this change as a developmental transition, and that transition will be the focus of the next chapter. In addition, you must master a set of interpersonal skills that may be unfamiliar, underdeveloped or underused. Again, these will be discussed throughout our subsequent chapters.

Here, a key question must be posed — fortunately one that has been the focus of considerable research, as well as a range of informed and thoughtful discourse. What competencies do high-potential physician leaders really need? Let’s look at the data.

Drawing from interviews with faculty physicians at the Cleveland Clinic, researchers found four recurring themes that were seen as requisite for physicians aspiring to leadership positions. The themes: position-related knowledge of finance, budgets, etc., and field-related expertise; people skills, including dimensions of emotional intelligence; vision, and organizational orientation, including understanding the history and operating structure of the organization and a commitment to working for the good of the organization. Importantly, within the context of this study, the people-oriented and emotional intelligence theme was most frequently noted.

Numerous studies have specified the more critical of these leadership
skills and competencies, portraying a decidedly behavioral perspective. With remarkable consistency, studies have noted several interpersonal factors. These include engaging in deep listening and respectful communication, generating persuasive arguments and creating influence and buy-in, demonstrating conflict resolution and negotiation, applying emotional and social intelligence, understanding teamwork and team building, understanding and working effectively in politicized contexts, providing vision, motivating others, and leading transformational change. Attention to these critical interpersonal factors provides the framework of this book.

**Performance Clarity Through Crystal-Clear Expectations**

Although our exploration of leadership will have a decidedly behavioral thrust, we must conclude this opening chapter by underscoring the centrality of performance and crystal-clear expectations.

Performance is the unmitigated, essential metric of leadership. In his No. 1 bestseller, *Good to Great*, Harvard professor Jim Collins differentiated highly successful leaders from others. Among his major findings were that these top-level leaders demonstrated an unwavering focus on performance. We will highlight throughout this book the importance of setting and carefully communicating crystal-clear expectations. There are few themes of greater significance. Scholars have studied the nature of performance expectations, and we accept that performance is enhanced when expectations are clear, specific and challenging. The behavioral dynamics underlying these criteria are well established and help us avoid the toxic lure of “do-your-best” goals. When performance targets are missed and when questionable and problematic behaviors surface, we always return to the mantra of clarifying expectations.

Physicians certainly understand the prominence of high standards and challenging expectations. Excellence is paramount and mistakes are abhorred, largely because of the risks involved. However, assuring that others recognize and understand these expectations may be an area begging for greater attention. Physicians, being quick studies with high personal standards, readily accept demanding standards of performance and assume that others respond similarly and are onboard. This can result in disappointment and frustration as others fail to grasp the level of performance needed. State and restate
your expectations — crystal-clear expectations — as a starting point. High, challenging, uncompromised performance expectations are keys to success.

We see important links between our attention to interpersonal dynamics and performance. Understanding behavioral complexities and nuance will enhance the interpersonal context, unleashing the potential and talent of all involved, and thereby helping to ensure immediate and longer-term performance. Further, as standards of performance change — as they assuredly will in the turbulent world of health care — the behavioral tone you have established will help you adapt nimbly and less disruptively.

**Concluding Thoughts: The Leader as Trailblazer**

Leaders are trailblazers. They always have been. Some members of your organization — be it a professional office practice, specialty clinic, regional hospital or massive health care system — are comfortable with clearly defined and segmented roles that can be executed with precision and quality. These “diligent doers” are the heart and soul of action — the proverbial “good citizens” of collective organizational life.

Still others are natural administrators, capable of bringing structure and order to seeming confusion. They assign tasks, administer budgets and align resources to meet target goals. They are careful and judicious caretakers who assure effectiveness and efficiency around our central missions. They ensure that care is provided within a context of limited resources.

But you are different. You do not eschew these foundational roles, and you have, in all likelihood, demonstrated considerable proficiency as one who performs your clinical duties with competence. Moving into the challenges of leadership, you remain a respected and reliable font of clinical expertise and wisdom. Yet there is more.

As we have noted, it will be your job to challenge systemic status quo; to urge and move others to new frontiers. And, as we will see shortly, you must push these frontiers while others bask in relative comfort and security. Unlike your peers, you transcend “what is” and veer into the nebulous territory of “what can be” and “what should be” and “what must be.”

If you are a leader, you have the rare and elusive capacity to embrace others, understand their condition, move fearlessly into the realm of emotional understanding, capture the minds and hearts of others and unleash
their talents. As you push the boundaries of progress, you bring others with you. You understand the reality, perhaps even the essential contradiction of leadership — we succeed through others. Leadership failures are rarely because of a dearth of good ideas, insightful visions and competitively accurate strategies. Leaders fail because they cannot traverse the behavioral complexity and interpersonal nuance of emboldening others to embrace the journey.

Previews of Coming Attractions

Although the need for physician leaders has received considerable attention, there has been limited focus on what doctors must actually do to become difference-making leaders. Our goal is to facilitate that focus through a careful, in-depth plunge into the critical behavioral and interpersonal dynamics that undergird contemporary leadership. As such, let’s offer a brief overview of subsequent chapters.

In Chapter 2, “Transitions: The Nature and Challenge of Clinician/Leader Interplay,” we will explore the dynamics and complexities of the various forms of clinician/leader roles and the transitions that these roles present. Chapter 3, “Tone: The Significance of the Interpersonal Factor,” builds the case, through data and example, that the leader’s interpersonal awareness and finesse can be a key foundation for success. Elements of emotional intelligence will be woven throughout the chapter. Importantly, this chapter introduces a series of interpersonal themes and considerations that represent new ways of looking at people and generating desired outcomes.

In Chapter 4, “Dialogue: Communicating for Understanding and Influence,” we provide a unique look at creating reciprocal understanding through deep listening, respectful inquiry, open-ended questioning and engaged dialogue. We put these ideas into bottom-line practices, emphasizing clear communication and the ongoing use of “brief coaching encounters.”

Chapter 5 explores the theme of “Teamwork: The Foundations of Collective Synergy.” Physicians are used to working in teams. In fact, the operating room may be one of the most finely honed conceptualizations of teamwork in action that we could ever find. However, surgical teams differ dramatically from project and administrative teams that physician leaders now encounter. This pivotal chapter deals with key team issues that may be new for physician leaders. Drawing from solid research and theory, this chapter presents a practical set of skills and competencies.
Chapter 6 addresses the ever-relevant theme of “Conflict: The Power of Respectful Conflict Encounters.” Research has consistently placed conflict (and more specifically how to respectfully and successfully address conflict) as one of the major concerns and stumbling blocks for leaders. This chapter explores how conflict arises and evolves, and we discuss how to address tough, interpersonal conflict.

In Chapter 7, “Negotiations: Politics and Principled Outcomes,” we explore the array of political dynamics that often frustrate physician leaders. Armed with this perspective, we address the dynamics of negotiating and the importance of the understanding and judicious use of influence.

Chapter 8 addresses the timely and critical themes of “Motivation: Building Performance Through People.” This chapter will help you understand how you can build a sense of commitment and engagement where people experience challenge, energy, fulfillment and ownership. Proven approaches drawn from underlying theory are examined.

Chapter 9, “Change: A Future of Opportunity,” will challenge your thinking about and approach to change. We next explore the very real and common pitfall of initiative decay and address how leaders can mitigate its impact. We offer a model of change, which draws heavily on the behavioral and interpersonal topics discussed throughout the book. Finally, Chapter 10, “Tomorrow: A Case for Possibility,” offers a brief view of the resilience needed for physician leaders to move forward as key difference-makers in health care’s future.

6. Ibid.


15. Ibid.


19. Ibid., p. 68.


37. Bohmer, p. 15.
Charles R. Stoner
Chuck Stoner is an award-winning teacher and scholar, an engaging speaker and facilitator, and a specialist in leadership, interpersonal dynamics and organizational change. Chuck’s 30-year career in leadership development has allowed him to work with a number of Fortune 100 companies and provide executive coaching for key leaders, ranging from emerging high potential managers to CEOs. Chuck’s consulting and speaking enable him to work with a range of businesses and organizations throughout the United States.

Chuck holds bachelor’s, master’s and doctoral degrees from Florida State University and serves as professor of management and leadership at Bradley University. He is also co-founder of Mindset Consulting. He has authored 11 books and numerous articles and papers.

Chuck is an avid runner — logging more than 65,000 miles to date.

Jason S. Stoner
Jason Stoner serves as associate professor of management at Ohio University. Jason earned his BS and MBA degrees from Bradley University and his PhD from Florida State University.

With primary research interest in the areas of stress and identity, he has published in numerous journals and is co-author of the book Building Leaders: Paving the path for emerging leaders.

Jason has received both teaching and research awards from Ohio University. In his spare time, Jason is a competitive bicycle racer.