healthleaders exchange

# PHYSICIANS ARE FEELING THEIR POWER. WHAT'S NEXT?

## The axiom that physicians lead physicians—but administrators lead hospitals doesn't work anymore.

**By Jim Mulpus**

**Leadership transitions are often rocky. That certainly was** the case in 2000, when the CEO of Scripps Health in San Diego resigned after votes of no confidence by five of the six hospital medical executive committees of the system.

One nuance now lost in the transition was that the CEO who stepped down was himself a physician, and his replacement was most certainly not. Chris Van Gorder was a former Los Angeles–area police officer and system chief operating officer. But he had an inherent sense of teamwork and a respect for clear leadership communication from his law enforcement days.

Now two decades later, Scripps Health has, by every reasonable industry measure, thrived. In no small part because of one axiom that Van Gorder and his team have followed.

"We're not just putting physicians in clinical leadership," Van Gorder says. "We're putting them in *leadership*.'

Hospital leadership and decision-making has traditionally been a fragile balance between physician and administrator. It's a duality that believes that the business decisions are best left to traditional, MBA/MHA-trained administrators while the clinical decisions are, by regulation and practice, left to physicians. It's a partnership that has a new reality.

Physicians came out of the pandemic as an even more scarce resource, with physician retirements expected to accelerate over the next decade. Physicians are also under increased demand by non-hospital competitors, with UnitedHealth Group's Optum division now the single largest employer of physicians in the U.S. with an estimated 70,000 physicians under contract.

So physicians would seem to have some leverage when it comes to pushing for what they want from health system leadership. The question is what will they do with it? Will physicians get frustrated with lingering health system issues and hop to non-hospital providers? Or will they lean into it and use their leverage to get the kind of changes they want in traditional health systems and medical groups.


The answer may lie in what it is that physicians really want.

"Nothing frustrates a physician more than seeing a problem and not being able to fix it," says Chris DeRienzo, MD, senior vice president and chief physician executive at the American Hospital Association and until late 2022 system chief medical officer and vice president of quality at WakeMed Health and Hospitals in Raleigh, North Carolina.

The one problem many want to most see addressed: being tethered to the data-entry side of electronic health records, DeRienzo says. Physicians are not anti-technology, generally speaking, but having to wade through "required, structured data elements" while also trying to actively engage with the patient" would exasperate anyone. It's a real problem and—given how thorny the challenges are in solving it—it's easy to feel like no one is listening."

## OPERATIONALIZED LISTENING

There are any number of consultants and communications gurus who will coach healthcare leaders on the value of "active listening" with physicians and doing regular "I have time" leadership rounds. All good, to a point. For physicians, having input welded into the operational leadership of the system was the key at Scripps Health. After the vote of no confidence, the first order of business was to rebuild trust. To do that, Van Gorder knew he had to make a statement to the medical staff, which currently numbers more than 3,000 affiliated physicians.

"It started with the establishment of our physician leadership cabinet (PLC) which still exists today," Van Gorder says. "The hypothesis 23 years ago was that if we could fill that gap of information, we could rebuild trust. I'm not a physician. I will never admit a patient to our hospitals. I will never order a lab test. I will never do any of those things, but I understand the business of healthcare. The clinicians need to fill that information gap on my side so that in the end, we make the best business decisions and the best clinical decisions for our patients."

The PLC does not replace the usual structures of a self-governing medical staff but works alongside it. In addition to Van Gorder and two system CMOs, the 21-member PLC is made up of both the elected chief of staff and vice chief of staff (who is the chief of staff-elect) from the five hospital medical staffs. The PLC also includes the administrative leaders from each of the hospitals, two regional CEOs, the system CQO, and two system CMIOs for both the inpatient and ambulatory sides, as well as the medical director of a joint venture cancer center with M.D. Anderson. Ten of the physicians on the PLC are elected by the medical staff. "So nobody could accuse me of picking favorites," Van Gorder says.

Medical leadership at the system level is split in two, with one CMO covering acute care operations and another covering the ambulatory side.

"We split the CMO role because finding one leader with the expertise to run both the ambulatory business and clinical care and inpatient clinical care was virtually impossible. The expertise is different," Van Gorder says. Anil Keswani, MD, now heads up leadership of the ambulatory side and Ghazala Sharieff, MD, MBA, heads up acute care operations. The PLC is co-chaired by Van Gorder and Sharieff, so the balance between clinical and administrative leadership is reinforced. "It has worked fabulously well, and obviously they are both involved in strategic decisions."


Another way of hardwiring physicians into the system was to create a new operational role.

"Remember that the medical staff is supposed to be running the medical staff. Right? You are ensuring quality of care. All too many medical staffs, however, try to run administration more than they try to run the medical staff," Van Gorder says. "We moved away from that. And what we decided to do is create a position called the 'physician operations executive."

Each physician operations executive (POE) works with the hospital operations executive in a dyad partnership. The POE is still a practicing physician half of the time, which allows them to keep up to date with clinical concerns while also having a key voice in operational decision-making.

That split CMO role also allowed the system to realign the physician teams under them. Before, the hospital medical directors reported to the hospital executive, which had the potential to create localized fiefdoms. Now the medical directors report to the physician operations executive, who in turn reports to the CMO, Dr. Sharieff. To some, that may sound like an additional layering of administrative complexity, but in this case, it allowed a clear line of accountability and communication all the way from the hospital physician leadership to the system leadership.

"And so now they have annual goals, annual accountabilities, and they all tie back to things that we're trying to do as an organization," Van Gorder says. "Improved quality, lower cost, improved patient satisfaction, better utilization, reduction of clinical variation. For all of those different things we are aligned."

"The first thing that we had to do was align the medical team," Sharieff says. "That has been our secret sauce. We would not have got through COVID had it not been for that infrastructure and the communications out to the frontline docs."

Sharieff jokes that in terms of her dual role, she is still "a doctor first, second and third, and maybe an administrator fourth," but in terms of system decision-making on operational, strategic, and clinical issues, the usual administrator versus clinician barriers have been disassembled.

"It truly is one team now: clinical excellence and operational excellence."

The nexus is still the PLC. Van Gorder and the team are quick to point out that this is not a symbolic committee which meets in a vacuum to make recommendations no one takes seriously. Since its inception, 100% of the PLC recommendations have been adopted, and only one was less than unanimous. The discussions have included strategic issues, the partnership with M.D. Anderson, capital purchases, Epic system issues and updates, and medical staffing and recruiting issues.

If the PLC were not enough, both Sharieff and Keswani are on the system executive committee, as are the chiefs of nursing, information, finance, HR, and strategy.

It may seem like a lot of layers of physician organization, but the payoff comes in the redefined relationship. It eliminated the "them" part of the "us versus them" dynamic.

"We've blurred the lines a little bit, so it's not physicians versus administration or administration versus physicians," Keswani says. "By having physicians as service line leaders and by having physicians in operations, it's hard to point fingers because fingers point back at us."

## POWER OF PATHWAYS

The physician leadership structures at Scripps Health may represent the model more than the mean in the industry. Each market and each health system will have some variability in how it structures physician leadership. And those structures are fluid, particularly during the pandemic which forced many health systems to create better lines of communication.

The direction is clear: hospitals are listening to physicians more than ever and are coming up with creative systems of shared power. Anyone who still believes that physicians are mere influencers and not real decision-makers is seriously out of date.

But will that power surge work to keep physicians sticking around hospital floors and their ambulatory clinics? That's harder to pin down. Hospitals still offer a lot of advantages over the new competitors, from a sense of community, a larger scale to affect change and more interesting clinical cases.

DeRienzo says the key to keeping physicians also lies in creating pathways for physicians to grow into system leadership, much like he did.

"In terms of running healthcare operations, increasingly physicians, nurses, and administrative partners are all realizing that we're better together," DeRienzo says. "We are seeing health systems recognize that, and it means they need to start growing their future physician leaders when they start their careers as bedside physicians. They're finding a hospitalist leading a great unit-level project and asking themselves, "How do I offer that person a multiyear pathway to grow into an amazing CMO who someday can partner with the CNO, the CFO and the CEO?"

Van Gorder agrees.

"It is important for hospital leadership to build a path for physicians to healthcare administration by creating opportunities for administrative (not just clinical) experience," he says. "Hospitals and healthcare organizations are the most complex of organizations and the most regulated industry in the country. The foundation or basics can be learned in graduate school, but nothing will beat experience. Historically, hospitals have not given physicians a pathway to gain that experience." ■