



Training physician leaders to save the health system... and us

Lerman and Jameson¹ recently called for expanding formal leadership development of physicians and increasing the reach of effective physician leaders. From the perspective of physicians, these are certainly good goals. We *should* have leaders in white coats who understand the joy of practicing medicine and can rally for *our* missions, challenges, and passions as doctors, clinical educators, and researchers.

But the rationale for most of their argument seems to stem from the perceived need to train physician leaders to promote the survival of increasingly complex health systems and strategically guide individual institutions. This seems also to be the focus of many health systems as they search for and hire physicians for various system leadership positions. But only in the final sentence of their thoughtful essay do Lerman and Jameson mention “patient and physician satisfaction and improved clinical outcomes,” and then only as a byproduct of achieving “organizational efficiency.”¹

The financial success (ie, survival) of a health system and the emotional well-being and clinical skills of its physicians are clearly interrelated and cannot be completely dichotomized, and I am not implying that Lerman and Jameson have done so. But trying to promote both can create potential for mission malalignment. Achieving an appropriate balance between these two goals, which at a tactical level are not always congruent, is critical. Training leaders in the skills to achieve alignment with the organization’s culture and priorities may make it easier to administer and guide the course of a medical system with apparent physician leadership, but it still may not well represent the human constituents. The recent trend for health systems to establish new committees charged with improving physician wellness is a statement of problem recognition, but whether their existence can accomplish “mission alignment” remains to be seen.

Swensen et al² from the Mayo Clinic have highlighted the need to focus on the needs of the physician, and not primarily on those of the institution, to reduce the epidemic of physician burnout. A physician leader who is wonderfully trained in organizational psychology, communication skills, and performance metrics analysis, but who lacks a deep and authentic understanding of the joys of practicing medicine and delivering care to the sick, of the need to stoke the individual physician’s intellectual curiosity and provide time for reflection to clinicians working in their institutions, is a unidirectional institutional leader, and thus a leader in name alone. We need to be careful about grooming young physician leaders at too early a stage. Having the book knowledge of a physician is not the same as having the heart of one.

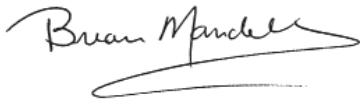
We have appropriately morphed away from the academic curriculum vitae as the only ticket to titled organizational leadership. But we need to look closely at our choice of physician leaders and be careful that the physician component of that

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terminology is not defined by degree alone. Just as the number of first-authored publications and surgical procedures performed should not suffice for selection to leadership positions, nor should participation in leadership courses or the ability to respond as desired in a behavioral interview be viewed as adequate for selection as a leader of physicians. Administrators with a tailored MBA degree, extensive and real job experience in a clinical center, and participation in a seminar on physician behavior can also be successful supervisors and (maybe) leaders in a medical center.

But if we really care about our clinical staff, organizational leadership must include physicians in positions of influence who are true advocates for clinicians and patients, and not primarily caretakers of the health system and enforcers of performance metrics. Although (some of) the latter are absolutely necessary, we need more than that from our physician leaders. We need them to reflect and support our perspective as well as the institution's needs. We need them to understand and defend the need to maintain the joy of practicing medicine. How can we as physicians really take care of others if there is no one to take care of us?³

Note: this discussion is not new. We had a dialogue on this topic in the *Journal* almost 10 years ago!⁴



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