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Leadership Education for Physicians

Refine your focus and communicate your goals when developing physician leadership programs.

Soon after arriving at the hospital, our new department chair at the Wayne State University School of Medicine presented us with a challenge. She envisioned that our group of clinical executives could enhance our business acumen and consequently draw on a vocabulary of management and leadership concepts in our work. This, she believed, would enable years of success in research, educational endeavors, and clinical productivity.

Although a new approach for us, her vision sounded promising. Academic physicians spend years training for their medical subspecialties but rarely have any formal education in management. Career advancement usually comes through success in research and publication, rather than from a history of clinical success or profitability. Funding for the three major endeavors of an academic institution (education, research, and clinical care) comes from several sources: clinical revenue, tenure (general funds), graduate medical education, administrative contracts, and disproportionate share payments. To maintain a successful practice, academic leaders must carefully balance all of these resources. Yet most of our leaders had never written a comprehensive budget for their divisions, much less a strategic plan. Thus, we embarked on a plan to develop our physicians' management and leadership skills.

Planning. Our initiative began with a planning group, which assessed physicians' needs. We believed that leadership skills were important and should be an underlying theme for the program. However, we also felt that a more comprehensive scope, incorporating other areas of business administration, would be most beneficial to a group that lacked training. We sought a program that would address leadership, human resources, financial accounting, business planning, strategic planning, customer service, communication, negotiations, and problem solving.

Four local universities presented proposals. Three of the four had never created a program similar to this one, although one did offer a healthcare M.B.A. The fourth had recently collaborated with its own hospital and medical group and presented that program to us. In the end, we chose the university that offered the healthcare M.B.A. Their balance of experience, flexibility, location, and price appealed to us.

During the next two months, we developed a course called the "Executive Leadership in Health Care Management Series," consisting of eight modules, which covered topics ranging from leadership development to strategic planning to managerial accounting.

We believed that the insights gained and avenues of communication developed would be beneficial to the entire hospital community, so we expanded the offering from our single department to the entire hospital.

Execution. The initial sessions of the course were taught at the collaborator's university, 40 miles from our workplace. We elected to use the off-site facility to minimize distractions from pagers and clinical duties in the hospital. Eventually, however, the site was changed back to our hospital campus because of complaints about the long drive.

We hoped to create measures to compare the before-and-after states of the participants. The lecturers created a multiple-choice pre-test administered to the students through a Web-based interface, with the results held for later comparison with post-test results. We planned on a multivariate analysis of the function of each unit, so that we could try to hone in on the effects of the course.

The focus was on the classroom sessions rather than on assignment homework. During those sessions, participants frequently interacted with the lecturer and occasionally in small groups. An interesting dynamic developed in class wherein participants frequently led the discussions. Seemingly innocuous lessons

about accounting practices and customer service turned into heated debates.

All of this wrangling did serve an important purpose. Since many of these individuals had never before sat around a table to talk about these issues, the classes—as disrupted as they were—served as an excellent forum for protracted discussion. By the final session, the group had formed a new sort of a bond, created from their shared experience. The summary session was filled with big plans for future collaboration.

Assessment. That was a year ago. In the intervening time, participants completed a post-test. Overall, the participants completing the post-test did slightly better than they had on the pre-test.

Other measures were more difficult to correlate with the effects of the course. None of the various departments used a common accounting system or other metrics, and it was difficult to determine which functions would be directly related to the learning, rather than other initiatives within the department and hospital. We were left with financial and productivity results for the initial department that had devised the program, rather than the envisioned multivariate analysis. We compared data on charges, net collections, and work Relative Value Units (wRVUs) with the percentage change in scores for course participants. The majority of our divisions actually did show improvement year-over-year. However, when compared with the scores of their division chiefs on the pre- and post-tests, there was no correla-

tion with charges or productivity. The slightly higher correlation with collections might suggest a better understanding of how charge capture in the revenue cycle can lead to improved collection rates.

The initial interest and excitement expressed by the participants for collaborative projects has mostly fallen by the wayside. While there are still efforts that involve many of the parties, the progress seems to be occurring with the same snail's pace that occurred before the program. Most of the large problems that confronted the physicians and administrators still remain, and many have intensified.

Lessons Learned. We are unclear as to whether the organization learned from



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the experience. The most common improvement the organizers have noted is a better understanding of financial issues, with a common vernacular for discussions. We certainly have a long way to go and have failed in many ways to draw upon the commonalities we found in our time together.

Likely our problems arose, in part, from a lack of clear communication of our situation and needs in the original planning stages. The focus of the lectures seemed to depend on "The Hospital," while in reality we acted as disparate entities. This misplaced focus may have compromised the ultimate goal of our program: to create an integrated society that acts for the improvement of the whole, rather than pursuing sometimes conflicting paths.

Perhaps a longer course, more focused on team building, would have served us better. Incorporating a more problem-based approach, focusing on real issues affecting the medical center, also would have contributed to increased relevance. Lastly, our move during the course of the program from an off-site venue to our hospital was accompanied by added distractions and a significant decrease in attendance.

With a refined focus and clearly communicated goals, physician leadership education projects can be of great value to complex healthcare organizations—not only to improve technical competencies but also to create a new forum for discussion. Programs with this sort of focus should become more common to give medical executives the skill set required for effective and collaborative management and leadership. ▲

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