The Board's Role in Physician Leadership Development

BY ELAINE ZABLOCKI, STAFF WRITER, NATIONAL RESEARCH CORPORATION

In the past, medical staff leaders were responsible for a relatively narrow range of professional issues such as credentialing, physician relations, medication safety, and peer review. Physician leaders traditionally carried titles such as vice president of medical affairs, chief medical officer, or medical director.

Now physician leaders are needed to help redesign all aspects of the healthcare system. They are invited to share responsibility for cost-effectiveness as well as quality and safety. Some physician leaders are responsible for managing care outside hospital walls, or leading multi-skilled teams that deliver care. Some are learning how to manage risk for large populations of patients; some are forming alliances with external partners in order to integrate the entire continuum of care.

This means physician leaders need a host of new skills and new ways of looking at the world:

- Managing population health
- Understanding how to thrive in a risk-bearing environment
- Epidemiology and public health
- Health services research
- Managing care processes in multiple settings
- Organizational design and organizational change
- How to function as a team leader

No single person could master all those skills, of course. But as we move forward, hospitals and health systems will require an expanding cohort of physician leaders able to play many different roles in complex, integrated health systems...and all of those skills will be useful.

"Not every physician needs to be a physician leader or manager, nor is every good leader and manager a physician," said Robert M. Wachter, M.D., professor and associate chairman of the Department of Medicine at the University of California, San Francisco. "But certainly some of the organizations that are making great strides in the things we have to do—improved quality, improved safety, improved efficiency—have accomplished that through robust physician leadership. This requires a new kind of physician, a new kind of training, a new set of competencies."

This means it is essential for the board to ensure there is a system in place to systematically develop physician leaders, physician partners, for the overall success of the organization. "The key point is, these people are in great demand," said P. Terrence O'Rourke, M.D., executive vice president for clinical transformation at CHE/Trinity, based in Livonia, MI. "You can't just go out and recruit them, you need to develop them within your own organization."

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The largest, most sophisticated healthcare systems have been working on physician leadership development for several years. "A significant number of organizations have already recognized this need," said David B. Nash, M.D., M.B.A., dean of the Jefferson School of Population Health in Philadelphia. "They choose to identify and nurture emerging leaders, believing this will raise all boats in terms of physician performance, willingness to integrate care, and improve practice based on evidence-based guidelines."

Healthcare strategies today are built around improving value and demonstrating higher levels of quality and safety, more patient-centered care, and lower costs. "It has become difficult to lower healthcare costs further unless physicians are involved in redesigning care," said Todd Sagin, M.D., J.D., president of Sagin Healthcare Consulting in Laverock, PA. "We have already tried the straightforward approaches to cost reduction. Hospitals have gotten as efficient as possible using current delivery methods. If our strategic plan is to redesign care delivery through tactics such as medical homes, system-wide medical records, and proactive care for people with chronic diseases, physicians are the linchpin to the design and implementation of such efforts."

As the healthcare system evolves, we observe quite a few situations where physicians are taking on new roles. A physician may function as chief innovation officer or physician informatics officer. There are emerging physician roles in employed physician groups and in ACOs. "Many of these roles are so new, they don't even have standardized titles and responsibilities," noted Dr. Sagin. "At present, many organizations are working to create a rational organizational framework for their expansion of physician leadership positions."

Salem Health: Substantial Efforts Yield Substantial Results

Eight years ago, when W. David Holloway, M.D., arrived at Salem Health as CMO, there was a physician leadership program underway, but it didn't have much impact. "There was a series of outside speakers on Friday afternoons, but when you came in on Monday morning, nothing had changed," he recalled.

During the next two years a large advisory group, including board members, set about reinventing the Salem Health Physician Leadership Institute. They enrolled in five of the best leadership courses around the country. Each course had its good points, but none of them offered everything they needed. "We decided we wanted a single, crystalline theme at the core of our program," Dr. Holloway said. "That theme is, how do we eliminate unnecessary variation? Because unneeded variation is the root cause of most quality, safety, and cost issues."

Salem Health isn't a major system like Sentara or CHE-Trinity (profiled later in this special section). It includes the 450-bed Salem Hospital, plus a rural hospital 20 miles away. However, the Salem Health board determined that physician training was a top priority. The organization designed its revamped Physician Leadership Institute (PLI 2.0) around three themes:

- Bring in external speakers—the best in the field
- Gather people together in a pleasant environment, without interruptions
- Help physicians understand the imperative to change, teach them to lead a change team, and involve them in making actual changes

The typical PLI class has about 40 people. About half are physicians, while the remainder includes nurses, pharmacists, and other members of the healthcare team. Each class includes a board member and someone from the C-suite.

In order to reduce variation, physicians first need to understand the imperative reasons to improve quality and reduce waste, so that's the initial topic of discussion. Additional subjects include:

- How to lead a team when major change is needed
- How to manage small tests-of-change and spread the changes that work
- How to mistake-proof processes to improve safety
- How to deliver clinical excellence

PLI now offers two courses a year; each course takes one weekend per month, for four months. During the course, participants get a solid introduction to quality improvement, project management, and change theory. "We know adults don't learn by just sitting in class, they have to actually put what they learn into practice," said Dr. Holloway. "Everybody is involved in a team quality improvement project." These hands-on projects offer an opportunity to put new skills into practice, and a trained coach is attached to each project team.

In recent years, PLI quality improvement projects included:

- Reducing outpatient narcotics prescriptions from the ER
- Eliminating unnecessary Pap tests in women younger than 21 years
- Reducing the time to treat emergency adult psychiatric patients
- Eliminating waste during surgery by reducing variation in items chosen by surgeons

PLI costs about $7,500 per person. The hospital covers all expenses, but physicians and board members donate their time in order to attend. That's a significant expense. Is it worth it?

"It is definitely worth it because PLI has truly become the farm team for hospital leadership," said board chair Alan Costic. "We've identified potential leaders, exposed them to cutting-edge speakers within the healthcare industry, and given them the essence of quality improvement tools. Just as importantly, this process creates an ongoing web of relationships among people who don't necessarily come into contact with each other during their ordinary hospital routine."

So does PLI 2.0 have an effect when people come in on Monday morning? Does it change the water cooler conversation? "Absolutely," said Dr. Holloway. "When you talk to our physician leaders or nursing directors, they'll say that when they gather a group of physicians who've done PLI, they can accomplish so much more improvement work in a given period of time. They don't have to start again from the beginning—everyone is already up to speed."

At this point, about 20 percent of Salem Health's medical staff has been through the training, and all slots are full into 2015. Why has this program been so successful? "We had a major effort, led by the board," said Dr. Holloway. "And it wasn't just the board—it was also the medical executive committee plus core physician leaders. You can't just send a couple of doctors off to a course and expect that to have a big effect. You have to put substantial effort into this. But it is worth it."

Physician Leaders throughout the Organization

When it comes to developing the next generation of physician leaders, the governing board has two different but related responsibilities, according to Dr. Wachter. "First, the board needs to encourage a high level of physician engagement and leadership throughout the organization," he said. "In addition, for those physicians who have the skills and interests to take on additional leadership responsibilities, the board should ask what it can do to promote their growth. That will often involve leadership training."

Richard Afable, M.D., M.P.H., makes a similar point when he distinguishes three different levels of physician leadership: the direct provider of care, the manager of care, and the leader of care and care processes. Dr. Afable is president and CEO of Covenant Health Network, a seven-hospital system serving three million people, and the executive vice president of St. Joseph Health, Southern California region.

"That first level often gets lost, but it is of vital importance," Dr. Afable said. "In the end it is through direct patient care that real value is created and delivered. When we have a doctor who is great at the bedside and can show by example how to interact with patients, let's consider them a leader and support them in what they do best." These physicians typically might need support through training and education in electronic messaging and telemedicine.

On the other hand, excellent clinical practitioners may find themselves now managing care for a large population of patients. Previously, a diabetes specialist would see patients one by one, caring for a

panel of 1,500 or 2,000 people, seeing each of them every 12 weeks. Now that same physician could manage a diabetes program that includes nurse practitioners, physician assistants, a dietitian, a patient portal, and shared information via remote technology. "This is very different than knowing what insulin doses to give," Dr. Afable said. "This is about managing people, managing processes, understanding costs, knowing how to access and use resources efficiently, and reporting outcomes."

Another essential role for mid-level physician managers is staying in touch with direct service physicians and helping them cope with change in a meaningful, systematic, constructive way. "For the average doctor, who's run ragged just taking care of patients, constantly changing expectations and requirements can be overwhelming," said Dr. Sagin. "Mid-level physician leaders need to be shock absorbers. They need to explain the reasons for change, and also dampen the impact on everyday doctors."

As physicians move into clinical management roles, some hospitals and health systems are offering short but effective training in the vocabulary and thinking processes those roles require. They intend to have trained physician leaders scattered thickly throughout the organization, ready to cope in every department and service line.

Dr. Wachter serves on the board of Salem Health, in Salem, OR, a community hospital that has formed its own physician leadership institute (see sidebar). "One reason they did that was they wanted to seed the organization with physician leaders," Dr. Wachter said. "They've been at it for four years, and now they can expect that when any major issue comes up at the hospital and its medical staff, there will be at least one, and often several physicians who've experienced this training, see problems through a new lens, and have a set of tools and competencies that allow them to respond effectively."

The goal of leadership training isn't simply to convey new information, Dr. Wachter said. "If these leadership courses are any good, they not only teach physicians a new set of competencies, but allow us to understand the managers' predicaments in new ways. Traditionally physicians feel, 'Here I am working my tail off taking care of patients while "The Suits" are pushing pencils and saving pennies.' By the end of these courses, there is a much greater appreciation of non-physician managers, which is very important for an organization operating in today's rapidly changing environment."

Mid-Level Managers

As physicians take on increased managerial responsibility, they may benefit from more concentrated and longer training. Dr. Afable estimated that in a large organization, perhaps 10 percent of physicians will become managers, and perhaps 10 percent of those managers will go on to become executive leaders. Covenant has partnered with a local university to develop a leadership and healthcare transformation course, specifically aimed at training managers of care. It is a year-long course, with about 35 physicians enrolled each year.

Another option for more concentrated training is to obtain an M.B.A. with a healthcare focus, or a Master's degree in public health, or any health management-related advanced degree. A number of organizations offer online Master's degree programs, so a physician can take two or three years to study for the degree, and combine that with continuing clinical experience. The American College of Physician Executives (ACPE) offers an M.B.A. with a focus in medical management through the University of Massachusetts, Amherst. The Jefferson School of Population Health offers a Master's degree and a graduate certificate in quality and safety management.[1]

"We are now seeing more younger physicians who have additional degrees," said Dr. O'Rourke. "Some have done combined programs where they were able to work towards both degrees at once. On the other hand, if someone wants to be a clinical leader, solid experience is essential. There is often an advantage in waiting, and then doing the second degree after they've been in practice for a few years."

The final decision on when and how to do advanced training will depend a great deal on each person's individual learning style, their family situation, and many other factors. Some people find it helpful to take nine months off and immerse themselves in a new field of academic study, instead of fitting it in at the end of a day spent seeing patients. Others, especially those who have families and are embedded in community activities, may value a learning style that merges into their existing responsibilities.

In any case, the choice about which form of advanced training to pursue is very personal. "The breadth of options is extraordinary," Dr. Wachter said. "If you decide you want to focus on leadership in quality improvement, you might do that within academia, or through a community delivery system,

1 See www.isenberg.umass.edu/online/mba/about/partnerships/acpe and www.jefferson.edu/population_health/academic_programs/quality_safety.html for more information about these programs.

Consider the Context

When you ask Dr. Afable about physician leadership development, he starts by vividly describing the changing healthcare context. Everyone knows healthcare is changing with unprecedented speed, but he emphasized this transformation goes far beyond the effects of the Affordable Care Act and efforts to rein in national healthcare costs. He said:

What we are experiencing now is the consumerist transformation of healthcare. Market-based decision making grounded on consumer preferences has transformed a host of major industries in recent years. Think of the airlines, commercial banking, telecommunications, utilities, all sorts of consumer goods. But in the past, healthcare was not susceptible to consumer decision making, primarily because patients didn't have enough knowledge or access to information to allow them to act like consumers, making independent choices based on their own values and preferences.

Now, all that has changed. For the first time, consumers of healthcare services can easily access a wealth of information to assist them in making decisions about their health and healthcare. Someone who is diagnosed with a dreaded disease can Google it and access pretty much the same information their doctor is reading. They can find online ratings for treatment facilities and specific physicians. They can interact with social networks organized around specific diseases, offering analyses of treatment options and blunt appraisals of particular hospitals and doctors.

Nowadays most employers are using high-deductible insurance plans, so a consumer spends the first $5,000 or in some cases the first $10,000 from their own pocket. This means they have significant incentives to do research first, to ask probing questions, to make sure there's a real benefit before they pay for an expensive test.

Consumer preferences will alter healthcare in substantial ways, just as they have transformed so many other industries that will never be the same. Consumers vote with their feet and their pocketbooks as they "shop for good value" in the healthcare marketplace. Their perception of value is based on many factors, including subtle perceptions that are difficult to discern and define, but they have an effect!

In healthcare, value varies enormously, since the term "healthcare" covers so many different situations. Someone with cancer has a clear target: they want a cure. They search the Internet for organizations with top results for that form of cancer. This means, if you're a cancer center, you need to aim at the best outcomes in the world. Otherwise, the consumer will put you out of business.

Consider another example, a couple who is about to have a baby. In this case, cure and survival are not relevant. For the most part, obstetrical delivery is about amenities: comfort, a homelike atmosphere, friendly nurses, the meal you eat together after the baby arrives. If a health system wants a successful OB program, then it will add amenities, like a four- or five-star hotel.

In a consumer-oriented world, this is how you drive business. How well various industry components respond to a consumer-driven healthcare environment will make a major difference as to who is or is not successful in the long run.

or by working in industry. In the same way that physicians struggle in medical school to decide whether to become an internist or an orthopedic surgeon, now we must decide whether to combine clinical work with leadership, or move towards a full-time leadership position. Some doctors will find all these choices a bit daunting, while others might feel like kids in a candy store." His advice to physicians at this stage: "Find people who are already on this path who can help you think through these questions. Find role models who look like what you want to be five years from now."

Visionary Leadership

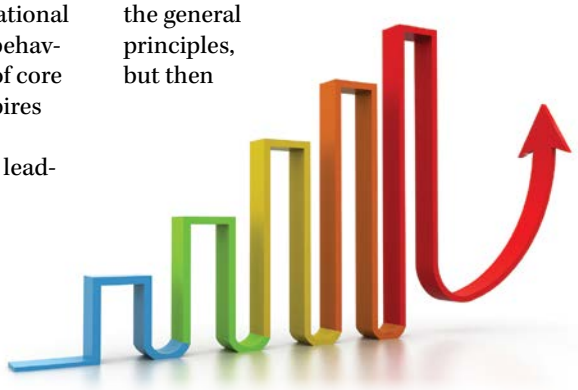
When you ask healthcare experts about the top levels of physician leadership, they describe an interesting mix of knowledge, skills, and personal character. We're thinking of the top leaders who are able to envision the big picture, draft a strategic plan, allocate resources across a broad spectrum of choices, and use resources in the most effective way. In addition to understanding the intricacies of clinical care, these leaders need to understand the politics and financing of healthcare, on a local and national level. They need the ability to communicate with many different people, to understand differing viewpoints, and to get things done.

"Keep in mind, you're not looking for the smartest person in the room, who will tell everyone what to do," Dr. Afable said. "That person might be an effective dictator, or a superb surgeon in the operating room, but he is not a leader." Leaders have the ability to listen, to persuade, and to inspire.

"Leadership is all about relationships," said Joseph S. Bujak, M.D., FACP, healthcare speaker, facilitator, and consultant. "Leaders focus on people, intangibles, and the future. They work to create new paradigms. Managers, on the other hand, focus on processes and tangibles, work in the present and within current paradigms. For the leader, it is all about organizational purpose, and a commitment to the behavioral manifestations of a shared set of core values in pursuit of a vision that inspires the workforce."

Identifying and training potential leaders, on this level, is a very individual process. "The first thing you do is put them in a situation where they can see, and you can see, whether this is really something they want to do," Dr. Afable said. "Put them on a committee where they have to sit through meetings, listen attentively to a variety of opinions, and end up with a group decision. In my experience, when you put potential physician leaders in that environment, 80 percent of them say, 'No, this is not for me.'"

For those who do aspire to the top levels of leadership, some organizations offer a combination of formal training and informal mentorship. "Someone may broaden their knowledge, but then struggle when it comes time to actually apply it," Dr. Sagin said. "Think about developing a strategic plan for your service line, or creating a work plan for a major project. These are not cookie-cutter projects. You can study the general principles, but then



you need to apply them in specific circumstances. Leadership training for physicians needs to encompass mentoring and coaching in the application of their new knowledge."

Mutual support can be extremely valuable. An experienced physician executive can serve as a sounding board over the phone. A cohort of physician leaders can benefit from each other's experiences. "Get your service line chiefs all together a couple of times a year and let them share their common woes," suggested Dr. Sagin. "They can learn from one another. They can realize that some of the things that are really challenging for them are not unique; their colleagues wrestle with the same issues."

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Challenges

Physician leaders will play a wide range of essential roles in the emerging healthcare system that focuses on maintaining population health and offering a full continuum of care. But, as we might expect in any period of rapid change, this isn't going to happen automatically or smoothly. A few challenges are only to be expected.

For example, some hospital and health system CEOs could experience ambivalence about the degree of change that's underway. "When you look at surveys, you see that more and more CEOs say physician leadership is an essential, critical need," Dr. Sagin said. "At the same time, there are some who still see physicians as problems to be managed. Some may know how to talk the latest trends but may not know how to actually live them."

As a counterweight, Dr. Sagin noted there are also physicians who hear the latest talk about physician leadership and want to take on responsibility before they've fully prepared themselves to do things well. "They want to run before they've learned to walk."

For physician leaders to function effectively, they need to be more involved in the development of strategic plans than they have been in the past. Historically, many institutions would take pieces of the strategic plan out to specific departments for feedback, after completing the first draft. Going forward, we expect to see more physicians integrally involved from the beginning in strategic planning.

Varying Approaches to Fit Unique Circumstances

There are many ways to structure physician leadership development programs, and each organization chooses a structure that fits its own specific needs and its stage of development. In this section, we will look at programs that offer a variety of approaches.

Trinity Health, a large health system, started its physician leadership development program in 2009. To date, about 400 people have completed the training. It includes eight modules in four sessions, over two years, available at various locations throughout the country. Typical modules include:

- Drivers of Financial Performance
- Problem Solving and Innovation
- Mediating Medical Staff Conflict
- Physician–Executive Summit: Envisioning a Model for Working Partnership

Each module takes half a day, so each session takes two days, including time for travel. This training is offered to emerging physician leaders, such as someone who's just been elected as chief of medicine. "There's a strong need for physicians who are embarking on leadership roles to absorb basic skills," said Dr. O'Rourke. "They need to understand enough about finance to get the main points when the CFO presents a budget. They need leadership skills such as how to craft an agenda or manage a meeting. We find they are like sponges as they absorb this new material." One advantage of the training program is that each group develops skills and relationships that are useful when they work together on future projects. Trinity has follow-up programs for each cohort that has been through the initial training.

For experienced physician leaders who may take on roles at the top levels of the organization, Trinity has developed individualized mentoring relationships. "This is for people such as the chief medical officer, chief quality officer, chief nursing officers,

and physician executives in the system office," Dr. O'Rourke said. "We've created informal settings where it is possible for someone to test out ideas, better understand how they're perceived, and get the benefits of a 'coaching' type of atmosphere."

Texas Children's Hospital in Houston set up its leadership training program in 2009. Its Advanced Quality Improvement and Patient Safety Program (AQI) takes eight days, spread over five months. There are about 35 to 40 people in each class, about half of them physicians, and the remainder nurses, therapists, administrators. "Our goals are to improve care delivery, to create leaders of quality, and to change the culture," said Margaret Holm, RN, Ph.D., Director of Quality and Education, Health Policy, and Research at the hospital.

Each class divides into several teams, and each team has a quality improvement project to work on. They meet for two days in a hotel; when they get back to the hospital, they recruit additional team members to help with their improvement project.

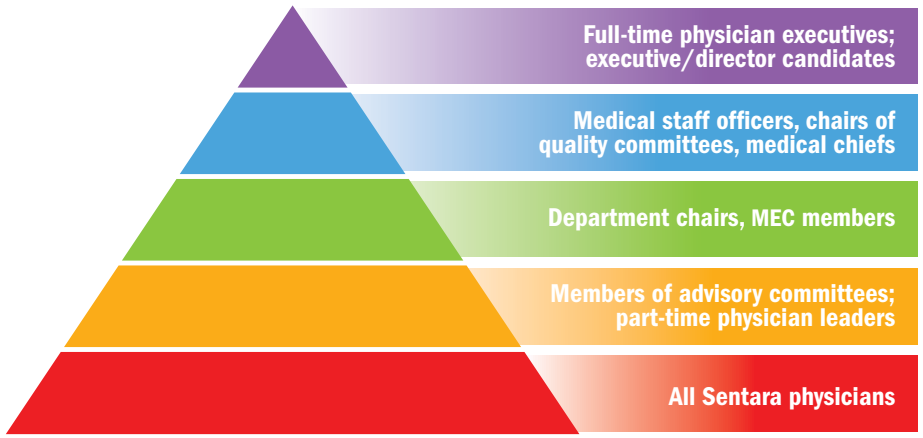
For the first three months, they go to the AQI presentations two days a month, then they take a month off to work on their projects. During the fifth month there's one final day of training, followed by "graduation day" when they present their work.

"The benefit of having physicians and other healthcare professionals together during the training is that they learn to collaborate," Dr. Holm said. "The program gives them an opportunity to work together with people from different professional backgrounds, and this sort of teamwork is essential in care delivery."

The program relies on *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* as a textbook.[2] At this point over 300 people have done the training, and over 94 quality improvement projects have been completed. "Our experience is that this program gives us a common foundation and set of tools to make needed changes," Dr. Holm said. "It gives people an opportunity to apply new information in a safe, learning environment. Most importantly, it helps us start learning how to manage populations, to review data and examine systems and processes that impact patient care delivery."

2 Gerald J. Langley, et al., *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd Edition), Jossey-Bass, April 2009.

Exhibit 1. Sentara Healthcare's Tiered Approach to Physician Leadership Development



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Sentara Healthcare is an 11-hospital health system with a 2,400-physician clinically integrated network, serving southeastern Virginia and northeastern North Carolina. It has been offering physician leadership education for more than 15 years. "Initially, we had a general sense that partnering with physicians was good for the organization and good for the community. We saw that when private practice groups had solid physician leadership, they tended to do better in terms of recruitment and general functioning," recalled Gary R. Yates, M.D., president of Sentara Quality Care Network (Sentara's integrated physician network) and vice president of Sentara Healthcare.

Over the past five years Sentara's board and senior management has recognized that to reach top levels of performance in quality, patient safety, service excellence, and customer satisfaction, physicians must be fully involved. "Where we have strong physician champions, that is where we see our best successes," Dr. Yates said. "As we look at the future growth around population management and accountable care organizations, we consider engaging with physicians as a key strategy moving forward."

The system has tested several different approaches over the years. At one point it offered a mini-M.B.A. program for physicians through the College of William and Mary. At another point it set up a partnership with the American College of Physician Executives, which presented programs on the Sentara campus every month. "These programs were well received, but we kept struggling to tailor education to the needs of each physician, and be sure to get the

right physicians into our leadership development offerings," Dr. Yates recalled.

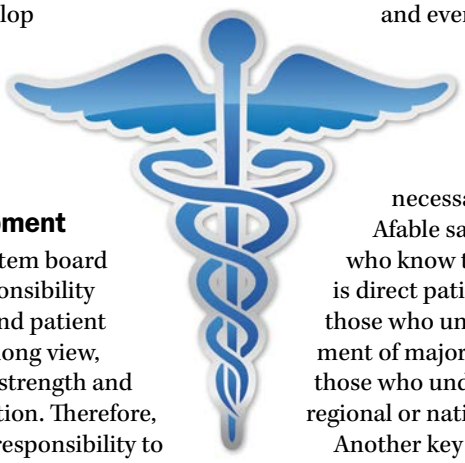
More recently, Sentara shifted to an approach that incorporates physician leadership development as part of a general leadership development strategy within the human resources department. "Our starting point was taking time to analyze and identify the competencies and skills that will be needed in various physician leadership roles as we go forward," Dr. Yates said. "Then we considered what they might look like in various roles within our hospitals, at the health system level, and within our clinically integrated network."

Sentara decided to shift to a tiered approach for physician leadership development, in terms of a pyramid with five levels (see **Exhibit 1**).

The system is currently working to evolve programs that will be appropriate for each level of the organization. For physicians who have potential for senior leadership roles, Sentara offers a 10-month executive development program, taught almost entirely by internal Sentara executives. Each group of 15 to 20 students includes nursing and administrative leaders as well as physicians; each member of the class is paired with a senior executive as a personal mentor. "Hopefully we are sharing real knowledge about the organization, and developing relationships between current executives and the rising generation of leaders," Dr. Yates said. "Members of each class have an opportunity to form relationships among themselves and understand how they can work together as part of this process."

At the same time, Sentara has developed a series of monthly Webinars that are open to all physicians who want to participate. Typical topics include emotional intelligence, time management, and conflict management. "These topics are valuable to physicians in any sort of leadership role, and the Webinar structure allows a large number of physicians to participate," Dr. Yates said. "It is important to have a fundamental level of competency throughout the organization."

Sentara is a large integrated system. Does its work stand as a potential model for smaller organizations and community hospitals? "Everyone needs to be thinking about this," said Dr. Yates. "I don't think it's size-related. It is important for every organization to come up with a plan for developing physician leadership skills and effective physician partnerships. Any organization could start with a needs analysis, looking at their current situation and potential goals to develop a sense of needed competencies. After that, they can explore various leadership development options, and develop a structure that fits the needs of their organization."



The Board's Role in Physician Leadership Development

The hospital/health system board bears the ultimate responsibility for healthcare quality and patient safety. It must take the long view, planning for the future strength and success of the organization. Therefore, it is clearly the board's responsibility to ensure appropriate training for the next generation of physician leaders.

"Since this is the board's responsibility, how do we operationalize that?" asked Dr. Nash. "As a board member, the first question I would ask is, are we producing the physician leaders we will need for the new delivery system of the future? Recognizing that doctors do not receive this training in the typical clinical setting, where do they obtain this training?" (Dr. Nash is the chair of the board quality and safety committee at Main Line Health, Philadelphia.)

Dr. O'Rourke agreed that physician leadership development is an essential board function. "It should be an integral part of the system's strategic plan," he said. "I would hope that the CEO is bringing this subject to the board, but if they are not, then the board needs to ask, 'what are we doing about this? Where will we obtain our physician leaders?'"

Dr. Sagin added another critical point. "The board wants to ensure it is developing a strong cohort of physician leaders. This includes physician development, and also *succession planning* for critical physician leadership positions."

The board should recruit emerging physician leaders to board committees and eventually to the board. "Since physician leaders play three roles within the organization, all three roles are also necessary in governance," Dr. Afable said. "You need doctors who know the core business, which is direct patient care. You need those who understand the management of major service lines, and also those who understand healthcare on a regional or national scale."

Another key aspect of physician leadership development is to learn what other organizations are doing, and to benchmark the entire process of identifying and training physician leaders against national best practices. "I put this responsibility fully on the shoulders of the board," said Dr. Nash. "Over time, they need to create some form of leadership nurturance and training, a farm team if you will. The board is responsible for allocating attention, energy, and resources now, to train the physician leaders who will be essential for tomorrow."

Most of all, the board needs a deep understanding of why physician leadership is so essential to the new business model. "Over the last 40 years, some hospitals have learned to work without truly effective physician leadership, and they may feel they can continue to operate that way," said Dr. Sagin. "Health systems that fully understand the great potential of physician leadership are the ones that will be winners in the shakeout that's currently underway."