CHAPTER 1

Physicians

Men who are occupied in the restoration of health to other men, by the joint exertion of skill and humanity, are above all the great of the earth. They even partake of divinity, since to preserve and renew is almost as noble as to create.

—*Voltaire*

God heals and the doctor takes the fees.

—*Benjamin Franklin*

Physicians are a popular topic of conversation. Few people lack opinions about them. Yet few fully understand the nature of physicians' education, their preparation, or the issues they face. Sadly, this is also true of some nonphysician administrators.

Despite being at the core of what happens to patients, physicians are often far from the core of decisions related to how patients are managed. Unfortunately, some healthcare leaders view physicians primarily as widget producers. Physicians are educated in clinical matters; their curriculum does not allow much time for management and leadership training. Having a deep understanding of the nature of physicians is necessary before undertaking any changes to any healthcare system.

Before beginning to build a physician leadership development program, understanding physicians, their typical background, education, and propensities is important. This may seem counterintuitive or obvious to some readers, but it is still important as a foundation for the many considerations proposed throughout this book. This chapter sets the tone for the book with a discussion on the special nature

of physicians—their role in the healthcare enterprise; their impact on quality, costs, and outcomes; their seemingly opposite nature to nonphysician administrators; and the critical role they will play in future clinical integration. This chapter asks the reader to gain a foundational understanding of the nature of physician education and its differences from other educational avenues. It respectfully suggests that many nonphysicians do not fully comprehend the role that physicians play in the process of health. Moreover, many do not fully grasp the viewpoints and philosophies of physicians to properly integrate them into organizational decision making. Our hope is that this chapter will draw attention to the need for enhanced physician involvement and leadership.

Questions to ponder at this point:

- Are physicians really any different from any other professionals?
- By using the word *special* in the opening paragraph of this chapter, have we as authors set up artificial barriers?
- Are we according too much deference and reverence to those who are, in fact, really just some of many players on the healthcare stage?

These questions and similar ones can cause heated debate in healthcare circles. However, within the healthcare field, physicians are the drivers. Physicians generate the orders for patient treatments and, as one CEO said, "They are the top of the food chain." The courts and laws and regulations have long spelled out physicians' premier role in the provision of healthcare services. Essentially, under most state laws, little can be done to or for a patient without a physician's order.

Describing physicians can (a) bring up a lot of stereotypes (see the quotes throughout this chapter); (b) be akin to the old tale of the blind men describing an elephant by touch—it depends on the part of the elephant being felt; and (c) result in different assessments depending on whether or not you are a physician—perhaps "you have to be in the club to know the secret handshake." And some understanding may relate to whether you actually respect (or do not respect) physicians.

To what extent are our views of physicians driven by factors such as these? "Doctors are sometimes portrayed as heartless individuals who make too much money and do not care about the patients they are supposed to be treating, or as egomaniacs who like being the center of attention. I do not, and never will, understand either of these descriptions of a physician, and do not understand how we as a society ever got to this point" (Prime Education 2007).

We believe understanding physicians includes knowledge of their educational preparation, a sense of their typical value systems, the contrast between physicians

and administrators, awareness of what physicians do, and insight into what physicians are typically like.

To begin, we'll briefly describe the educational preparation of physicians, because this is one of the primary differences that often sets them apart from other professionals.

HOW PHYSICIANS PREPARE: THE EDUCATION PROCESS

The process of selecting a medical school class is complex and intense. American medical schools receive, on average, 31 applications for each place in the entering class, with a range of 2.5 applications for each place among public medical schools to 76 applications among private medical schools.

—Association of American Medical Colleges, 2012

> No physician, in so far as he is a physician, considers his own good in what he prescribes, but the good of his patient; for the true physician is also a ruler, having the human body as a subject, and is not a mere money-maker.
>
> *—Plato*

The education of physicians is typically much longer and more complex than that of any other profession. It entails undergraduate education (such as a degree in biology), medical school, and graduate medical education (a residency and fellowship). Medical school typically takes four years, awards an MD or DO degree, and is followed by three to seven years of specialized residency training and, for some, another one to three years of focused additional training. After completing the required graduate medical education (GME), a physician then applies for a license to practice medicine issued from a state where she plans to practice.

All these years of education led one physician executive to remark, "I was 32 years old before I got my first job."

Board certification, an optional and voluntary process, involves another round of testing. Certification indicates that physicians have been tested on knowledge and skills in a specialty. Currently, 24 specialty boards manage the board certification process, and physicians can be certified in 36 general medical specialties and 88 subspecialty fields. Finally, physicians are required under state laws to take continuing medical education—the CME that some nonphysicians confuse with the also-required GME described previously—to renew their licenses.

> Physicians. Oh, my, what a different breed! And what they say about trying to lead them being like trying to herd cats is so true. Oh, you can't live with them and you can't live without them.
>
> *—Anonymous hospital CEO, circa 2009*

Changing the Way Physicians Are Educated

Because of the increased complexity of medicine, the move toward more holistic views of medicine, and the segmentation of medicine into specialties, major changes to the manner in which the medical school curriculum is structured are occurring. Readers would benefit from a review of the websites of various medical schools as well as the website of the Association of American Medical Colleges (www.aamc.org) and the Liaison Committee on Medical Education (www.lcme.org) to see how education is changing. Often the goal is greater integration of the "what to do" and the "how to do it in the real world" aspects of medical education.

Indeed, AAMC (2005) notes that thinkers in the medical education realm focus on eight key themes in education reform: technology, financing, workforce development, research and assessment, breaking regulatory barriers in the educational continuum, social accountability, leadership, and trends in healthcare delivery. At a structural level, an AAMC report has called for medical colleges to combine two approaches to future doctor schooling: the "tea bag steeping" approach, which is a time-based model, and "an outcomes-based approach centered on specific learning objectives, with the goal of adapting physicians to the needs of 'users' and strengthening physician 'products' through constant feedback and standardized methods of ensuring safety and quality" (AAMC 2005). The report continues:

> In many medical schools, clinical content has been integrated into the basic science course work offered during the first two years of the educational program. In addition, many schools offer courses in the first two years that focus on various aspects of the doctor–patient relationship, with specific emphasis on taking a history, performing a physical examination, and communicating with patients and patients' families.

The AAMC report added:

> During the past decade, some schools have changed the organization of the third year by creating block rotations. Each of the blocks is composed of several clerkships that students must take in sequence within the block period. More than half of schools [in recent site visits] have adopted this structure. The block structure has been adopted primarily as a means of promoting integration of clinically relevant content across related disciplines (e.g., psychiatry and neurology, pediatrics and obstetrics/gynecology, family medicine and general internal medicine). Several schools have established clerkship blocks that run for three to six months during

the third year. In those schools, the discipline-specific, departmental orientation of individual clerkships has been largely eliminated.

Temple University School of Medicine in Philadelphia, Pennsylvania, recently overhauled its curriculum to better meet the needs of tomorrow's healthcare system. Here is a report from the school's website (2012):

> Doctors are men who prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing.
>
> —*Voltaire, circa 1760*

> Temple University School of Medicine previously provided a curriculum that was four years in length and culminated in [an] MD degree. It consisted of 158 student instructional weeks, with approximately 25 instructional hours each week in Years 1 and 2 and approximately 45 instructional and patient contact hours each week in Years 3 and 4. Similar to approximately one-third of US medical schools, for several decades, the School of Medicine employed a discipline-based curriculum. In another model, curricula are based on body and organ systems. We believe that such curricula provide better integration of material across basic sciences and between basic and clinical sciences. We have therefore chosen to introduce an Integrated Curriculum [IC].
>
> The curricular content taught in the new IC is similar to the previous curriculum; however, the way in which it is taught has changed. Instead of being divided into a number of courses based in and administered by the academic departments, the IC is now divided into a number of interdisciplinary "blocks." Each block is organized according to body or organ systems and is planned and taught in a coordinated fashion by faculty from a number of basic science and clinical academic departments. As an example, students in the previous curriculum were taught about the normal structure of the body in three different anatomy courses and the normal function of the human body in the physiology and biochemistry courses. Students in the IC are now taught about the cardiovascular system in two "cardiovascular blocks." One block in Year 1 presents in an integrated fashion the relevant anatomy, biochemistry, and physiology. A second block in Year 2 presents the major disease processes (pathology and pathophysiology) and therapeutic options (pharmacology, pathophysiology, medicine, surgery).
>
> The clerkships in Years 3 and 4 are now discipline-based, similar to the previous curriculum, but there are some modifications. The clerkship in neurology has moved from Year 4 to Year 3. Ambulatory medicine in the new, integrated curriculum now receives additional emphasis in Year 3. In Year 4, required clerkships have been added in radiology and critical care medicine. The number of elective clerkships has been

reduced from five to four. Teaching strategies now place additional emphasis on the incorporation of basic science principles into clinical medicine.

Identical to the previous curriculum, Temple University School of Medicine's new IC consists of 158 weeks of instruction over four years leading to the MD degree, but without areas of concentration or specialization. Instruction in Years 1 and 2 has been shortened from the previous 75 weeks to 70 weeks. Instruction in Years 3 and 4 has been lengthened from the current 83 weeks to 88 weeks. The Year 3 portion of the curriculum, instead of beginning in July of the third year, now begins in May of the second year and concludes in April of the third year, followed immediately by the Year 4 portion of the curriculum.

I am dying with the help of too many physicians.
—*Alexander the Great, on his deathbed*

We point out these changes and suggest that readers who need more in-depth knowledge of the physician education process do an aggressive web search. We strongly feel that a firm understanding of these processes will give additional insight in dealing with physicians.

THE TYPICAL CONTRAST BETWEEN PHYSICIANS AND ADMINISTRATORS

Kenneth Cohn (2008) wrote, "For physicians trained in the scientific method, problem solving is deductive and linear, leading to one best diagnosis and treatment. In general, physicians lose patience with an administrative approach that seeks multiple correct answers (options)."

Providing management and leadership education is a challenge, given the differences between physicians and administrators. Most readers will recall seeing charts similar to the one in Exhibit 1.1, showing the contrast between physicians and administrators.

While great differences exist between physician and administrators, the two opposites must find ways to work together. This can be done through a better understanding of each other—which should be a foundation block of any development program—and by ensuring an adequate conflict management mechanism is in place organizationally (one of the topics of Chapter 8).

The dedicated doctor knows that he must be both scientist and humanitarian; his most agonizing decisions lie in the field of human relations.
—*David B. Allman, inaugural presidential address to the American Medical Association, June 1957*

Exhibit 1.1: Characteristics of Physicians Versus Administrators

Physicians	Administrators
Science-oriented	Business-oriented
One-on-one interactions	Group interactions
Value autonomy	Value collaboration
Focus on patients	Focus on organization
Identify with profession	Identify with organization
Independent	Collaborative
Solo thinkers	Group thinkers

WHAT PHYSICIANS DO

Have you ever actually read the Hippocratic Oath? Here's the original—and not at all politically correct—Greek version translated into English:

> I swear by Apollo, the healer, Asclepius, Hygieia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment the following Oath and agreement:
>
> To consider dear to me, as my parents, him who taught me this art; to live in common with him and, if necessary, to share my goods with him; to look upon his children as my own brothers, to teach them this art; and that by my teaching, I will impart a knowledge of this art to my own sons, and to my teacher's sons and to disciples bound by an indenture and oath according to the medical laws, and no others.
>
> I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.
>
> I will give no deadly medicine to any one if asked, nor suggest any such counsel; and similarly I will not give a woman a pessary to cause an abortion.
>
> But I will preserve the purity of my life and my arts.
>
> I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art.
>
> In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves.

All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.

If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all humanity and in all times; but if I swerve from it or violate it, may the reverse be my life.

And here's the modern version, written in 1964 by Louis Lasagna, MD, one-time academic dean of the School of Medicine at Tufts University:

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given to me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, be respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

To what extent is this oath as relevant to new physicians today? Our challenge to our readers is to take this question on as an assigned homework project.

But what do physicians do? Consider the following discussions.

WHAT PHYSICIANS ARE LIKE

A lot has been said—maybe by you or a colleague—about how physicians relate to hospital administration. For example, "Doctors are soloists—but this too is changing." Or, "New physicians entering practice are different."

"Physicians have been trained and socialized to be fiercely independent. Practicing the art of medicine is a solo endeavor" (Wachter 2004). And yet, when considering Wachter's comment, successful physicians, even those few still in solo practice, have to get along with others, both in the community and in business situations.

Consider the following comment from John Morrissey (2010) regarding the impact of the new reform legislation: "The Patient Protection and Affordable Care Act, along with other economic forces and regulatory wrinkles, [is] driving physicians and hospital administrations into each other's arms, often for strategic reasons, but also for survival in the face of declining reimbursement. These forces will alter the ways hospitals and their physicians work with one another."

And meeting both sides' needs is possible (Lindberg and Paller 2008):

> Physicians don't want to be treated solely as customers, nor do they wish to be considered team members like the rest of the hospital staff. Physicians need to be engaged in the planning process that supports and provides opportunities for their practices. Key drivers of physician relationships with hospital administrators include: planning for the future, ability to change, responsiveness to concerns and confidence, and trust. These drivers are what build and sustain a relationship that motivates physicians to refer patients to the facility, to comply with hospital guidelines and to share in the vision of the organization.

But readers should ask themselves, "To what extent am I viewing the physician world from the eyes of physicians who are in their late 40s and older?" These physicians grew up during the era of the soloist. Yet new residents scratch their heads at this notion and often state, "I was trained to be part of a team." Even traditional baccalaureate education for nonphysicians (business and social science majors, for example) includes many group and team assignments.

New physicians entering the workforce are focusing on different issues than their predecessors did. We no longer live in the world of Marcus Welby, and only one in four physicians plans to go into primary care. And those who move into internal medicine residencies usually end up specializing. Carrying large student loan debt has significantly changed the perspective of many new physicians. The newer generation also expects a balance of personal and work life. And finally, the

personal economics of the earnings potential for various physician specialties continues to drive choices. Paul Keckley (2012b) reported that the "income disparity between primary care and specialty medicine continues to widen (per Medical Group Management Association, 2010 median compensation for primary care was $202,392 versus specialists at $356,885)."

It is the physician's pen that causes all motion in healthcare.
—*Quote from many healthcare administrators*

If you acknowledge some stern realities and some significant changes, you can see the importance of understanding the preparation of physicians in making a hospital–physician relationship (or a clinical integration organization) work.

SOME BRIEF THOUGHTS

Physicians have been pursued by hospitals and health systems to become close, and the twenty-first century opened with some experts reporting that practically two-thirds of all physicians had some type of arrangement with a hospital or health system (Zasa 2011). These arrangements range from income guarantees for recruitment to partnering on medical office buildings to joint ventures to comanagement models to outright employment by the hospital. The true solo physician is almost completely extinct. During the 1990s—when the industry predicted that reimbursement would lead to a capitated model requiring significant physician involvement in directing care—many organizations talked of creating "alignment" between physicians and hospitals or health systems. We think there has been much effort toward that but there are "miles to go before we sleep."

Many physicians continue to have connections to hospitals and health systems through medical staff committees, task forces, invitations to participate in strategic planning, and interaction with the physician relations staff. Even those physicians who practice exclusively outside of the acute care entities still interact with hospital-based specialists and often hospitalists.

A few organizations have become legendary in their synergy and connectedness with physicians. Many of these are clearly physician driven (e.g., Mayo Clinic, Cleveland Clinic), while others have begun innovative approaches to partnership (Advocate, Lehigh Valley Health Network, Heartland Health), and still others have strong alignment, cooperation, and connectedness because of specific interpersonal relationships among leaders from both sides. It is widely accepted in the field that organizations that have CEOs, COOs, and other senior executives who are open and inclusive with all physicians will have the strongest alignment. When this exists, all parties seem to sense the greater good, and the organization usually has higher quality and stronger operational and financial performance.

Finally, many partnerships spring from the relationships between physicians and the direct caregivers of a hospital or health system—the nurses, pharmacists, therapists, techs, and so forth. Team care and interdependence build strong relationships and ultimately benefit the greater partnership. This is increasingly having more impact on how physician management and leadership operate within the framework of the larger organization.

Later chapters will address the issue of collaboration more fully. Suffice it to say in this early chapter that collaboration is one key to enhanced physician leadership development.

Physician to Physician

Doctors are not a homogeneous group. In looking at how to achieve strategic management objectives, you have to be aware of the expectations for the different physician populations that are critical to the enterprise or organizational success as a whole. There is too often a tendency to say, "This guy is a doctor, so he will be overfocused on clinical and be totally impractical." But at the end of the day, that may be far from it. Those kinds of stereotypical characterizations will work against you in building effective leadership.

—Jacque Sokolov, MD

THE NEW BREED OF PHYSICIANS

Ask any physician recruiter today and you will hear details of a different group of physicians entering the workforce. As members of generations X/Y, the millennials, or whatever label is applied, these younger physicians are poles apart from their predecessors. The group's gender mix is more balanced—a little more than 50 percent of medical school graduates today are women. Younger physicians seek much more control over their work hours and personal lives; the issues of taking call and working weekends have become serious challenges for those staffing for patient care. With the advent of these needs, physicians have a greater interest in part-time schedules, job sharing, and different work patterns.

And one huge change stands out: Younger physicians want to be employed. These are not the doctors of the prior generation, who went into the private practice of medicine and essentially became small business owners. Many younger physicians come out of residencies with large student loans to repay and do not have

the financial ability to buy into an existing practice. From 2000 to 2010, hospitals' physician employment jumped 32 percent to roughly 212,000 physicians (Bush 2012). What's more, the number of hospitals employing hospitalists rose from 29.6 percent in 2003 to 59.8 percent in 2010. That means hospitals now employ almost 20 percent of all physicians (Bush 2012).

Finally, physicians are working in larger and larger groups and settings and becoming more "institutionalized." "Physicians increasingly are practicing in mid-sized, single-specialty groups of six to 50 physicians" (Liebhaber and Grossman 2007).

Primary care has become less attractive and is less connected to the inpatient hospital enterprise. The rise of hospitalists has also changed the face of medicine significantly. From 2007 to 2010, the proportion of hospitals employing intensivists grew from 20.7 percent to 29.7 percent (Bush 2012).

CONCLUSION

No two physicians are exactly alike; that is just as true of them as it is of nonphysician healthcare administrators. Still, physicians do share many traits: their education is long, arduous, and focused on getting something done with a minimum of interference or outside input; they expect to control their professional destiny; and they recognize that they play a part in an increasingly complex healthcare system. Those key similarities are what healthcare administrators must be familiar with to maximize the value that physicians bring to the clinical integration table.

This chapter opens our discourse on physician leadership. Our purpose is to ask readers to take some time to ponder physicians and their nature. Physicians vary greatly in terms of practice, interests, and areas of focus. But to work best with them requires some fundamental understanding. Moreover, to presume to educate them in leadership demands an even greater understanding of their distinctiveness and hallmarks. Those charged with enhancing physician leadership must have a core understanding of physicians and the changes occurring in the physician population.

Thoughts for Consideration

Have you ever had a discussion with a physician about her educational background and professional history?

Do your institution's policies acknowledge the special place that physicians have in the healthcare community?

What do the specifics in the Hippocratic Oath tell you about physicians' perspective on hospital–physician relationships?

To what extent do the new and younger physicians entering the healthcare field believe in the oath?

Do you agree with the comments in "What Physicians Are Like"? Why or why not?

Is your institution prepared for the physicians of tomorrow and their evolving work–life demands?

How well do you know and understand physicians?

SUGGESTED READING

Cohn, K. H., S. L. Gill, and R. W. Schwartz. 2005. "Gaining Hospital Administrators' Attention: Ways to Improve Physician–Hospital Management Dialogue." *Surgery* 137 (2): 132–40.

Stevens, R. E., L. W. Lawrence, and D. Loudon. 1991. "The Public's Image of Doctors, Dentists and Pharmacists." *Health Marketing Quarterly* 9 (1–2): 97–105.

Note: Readers unfamiliar with the medical school and residency processes are encouraged to visit the website of the Association of American Medical Colleges (AAMC), www.aamc.org.