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Leadership in Health Care for the 21st Century: Challenges and Opportunities

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The health care industry in the US is at a crossroads. The cost of health care in the US has increased substantially with the Federal health care cost reaching $950 billion in 2011, to make it the single largest contributor to the national debt. Despite the investment, the US ranks in the lower quartile of the countries in the developed world for quality and access.[1]

Contributors to rising US health care costs include medical progress (new drugs, new tests), the comparatively high compensation paid to US providers,[2] and a care delivery system that is fragmented and disorganized.[3] Although medical progress has led to near-miraculous care for individual patients, as a system it often provides chaotic care of poor quality associated with patient and family dissatisfaction.

Thomas H. Lee, MD, Professor of Medicine at Harvard Medical School, said that health care delivery systems must develop a new kind of leadership to reduce chaos and improve outcomes.[3] In this difficult transition, health care leaders must ensure that 3 issues are understood by the work force: performance matters; "value" is not a bad word; and performance improvements require teamwork.[2]

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Currently, the business of medicine is organized around physicians rather than patients. Lee suggests that different organizational structures are needed if we are to efficiently achieve excellent outcomes.[3] For example, cardiothoracic surgeons, cardiologists, and anesthesiologists working collaboratively in the same physical space could deliver team-based care to patients with cardiovascular disease. This simple change in health care delivery requires a major organizational effort that can only be achieved with high-caliber leadership.

A leader in health care should be able to clearly articulate the rationale and the goals for change, cast a clear vision of how such change will improve patient and community care, and motivate people to engage in the needed change. John Kotter suggested that the function of a leader is to produce change.[4] Setting the direction of that change is a fundamental function of leadership. Creating a credible message is essential when setting the direction of the change.

WHERE ARE WE?

The challenges for the health system leader in the 21st century include: What have I done to improve the health of the community? How do we balance investment in the social determinants of health and more medical care? How do I develop a plan with my health system to achieve better personal and community health care?[5]

Leaders in academic medical centers are ill prepared to lead, but are in a position to influence and choose the

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new generation of leaders. The long-term implications are important because failing to adequately train new leaders may negatively impact health care for many years. Most health system leaders above 50 years of age were chosen to lead because of productivity, published research, solid clinical skills, or because they were great educators. Sadly, most of these leaders never received formal leadership training, but instead learned by observing role models who were accomplished researchers, clinicians, or educators, but were not formally trained leaders. Current courses for health care leaders are isolated and are usually taught within the limited context of medicine.

PERSPECTIVES VIEWPOINTS

- Health care leaders must ensure that 3 issues are understood by the work force: performance matters; value is key; and performance improvements require teamwork.
- The modern playing field requires changing the models by which we provide health care by putting the patient and the community at the center of the medical practice.
- Modern management of patients and institutions requires interdisciplinary teams.

Until now, leadership in health care has been based on conferred authority,[6] defined as power to perform a service. Current leaders in health care typically distinguished themselves and provide a service to the community of physicians as department chair or other leadership positions. The modern playing field requires changing the models by which we provide health care by putting the patient and the community at the center of the medical practice. Until now, physicians have "fixed" problems that are presented to them. "Fixing" requires a technical response in those cases where the problem is clear (patient has diabetes), as are the solution, implementation (the physician prescribes insulin), and locus of responsibility (the physician will prescribe and the patient will take the insulin). The coming change will require us to avoid chronic conditions and promote healthy populations.

Most challenges faced by our health care system require an adaptive response. They are complex and require study to define the challenges clearly, look for an answer, and implement a solution.[6] As suggested by Porter and Teisberg,[7] the only solution to the national health care challenge is to increase the value (quality/cost) of the care delivered. The increase in value will not be achieved from external forces, but will be accomplished by physicians changing their mode of practice.

Medical education typically produces solo practitioners; however, modern management of patients and institutions requires teams. The need for teams is due to an individual's inability to efficiently process the vast knowledge generated in the last 3 decades. Some authors suggest that to maintain knowledge, physicians must read 19 original articles in their specialty every day each year.[8] Despite this challenge, working in teams does not come easily to physicians who see themselves alone saving the world (as an example, please see the award-winning television series "House, MD", which narrates the diagnostic accomplishments of a senior, arrogant physician). Stoller[9] suggested several features of physician training that do not promote working in teams: the experience of long and hierarchical training with extended subordination (internship, residency, fellowship), evaluations based on individual performance (licensure, in-service, and board certification examinations), extrapolated leadership (extend clinical authority to other areas, such as entering first in an elevator at the hospital), and training based on "deficit thinking" (always trying to find and solve the problem).

WHERE DO WE NEED TO GO?

In the book *Leadership in Health Care*,[10] Gunderman suggests that people who have a high need to achieve may not be the best leaders. Success of an organization rests on responsibility and control at the group level, and the required wider diffusion of responsibility and control may not suit some high achievers. A better leader may be an individual with a high need for power but who thinks in terms of the group and takes responsibility for what happens in it. As a leader, it will be important to understand what really motivates the group of health care workers to increase the performance of the group and the value of what they produce (better results at lower cost).

What are some expected characteristics of the new leader in health care? Similar to other industries, a leader should be honest, forward-looking, inspirational, and competent.[11] Being honest in this context means telling the truth and having ethical principles and clear standards by which the leader lives. Being forward-looking means having a sense of direction and a concern for the future of the organization and community. To be inspiring means to share the genuine enthusiasm, excitement, and energy the leader has about the future. Being competent refers to the track record and ability to get things done. We need resonant leaders who are able to listen to their inner selves with high clarity of personal values and high clarity of the values of the organization.[12]

Three senior leaders in our organization suggested that the new breed of leaders in health care should be people who are ready to serve with a high state of

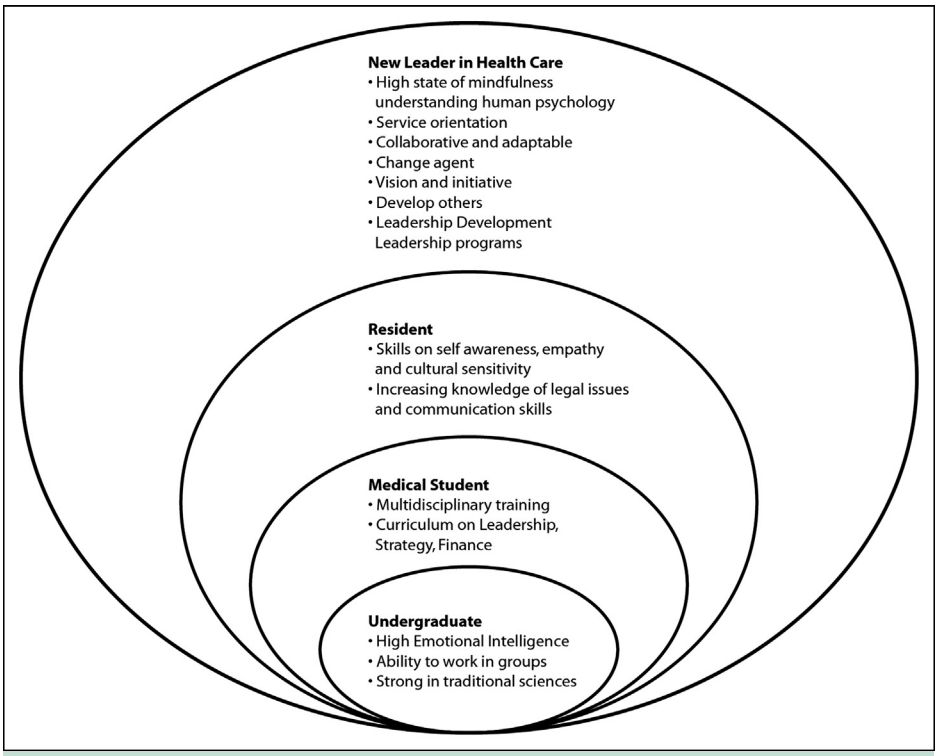

Figure Desired characteristics of the future health care leader at different stages in development.

mindfulness. Being mindful to others may reduce distortion and more accurately interpret thoughts and perspectives.[12] Leaders in the 21st century should be aware of their emotional state and be emotionally mature and self-motivated.[11] Self-motivation is something that current leaders already have, but few have cultivated the other 2 characteristics to make a sophisticated and emotionally intelligent leader.

Last, emotional empathy is absolutely important. The effective 21st century leader will not only be bright and able to generate wonderful ideas, but also will be able to go 3 levels down and broadly understand what the person at the third level is doing. Additionally, this new breed of health system leader will know the barriers faced by that third-level employee and try to remove barriers to achieve organizational progress. The leader must connect with the third-level person who has to feel empathy coming from the leader. This third-level employee also must understand that the leader wants to develop healthy patients and communities, as well as the essential role the employee plays in achieving this goal. Stoller suggested that several characteristics of emotional intelligence seem especially important for effective leadership: having a service orientation, being collaborative and adaptable, being a change agent, having vision and initiative, and developing others.[13]

To bridge the gap of formal training for future leaders in our institution, we created the Scott and White Executive Educational Program (SWEEP) 6 years ago. Other health care organizations, including the Mayo Clinic, University of Kentucky, Medical College of Wisconsin, and Cleveland Clinic, also have leadership programs.[13] SWEEP's main goal is to provide basic principles of leadership to members of the staff. The program was implemented by the then-chair of the board of directors (the governing body of the medical staff), Paul Dieckert, MD, MBA, and the chief executive officer of Scott and White Health Care, Alfred Knight, MD. They partnered to create SWEEP with Courtland Huber, PhD, former Director of the Executive MBA program of the University of Texas in Austin. SWEEP's curriculum includes fundamental concepts on marketing, strategy, and culture of the institution, finance, and leadership. Its faculty include former faculty from the MBA program at the University of Texas and leaders of Scott & White Healthcare. The practicum includes projects that are chosen by Scott and White. Initially, the program accepted only physicians with high leadership potential. Currently in its 7th iteration, the program included registered nurses and other health care professionals during the last 4 cycles; last year, physicians from other health care delivery organizations also were accepted. With the group graduating this year, we will have provided 150 physicians, nurses, and other health care professionals the tools that will benefit patients, society, and institutions.

Local efforts are important because they will help local institutions secure a continuous supply of able, well-prepared leaders. However, to fundamentally change the way new physicians think, leadership training should start in medical school or earlier (**Figure**). To start, classes should include other members of the health care team to emphasize the value of team effort and move physicians away from the idea of functioning as a solo practitioner to functioning as a member of the health care team. Team members should include students from nursing schools, advanced care practitioners, nutritionists, social workers, dentists, and pharmacy and health care administration. The curriculum should include courses on leadership, strategy, and finance.[14,15] As it will be difficult to teach this content during medical school or residency training, a "horizontal" program is needed to teach basic skills such as emotional intelligence (self-awareness, empathy, cultural sensitivity), how to master humble confidence, and teamwork skills.[14] These skills may be followed through residency with additional training in legal issues and communication skills.[14] More in-depth training will be needed for a dedicated group interested in following an administrative/leadership track.[16] Participation in organized programs such as the Cleveland Clinic Academy[13] or SWEEP will be essential to continuing the education of leaders in health care.

The idea of multidisciplinary training of future leaders cannot be overemphasized. We believe that if these leaders have multidisciplinary education, it will facilitate communication in the future. If we start early with shared education, difficult communications between these groups will disappear.[17] Additionally, material related to reducing waste in health care (such as Lean Leadership) will be important. This approach will transform the work place, putting the front-line workers on top of an inverted pyramid, with the rest of the stakeholders supporting the personnel who are taking care of patients.

Furthermore, we believe selection for admission to medical school should change. Metrics to measure emotional intelligence, and ability to work in groups, in addition to the traditional sciences, should be utilized. Although medical schools are starting to pay attention to emotional intelligence, systematic applications of these metrics are still not common.

In summary, the need to train and implement a rigorous curriculum teaching leadership skills is crucial if we want to create and sustain the major changes in health care that will be needed in the next decade. Health care leadership must include physicians who organize their colleagues into highly functional teams. The new leadership will hold the health care workers accountable for the health of patients and communities. To create a harmonious environment, the dysfunctional individualistic culture prevailing in health care must disappear.

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