PLJ

PHYSICIAN LEADERSHIP JOURNAL

September/October 2022 | Volume 9 | Issue 5

www.physicianleaders.org

- GEARING UP FOR DIGITAL TRANSFORMATION
- PHYSICIANS AND ADVANCE MEDICAL DIRECTIVES
- THE ART OF THE APOLOGY
- SELF-TALK — THE VOICE IN YOUR HEAD
- MAKING THE BUSINESS CASE FOR QUALITY
- THE ROLE OF A BALANCED SCORECARD IN STRATEGIC MANAGEMENT
- RECOGNIZING AND MANAGING A TOXIC LEADER
- EQ, SPECIALTY PREFERENCE, AND BURNOUT AMONG PHYSICIANS-IN-TRAINING
- ARCHETYPES OF BURNED-OUT PHYSICIANS AND STRATEGIES TO HELP THEM
- TRANSITIONS AND TRANSFORMATIONS — OUR CHOICE?
- STUDYING PHYSICIAN LEADERSHIP: THEORETICAL UNDERPINNINGS

American Association for PHYSICIAN LEADERSHIP

Inspiring Change. **Together.**

Learn, Connect, and Advance *at this year's*

FALL INSTITUTE

Scottsdale, AZ | Oct 27-30

An Unparalleled Gathering for Physician Leaders.

At the **2022 Fall Institute** we are once again bringing back our top faculty, CME courses, and in-person peer networking —all against the backdrop of sunny Scottsdale.

The Fall Institute brings together industry-leading faculty, inspirational breakout sessions, workshops, mission-driven initiatives, and more.

MEET YOUR COLLEAGUES

Networking is one of the most valuable takeaways of in-person events. Join us and meet colleagues who share your drive and ambitions for true Physician Leadership.

Save 15% or more with an AAPL Membership

Industry-Best Leadership Education

At Fall Institute the breadth of courses and renowned faculty create high-impact learning opportunities for every phase of a physician's career.

> **The quality of education from AAPL is second to none in preparing physicians to lead the future of healthcare.**

Michael A. Torres, MD, MBA, CPE, CHCQM, FAAPL

A FULLY-CUSTOMIZABLE LEARNING EXPERIENCE

This is not your one-size-fits-all conference. That's why we're enabling you to create a fully customizable learning experience where you select only the courses you're interested in, while still having access to event networking, amenities and happenings.

Join Us and Improve Healthcare and Yourself

PLJ
PHYSICIAN LEADERSHIP JOURNAL

PRESIDENT and CEO
Peter B. Angood, MD, FRCS(C), FACS, MCCM, FAAPL(Hon)

EDITOR-IN-CHIEF
Anthony D. Slonim, MD, DrPH, CPE, FAAPL

American Association for PHYSICIAN LEADERSHIP
Inspiring Change. **Together.**

CHIEF FINANCIAL OFFICER
Michelle Martin

CHIEF INFORMATION OFFICER
Brian Fending

SENIOR VP, CONTENT DEVELOPMENT & ACQUISITION
Nancy Collins

CHIEF OPERATING OFFICER
G. Anthony Talbot

BOARD OF DIRECTORS

CHAIR Stephanie Duggan, MD, CPE, FACEP, FAAPL
VICE CHAIR Bruce Levy, MD, CPE, FAAPL
PAST CHAIR Ash R. Gokli, MD, CPE, FACEP, FAAPL
Zulma M. Berríos, MD, MBA, CPE, FAAPL
Randall Bickle, DO, JD, CPE, FAAPL
Michael R. Canady, MD, MBA, CPE, FACS, FAAPL, FACHE
Jimmy Y. Chung, MD, MBA, FACS, FABQAURP, CMRP
Colleen F. Inouye, MD, MS-PopH, MMM, FACOG, CPE, FAAPL
Julie T. Joseph, MD, MPH, MBA, CPE, FAAPL
Saju Joy, MD, MBA, MS, CPE
Teresa Malcolm, MD, FACOG, MBA, CPE, CPXP, ACC
Anne VanGarsse, MD, CPE, FAAP, CHCEF, FAAPL

AMERICAN ASSOCIATION FOR PHYSICIAN LEADERSHIP

Mail Processing Address
PO Box 96503 I BMB 97493
Washington, DC 20090-6503

Payment Remittance Address
PO Box 745725
Atlanta, GA 30374-5725

www.physicianleaders.org
TOLL-FREE 800-562-8088
INTERNATIONAL 813-287-2000
FAX 813-287-8993
EMAIL info@physicianleaders.org

MEMBERSHIP

Membership is open to licensed physicians (MDs and DOs) in the United States, Canada and Mexico, and licensed physicians abroad holding an equivalent Standard Certificate certification. Other criteria may apply.

membership@physicianleaders.org

EDUCATION

The association is an accredited provider of continuing medical education (CME) through live and online programs. It also offers advanced degrees and certifications, including Certified Physician Executive (CPE) designation.

info@physicianleaders.org

CAREERS

Physician leaders can navigate their careers with the association's extensive support services, including capability assessments, résumé assistance, skill-building plans and customized coaching.

careers@physicianleaders.org

THOUGHT LEADERSHIP

The *Physician Leadership Journal* welcomes articles about leadership topics related to medicine and health care. We seek articles that spotlight original research, operational interventions and findings, and discussions that orient readers to important topics in physician leadership. We also welcome commentary and points of view related to physician leadership.

All manuscripts are subject to peer review by our editorial board. To request guidelines for submissions or to submit a manuscript, email:

editor@physicianleaders.org

MORE ONLINE

The Physician Leadership News is an essential resource of practical information and news you can use. Visit **physicianleaders.org/News** for updates. Follow us on **LinkedIn** (linkedin.com/company/physicianslead), **Twitter** (@PhysiciansLead) and **Facebook** (PhysiciansLead) for ongoing conversations and other useful information.

Physician Leadership Journal (ISSN: 2689-274X) Published bimonthly for members of the American Association for Physician Leadership®. Any reproduction without permission is prohibited by law. Annual subscription rate is $100 ($120 outside the U.S.). Copyright ©2022 by the American Association for Physician Leadership®, 400 North Ashley Drive., Suite 400, Tampa, Florida 33602, (813)287-2000. Physician Leadership is indexed in the American Hospital Association's Hospital and Health Administration Index.

Accreditation: The American Association for Physician Leadership® is accredited by the Accreditation Council for Continuing Medical Education to provide continuing education for physicians.


American Association for
PHYSICIAN
LEADERSHIP
Make meaningful connections.
Whether you're looking for solutions to your toughest on-the-job challenges, the contact that can help you advance your career, or a lifelong connection to like-minded colleagues, you'll find it at AAPL.
APP.PHYSICIANLEADERS.ORG/COMMUNITY

CONTENTS

September/October ■ Volume 9, Issue 5

FEATURES

Gearing Up for Digital Transformation
By Lola Butcher 41
The use of digital tools to improve the quality of care delivery is a top priority for health systems. Are you ready?

The Role of Physicians in Endorsing Advance Medical Directives
By Timothy E. Paterick, MD, JD 44
Physicians have a fiduciary duty to educate patients regarding all options available for end-of-life medical care.

COLUMNS

FROM THE CEO
Transitions and Transformations — Our Choice?
By Peter B. Angood, MD, FRCS(C), FACS, MCCM, FAAPL(Hon) 6
As leaders, physicians must continue to lead through and manage the transitions and transformations required to improve the complex healthcare industry.

FROM THE EDITOR-IN-CHIEF
Studying Physician Leadership: Theoretical Underpinnings
By Anthony Slonim, MD, DrPH, CPE, FAAPL 14
Highlighting theoretical underpinnings of leadership will encourage and stimulate our collective thoughts on how they may promote leadership study in our profession.

ARTICLES

The Art of the Apology
By Neil Baum, MD, and Alvin Merlin, MD, MBA, CPE 58
When physicians are comfortable saying "I'm sorry" easily and with sincerity, perhaps they can expect increased job satisfaction and lower malpractice premiums.

THE COACH'S CORNER: The Voice in Your Head
By Robert F. Hicks, PhD 60
Coaching requires us to keep a laser focus on the person we are helping, but that's not always easy when distractions — both external and internal — continually bombard us.

Making the Business Case for Quality: Linking Quality and Cost
By Richard Priore, ScD, MHA, FACHE, and Brad Beauvais, PhD, MBA, FACHE 62
This third installment of the four-part series examines the benefits of linking quality and cost by creating an integrated performance measurement scorecard and evaluating potential sources of financial data.

DEPARTMENTS

FIVE QUESTIONS 46
YOUR CAREER. 48
COFFEE BREAK COURSE 54
DEEPER DIVE. 56
NEWS. 66
LAST LOOK 75

CONTENTS

September/October 2022 ■ Volume 9, Issue 5

THE PEER-REVIEWED PLJ

INNOVATION

Lessons Learned: Evaluating the Role of a Balanced Scorecard in the Strategic Management of a Translational Science Research Institution

By Verónica Hoyo, PhD, and Daniel L. Bouland, MD, MS, FACP **16**

The balanced scorecard is a valuable strategic management roadmap for optimal performance that organizations may adapt to various environments through thoughtful design and execution.

LEADERSHIP

Recognizing and Managing a Toxic Leader: A Case Study

By Bhagwan Satiani MD, MBA, FACHE(R), FACS, and Anand Satiani MD, MBA **23**

Lack of effective leadership development, dysfunctional teams, loss of productivity, and low morale because of toxic leadership lead to a high burnout rate and turnover.

CAREERS

The Relationship Among Emotional Intelligence, Specialty Preference, and Burnout Among Physicians-in-Training

By Eiman Khesroh, MBBS, DrPH; Melissa Butt, DrPH; Annahieta Kalantari, DO, FACEP, FACOEP; Yendelela L. Cuffee, MPH, PhD; Douglas L. Leslie, PhD; Sarah Bronson, PhD; Betsy Aumiller, DEd; and Andrea Rigby, PsyD **28**

A survey was used to evaluate the impact of EQ on burnout levels among physicians-in-training who changed their specialty compared to those who remained in their original specialty.

LEADERSHIP

Archetypes of Burned-Out Physicians and How To Help Them

By R. John Sawyer II, PhD, ABPP-CN, and Ashton Sloan, PA-C, MSHA **36**

Lessons from an internal physician coaching program — informed by ongoing research into physician personality factors — suggest that four core personality typologies affect burnout in the current healthcare environment.

Physician Leadership Journal is dedicated to being the voice of physician leadership. Each issue includes a section of peer-submitted articles that focus on medical leadership and healthcare delivery. These articles have passed the critical appraisal of our editorial board of Certified Physician Executives from around the world. Articles in this section spotlight original research, operational interventions and findings, and discussions that orient readers to key topics in healthcare and physician leadership. *PLJ* is your source for insights, ideas, and conversations relevant to healthcare professionals.

Transitions and Transformations — Our Choice?

Peter B. Angood, MD, FRCS(C), FACS, MCCM, FAAPL(Hon)

All physicians are leaders at some level, and as such, all must continue to lead through and manage the transitions and transformations required to improve the complex healthcare industry. But this can come at a costly price unless they simultaneously embark on personal transitions and transformation as well.

> *"We cannot become what we need to be by remaining who or what we are."*
>
> — Max De Pree

Our lives are a series of transitions, coupled with the occasional significant transformation. Successfully identified, embraced, and effectively managed, our lives may become rich and fulfilling. If not managed fruitfully, our lives may take a course toward frustration and disenchantment. Managing our expectations for success is pivotal in how we approach opportunities.

The healthcare industry is also a series of transitions coupled with occasional significant transformations. Each of us in healthcare has navigated a host of transitions in our attempts to keep pace with market forces; some of us have undergone significant personal and professional transformations in the process. To quote leadership guru Forrest Gump, "Life is like a box of chocolates. You never know what you are going to get."

As physicians, we have been able to craft or navigate the necessary large-scale transformation in healthcare by using the platform of physician leadership. Physician leadership has been linked to more profitable, higher-quality healthcare delivery at the organizational level, as well as better patient outcomes, increased provider satisfaction, decreased physician burnout, and improved performance of basic clinical skills.

As the pandemic has unmasked numerous vulnerabilities in the industry, from my perspective, the pipeline for physician leadership has never been more important. Newer and younger generations' approaches to physician leadership are sorely needed.

TOTAL EXPERIENCE MANAGEMENT

It takes time to create a significant transformation. Just before the pandemic's onset, AAPL began to embrace a total experience management approach with its focus on the AAPL community of members and customers, while also diversifying the variety of the association's programs, products, and services offered.

Total experience management is a relatively new business strategy that aims to create a better, holistic experience for *everyone* who engages with a brand program or business offering (customers, employees, users, partners, etc.), fusing the voice of customers and employees with the ability to deliver extraordinary customer, employee, product, and brand experiences. It does this by combining four key experience disciplines[1]:

1. Customer experience (CX): How a customer interacts with and feels about a brand.
2. Employee experience (EX): How an employee interacts with and feels about their company.
3. User experience (UX): How a user interacts with and feels about a product or experience, especially in the digital realm as well as face-to-face interactions.
4. Multi-experience (MX): How an experience is enhanced and delivered simultaneously across multiple devices, modalities, and touchpoints.

As part of its transformation, AAPL has shifted to being a virtual organization and now recruits the highest caliber of staff from across the country while continuing to engage with healthcare leadership development initiatives nationally and internationally. AAPL also continues to refine its technical infrastructure and the AAPL Platform so that we can optimally deliver the full spectrum of AAPL programs, products, and services in an integrated fashion.

Our AAPL community of members and customers, along with our staff, are the highest priority as we facilitate large-scale change in healthcare. Our ongoing efforts with brand messaging, marketing, and thought leadership

reflect this commitment as an organization to a total experience approach.

As we consider the potential of a total experience approach in healthcare, patient-centered/person-centered care, or PCC, is a priority as well. The challenge with PCC is that many systems and process changes are required across the clinical delivery systems and inside the various industry sectors before true PCC is possible. Transforming healthcare to PCC requires significant and sustained efforts over time. This is where the opportunity lies for physician leadership: leveraging the recognized platform of physician leadership to create the change needed.

Surprisingly, transformation requires only three things: recognizing what the current situation is, knowing what is needed or desired, and having the determination required to make the change. The challenge for healthcare is that we have only two of those three elements: we know who we are, and we seem to have the resolve required for real change.

What we don't yet know, or have not adequately defined, is what healthcare should become during its next major transformation. We can, and must, do better on this latter point.

TRANSFORMATIONAL LEADERSHIP

Transformational leadership is defined as a leadership approach that causes change in individuals and social systems. In its ideal form, it creates valuable and positive change in the followers with the end goal of developing followers into leaders.[2]

Physicians are naturals for developing transformational leadership approaches within a variety of healthcare systems and processes.

Yukl suggests several important aspects of successful transformational leadership[3]:

1. Develop a challenging and attractive vision with employees.
2. Tie the vision to a strategy for its achievement.
3. Develop the vision, specify, and translate it to actions.
4. Express confidence, decisiveness, and optimism about the vision and its implementation.
5. Realize the vision through small, planned steps and small successes in the path toward its full implementation.

In their book *Words Can Change Your Brain*, Andrew Newberg, a neuroscientist at Thomas Jefferson University, and Mark Waldman, a communications expert, state, "A single word has the power to influence the expression of genes that regulate physical and emotional stress." Over time, given sustained positive thought, functions in the parietal lobe start to change, which changes our perception of ourselves and those around us.

Essentially, holding a positive view of ourselves helps train our brain to see the good in others. Thus, by exercising *consistent, positive thoughts and speech*, we change our self-perception and how we perceive the world around us. Ultimately, this grants us the ability the shape our reality and change the world for the better.

Aaron Barnes, CEO of BRM Institute, provides examples of this reshaping of reality by using different types of words (www.brm.institute):

- *Capability* instead of Process
- *Convergence* instead of Alignment
- *Shared Ownership* instead of Accountability
- *Demand Shaping* instead of Demand Management
- *Business Capabilities* instead of Services

Simply changing the words we use to express ideas creates a culture that doesn't single out or place blame on anyone within an organization. Rather, it *promotes transparency*, *elevates communications*, and *appreciates individual value*. In the end, shared positive language promotes effective communication and collaboration, breeding innovation, success, and organizational value.

EMBRACE THE REALITY

The medical profession is viewed as a leadership profession not only by our industry, but also by general society. Consequently, the opportunity always is available to exhibit some version of transformational leadership in our practices, in our communities, in our organizations, in our volunteer activities…essentially in all aspects of our lives. We can, therefore, use this distinct privilege by speaking about healthcare in a positive way and by focusing on positive transformation rather than on negative market force transitions.

And so, as physician leaders, we must embrace the complexities of our industry. We must embrace the reality we chose when transitioning to this profession. And we can choose to embrace the opportunities in which our individual and collective energies create the transformation needed for our industry as we continue to emerge from the pandemic.

Remember, leading and helping create significant change is our overall intent as physicians. AAPL focuses on maximizing the potential of physician-led, interprofessional leadership to help create personal and organizational transformation that benefits patient outcomes, improves workforce wellness, and refines the delivery of healthcare internationally.

We must all continue to seek deeper levels of professional and personal development and to recognize ways we can each generate constructive influence for one another at all levels. As physician leaders, let us become more engaged, stay engaged, and help others to become

engaged. Exploring and creating the opportunities for broader levels of positive transformation in healthcare is within our reach — individually and collectively.

REFERENCES

1. Zande JV. What Is Customer Experience? CX Defined. The Future of Customer Engagement and Experience. www.the-future-of-commerce.com/2019/06/13/what-is-customer-experience.
2. Transformational Leadership. www.langston.edu/sites/default/files/basic-content-files/TransformationalLeadership.pdf.
3. Yukl G. An Evaluation of Conceptual Weaknesses in Transformational and Charismatic Leadership Theories. *The Leadership Quarterly*. 1999;10(2):285–305.

DOI: https://doi.org/10.55834/plj.8225470856
Copyright © 2022 by American Association for Physician Leadership®

Peter B. Angood, MD, FRCS(C), FACS, MCCM, FAAPL(Hon) is president and CEO of the American Association for Physician Leadership.

Inspiring Change. **Together.**

HEALTHCARE PROFESSIONALS

treated fairly

With the recent acquisition of NORCAL Group, ProAssurance is now the nation's third largest medical professional insurance carrier with claims and risk management expertise in every major healthcare region.

Meet the new best-in-class, where the principle of fair treatment guides every action we take in defense of our medical professionals.

ProAssurance
NORCAL GROUP

Healthcare Professional Liability Insurance & Risk Management Services

For information regarding the NORCAL Group acquisition ››› **ProAssurance.com**

THE PEER-REVIEWED PLJ

Original research ■ Interventions and findings ■ Topics for discussion

Editor-in-Chief

Anthony Slonim, MD, DrPH, CPE, FAAPL

Physician leaders play an important role in the future of health care. They've seen a lot. They've done a lot. And they have a lot of knowledge to share. That's why we invite physician leaders to share their experiences with colleagues around the world.

In addition to thought-provoking content, informative journalism, practical news and commentary that keeps professionals in the know, the *Physician Leadership Journal* also offers opportunities for physician leaders to demonstrate their knowledge and have their voices heard by others throughout the industry.

We welcome articles about leadership topics in medicine and health care. We invite submissions that spotlight original research, operational interventions and findings, and discussions that orient readers to important topics. Being published in the *PLJ* is a great way to demonstrate your professional expertise and have your voice heard by other physician leaders.

We seek original articles that advance the scope and practice of physician leadership. Articles must address one of the following competencies to qualify for peer review and potential publication:

Careers: The journey of a physician leader throughout his or her clinical and/or executive maturation.

Communication: Strategies to convey meaning from one entity or group to another.

Finance: Dealing with the operational aspect of budgeting and planning as a physician leader.

Health Care Organizations: The organizational role of the physician leader within health care systems.

Health Care Professionals: The role of the physician leader within clinical practice.

Health Law and Policy: Current or past policy issues or topics influencing physician leadership.

Innovation: The use of novel and creative methods to enhance the role or capabilities of leaders.

Leadership: Tactics to develop and/or enrich a leader's ability to guide individuals and teams.

Management: Pertaining to the administration of any organization as a physician leader.

Patient Care and Quality: The scientific improvement of quality and patient safety for physician leaders.

Technology: Tools and technologies influencing leadership.

Learn more about how you can make a difference as a physician leader. Review our Instructions for Authors and contact us at editor@physicianleaders.org with any questions.

We look forward to receiving your submission.

THE PEER-REVIEWED PLJ

Original research ■ Interventions and findings ■ Topics for discussion

INSTRUCTIONS FOR AUTHORS

The *Physician Leadership Journal* welcomes articles about health care leadership topics. Articles spotlight original research, operational interventions and findings, and discussions that orient readers to important topics. We seek original articles that advance the scope and practice of leadership. Articles may not be under consideration for publication elsewhere, nor published previously.

ARTICLE TOPICS: Articles must address one of these 11 competencies to qualify for peer review:

- **Careers:** The journey of a physician leader throughout his or her clinical and/or executive maturation.
- **Communication:** Strategies to convey meaning from one entity or group to another.
- **Finance:** Dealing with the operational aspect of budgeting and planning as a physician leader.
- **Health Care Organizations:** The organizational role of the physician leader within health care systems.
- **Health Care Professionals:** The role of the physician leader within clinical practice.
- **Health Law and Policy:** Current or past policy issues or topics influencing physician leadership.
- **Innovation:** The use of novel and creative methods to enhance the role or capabilities of leaders.
- **Leadership:** Tactics to develop and/or enrich a leader's ability to guide individuals and teams.
- **Management:** Pertaining to the administration of any organization as a physician leader.
- **Patient Care and Quality:** The scientific improvement of quality and patient safety for physician leaders.
- **Technology:** Tools and technologies influencing leadership.

MANUSCRIPT SUBMISSION: Articles must be submitted via email to editor@physicianleaders.org. Be sure to indicate which competency your manuscript addresses, and the submission type of your manuscript.

The file (Word document) should include a cover page with the suggested title of the article, the names of the authors in the order they are to appear, the authors' degrees and professional affiliations, and complete contact information for all authors.

All text, references, figures and tables should be in one double-spaced document (1-inch margins, 12-point type). Use subheads to organize the article and break up large amounts of text. References, figures and tables should be at the end of the document.

ABSTRACTS: Please provide an abstract — a summary — of no more than 250 words for the submission.

PERMISSION: Obtain written permission from the copyright holder (usually the publisher) to reproduce previously published material. All letters of permission must accompany the manuscript upon submission.

TABLES: Tables should be numbered and titled, cited in numerical order in the manuscript. Spell out any abbreviations used in the table's footnote section. Tables must be included as editable components of the manuscript file, placed at the end of the manuscript.

FIGURES: All figures (charts, graphs, screenshots, etc.) must be numbered and have legends. All figures cited must be in numerical order in the manuscript. Figures should be editable (in native file format) when possible.

SUBMISSION TYPES: All submissions must be structured using one of three formats.

1. **Research articles:** Manuscript submissions that include a controlled experimental investigation and provide statistical support for research findings. These should include:
   - A clear description and literature support of problem
   - A clear description of experimental methodology
     - Participant count and setting
     - Research design
     - Intervention
     - Dependent variables
     - Measurement tools
     - Procedures
     - Statistical analysis
   - A clear description of results
   - A clear description of the implications
   - A limit of 15 double-spaced pages (not including title page and references)
2. **Field reports:** These manuscript submissions provide an outlet for authors to highlight the value of operational interventions and findings that do not satisfy the needs for a full-length research article. These should include:
   - A brief description of problem and operational significance
   - A review of the operational process that led to development of an intervention
   - A brief description of intervention/solution used
   - A concise description of results
   - A concise description for next steps
   - A concise description of operational implications
   - A limit of 10 double-spaced pages (not including title page and references)
3. **Discussion articles:** Manuscript submissions that provide reader orientation to an important topic affecting the health care and/or leadership climate. They should include:
   - A review of the relevant literature to set context for the discussion
   - A concise discussion about future research direction
   - A limit of 15 double-spaced pages (not including title page and references)

REFERENCES: References in text must be cited numerically, in order as cited in the manuscript. The reference list must appear at the end of the text. Do not use automatic footnote or endnote programs or embedded footnotes. Use exponent font instead. References should follow AMA style. For example:

- **Journal article:** Silber JH, Bellini LM, Shea, JA, *et al*. Patient Safety Outcomes Under Flexible and Standard Resident Duty-Hour Rules. *N Engl J Med*. 2019; 380:905-914.
- **Book:** Dahl, OJ. *The High-Performing Medical Practice: Workflow, Practice Finances, and Patient-Centric Care*. Phoenix, MD: Greenbranch Publishing; 2019: 25-30
- **Newspaper article:** Armour S. Health-care spending Projected to accelerate as population ages. *Wall Street Journal*. Feb. 20, 2019.
- **Website:** A good meeting needs a clear decision-making process. *Harvard Business Review*; https://hbr.org/2019/03/a-good-meeting-needs-a-clear-decision-making-process. Accessed March 11, 2019.

FUNDING: If research was funded by a granting agency, include the information on a separate page of your file.

QUESTIONS: Send questions about submissions to editor@physicianleaders.org.

OUR EDITORIAL BOARD

The *Physician Leadership Journal* is a peer-reviewed publication, with physician leaders commissioned to review submitted manuscripts.

Nicole L. Aaronson, MD, MBA, CPE, CHFP, FACS, FAAP
Pediatric otolaryngologist, Nemours Children's Health of Delaware
Associate clinical professor of otolaryngology and pediatrics, Thomas Jefferson University Sidney Kimmel School of Medicine
New Jersey

Patricia A. Abboud, MD, CPE
Medical director, Pediatric Intensive Care Unit, Sidra Medicine
Doha, Qatar

Mouin Abdallah, MD, MHCM, MSC, CPE, FACC, FASE, FASNC
Medical director, IQVIA
Washington DC

Bryan Neil Becker, MD, MMM, FACP, CPE
President, Acclaim Physician Group
Texas

Donald Casey, MD, MPH, MBA, FAAPL, FACP, FAHA, DFACMQ, CPE
Principal, IPO 4 Health
Adjunct faculty member, Jefferson College of Population Health
Affiliate faculty member, University of Minnesota Institute for Health Informatics
Associate professor of medicine, Rush Medical College
Illinois

Edgar G. Chedrawy, MD, MSc, FRCSC, FACS, MHA, CPE, FAAPL
Cardiac surgeon, Nova Scotia Health
Associate professor of surgery and health administration, Dalhousie University
Nova Scotia, Canada

Gregory E. Cooper, MD, PhD, CPE
Neurologist, Baptist Health Medical Group Neurology
Medical director, Baptist Memory Care Program
Community faculty, University of Kentucky College of Medicine
Regional president (East Region), Baptist Health Medical Group
Kentucky

Elaine Cox, MD, CPE, FAAP
Chief medical officer, Riley Children's Health
Professor of clinical pediatrics, Indiana University School of Medicine
Indiana

Rakhi C. Dimino, MD, MMM, CPE
Medical director of operations
OB/GYN hospitalist, Ob Hospitalist Group
Texas

Nicholas Gavin, MD, MBA, CPE, MS
Associate professor, Icahn School of Medicine
New York

Amit K. Ghosh, MD, MBA, CPE, FACP, FASN, FAAPL, FRCP(Edin)
Professor of medicine, Division of General Internal Medicine, Mayo Clinic
Minnesota

Elder Granger, MD, FACP, FACHE, FAAPL, Major General, U.S. Army (retired)
President/CEO THE 5Ps, LLC
Colorado

Amin Hakim, MD, CPE, FIDSA, FACPE
Vice president, clinical operations
UnitedHealthcare
New York

Amy L. Harrington, MD, CPE, FAPA
Assistant professor, University of Massachusetts Medical School/ UMass Memorial Health
Massachusetts

Thomas Higgins, MD, MBA, CPE, FACP, MCCM, FAAPL
Chief medical officer, Center for Case Management
Massachusetts

Girish Bobby Kapur, MD, MPH, CPE, FAAEM
President, Allegheny Health Network Emergency Medicine Management
Pennsylvania

Suzanne Kaseta, MD, MMM, CPE, FAAP, FACHE, FAAPL
Chief medical officer, Boston Children's Health Physicians
Massachusetts

Ralph A. Korpman, MD, CPE, FACPE
Professor and director of laboratories, Loma Linda University School of Medicine
California

Ponon Dileep Kumar, MD, FACP, CPE
Attending physician and hospitalist, Department of Medicine, Port Huron Hospital, Mercy Hospital, and River District Hospitals
President, East Michigan Hospitalists PLLC
Michigan

Arthur Lazarus, MD, MBA, CPE, FAAPL
Adjunct professor of psychiatry, Temple University – Lewis Katz School of Medicine
North Carolina

David F. Lewis, MD, MBA, CPE
Dean, School of Medicine, LSU Health Shreveport
Louisiana

Nandini Nair, MD, PhD, CPE, MHL, FACC, FSVM, FACP, FAHA, FHFSA
Professor of medicine, TTUHSC
Texas

Zeev E. Neuwirth, MD
Clinical chief of care transformation and strategic services, Atrium Health
North Carolina

Dilip R. Patel, MD, MBA, MPH, FAAP, CPE, CPHQ, FAACPDM, FACSM
Professor and chair, Department of Pediatric and Adolescent Medicine
Western Michigan University Homer Stryker MD School of Medicine
Michigan

Mobeen H. Rathore, MD, CPE, FACPE
Director, University of Florida Center for HIV/AIDS Research, Education and Service (UF CARES)
Florida

Amjad Riar, MD, FACP, FAAHPM, HMD-C, CPE, FAAPL
Chief operating officer and senior consulting medical officer (SCMO), Baltimore Medical System Inc.
Maryland

Amyn M. Rojiani, MD, PhD, CPE, FAAPL
University chair in pathology, Penn State College of Medicine
Pennsylvania

OUR EDITORIAL BOARD

The *Physician Leadership Journal* is a peer-reviewed publication, with physician leaders commissioned to review submitted manuscripts.

Marshall Ruffin, MD, CPE, FAAPL
Founder and CEO, Ruffin Health, LLC
Virginia

Richard H. Savel, MD, MBA, CPE, FCCM
Director, adult critical care services, Norman Regional Health System
Oklahoma

Gurmukh Singh, MD, PhD, MBA, FCAP, CPE, FAAPL
Walter L. Shepeard chair in clinical pathology, vice chair in clinical affairs – pathology, Medical College of Georgia at Augusta University
Georgia

Krista Skorupa, MD, CPE
Division chair for regional practices, Essentia Health
Minnesota

Jon Thomas, MD, MBA, CPE
Managing partner, Ear, Nose and Throat SpecialtyCare
Former chair, National Federation of State Medical Boards
Minnesota

Albert Tzeel, MD, MHSA, CPE, FAAPL
Regional vice president for health services – senior products, Humana
Florida

Jamie Wooldridge, MD, CPE
Professor of pediatric pulmonary, University of Rochester Medical Center
New York

Michael J. Zema, MD, FACP, FACC, FCP, CPE, CSSGB
Physician, consultant, speaker
Tennessee

American Association for PHYSICIAN LEADERSHIP

Be at the forefront of influential change.

Earn your Certified Physician Executive **(CPE)** credential with us.

PHYSICIANLEADERS.ORG/CPE

Studying Physician Leadership: Theoretical Underpinnings

Anthony Slonim, MD, DrPH, CPE, FAAPL

At *Physician Leadership Journal,* we aim to publish some of the most progressive bodies of work that inform our evolving profession and provide evidence of the unique contributions that physician leaders bring to patients and populations.

While physician leaders have been influencing healthcare for decades, empirical data supporting their unique contributions are still lagging. Fortunately, a large body of leadership knowledge has been created outside the physician realm. The theoretical underpinnings of this body of knowledge can also be applied to study physician leadership as our profession advances.

Highlighting a few of these theoretical underpinnings will, I hope, encourage and stimulate our collective thoughts on how they may promote leadership study in our profession.

RELEVANT LEADERSHIP THEORIES

During the past century, leadership has been extensively studied across industries. While there are many definitions of leadership, Gardner defined leadership as "the process of persuasion or example by which an individual or team induces a group to pursue objectives held by the leader or shared by the leader and his or her followers" (Gardner, 1990).

Each leader has their own unique approach to work, grounded in family, lifestyle, socioeconomic status, education, and experiences, personal and professional. Many of the personal characteristics cited as essential for successful leadership are rooted in the individual's development from early childhood through adolescence and adulthood (Fitzimmons and Callan, 2016) and depend on the socio-environmental contexts in which they were raised (Brofenbrenner, 2009).

According to Gardner (1990), characteristics like decisiveness, people skills, and courage differentiate leaders; however, a host of additional traits and characteristics that also may be relevant to leadership success often are not highlighted. Further, inherent characteristics drive leadership behaviors that ultimately result in attaining leadership positions like medical director, chief medical officer, or chief executive officer.

Physicians and non-physicians alike may share leadership traits and behaviors, so the presence or absence of these attributes cannot alone explain the imbalance of physicians and non-physicians in leadership positions. Hence, there must be other important characteristics innate to physicians' experiences that distinguish them as effective leaders.

Two theoretical examples provided here represent foundations with which to further study this notion of physician leadership.

ROLE THEORY

Role theory has its origins in the last century and suggests that individuals are prescribed specific roles based on societal beliefs. These roles govern their behaviors and attitudes during their leadership development (Van der Horst, 2016). Over time, this theory, particularly as it relates to physician leaders, has become less structural than interactional, recognizing that people often integrate multiple roles, physician *and* leader, and can adapt these combined roles as they interact with others.

As physicians evolve as leaders, role theory provides an important theoretical backdrop because it suggests that certain attitudes and behaviors that we develop as we mature in our medical profession may also be important for leadership. From a contemporary perspective, while role-based biases may still exist at the societal level, how we educate and train physician leaders in a more interactional way may be relevant to enhancing a leader's outcomes, which are the benchmarks for evaluation and success.

Role theory proposes that expectations are associated with the role as a physician and those expectations correspond to stereotypes that are important to consider,

particularly as physicians take on additional leadership roles beyond healthcare.

For example, the 117th Congress includes 4 physicians in the Senate, 14 physicians in the House, plus 5 dentists, a number which far exceeds the two physicians who served in the 101st Congress in 1990. When physicians take on roles that are considered nontraditional for their profession, such as politician, they must break through the social stereotypes. This is often a double-edged sword, however. When physicians in political leadership roles demonstrate characteristics that are perceived to be inconsistent with the physician role that society ascribes to them, they could be criticized for breaking with societal norms.

Similarly, if a physician demonstrates characteristics that are typically less political in their characterization, such as listening intently, speaking softly, or looking toward teamwork and collaboration to solve problems, they be may perceived as too much of a physician and incapable of achieving political goals.

These biases highlight the important influence of role theory in studying physician leadership because these biases are based on the powerful perspective that society has of all physicians regardless of the additional roles they may take on.

UPPER ECHELON THEORY

In 1984, based on the lack of a comprehensive framework to understand why organizations act as they do, Hambrick and Mason (1984) developed a model entitled upper echelon theory (UET) to link the overall strategic choices organizations make to the values and cognitive bases of their leadership.

This theory suggests that leaders' background traits or personal characteristics impact organizational decisions, performance levels, and outcomes. The theory also proposes that leaders tend to rely on their personal traits and behaviors, which have been developed and conditioned over time, to make more complex decisions, such as prioritizing strategic initiatives. This theory proposes that strategic decisions and operational effectiveness require an appreciation of the demographic, experiential, educational, and psychological characteristics of the senior most members of the team responsible for making those decisions (Hambrick and Mason, 1984).

The rationale underlying the theoretical concept is that leadership teams are unable to fully appreciate all the variables that go into formulating an organizational strategic direction; hence, the lens that the team applies is selective, based on the criteria deemed most important to the team, and interpretive, based on historical constructs of their leader (Hambrick and Mason, 1984).

While Hambrick and Mason in their original work did not explicitly test the role of any specific trait or characteristic, such as being a physician, they did imply that there was a relationship between the traits of top leaders and the strategic choices that a leader makes and hence, the outcomes that result from those choices.

For example, as physicians participate more fully on leadership teams, it may be important to evaluate their ability to contribute to the team's decision making across a range of domains. A dyadic leadership model where a physician and non-physician leader partner and are responsible for the clinical, operational, and financial outcomes of the assigned service highlights UET's relevance.

The dyad team represents the upper echelon of the leadership structure for the service. The personal and professional experiences of both dyad members contribute a broader and more complementary set of experiences to a shared mission, vision, values, priorities, and outcomes of the service line.

The use of UET as a theoretical underpinning for guiding physician leadership research may be relevant as one seeks to identify the selective biases, both positive and negative, that may influence the outcomes associated with physician leaders.

As physician leadership continues to mature as a profession, empirical data generated through research that helps to identify the leadership contributions of physician leaders is necessary and important. A framework for studying these contributions depends on the numerous theories that may have relevance in creating a conceptual model that guides the research.

Role theory and upper echelon theory represent examples of leadership theories that may have relevance as we build conceptual models in research to study physician leadership contributions within and beyond healthcare.

REFERENCES

1. Bronfenbrenner U. *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge. MA.: Harvard University Press;2009.
2. Fitzimmons TW, Callan, VJ. Applying a Capital Perspective to Explain Continued Gender Inequality in the C-Suite. *The Leadership Quarterly*. 2006;27(3):354–370.
3. Gardner J. *On Leadership*. New York, NY: The Free Press;1990.
4. Hambrick D, Mason P. Upper Echelons: The Organization as a Reflection of Its Top Managers. *The Academy of Management Review*. 1984;9(2):193–206.
5. Van de Horst M. Role Theory. In: *Sociology. Oxford Bibliographies*. Oxford, UK: Oxford University Press;2016.

DOI: https://doi.org/10.55834/plj.5711987074
Copyright © 2022 by American Association for Physician Leadership®

Anthony Slonim, MD, DrPH, CPE, FAAPL, is editor-in-chief, *Physician Leadership Journal*.

Lessons Learned: Evaluating the Role of a Balanced Scorecard in the Strategic Management of a Translational Science Research Institution

Verónica Hoyo, PhD, and Daniel L. Bouland, MD, MS, FACP

The balanced scorecard is a valuable strategic management roadmap for optimal performance that organizations may adapt to various environments through thoughtful design and execution. The evaluation unit at the University of California San Diego Altman Clinical and Translational Research Institute developed, refined, and implemented a BSC tailored to its academic research environment. The big-picture value of the scorecard approach has been its ability to incorporate direct "customer/stakeholder" insights; increase capacity to align and re-align initiatives and bring them back to the funding institution's changing goals and priorities; and strengthen inter-group collaborations and emphasis on "learning from within."

Medical translational science, the process of converting scientific discoveries into improved health, requires innovation, analysis, adaptability, and dissemination of information.[1] The tracking and evaluation of translational science endeavors, necessary to safeguard strategic planning, steps forward, and compliance with various governance requirements, demands similar dynamic oversight.

The evaluation unit at the University of California San Diego (UCSD) Altman Clinical and Translational Research Institute (ACTRI) supports the ACTRI's programs and unit leaders in developing goals, targets, and relevant metrics of success; assessing progress; reviewing performance and management; and establishing continuous quality improvement methods.

Finding existing logic models[2] lacking, the evaluation unit conceived a novel application of the balanced scorecard (BSC), a tool that businesses traditionally have used for strategic management and performance tracking, by incorporating non-economic performance metrics to supplement conventional financial criteria.[3]

The evaluation unit painstakingly developed, refined, and implemented a BSC tailored to the academic research environment. The big-picture value of the scorecard approach has been its ability to incorporate direct "customer/stakeholder" insights (through satisfaction metrics); increase capacity to align and re-align our initiatives and bring them back to our funding institution's changing goals and priorities; and strengthen inter-group collaborations and emphasis on "learning from within."[4]

In practical terms, the BSC informs the strategies of the ACTRI that drive adherence and effective outcomes to grant requirements and thus serves as an integral tool contributing to continued funding. Here, we present an overview of the basic attributes/benefits of the BSC in our application and the process of piloting novel change with a focus on the actors involved, the lifecycle of adoption, lessons learned, and a path forward.

In fall 2012, after experiencing earlier BSC successes in the academic department of medicine,[5,6] ACTRI implemented an electronic in-house version of the balanced scorecard for strategic management purposes.

Not to be confused with a data dashboard, the original BSC product of Drs. Robert Kaplan and David Norton was created for the purpose of unifying mission, vision, and planning, while offering a high-level view of how the institution or system is performing in regard to its main domains, key stakeholders, and available assets.

Other advantages of the BSC framework include its focus on cross-functional relationships; ability to present

strategic objectives tied into actionable measures; and capacity to visually communicate organizational strategy in an adaptive, continuous cycle process of planning, doing, monitoring, learning, and acting.[7] Although the balanced scorecard has gradually become better known in healthcare settings,[8] we have not seen it applied to translational research institutions such as ours.

CONTEXT OF ADOPTION AND IMPLEMENTATION

A relevant starting point for analyzing the BSC implementation process at the ACTRI is the lifecycle of technology adoption; its four phases are formative, growth, mature, and decline.[9]

The formative phase is defined as a period of little growth and small numbers of actors engaging the novel technology. The second stage is characterized by high growth and high entry rates, a period of rapid expansion whereby the system starts enjoying a critical mass of users and standardization processes begin.

A high degree of specialization but low growth rates in user numbers characterizes stage three, with a period of stabilization and institutionalization of the technology. The fourth and last phase, the decline, is the stage at which no new users are expected; rather, increasing numbers of users abandon the technology system in search of new options. The technology eventually loses its relevance and established value, and a final breakup may take place.

To fully understand how a new technology is adopted and implemented, we need to consider the actors involved in the process as well as their particular nature in relation to the ecosystem where they interact. The work of sociologist Everett Rogers[10] is particularly enlightening. Rogers detailed five categories of technology "adopters":

1. Innovators: Risk-takers, usually the first individuals to adopt an innovation, youngest, highest social class, have the financial resources to tolerate and absorb failures, have closest contact to scientific sources and interactions with other like-minded entrepreneurs.
2. Early Adopters: Opinion leaders among adopters, higher social status, financial liquidity, more socially forward than the next categories, more discreet in their adoption choices than the innovators.
3. Early Majority: Those who adopt the innovation significantly later than the two previous groups, above-average social status, some contact with early adopters but seldom opinion leaders in the system.
4. Late Majority: Accept the innovation well after the average participant, naturally skeptical toward innovation, have below-average social status, little financial liquidity, in contact with late majority and early majority, little to no opinion leadership.
5. Laggards: Last to partake of the innovation, no opinion leadership, tend to be risk- and change-averse, focused on traditions, lowest social status, lowest financial liquidity, oldest among adopters, little contact with anyone outside their immediate circle.

Although our institute is not a classic representation of society, there are internal and external hierarchies among our various units and their leaders (Figure 1). During the implementation of the balanced scorecard,[5] we have witnessed well-segmented and identifiable periods of BSC adoption and various "types" of innovation adopters among unit leaders and their staff that synchronize with the above-noted classifications.

Additionally, our lifecycle of technology adoption did, indeed, loosely correlate with the previously referenced observations of Markland.[9] Detailed below are our observations.

Formative Phase (2012–2015)

All ACTRI units were mandated to utilize the BSC beginning in fall 2012.[5] The scorecards, as initially implemented, were a slightly revised version of the original tool, the most noticeable difference being the addition of a radio tab labeled

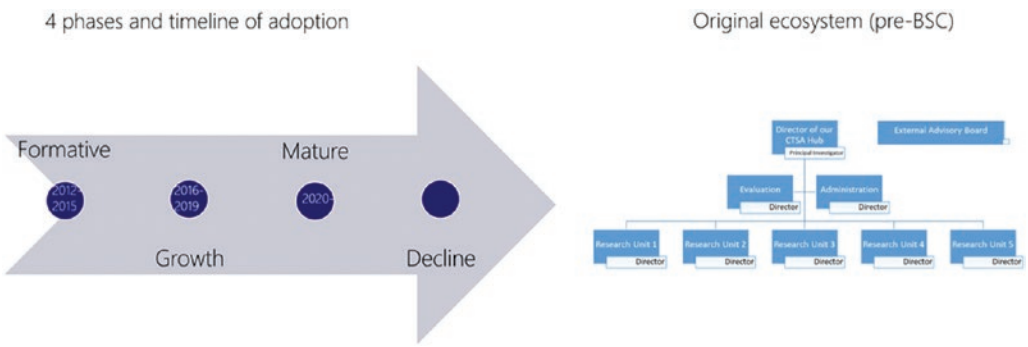


Figure 1. Timeline of BSC Adoption and Phases of Technological Innovation

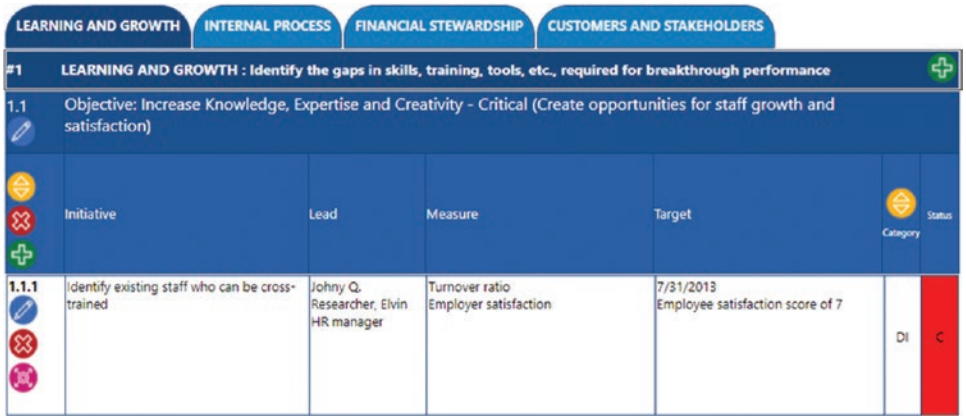


Figure 2. Sample BSC Formative Phase

"Customer and Stakeholders" to provide greater inclusivity and accountability to the decision-maker domain.

The formative stage was characterized by significant pushback and few truly committed users (better depicted as a combination of "innovators" and "early adopters"). Our evaluation unit conducted one-on-one training sessions with unit leaders and their staff, providing extensive "how-to" and FAQ documentation, as well as other learning materials, including background knowledge on the original Kaplan and Norton[3] work.

Leaders and staff members for whom adoption was easiest were in the more technology-intensive units as compared to service/people-oriented entities.

A recurrent problem encountered at this juncture was the lack of specificity in the information entered. Often, units left one (or several) items blank; the "Lead" category was frequently unpopulated, which presented a hurdle in terms of accountability. Similarly, as Figure 2 shows, measures and targets were often not S.M.A.R.T. (specific, measurable, achievable, relevant, and time-bound).

Toward the end of the second year, and with the help of the early adopters and their targeted efforts in diffusing the tool, we managed to increase acceptance and trust as shown in the dashboard presented in Figure 3.

Growth Phase (2016–2019)

After the initial buy-in process, we progressed to the second growth phase in which early majority users were brought in. Although we believed our electronic scorecards to be designed to best suit our internal needs, in reality, few units maintained continuous updating (i.e., entering the most recent data on their self-determined Key Performance Indicators or KPIs).

Most of these difficulties stemmed from users' misunderstanding that projects, ongoing collaborations, etc., were static, (i.e., once an initiative was placed within a domain, that spot was permanent) as opposed to the purposefully designed ability to dynamically move through various fields as an item evolved.

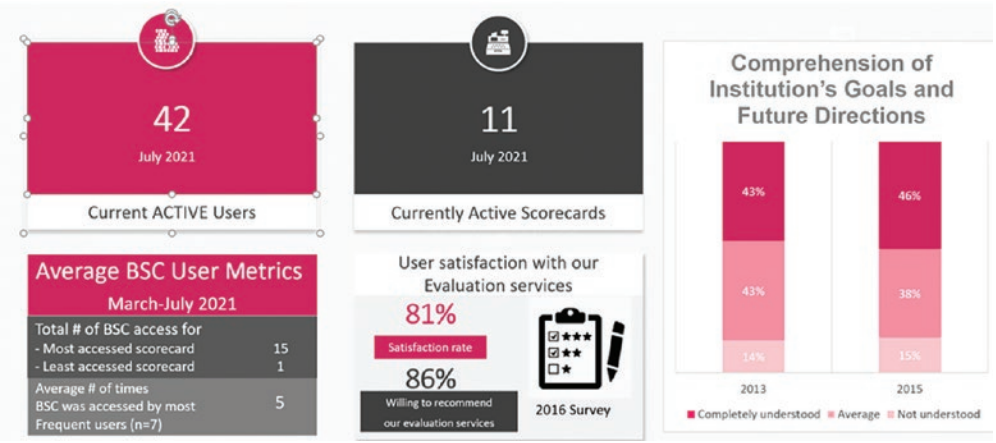


Figure 3. BSC User Adoption Dashboard

Some of our unit leaders were, perhaps, still affixed to the linearity of the previously used logic model strategic management tool. A reticence to change coupled with incomplete recognition of the flexibility of the BSC to accommodate fluid KPIs also contributed to the updating deficiency.

The evaluation unit used one-on-one meetings to resolve the confusion, although this may be the most recurrent issue we encounter with every BSC review. (Every quarter, our evaluation team meets once or twice with each unit management to review their individual scorecards and "refresh" or update them in a more systematic way. Although each unit is left alone to decide how often they modify their specific KPIs, at least once quarterly, they must comply with this standard institutional requirement.)

The few late majority arrivals for the most part were new unit leaders or administrative staff for whom the process of quantifying and measuring their strategic goals proved more challenging, given their lack of familiarity with our processes and our electronic software tool.

Beyond technological competency, some of these late majority arrivals were not necessarily the most open to change, and that is why the leadership's buy-in was essential for our success. However, the consistent support for the BSC from our institute's leadership guaranteed its full adoption.

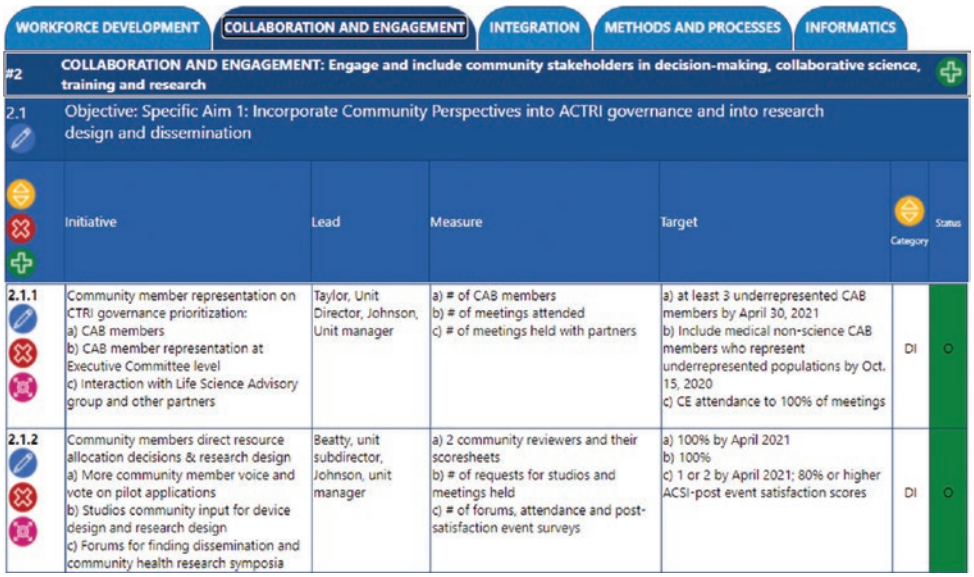
To gauge BSC impact, the evaluation unit conducted three voluntary and anonymous standard satisfaction surveys of all unit leaders in 2013, 2015, and 2016, as well as follow-up semi-structured participant interviews with unit leaders and their staff over a span of three years corresponding to the growth phase. (The 2013 and 2015 surveys took place during the directors retreat and, as such, had high participation rates — 93% for each of them — while the 2016 survey was a standalone with a participation rate of 62%.)

Mature Phase (2020–)

We currently are in the third phase (mature) of BSC implementation. Quality improvement emphasis has been focused on scorecard redesign to match our most recent CTSA grant goals (Workforce Development, Collaboration and Engagement, Integration, Methods and Processes, and Informatics) while incorporating a parallel mechanism of accountability.

Figure 4 illustrates the differences in completion and detail for the scorecard entries. In addition, a day-to-day operations/project management software is being applied to track progress toward balanced scorecard targets.

While the evaluation unit continues to advocate for the strategic management nature of the BSC, the unit leaders in our center requested help creating more accountability mechanisms; subsequently, project management software serves as a complement to our BSC but is limited to detailed day-to-day operations (Figure 5).



WORKFORCE DEVELOPMENT | COLLABORATION AND ENGAGEMENT | INTEGRATION | METHODS AND PROCESSES | INFORMATICS

#2 COLLABORATION AND ENGAGEMENT: Engage and include community stakeholders in decision-making, collaborative science, training and research

2.1 Objective: Specific Aim 1: Incorporate Community Perspectives into ACTRI governance and into research design and dissemination

	Initiative	Lead	Measure	Target	Category	Status
2.1.1	Community member representation on CTRI governance prioritization: a) CAB members b) CAB member representation at Executive Committee level c) Interaction with Life Science Advisory group and other partners	Taylor, Unit Director, Johnson, Unit manager	a) # of CAB members b) # of meetings attended c) # of meetings held with partners	a) at least 3 underrepresented CAB members by April 30, 2021 b) Include medical non-science CAB members who represent underrepresented populations by Oct. 15, 2020 c) CE attendance to 100% of meetings	DI	
2.1.2	Community members direct resource allocation decisions & research design a) More community member voice and vote on pilot applications b) Studios community input for device design and research design c) Forums for finding dissemination and community health research symposia	Beatty, unit subdirector, Johnson, unit manager	a) 2 community reviewers and their scoresheets b) # of requests for studios and meetings held c) # of forums, attendance and post-satisfaction event surveys	a) 100% by April 2021 b) 100% c) 1 or 2 by April 2021; 80% or higher ACSI-post event satisfaction scores	DI	

Figure 4. Current View of BSC

Up Next

	Subite...	Requestor	Priority	Responsible	Backup	Status	Next Deliverable
Research education grants, other than VentureWell, to present fo...	2		Medium			Up Next	Look on web for other opportu...
San Diego LEND program administrative support/start-up resour...	2		Medium			Up Next	Support needs ad hoc
Blueinc	12	Edu	Medium			Up Next	Schedule next meeting with Sh...

Figure 5. Current View of Project Management Board for One Unit

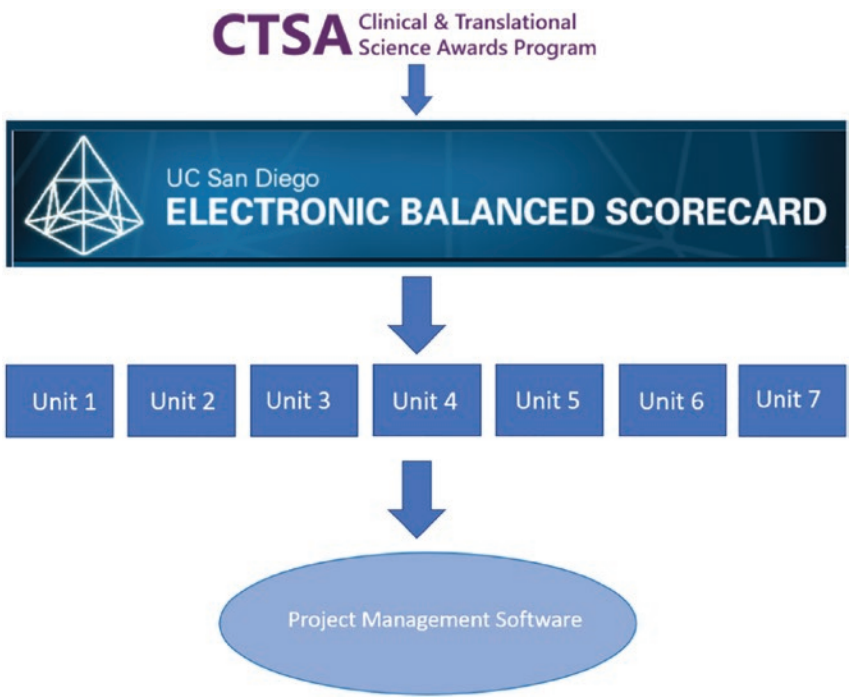


Figure 6. Workflow of Delegation Lines/Accountability for Strategic Management in Our Institute

In creating novel, complementary adjuncts (Figure 6), we believe the logical decline of the BSC strategic management tool is delayed, at least for the time being. We believe that any and all technologies and software are, at least theoretically, bound to decline, regardless of how dynamic and adaptive they may be by nature. This is due to the ever-increasing possibility of new technologies and new software options coming to the market and disrupting the balance of new threats to security and privacy that may not have been originally incorporated to the actual tools. Policy changes and funding opportunities at the institutional level also may be examples of potential threats to the survival of any tool.

We are currently in the process of standardizing the interaction and cross-software connectivity of the BSC and project management platforms to facilitate data input and visualization for unit leaders and their staffs.

DISCUSSION: LESSONS LEARNED

The balanced scorecard was introduced to better align our institute's research mission and vision with our actual initiatives and performance, following the established commitments of our foundational grant. Before the balanced scorecard, this connection between our mandate and our work was not as clearly delineated, and neither were the variety of stakeholders involved in each of the translational continuum stages. Through the scorecard, we have rendered more visible the inner workings of our organization.

Our implementation and quality improvement processes of the balanced scorecard have taught three primary lessons.

1. You get what you put in.

The balanced scorecard is a living document. As such, it requires relatively constant interaction and flexibility, usually at every reporting deadline for the near term (annual progress reports) and for mid-term grant progress milestone setting.

Strategic management under this approach is brought online by the individual user through our in-house developed, maintained, and copyrighted software that is password-protected, easy to access, and self-explanatory. Users arrive at a landing page that has training materials, inter-unit message boards (for internal communication), an institutional level message board (for general announcements), and a drop-down menu to access each unit's specific scorecard(s). Having gained access to their scorecards, units have editing privileges and control of their views.

Each scorecard has a general format (four or five tabs, each pertaining to the main programmatic domains, depending on the scorecard year) and as many items (initiatives) as unit leaders decide. As explained, the frequency of access to scorecards is primarily left to unit leaders and their staff, except for the minimum requirement to have updated information every quarter. Given the "high level"

of information captured in the scorecard, there is no need to view the BSC daily.

Those unit leaders and managers who routinely codify their particular scorecards (i.e., major accomplishments, new initiatives, completed tasks, required grant-based KPIs, and unit-created original metrics) tend to do significantly better at BSC upkeep than those who need to be coerced into compliance. Consequently, a well-maintained BSC facilitates preparing for annual reports and external advisory board meetings.

2. There are many drivers of implementation.

Several factors have influenced BSC adoption in our environment. In the broader picture, the BSC has a well-established reputation as a strategic management tool and is employed by our institutional body, the University of California San Diego.

The primary drivers of local implementation were the most frequent users (unit managers) and/or tech-savvy unit leaders who were early adopters. Word of mouth among unit leaders and their opinion leadership with their own staff has been the single most important diffusion mechanism.

A key component in ongoing applicability has been a regularly scheduled bi-annual meeting between the evaluation unit and individual units to review the scorecard; an additional review is initiated when preparing for institution-wide reporting deadlines, and ad-hoc meetings are conducted upon request.

3. Tool flexibility and adaptability are important.

We have learned that constant solicitation of feedback from users, implementation of requested changes, and introduction of updated/novel features are requisite for survival. As an example, our most recent balanced scorecard revamp occurred two years ago when we created a more customizable, better-looking interface following findings from a 2016 survey.

Specifically, the original four domains were modified to five strategic aims as outlined by the National Center for Advancing Translational Sciences in our Request for Application. Additionally, several extra "edit" features were introduced, such as the ability to move initiatives across quadrants/domains, the capability to renumber items according to reprioritization, and, finally, the removal of unused features.

We are committed to continuous process improvement, and the most recent addition of project management is having a clear, immediate effect in increasing unit leader and staff engagement with both strategic and project management software.

The decision to integrate these two very different tools was a response to our own commitment to user satisfaction and stakeholder accountability; some unit leaders consistently requested added functionality from our balanced scorecard interface that, by design, was not available in a strategic management tool. Adding the link within our in-house scorecard platform to a commercial-project management tool allows a "single-stop shop" where a bird's- eye view of their plans, milestones, targets, and accountability is presented together with direct access to delve into the minutiae of daily operations.

Although these changes have not yet been assessed for their impact on user satisfaction, we will engage in such efforts in the near future. Evidence suggests that the BSC continues to provide unit and institutional leadership with high-level visual organization, understanding, and cross-unit sharing of institutional plans. It constitutes a consolidated roadmap for success, while the project management tool is a daily log of day-to-day tasks.

There is no confusion about the benefits of each platform. The updating required for effective record keeping has driven a division of labor: unit leaders focus more on the BSC while unit managers/other staff handle the project management tool.

FUTURE WORK

An external advisory board comprised of national subject-matter experts meets annually to review our ACTRI. Year-over-year progress in meeting the goals of translational science has established the balanced scorecard as an integral component to successful outcomes and continued grant funding.

To avoid the decline phase in technology lifestyle adoption, the UCSD ACTRI evaluation unit has begun the process of incorporating major changes to our balanced scorecard. Opportunely, we are beginning our third grant-renewal year, and as such, most current initiatives are new or have a renewed scope. This novelty, coupled with an updated set of strategic aims, has allowed for additional latitude in adjusting to recent changes in mission and vision, i.e., increased responsiveness to issues of diversity, equity, and inclusion (DEI).

Our BSC is undergoing adaptations that will expand the pool of stakeholders and incorporate performance metrics to track societal impact. These changes will be documented, evaluated, and our findings disseminated over the next few months.

In our application, the balanced scorecard has proven its value; as such, we aim to extend its lifecycle. Now coupled with project management software, the BSC is fully responsible for ensuring key performance indicators match the larger values and mission of our translational science

research institute in the quest to bring innovative research to clinical fruition.

REFERENCES

1. National Center for Advancing Translational Sciences. Translational Science Spectrum. National Institutes of Health, National Center for Advancing Translational Sciences. March 12, 2015. https://ncats.nih.gov/translation/spectrum
2. Frechtling JA. Logic Models. *International Encyclopedia of the Social & Behavioral Sciences*. 2015; 299–305. Accessed February 17, 2022.
3. Kaplan RS, Norton DP. Using the Balanced Scorecard as a Strategic Management System. *Harvard Business Review*. July–August 2007. https://hbr.org/2007/07/using-the-balanced-scorecard-as-a-strategic-management-system
4. Bersin J, Zao-Sanders M. Making Learning a Part of Everyday Work. *Harvard Business Review*. February 19, 2019. https://hbr.org/2019/02/making-learning-a-part-of-everyday-work
5. Fontanesi J, Alexander A, Dworschak D, *et al*. Balanced Scorecards: An Alternative to the Logic Model Assessment Framework for CTSAs. Unpublished Manuscript; 2011.
6. Bouland D, Fink E, Fontanesi J. Introduction of the Balanced Scorecard into an Academic Department of Medicine: Creating a Road Map to success. *Journal of Medical Practice Management*. 2011;26(6):331–335.
7. Kopecka N. The Balanced Scorecard Implementation, Integrated Approach and the Quality of Its Measurement. *Procedia: Economics and Finance*. 2015;25:59–69.
8. Mutale W, Stringer J, Chintu N, *et al*. Application of Balanced Scorecard in the Evaluation of a Complex Health System Intervention: 12 Months Post Intervention Findings from the BHOMA Intervention: A Cluster Randomised Trial in Zambia. Carlo WA, ed. *PLoS ONE*. 2014;9(4):e93977. doi:10.1371/journal.pone.0093977
9. Markard J. The Life Cycle of Technological Innovation Systems. *Technological Forecasting & Social Change*. 2020;153.
10. Rogers E. *Diffusion of Innovations*. New York: The Free Press;1962.

DOI: https://doi.org/10.55834/plj.1620793732
Copyright © 2022 by American Association for Physician Leadership®

Verónica Hoyo, PhD, is the executive director of the network of the National Library of Medicine Evaluation Center (NEC) at Northwestern University. She was previously evaluation manager at the University of California San Diego Altman Clinical and Translational Research Institute.
veronica.hoyo@northwestern.edu

Daniel L. Bouland, MD, MS, FACP, is a clinical professor of medicine and currently serves as director of evaluation at the University of California San Diego Altman Clinical and Translational Research Institute, with additional duties as chief of hospital medicine and vice chair for quality in the Department of Medicine.
dbouland@health.ucsd.edu

Recognizing and Managing a Toxic Leader: A Case Study

Bhagwan Satiani MD, MBA, FACHE(R), FACS, and Anand Satiani, MD, MBA

Leadership literature focuses on highlighting the types, ideals, characteristics, and habits of good leaders. Although healthcare organizations may endure less than ideal leaders, some reports indicate that toxic leaders comprise up to 20–30% of leadership. A distinctive set of characteristic behaviors separate the difficult and demanding leader from the toxic leader. Toxic leaders can be characterized as autocratic, manipulative, controlling, deceitful, and callous. Organizations must have a mechanism for identifying, monitoring, counseling, coaching, or even removing toxic leaders. Lack of development of good leaders, dysfunctional teams, loss of productivity, and low morale because of toxic leadership lead to a high burnout rate and turnover.

Personality development is a process common to all humans and encompasses an individual's patterns of thinking, feeling, and behaving.[1] It is influenced by the combination of life experience and genetics. Consequently, there is significant variability in personality from person to person, as well as in levels of emotional intelligence, the employment of mature and immature defense mechanisms, and styles of interaction. No individual, including one aspiring to a leadership role, is immune from developing traits that can be viewed as maladaptive.

Most articles on leadership spotlight good leadership. This report highlights the extreme opposite: a situation in which an individual with maladaptive traits is installed as a leader and generates a destructive, toxic culture. What follows is a summary of the individual's impact on the department and the organization, with recommendations for managing such an individual.

TOXIC LEADERSHIP

The word "toxic" is derived from Greek mythology and the word "toxikon," meaning poison or arrow poison.[2,3] Twenty percent of Americans report hostility or feeling threatened in the workplace.[4] Bullying also occurs to some degree in many workplaces. A workplace poll by a large recruiting firm showed that 51% of respondents were bullied by their boss or manager and 39% by co-workers.[5]

A working definition of toxic leadership is "a series of purposeful and deliberate behaviors and acts of a leader that disrupt the effective functioning of the organization and are intended to maneuver, deceive, intimidate, and humiliate others with the objective of personal gains."[6]

Toxic leadership is present across industries around the world, including healthcare. There is evidence that between 20% and 30% of leaders globally are described as toxic.[3] In a study of 400 leaders, 39% of whom worked in the healthcare setting, almost 95% reported encountering toxic characteristics in someone at work.[7]

No healthcare environment or medical specialty is immune to toxic leadership. Labrague studied the impact of toxic leadership behaviors among nurse managers on adverse events and quality of patient care using three different standardized scales to survey 1,053 registered nurses.[8] Nurse-reported adverse events, including reports of complaints, verbal mistreatment from patients and their families, patient falls, healthcare-associated infections, errors in administering medication, and decreased quality of care, were all strongly associated with toxic leadership behaviors in nurse managers.

CASE STUDY

A specialty division at a large private health system thrived due to harmonious relationships among employed physicians and staff, but was held back by poor financial performance. A 12-month search for a new division chief followed.

Although a search committee of physicians, nurses, and administrative staff was formed, previous hires in this and other specialties tended to be at the whim of the department head. The candidate selected was a model of good behavior

and charm at the interview. The physician was hired for the role despite opposing feedback from a few physician interviewers who had concerns about the individual's abbreviated tenure at his two prior employers and cursory information provided by those employers.

Within six months, the division's culture rapidly deteriorated. Initial dissatisfaction among faculty, trainees, and the staff was noted and based upon intimidation, manipulative behavior, lack of empathy toward employees, and lack of ownership of poor decisions. As a result of this behavior over three years, many complaints directed at the division leader were filed with human resources. The department head dismissed these, presumably based in large part on the division's improved financials over 36 months.

After four years and an overwhelming number of formal complaints to human resources, the department chair asked for the division chief's resignation.

OPERATIONAL SIGNIFICANCE

Task-focused leaders, especially those coming into a new job, may be given specific charges with a timeline to fix problems such as financial deficits, as in this case. The new leader may be single-minded in following the department head's instructions almost to the exclusion of other facets, such as the relational aspect.

How goals are accomplished is just as important as what is achieved. In this case, financial gains were recognized, but they came at the significant expense of a supportive culture and psychological safety for team members. Further, the built-in safeguards — HR and the director's supervisor — failed in this instance for almost four years. The director's authoritarian style created a toxic environment through his use of bullying, aggression, intimidation, and manipulation (Table 1).

Other associated behaviors might include confronting with false accusations and assuming credit for the team's success. It is also common for these leaders to exhibit the "kiss up and kick down tendency."[9]

Given the harm done to organizations, why are individuals who create such toxic environments tolerated? Most often, subordinates fear retaliation if they voice concern, and superiors are focused on the achievement of specified metrics (e.g., research dollars, clinical revenue). In this case, the individual improved the financial status of the organization, but at a high cost.

Supervisors become passive enablers, observing the inappropriate behavior but not advocating for change. The HR department's ability to implement change depends on the policies by which they abide; these can require the verification of complaints, internal investigations, placing the individual on a performance plan, or involving a coach over several months before the recommendation is made to terminate employment. In addition, HR and senior leadership may wish to avoid the prospect of legal action involving termination without a foolproof record of verifiable complaints and evaluations. The department and the health system may also be conflicted because the division is now profitable.

OPERATIONAL IMPLICATIONS FOR THE ORGANIZATION

Toxic leaders may succeed and benefit the organization in the short term. However, because they are incapable of developing good leaders or well-functioning teams, their success is usually short-lived before they are forced to move on to another institution. Therefore, organizations must have a mechanism for identifying and monitoring or removing toxic leaders.

Most healthcare institutions have a top-down performance evaluation process in place, which allows such a leader to not only suppress any dissent, but also progress upwards in the leadership chain.[9,10] Their behavior affects the organization in many ways. Instead of authentic and

Table 1. Impact of a Toxic Leader on the Organization

Behavior	Consequences
Abusive behavior: Bullying, aggressive and offensive behavior toward subordinates, autocratic, intimidates peers	No psychological safety, low engagement, loss of creativity, absenteeism, attrition and turnover
Lies and blame shifting: Frequently caught in falsehoods and inconsistency; rejects any blame, transferred to subordinates; reminds employees of their past mistakes/faults without any sympathy; makes unsubstantiated allegations at unexpected times	Loss of faith in the leader, leads to a defensive attitude in direct reports and peers, dissatisfaction and undue stress for others, low morale
Communication: Very limited communication outside the clique; holds important knowledge close, including finances; unwilling to listen to feedback; Encourages and hires a "yes" group of people	Relationships with and between peer group suffers, creates team conflicts, establishment of cliques, widespread office politics
Egotistical: Selfish, manipulative, deceitful, has arbitrary behaviors and/or decisions, think they are more talented than others, exhibit completely different behavior with superiors	Loss of trust

nurturing leadership, toxic leaders erode the self-worth, dignity and "psychosocial well-being" of workers.[3]

Morale suffers as employees become unengaged or actively disengaged, impacting efficiency and productivity. Employees exposed to this leader may be noncommunicative and afraid to disagree with the leader. The pressure to watch every word and survive each day within the poisonous culture leads to a loss of creativity.

Other than those who are favored by the leader, faculty or peer relationships suffer as they go further into isolation. Unproductive teams do not manage the normal day-to-day conflict well, and there is decreased resilience, hastened burnout, and high turnover.

Although this behavior ruins the culture within the workplace, it is sometimes difficult for the leader's supervisor to discern because these leaders usually present as confident and assertive; however, they often exhibit what is called the "dark triad."[11,12]

First exposed by Delroy Paulhus and Kevin Williams in 2002, the dark triad of personality consists of narcissism, Machiavellianism, and psychopathy.[13] The narcissistic leader, sometimes exhibiting pathologic tendencies, focuses only on their own needs. The leader profiled in the case study had an inflated view of self-worth, exaggerated his scientific knowledge, and often quoted non-existing literature to appear more knowledgeable.

Machiavellianism is described as "strategic exploitation and deceit."[11] These leaders will do whatever is necessary (manipulation, deceit, and exploitation) to accomplish their goal.

The final part of the triad is psychopathy, exhibited by callousness, cynicism, aggressiveness, and episodes of anger directed primarily at direct reports or trainees.[14] The leader in the case study was opaque about essential information, acted unpredictably, and intimidated people within groups to send a message.[15]

Another typical behavior of the toxic leader in our case study was that he hired and favored a small circle, and tried to drive a wedge between them and the pre-existing faculty. Faculty were never included in major decision-making.

Although the difference between a "tough" leader focused on the task and a toxic leader can be difficult to discern at times based on the situation, a constellation of signs is important to recognize (Table 1). Tough and sometimes difficult leaders may be intense, demanding, perfectionistic, and difficult to work with, but they are fair and understand the balance between achieving financial targets and crossing the line to personal attacks. They also show emotional maturity by exhibiting empathy, leading employees and peers to conclude that the leader's behavior is never personal. Both types of leaders can bring success to the organization, but the disruption and impact on the culture associated with the toxic leader may not be sustainable.

During the hiring process, employers focus on candidates' fit with the job and the organization. However, few hospitals go beyond conventional inquiries such as structured or unstructured interviews to match personality traits with job performance. A variety of leadership personality tests are available, but there is still uncertainty about the predictability of these tools as well as the cost associated with widespread use.[16,17] Selective use of personality and behavioral testing may be worthwhile for senior executive and critical leadership positions.[18]

NEXT STEPS IN MANAGING THE TOXIC LEADER

Toxic leadership may be due to behavioral concerns and can also be rooted more deeply within personality. Strategies for managing the toxic leader involve several steps.

Supervisor/manager actions toward toxic leader's peers and employees include:

- Listen.
- Show empathy.
- Provide counseling for victims.
- Reiterate core values repeatedly.
- Establish a hotline to allow fearful employees to report abusive behavior.
- Urge documentation of behavior and falsehoods.
- Direct employees to avoid solo conversations.
- Provide peer recognition and reward programs.
- Encourage coalitions.
- Facilitate team-building exercises.

Supervisor/manager possible actions toward a toxic leader include:

- Involve human resources and, if necessary, the legal department.
- Address modifiable causes of behavior (e.g., substance use, personal relationship challenges, health problem) or mental health disorder.
- Disclose specifically how the behavior is affecting others and encourage positive change and monitor consequences.
- Bring in an independent third party to evaluate the workplace.
- Facilitate 360-degree behavior evaluations.
- Mandate coaching.
- Ask the leader to accept responsibility.
- Practice zero tolerance when necessary.
- Impose sanctions if needed.
- Ask for resignation or dismiss if appropriate.

The first step is to involve HR personnel, who may be able to gather the necessary information from all sources.

Causes of the behavior may include a stressful situation outside of work or another temporary situation. It is likely the embattled leader will ask for specific examples of behaviors that are at issue. Leaders may lack self-awareness and be surprised to learn how toxic the culture has become

due to their behavior. Some leaders may recognize the problem or benefit when senior management demonstrates a commitment to addressing it instead of looking the other way.

A supervisor (CEO/physician supervisor/administrator) should refrain from judging the leader and instead offer HR assistance and advice. The supervisor may distinguish whether the leader is deflecting blame or accepting responsibility. The leader then needs to face potential consequences and be given a timeline and specific behaviors to implement that will be monitored.

The intervention should continue, with progress documented by HR, until specific milestones are achieved. The leader should also be encouraged to keep interactions within well-accepted professional boundaries. Supervisors who learn of the behavior must give supervised peers, trainees, and employees an opportunity to speak in a nonthreatening situation away from the leader. It is worth repeating that HR should be involved at every step of any advice or action.

Escalation of the intervention proceeds from an informal awareness meeting to a disciplinary intervention if necessary[19] (Figure 1). If the leader does not change behavior after several warnings, the supervisor may recommend counseling and a 360 survey, which seeks feedback on the employee from several sources such as supervisors, peers, direct reports, and self-assessments. A commonly used instrument in this context is called the DISC–Behavior Styles Purpose (drive, influence, steadiness and compliance).[20] This does not measure intelligence or skills, but provides feedback on behavior and emotions.

HR staff should assist in this task, but they can only offer advice based on the documentation, interviews, and institutional policies and procedures. Decision-making rests with the leadership with input from the legal team.

Once the evaluation is completed, counseling sessions and coaching, followed by further evaluations, may then decide the toxic leader's future. If there is improvement based on the intervention, as indicated by reports by a coach or counselor and supplemented by employees or peers, progress is documented, including attainment of specific goals. If not, the institution must make a decision about termination.

Although policies and procedures vary by hospital, most if not all hospital bylaws applicable to physicians refer to "disruptive" behavior allowing the hospital to initiate disciplinary proceedings. The legal team must follow each step as mentioned in the bylaws, protecting the physician's due process accurately and within the time specified.

While there is a wide range of leader behavior, including demanding and tough bosses, a distinctive set of characteristic behaviors separate these from a toxic leader. Once this type of leader is identified, intervention consistent with hospital bylaws is necessary by supervisors and managers. This could range from informal conversations to disciplinary action, including termination.

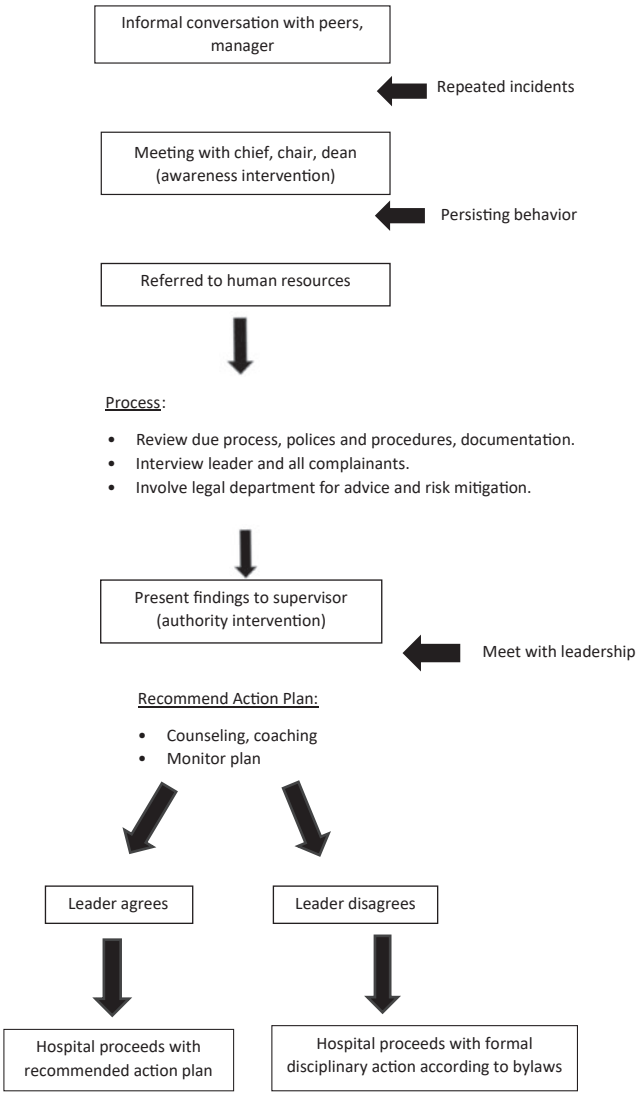


Figure 1. Flowchart of Steps Dealing with a Toxic Leader

REFERENCES

1. American Psychiatric Association. What are Personality Disorders? APA website. www.psychiatry.org/patients-families/personality-disorders/what-are-personality-disorders.
2. Singh N, Sengupta S, Dev S. Toxic Leadership: The Most Menacing Form of Leadership. In *Dark Sides of Organizational Behavior and Leadership*, eds. Brandebo MF and Alvinius A. London: IntechOpen Ltd.;2019. www.intechopen.com/chapters/60316.
3. Veldsman T. How Toxic Leaders Destroy People as Well as Organizations. BIZCATALYST360. January 5, 2016. https://medium.com/bizcatalyst-360/how-toxic-leaders-destroy-people-as-well-as-organizations-ee79b3048b41.
4. CNBC. One-fifth of Americans Find Workplace Hostile or Threatening. CNBC.com. August 14, 2017. www.cnbc.com/2017/08/14/one-fifth-of-americans-find-workplace-hostile-or-threatening.html.
5. RAND, American Workplace Is Physically and Emotionally Taxing; Most Workers Receive Support from Boss and Friends at Work. RAND

Corporation Press Release. August 14, 2017. www.rand.org/news/press/2017/08/14.html.
6. Maheshwari G, Mehta S. Toxic Leadership: Tracing the Destructive Trail. *International Journal of Management.* 2014;5(10):18–24.
7. Kusy M, Holloway E. *Toxic Workplace! Managing Toxic Personalities and Their Systems of Power.* San Francisco: Jossey-Bass;2009.
8. Labrague LJ. Influence of Nurse Managers' Toxic Leadership Behaviours on Nurse-reported Adverse Events and Quality of Care. *J Nurs Manag.* 2021 May;29(4):55–863. doi: 10.1111/jonm.13228
9. Reed GE. Toxic Leadership. *Military Review*. 2004;84(4):67–71.
10. Wilson DS. Toxic Leaders and the Social Environments That Breed Them. *Forbes.* January 10, 2014. www.forbes.com/sites/darwinatwork/2014/01/10/toxic-leaders-and-the-social-environments-that-breed-them/?sh=41c9ac51dac5.
11. Relihan T. Fixing a Toxic Work Culture: Guarding Against the 'Dark Triad.' MIT Sloan School of Management. April 29, 2019. https://mitsloan.mit.edu/ideas-made-to-matter/fixing-a-toxic-work-culture-guarding-against-dark-triad.
12. Kaufman SB. The Light Triad vs. Dark Triad of Personality. *Scientific American* blog. March 19, 2019. https://blogs.scientificamerican.com/beautiful-minds/the-light-triad-vs-dark-triad-of-personality.
13. Paulhus D, Williams KM. The Dark Triad of Personality: Narcissism, Machiavellianism, and Psychopathy. *J Research in Personality.* 2002; 36(6):556–563.
14. Maxwell SM. An Exploration of Human Resource Personnel and Toxic Leadership. Doctoral Dissertation. Walden University College of Management and Technology. 2015. https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=1547&context=dissertations&httpsredir=1&referer=.
15. Dobbs JM. The Relationship Between Perceived Toxic Leadership Styles, Leader Effectiveness, and Organizational Cynicism. Doctoral dissertation. University of San Diego. 2014. https://digital.sandiego.edu/cgi/viewcontent.cgi?article=1859&context=dissertations.
16. Reynolds B. Top Five Leadership Personality Tests. Towson University EngageTU. September 7, 2017. www.engagetu.com/2017/09/07/top-five-leadership-personality-tests/.
17. Hogan R, Hogan J. Assessing Leadership: A View from the Dark Side. *International Journal of Selection and Assessment.* 2001;9:40–51.
18. Ones DS, Dilchert S, Viswesvaran C, Judge, TA. In Support of Personality Assessment in Organizational Settings. *Personnel Psychology.* 2007;60(4): 995–1027. doi:10.1111/j.1744-6570.2007.00099.x.
19. Hickson GB, Pichert JW, Webb LE, Gabbe SG. A Complementary Approach to Promoting Professionalism: Identifying, Measuring, and Addressing Unprofessional Behaviors. *Acad Med.* 2007 Nov;82(11): 1040–1048. doi: 10.1097/ACM.0b013e31815761ee.
20. Disc Profile. Available at https://www.discprofile.com/what-is-disc/disc-styles#:~:text=What%20is%20the%20purpose%20of,effectiveness%20of%20leaders%20and%20managers.

DOI: https://doi.org/10.55834/plj.6849841215
Copyright © 2022 by American Association for Physician Leadership®

Bhagwan Satiani, MD, MBA, FACHE(R), FACS, is professor of surgery emeritus at the Ohio State University College of Medicine, Columbus, Ohio. Previously, he started and was director of the Faculty Leadership Institute. He blogs at www.savvy-medicine.com.
bhagwan.satiani@osumc.edu

Anand Satiani, MD, MBA, is a psychiatrist at Southeast Healthcare and at the Ohio State University Wexner Medical Center in Columbus, Ohio.
satiani.2@osu.edu

The Relationship Among Emotional Intelligence, Specialty Preference, and Burnout Among Physicians-in-Training

Eiman Khesroh, MBBS, DrPH; Melissa Butt, DrPH; Annahieta Kalantari, DO, FACEP, FACOEP; Yendelela L. Cuffee, MPH, PhD; Douglas L. Leslie, PhD; Sarah Bronson, PhD; Betsy Aumiller, DEd; and Andrea Rigby, PsyD

Burnout among physicians-in-training has increased at an alarming rate, leading the American College of Graduate Medical Education to impose mandates aimed at securing their well-being. One factor contributing to burnout is choosing a specialty that is not aligned with one's personality. Studies have shown that higher emotional intelligence (EQ) skills are associated with better choice-making and lower burnout levels. A survey was used to evaluate the impact of EQ on burnout levels among physicians-in-training who changed their specialty compared to those who remained in their original specialty. There was no difference in burnout and EQ levels between physicians-in-training who changed their specialty and those who did not. Further, this study showed that a change in specialty does not moderate the effect of EQ on burnout. The findings also indicate that culture and support may be important structural factors affecting burnout.

With the increasing trend of burnout among physicians-in-training reaching close to 60%,[1,2] the Accreditation Council for Graduate Medical Education (ACGME) developed recommendations in 2019 requiring training programs to secure the well-being of residents and fellows.[3] These recommendations reiterated the responsibility of the institution to provide "a positive culture in a clinical learning environment that models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers."[3,p.41] Also, the recommendations underscored the importance of a physicians' ability to recognize signs of burnout and know how to seek help.[3]

Burnout, an occupation-related phenomenon of experiencing emotional exhaustion, cynicism, and lack of personal achievements, has many contributing factors.[4,5] In the medical profession, these factors include long work hours; excessive workload, bureaucracy, and charting; and lack of respect from colleagues and administrators.[6]

Related to these factors are the characteristics and demands of the physician's specialty. The process of choosing a specialty, which starts as soon as medical students begin exploring topics and rotations, may affect the risk of burnout, particularly if the specialty area is in alignment with the student's personality.

Data from the Association of American Medical Colleges (AAMC) on medical specialty selection (2020) revealed that only one-quarter (26%) of medical students maintained the same specialty between matriculation and graduation, and 10–15% changed specialty during residency.[7-10] More than 55% of residents were contemplating a change in specialty or even their career.[11] Those who said they regretted their specialty reported the highest rates of burnout.[12]

Schafer and Shore described choosing a specialty as "assessing one's fit with perceived attributes of potential specialties, which might include personality, income, lifestyle, intellectual challenge, technological orientation, clinical skills, and potential for research or leadership."[13, p.27-82]

The mechanism of choice-making relies greatly on using one's emotional intelligence (EQ).[14,15] Individuals with high EQ skills have been found to be attuned to avoiding risks and engaging in activities that are aligned with personality and profitability.[14,15] The impact of EQ on making a choice is substantial. Medical students and graduates who possess EQ skills may be better able to choose their specialty wisely and with confidence that their abilities are a good match for the specialty. Medical students and graduates often choose

their specialty based on recommendations given by mentors, elective rotations, or freely available tools such as the Myers-Briggs personality test.[16]

To date, no studies have examined the impact of medical students' or graduate students' EQ skills on burnout based on their decision to change specialty. Thus, the objective of this study is to compare the impact of EQ skills on burnout levels among residents and fellows who did and did not change their specialty. We hypothesize that residents who did not change their specialty practice will report higher levels of EQ skills and experience less burnout compared to residents who did change their specialty preference.

METHODS

Setting and participants. A cross-sectional survey was administered from May 17, 2021, through June 30, 2021, at one academic medical center in central Pennsylvania. Recruitment of participants was conducted via a list of email addresses provided by the directors of graduate medical education.

Using a secure online web application REDCap,[17] 628 residents and fellows from 22 residency and 53 fellowship programs were invited to participate. Informed consent was obtained and confidentiality was assured. Participants could opt to participate in a gift card raffle for completing the survey. This study was reviewed and approved by the academic medical center's institutional review board.

Outcome measures. The survey included two instruments: the Copenhagen Burnout Inventory (CBI) and the Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF). The CBI is a validated instrument with high internal reliability and consists of 19 questions divided into three categories: personal-, work-, and colleague-related burnout. Each category is evaluated on two physical and psychological cores: exhaustion and fatigue.[18]

Instruments were scored and totaled per instrument guidelines. Ordinal scores were established with scores from 0 to 49 being minimal burnout, while scores between 50 and 74 were considered moderate, and scores higher than 75 were considered high levels of burnout.[19]

The TEIQue-SF is a 30-item validated instrument that provides a global assessment of four scales: well-being (WB), self-control (SC), sociability (SOC), and emotionality (EM).[20,21] The TEIQue-SF is scored on a 7-point Likert scale ranging from 1 (completely disagree) to 7 (completely agree).[20] Additionally, the survey included a demographic section where participants provided specific background information. The survey ended with an open-ended question asking the participants to describe burnout in their own words. Internal consistency of the measures in this sample was calculated using Cronbach's alpha and was excellent for both the CBI (0.95) and the TEIQue-SF (0.93).

Statistical Analysis. The student's t-test and ANOVA were used to test differences in continuous variables. Associations between burnout and EQ traits were evaluated using Pearson correlation coefficients with Fisher Z-transformation to obtain the 95% confidence interval.

To determine if change in specialty moderated the association between EQ and burnout, two linear regression models were built. The base model included EQ scores and change in specialty as predictors of overall burnout scores, and the expanded model added the interaction term between change in specialty and EQ scores. Moderation was indicated if the interaction term was significant and by comparing the adjusted R^2 and Akaike information criterion (AIC).

All data were analyzed using SAS version 9.4 (SAS Institute Inc. Cary, North Carolina). Results from the open-ended question were analyzed through a phenomenological approach using inductive coding methods. Codes were evaluated independently by two study team members (EK and MB) to ensure accuracy and complete consensus.

RESULTS

Of the 628 physicians-in-training invited to participate, 118 (18.79%) completed the survey. Sample characteristics are presented in Table 1. Of these 118 participants, 50 (42.37%) identified as male and 67 (56.78%) as female. Nearly half physicians-in-training were ≤ 29 years old (n = 54; 45.76%) with 79 (66.96%) respondents identifying as White. Further, 111 (94.07%) identified as U.S. citizens while 7 (5.93%) identified as non-U.S. citizens.

All participants held medical degrees (MD or DO) with 5 (4.24%) also having a PhD. The majority of residents who responded to the survey were in their postgraduate training year 1 (n = 29; 32.20%) or year 3 (n = 25; 27.80%), while for fellows, the majority were in year 1 (n = 10; 38.50%) or 2 (n = 11; 42.30%). A slight majority (n = 58; 49.15%) of participants indicated that they worked 70 hours or more on a weekly basis; only 11 (9.32%) reported practicing 40 to 49 hours per week.

A large part of the sample (n = 109; 92.37%) had been accepted in the specialty of their first choice. The number of respondents (n = 49; 41.53%) who changed their specialty choice between matriculation and graduation (M2G) greatly exceeded the number (n = 8; 6.78%) who changed their specialty during residency (R). The data showed that seven respondents changed their specialty at least twice during both M2G and R. Table 2 shows the differences in factors contributing to changing specialty between M2G and R, as both endorsed personality fit as a leading cause (n = 39; 79.59% and n = 5; 62.50%, respectively).

In terms of specialty satisfaction, 52 respondents (45.61%) were very satisfied with their current specialty, and 6 (5.26%) were very unsatisfied. Among those who changed their

Table 1. Demographics

Demographics	N (%)
Gender	
Male	50 (42.37%)
Female	67 (56.78%)
Decline to answer	1 (0.85%)
Age	
≤ 29 years	54 (45.76%)
30–34 years	53 (44.92%)
>34 years	11 (9.32%)
Race	
White/ Caucasian	79 (66.95%)
Black/ African American	2 (1.69%)
Asian/ Pacific Islander (e.g. Native Hawaiian)	20 (16.95%)
Two or more	8 (6.78%)
Other	6 (5.08%)
Decline to answer	3 (2.54%)
Marital Status	
Single/ Widowed	34 (28.81%)
Married/ Significant Other (living together)	72 (61.02%)
Married/ Significant Other (not living together)	8 (6.78%)
Other	1 (0.85%)
Decline to Answer	3 (2.54%)
Citizenship	
U.S	111 (94.07%)
International	7 (5.93%)
Degree Title	
MD	72 (61.02%)
MD/PhD	5 (4.24%)
DO	39 (33.05%)
Other	2 (1.69%)
Matched in the Specialty of First Choice	
Yes	109 (92.37%)
No	9 (7.63%)
Hours Spent Working Per Week	
40–49 hours	11 (9.32%)
50–59 hours	19 (16.10%)
60–69 hours	30 (25.42%)
70–79 hours	32 (27.12%)
80+ hours	26 (22.03%)
Year of Residency	
PGY 1	29 (32.20%)
PGY 2	21 (23.30%)
PGY 3	25 (27.80%)
PGY 4	10 (11.10%)
PGY 5	5 (5.60%)
Year of Fellowship	
1st year	10 (38.50%)
2nd year	11 (42.30%)
3rd year	4 (15.40%)
4th year	1 (3.80%)
Changed Specialty during Time Entering Medical School to Applying for Residency	
Yes	49 (41.53%)
No	69 (58.47%)
Changed Specialty during Residency	
Yes	8 (6.78%)
No	110 (93.22%)
Intention of Pursuing Fellowship Training Post-Residency Training	
Yes	60 (65.93%)
No	31 (34.07%)

specialty, 25 (54.26%) reported being very satisfied, and 2 (4.35%) very unsatisfied.

Results from the CBI determined that the majority of respondents were in the low range of burnout (n = 87, 59.18%), 52 (35.37%) were in the moderate category, and 8 were in the highest category for burnout (5.44%). Table 3 demonstrates no significant difference in burnout levels between those who changed their specialty and those who did not. Similarly, the TEIQue-SF subscales showed no difference in EQ levels between those who changed their specialty and those who did not.

Evaluating the differential impact of EQ on burnout between those who changed their specialty and those who did not was conducted through moderation analysis. This analysis showed that a change in specialty does not moderate the effect of EQ on burnout, as the adjusted R^2 of the base model was higher (0.31 versus 0.30) and the AIC of the base model was lower (614.39 versus 616.34). Further, the interaction term between change in specialty and total EQ score was not significant ($p = 0.82$).

However, the Pearson correlation coefficient (95% confidence interval) showed a moderate inverse association between burnout and EQ (-0.56 [-0.67, -0.41]), indicating that higher levels of EQ could protect against burnout overall. Further, for those who changed their specialty, higher levels of EQ ($p = 0.002$; Figure 1) and lower levels of burnout ($p < 0.0001$; Figure 2) were associated with higher levels of satisfaction. Additionally, overall satisfaction with current specialty was significantly associated with higher EQ skills

Table 2. Differences in Factors Contributing to Specialty Change Between Those Who Changed During Medical School and Those Who Changed During Residency

	Factors contributing to changing specialty during medical school N (%)	Factors contributing to changing specialty during residency N (%)
Stressful specialty	19 (38.78%)	3 (37.50%)
Long work-hours	22 (44.90%)	3 (37.50%)
Heavy workload	12 (24.49%)	3 (37.50%)
Many on-calls	14 (28.57%)	2 (25.00%)
Unpredictable emergencies	12 (24.49%)	1 (12.50%)
Education debt	7 (14.29%)	-
Personality fit	39 (79.59%)	5 (62.50%)
Future family plans	19 (38.78%)	2 (25.00%)
Role model/ mentor influence	23 (46.94%)	3 (37.50%)
Other	5 (10.20%)	1 (12.50%)

Table 3. Differences in Emotional Intelligence and Burnout Between Those Who Changed Specialty and Those Who Did Not

	Did not change specialty Mean, SD	Did change Specialty Mean, SD	p-value
TEIQUE-SF Domains			
Well-Being[1]	4.50, 1.01	4.44, 1.01	0.74
Self-Control[2]	4.85, 0.86	4.76, 0.80	0.57
Emotionality[3]	5.23, 0.85	5.16, 0.99	0.66
Sociability[4]	4.57, 0.98	4.48, 0.87	0.57
CBI Domains			
Personal	49.96, 21.95	55.58, 20.80	0.13
Work	50.21, 20.72	53.94, 21.23	0.31
Colleague	30.35, 20.33	32.25, 24.07	0.61

1. Well-Being (WB): provides an insight into how happy and positive an individual is
2. Self-Control (SC): determines the extent to which an individual is able to cope with external stressors
3. Emotionality (EM): evaluates the ability of an individual to express and interpret emotions needed to establish and maintain a relationship with others
4. Sociability (SOC): examines the ability of an individual to listen and communicate in a self-assertive manner

($p < 0.0001$; Figure 1) and lower burnout scores ($p < 0.0001$; Figure 2).

The answers to the open-ended question were categorized into 14 themes: mentors, directors and faculty (leadership); wellness and well-being; communication; schedule flexibility; lack of exposure/educational opportunities; culture and support; autonomy and micromanagement; work hours/load; work-life integration; financial burden; regret; positive reactions; built environment; and effective evaluation. The top five themes associated with burnout were ranked in the following descending order: culture and support (coded 17 times), leadership of mentors, directors, and faculty (coded 7 times), wellness and well-being (coded 7 times), and lack of exposure/educational opportunities (coded 6 times).

DISCUSSION

While there was no statistical difference in burnout or EQ scores between those who changed their specialty and those who did not, higher EQ skills were found to be potentially protective against burnout among physicians-in-training with a moderate inverse correlation between the variables. Additionally, those who changed their specialty and reported high satisfaction with the change had higher EQ and lower burnout scores compared to those who reported less satisfaction.

The research on burnout in medical students and residents indicates that factors affecting their specialty choice are personal compatibility with the specialty, followed by

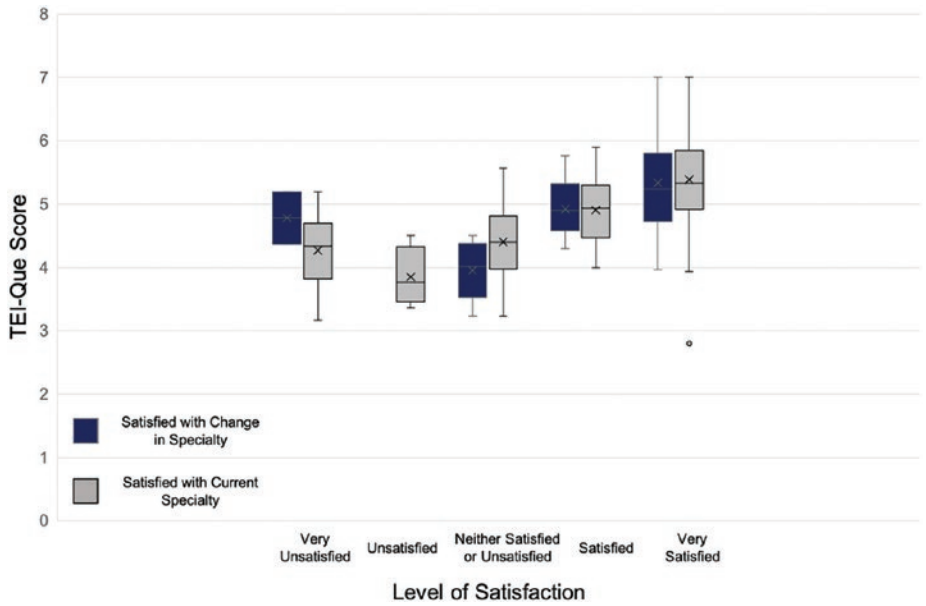


Figure 1. Associations Between Emotional Intelligence and Satisfaction with Current Specialty and Change in Specialty

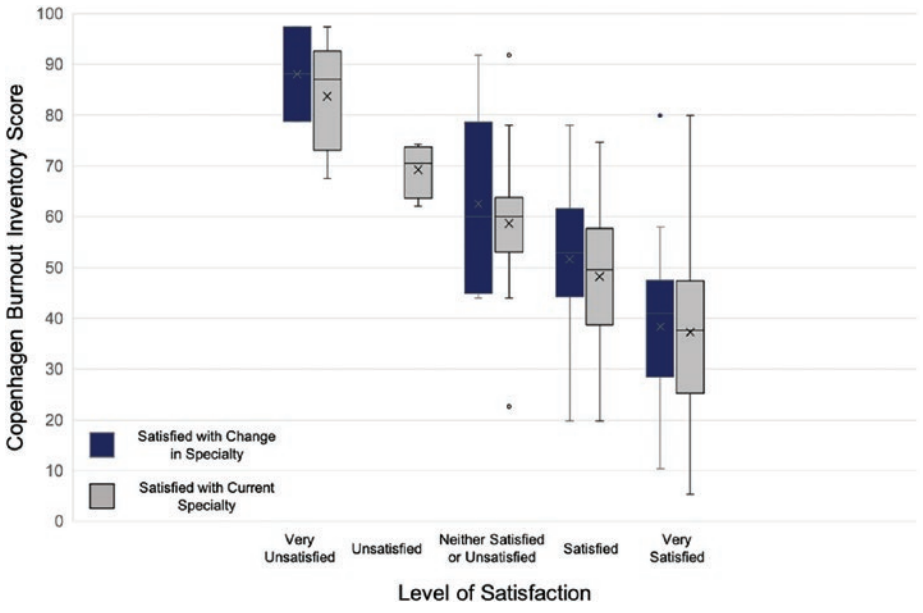


Figure 2. Associations Between Burnout and Satisfaction with Current Specialty and Change is Specialty

workload and work-life balance.[11,22,23] This is consistent with our findings that personality fit is the leading reason for changing specialty.

The mechanism of decision-making during specialty choice is complex and requires high levels of self-awareness, self-confidence, and self-recognition in order to achieve personal fulfillment.[15,22] EQ as a construct consolidates these major skills.[15] Individuals with high EQ were found to excel in decision making and experience less burnout.[24,25]

Choosing the specialty that is consistent with personality factors and leans toward higher satisfaction may ultimately lead to less burnout. As one responder stated, *"I wish I would have known about some of the other areas in medicine prior to doing what I do. I think having more time to myself*

would make me happier. I think sleeping more would also make me happier. I feel like medicine has stolen the best years of my life and spit right back at me without thanking me for it. All in all, I'd never choose medicine again and I would never recommend it to someone with high intelligence to choose this unforgiving field."

Even though the findings of this study did not support our hypothesis, several respondents reported in the open-ended question that culture and support, as well as leadership quality of mentors, directors, and faculty, were the leading contributors to burnout in comparison to studies that reported bureaucracy and long work hours to be the primary reasons.[26,27]

Several studies have stressed competent medical leadership as important for achieving high-quality healthcare, well-established communication, and high-performance teamwork.[28-30] Competent leadership qualities include high levels of self-awareness, empathy, cultural sensitivity, and professionalism[31]; many respondents in the current study cited these as lacking among leaders.

Respondents described their experience with lack of empathy from program leaders, lack of opportunity to voice their concerns, and lack of respect. One respondent reported a *"lack of respect in interactions with other employees — whether residents from other specialties, nursing, social works, fellows/attendings. A lot of our day is spent by people not respecting our decisions and our choices, and there is never a time to debrief and discuss what happens. This leads to internalizing a lot of emotions and frustrations, creating emotional fatigue and burnout."*

Physicians-in-training were demanding more *"room for mistakes"* and *"organized lectures, more mentor relationships and career guidance."* They also asked for *"Effective leadership. Support. Wellness"* because they believe that the problem is not with the specialty but with the program itself. One respondent said, *"Love my specialty. Hate my program."* It was also suggested that the *"wellness time should be more tailored to individual needs. If personal time is what is required, then that should be okay. Modules that describe what wellness is do not promote wellness."*

These inputs point to the need for well-developed EQ courses that enhance skills at the interpersonal level. These inputs also point to the importance of equipping physicians-in-training with EQ skills before they begin practicing in the field and that EQ courses should not be limited to physicians-in-training but also to include physicians in the process of becoming leaders.

These findings suggest that an important factor contributing to burnout is culture and support. In many previous studies, this factor was ranked third among factors contributing to burnout, yet it was least-addressed.[27,32] Our research suggests that this factor is as important as limiting work hours and workload.

The assurance of the success of physicians-in-training in working in any healthcare organization relies on emotional culture, which is comprised of exchange and expression of emotions working together in one organization.[33]

Numerous studies have shown the significant impact of emotions on decision making, commitment to program, engagement in activities, and performance.[33-35] When the healthcare organization had strong culture, it was reported that employees became more engaged, had a deeper sense of connection working with other employees, and a unique experience that prevented them from quitting.[33-35] Having regular EQ courses and burnout checkups throughout medical education and training with an emphasis placed greatly on program directors as their EQ skills and burnout level could influence their interaction with their team and ensure positive emotional culture for learners.[30,36] An emotionally less-exhausting culture can also be achieved by enacting a policy mandating that burnout measures be part of the health accreditation system report for institution incentives.

LIMITATIONS

Limitations of the study include the relatively small sample size, which could result in response bias. Further, responses represented trainees across different specialties, but due to limited sample size, results were not stratified by specialty, and specialty-specific culture could vary.

Also, this study was administered toward the end of the academic year and during the COVID-19 pandemic; consequently, some of the burnout results could have been elevated due to historical bias. Additionally, this study was conducted at a single academic medical center that offers a variety of residency and fellowship programs; thus, the findings might not be generalizable, as each institute or even department has its own structure and design of its own program.

Another limitation is that the results from the TEIQue-SF reflect self-report measures that could have been affected by respondents who believe they must answer a particular way.[37] Lastly, as this was a cross-sectional analysis, only associations between the variables could be ascertained, and no causal relationships could be explored or assumed.

Future studies might want to control for this limitation by asking peers or supervisors to rate the person's EQ skills. Additionally, future research should aim to attain a higher response rate as well as include multiple institutions to ensure these trends are not specific to the institution where these data were collected.

CONCLUSIONS

EQ skills are important in the process of decision-making and career retention. Combating burnout starts with choosing the specialty that fits one's personality and continues with sustaining good culture and support during training.

At a personal level, EQ skills and a high satisfaction with specialty are cornerstones to less burnout and successful

career experience for physicians-in-training. Future research should investigate EQ skills using a qualitative method, and conduct the investigation at both personal and interpersonal levels. It is also important that each specialty be actively engaged in tailoring the EQ training programs that serve the needs of the department.

Nonetheless, medical schools should also introduce EQ courses earlier in the medical education. Teaching medical students the skills of EQ such as communication, decision-making, understanding and perceiving nonverbal cues from colleagues will significantly prepare them for the next step in the field, which is residency training.

REFERENCES

1. Dyrbye LN, Thomas MR, Huntington JL, *et al*. Personal Life Events and Medical Student Burnout: A Multicenter Study. *Acad Med*. 2006;81(4):374–384.
2. Shanafelt TD, Sloan JA, Habermann TM. The Well-being of Physicians. *Am J Med*. 2003;114(6):513–519.
3. (ACGME) ACfGME. Common Program Requirements (Residency). www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf. 2019.
4. Maslach C, Leiter MP. *The Truth About Burnout: How Organizations Cause Personal Stress and What to Do About It*. San Francisco:Jossey-Bass;1997.
5. Maslach C, Leiter MP. Understanding the Burnout Experience: Recent Research and Its Implications for Psychiatry. *World Psychiatry*. 2016;15(2):103–111.
6. Patel RS, Bachu R, Adikey A, Malik M, and Shah M. Factors Related to Physician Burnout and Its Consequences: A Review. *Behavioral Sciences* (Basel, Switzerland). 2018;8(11).
7. (AAMC) AoAMC. Continuity of Specialty Preference on the Matriculating Student Questionnaire and the 2020 Graduation Questionnaire. 2020. www.aamc.org/data-reports/students-residents/interactive-data/report-residents/2020/table-a1-continuity-specialty-preference-matriculating-student-questionnaire.
8. Davis WK, Bouhuijs PJ, Dauphine WD, *et al*. Medical Career Choice: Current Status of Research Literature. *Teaching and Learning in Medicine*. 1990;2(3):130–138.
9. Tardiff K CD, Seiferth C, Perry S. Selection and Change of Specialties by Medical School Graduates. *J Med Ed*. 1986;61:790–796.
10. Weisman CS LD, Steinwachs DM, Chase GA. Male and Female Physician Career Patterns: Specialty Choices and Graduate Training. *J Med Ed*. 1980;55(10):813–825.
11. Iturki ST, Albusair MK, Alhumaid F, Alsharif S, *et al*. Factors Influencing the Choice of Radiology Subspecialty Among Radiology Trainees in Saudi Arabia. *Curēus* (Palo Alto, CA). 2019;11(11):e6149–e6149.
12. Dyrbye LN, Burke SE, Hardeman RR, Herrin J, *et al*. Association of Clinical Specialty with Symptoms of Burnout and Career Choice Regret Among US Resident Physicians. *JAMA*. 2018;320(11):1114–1130.
13. Schafer SW, Hearst N. Is Medical School the Right Place to Choose a Specialty? *JAMA*. 2001;285(21):2782–2783.
14. Yip JA, Stein DH, Côté S, Carney DR. Follow Your Gut? Emotional Intelligence Moderates the Association Between Physiologically Measured Somatic Markers and Risk-taking. *Emotion*. 2020;20(3):462–472.
15. Goleman D. *Working with Emotional Intelligence*. New York: Bantam;1998.
16. (AAMC) AoAMC. Careers in Medicine: Assessment Dashboard. 2021. https://mec.aamc.org/cim-assessments/#/landing.
17. Harris PA, Thielke R, Payne J, Gonzalez N, Conde JG. Research Electronic Data Capture (REDCap) — A Metadata-driven Methodology and Workflow Process for Providing Translational Research Informatics Support. *J Biomed Inform*. 2009;42(2):377–381.
18. Sestili C, Scalingi S, Cianfanelli S, *et al*. Reliability and Use of Copenhagen Burnout Inventory in Italian Sample of University Professors. *Int J Environ Res Public Health*. 2018;15(8).
19. Creedy DK, Sidebotham M, Gamble J, Pallant J, Fenwick J. Prevalence of Burnout, Depression, Anxiety and Stress in Australian Midwives: A Cross-sectional Survey. *BMC Pregnancy Childbirth*. 2017;17(1):13.
20. Petrides KV. Psychometric Properties of the Trait Emotional Intelligence Questionnaire. In *Advances in the Assessment of Emotional Intelligence,* eds. Stough C, Saklofske DH, Parker JD. New York: Springer;2009.
21. Robinson E, Hull L, Petrides KV. Big Five Model and Trait Emotional Intelligence in Camouflaging Behaviours in Autism. *Personality and Individual Differences*. 2020;152.
22. Yang Y LJ, Wu X, *et al*. Factors Influencing Subspecialty Choice Among Medical Students: A Systematic Review and Meta-analysis. *BMJ*. 2019;9(e022097).
23. Smith F LT, Goldacre MJ. Factors Influencing Junior Doctors' Choices of Future Specialty: Trends over Time and Demographics Based on Results from UK National Surveys. *J R Soc Med*. 2015;108(10):396–405.
24. Cofer KD, Hollis RH, Goss L, Morris MS, Porterfield JR, Chu DI. Burnout Is Associated With Emotional Intelligence But Not Traditional Job Performance Measurements In Surgical Residents. *J Surg Ed*. 2018;75(5):1171–1179.
25. Satterfield J, Swenson S, Rabow M. Emotional Intelligence in Internal Medicine Residents: Educational Implications for Clinical Performance and Burnout. *Ann Behav Sci Med Educ*. 2009;14(2):65–68.
26. Pejuskovic B, Lecic-Tosevski D, Priebe S, Toskovic O. Burnout Syndrome Among Physicians–The Role of Personality Dimensions and Coping Strategies. *Psychiatr Danub*. 2011;23(4):389–395.
27. Kane L. Medscape National Physician Burnout & Suicide Report 2020: The Generational Divide. Medscape;2020.
28. Chen TY. Medical Leadership: An Important and Required Competency for Medical Students. *Ci Ji Yi Xue Za Zhi*. 2018;30(2):60–77.
29. Warren OJ, Carnall R. Medical Leadership: Why It's Important, What Is Required, and How We Develop It. *Postgrad Med J*. 2011;87:27–32.
30. Shanafelt T, Swensen S. Leadership and Physician Burnout: Using the Annual Review to Reduce Burnout and Promote Engagement. *Am J Med Qual*. 2017;32(5):563–565.
31. Goleman D. *Emotional Intelligence: Why It Can Matter More Than IQ*. New York: Bantam Books;1995.
32. Nicholls M. Cardiologists and the Burnout SCENARIO. *Euro Heart J*. 2019;40(1):5–6.
33. Barsade S, O'Neill OA. Manage Your Emotional Culture: Most Leaders Focus on How Employees Think and Behave — But Feelings Matter Just as Much. *Harvard Business Review*. 2016.
34. Johnson DR. Emotional Intelligence and Public Health Education: A Prescriptive Needs Assessment. *Pedagogy in Health Promotion*. 2016;2(3):193–200.
35. Freshman B, Rubino L. Emotional Intelligence: A Core Competency for Health Care Administrators. *The Health Care Manager*. 2002;20(4):1–9.
36. Shanafelt TD, Gorringe G, Menaker R, *et al*. Impact of Organizational Leadership on Physician Burnout and Satisfaction. *Mayo Clin Proc*. 2015;90(4):432–440.
37. Butt M, Wagner A, Rigby A. Associations of Social Desirability on Psychological Assessment Outcomes for Surgical Weight Loss Patients. *Clin Psychol Med Settings*. 2021; 28(2):384–393.

DOI: https://doi.org/10.55834/plj.4085202057
Copyright © 2022 by American Association for Physician Leadership®

Eiman Khesroh, MBBS, DrPH, is a physician at the Ministry of Health of Kuwait and was previously a DrPH student at Penn State College of Medicine.
Ezk241@psu.edu

Melissa Butt, DrPH, is a postdoctoral fellow in the Department of Family and Community Medicine at Penn State Milton S. Hershey Medical Center.

Annahieta Kalantari, DO, FACEP, FACOEP, is associate program director of emergency medicine residency and vice chair of education in the Department of Emergency Medicine at Penn State Milton S. Hershey Medical Center.

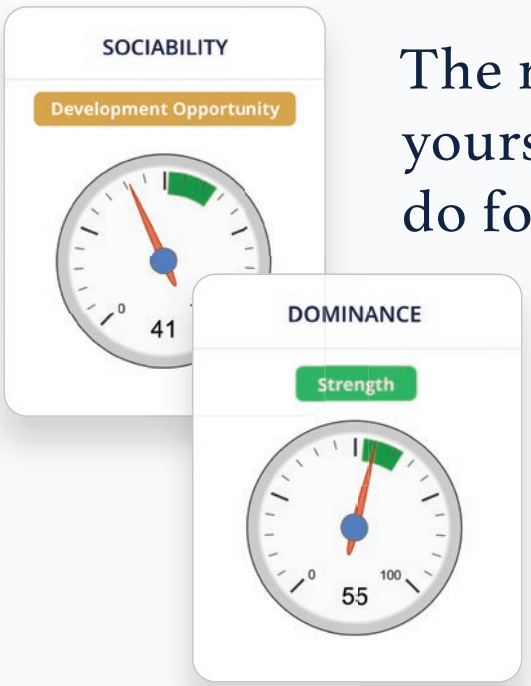
Yendelela Cuffee, MPH, PhD, is an assistant professor in the epidemiology program at the University of Delaware.

Douglas Leslie, PhD, is a professor and chief of the health services and behavioral research division in the Department of Public Health Sciences at Penn State College of Medicine.

Sarah Bronson, PhD, is associate dean for Interdisciplinary research and associate professor in the Department of Cellular and Molecular Physiology at Penn State College of Medicine.

Betsy Aumiller, DEd, is an assistant professor in the Department of Public Health Sciences, Division of Health Services and Behavioral Research and program director of the Doctor of Public Health (DrPH) program at Penn State College of Medicine.

Andrea Rigby, PsyD, is an associate professor in the Department of Surgery, Division of Minimally Invasive Surgery at Penn State Milton S. Hershey Medical Center.



The more you know about yourself, the more you can do for others.

By discovering and understanding the critical insights and characteristics that push you ahead, and those that keep you behind, you will greatly enhance your life, career and the care you provide to others.

40 Minutes Start by taking the self-assessment today at **physicianleaders.org/leadership-assessment**

Archetypes of Burned-Out Physicians and How To Help Them

R. John Sawyer II, PhD, ABPP-CN, and Ashton Sloan, PA-C, MSHA

Most burnout interventions emphasize large-scale organizational changes to the practice environment, such as technological innovations and practice efficiency to reduce EMR use or optimize the functions of nonphysician care team members. However, these critical organizational efforts to mitigate burnout take significant time to assess, implement, and re-assess to determine effectiveness. Although decades of research show that individual personality traits significantly influence occupational outcomes, the physician burnout literature has focused less on how personality factors influence physician wellbeing. Lessons from Ochsner Health's new internal physician coaching program — informed by ongoing research into physician personality factors — suggest that four core personality typologies affect burnout in the current healthcare environment.

Clinician burnout in medical practice represents a significant problem that is exacerbated by the series of COVID-19 pandemic waves. Workplace burnout is characterized as a psychological syndrome involving emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment.[1,2] It is associated with numerous healthcare organizational metrics, including higher physician turnover, lower patient satisfaction, various quality metrics, and decreased productivity.[3] National estimates of physicians experiencing at least one symptom of burnout vary and range from 44% to 66% of U.S. physicians with a financial impact of almost $5 billion annually.[4,5,6]

Key drivers of burnout include *systemic factors* (e.g., regulatory requirements, payor challenges), *organizational factors* (e.g., lack of job control, excessive workloads, stressful team dynamics, conflicting metrics, practice inefficiency, leadership, workplace support structures), and *personal factors* (e.g., change in interest/goals, home situational factors).[7,8] Since many dynamics influence physician wellbeing, the entire healthcare ecosystem (e.g., leaders, health systems, payors, individual physicians, etc.) has the shared task of reducing burnout.

In 2018, Ochsner Health created the Office of Professional Well-Being (OPW) as a resource to help mitigate burnout and promote the well-being of physicians and advance practice providers (APPs). Our work is focused heavily on organizational/systemic factors such as practice efficiency, leadership development, and team-based care strategies. Because system-level changes take time, in addition to our long-range strategy, we concentrated on physicians with more severe burnout who needed immediate support in the form of one-on-one peer coaching.

PERSONALITY AND PHYSICIAN BURNOUT

Unfortunately, there is little discussion and research into personality-based factors that lead to burnout in medical professionals. We imagine this gap exists for various reasons, including the understandable desire to avoid "blaming the victim" and the current consensus that physician burnout is primarily a response to the healthcare system.[8] Nevertheless, research shows that personality factors, such as one's degree of agreeableness and openness to change, contribute to individual physician burnout symptoms.[9]

We maintain that focusing on individual-level factors is not a deflection of blame away from systems/organizations, but instead provides additional tools to better address physician burnout. Moreover, because systemic factors impacting burnout, given their inherent complexities, take longer to address, individual factors are more easily coachable — particularly if leaders are attentive and skilled at helping their teams.

PROFESSIONAL EXPERIENCE PROGRAM (PXP)

Given the support for one-on-one coaching to improve physician burnout,[7,10] we developed an internal coaching

program (Professional Experience Program or PXP) to support physicians who had more significant burnout. In working individually with more than 30 clinicians experiencing moderate to severe burnout in the PXP, we have identified four personality styles or "archetypes." These archetypes, like all personality styles, have strengths; however, when the person is under considerable stress, these strengths can become liabilities and make a stressful situation even worse.

Consider, for instance, the physician who is detail-oriented. Usually, this is a desirable characteristic because we want physicians to avoid careless errors. Taken to an extreme, obsessiveness can slow down physicians so much that they may have difficulty maintaining a normal workload or focusing on the bigger picture. This is an example of a strength becoming a liability.

ARCHETYPE/PERSONALITY AND LEADER MANAGEMENT STRATEGIES

Successful physician leaders know their teams well — what makes them happy, what frustrates them, etc. When a leader begins to sense that a physician is burned out, that leader might ask *what burnout archetype or blend thereof do they fit into?* Then, based on the physician's archetype, leaders can select from specific coaching tactics to help that physician address the factors affecting their burnout.

Critically, the four proposed archetypes are not meant to pigeonhole physicians; many may fit into more than one personality type. These archetypes are presented as a conceptual frame of reference to help leaders more easily and quickly help burned out team members (Table 1). Leaders should also know when it is more appropriate to involve behavioral health to support their physicians more intensively.

TYPE 1: OVER-ENGAGED

The over-engaged archetype is common in healthcare. We all know these people. Over-engaged physicians reflexively say yes and quickly become overextended. Their key needs are to feel valued, successful, important, relevant, and "always part of the solution." They fear feeling irrelevant, feeling stagnant, not being promoted, and losing value within the group.

Leaders might observe the following behaviors: reflexively saying yes, overestimating the professional consequences of saying no, and being known by colleagues as someone who does too much, resulting in their sense of being overwhelmed and burned out.

The core leader strategy is to help the physician stay engaged for the long term and not burn out too fast. Leaders often avoid having burnout conversations with the over-engaged physician out of fear of upsetting or completely disengaging the individual.

Like any feedback or potentially "difficult" conversation, it can be helpful to start with acknowledging how valued the over-engaged physician is. *Remember, they want to feel valued*. Next, it is important to ask them if they feel overly stretched. You may say, "How can you do so much? I'd be exhausted!" or "Is your tank near empty?" or "Are you passionate about everything you are involved in right now?"

Note: In this moment, the over-engaged physician still wants you to be impressed with them. If you don't think the physician is being completely open with you, it is okay to take a risk. You might say something like, "You seem overextended. How can I help us have a safe and open conversation about that?"

When the over-engaged physician acknowledges doing too much, the second part of the coaching conversation must focus on understanding the *why*. What are they hoping to achieve (a promotion, a specific role, compensation, etc.)? It is essential for leaders to know the answer to this question, and to do so, they may need to ask explicitly about the physician's goals. This helps them focus on tasks that align with their core goals.

Once you understand their *why*, the third part of the coaching conversation involves asking them to offload certain tasks. Remind them that saying no to requests will help

Table 1. Archetypes and Leader Management Strategies

Archetypes	Observables	Key Question	Key Task
Over-Engaged	• Reflexively saying yes • Clearly doing too much	• What are your main goals	• Becoming more reflective about what tasks they take on
People Pleaser	• Avoiding speaking up • Trouble stating their needs • Weak boundaries around their time	• What is not working well in your current practice?	• Improving self-advocacy
Perfectionist	• Inefficient documentation • Working below their license • Trouble delegating	• What task(s) could be less perfect?	• Directing their perfectionism to where it matters
Cynic	• Worst case scenario thinking • Help rejecting complainer • Assumes negative intent	• Are you open to being less cynical and looking for positives?	• Seeing that cynicism is not working for them

them direct energy to their goals. Moreover, offloading tasks can be an opportunity for someone else to step up.

Finally, leaders need to check frequently with over-engaged physicians to ensure they are consistently being more reflective before saying yes and cultivating a greater work-life balance as a result of their action.

TYPE 2: THE PEOPLE-PLEASER

Despite popular culture's depiction of doctors as overly demanding and assertive, many physicians struggle with facing confrontation and setting limits/boundaries. Key needs for the people-pleasing physician are living in harmony, being liked and well regarded, and feeling helpful and reliable to the team. Key fears include being disliked, facing confrontation, upsetting others, and not being perceived as a team player.

Leaders can observe these people-pleasing physicians doing various things such as not expressing a difference of opinion, avoiding delegation for fear of dumping on colleagues/staff, and preferring to fix someone's mistake rather than provide corrective feedback. As a leader of people-pleasing physicians, your goal is to help improve their self-advocacy and ability to clearly express their needs. As Brené Brown says, "Clear is kind."[11]

When leaders approach a people-pleasing physician, they must remember that this archetype tends to avoid confrontation. Leaders may hear "everything is fine" or "I don't want to rock the boat…" Leaders should foster enough psychological safety for the people-pleasing archetype to ensure an authentic conversation. If you are uncertain of how your message will be received, it may be helpful to say, "This is 'off the record,' and I really need your honesty here; nothing is going to upset or surprise me."

Next, model clear communication by expressing your concern for them and how they seem burned-out to you. To reduce stigma and foster a feeling of safety, you may also share your own burnout experience.

The second task for the leader is to help this physician identify how aspects of their people-pleasing personality contribute to their burnout, but avoid discussing what the physician cannot control.

For example, a physician may say, "I'm burned out because patients want to talk about every problem, and I don't have enough time." Help this physician set clear boundaries and expectations during patient visits. When people-pleaser physicians communicate how setting boundaries is impossible with "But, that will make patients angry," or "My patient experience scores will tank," your job as a leader is to help them realize that their approach is working against their goal of maintaining a sustainable/joyful medical practice.

Third, the coaching conversation must transition to the leader helping the physician identify one tangible day-to-day practice that increases their comfort with speaking up, setting a boundary, or being clear about what they need. Check in to ensure this goal is consistently being met.

TYPE 3: THE PERFECTIONIST

Perfectionism is highly rewarded in medicine — after all, what patient does not want "perfect" results from their healthcare? The perfectionist physician archetype leverages control over all aspects of a patient's care and finds delegation and trusting other care team members daunting.

Leaders who coach these physicians are wise to identify key needs of excellence, autonomy, and control. Key fears involve losing control, falling short of internal/external standards, compromising unnecessarily, and failing or making a mistake.

Leaders can recognize these at-risk physicians as those who take overly detailed/long clinical notes, assume tasks other staff should/could do, or say, "Better to do this myself." Often these physicians are exasperating because no one on the team can live up to their expectations.

Leaders who work with a perfectionist archetype should not tell the physician to "just relax and let go." Telling someone to relax when they are tightly wound usually makes them feel misunderstood. Instead, leaders must praise these physicians for their standards. Next, they should coach them to recognize how their perfectionism/need for control has clear *costs*. The goal here is to show that perfectionism and being overly controlling can have diminishing returns, meaning their perfectionism is working against their goals. For example, is that perfect note worth it when the physician does not have time to respond to an urgent patient issue?

Next, with established buy-in, have these physicians identify tasks about which they could be less perfectionistic or tasks they can delegate. Finally, develop concrete metrics to assess their follow-through. For instance, a leader can use data from the medical record to review documentation efficiency or the level of team collaboration.

TYPE 4: PROBLEM FINDER/CYNIC

Cynical archetypes are well known. They are excellent at pointing out problems in meetings, saying, "I knew it" when things fall apart, and are quick to perceive negative intentions. Often, a leader's primary management strategy with the cynic physician is avoidance or sarcasm/humor ("there goes Dr. X spouting off again"). Unfortunately, these physicians are often the most wounded in the group, and management by avoidance typically leads to ongoing problems for the leader and the surrounding team.

Key needs for the cynic physician archetype include self-protection, trust, strength, and transparency. Leaders should understand that these primary needs are rooted in fears, including fear of being let down, fear of being taken

advantage of, and fear of being perceived as weak. The physician cynic tends to rant about minor issues, see the worst-case scenario first, assume people have hidden agendas until proven otherwise, and quickly reject solutions after pointing out a problem.

Leaders should first show empathy with cynics even though they initially view these physicians as "difficult" and causing their own problems. Empathic leader behaviors might include arranging initial interactions that establish trust and safety, such as bringing coffee to their office, inquiring about their well-being and listening to their response. The aim is to open a trust bank account, because these cynic physicians have often lost trust in their leader or organization.

Next, it is critical to be authentic and transparent when you are ready to talk to them about burnout. Be clear and concrete (e.g., have a list of examples/behaviors) about how you see their cynicism and how their problem-finder behavior contributes to their burnout. Next, affirm that these physicians have had past experiences that contribute to their cynicism, such as instances when the physician was let down or treated unfairly. This helps them know you "get it."

Finally, help these physicians recognize that their default cynical/problem-finding attitude may be doing more harm than good by contributing to these negative interactions. Suggest these physicians try to notice positive things staff members do and verbalize the acknowledgment more frequently. Staff will immediately notice the change if the physician does this.

Next, talk to them about how to *productively* discuss problems or to assess for trust rather than always assuming the worst at the outset. The overall goal is to help the cynics realize that their attitude and perceptions partially contribute to their burnout.

NEXT STEPS FOR PHYSICIAN LEADERS

Physician leaders struggle to balance two key tasks when dealing with burned-out physicians: projecting enough empathy and responsiveness so team members feel heard and effectively communicating what the leader or organization is doing to address the systemic problem for the burned-out physician.

When considering the personality types described above, physician leaders have a *third task* to support their team members. This third task is important to quell burnout, and is understandably difficult. Frontline physicians do not want their legitimate organizational problems ignored, and leaders do not want to appear as though they are shifting blame. Leaders must explicitly highlight everyone's role in mitigating burnout: the leader's tasks, current/planned organizational work, and the frontline physician's tasks.

As physician leaders support burned-out staff, transformative moments can occur when a leader coaches over-engaged physicians to offload work or reminds the perfectionist to focus on details that matter. This and similar individual-based strategies are an important element in the wellbeing toolkit. Leaders can help physicians address burnout more quickly and personally. After all, organizationally driven well-being strategies that work today may be irrelevant tomorrow in our rapidly changing healthcare ecosystem.

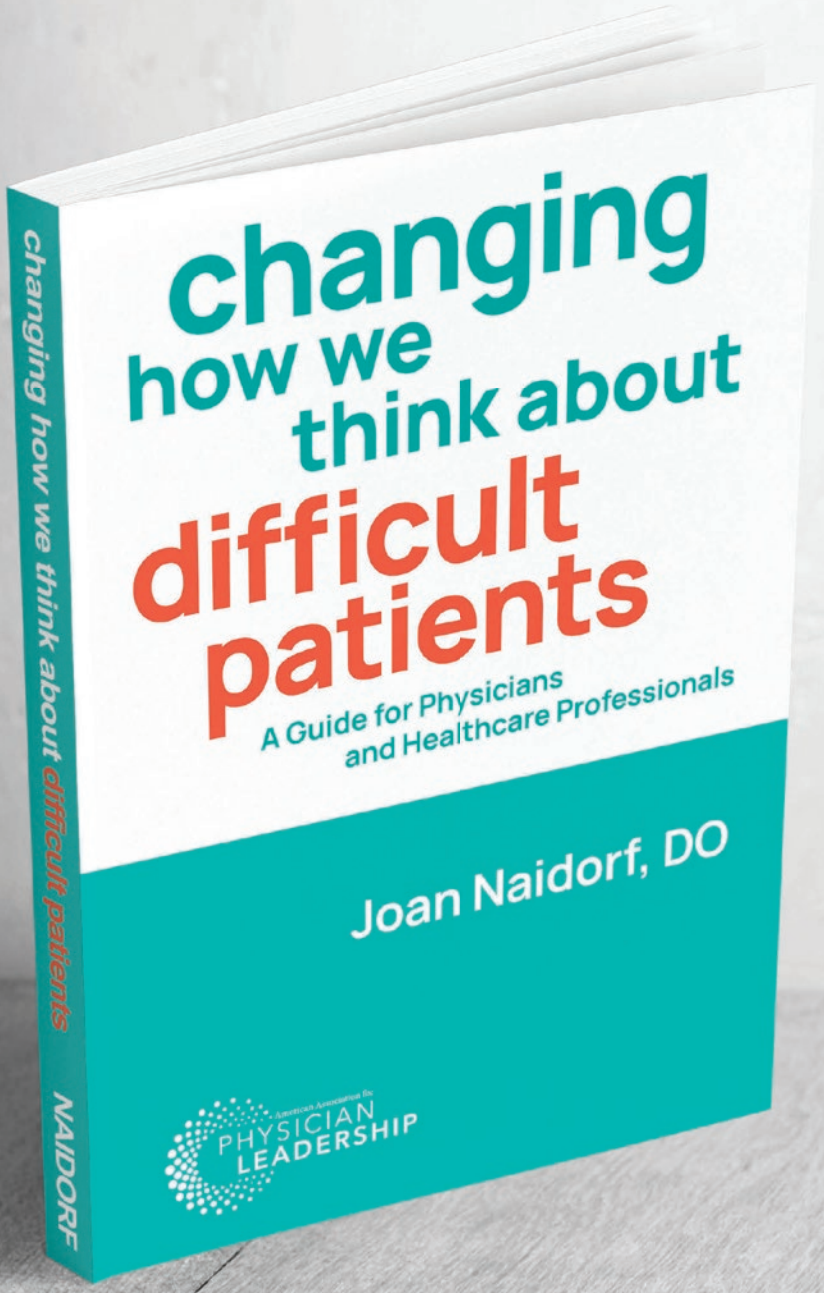
REFERENCES

1. Maslach C. *Burnout: The Cost of Caring*. Englewood Cliffs, NJ: Prentice Hall; 1982.
2. World Health Organization. International Statistical Classification of Diseases and Related Health Problems (11th rev.). 2019. https://icd.who.int/
3. Han S, Shanafelt TD, Sinsky CA, *et al*. Estimating the Attributable Cost of Physician Burnout in the United States. *Ann Intern Med*. 2019;170:784–790.
4. Kane L. "Death by 1000 Cuts": Medscape National Physician Burnout & Suicide Report 2021. Medscape; January 22, 2021.
5. Shasha Han, TD. Shanafelt, Sinsky CA, et al. Estimating the Attributable Cost of Physician Burnout in the United States. *Ann Intern Med*. 2019;170:784–790.
6. Shanafelt TD, West, CP, Sinsky C, *et al*. Changes in Burnout and Satisfaction With Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2017. *Mayo Clin Proc*. 2019;94(9):1681–1694.
7. West CP, Dyrbye LN, Shanafelt TD. Physician Burnout: Contributors, Consequences, and Solutions. *J Intern Med*. 2018 Jun;283(6):516–529.
8. Shanafelt TD, Noseworthy JH. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. *Mayo Clin Proc*. 2017;92:129–146.
9. Brown PA, Slater M, Lofters A. Personality and Burnout Among Primary Care Physicians: An International Study. *Psychol Res Behav Manag*. 2019;12:169–177. doi:10.2147/PRBM.S195633.
10. Dyrbye LN, Shanafelt TD, Gill PR, Satele DV, West CP. Effect of a Professional Intervention on the Well-being and Distress of Physicians: A Pilot Randomized Clinical Trial. *JAMA Intern Med*. 2019;179(10):1406–1414. doi:10.1001/jamainternmed.2019.2425)
11. Brown B. *Dare to Lead*. New York: Random House; 2018.

DOI: https://doi.org/10.55834/plj.7733527450
Copyright © 2022 by American Association for Physician Leadership®

R. John Sawyer, II, PhD, ABPP-CN, is the medical director of Professional Staff Experience in Ochsner Health's Office of Professional Wellbeing in New Orleans, LA. Clinically, he is a neuropsychologist and co-directs the Center for Brain Health within the Ochsner Neuroscience Institute.
Robert.sawyer@ochsner.org

Ashton Sloan, PA-C, MSHA, serves as assistant vice president also in Ochsner Health's Office of Professional Well-Being. Clinically, he is an ICU physician assistant.
wsloan@ochsner.org



Strategies for interactions with patients and families that challenge you the most.

Regular Price: $32
Member Price: $28

Joan Naidorf, DO

To purchase, visit
www.physicianleaders.org
/difficult-patients

American Association for PHYSICIAN LEADERSHIP

Gearing Up For Digital Transformation

Lola Butcher

The use of digital tools to improve the quality of care delivery is a top priority for health systems. Are you ready?

Digital transformation — the use of digital tools to improve the quality and efficiency of care delivery — is a top priority for health systems. Indeed, 99% of U.S. health system leaders responding to a HIMSS survey in late 2021 said investing in digital transformation is "very important" or "somewhat important."

The physicians and other clinicians working in those systems, however, may have a limited view of what digital transformation entails and how it will affect their work, says Darryl Gibbings-Isaac, MD, a clinical innovation subject-matter expert with Accenture, a member of the HIMSS Trust partnership.

Many clinicians responding to the survey considered their organization's digital efforts to be at an advanced level; 16% said digital transformation has been completed. In reality, Gibbings-Isaac says, the digital transformation of healthcare is just getting started.

Nearly 80% of health systems are in the process of digital transformation, according to system-level executives who submitted survey responses. And their work will never be done, Gibbings-Isaac says: "The transformation is not an end destination — it is an ongoing journey."

Gibbings-Isaac, an internist by training, attributes the disconnect to the fact that most clinicians are using some digital tools, but they are not seeing the big picture. He points to a likely explanation: 32% of clinicians cited a lack of clear communication of what digital transformation means within their organization.

There were other worrisome results from clinician respondents as well:

- Almost half said digital tools were a burden or wasted their time.
- A majority (69%) said that digital transformation contributed to greater work-related stress.

Still, Gibbings-Isaac and other physician executives interviewed by *Physician Leadership Journal* say the digital transformation of healthcare does not have to follow the torturous path of electronic health record (EHR) adoption. Rather, there are lessons learned from the EHR adoption that should inform health systems' plans as they embrace new ways of delivering care, courtesy of digital technology.

"This is an organization-wide endeavor, and it requires the same change management practices that we need for any other major change," says Stephanie Lahr, MD, chief information officer and chief medical information officer at Monument Health, a six-hospital system based in Rapid City, S.D. "Just because something is better doesn't mean adopting it won't be hard work and disruptive at times."

BE STRATEGIC

Chief digital officer Nick Patel, MD, is in charge of transforming care delivery in Prisma Health, an 18-hospital system based in Columbia, S.C. "I don't start with technology," he says. "That is the last thing that should be on your mind when you think about digital transformation."

He views transformation through three domains: patient access/experience, operational efficiency, and population health. "You have to look at all the issues and almost do a SWOT (strengths/weaknesses/opportunities/threats) analysis of the organization in each area," Patel says.

That assessment, along with a review of current workflows, is used to identify where technology can move an organization toward its strategic goals.

For example, Prisma Health wants to enhance primary care, which means making it easy for patients to find the doctor who is right for them. To do so, the health system created a robust provider directory that allows patients to compare physicians online. "We have very detailed videos so the provider talks in layman's terms not just about healthcare, but about themselves," he says.

To help patients access the right care at the right time, Patel's team created a digital health continuum of services. "I started off looking at a journey map for a patient: What does it look like for a person to be seen?" he says. "I wanted to align technology that made sense for that journey."

Depending on a patient's situation, the right care might be asynchronous care delivered electronically, a synchronous video visit, an enhanced video visit in which a wearable device or an at-home digital kit provides diagnostic information for the provider, a hospital-at-home admission, or monitor-at-home care that supports early discharge from a hospital stay.

Prisma Health is working to deploy customer relationship management technology so that everyone in the organization knows which patients need, for example, a chatbot nudge to schedule a mammogram or a telephone call to check on their status.

To support population health management, Prisma Health uses technology to identify patients' care gaps and remind them to schedule colonoscopies, vaccinations, and other routine care at the appropriate time. The system also uses technology to identify patients who need help with chronic care management.

"You look at your clinical data to find your patients with diabetes, hypertension, or congestive heart failure that is uncontrolled and give them a kit that allows the care team to monitor them remotely and do real-time management so they get to their goals faster," Patel says. "It's very important for chief medial officers to partner with their chief digital officers to try to meet those benchmarks."

FOCUS ON THE BENEFITS

MyMichigan Health, based in Midland, Mich., operates 10 medical centers in 25 counties, serving a large rural population. Adopting a single electronic medical record system for the entire system in 2017 set the foundation needed to be an early adopter of technology that moves care delivery closer to patients where they live says Pankaj Jandwani, MD, regional vice president for medical affairs and chief innovation officer.

The single electronic medical record allows the information sharing among nurses, physicians, and patients needed to support virtual visits and remote monitoring, he says.

Having started telemedicine pilots in 2015, MyMichigan was well-positioned to expand its virtual care in all settings when the COVID-19 pandemic hit. It soon adopted the technology for new uses.

Capacity shortages at larger hospitals forced MyMichigan hospitalists working at a critical access hospital to manage COVID patients who needed intensive care, including ventilator management.

"During the stressful times of COVID surge and ICU bed shortages, our hospitalists and emergency teams felt immensely supported by our intensivists in Midland, who provided teleconsultations to help manage critically ill patients in our rural locations," Jandwani says.

Because of that experience, MidMichigan is currently working to implement a systemwide tele-ICU model to serve its smaller hospitals.

"Now they look back and say 'Yes, we can do this,'" Jandwani says. "The tele-ICU will reduce the need to transfer patients to our bustling tertiary care center while offering advanced ICU care closer to home at our rural sites."

MyMichigan is also using technology to help patients stay in their own homes through a tiered Hospital at Home program.

In early 2022, the Centers for Medicare & Medicaid Services (CMS) certified that MyMichigan's Hospital at Home program met its stringent requirement for treating a specific subset of patients for an acute illness in their homes. Within MyMichigan, that CMS program is called Level 1 Hospital at Home. "However, our program includes many more patients," Jandwani says.

MyMichigan Level 2 Hospital at Home patients are those who would otherwise qualify for a hospital observation stay. Remote monitoring technology and other support allow them to get discharged early, avoiding the often expensive and frustrating experience associated with observation status.

MyMichigan identifies Level 3 as those admitted, clinically stable patients who anticipate being discharged in the next 24–48 hours, but who need monitoring of their comorbidities like COPD or CHF.

"The goal for Level 3 patients is to get discharged from the hospital a little sooner, but with a comprehensive array of services like remote monitoring, nurse visits, virtual visits with our hospitalists, and close follow-up and coordination through our care managers," Jandwani says.

Level 4 patients are those who were recently hospitalized and will benefit from care management for a chronic condition such as heart failure, COPD, and diabetes for up to 90 days after their hospital discharge.

Early results show that all levels of the Hospital at Home program are reducing readmissions in a high-risk population of patients and proving to be a big patient-pleaser. "We've had nothing but rave reviews," Jandwani says. "The patient experience reports as we have delivered this care have been just heartwarming to see."

MAKE PHYSICIANS' LIVES EASIER

"My two main goals are to reduce friction points and to bring the joy back to the medicine," says Lahr, of Monument. "This ambient-listening technology is one of those things that does both of those. This is the kind of technology that makes me as a physician excited to live in this space."

She is referring to ambient clinical intelligence technology that captures clinician-patient conversations in both virtual and in-person visits and updates the electronic health record accordingly.

"We have a number of physicians across different specialties who are leveraging that note-writing technology," she says. "They can focus their attention on interacting with

their patients instead of looking at the computer screen to do their documentation or spending hours at the end of clinic working on it."

Lahr sees the voice-recognition technology evolving so that keyboards can be eliminated in exam rooms. Instead of clicking into a patient's record in search of the last CT scan, for example, the physician can ask the technology for its details. If the system recognizes that a clinician needs a data element that exists in the EHR, it will make it known.

For now, however, the technology is still developing — and it is most appropriate for early adopters who are frustrated with the burden of EHR documentation. "We go through a selection process to make sure that the physician–technology matchup is there," she says. "We will roll that tool out basically to any physician across the health system in any specialty that has a need for the tool and interest in the tool."

Monument introduced the listening technology in late 2020, and Lahr is pleased with the results so far. In most cases, physicians using it are adding more patient visits to their day, which offsets the clinic's expense for using the system.

"Even more than that, the joy and experience that both the clinician and the patient are getting out of being able to sit across from each other and have a conversation and not be trying to type or look around the computer at the same time has been so valuable," she says.

She expects that, within a couple of years, every clinic in the health system will have some physicians using the technology. She emphasizes the word "some."

"I don't know that we'll ever be at a point where everyone is using it because that's really not the point," she says. "I'm trying to make sure that the right tools are available for the right person at the right time in the right setting so that whatever and however that's defined for that provider, we can accommodate."

AVOID AVOIDABLE PROBLEMS

As organizations move forward with their digital transformation initiatives, Gibbings-Isaac warns against two common pitfalls: "Either involving clinicians too late or not having them involved enough. You're almost guaranteeing that you're going to have some friction later if you do that."

His advice:

- Before asking physicians to be trained on new technology, make sure they understand how it will benefit them and their patients. "Training is adding an extra task and amount of time into an already stretched workforce, so you need to be able to justify that to make sure the training is received in the right way," he says.
- Position technology training not as a "one and done" task, but as an ongoing collaboration between clinicians and the digital team. "It needs to be a two-way effort," Gibbings-Isaac says. "The training to get someone started with a set of tools is not the endpoint. Once someone is comfortable with these tools, how do we improve the technology, the processes around it, or the training?"
- Getting quick feedback about users' experience is important, but that's only one step. Respond to complaints and critiques by promptly addressing them.
- Clinicians like evidence, and they want to see the use of technology improve their patients' health or their own workflow. Measure the results of new technology so you can communicate that success to clinicians or adapt if it is not meeting its intended goal.

DOI: https://doi.org/10.55834/plj.2027503290
Copyright © 2022 by American Association for Physician Leadership®

Lola Butcher is a freelance healthcare journalist based in Missouri.

REFRAMING CONTEMPORARY PHYSICIAN LEADERSHIP:
WE STARTED AS HEROES

Grace E. Terrell, MD, MMM, CPE, FACP, FACPE

- Most physicians work in environments where current cultural paradigms, such as physician as hero, lead to burnout.
- Physicians have not been adequately trained in many of the skills necessary for leadership competence and therefore lose agency with respect to important decisions.
- The pace of technological change impacts physician work in ways traditional workflows cannot accommodate.

Order your copy today.
www.physicianleaders.org/reframing-physician-leadership or call (800) 562-8088.

The Role of Physicians in Endorsing Advance Medical Directives

Timothy E. Paterick, MD, JD

Physicians have a fiduciary duty to educate patients regarding all options available for end-of-life medical care as patients, physicians, and families explore together the patients' wishes for end-of-life treatment.

More than a million people have died from COVID infections since the pandemic began; many of them did not have advance medical directives indicating how they wanted healthcare decisions to be made if they were unable to express their desires. As a result, families struggled to determine the best approach to end-of-life care for their loved ones.

Advance directives guide the medical team to provide medical care and alleviate the burden on families to decide what types of medical care and treatment the patient would want. The two forms of advance directives that physicians should discuss with families are the Power of Attorney for Health Care and the Declaration to Physicians (the Living Will).

These and other documents discussed in this article are available on the internet and at some retail stores; however, if they are to be used for legal purposes, they must be notarized and properly filed.

A POWER OF ATTORNEY FOR HEALTH CARE

If patients lose the ability to make their own healthcare decisions, the Power of Attorney for Health Care designates an agent who, in collaboration with the personal physician, can make healthcare decisions for a patient. Additionally, the patient may complete a Power of Health Care addendum, which outlines treatment preferences and desires that will guide the designated healthcare agent's decision-making.

The healthcare agent can advise the patient's personal physician, physicians providing medical care, and the hospital staff on what medical treatment the patient wants in all anticipated healthcare end-of-life situations. If the Power of Attorney for Health Care has been completed correctly, in most cases, this advance directive can prevent a court-supervised guardianship or a protective placement proceeding. For this reason, it is often preferable to consult an attorney who can write or review the document as it applies to the individual situation.

The Power of Attorney for Health Care may prevent heated debates between family and healthcare providers and costly guardianship proceedings in court. It is a more robust document than the Declaration to Physicians because it can include an addendum specifying treatment preferences.

THE DECLARATION TO PHYSICIANS

The Declaration to Physicians describes the life-sustaining medical care to be given to a patient with a terminal condition or who is in a persistent vegetative state. The declaration guides the physicians and healthcare team in deciding whether to withhold or withdraw life-sustaining treatment, such as a feeding tube, if the patient cannot be "cured" and death is imminent; however, the Declaration to Physicians does not give physicians or healthcare providers authority to make healthcare decisions on the patient's behalf. A court-supervised guardianship and protective placement proceeding are required if the patient is moved to a nursing facility. Such action would be covered under a Power of Attorney for Health Care directive.

When there is no one to assume the healthcare agent role or the agent becomes incapacitated or dies, the Declaration to Physicians is the next best option. If a patient has both types of advance directives, they should be consistent; if there is any conflict, the Power of Attorney for Health Care will prevail.

Concerning life-saving measures, physicians should instruct patients that cardiopulmonary resuscitation (CPR)

is an emergency medical procedure designed to restart the heartbeat and breathing. If CPR is administered early and correctly, it may result in adequate blood pressure that allows the vital organs to survive.

If CPR does not revive the patient, the emergency team may initiate advanced cardiac life support (ACLS), which may include shocking the heart, inserting a breathing tube into the trachea, and administering intravenous medications in an attempt to support life.

The patient's medical condition plays a critical role in determining the success of CPR and ACLS. If the patient's medical condition warrants a discussion of such procedures, the physician should detail the best approaches.

A do not resuscitate (DNR) order applies to patients who suffer from a terminal medical condition or a medical condition such as severe heart, lung, kidney, or brain disease that makes it highly unlikely CPR would be successful.

To be eligible for a DNR bracelet, patients with the described medical conditions must be at least 18 years of age and not be pregnant.

The patient and the physician must sign an order for a DNR status; when approved, the physician, or representative agent, places the bracelet on the patient's wrist.

Mentally competent patients can revoke a DNR order by communicating to their family, agent, or physician that they wish to revoke the DNR order and remove the bracelet. Ideally, this action to revoke the DNR order should be a written document entered into the medical record and acknowledged by the family, the agent, and the physician.

Emergency responders are prohibited from performing chest compressions, inserting airways, administering cardiac resuscitation drugs, or applying electric shock therapy on DNR patients. Emergency responders are allowed to clear airways, administer oxygen, position the patient for comfort, provide pain medications, control bleeding, splint injured bones, and provide emotional support.

WHY AN ADVANCE DIRECTIVE IS ESSENTIAL

Advance directives are often prepared under the guidance of an attorney familiar with individuals who wish to make clear their end-of-life wishes to family, friends, and healthcare professionals while mentally competent. These directives prevent conflict among family members and/or physicians about the treatment the patient should receive if incapacitated and offer an advantage to healthcare providers and family members.

Physicians should stress to patients that if they become incapacitated and do not have an advance directive, no one has the legal authority to make their medical decisions. Then decisions left to the physician, spouse, adult children, or court-appointed guardian might generate discord.

So long as they demonstrate their competency as adults, patients have the right to make their own decisions about medical care, including whether to accept or refuse recommended treatment and procedures.

These documents do not become relevant until patients are no longer competent to make rational decisions regarding their healthcare. For that to occur, two physicians or a physician and a psychologist must declare that the patient no longer has the capacity to make healthcare decisions.

ROLES AND RESPONSIBILITIES OF THE HEALTHCARE TEAM AND FAMILY

The patient can appoint a spouse, trusted relative, or close friend to be their healthcare agent; however, an employee or spouse of the employee of the healthcare facility where the patient resides is not eligible to be an agent. The healthcare agent must be at least 18 years old.

The patient's healthcare agent should meet with the medical team to ensure mutual understanding of the patient's healthcare status, treatment plan, and chances for recovery. A discussion of end-of-life measures will verify that everyone is on the same page.

A clear articulation of a patient's wishes will help the agent honor and protect the patient's wishes. This discussion should cover all potential issues such as using a ventilator, kidney dialysis, artificial nutrition, CPR, pain control, where the patient prefers to die, and whether the patient wants to donate their tissue and organs.

CONCLUSION

Physicians should play a pivotal role in educating patients on how they want to approach end-of-life situations and how advanced directives will allow their wishes to be carried out. Physicians must understand their fiduciary duty to take an active role in their medical communities by educating patients about the benefits of advanced medical directives to allow for a peaceful and harmonious end of life for patients, medical teams, families, and friends.

DOI: https://doi.org/10.55834/plj.1660108871
Copyright © 2022 by American Association for Physician Leadership®

Timothy E. Paterick, MD, JD, is professor of medicine, Loyola University Chicago Health Sciences Campus in Maywood, Illinois.tpaterick@gmail.com.

Addressing Unprofessional Conduct

One of physician leaders' most challenging tasks is managing and mitigating unprofessional physician conduct complaints from patients, colleagues, nurses, and staff. Newly appointed physician leaders may be uncomfortable confronting these issues with their colleagues.

In Dr. Matthew Mazurek's leadership positions, he has conducted dozens of investigations of unprofessional and disruptive conduct, from the mundane to the serious. He offers insight on how to address disruptive behavior.

Matthew J. Mazurek, MD, MHA, CPE, FACHE, FASA

Assistant professor, Department of Anesthesiology, Yale School of Medicine, New Haven, Connecticut

Author of *Physicians and Professional Behavior Management Strategies: A Leadership Roadmap and Guide with Case Studies*
www.physicianleaders.org/physicians-professional-behavior-management-strategies

Member since 2014

What is the best way to set the stage for a professional behavior meeting?

First, determine if the meeting should be one-on-one (with a witness) or if it warrants a formal professional behavior committee meeting. Minor concerns are best-handled one-on-one. If it is the attributed physician's first offense, consider a one-on-one meeting. For more egregious or repeat behaviors, a committee meeting is the best option.

After this, communicate the need for a formal meeting with committee members and then contact the physician with a professional phone call. Phone calls are more personal and less threatening than an email or letter. If the physician is a repeat offender, a certified letter may be necessary.

What type of prework is necessary?

Prework includes gathering all objective facts, interviewing witnesses, and preparing the main points of the meeting. A preliminary meeting with committee members is especially useful as a rehearsal for how the committee would like to proceed. If the physician is a repeat offender, knowledge of past concerns and disposition is also helpful.

Additionally, it is essential to examine the bylaws, rules and regulations, and a copy of the signed professional conduct policy. Ensure you are following the process as outlined. Lastly, never discuss the conduct with physicians or colleagues who are not members of the committee.

In your experience, how do these meetings with physicians usually go?

It's important to open the meeting with a brief introduction and assurance that all discussion is confidential. Then, jump in and ask the physician to tell their side of the story without interruption. This demonstrates respect and helps establish trust.

Most meetings with first-time offenders usually go well, and the physician acknowledges the concern and apologizes. However, some physicians will attempt to "hijack" the meeting, take control, and blame others. Keep the discussion focused on the behavior, not the causes.

Some physicians blatantly state the meeting is a waste of time or become hostile and angry. Other physicians are somewhat quiet and conciliatory. Most meetings go well despite these challenges if a clear expectation for a change in behavior is stated. It is difficult to defend poor behavior, and ensuring the meeting is solely about the physician's behavior will keep it from going off on tangents.

A classic example is a surgeon who threw an instrument that was broken. The surgeon will "justify" the behavior due to the faulty equipment. The broken instrument is a separate and important concern. Acknowledge that you, too, would be frustrated and angry. Your acknowledgment of how a physician feels can go a long way during a meeting, but always make sure you are focused on the behavior itself.

Most meetings go well, but don't be surprised when a physician becomes accusatory or angry at others.

Any hints for dealing with physicians who are repeat offenders?

Repeat offenders are your biggest challenge. It can be difficult to rehabilitate a physician who just doesn't seem to "get it." Your task is even more difficult if the physician lacks insight or remains unapologetic.

In these instances, it is essential to communicate that there will be a no-tolerance policy, and further incidents

can lead to loss of privileges. It is a last resort, but the message needs to be clear. If you fail to escalate the consequences, you maintain the status quo and a double standard. Your own credibility is at risk.

It is also important to examine whether the physician is a "high producer." Some organizations have a strong desire to protect high-earning physicians, and they will be granted a pass. It may not be overt, but it is a consideration.

If you believe this might be the case, your response is to point out that the physician seems to be "let off the hook" a lot without any consequences. Ask why. If there is a CMO, ask the CMO. If you are the CMO, then ask the CEO or chief-of-staff. The responses will tell you what is going on.

After the responses, tell them the behavior cannot continue and list the reasons. High turnover, for example, impacts patient care and finances in the department. Also, point out the risks and liabilities of not intervening.

Another tactic is to use another physician's conduct and disposition as an example that there seems to be a double standard. Be firm in your resolve to find a solution. Recognize you will be cast as a "villain" by the attributed physician. Don't take any of it personally. You are performing the duties the role requires.

Lastly, go slow and take a measured approach. Pressure applied slowly and consistently will usually get results.

And what about follow-up? What should happen post-meeting?

Post-meeting, write a professional, courteous letter that includes a personal thank you, discussion points, disposition, and professional closing. If it is the physician's first event, explain that the process is not meant to be punitive. The purpose of the meeting is to discuss the events, hear the physician's perspective, and ensure the physician understands why they have been summoned.

If the disposition includes any actionable items such as anger management programs, coursework, etc., make sure you include deadlines for the physician to complete the items as well as the consequences if they choose not to participate.

SELF-STUDY ONLINE EDUCATION

Courses that provide skills essential to leading healthcare organizations in a changing environment — all on your schedule.

POPULAR TOPICS

- Conflict Resolution
- Building and Leading Effective Teams
- Managing Physician Performance
- Building a Path to Physician Leadership
- Financial Skills for Executive Decision Making
- Transforming Healthcare through Quality Improvement
- Leading Innovation in Healthcare Organizations

Explore these courses and more at https://shop.physicianleaders.org/collections/online-courses.

Physician Career Transitions

Physician leaders Peter Angood and Jay Bhatt have successfully navigated significant career transitions, from clinical care to executive leadership. Mike Sacopulos, the host of the *SoundPractice* podcast, interviewed Dr. Angood and Dr. Bhatt on strategies for career transitions.

This transcript of their discussion has been edited for clarity and length.

Mike Sacopulos: My guests today at the *SoundPractice* podcast are Dr. Peter Angood and Dr. Jay Bhatt.

Peter Angood is the CEO and president of the American Association for Physician Leadership. He previously served as a chief patient safety officer and vice president for The Joint Commission. Angood's career has been focused on developing the leadership potential of physicians as a mechanism to advance patient care and public health.

He is joined by Dr. Jay Bhatt. Bhatt is a nationally recognized physician leader and served as senior vice president and chief medical officer of the American Hospital Association. Bhatt's career as a public health professional has focused on underserved and vulnerable populations. He currently is a director at Deloitte and is the executive director of Deloitte's Health Solutions and Health Equity Department.

Physicians go through several transitions in their careers, and opportunities sometimes appear when least expected. How can physicians prepare for career changes?

Jay Bhatt: Thank you so much for having me in this conversation, and I appreciate the leadership of AAPL and Dr. Angood. To answer this question, as a physician, it can be challenging to figure out if transitioning from practicing medicine to an administrative role is the right decision for you. It is important to remember that moving into management means shifting your focus from individual patients to an organization as a whole.

Leadership is about practice and not a role. As physicians, we exercise leadership quite often in care delivery with teams. I think clinicians think about that experience in shadowing, in working with other clinicians, as they've been on the journey to becoming a physician.

I would apply some of the same actions. Moving into a healthcare administration role means you can draw from your leadership skills as a physician and continue not only to help your patients, but also to provide quality care from an organizational and system level. So, I would shadow some leaders. Take on a small project at your organization or in your practice and look at it through a system or population lens.

That experience will help you prepare for a career change. You've got to come back and ask the questions of what do you want to advance in healthcare and how do you want to be a part of that? Also, think about accessing your network. There are a lot of physicians in your network over the years who may have changed jobs or gone into administration or policy or organizational leadership and management opportunities. And it'd be great to hear their experience.

Sacopulos: Dr. Angood, what led you on the path to physician leadership? Was there one catalyst that made you consider a transition to leadership and executive duties?

Peter Angood: Jay's response is excellent in terms of how we should think about what we consider leadership. As we know, as we advance through medical school and our training, none of us get any exposure to leadership or management skills.

I often say that at some level, all physicians are leaders, and that's mainly because society looks at our profession as a lead profession. And so we have a responsibility to develop our leadership and our management skills over time. And we each do that in different ways.

In the first part of that, you have to recognize that you may have an aptitude for leadership. For me, I followed the clinical trajectory of trauma surgery and surgical intensive care medicine, both of which are fairly systems-oriented for them to function properly. And so, as I got further into my career, I began to appreciate that, "Gosh, I need to know and learn more about systems and processes and how to create change if I'm going to be able to effectively lead these types of clinical enterprises."

There were a couple of clinical cases that wound up not having the best of outcomes because the systems and processes weren't supporting the efficiencies there. And that bothered me on a personal level. It impacted the patient and their families. And so that was the impetus for me to say, "You know, I've got to be able to develop my skills and my aptitudes and my experience to help create those changes in the systems and processes."

Sacopulos: Dr. Bhatt, what about your leadership journey? Can you tell us a little bit?

Bhatt: Sure. I echo some of the sentiments Peter had — particularly around the system inefficiencies and that impact on outcomes and experience.

I grew up as a son of a pharmacist who worked on the South Side of Chicago. I got a front-door view into the challenging health issues that underserved communities faced when we would make house calls and deliver medications or when they'd show up at the clinic. That sparked my interest to ask questions about why that was happening. Why are my outcomes and outcomes of others I see different than those that I'm meeting in communities of families? Why were they struggling with some chronic diseases—cancer and others? I held onto that over the course of my career.

When I was in college, I spent some time with physicians who were looking at the health system from a systemic view, particularly with one of my early mentors, Dr. David Meltzer, who was looking at the hospitalist movement as an opportunity to deliver better care at a lower cost and manage the growth of HMOs that was happening in the environment.

So within that, as well as seeing how healthcare was delivered in the community at barbershops, it was meeting people where they were. They could be empowered to change their future; that was the catalyst for me. Another catalyst for me was my first year of training in medical residency, where I spent time taking care of a patient, an older woman, who'd come in with chest pain and difficulty urinating. And she ended up not having damage to her heart, improved her urination, but had a telemetry catheter.

Because there were so many patients that day, we did the rounds and kept going. Several hours later, we found out that she tripped over the wires and fell and had an impact on her hip. She was then sent to post-acute rehab, got an infection there, and came back from rehab. What should've been overnight, in and out, turned into a three-week ordeal. That caused me to wonder what we could do as a system to improve safety and quality. That led to a checklist that was consistent, reliably deployed, and made an impact, reducing adverse outcomes by 25% and saving money to the system, but most importantly, suffering for patients.

There was another catalyst for me to launch into a system career in quality and safety. We started to organize as a team within the residency program on these issues at a system level, and that's continued for me over the course of the years. I know that policy has such an impact on how we implement and deliver care, so I need to have a perspective on that.

I spent time on Capitol Hill, and certainly over the course of my work in public health and hospitals and health systems, as well as in health plans, I've been able to use my skills as a physician in leadership and management — which I already felt I did just with patients we were caring for, but sort of taking it to the next level. I've been fortunate and grateful to have these experiences, mentors, and teammates along the way that have helped me learn and get better at leadership and management.

Angood: Jay, our trajectories have been different, obviously, but we both have been fortunate in being able to experience some of that higher-level impact on the industry by policy and whatnot. And part of my trajectory included my time at The Joint Commission National Quality Forum.

Yet we both appreciate there's this gap oftentimes between that policy development and the implementation versus what's still going on out at the front line. For those who are listening, it's important to recognize that as you aspire to different types of leadership roles, the policy isn't always going to solve all the answers.

We always, as physicians, need to be looking at how we bridge that gap, whether it's policy accreditation, payer communities, and the front line. And I think both you and I have done that quite well over time, but for our listeners, I think that's an important recognition: there is this gap out there.

Bhatt: I agree, Peter. That's so important and well said. That's part of why it's so important for physicians to provide their voice of experience from the front lines to help bridge that gap, and to help the policymakers and stakeholders understand the unintended consequences of policy and the challenges in implementing policy and too many measures that might be asked for, which we know can contribute to burnout.

This is a really important opportunity for us to bridge that gap.

Sacopulos: Very good points from both of you. Dr. Bhatt, in your first answer, you explicitly mentioned networks. I'm interested in networks. How should physicians best grow their networks? Is this something that's done through social media, clinical organizations, and state medical societies? What are your suggestions?

Bhatt: I think about building relationships as an opportunity to look at your own experience and skills through a different lens because of the people you come across. Having some of these conversations and building relationships help you see a different view.

For me, that was such an important catalyst. Early in my career, I spent a lot of time talking to physicians who were engaged in different areas of healthcare delivery, life sciences, and technology. That helped me broaden my view of the healthcare system.

And I think the other thing is that we also have to think about language. We were oriented and anchored in a particular language as we were trained in medical school and residency. But if you want to switch careers or broaden your scope, you've got to come out of that shell. Part of doing that means talking to other people who can help you think about the language and experiences differently.

It's not one or another; it's finding the mediums that work best for you. For some people, that may be going to conferences and having the conversations and listening to talks and being in workgroups there. It might be, for some, contacting strangers on physician social media sites, career change sites, or in person. And for some, that might feel

hard. If you look at it from "I'm building relationships, so I can better contribute to changing healthcare," that reframing is important.

We've already done this in our life and successfully, right? We were pre-med, we shadowed, and we made friends with people that we are going to need for letters of recommendation. We did side projects. Whether we knew we liked it or not, whether that's research or volunteering or other things, we checked through some of those experiences, and part of it is the realization that we can do this. We can have these conversations.

For me, just exposure to a set of organizations I was aligned with from a value standpoint could make an impact, but also learning and building relationships. What was important early in my career was the American Medical Student Association — a community that saved me from feeling isolated in medical school.

I found my community there, which then really was a catalyst for all that came after. It was a group of people who acted as change agents and saw a different future for physicians and healthcare. I continued that through the rest of my career. I think my role as managing deputy commissioner of the Chicago Department of Public Health was a result of shadowing and doing some projects in Chicago when I was in fellowship. You have to identify what's right for you. And that will take experience and time.

Sacopulos: Dr. Angood, the AAPL excels in this area of helping physicians develop networks and relationships. Maybe you could talk a little bit about how the AAPL does that.

Angood: Yes, sure. Well, Jay's comments were spot on, regardless if you're an introvert or an extrovert. If you have this aptitude, you want to engage in leadership and management at whatever level in your community or your institution, stay true to yourself.

We are fortunate in this day and age that we can channel our energies and our thoughts to network through a whole variety of mechanisms, whether it's live meetings or through social media. It's a ripe period in the evolution of the industry for physicians who want to engage in leadership in different ways and to do it in a variety of different channels.

So, yes, in our organization, we do several face-to-face meetings every year. Some of the most valued aspects of those live meetings are the opportunity to network and be amongst a similar peer group and to not feel like you're isolated, be able to recognize that others are dealing with similar issues as you are, and you can learn from one another in a spontaneous set of meetings.

But we've also invested heavily in a technical platform that brings all of our programs, products, and services together under one umbrella on this technology platform.

There's the learning management side of it. There's the online community side of it. But there's also a whole set of information resources, and we're active in social media as well. It's interesting. We've got more members in our LinkedIn group than we have actual members in the association these days — which is intriguing all by itself. But what that tells me is that physicians are out there looking to connect with like-minded peers.

So, again, I'll say it doesn't matter if you're an introvert or an extrovert. You can find avenues and channels in which to connect with others. It's being able to learn from those others that helps move you along in your own choices and your own experiences. Then you can begin to better create the impacts that any of us desire, whether it's on a personal level, whether it's at our institution, or whether it's on a broader level within the industry as a whole. Multiple channels. Doesn't matter what type of personality you are. Believe in what your voice inside is telling you. Follow that voice to leadership.

Bhatt: Peter's comments are correct. It's also this sense that sometimes people think it's an either/or, introvert or extrovert, but it's not. You can be an introvert sometimes, and sometimes you'll work to be an extrovert if you default to an introvert. But then, what are the things that'll help you accomplish the goals given your personality? That might be one-on-one conversations or emails and phone calls versus larger group settings. There are a lot of different opportunities to forge ahead.

Angood: Just to build on that a little bit further, Jay. In this day and age, still the best way to get your next position is through networking, and the search community folks will always tell you that — 80% of your next jobs come through networking, not through looking at the classified ads.

Sacopulos: Good information. Somewhere out there is a physician who is thinking about making a transition to an executive position. Can we talk mechanically, nuts and bolts, about what you believe would be helpful or what is involved in that type of transition for the physician?

Bhatt: I would think that it's important to spend some time reflecting on where your strengths are and where you want to grow. Most importantly, what issues do you want to impact and how? Some of that you may not know early on, but having an initial point of view will be important. That preparation is important as you talk to various individuals in the field: physicians, operators, and other C-suite leaders.

I also think it's important not only to talk to physicians in that transition process, but [also] to talk to the whole interprofessional team to get a sense of the dynamics and how you might need to work differently, work together in a system-level environment, in a transition to another kind of role. I learned lessons from my mentors about building relationships and communicating and being transparent.

Once you start to have those conversations, you come back and, after a set of them, reflect and see if your point of view has evolved and how it's evolved. Then start thinking about, okay, well, what are the experiences I might need?

It may be a short shadowing experience or a project experience to help you learn more about the questions that

may have surfaced about what you may want to do in your next opportunity. Sometimes it takes a few opportunities to land the one that you then excel at, that makes sense for you. It's okay to know that you may not get it right the first time. It's important to know that. Also, believe in yourself. I think about [Apple TV+ series] *Ted Lasso* and that sign "BELIEVE." I think that's also important.

Believe you can make this transition. Believe you have the skills and experiences to do it. Have your support system around you, whether it's family, friends, or others who can help you through that process.

But it can be a scary thing. For me, I was fortunate that a lot of the inquiry and desire for systems change happened because of community experiences and experiences with mentors and physicians I saw thinking about healthcare differently than we traditionally had.

Individuals have, over the course of my career, shaped my thinking — not just physicians, but others as well. And certainly, Peter's been just an incredible partner and has pushed me to think differently about healthcare and evolving my leadership and management, as well as others at the Chicago Department of Public Health, the Illinois Hospital Association, the American Hospital Association, and now the Medical Home Network, which is an ACO, and Deloitte.

All of those experiences gave me unique and different insights. I'm just grateful to be in a role at Deloitte now where we're driving system-level impact. Where we're producing research in insights and eminence, along with the future of health, future of equitable health point of view that is going to impact the industry and the field.

Sacopulos: Dr. Angood, same question to you. Because I know that you've seen this many times through the AAPL: physicians ready to launch themselves into the C-suite. What advice do you have, and what should they expect in that transition?

Angood: All of us enter into healthcare, whether as a physician or a nurse or one of the other professions, because we are caring individuals, and we, therefore, carry a high level of altruism and idealism. And it's not uncommon as an offshoot of that altruism to then, as you learn this system you're working in, want to create larger system change. So I think an early step for anybody is to recognize that you've got that awareness, and then decide whether you have the aptitude.

Not everybody's got the original aptitude to be a leader or to move into leadership roles. As Jay was describing, you need to look for ways to partner up, to get increasing experiences. Yes, we get the experiences in the clinical realm, but if you are becoming passionate about leadership and what you can do to create change, then look for the avenues in which you can gain more experience.

It becomes a gradation of experience, and none of us ever gets one experience that nails it. That's why we all have different jobs over time, right? And each job creates a new growth opportunity and increases experience levels. Some move through a trajectory faster than others, and that's perfectly fine. That's circumstances and, to some degree, luck, at times. But regardless, anybody can move along a trajectory and set up a ladder of success and progression.

In this day and age, though, what Jay didn't mention is oftentimes, you need some extra education. You just don't get it in medical school or residency. AAPL offers a whole range of educational programs and career development initiatives, and there are other channels out there for people to get that as well. Many delivery systems and even some of the nonclinical sectors in healthcare as an industry are looking for physicians who have the added experience, but to some degree, need some added education.

And that doesn't always necessarily mean a master's degree or a doctorate. There're other ways. And I'll put in my plug for AAPL. We've got lots of great resources, including a Certified Physician Executive (CPE) credential. But it's often that combination of education and experience and then the mentorship and networking with others.

But one thing that I think we have to pay attention to as well is that we've had experiences with the system's inefficiencies and the failures and the flaws, as a part of all of the frustration in healthcare, especially in part as the pandemic has further shown. But there is anxiety, frustration, burnout, and all those symptoms going on at high percentages in the healthcare workforce.

And an initial reaction for many people is just to be angry and disgruntled, and then they want to pull the lever, right? Okay. I'm out of here. But if you can productively rechannel that discontent and then learn where and how to engage with the systems and then begin creating the changes in the systems, that can often defuse some of that anger and some of that frustration. And that's where you can gain the experience. Maybe gain a little bit more education.

And to Jay's point earlier, you start to learn a different set of languages and perspectives on healthcare. And so, again, that helps decrease some of that anger, that hostility, that disappointment that many people have in the system overall. So it's learning new approaches, and there's a whole variety of ways to do it.

Bhatt: Peter, that was so well said. I just want to pick up on this education piece, which is so important too. When I mentioned reflection and having those conversations, it's through that reflection and conversations one might decide that further education is needed. In my career, I've gotten public health training, was also trained in public administration, as well as physician leadership courses and other kinds of fellowship experiences. All of those have helped me in different ways, but they've been so important to push my lens of thinking about challenges and opportunities, and solutions.

I would say that you've got to find good mentors to help you navigate the space. And sometimes those aren't always people decades ahead in their career. Sometimes they're

peers who are going through things differently. They're maybe in different industries but have similar experiences.

So there's so much that translates beyond just the subject matter when you get into leadership. It's really about relationships, communication, transparency, values and vision, learning and adapting, and then identifying metrics and goals that help drive your success trajectory.

The other important thing is putting yourself in a position to speak and communicate and practice that until you get comfortable, because that's going to be an important part of what you do in leadership and management.

Sacopulos: We're wrapping up our time together. I want to think that there is some young physician out there who has started their career during the pandemic and is preparing for a future leadership role. Can you speak directly to them with your best suggestions for someone just getting started in their career that had already coped with the pandemic?

Bhatt: The pandemic has certainly been a challenge. But I see challenges as an opportunity for positive transformation. And so young physicians should recognize that the pandemic has also made the field more confident in innovation. More confident in different ways of approaching challenges in the field. And that it has accelerated innovation, saying, "We can't wait any longer." It's also accelerated the impact of virtual telemedicine.

One thing we haven't talked much about is the opportunities around being an entrepreneur and startups that have emerged over the last 10 years. Healthcare has had significant investment, and it's continuing to grow. So there are opportunities. If there's a particular issue that you are passionate about and want to advance, it's important to also think about doing that potentially from the lens of working with a startup or a mid-stage company.

But it's also, I would say, about what skills are needed at different stages of your career. And early on, it's going from relational and clinical to adding business and strategic skills. I would say do the work, spend some time reflecting, getting out and meeting people as you can, or talking to them via social media, LinkedIn, or online, but get exposure and try some things out. Have some different experiences.

And listen certainly to all the AAPL podcasts, which I think have been great about this topic. And as I go back to what Ted Lasso said: just "Believe."

Angood: As young people enter the industry, sure, you've got to learn the clinical aspects of all of this and how to care for patients and tap into your altruism of wanting to look after people. But come in with an open mind in that there are all of these deficiencies in the industry that need and are seeking solutions.

The next generation of physicians and other interprofessionals in the industry have a wonderful opportunity to capitalize on this recent pandemic crisis and to bring in creative new ideas to solve some of the inefficiencies and inadequacies of the system.

And let's not make any mistake here. Every industry has inadequacies and inefficiencies and all those sorts of things. We're not a bad industry, but we've got some work to do. And we would welcome the younger folks coming in and helping with some creative, innovative, entrepreneurial ideas to help solve those issues. So thanks, Mike. Great question.

Sacopulos: We'll let that be the last word. My guests on today's podcast have been Dr. Jay Bhatt, who is the managing director at Deloitte and serves as the executive director of Deloitte Center for Health Solutions and Deloitte Health Equality Institute. My other guest has been Dr. Peter Angood, who is the chief executive officer and president of the American Association for Physician Leadership. Gentlemen, thank you so much.

www.soundpracticepodcast.com/e/angood-bhatt/

Peter B. Angood, MD, FRCS(C), FACS, MCCM, FAAPL(Hon), president and CEO, American Association for Physician Leadership.

Jay Bhatt, DO, MPH, MPA, managing director, Deloitte Services LP, and executive director, Deloitte Center for Health Solutions and Deloitte Health Equity Institute, Chicago, Illinois.

Michael J. Sacopulos, JD, CEO, Medical Risk Institute, and host of the SoundPractice podcast. He's based in Terre Haute, Indiana.
msacopulos@physicianleaders.org
www.soundpracticepodcast.com

You are the leader health care needs.

The Heinz College Master of Medical Management provides the analytic and leadership skills you need to stand out as a health care executive.

Apply Today!

Carnegie Mellon University

Contact: Rebekah Apple
Director, Master of Medical Management Program
Carnegie Mellon University
412-268-8634
rebekaha@andrew.cmu.edu

www.heinz.cmu.edu/mmm

JEFFERSON COLLEGE OF POPULATION HEALTH

ACCELERATE YOUR CAREER

New Online Executive Master's Degrees for Physician Leaders

Gain the skills you need to lead healthcare transformation!

100% online programs | **Accelerated 7-week semester format** | **Earn your Master's Degree in 2 years**

Special tuition rates and course reductions for AAPL members. **Jefferson.edu/AAPL**

Jefferson
Thomas Jefferson University

Considering a Nonclinical Career?

The Challenge: Have you ever considered leaving your physician job to pursue a nonclinical career?

If so, you are not alone. According to the Medscape Physician Nonclinical Careers Report 2021, many physicians are burned out, want to work fewer hours, realize that being a physician is not what they expected, or believe they will earn more in a nonclinical career — all reasons to move on to a new career.

If any of these thoughts have crossed your mind, you are probably trying to figure out the next steps. According to Sylvie Stacy, MD, MPH, the author of *50 Nonclinical Careers for Physicians*, there are certain steps you can take to guide you.

Key Takeaways

Recognize your passion, skills, and values. Often, finding a nonclinical career can address some factors that lead to a lack of fulfillment in your current clinical job. Addressing these factors requires you to find the "sweet spot" where your skills, values, and passions overlap. Try taking some time to reflect on the following questions to help you identify your passion:

- What makes your heart sing?
- What piques your curiosity?
- What activity makes you lose track of time?

Dispel common myths about physicians and nonclinical careers. You may hold misconceptions about what it means to have a nonclinical job. Some common misconceptions about nonclinical work include:

- Many years of clinical experience are needed to transition to a nonclinical career.
- Taking a nonclinical job is "selling out."
- Nonclinical work is for physicians who are burned out.
- Physicians owe it to society to care for patients.
- A nonclinical career is a waste of a physician's medical training.

Translate your skills into a new career. Physicians use their medical training and skills to varying degrees in a nonclinical career. Think about the skills you already have and how they can translate to a nonclinical career. Many nonclinical job opportunities require communication, interpersonal, management, analytics, and leadership skills that most physicians have already mastered. You probably have technical skills such as industry knowledge, research, teaching, and enterprise experience you can leverage in a nonclinical role.

Try reverse engineering a nonclinical job description you are interested in by highlighting the knowledge and skills listed and noting the relevant experience that demonstrates your mastery of that skill.

Use an action plan to find and get a nonclinical position. Reflect on these questions to create an action plan and take your first step toward a nonclinical career.

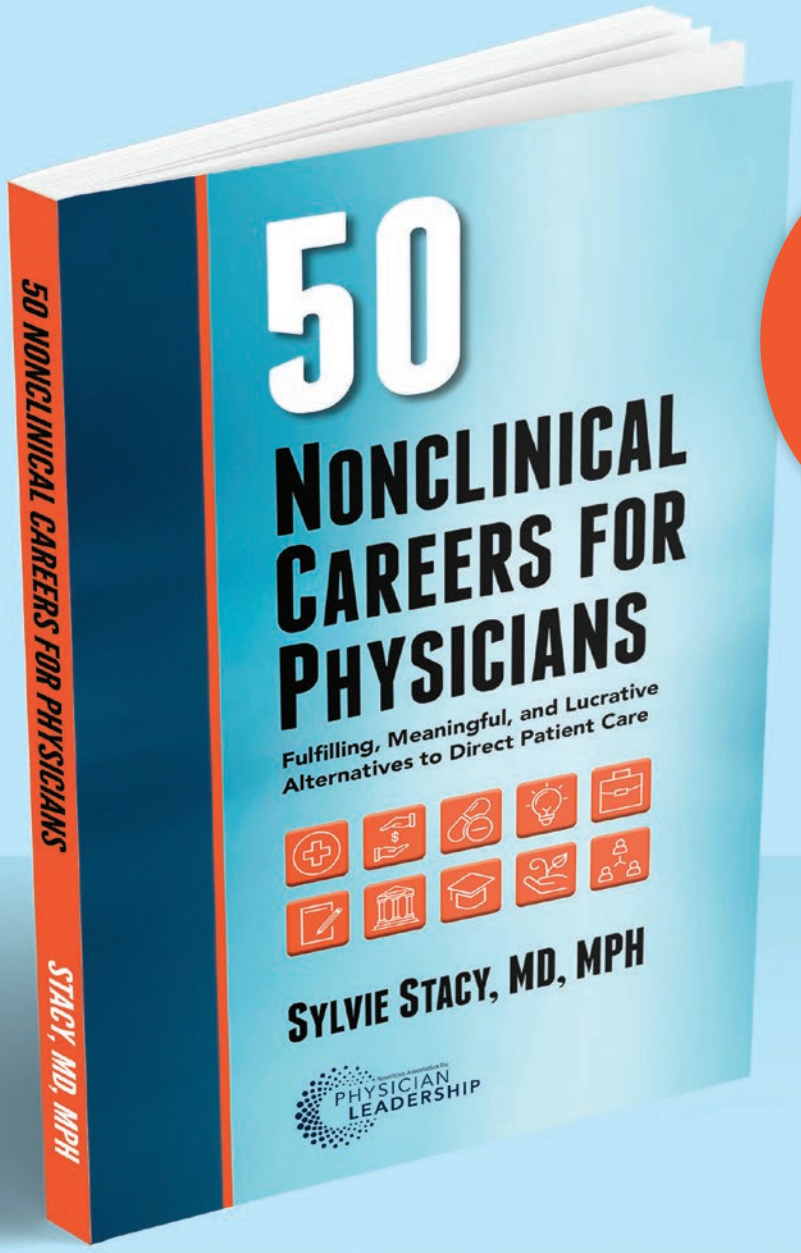
- What action am I going to take?
- Why am I taking this action?
- What is the process for this action?
- What is the estimated timeframe for this action?
- What other resources might I need to complete this action?

The Bottom Line: There is nothing wrong with exploring the options of a potential new role you may be more passionate about, or even exploring nonclinical work opportunities on the side while maintaining your clinical practice.

Join Sylvie Stacy at the Fall Institute for a course that dives deeper into this transition, or read her book, 50 *Nonclinical Careers for Physicians: Fulfilling, Meaningful, and Lucrative Alternatives to Direct Patient Care*. www.physicianleaders.org/50-nonclinical-careers

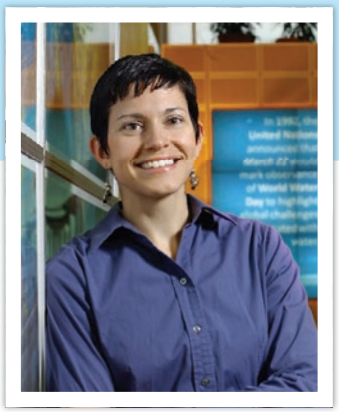
Find more information about our educational offerings at physicianleaders.org/education.

How Physicians Can Leverage Their Clinical Skills to Transition to Another Career



Regular Price: $29.95

Member Price: $25



Sylvie Stacy, MD, MPH

To purchase, visit

www.physicianleaders.org/50-nonclinical-careers

American Association for PHYSICIAN LEADERSHIP

Here's some of what's new for you, exclusively at our website.

HOT TOPIC

The Physician's Compact

The skill set of today's physician workforce typically has not included statistical process analysis, team-focused approaches to patient safety, and results-based, information-driven infrastructures. These are the building blocks upon which 21st-century healthcare systems will be based. The long apprenticeship of medicine needs to include physician leadership skills that position young physicians for success in the healthcare of the future.
www.physicianleaders.org/news/the-physicians-compact

TRENDING

How to Steer Clear of Groupthink

When organizations need to solve a problem, they often create a task force, selection panel, or steering/advisory committee. These groups are tasked with developing consensus around new ideas, such as procedures, policies, products, or services.

Unfortunately, research shows that consensus-based problem-solving groups are often where innovative ideas go to die. These groups are highly prone to groupthink — quick agreement around status quo solutions with little discussion or deliberation.

Researchers studied four virtual task forces that were to recommend a process to make Americans' healthcare records electronic. They found that the groups who avoided groupthink followed three steps: 1) They challenged the status quo; 2) They adopted a placeholder solution that allowed them to agree on broad principles even if they disagreed on the details; and 3) They celebrated progress toward a final agreement, which allowed them to maintain morale and momentum.
www.physicianleaders.org/news/how-to-steer-clear-of-groupthink

Changing Roles and Skill Sets for Chief Medical Officers

There is a sea change occurring in American hospitals and healthcare organizations. We are witnessing a radically changing healthcare environment in which hospitals and physicians are scrambling for a diminishing piece of the reimbursement pie, as the fee-for-service model of reimbursement gives way to the value-based model.

CMOs must acquire leadership skills to direct hospitals and systems. The author reviews their changing responsibilities in today's complex healthcare environment.
www.physicianleaders.org/news/changing-roles-skill-sets-chief-medical-officers

Physician Leadership and Ambulatory Care: Small and Rural Hospitals

Experience has shown that the greatest deficiency in developing and implementing an integrated ambulatory system of care is leadership — both administrative and physician leadership.

Most physicians and administrative leaders, even in larger systems, do not have experience working in this type of setting. Without a dynamic leader, there is almost always a default back to the familiar. This makes it difficult to visualize the integration possibilities.
www.physicianleaders.org/news/physician-leadership-and-ambulatory-care-small-and-rural-hospitals

Call for Manuscripts to the Physician Leadership Journal

Instructions for Authors

Physician Leadership Journal (*PLJ*) welcomes articles about healthcare leadership topics. Articles spotlight original research, operational interventions and findings, and discussions that orient readers to important topics. We seek original articles that advance the scope and practice of leadership. Articles may not be under consideration for publication elsewhere, nor published previously.
www.physicianleaders.org/news/call-for-manuscripts-to-the-plj-physician-leadership-journal

Companies Need to Rethink What Cybersecurity Leadership Is

For businesses today, cyber risk is everywhere. Yet for all the investments companies have made to secure their systems and protect customers, many are still struggling to make cybersecurity a vibrant, proactive part of strategy, operations, and culture.

The root cause is twofold: Cybersecurity is treated as a back-office job, and most cyber leaders are ill-equipped to exert strategic influence. Given that a cyber leader's average tenure is just 18 months, it's clear that something needs to change. Companies need to put cybersecurity where it belongs: with organization leaders.
www.physicianleaders.org/news/companies-need-to-rethink-what-cybersecurity-leadership-is

Read these articles and others at physicianleaders.org/news

Advance your career with an online master's degree

Flexible programs designed for health care professionals.

- Master of Applied Science in **health informatics**
- Master of Science in the **science of health care delivery**

#1 BEST COLLEGES U.S.NEWS in the U.S. for innovation
ASU ahead of Stanford and MIT – U.S. News & World Report 5 years, 2016–2020

AAPL members receive special benefits.

ASU College of Health Solutions
Arizona State University

Learn more at **chs.asu.edu/aapl**

An MBA Program That Fits Your Life. And Your Future.

Online Master of Business Administration

Develop the leadership and management skills necessary to thrive in today's evolving healthcare market with the top-ranked Online MBA at the Isenberg School of Management. Our specialized curriculum and benefits are designed for physicians looking to build a smarter working world.

isenberg.umass.edu/mba/physicianleaders

UMassAmherst | Isenberg School of Management

The Art of the Apology

Neil Baum, MD, and Alvin Merlin, MD, MBA, CPE

When physicians are comfortable saying "I'm sorry" easily and with sincerity, perhaps they can expect increased job satisfaction and lower malpractice premiums.

"I'm sorry" is one of the most-used phrases in any language. Most of us don't think twice about offering an apology when we unintentionally bump into a stranger on the sidewalk. However, when we have made a medical mistake, which most of us have in our medical careers, apologies seem to get stuck in our throats and become difficult or impossible to articulate.

We begin learning detachment early in our medical training. The problem is compounded by the stress of declining reimbursements and increasing overhead costs, giving us less time to bond with our patients. In addition, we are often reluctant to engage our patients in honest, open dialogue.

Moreover, our malpractice insurers tell us that an apology might be interpreted as an admission of fault or negligence that could make defense difficult if the patient files a lawsuit.

THE IMPORTANCE OF COMMUNICATION

Assuming an inverse relationship between a lawsuit and communication with the patient, the likelihood of being sued decreases significantly as communication between physician and patient increases.

The physicians demonstrate good communication skills when they ask the patients questions, encourage them to talk about their feelings, use humor when appropriate, and educate patients about what to expect during treatment.

Physicians with enhanced communication skills spend about 3 minutes more with their patients than those who have been sued. Another fact that is worth noting is that when an apology is offered, and the details of the medical error are disclosed in a timely fashion, the likelihood of a lawsuit decreases by 50%.[1]

Is it surprising that with the current time constraints on surgeons who send a resident, nurse, or medical assistant to the patient's bedside to obtain the consent for surgery, there is a potential lawsuit if the outcome is less than anticipated?

How can we effectively apologize without admitting guilt or wrongdoing? An authentic apology is one that is heartfelt and driven by true regret or remorse. Five reasons to consider an apology are:

1. To show the patients you respect them.
2. To accept responsibility for the situation.
3. To demonstrate that you care how the patient feels.
4. To express your empathy.
5. To dissipate a patient's anger.

Patients want to know what happened and why it happened, how the problem or error will affect their health in the short and long term, what is being done to correct the problem, who will be responsible for the cost of the error or complication, what has been learned, and what the physician is doing to avoid this happening again.

EXPRESSING THE APOLOGY

The first step in apologizing is admitting to yourself that there has been a mistake and that an apology is in order. Then, deliver the apology.

1. Whenever possible, offer the apology in person, face to face with the patient or family. The apology should take place in a quiet environment with no distractions. Give the apology your undivided attention. Any distraction or interruptions will negate its impact. Turn off your cell phone and inform your staff that you are not to be interrupted while you are with the patient. Sit near the patient with no barriers such as an exam table, desk, or computer between you.

2. Begin the conversation by stating that you are sorry. This means using "I" words and not pointing fingers or using "you." Say, "I am sorry." Do not follow the apology with "but"! Don't make excuses or blame someone else.

3. Own the mistake. Show the patient that you're willing to take responsibility. Admit something went wrong; anything else makes the apology ineffective.

4. Be honest and describe what happened. Use language that the patient understands. Consider using visuals to explain the issue or problem.

5. Acknowledge their hurt and suffering. Consider saying something like, "I know how this must make you feel, so before I continue, I would like to hear what you have to say."

6. Stop talking. Listen to the patient without interruptions. Studies have indicated that a patient explaining their medical problem to a physician is typically interrupted by the physician after 16 seconds.[2] Ideally, patients will share their feelings and forgive the doctor for the error. This forgiveness won't occur if the doctor is frequently interrupting the patient.

7. Offer a plan of action. Offer to obtain another opinion or refer to another more experienced colleague. If there will be no charge, share that with the patient, who may have concerns about the finances associated with the follow-up care. Indicate that you will continue to be involved until a satisfactory solution is reached. This indicates that you will stay with the patient physically and emotionally.

8. Describe the error as a learning experience for you and your practice. Emphasize that you will make every effort to ensure that the situation does not happen to future patients and describe how you intend to do so.

9. Finally, reiterate your apology. Cycle back and repeat, "I'm really sorry this happened. I hope you will forgive me." The patient may not forgive you right then, but if you were sincere and honest, the forgiveness might be forthcoming.

AN APOLOGY SCENARIO

A Hispanic patient with limited English proficiency had a ureteral stent placed following shock wave lithotripsy for a kidney stone. The patient didn't return for follow-up. A year later, the patient returned. The stent had been encrusted with calcium deposits, making it impossible to retrieve through a simple cystoscopy. The patient required additional open surgery to remove the stent.

The urologist requested a translator to facilitate communication with the patient and met with the patient and one of his family members in the doctor's private consultation room. It was the end of the day, and most of the staff had left. The urologist turned off his cell phone and told the remaining staff he did not want to be interrupted. Chairs were arranged for the patient, his wife, the translator, and the doctor, all on the same side of the doctor's desk.

The doctor begins, "Nice to see you and meet some of your family. Thanks for coming in so we might discuss what has happened to you.

"We placed a tube between your kidney and your bladder for the purpose of preventing any blockage with fragments of the small stones after that machine we used to break up the stone in your kidney. This tube was to be removed in two weeks. Our office tried to reach you, but we weren't successful in locating you or a family member.

"I take full responsibility for not trying harder to find you and to remove the tube.

"Because the tube remained for a longer period, we had to make an incision to remove the tube. I know that this caused you pain, discomfort, and loss of time from your work. I want you to know that I take full responsibility, and we are putting into place a plan to reach all patients who have this tube so they aren't lost to follow-up.

"We have contacted your insurance company, and they have assured us, and we assure you, that the additional surgery will be covered and you will not have any additional out-of-pocket costs.

"Do you understand what happened and the explanation? Again, I am sorry that this happened to you. Do you have any questions?"

The patient asks a few questions about his kidney function and restrictions to protect his kidneys. The patient acknowledges an appreciation for the doctor, his staff, and all their care. He understands what happened and appreciates the honesty of the doctor. The doctor is silent and does not interrupt the patient's response.

The doctor reiterates, "I'm really sorry this happened. I hope you will forgive me, and I want you to know that you are a terrific patient, and I appreciate the opportunity to take care of you. If you ever have any questions or concerns, please call me any time."

CONCLUSION

Mistakes are not only devastating for patients, but also damaging to the physician. An apology by the physician demonstrates understanding, compassion, and empathy. It is an opportunity to preserve the doctor-patient relationship. Doctors who admit responsibility and apologize are less likely to be involved in litigation.

REFERENCES

1. Dahan S, Ducard D, Caeymaex L. Apology in Cases of Medical Error Disclosure: Thoughts Based on a Preliminary Study. *PloS One*. 2017;*12*(7):e0181854.
2. Groopman, J. *How Doctors Think*. New York: Houghton Mifflin Harcourt;2008.

DOI: https://doi.org/10.55834/plj.6700451491
Copyright © 2022 by American Association for Physician Leadership®

Neil Baum, MD, is a professor of clinical urology at Tulane Medical School, New Orleans, Louisiana, and the author of *The Three Stages of a Physician's Career-Navigating From Training to Beyond Retirement* (American Association for Physician Leadership, 2017).

Alvin Merlin, MD, MBA, CPE, is a retired physician involved with hospital development and management.

THE COACH'S CORNER: The Voice in Your Head

Robert F. Hicks, PhD

Coaching requires us to keep a laser focus on the person we are helping, but that's not always easy when distractions — both external and internal, continually bombard us.

"Of course, I talk to myself. Sometimes I need expert advice."

– Anonymous

Every coaching conversation has two parts: the one you have with the other person and the one you have with yourself. The conversation with yourself is known as self-talk. Simply put, it is the voice in your head. When you allow that voice to dominate your attention during a coaching conversation, you direct your mental energy inward, reducing your connection to the person you are helping.

Self-talk is natural, but its value is determined by the type and the amount of self-talk. When the voice in your head becomes the voice of judgment — critical of others or yourself — it impedes your ability to help. Consider this example:

Dr. Rajiv is a 42-year-old internist. He prides himself on his analytical skills, which enhance his differential diagnostic abilities. He also likes to use his rationality to appraise a situation and points out flaws inherent in an idea, a plan, or a proposed solution. While he sees himself as analytical, his peers describe him as a nitpicker, overly critical, and always challenging their thinking.

Dr. Rajiv had been the medical director for his hospital's telemetry unit for about a year when he requested some "leadership" coaching. When asked why he was reaching out for help at this time, he said that his boss, the chief of medical services, was critical of his ability to develop some of the younger physicians in the group and was questioning his leadership skills.

Dr. Rajiv was asked to describe some of the developmental conversations and what he thought about during those conversations. It turned out that he wasn't listening to what was being said; rather than attempting to understand others, he was judging what they were saying.

Judging often results from a dichotomous thinking process, e.g., things are good or bad, right or wrong. We perceive the world in binary terms with no nuance or shades of gray and consider ourselves the arbiters of truth. Dr. Rajiv could not develop younger physicians because the voice in his head judged the people he was trying to help.

Judging and coaching cannot coexist. Humanist psychologist Carl Rogers believed that our ability to help others depends on our ability to withhold judgment regardless of what the person says. In his 1957 *Journal of Consulting Psychology* article, "The Necessary and Sufficient Conditions of Therapeutic Personality Change," he called this "unconditional positive regard": showing complete support of the person we are helping, whether they express "good" or "bad" views.

Withholding judgment and maintaining unconditional positive regard does not mean agreeing with everything the other person says. It does mean that you do not allow the judging voice in your head to capture your attention and prevent you from attending to the other person in a way that fosters acceptance and understanding.

TYRANNY OF THE SHOULDS

The voice in your head that judges others does not discriminate; it also judges you. These self-judgments take the form of "shoulds" and can be so disruptive that they are often referred to as "the tyranny of the shoulds."

Suppose you just had an uncomfortable conversation with a colleague, and it's nagging at you when you sit down for a coaching conversation. As you try to listen, your attention is distracted by the voice in your head that says, "I should have handled the situation differently, but I didn't, and look what happened." You begin to feel upset and guilty about what you *should* have done, and the distraction limits your ability to help someone else.

Here's another example: You are a speaker at an upcoming conference but haven't begun to prepare your presentation. The voice in your head says, "I *should* be working on my presentation, and I'm way behind. If I don't start soon, I won't have time to do a good job, and I'll embarrass myself."

You have just been inflicted with the tyranny of the shoulds. When a disruptive *should* (and its variations like *must* and *ought*) is directed inward, it can bring about feelings of guilt and self-reproach.

Contrast that with what happens when you stay disciplined and put your energy into understanding the other person's perspective and eliminating judgment. It allows you to hear what the other person is saying and understand that situation or point of view, which are prerequisites to coaching. Preventing the voice of judgment from grabbing your attention requires mental discipline and effort, but that is a small price to pay for control over the voice in your head.

SUMMARY

Giving 100% of your attention to the person you are coaching is critical. Many distractions compete for your attention; the biggest distraction is the voice in your head. While self-talk is natural, it can become disruptive to the coaching process when it is the voice of judgment. Judgment interferes with understanding and disconnects you from the other person.

The voice in your head can be the critical voice that judges others or the self-judgment that occurs when the tyranny of the "shoulds" dominate your self-talk. Either form of judgment is counterproductive. Fortunately, just as working out with weights builds muscle, practicing mental discipline can control the voice in your head.

DOI: https://doi.org/10.55834/plj.5055089078
Copyright © 2022 by American Association for Physician Leadership®

Robert F. Hicks, PhD, *is a clinical professor of organizational behavior at the University of Texas at Dallas and founding executive director of the organizational development, coaching, and consulting program at the Naveen Jindal School of Management. Hicks is a licensed psychologist and holds an appointment as a faculty associate in the Department of Psychiatry at UT Southwestern Medical Center, where he coaches clinical chairs for leadership effectiveness. He is the author of* Coaching as a Leadership Style: The Art and Science of Coaching Conversations for Healthcare Professionals *(2014) and* The Process of Highly Effective Coaching: An Evidence-based Framework *(2017).*

COMMUNITIES

Find support, shared experience, and connections with physician leaders like you.

As a physician-created, led, and focused organization, AAPL's greatest strength is in the community. Like-minded physician leaders can:

- Connect in-person at live events
- Connect virtually via the Platform and Physician Leadership Connect — an online forum designed for and by physicians.

Access to this network of active members and alumni offers:

- Everyday peer support
- Career mentorship
- Real doorways to new opportunities

Explore the community today at https://app.physicianleaders.org/community.

Making the Business Case for Quality: Linking Quality and Cost

Richard Priore, ScD, MHA, FACHE, and Brad Beauvais, PhD, MBA, FACHE

This third installment of the four-part series examines the benefits of linking quality and cost by creating an integrated performance measurement scorecard and evaluating potential sources of financial data.

Linking quality improvement efforts with their anticipated financial impact is critical to making an effective business case. It is also essential to achieving a competitive market advantage, considering the increasing prevalence of value-based payments.

In addition to the various Medicare and Medicaid "at-risk" pay-for-performance incentives and penalties, private health insurers and large employers are increasingly seeking exclusive partnerships with providers that consistently demonstrate the "best" value for their members and employees. In other words, payers are rewarding providers that consistently deliver the highest relative quality outcomes at the lowest possible cost.

Beyond monetizing quality improvement efforts and connecting them to the anticipated financial impact with a measurable return on investment (addressed in the second article in this series), healthcare leaders must integrate enterprise quality and cost data to inform timely and effective decision-making. Integrating quality and cost data enables allocating increasingly scarce resources to support aligning the organization's mission with the business case for it.

To continuously improve value, leaders must recognize that quality and cost are inextricably linked. One usually does not change without impacting the other; however, balanced scorecards or dashboards leaders use to monitor and manage their organization's performance are often short-term in focus and typically do not integrate quality and financial measures.

INTEGRATED PERFORMANCE MEASUREMENT SCORECARD

Quality measurement reports often do not include the cost of waste associated with poor quality, such as a clinically ineffective or inefficient process. Table 1 presents an example of how quality and cost can be integrated easily into the same dashboard to improve decision-making effectiveness.

Note that the estimated financial impact for each quality measure is provided on the same line and then summed to identify the total cost of waste and the potential savings or revenue growth opportunities across the portfolio of organizational performance improvement initiatives. Integrating quality and cost in the same performance measurement report can improve decision making in three ways.

1. Presenting both types of data in one place forces leaders and staff to confront the cost of waste stemming from ineffective or inefficient practices or processes.

Recall from the first article (May/June 2022 *PLJ*) that the cost of waste is the total measurable financial impact resulting from poor quality, including potential lost revenue or avoidable expense. Adding the estimated cost of waste to a traditional performance scorecard or dashboard enables translating patient safety and clinical quality gaps into the language of finance. Only then can clinical and non-clinical healthcare leaders fully grasp the total impact of poor quality to identify, discuss, and prioritize measurable and achievable savings opportunities.

2. Physicians as scientists expect and rely on comprehensive and complete data to inform their clinical decision-making.

Integrating quality and cost measures supports frontline providers correlating potentially ineffective practice patterns with the associated financial impact, with which they can consider adopting evidence-based guidelines that simultaneously improve clinical efficacy and cost-efficiency.

Table 1. Integrated Performance Measurement Scorecard

Performance Improvement Initiative	Baseline				Target		
	January 1 - December 31, 20X1				By December 31, 20X2		
	Cases	Rate	Cost per Case	Total Cost of Waste	Cases	Rate	Cost Reduction
C. diff Infection	84	6.0%	$7,285	$611,940	42	3.0%	$305,970
MRSA	43	8.0%	$6,248	$268,664	27	5.0%	$99,968
SSI	11	4.5%	$23,272	$255,992	5	2.0%	$139,632
LWOBS	900	3.0%	$725	$652,500	750	2.5%	$108,750
Re-admissions	78	3.6%	$7,300	$569,400	32	1.5%	$335,800
Clinic no-shows	341	18.0%	$230	$78,430	208	11.0%	$30,590
Total				$2,371,361			$1,020,710

Performance							
January 1, 20X1 - December 31, 20X2							
September		October		November		Year-to-Date	
Cases	Cost Savings	Cases	Cost Savings	Cases	Cost Savings	Cases	Cost Savings
5	$14,570	9	($14,570)	4	$21,855	68	$116,560
0	$24,992	1	$18,744	1	$18,744	27	$99,968
1	($23,272)	0	$23,272	1	$0	5	$139,632
83	($5,800)	61	$10,150	53	$15,950	711	$137,025
2	$36,500	2	$36,500	1	$43,800	51	$197,100
26	$460	20	$1,840	13	$3,450	216	$28,750
	$47,450		$75,936		$103,799		$719,035

Physicians and other providers control — or at least significantly influence — a large portion of healthcare spending. Although they are the only ones who can admit or discharge a patient, order a test or drug, or perform a procedure, most are not apprised of the cost implications from their practice patterns.

Financial information presented to providers at the point of ordering can have a meaningful impact. In a randomized controlled study conducted at Johns Hopkins Hospital, physicians who were given cost information when ordering certain lab tests reduced orders for ostensibly unnecessary tests, waste, and cost without compromising clinical outcomes.[1] Presumably, this approach would have a similar beneficial impact in other clinical settings.

3. Monetizing the anticipated financial impact of performance improvement initiatives supports more focused strategic planning and prioritization.

Leaders can more accurately forecast cost during the financial planning cycle by identifying the anticipated total cost of waste across the organization. Also, quality improvement initiatives that have the greatest impact on clinical outcomes, safety, patient experience, and cost savings can be prioritized to achieve the organization's strategic goals.

The potential impact on the organization's financial health can support investment in substantial and sustainable quality improvement efforts. In other words, quality begets quality.

DATA-RICH, INFORMATION-POOR (DRIP)

Cultivating, collecting, and reporting valid and reliable financial data is a common rate-limiting factor to integrating quality and cost. In fact, most executives admit they lack a cost accounting system capable of providing the necessary financial data across the continuum of care.[2] Clinical leaders therefore are rightfully reluctant to rely on any cost data shared about their practice patterns, especially if the data are not risk-adjusted to reflect the relatively higher cognitive and other resources required to treat patients who are sicker.

Despite the challenges of translating big data into informed decision-making, even rudimentary efforts to link cost and quality can have a meaningful impact. Acknowledging that "perfect" data do not exist, leaders should not compromise "good enough" for great, or otherwise be

deterred from incorporating reasonably accurate financial data to estimate and report the cost of waste. Using common and conservative financial data collection methods with reasonable assumptions supports reliable and defensible estimates.

SOURCES OF DATA FOR DETERMINING FINANCIAL IMPACT

Several potential sources of financial information can be used, ideally in combination, to calculate and validate the estimated total cost of waste and the potential savings from a planned quality improvement initiative. They include (1) activity-based costing, (2) cost-to-charge ratio, (3) manual data collection, and (4) published research or white paper.

Activity-based Costing

Data provided from an activity-based cost (ABC) accounting system are usually the most useful for estimating costs, particularly across multiple complex services or service lines. ABC assigns direct and indirect operating costs to a specific and discrete unit of service, such as a test, procedure, clinic visit, or inpatient admission.

Despite its value, a robust cost accounting and reporting system can be labor and resource intensive to develop. Other, reasonable approaches, albeit less accurate and more time consuming, can be applied to support estimating costs.

Cost-to-Charge Ratio

The cost-to-charge ratio (CCR) is determined by dividing the costs to provide services by what the organization charges. CCR generally is used with inpatient or outpatient hospital services. The closer the ratio is to one, the less difference there is between actual costs and charges. Multiplying the cost-to-charge ratio by total charges provides an estimate of the cost of the service.

The example in Table 2 shows the estimated cost for a hip replacement procedure using the CCR method. While the CCR is a simple approach that can be used to estimate total cost of a service, it does not identify the cost of waste, which must be estimated using internal or external best practice benchmarks. Therefore, some manual data collection is required to identify and differentiate ideal quality outcomes with poor quality.

Table 2. Calculating Cost Using Cost-to-Charge Ratio

Number of hip replacements per month	30
Total charges (gross)	$900,000
Average charge per procedure	$30,000
Cost-to-charge ratio	40%
Estimated cost per procedure	$12,000

Manual Collection

Capturing the cost of waste manually can be time consuming and tedious, yet usually insightful when attempting to reasonably estimate the financial impact of an ineffective or inefficient practice or process. It is also a better alternative to doing nothing.

Manually calculating the cost of waste typically involves aggregating pieces of disparate data from multiple systems, such as from financial and operating activity statements, human resources payroll, and supply chain invoices. A common example of manual data collection is a chart audit.

Reviewing clinical charts provides important data that can be translated into useful financial information. For example, a chart audit can support identifying the adverse financial impact of treating a hospital-acquired condition, such as *Clostridium difficile* infection (CDI), by comparing a random sample of charts with and without the infection.

As Table 3 shows, the same risk-adjusted diagnosis should be used to randomly draw at least 30 charts for each status to ensure the results are statistically significant.

Table 3. Estimating the Cost of Waste from Conducting a Chart Review

DRG195 Simple pneumonia and pleurisy w/o CC/MCC	**CDI not present on admission**	**CDI present on admission**
Modifier A04.72 *Clostridium difficile* not specified as recurrent	**n = 30 charts**	
Average length of stay	3.0 days	4.5 days
Total cost of care	$9,000	$13,500
Total cost of waste	$225,000	

The cost for a length of stay from a specific diagnosis is a reasonable proxy to determine the total cost per patient day or bed day. Assume in this example a $3,000 total direct and variable cost per bed day. Multiplying the length of stay of CDI "not present on admission" and subtracting the result from multiplying the length of stay of CDI "present on admission," the cost of waste from the additional 1.5 days is $4,500 per day. Extrapolating the total cost of waste and potential savings opportunity, if the organization can reduce by half 100 episodes of hospital-acquired CDI, the potential annual savings would be $225,000.

Scholarly Article or White Paper

Using published reports in a white paper from a vendor or trade association or a research study from a scholarly journal can provide another source of cost information. However, recognize that reports from vendors or consultants may be inherently biased in favor of supporting a specific product or service.

Mining translatable financial information from journal articles is also a challenge because few include cost

information. The information may not be relevant when the article is available due to the significant research publication lag. Nonetheless, both sources can be used as a reasonable check of the data identified in one of the previous methods.

CONCLUSION

Quality guru Philip Crosby observed that "It is always cheaper to do the job right the first time." The beneficial impact on leading indicator includes improving clinical outcomes and the patient experience while reducing unnecessary waste and associated cost — the lagging indicator. The resulting savings can be reinvested to drive further sustainable performance improvement.

Notwithstanding avoiding increased medical-legal risk and regulatory compliance penalties, measuring and reporting the financial impact from both desirable evidence-based and poor quality practices drives improved leadership decision-making. What's more, integrating quality and cost data supports leaders' strategic and financial planning and prioritization to support their mission.

The next and final article in this series will address how to overcome common barriers to getting a business case approved and implemented, including risk aversion and financial austerity.

REFERENCES

1. Feldman LS, Shihab HM, Thiemann D, Yeh HC, Ardolino M, Mandell S, Brotman DJ. Impact of Providing Fee Data on Laboratory Test Ordering: A Controlled Clinical Trial. *JAMA Intern Med*. 2013;173(10): 903–908.
2. Lawson R. Key Findings of the HFMA-IMA Initiative. Healthcare Financial Management Association;2017.

DOI: https://doi.org/10.55834/plj.9289649596
Copyright © 2022 by American Association for Physician Leadership®

Richard Priore, ScD, MHA, FACHE, is the founder/CEO of Excelsior HealthCare Group and a clinical associate professor at Tulane University in New Orleans, Louisiana.

Bradley Beauvais, PhD, MBA, FACHE, is a strategic advisor to the Excelsior HealthCare Group and associate professor at Texas State University, San Marcos, Texas, specializing in financial management and business development.

AAPL SOLUTIONS

Leadership development programs specifically tailored to your staff and organizational needs.

- ENGAGE AND RETAIN STAFF — Invest in your team and retain your most valuable team members; at the same time developing future leaders from within.
- ACHIEVE BETTER PATIENT OUTCOMES — Improve physician manner, teamwork, personal wellness, and financial stability through professional development.
- UP-TO-DATE EDUCATION — Keep your staff on the cutting edge with the latest in competency-oriented training.
- FLEXIBLE, MODULAR PROGRAMS — A comprehensive leadership program, or a cohesive addition to your existing one.
- INVALUABLE CREDENTIAL — Your physicians can work toward healthcare's highest standard in leadership — the CPE.

Learn how AAPL Solutions can help to transform your organization at https://www.physicianleaders.org/education/business.

Compiled by the AAPL Editorial Team

HEARD AROUND THE APPL COMMUNITY

The AAPL Membership Open Forum: Connect with Your Peers

Physician Leadership Connect is an online community for physician leaders to share knowledge, exchange ideas, and support one another. The community's early success has demonstrated the importance of our community coming together in these challenging times.

Here's what your colleagues are talking about:

Board Governance

I was reading the November/December *Physician Leadership Journal* and the article "A Seat at the Table: Serving on a Board of Directors" caught my attention (pp. 46-50). It is by Sara Larch and Michael J. Sacopulos and is a transcript of their interview on the AAPL SoundPractice Podcast. It is an excellent conversation with advice for those interested in serving on a board of trustees, what boards are looking for in prospective directors, considerations on whether to serve on a board of trustees, conflict of interest policies, as well as advice on serving.

I have served on the board of directors for both medical groups I have been a part of and, by virtue of being medical staff president, serve on two hospital boards and I think their advice is pretty spot on — in particular: "...the first thing is to listen. As a new board member, it is important to learn the board issues, the board culture, and get smart. Read all the materials that you're sent, stay current on your industry and future trends."

What advice do you have about serving on a board of directors or what do you wish you might have known before serving?

"Long COVID" / Chronic COVID

In anticipation of "Long COVID" becoming a more well-defined and acknowledged entity requiring care and benefits, I am reaching out to ask if anyone can point me toward any key resources/authorities on the topic. I would like to start becoming point person on this in my organization but I'm unsure of where to start. Please reach out with any insights or perspectives. My goal is to provide our clients and members with education and then try to understand how to best diagnose and offer benefits to those affected.

Compensation Premium for Medical Director

Hello everyone. I was offered a medical director position for a > 60 FTE hospitalist group (hospital employed group), currently in contract negotiation phase. What is a reasonable premium for medical director role compared to usual clinical pay for 1 FTE in the group? Admin time is 0.75 FTE. Thanks in advance!

Behavioral Health

We have been experiencing a significant increase in behavioral health patients presenting to the emergency department for care lately. While it is not unusual to have behavioral health patients in the ED, our numbers had doubled (and at one point tripled) in recent weeks. Of course, I realize that it is a stressful time and resources are limited (i.e., inpatient behavioral health beds, psychiatrists, case workers), and I know that it is not a local phenomenon. I am originally from Michigan and experienced the same thing there. In fact, I served on the Community Mental Health Board and saw a drastic reduction in providers, services, and programs which left patients and families struggling to find the help that they needed so they would just show up at the hospital.

With an understanding that resources are limited and the existing system stretched thin, we have been exploring alternative options, including tele-psychiatry services and crisis stabilization programs to help decompress our emergency department. We have found ourselves holding several behavioral health patients on a daily basis, waiting to disposition them to the care that they need. The problem is that our ED is not equipped to hold these patients, our staff is not trained to care for their special needs, and holding them impacts the ability to see patients with medical needs.

I am curious to hear the experiences of others and what strategies have been implemented to address these challenges.

APPs on Medical Staff Committees

I was wondering who has had experience with having Advanced Practice Providers on medical staff committees in the hospital. The organization that I worked in previously considered APPs part of the medical staff and also had APP representation on committees. Additionally, there were residents invited to participate on committee work as well (which I though was great since it introduced newer physicians to medical staff governance and better prepared them for participation when they became attending physicians). There was valuable insight added from the perspective of our APP colleagues and seemed to help with overall engagement in committee activities.

Log on and explore. Log into the forum and become a part of the conversation. Ask a question, share a resource, learn from your colleagues. https://app.physicianleaders.org/community

To access member-only content, you must be logged into the Platform. If you need assistance, contact us at 800-562-8088 or membership@physicianleaders.org.

Tip! Add the Platform to your desktop or mobile home screen for an app-like experience.

Complete your profile. We want to know a little more about you, so we can deliver the content and communications you will find most valuable. Complete your member profile today.

Schedule an advising session. Schedule a brief phone conversation for a personal virtual session with one of our education advisors at a date and time that works best for you. We will ask about your professional background and goals and then help you create an individualized learning path.

Remember: AAPL is always ready to help. Please contact us with any questions at 800-562-8088 or membership@physicianleaders.org.

SOUNDPRACTICE PODCAST

SoundPractice Celebrates 100 Episodes

In this 100th episode of SoundPractice, host Mike Sacopulos speaks with luminaries who shed light on the need to provide physicians with business training and leadership skills for the betterment of healthcare delivery.

This roundup of interview excerpts with national and international leaders includes expert commentary from Peter Angood, MD, FRCS(C), FACS, MCCM, FAAPL(Hon), CEO of AAPL.

- Anthony Fauci, MD, director of the National Institute of Allergy and Infectious Diseases
  www.soundpracticepodcast.com/e/physician-leadership-in-the-time-of-covid-19-with-dr-anthony-fauci/
- Gary Schwartz, MD, president of Associated Eye Care, author of a blog post on *Lessons from Ted Lasso*
  www.soundpracticepodcast.com/e/leadership-lessons-for-physicians-from-ted-lasso/
- Joan Naidorf, DO, author of *Changing How We Think about Difficult Patients: A Guide for Physicians and Healthcare Professionals*
  www.soundpracticepodcast.com/e/treating-the-difficult-patient-by-joan-naidorf-do/
- Shannon Prince, PhD, JD, and author of the new book, *Tactics for Racial Justice: Building an Antiracist Organization and Community*
  www.soundpracticepodcast.com/e/dr-shannon-prince-on-racial-justice-in-healthcare/
- Peter Hotez, MD, PhD, professor of pediatrics and molecular virology at Baylor College of Medicine
  www.soundpracticepodcast.com/e/dr-peter-hotez-on-covid-19-bonus-soundpractice-episode/
- Laurie Cameron, mindful leadership expert and National Geographic author of the *The Mindful Day: Practical Ways to Find Focus, Calm and Joy from Morning to Evening*
  www.soundpracticepodcast.com/e/mindfulness-and-healthcare-a-discussion-with-laurie-cameron/
- Kara Swisher, digital expert and former reporter for *The Wall Street Journal* and *The Washington Post*, and host of the "Pivot" podcast
  www.soundpracticepodcast.com/e/medical-misinformation-on-tech-platforms-and-the-threat-to-our-public-health-with-kara-swisher/
- Luis Pareras, MD, PhD, founding partner of two venture capital funds (HealthEquity and Invivo Ventures, based in Barcelona) and author of *Innovation and Entrepreneurship in the Healthcare Sector: From Idea to Funding to Launch*
  www.soundpracticepodcast.com/e/is-it-a-good-idea-or-a-good-business-opportunity-a-discussion-with-entrepreneur-and-venture-capital-founder-dr-luis-pareras/
- Jennifer O'Brien, author of *The Hospice Doctor's Widow*
  www.soundpracticepodcast.com/e/an-insider-s-perspective-on-end-of-life-and-palliative-care-with-jennifer-o-brien/
- Sylvie Stacy, MD, MPH, author of *50 Nonclinical Careers for Physicians: Fulfilling, Meaningful, and Lucrative Alternatives to Direct Patient Care*
  www.soundpracticepodcast.com/e/pivoting-tapping-out-or-trading-up-physicians-transitioning-to-nonclinical-careers/

Listen now at:
www.soundpracticepodcast.com/e/100th-episode-of-soundpractice/

Recent popular episodes of SoundPractice include:

- Jay Bhatt, DO, MPH, MPA, and Peter B. Angood, MD, FRCS(C), FACS, MCCM, FAAPL(Hon), on Physician Career Transitions
  www.soundpracticepodcast.com/e/angood-bhatt/
- Ellis "Mac" Knight MD, MBA,on Healthcare Economic Reform and Physician Leadership
  www.soundpracticepodcast.com/e/healthcare-economic-reform-and-physician-leadership-with-dr-ellis-mac-knight/

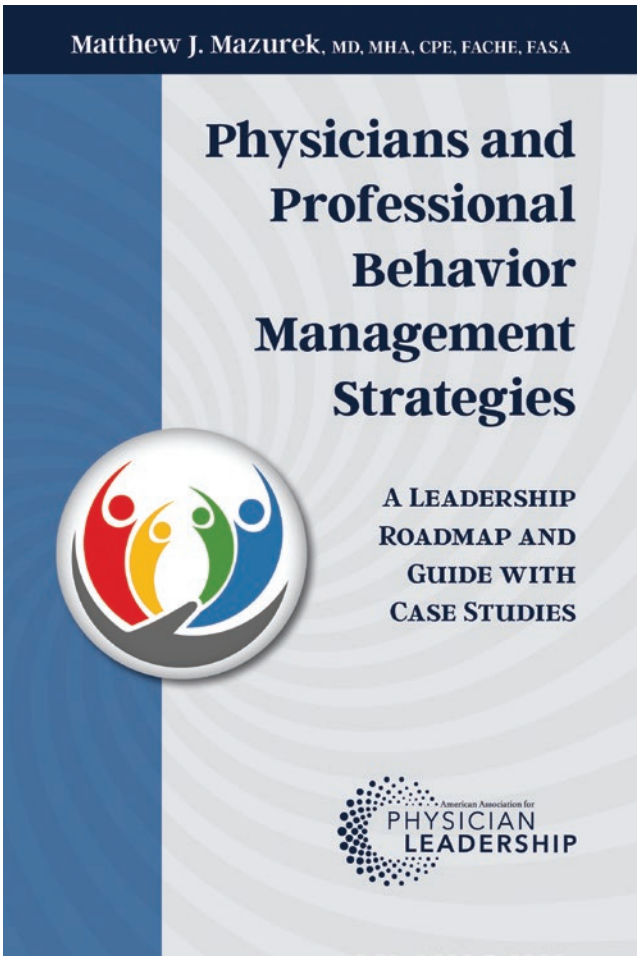
SoundPractice is one of many information resources hosted by the American Association for Physician Leadership®. Our goal is to expand the impact of physician leadership that embraces and promotes inter-professionalism, ultimately improving healthcare globally by independently and collaboratively innovating and delivering exceptional offerings.

NEW BOOK

Author Provides a Roadmap for Recognizing and Managing Chronic Disruptive Behavior

In his book *Physicians and Professional Behavior Management Strategies: A Leadership Roadmap and Guide with Case Studies*, author Matthew J. Mazurek, MD, MHA, CPE, FACHE, FASA, offers practical advice and guidance on managing disruptive behavior, provides descriptions and analysis of personal traits and disorders of disruptive physicians, and offers strategies to reduce the incidence of these behaviors.

Through his own experiences, Mazurek has had an opportunity to conduct dozens of investigations of unprofessional and disruptive conduct from the mundane to the serious. "Navigating the process effectively is usually a trial-by-fire exercise for most physicians who have just accepted a leadership position," Mazurek says. "My own leadership journey included learning how to investigate professional behavior issues, conduct meetings, and continue with follow-up, including discipline and peer support. I stumbled along the way and made mistakes. Having a roadmap with a variety of case examples would have helped me better manage disruptive behaviors."



Published by the American Association for Physician Leadership, this book is a roadmap that aims to instill confidence in and assuage concerns of physician leaders who are uncomfortable confronting unprofessional physician conduct with their colleagues. It provides insight and an increased understanding of this difficult topic through real-world examples.

Case examples include:

- Sexual harassment
- Physical aggression
- Substance abuse
- How to have difficult conversations and conduct meetings with proactive follow up

Complementing the case discussions are strategies to reduce and mitigate disruptive behavior.

Matthew J. Mazurek, was born and raised in Fresno, California, and earned his Bachelor of Arts in English, *magna cum laude,* at California State University, Fresno. He attended medical school and completed anesthesia residency at the University of California, San Francisco. He was a partner in private practice for 12 years with Southern Arizona Anesthesia Services, P.C., and served as both chair of anesthesia and chief-of-staff at St. Mary's Hospital in Tucson, Arizona. He also held the position of medical director for Envision Physician Services and Sanford Health in Bemidji, Minnesota, and served on the board of directors for the Minnesota Chapter for the American College of Healthcare Executives.

His interest in leadership led him to pursue completion of his Master's in Healthcare Administration as a distinguished scholar at Colorado State University-Global as well as CPE and FACHE certification through the American Association for Physician Leadership and the American College of Healthcare Executives. More recently, he was designated Fellow of the American Society of Anesthesiologists (FASA). He has held numerous positions as adjunct assistant professor providing clerkships and rotations for medical students, residents, and CRNA students. Currently, he is assistant professor in the Department of Anesthesiology at the Yale School of Medicine, dedicating his time to teaching, writing, and research.

To learn more or purchase the book, visit www.physicianleaders.org/physicians-professional-behavior-management-strategies.

Table of Contents

Introduction

The Joint Commission Sentinel Event Alert 40: Behaviors That Undermine a Culture of Safety
- Behaviors that undermine a culture of safety
- Root causes and contributing factors
- Existing Joint Commission requirements
- Other Joint Commission suggested actions

Chapter 1: History of Disruptive Behavior

Chapter 2: Definition of Disruptive Behavior

- Types of Physician Disruptive Behaviors
  - Passive Disruptive Behaviors
  - Passive-Aggressive Behaviors
  - Aggressive Behaviors
- Consequences of Disruptive Behavior
  - High Turnover and Low Morale
  - Patient Safety
  - Economic Impact
  - Non-Action Risks

Chapter 3: Codes of Conduct, Bylaws, and Committees

Chapter 4: Know Yourself: Your Emotional Intelligence Quotient (EIQ) and Behavior

Chapter 5: Determining Your Leadership Style

- Defining Leadership
  - Democratic Leadership
  - Autocratic Leadership
  - Laissez-Faire Leadership
  - Strategic Leadership
  - Transformational Leadership
  - Transactional Leadership
  - Coach-Style Leadership
  - Bureaucratic Leadership
  - Servant Leadership

Chapter 6: The Process of Investigating a Professional Behavior Complaint

- Be Curious
- Talk with Parties Involved and Witnesses
- Gather Evidence
- Discuss and Plan
- Conduct a Professional Behavior Meeting
- Disposition and Action Plan

Chapter 7: Case Examples

- Sexual Harassment Behavior
  - Case 1: A Love Letter
  - Case 2: The Off-Handed Comment
  - Case 3: Working After Hours
- Title VII
  - The #MeToo Movement and One Medical System's Response
- Inappropriate and Abusive Physician-Patient Relationships
- Passive-Aggressive Behavior
  - Case 1: I'm Late. So What?
  - Case 2: Bad Jokes at a Bad Time — All the Time
  - Case 3. I Hate My Job and St. Anywhere Sucks
  - Case 4: He Will Not Answer His Pager
- Physical Aggression and Assault
  - Case 1: Should I Call the Police?
  - Case 2: Operating Room Rage
- Violence in the Healthcare Setting
- Drug Diversion and Impairment
  - Case 1: Missing Drugs
  - Case 2: The Impaired Physician
- Passive Behavior
  - Case 1: A Mountain of Unfinished Charts
- Patient Complaint
  - Case 1: The Doctor Told Me I Am Fat
- Physician Denigrating Another Physician
  - Case 1: Dr. S Is Incompetent
  - Case 2: Consequences of Doing Nothing
- Social Media Pitfalls
- Disruptive Physician Leaders

Chapter 8: Avoiding Pitfalls: The Legal Minefield

- Due Process and Fair Hearings
- Legal Counsel's Role and When to Seek Counsel
- Human Resource's Management and Role
- State Medical Boards and the National Practitioner Databank
- Hospital Administration's Role
  - CEO's Role
  - Chief Medical Officer's Role
  - Medical Executive Committee's Role
  - Board of Directors' Role

Chapter 9: Personality Types and Personality Disorders: Behavioral Impact and Management

- Personality Traits and Profiles of Disruptive Physicians
- Personality Disorders and the Disruptive Physician

Chapter 10: Rehabilitation of the Impaired Physician

- Drug and Alcohol Use Disorders
- Deciding Whether to Refer a Colleague to a Physician Health Program
- Physician Health Programs

Chapter 11: Preventing Physician Disruptive Behavior

- Effective Communication
- Managing and Minimizing Drama in the Workplace
- Environmental Factors and Stress
- Physician Specialties and Disruptive Behavior
- 360 Feedback and Performance Evaluations
- Conflict Management
  - Case Example
- Preventing Sexual Harassment
- Creating a Just Culture
- High-Reliability Organizations and Disruptive Behavior

Chapter 12: Physician Burnout: Impact on Behavior

Chapter 13: Moving Forward: Leadership Investment Strategies

Chapter 14: Conclusion

Appendix

- Sample Report and Disposition Form
  - St. Anywhere Hospital Professional Conduct Report and Disposition Form
- Professional Conduct Policy Examples
  - Employed Physician Example
  - Mixed Medical Staff Conduct Policy Example

NEWSMAKERS

27 Members Added to *PLJ* Editorial Board

Anthony Slonim, MD, DRPH, CPE, FAAPL, editor-in-chief of the *Physician Leadership Journal (PLJ)*, has announced the selection of 27 association members to the *Physician Leadership Journal*'s editorial board of directors.

The new board members are:

NICOLE L. AARONSON, MD, MBA, CPE, CHFP, FACS, FAAP, associate clinical professor of otolaryngology and pediatrics, Thomas Jefferson University Sidney Kimmel School of Medicine in New Jersey.

PATRICIA A. ABBOUD, MD, CPE, medical director, Pediatric Intensive Care Unit, Sidra Medicine in Doha, Qatar.

MOUIN ABDALLAH, MD, MHCM, MSC, CPE, FACC, FASE, FASNC, medical director, IQVIA in Washington, DC.

BRYAN NEIL BECKER, MD, MMM, FACP, CPE, president, Acclaim Physician Group in Texas.

EDGAR G. CHEDRAWY, MD, MSC, FRCSC, FACS, MHA, CPE, FAAPL, associate professor of surgery and health administration, Dalhousie University in Nova Scotia, Canada.

ELAINE COX, MD, CPE, FAAP, professor of clinical pediatrics, Indiana University School of Medicine in Indiana.

RAKHI C. DIMINO, MD, MMM, CPE, medical director of operations, OB/GYN hospitalist, OB Hospitalist Group in Texas.

NICHOLAS GAVIN, MD, MBA, CPE, MS, associate professor, Icahn School of Medicine in New York.

AMIT K. GHOSH, MD, MBA, CPE, FACP, FASN, FAAPL, FRCP(EDIN), professor of medicine, Division of General Internal Medicine, Mayo Clinic in Minnesota.

ELDER GRANGER, MD, FACP, FACHE, FAAPL, Major General, U.S. Army (retired), President/CEO THE 5Ps, LLC, in Colorado.

AMY L. HARRINGTON, MD, CPE, FAPA, assistant professor, University of Massachusetts Medical School/UMass Memorial Health in Massachusetts.

GIRISH BOBBY KAPUR, MD, MPH, CPE, FAAEM, president, Allegheny Health Network Emergency Medicine Management in Pennsylvania.

SUZANNE KASETA, MD, MMM, CPE, FAAP, FACHE, FAAPL, chief medical officer, Boston Children's Health Physicians in Massachusetts.

RALPH A. KORPMAN, MD, CPE, FACPE, professor and director of laboratories, Loma Linda University School of Medicine in California.

DAVID F. LEWIS, MD, MBA, CPE, dean, School of Medicine, LSU Health Shreveport in Louisiana.

NANDINI NAIR, MD, PhD, CPE, MHL, FACC, FSVM, FACP, FAHA, FHFSA, professor of medicine, TTUHSC in Texas.

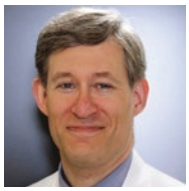
ZEEV E. NEUWIRTH, MD, clinical chief of care transformation and strategic services, Atrium Health in North Carolina.

MOBEEN H. RATHORE, MD, CPE, FACPE, director, University of Florida Center for HIV/AIDS Research, Education and Service (UF CARES) in Florida.

AMJAD RIAR, MD, FACP, FAAHPM, HMD-C, CPE, FAAPL, chief operating officer and senior consulting medical officer (SCMO), Baltimore Medical System Inc. in Maryland.

AMYN M. ROJIANI, MD, PhD, CPE, FAAPL, university chair in pathology, Penn State College of Medicine in Pennsylvania.

MARSHALL RUFFIN, MD, CPE, FAAPL, founder and CEO, Ruffin Health, LLC, in Virginia.



RICHARD H. SAVEL, MD, MBA, CPE, FCCM, director, adult critical care services, Norman Regional Health System in Oklahoma.

GURMUKH SINGH, MD, PhD, MBA, FCAP, CPE, FAAPL, Walter L. Shepeard chair in clinical pathology, vice chair in clinical affairs – pathology, Medical College of Georgia at Augusta University in Georgia.

KRISTA SKORUPA, MD, CPE, division chair for regional practices, Essentia Health in Minnesota.

ALBERT TZEEL, MD, MHSA, CPE, FAAPL, regional vice president for health services – senior products, Humana in Florida.

JAMIE WOOLDRIDGE, MD, CPE, professor of pediatric pulmonary, University of Rochester Medical Center in New York.

MICHAEL J. ZEMA, MD, FACP, FACC, FCP, CPE, CSSGB, physician, consultant, and speaker in Tennessee.

Members remaining on the board for another term are: Donald Casey, MD, MPH, MBA, FAAPL, FACP, FAHA, DFACMQ, CPE; Gregory E. Cooper, MD, PhD, CPE; Amin Hakim, MD, CPE, FIDSA, FACPE; Thomas Higgins, MD, MBA, CPE, FACP, MCCM, FAAPL; Ponon Dileep Kumar, MD, FACP, CPE; Arthur Lazarus, MD, MBA, CPE, FAAPL; Dilip R. Patel, MD, MBA, MPH, FAAP, CPE, CPHQ, FAACPDM, FACSM; and Jon Thomas, MD, MBA, CPE.

The new board members were selected from a list of applicants by a committee headed by Slonim. The board primarily is tasked as ambassadors of the *PLJ* and they work on the peer-reviewed section of each issue of the journal.

Send your ideas for article topics to editor@physicianleaders.org.

Magazine's Top 50 List Includes 2 AAPL Members

ELISSA CHARBONNEAU, DO, chief medical officer of Encompass Health in Birmingham, Alabama, was recognized as one of *Modern Healthcare's* 50 Most Influential Clinical Executives of 2022. This is her third consecutive year of receiving this honor. In her role at Encompass Health, she oversees medical operations at the company's 149 inpatient rehabilitation hospitals; 55 are joint ventures, 252 home health, and 99 hospice locations. Her strategy emphasizes the implementation of data analysis refinement to target better quality of care. Charbonneau has been an AAPL member since 2019.

GEORGES C. BENJAMIN, MD, executive director of American Public Health Association (APHA) in Washington, DC, was recognized as one of *Modern Healthcare's* 50 Most Influential Clinical Executives of 2022. From his firsthand experience as a physician, he knows what happens when preventive care is not available and when the healthy choice is not the easy choice. In his role at the APHA, he is leading the association's push to make the United States the world's healthiest nation. Benjamin has been an AAPL member since 1988.

FALL INSTITUTE

Scottsdale, Arizona | October 27–30

Learn, Connect, and Advance at this year's Institute.

- Advance your physician leadership skills and transform patient outcomes and improve healthcare
- Invest in yourself with up to 28 CMEs across 16 course offerings
- Connect with hundreds of your peers, SMEs, and reconnect with colleagues
- Engage with fellow Certified Physician Executives, Fellows, and Vanguard
- The Westin Kierland Resort & Spa will host us for five days of activities and events that benefit every physician leader, whether they're veterans of the C-suite or just beginning the leadership path.

Explore an unparalleled gathering of physician leaders:

https://shop.physicianleaders.org/collections/2022-fall-institute

NEW MEMBERS

AAPL Membership offers a lifelong partnership for physicians in every phase of their clinical and non-clinical paths. To learn more about AAPL membership, visit physicianleaders.org/membership.

Abraham, Roy
Adams, Haley
Aizenberg, Debbie
Aldurrah, Rana
Aleti, Vikram
Allard, Eloise
Alsmaan, Fawaz
Amianda, Erica
Amiri, Mirwais
Arehart, Lisa
Arrasmith, Lisa
Arthur, Bruce
Bala, Mohamed
Barsaloux, Andrew
Beers, Ann
Bendure, William
Bergeron, Mark
Beste, Lauren
Biedermann, Shane
Bikhchandani, Jai
Bokhari, Qammer
Brack, Lawrence
Brandt, Jerel
Breen, Gregory
Brettler, Jennifer
Brewer, Olaya
Brister, Marilyn
Brown-Puryear, Latonya
Bucci, Paul
Burmeister, David
Cadenhead, Krystina
Carey, Chris
Carey, Deanna
Caudill, Stacy
Cavaness, Keith
Chan, Vickie
Chauhan, Varun
Clapp, Todd
Conway, Jane Arden
Crookes, Bruce
Cruzan, Jeffrey
Cummins, Thomas
Cuyler, Gina
Dai, Sun-Chuan
Dallefeld, Samantha
Dalton, Christina
Debay, Marc
Dedeke, Eric
Desai, Amar
Donahue, Eric
Dontaraju, Venkata
Downey, Tabatha
Drexler, Jennifer
Dubin, Patricia
Dunham, Kati
Dunker, Dalgis
Edmundowicz, Steven
Eguilos, Roderick
Eide, Richard
Eldadah, Mustafa
Elsharkawy, Karim
Enzweiler, Matt
Erickson, Elizabeth
Fannin, Mark
Farhat, Nourhene
Faust, Michael
Fennimore, Blair
Fenton, James
Flink-Bochacki, Rachel
Flores, Breanne
Franklin, Shawn
Gabbert, Michelle
Gandhi, Seema
Garala, Pavan
Gerena, Davida
Gerrald, Helene
Gibson, Aleah
Gill, Jim
Goetz, Kevin
Gomelsky, Alexander
Gonzalez, Cynthia
Good, Stacey
Gowda, Chandrika
Grabert, Jason
Gray, Brad
Greig, Danny
Grove, Gina
Gupta, Sachin
Hart, Jeremy
Harvey, Russell
Hayes, Maureen
Huff, Audrey
Igbinosa, Owen
Isabell, Anwar
Jackson, Michael
Johnson, James
Jones, Dorian
Jones, Kristy
Jovani, Manol
Kalakonda, Aditya
Kamal, Maliha
Kaur, Parveen
Kaveti, Vamshi
Kelly, Steven
Kennedy, Tara
Keuchel, Mark
Khalaf, Dareen
Kickland, Erich
Kil, Alyson
King, Marta
Konda, Vani
Koomsman, Meredith
Kramer, Elisabeth
Kumaralingam, Pradeep
Kupiec, Craig
Law, Joanna
Lewis, Ron
Lipton, Galina
Longwell, Jason
Lu, Amy
Luber, Samuel
Mai, Van
Maigur, Andrew
Mandapakala, Chai
Mango-Kelley, Laura
Markan, Sandeep
Markovich, Meghan
Massaro, Inna
McGhee, Phillip
McKee, Neil
Medeyinlo, Oluseun
Mikals, Kyle
Moise, Ephese
Mueggenborg, Jarrod
Mulamalla, Keerthi
Munoz-Mantilla, Doris
Munsey, Donna
Naddour, Mouhib
Newton, Monica
Nimbley, Erik
Nollin, Zachary
Nottingham, Braxton
Nyberg, Carl
O'Kane, Jacqui
O'Leary, Dena
Palisoc, Kathryn
Paoli, Matthew
Parashar, Susmita
Parsons, Kenneth
Patel, Vaishali
Patel, Vedvati
Patel, Viral
Patel, Vishal
Patterson, Brad
Perez, Oscar
Phillips, Brooke
Phillips, Jennifer
Puro, Amanda
Rahman, Anwer
Rana, Mandeep
Randhawa, Pal
Rasool, Farheen
Reeves, Patrick
Regan, Kate
Rhodes, David
Rickards, Gretchen
Riggs, Gary
Roach, Dillon
Rockler, Kendall
Rogers, Scott
Roy, Tuhin
Sachar, Hamita
Sanford, Darek
Savage, Sasha
Schauf, Kyle
Scheid, Christopher
Schiesser, Rachel
Schutte, Stefan
Scott, Andrea
Sekulic, Milan
Serouya, Sam
Sharafsaleh, Golnosh
Sharma, Abhilasha
Sharma, Vibha
Sheikhaden, Zakaria
Siddiqui, Irshad
Siddiqui, Muhammad Zeeshan
Sidhu, Jasdeep
Simmons, Todd
Singh, Ajay
Singh, Garima
Singh, Gurpreet
Singla, Sumit
Sirota, Susan
Skilton, Frederick Jonathan
Smith, Cara
Smith, Jeffrey
Smith, Jennifer
Smith, Zach
Solaiman, Deana
Souza, Victor
Sparkes, Elisa
Sparkes, Justin
Spicer, Mark
Srinivas, Coimbatore
Stec, Andrew
Stenz, Cari
Steury, Monica
Strear, Chris
Sunderji, Sherzana
Swant, Laura
Taksali, Sudeep
Thier, Gregory
Thomas, Benjamin
Tiwari, Namita
Tochterman, Alyssa
Toom, Pratima
Torres Navarro, Vanessa
Trachtman, Claire
Tsai, Felix
Uddin, Shahaab
Vargo, John
Varshney, Leena
Vassy, W. Matthew
Verma, Varun
Waalkes, Annica
Walker, Savannah
Wang, Ernest
Wendt, Barry
Wicks, Ryan
Widmer, Jessica
Wieland, John
Wisner-Carlson, Robert
Wolff, Emily
Woo, Raymund
Woods, Bronwyn
Zonka, Kristine
Zubelevitskiy, Konstantin
Zumsteg, Jennifer

ADVERTISING INDEX

AAPL FALL INSTITUTE C2-1
physicianleaders.org/2022-fall-institute

MAKE MEANINGFUL CONNECTIONS 3
app.physicianleaders.org/community

AAPL BOARD OF DIRECTORS NOMINATIONS . . . 8
physicianleaders.org/about/board

PROASSURANCE 9
proassurance.com

CERTIFIED PHYSICIAN EXECUTIVE (CPE) 13
physicianleaders.org/cpe

LEADERSHIP ASSESSMENT 35
physicianleaders.org/leadership-assessment

CHANGING HOW WE THINK ABOUT DIFFICULT PATIENTS 40
physicianleaders.org/difficult-patients

THOMAS JEFFERSON UNIVERSITY 53
jefferson.edu/aapl

CARNEGIE MELLON UNIVERSITY 53
heinz.cmu.edu/mmm

50 NONCLINICAL CAREERS 55
physicianleaders.org/50-nonclinical-careers

UMASS AMHERST ISENBERG SCHOOL OF MANAGEMENT 57
isenberg.umass.edu/mba/physicianleaders

ARIZONA STATE UNIVERSITY 57
chs.asu.edu/aapl

WE STAND FOR WELLNESS 74
physicianleaders.org/wellness-resources

AAPL SOUNDPRACTICE PODCAST C3
soundpracticepodcast.com

LESSONS LEARNED: STORIES FROM WOMEN PHYSICIAN LEADERS C4
physicianleaders.org/lessons-learned-women-physician-leaders

Residency Applicants from U.S. MD-Granting Medical Schools to ACGME-Accredited Programs by Specialty and Sex, 2020–2021

ERAS Applicants from U.S. M.D.-Granting Medical Schools by Specialty and Sex	Men		Women	
	Applicants	Average Number of Applications	Applicants	Average Number of Applications
Anesthesiology	1,264	43.1	651	42.2
Child Neurology	83	18.7	116	23.1
Dermatology	368	55.3	428	75.4
Diagnostic Radiology/Nuclear Medicine/Nuclear Radiology	25	1.4	6	2.3
Emergency Medicine	1,400	51.6	901	52.2
Emergency Medicine/Anesthesiology	9	1.0	4	1.0
Emergency Medicine/Family Medicine	31	2.4	22	2.2
Family Medicine	1,404	35.6	1,525	33.4
Family Medicine/Osteopathic Neuromusculoskeletal Medicine	3	1.0	0	0.0
Family Medicine/Preventive Medicine	31	1.4	26	1.3
Internal Medicine	5,072	32.2	3,731	32.0
Internal Medicine/Anesthesiology	32	2.1	14	1.9
Internal Medicine/Dermatology	74	2.6	74	2.0
Internal Medicine/Emergency Medicine	52	6.9	32	8.3
Internal Medicine/Medical Genetics	18	1.8	8	2.1
Internal Medicine/Pediatrics	212	21.4	295	25.5
Internal Medicine/Preventive Medicine	30	1.7	26	1.5
Internal Medicine/Psychiatry	50	7.2	35	7.7
Interventional Radiology-Integrated	353	19.6	99	18.9
Neurodevelopmental Disabilities	8	3.9	13	3.4
Neurological Surgery	245	70.6	93	70.9
Neurology	361	27.3	324	32.1
Nuclear Medicine	10	3.4	2	5.0
Obstetrics and Gynecology	227	54.9	1,253	61.7
Orthopaedic Surgery	919	79.5	235	73.8
Osteopathic Neuromusculoskeletal Medicine	5	4.0	1	1.0
Otolaryngology	372	60.1	193	63.1
Pathology-Anatomic and Clinical	222	24.4	149	23.3
Pediatrics	740	28.7	1,645	30.0
Pediatrics/Anesthesiology	12	3.8	13	3.6
Pediatrics/Emergency Medicine	20	3.2	20	3.2
Pediatrics/Medical Genetics	23	6.0	27	5.7
Pediatrics/Physical Medicine and Rehabilitation	10	2.6	5	2.2
Pediatrics/Psychiatry/Child and Adolescent Psychiatry	29	7.0	51	6.8
Physical Medicine and Rehabilitation	294	34.4	126	33.1
Plastic Surgery	17	1.1	11	1.3
Plastic Surgery-Integrated	140	63.5	129	66.6
Preventive Medicine	56	10.6	61	8.2
Psychiatry	831	47.2	837	48.3
Psychiatry/Family Practice	38	4.4	54	4.1
Psychiatry/Neurology	15	2.5	12	2.5
Radiation Oncology	236	25.0	109	26.9
Radiology-Diagnostic	945	46.5	360	46.4
Surgery-General	1,913	42.8	1,317	52.9
Thoracic Surgery-Integrated	66	20.5	29	22.4
Transitional Year	2,166	12.9	1,387	11.2
Urology	265	71.7	127	76.0
Vascular Surgery-Integrated	175	16.4	74	16.3

Adapted from *Lessons Learned: Stories from Women Physician Leaders* edited by Deborah M. Shlian, MD, MBA.
www.physicianleaders.org/lessons-learned-women-physician-leaders

AAPL SoundPractice Podcast

Over 100+ Free Podcast Episodes for Physician Leaders

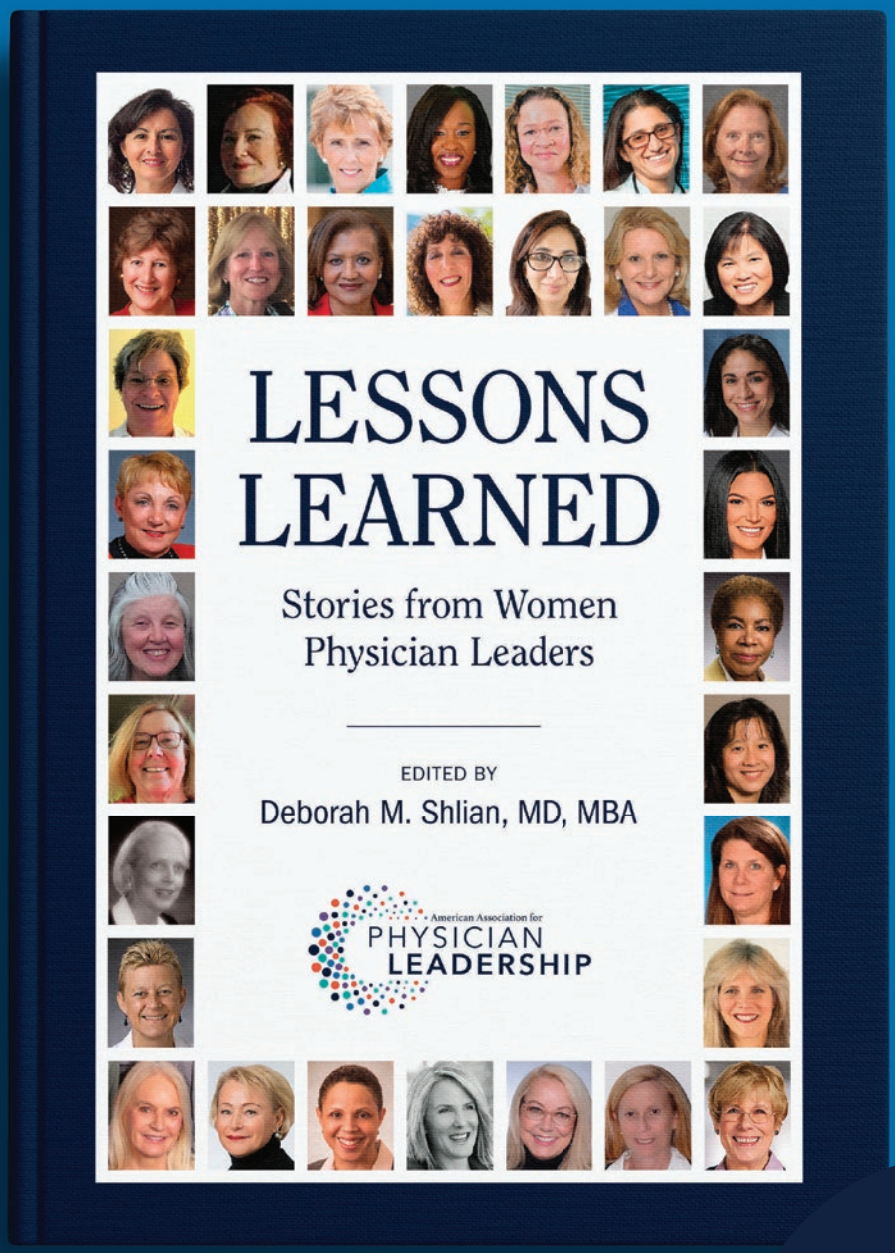
- 100th Episode of SoundPractice
- Is It a Good Idea or a Good Business Opportunity? A Discussion with Entrepreneur and Venture Capital Founder, Dr. Luis Pareras
- The Dr. Lorna Breen Heroes' Foundation and Physician Suicide Awareness
- The Mission of the American Medical Student Association (AMSA) with Dr. Michael Walls
- Toxic Behaviors in Colleagues and Bosses: Strategies for Civility in the Workplace

Listen at www.soundpracticepodcast.com

Subscribe to the AAPL SoundPractice Podcasts today.
A new episode posts every other Wednesday.

AAPL Podcasts are free, under 60-minutes, and available through Apple Podcasts, Google Play, or Spotify.

SP SOUND PRACTICE



Regular Price: $29
Member Price: $25

Edited by
Deborah M. Shlian
MD, MBA

www.physicianleaders.org/lessons-learned-women-physician-leaders

American Association for PHYSICIAN LEADERSHIP