Coaching in the Upside Down World of Health Care

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Most physicians do not go into medicine to be in "Business" with a capital "B." If you ask us, "Today, would you like to focus on being with your patients," or "Would you like to help us capture lost quality revenue, spend 30% of your time entering data into Epic, and help us re-organize your office workflow so you can see more patients in less time," I guarantee no one will choose option two.

Health care today, however, is big business and it is undergoing a massive and complex transformation with a future that is impossible to predict. Physician leaders find themselves in a difficult world. While they are clinical or research experts, they don't necessarily have a deep understanding of health care economics; the depth and breadth of the challenges facing their organization; the impact national and state health policy is having in various domains; the financial analyses needed to make decisions; or the operational knowledge to solve many existing and emerging problems.

As a physician who coaches executive physician leaders, the first thing I came to understand is that they have a steep learning curve. It is important to appreciate the transformation they themselves must go through. This article presents five areas of development that many physician leaders move through learning to lead in the tumult of the health care industry.

The Business of Health Care

Coaching physician leaders is more than helping them learn about leadership. It is also about helping them discover and fill the gaps in their knowledge at the intersection of medicine and management. In a survey conducted with my colleague Dr. Jon Chilingerian at Brandeis University, we queried physician leaders around the country about what they most needed to learn.[i] From 425 responses, they ranked the following topics as most important for their success:

1. Leadership
2. Health Care Finance
3. Organizational Behavior
4. Leadership Coaching and Management
5. Building High Performing Teams
6. Conflict Resolution and Negotiation

7. Quality and Performance Measurement
8. Operations Management
9. State Health Policy
10. Strategic Management
11. Technology and Informatics

Depending on one's professional background, some coaches may well be able to provide guidance on some of these "hard" topics, such as finance and operations management. Coaching, however, is not meant to be a mini-MBA. Without enough business knowledge, physician leaders sometimes feel they are "outside" the world of their administrative colleagues and unable to build the business case to influence or drive initiative's they know to be important. Many physicians I work with go on to get their MBA's, take in-depth management courses, or make a concerted effort to build their business, economic, financial, and policy knowledge. Understanding the business of health care deepens their ability to interpret what is happening in their institution and make leadership decisions with strong financial, operational, and organizational acumen.

That being said, physicians are quick learners. They know that once they gain hard business knowledge, they still need to understand the art of leadership. As coaches, we can guide them to build self-awareness and learn about leadership through the many small lessons of everyday experience. One client told me, "I feel like I'm building the plane while I'm flying it." That pretty much sums it up.

Becoming The Boss

One of the first adjustments a physician makes when transitioning into a major leadership role, is becoming the "boss" of their colleagues. On Friday they are "one of them" and on Monday they are "with the administration." The impact of this shift can be felt in ways both large and small.

Jeff was a client who had recently been named Chair of Emergency Medicine at the largest ER in his state. He had trained at this institution and worked in the ER for many years. Jeff considered his former chairman a wonderful and wise mentor and Jeff planned to model his predecessor's leadership approach; support the physicians, oversee good medicine, and keep up the academic success of the department.

What Jeff did not understand was how much pressure had built up on the department and how fast financial reform and quality demands needed to be met. The administration sent in a non-physician health care consultant without specific ER experience and the consultant went about his job with a zealous efficiency. Jeff and

the medical providers, who were not included in this decision, were dragged in as reluctant participants who felt they were quite capable of leading change on their own. The nursing staff was more aligned with the consultant and the ER quickly devolved into an "us" vs. "them" mentality.

Jeff was a gifted clinician and carried a very full load of ER shifts while being Chair. With tensions rising, small issues became big ones, even when the entire team needed to focus on more important matters. One that bubbled to the surface involved Richard. Richard was a physician who was always late; not a few minutes late, but 20 to 30 minutes late for his shift on a regular basis. The charge nurse spoke to him. Jeff spoke to him. His colleagues nagged him, but his behavior didn't change. Jeff spoke to him a second and third time and for a while Richard managed to come to work only ten minutes late before slipping back into his old pattern. His behavior held up the entire ER during the change of shift. This especially infuriated the nurses who felt Jeff was failing to hold Richard accountable while their own nurse leader held them to clear standards. Irritating them further, the doctors were continuing to have drinks at the clinical computer stations when a decision had been made that this was no longer allowed.

Jeff explained to me that Richard was an excellent doctor, one of the best. He lived far away and his wife's parents were aging and having difficulty. He didn't want to lose Richard. High quality ER docs were hard to attract to this gritty city and he couldn't understand why the nurses were making such an issue. He also thought the no drink rule was ridiculous, even though he had agreed to it. It became increasingly clear just how much difficulty Jeff was having managing the department.

The real issue was that Jeff wanted to remain "one of the team" and did not want to "pull rank" and hold Richard or the other doctor's responsible for more professional behavior. He thought the frequency of Richard being late was being exaggerated but he didn't actually have good data on it. Mostly, he didn't know how to set a limit or how to help Richard, who he knew had a lot on his plate.

I asked Jeff what being a "boss" meant to him and what he assumed it meant to his colleagues. He understood he needed to improve the finances and work flows of the ER and even embrace the role of the consultant. He was torn however, between his desire to protect his providers from the "often unreasonable demands of administrators" and the work of leading the ER into the future.

In my 360 interviews, Jeff's colleagues (both nurses and physicians) desperately wanted him to step up and into his leadership role. They thought he was the best physician in the ER but they wanted a boss who would both defend the ER and also

make tough decisions and lead. Jeff did not know how to translate the 360-feedback into managing people. Our work began with helping Jeff redefine his ideas of what being the chairman really meant. What does "professional behavior mean?" How do standards for behavior and establishing team norms help drive respect and the work? How could he support Richard while also setting clear expectations with specific consequences?

Over the course of the year we worked together, Jeff learned how to separate from his colleagues in order to lead them without losing his sense of connection. He also learned many basics of leadership from how to run an efficient meeting, to project management, delegating and empowering others, clarifying decision-making processes, and building rapport between the doctors and nurses. The docs stopped drinking at the computer stations and Richard was only late one more time. The ER quality metrics improved consistently. Jeff learned how to manage up and set realistic expectations for the C-suite and he became much more involved with the hospital at all levels.

I knew Jeff was really making progress in his understanding of his leadership when he said to me one day, "I think I finally get it. All this time you have been trying to show me that even though I am still a clinician, I am also running a multi-million dollar business." "Yes," I said, "That's it."

Being An Enterprise Leader

Another challenge for physician leaders is to understand how to wear both an enterprise and departmental or other functional hat. Providers and staff do expect their leaders to defend them against what are experienced as unrealistic demands by the administration. For physicians, these demands often get in the way of their time and ability to practice medicine. Yet, physician leaders who sit on the executive leadership team also see that executive level decisions may at times negatively impact their specific department. They know what it means to sit at the table, but they don't always know how to lead in both roles simultaneously.

I was working with an executive team of 12 leaders, including many physicians. The group had lost trust and was adrift in a team culture of blame, polarization, and indecisiveness. In one of our first workshops, I and another coaching colleague began to explore what leadership meant to them. We asked them to take a walk outside and take a picture to send to us that represented "leadership." We also asked them to think about the question "What does it mean to be an enterprise leader?"

Their photos became a visual representation of their role. For example, they described executive leaders as "being those who shine a light onto and into the organization," "see the possibilities," "give people the ability to climb higher," "provide a keystone of stability and a platform for growth," "see the sky as the limit," and "model hard work and being nice."

The team summarized the most important descriptors of leadership as Inspiring, Enabling, Responsibility, Service to Others, and Bearing the Burden and Privilege of Stewardship. They acknowledged, however, that it was easier to live these aspects of leadership overseeing their own individual departments than working together on institutionally wide change.

In the ensuing discussion about being an "enterprise" leader, they pulled together the following thoughts:

- Put the institution first
- Articulate the scope, roles, and expectations of the work we are asking others to do early and often
- Help the leadership team see when it is stuck
- Hold and contain the organizational anxiety as changes take place
- Find the path to problem-solving
- Have each other's back

These sound like the elements of any strong team and we continued to push them to talk specifically about the balance between the hats they wear. They discussed the challenge of aligning their people with the priorities of the organization. They realized the need to be much better at relentless communication, engagement, and listening. They determined they needed to actually remind each other if someone forgot to put on their enterprise hat.

The team also decided that the organization at large did not see them as aligned. They initiated monthly "listening tours" in which pairs of the executive team went out to different departments, satellite hospitals, and the research community to hear what was on people's minds and answer questions. They developed consistent messaging around specific initiatives and worked hard to clarify the high-level, decision-making processes that impacted many of the providers and faculty.

Most importantly, they learned more about each other. They began to build greater psychological safety and trust so they could discuss, argue, and hammer out issues more fully and honestly. They slowly moved away from blame to see difficult situations as an opportunity to problem-solve and find resolutions together.

Understanding Team

Understanding and leading clinical and research teams is very different than leading organizational teams. Hierarchy and command and control are integral elements of medical school, residency, and medicine. Medical students learn from and are told what to do by their interns, the interns by the residents, the senior residents by the chief resident, and everyone marches to the orders and teaching of their attending. The doctors write the medical orders and the nurse's carry out those orders. Sometimes, the attending is wonderful and a natural teacher. Sometimes, they can be rough taskmasters. Both impact the team profoundly. I vividly remember all six years of surgical trainees and all their medical students gathered in a room for a lecture by a famous and intimidating surgeon. He called on people randomly and grilled them to within an inch of their life. No one was spared and no one survived without being shamed, myself included after having gotten only half an answer right.

Hospitals are laser focused on how to re-build systems and deliver care to create greater efficiency and cut costs. As coaches know, giving commands no longer engenders willing participants, especially when those commands mean doing something differently. In teaching change leadership to physician Executive MBA students at Brandeis University, I often have to remind them that the best idea in the world will come to a grinding halt if the people doing the work don't agree with the change. This means that to lead change, they have to build the right team with the right people and understand how to bring people along.

If you want to improve the time it takes to turnover an OR suite between surgeries, you need to think beyond the surgeon, anesthesiologist, and head nurse. What about the OR scheduler, the environmental staff who clean the room, the techs who set-up the trays for the next surgery, and the recovery room nurse who has to be ready to take on the patient? They are all part of the process from when a surgery is completed to the room being ready for the next patient. All too often physician leaders will gather their colleagues, design a new workflow, and then be surprised when the roll out does not succeed.

Coaching physician leaders involves helping them understand the importance of engaging key stakeholders and taking the time to get buy-in. It involves coaching them to go the "Gemba" (the place where work is done); to be curious, respectful, and ask questions; and to value the collaboration of all those who are impacted by an initiative. A client once said, "I really think I need to slow down in order to go faster." Sometimes they are overly focused on getting results and don't pay attention to the process involved in getting there.

Jody Hoffer Gittell has done wonderful research into what drives success on multi-disciplinary teams working together on a specific task.[ii] She has found seven critical dimensions that not only drive better results, but also impact team engagement:

Shared Goals
Shared Knowledge
Mutual Respect
Timely Communication
Frequent Communication
Accurate Communication
Problem-solving vs. Blaming

Paying attention to process does not mean allowing for inefficient decision-making or creating unnecessary bottlenecks. It does mean helping leaders to be intentional about creating a shared vision, setting goals and expectations, and establishing the team norms that address Gittell's dimensions, or others that are relevant for team success. Do we all clearly understand our goals? How will we communicate and how often? How will we hold each other accountable? How will we deal with conflicts when they arise? How will we articulate and manage the decision-making process?

Physician leaders can use coaching to learn how to build, launch, and facilitate their teams as they are so different from the structure and dynamics of the clinical and research teams they are used to.

Critical Thinking

If you graph the efficiency and complexity of various industries, health care sits way out on the line in the top right quadrant, far away from any others. It is the Wild, Wild West and the poster child for being a VUCA industry. Leaders are setting strategies without the benefit of past experience because past strategies existed in another world entirely. It is an unpredictable business climate with an uncertain future and an army of providers who see the need for change but are firmly committed to their patients above all else.

This means that physician leaders need to carry their teams through a well-articulated, critical thinking process in order to make the best decisions possible. When physician leaders get overwhelmed by the chaos and difficulty of making decisions, which they do, it is helpful to remind them of their critical thinking skills and how to apply it to their leadership role. One model that is helpful is based on a book called Smart Choices: A Practical Guide to Making Better Decisions by

Hammond, Keeney, and Raiffa.[iii] The authors outline eight elements for thinking through decisions:

1. Carefully analyze the problem or situation
2. Set clear objectives
3. Consider all the alternatives
4. Determine the consequences of those alternatives
5. Determine the trade-offs between them
6. Discuss the uncertainties that exist
7. Weigh your risk tolerance
8. Link your decision to other decisions being made and determine, if together, they will affect the future and in what way

Under the enormous pressures that face health care institutions, it is easy for physician leaders to be swayed by the many factions at play. Groupthink develops, individual perceptions define individual realities, and leaders succumb to the biases we know impact all decision-making. Providing clients with a model helps them guide teams, and themselves, through a careful, thoughtful, decision-making process. Alfred P. Sloan Jr., the CEO of General Motors in the 1920's, once said,

> "My colleagues, I take it we are all in complete agreement on the decision here…Then I propose we postpone further discussion of this matter until our next meeting to give ourselves time to develop disagreement and perhaps gain some understanding of what the decision is all about."

Conclusions

Physician leaders are not unlike other subject matter experts that become leaders. Health care however, is unlike any other industry. Coaching physician leaders to excel in the business, while protecting the mission and their passion for caring for patients, is a challenge. Transformative change is desperately needed in health care, but it will be a wild ride through an upside down world to achieve it. Coaching is a wonderful tool to help provide physicians leaders with the support, guidance, and learning they need to keep them steady along the way.

[i] Chilingerian, Jon. "A Curriculum for 21st Century Physician Leadership Programs." *Www.physicianfoundation.org*, 1 Sept. 2016, physiciansfoundation.org/research-insights/building-a-21st-century-physician-leadership-curriculum/.

[ii] Gittell, Jody Hoffer. "Coordinating Mechanisms in Care Provider Groups: Relational Coordination as a Mediator and Input Uncertainty as a Moderator of Performance Effects." *Management Science*, INFORMS, Nov. 2002, dl.acm.org/citation.cfm?id=968536.

[iii] Hammond J, Keeney R, Raiffa H. (2015) Smart Choices: A Practical Guide for Making Better Decisions. Harvard Business Review Press