



## **#320: Stethoscopes to spreadsheets: The rise of the physician-executive**

VOICEOVER

This is Up Close, the research talk show from the University Of Melbourne, Australia.

ERIC VAN BEMMEL

I'm Eric Van Bommel, thanks for joining us. It's natural that we accept the clinical expertise and professional opinion of our doctors when seeking medical help, but how do we feel about our physicians having a say, even a leadership role, in the running of the medical organisations and health systems in which they work and on which we all rely? Doctors are trained in medicine, not management, so is there value in giving them executive power in our hospitals for example? There's an argument to be made that medical systems would benefit operationally, even financially, from the greater input of clinically experienced doctors. But then there are the conflicts of interest for the doctors in such roles, such as their commitment to the best possible care for their patients versus responsibility for keeping to health budgets constrained by fiscal realities.

Our guest on Up Close today, Associate Professor Helen Dickinson of the Melbourne School of Government has researched and published widely on issues of leadership, organisational behaviour, health care reform and public governance. She's here to tell us what we stand to gain when our doctors swap their stethoscopes for spreadsheets, and how far along hospitals, health networks, an entire national health systems have come in promoting doctors to positions of executive responsibility.

Helen Dickinson, welcome to Up Close.

HELEN DICKINSON

Thank you Eric.

ERIC VAN BEMMEL

Helen would it be fair to say that many of the greatest challenges in health care today are business problems?

HELEN DICKINSON

Arguably, yes. Today, the sorts of challenges that we see are more complex in nature, they relate to different sorts of diseases and disability where people are living for much longer and accessing different sorts of services over their life course. In

that context, a lot of the challenges that we face are about how we organise those systems to the best effect and how we can make the most of the limited resources that we have within health systems.

ERIC VAN BEMMEL

So how we manage that complexity. So why would we turn to doctors who are trained for clinical work, not management per se? Why is it important to have them in roles of leadership in health organisations?

HELEN DICKINSON

There's a few different answers to that question. I mean one is that doctors play a very important part within health systems. So the sorts of choices and decisions that doctors make have significant implications for our health systems. When doctors choose particular sorts of action that has resource implications which has broader implications for the system as a whole. If we want to make changes within our health systems doctors are important actors within that process. So they need to buy into that process, otherwise that typically won't happen. So what a lot of health systems have been trying to do is more actively engage doctors in process of leadership and management.

Henry Mintzberg wrote in the 1970s about the idea of different sorts of organisations, and health is what he would call a managed professional bureaucracy. Basically what that means is you've got a lot of highly specialised, highly knowledge professionals who work in a context where they might not be as amenable to the sorts of managerial and leadership controls as other individuals. What that means is that doctors effectively often respond more to horizontal levers of power rather than vertical ones. So they're more likely to listen or pay attention to a colleague that they respect than they may necessarily do to a formalised leader or manager within their organisations. One of the things that Mintzberg talked about being important in these organisational contexts is drawing on those horizontal levers. So the idea that if you have a doctor in a management position that you have both horizontal and vertical accountability in that context.

If you have a doctor in a managerial role other doctors may be more likely to respond positively to that than they would to a manager without a clinical background. It's partly an issue of professional cultures and the sorts of cues that the professionals respond to. And so the doctors in those sorts of roles would be paying attention to both the patient experience, the patient needs and the bottom-line in terms of the company. Now obviously, most managers and leaders that you talk to in a health context are perfectly aware of resource implications and patient experience, but there can be a perception sometimes that they may be more interested in the financial aspects than patient quality.

ERIC VAN BEMMEL

So Helen you've stated there are a number of benefits in putting doctors in leadership roles including, as you're suggesting, better patient experience, higher staff morale, less absenteeism as well and also stronger financial management.

HELEN DICKINSON

Yes, so the King's Fund which is a sort of research health tank in the UK did some research in 2012 looking at issues of staff engagement in the National Health Service in the UK context and the implications of that. So they found regardless of your background whether you're a manager, you're a nurse or you're a doctor that the more engaged that staff are within their organisations the more effective those organisations are. They found that where people are really engaged in their work that they were less likely to absent, they were less likely to be sick, they were more proactive in their environment. And that ultimately this led to a number of improved outcomes in terms of patient satisfaction and in terms of the financial bottom-line as well.

A lot of the movement that we've seen in the UK and other countries in terms of public services, and indeed this is a conversation we're having in Australia at the moment, about the ideas of different organisational structures that facilitate more engagement. There's conversations about mutuals or friendly organisations, they're rather kind of traditional types of organisational designs. But a lot of those are around how you get staff more engaged within your organisations. Doctors are one kind of part of that workforce. But as we've seen there are broader cases to be made for the engagement of staff, broadly and then doctors are a fairly special group within health organisations as well. So focusing on this has the potential to deliver a number of positive outcomes.

ERIC VAN BEMMEL

I imagine the usefulness of engaging the doctors in managing medical organisations depends on the type of organisation. You've got hospitals, you've got larger level sort of health networks, you know networks of hospitals and clinics. You've got national health systems as well. So how does the notion of engaging doctors in management extend or scale across these organisational sizes?

HELEN DICKINSON

There's no one size fits all in terms of this stuff. So there's no right or wrong answer but my take on it would be that doctors are crucial in all of those different levels.

Where we've probably focused most of our attention so far has been around a hospital based context and not as much has been done around primary and community care, a health network sort of setting. And arguably they're areas that are ripe for some significant focus in the coming years. In terms of the broader health system, in terms of departments of health or ministries of health there are absolutely crucial roles for doctors within those as well. We've seen some really fantastic examples in recent years of where differences can be made to that context.

ERIC VAN BEMMEL

Across international borders? I guess I'm trying to say across these very disparate health systems. Take the United States for example, very, very different from the UK or Australia, but I suppose the benefits are the same?

HELEN DICKINSON

Absolutely, they play out in slightly different ways but that idea of doctors being mobilised into action through communicating with other doctors about medical

practice we've seen some really great examples of the differences this can make in the European Union for example. A number of the changes that have happened there across health systems have been about bringing doctors together through that mechanism.

ERIC VAN BEMMEL

Now I have to ask you this. Doctors are typically influential in society in terms of their professional standing, the professional associations that tend to lobby on their behalf, their high remuneration et cetera. Do they really need more power?

HELEN DICKINSON

I don't know if it's necessarily about gaining more power. I absolutely understand that analysis. I think my take on it would be doctors, as you say, have an already extraordinary amount of power within our health systems and within our societies.

One of the issues in the context of health systems is doctors often, they practice on the basis of the person who's in front of them at the time. So they're very focused on clinical practice of the individual who's in front of them at that time, and not necessarily the broader population of patients. So one of things that this sort of approach is trying to encourage is a more explicit acknowledgement of their roles within these systems. And asking them to take greater responsibility within this. It's not just for the patient in front of them but for the broader population.

ERIC VAN BEMMEL

I'm Eric Van Bommel and on Up Close this episode we're speaking with Public Governance Researcher, Dr Helen Dickinson about the value of getting medical doctors into leadership roles in hospitals and health care systems. Up Close comes to you from the University Of Melbourne, Australia. Helen, scalpel in one hand, purse strings in the other, is this realistic?

HELEN DICKINSON

Yeah, it's highly realistic. I mean often we think of these issues as you talked about the stethoscope and the purse strings as being at opposite ends of a spectrum. But there's a growing amount of research about these sorts of issues. From the UK and the US we've seen research emerge that tries to analyse organisational performance, where you've got doctors engaged in these sorts of leadership roles.

So for example, a study in 2013 by Goodall, and this study was done in the US, they found there is better organisational performance where you've got CEOs who've got a physician background. Similarly research that I was involved in that was published in 2013 which we did for the National Institute of Health Research in England.

We found that where doctors were more engaged in leadership and management this improved the organisational performance outcomes. So around clinical quality, around patient experience and around the amount of cost savings that organisations were able to make and how effectively they were able to spend their budgets. And since then a number of people have started to do work to look at why doctors might go into these roles. One thing that we do know is that these roles are incredibly challenging. The ability to do clinical practice and management at the same time is not an easy feat by any means, as you would imagine. And so one of the things that

I've been really interested in is finding out why doctors go into these sorts of roles. What incentivise them into this? We've just finished looking at this in an Australian context where we've done interviews with a number of doctors who are in these sorts of roles, asking them exactly these sorts of questions.

ERIC VAN BEMMEL

Why did they?

HELEN DICKINSON

So why did you go into this? What things made that decision easier? What sorts of things got in the way? And trying to think about the implications of this around training and development.

ERIC VAN BEMMEL

But these doctors now are in management positions tended to self-select for these positions, did they not?

HELEN DICKINSON

Absolutely, yeah, yeah.

ERIC VAN BEMMEL

So it's a certain kind of person who happens to be a doctor, who will enter that position. Not just any old doctor?

HELEN DICKINSON

Well, yeah. But the interesting thing about this, and we found this also in research we did in England on a very similar topic in 2012, where we asked doctors who are Chief Executives of health organisations. We asked them about their career paths and why they chose this? There was a huge similarity with the Australian work, in that the only commonality across these stories was that everybody had a completely different story of how they got into this. This might be a reflection of the stage that these systems are with thinking systematically about these sorts of roles. But people tended to talk about coming into them in a very organic fashion. They either had a conversation with somebody or happened across an opportunity and went into it. Often if you want to think about the character types of people who are interested in these sorts of things people often talked about being interested in politics maybe at university or within their hospitals. Or they talked about being really frustrated by a particular issue and recognising that the biggest gains they could make in terms of practice weren't necessarily around the clinical element but around the organisation and the management sorts of processes. And so people talked about being spurred on by these particular things and going into these sorts of roles as a result of this. Whether that will change in coming years as we more systematically identify and develop and train individuals for these roles, I think remains to be seen.

ERIC VAN BEMMEL

It doesn't reflect a diminishing commitment to the clinical side of their profession?

HELEN DICKINSON

I wouldn't say so. I think one of the issues alongside the changes that we've seen to health systems is we're seeing changes to the nature of work that are going alongside this. We are all going to work for a lot longer than we have done, and so the way that we build up our careers will change over time. Whereas, before we might have seen somebody go in and train to be a specialist orthopaedic surgeon and reaching the top of their field and then retiring. What we're seeing now is they're reaching the top of that field earlier on than they ever did before. And so some people in different speciality areas may, for example say, I'm aware that I will be working but I don't necessarily want to be operating on somebody when I'm 65 so I need to look for another role to be involved in.

Or other people are saying, I need to keep active and engaged with my work and I need another sort of challenge to go into. So traditionally we've seen people go into these management and leadership roles towards the end of their careers. Although more recently we've started to see a number of people who come straight out of grad school who are wanting to go into this specialist area as a role. So it's starting to get legitimacy as an area of practice.

ERIC VAN BEMMEL

You've written about a number of issues that arise in the process of trying to integrate doctors into the management process. You talk about the importance of distributed leadership. Can you explain what that is and why it's important?

HELEN DICKINSON

Yeah, so when we think about engagement of doctors in leadership and management we could think that that means doctors in positional leadership roles. And that's been the major way that in the UK and the US we've tried to drive medical engagement. And so whilst that's been really successful in some areas and we've got some highly skilled doctors in those formalised roles, one of the implications is that that's only a very small proportion of the overall medical workforce. There are obviously more doctors in the workforce than those individuals who are in those positional sorts of roles. So when we talk about distributed leadership, what we're talking about there is about thinking about the broader medical professional workforce and how engaged they are overall within the leadership and management of their organisation.

So as I said, they don't have to necessarily have a formalised role to do that. But how engaged are they on a day to day basis? When they make decisions do they think about the broader implications for the organisation? How actively do they try and encourage other colleagues, other clinical or non-clinical colleagues in the overall leadership and management of their teams? So when we talk about distributed leadership that's what we're talking about, having the engagement of the broader workforce within health organisations. Although we may have gone a certain distance in getting doctors into management roles that's not the end of the story. We need to think about the broader medical workforce as well, and not just think we've achieved it if we've got 10 per cent of doctors in an organisation that are in leadership roles.

ERIC VAN BEMMEL

This is Up Close coming to you from the University Of Melbourne, Australia. I'm Eric Van Bommel. In this episode we're speaking with Associate Professor Helen Dickinson, a researcher in leadership, public governance and health care reform on the challenge of attracting and training doctors for roles in managing and leading the likes of hospitals, health care networks and national health systems. Helen, I've read that only medicine among all the industries would put somebody with no business training in front of a huge budget. So let's talk about training, formal training for doctors who wish to enter management roles.

HELEN DICKINSON

It depends which system we look at and which opportunities people take. There are a number of different Masters Programs that doctors may take as a route into this. So some people take an MBA, some people might take a Masters of Public Health or a Masters of Health Administration as a way of getting some formalised training for these sorts of roles. Obviously it depends on the sort of role you're going to take on as to the degree to which you need those different aspects of training. Your example of being responsible for large budgets isn't necessarily the reality of all leadership roles that the doctors go into. If you give up your clinical practice and go into management and leadership full time, obviously that is something that you would be expected to need. But if you have a hybrid, clinical managerial role then you might not have the same responsibility for budgets in the same sort of ways. So some of it has to be decided by the kind of role that you're going into.

ERIC VAN BEMMEL

You mentioned earlier that many people going into management are sort of late career doctors. But there's an increasing, now, interest among people studying to combine management and medicine. There are those programs, in the US particularly, combined MD and MBA double degree programs. I've read that the number of such programs has increased from six to 65 in the last 20 years. Now in the past interest in business was derided by doctors. There is that sort of culture of medicine I suppose, that was at one point, maybe less so now, a bit of a barrier.

HELEN DICKINSON

Yeah, absolutely. I mean the health context has often been seen as very tribal with different tribes who occupy different parts of that context. So we've got nurses and we've got doctors and we've got managers and often clinical practice was seen at some other end of a spectrum to best practice management which is all about, in this worst case scenario, about curbing the best intentions of doctors. And so you know it's not uncommon still to speak to doctors who are in these hybrid management medicine roles who have been warned against this in the past because it's seen as going over to the dark side by their colleagues. Often medicine is still a very tribal sort of space.

ERIC VAN BEMMEL

That's for those who are already in the tribe, they're already doctors. But I guess people who are studying they don't face quite that barrier so they are more likely,

more attracted to this double degree.

HELEN DICKINSON

Yeah, I mean there's particular issues about the US context that makes that more attractive. Which is a far greater number of doctors in leadership roles and it's often requirement of health organisations in the US that their Chief Executives and senior leaders do have a medical background. But you are right that there is more interest in the younger generations who are coming through medicine now who see management as helpful.

ERIC VAN BEMMEL

On that topic of these double degrees, MDs and MBAs, there was a study in June of 2014 that looked at two decades of such graduates from Wharton in the United States. About one fifth of the students skipped their residencies. So they were medically trained but they skipped the residencies, skipping their clinical experience because they decided, I guess early on they wanted to go into the health and medical business fields rather than clinical practice. Isn't that a problem because I mean you want to have that clinical credibility even though you may ultimately wish to work in the business side?

HELEN DICKINSON

Yeah, we need a bit more information I guess to make these sorts of judgements about where those individuals go. And the reality is that not everybody who comes out of medical school goes directly into an area of clinical practice. And a number of people, as you've indicated, will go and work for pharmaceutical companies or other medical related organisations. One of the big challenges we're really interested in our research is about this issue of clinical credibility, and how much clinical practice individuals need in order to have that. One of the reasons why having doctors in these leadership roles is important is they're seen by other doctors to understand clinical practice, to have been involved in it. So they've been called in at half past three in the morning on no sleep to go and respond to an emergency which other clinicians have as well. In a way that more generalised managers typically will not have experienced.

ERIC VAN BEMMEL

So they've paid their dues.

HELEN DICKINSON

Absolutely. So one of the reasons, the one we've talked that kind of issue of these horizontal forms of leadership, one of the reasons that people will follow them is they've got a degree of credibility. They understand it and they've been there in a way that managers may not have done. So if you don't go into clinical practice there is a question there about the degree to which you have that clinical credibility. You can speak the language and you may understand the concepts, although there's nothing stopping somebody who's not been through medical school doing a similar sort of thing as well. So one of the things that we're interested in in researching at the moment is this issue of what sort of things do doctors need, to have that clinical



credibility? At what point is it helpful that doctors have that clinical background, and not? My suspicion is it's not an amount of time per se but it might be more about the sorts of things that you do over that period of time.

ERIC VAN BEMMEL

Are there worries about the de-skilling of clinical practitioners? We spend a lot of money to train them and then once they get into practice they've got a certain skill set that they build up over time, the art of medicine as well as the science. They move into management roles, are we losing something there?

HELEN DICKINSON

You're very right, there's a big sort of societal concern about why would you train somebody for an amount of time to be a doctor if they're not going into clinical practice? If they're going broadly into the health area and they're using their clinical skills for health system improvement then there is an argument about the value of that. Although there is a different sort of value to the way that we've traditionally valued clinical practice. But I think it's also reflective of the nature of the medical profession which is going through a shift at this time as well. So we're seeing less of the doctor as clinical technician, which we've traditionally seen, going into a future where doctors will obviously need that clinical expertise. But also are going to be enablers and operators of broader sorts of health systems. If people are being clinically trained and then going broadly into these health system roles I think that's just reflective of the changing nature of the medical profession.

ERIC VAN BEMMEL

Will there be clinicians who will still be able to solely focus on clinical practice and not have to worry about these things in this new world you speak of?

HELEN DICKINSON

The idea that any doctor can just focus on their clinical practice and not think about the broader implications, I think the time for that is running out. I think now, today, we all accept that regardless of which health system you're operating within you've got a finite amount of resources and that it is a system. And what we do as individual clinical practitioners impacts on other parts of the system. We need to work with others as well. So I think there are certainly doctors who will not need management training, will not need to go through the same sort of leadership training as others. But the ideas that clinicians can just practice in complete isolation from the rest of the health system, I think that's had its time.

ERIC VAN BEMMEL

That notion of having maybe conflicting priorities, they want to provide the best possible care for the patient, they've got the Hippocratic oath they've signed on to. But they've also got these budgetary realities, they have to keep costs down. Doesn't that create a bit of cognitive dissonance? The stress of creating these almost opposing values or ideas in your head, that's got to be tough.

HELEN DICKINSON

I mean that there's no doubt that these roles are really difficult and if you look at the literature it talks about how incredibly challenging it is to undertake these roles. So often these managerial responsibilities take quite a bit of time which often aren't necessarily able to be reflected in job planning. Some of these hybrid management medical roles don't often have the sort of levers that the people need to make particular sorts of changes. Obviously straddling that dual existence of two different tribes, as we talked about it earlier that have different identities and different sorts of cultures is a challenging process. I think we overplay sometimes the amount of difference in terms of the cultures and values. And it can be quite easy to think about doctors just always wanting to do the best for their patients and being curbed by evil kind of management who are just thinking about resource constraints all the time.

What we do know actually is the best ways of organising care for the best patient experience often tend to be those that are cheaper as well. This is about having a more active conversation between the different elements of health systems about how best we organise those systems for the benefit of patient experience. These roles are really stressful but when they're done really well, and this is what people tell us when we do our research, is that when they're done really well the value and the payout for them is in terms of patient experience. That's not just the patient experience of the one person who's in front of you, which you tend to get in clinical practice, but a broader population. Then that's extremely valuable.

ERIC VAN BEMMEL

What helps the transition for doctors entering senior management roles? How can organisations make it easier for them?

HELEN DICKINSON

I mean there are a number of things. A number of doctors have talked to us about the value of having role models or mentors. So individuals who've been through this sort of process before and who can understand it and who can talk them through that sort of process. The availability of training where doctors identified that they have training needs depending on their roles. That can be hugely beneficial. A number of hospitals have recently started to invest in development programs, but alongside that have coaching. So executive coaching that runs alongside that. So individuals get personal development experience as well. Appropriate job design is another one.

Often these roles are kind of set up without giving extensive thought to what the sorts of levers that individuals will need.

If you're going to put a doctor into this executive sort of role, if they're going to give up clinical practice, then giving them some formalised levers. The ability to make change is really important. I mean one of the very practical issues that puts off some doctors is the financial rewards for these sorts of activities compared to what you can gain in clinical practice, is a lot lower. Because of the time demands in terms of these roles, most have to give up any private practice alongside their public or other practice that they may do. In a very basic way the levels of pay are far lower in the management roles, in these sorts of roles. So the most appropriate way to reward these sorts of activities is also something helpful to think about.

ERIC VAN BEMMEL

Helen, finally, in some parts of the world in some organisations there are purely professional managers brought in. In some cases in the US, one can get a PhD in Hospital Administration. So very specialised, formalised routes to top management in health. Are you suggesting that should continue alongside the inclusion of doctors, or should that be pushed aside? How do you compare the two? Should they be siloed, should they be combined?

HELEN DICKINSON

I'd argue that both are absolutely essential. As we talked about, doctors can bring particular things to management roles but at the same time what we're not saying is, we want to expand the intake of doctors threefold and then have two thirds of them just going to management sorts of roles. I think there's huge things we can gain from people who have very professionalised skills around management in this sort of context. And what we are starting to see is an acceptance of that as more, as you indicate, as a more skilled and more specialised area of professional practice. We're seeing more programs coming in to develop people. For example, in the UK the National Health Service is investing significant amounts of money into something called the Leadership Academy.

Whereby they put their general managers in health organisations through a formalised training program. And so it's got a number of different levels depending on where you are in terms of the organisation. But the idea is that you skill up general managers across the board. Professionalise them in that health context.

Programs like that are absolutely crucial. The other thing we shouldn't forget is those people who are more generalised managers aren't necessarily just people who have no clinical practice either. So we find in a number of health systems that a lot of nurses go into management as a way of moving up organisational hierarchies at a point where nursing often stops. So we do find in a number of health systems generalised managers have backgrounds in nursing or physiotherapy or other areas of clinical practice as well.

ERIC VAN BEMMEL

Helen Dickinson, thanks for being our guest on Up Close today.

HELEN DICKINSON

Thank you, Eric.

ERIC VAN BEMMEL

That was Public Governance and Leadership Researcher, Associate Professor Helen Dickinson of the Melbourne School of Government. For a full transcript of this episode and more information on our guest head to the Up Close website. Up Close is a production of the University of Melbourne, Australia. This episode was recorded on 7 October 2014, and produced by Kelvin Param and me, Eric Van Bommel.

Audio engineering by Gavin Nebauer. Up Close is created by me and Kelvin Param. Thanks for joining us. Until next time, goodbye.

VOICEOVER

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