C E Center for Effective Organizations

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CEO Publication
T 89-14 (157)

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WHY PHYSICIAN MANAGERS FAIL

> The doctor manager is the epitome of an oxymoron, for never in the history of language have two terms been so utterly opposed.[2]

The office was considerably smaller than one might expect for a manager at this high a level. Stacks of boxes filled with books and office paraphernalia partially obscured the window overlooking the parking deck. An award of some sort lay on the nearly empty bookcase, half buried under the flotsam of a recent move. Unhung pictures leaned carelessly against the walls. It took him a while to find his business card, and when he did he neatly drew a line through the words, "Vice President and Medical Director," leaving only M.D. to identify his position. Only his eyes betrayed his pain as he mentioned that there had been some changes since he had agreed to be a part of the research. "I'm not sure what I'll do next," he said. "They've offered to keep me on in some unspecified capacity."

It is no small step to leave behind years of training, apprenticeship, and clinical practice to take on a new profession. Yet that is what increasing numbers of physicians are doing as they enter managerial jobs. And, as was the case with the senior-level physician manager described above, success in these new roles is far from automatic.

Sometimes physicians enter management with their eyes open, but often the implications of their decisions aren't apparent until long after the commitment has been made. Whether anticipated or a belated surprise, the move from physician to manager turns out to be a major transition. And, when physicians fail in the new role, the price tag is enormous. First is the psychological

cost to the physician. While some physicians argue that there is no disgrace in failing at management (and returning to "honest work"), the psychological impact of resignation or of being demoted or fired is significant.[3]

While the personal pain of failure can be great, managerial failure can cause additional harm to the institution and to the people dependent upon the manager. Thus the second cost is in damage done to the organization and its mission, and to the people affected by the manager's role.

The third is a far-reaching cost. The health care field desperately needs leadership,[4] and every talented physician who fails in management contributes to the perilous future of medical care in this country. Because of their knowledge of patient care and medical advances, physicians are a logical source for leadership in health care. Yet, as one physician we interviewed pointed out, "Lay management doesn't trust physicians as high level managers." Every failure reinforces that stereotype and makes it that much harder for those who follow. Further, in the worst cases, not only does medicine lose badly needed leadership but the physician is also lost to clinical practice. Depending on how long and how far removed from clinical practice the physician has been, returning to it may not be an option.

While failure in management by physicians may be both dramatic and little-studied, it is by no means unique. Professionals of all kinds have difficulty making the transition from technical specialist to manager.[5] In fact, developing managerial and leadership skills is not automatic for anyone, including those who achieve high levels in corporate hierarchies. Even people with demonstrated managerial strengths can eventually stumble near the top of the executive mountain.[6]

Against this backdrop, we set out to explore the reasons that physicians who become managers sometimes fail. From studies of executives we knew that three kinds of information might shed light on the process: how physicians got to be managers in the first place, what flaws did them in, and what situations surfaced those flaws. To get this information we used a variety of strategies. We interviewed fifteen physician managers in depth,[7] asking them about their own career experiences and transitions as well as about physician manager failures they had observed directly.[8] This detailed information was supplemented by answers to similar questions generated in three workshops held for physician managers.[9]

The Leap into Management

> The greatest problem in my experience in an academic setting is that whoever selected them in the first place used the wrong criteria. They select a terrific independent investigator who can get government grants-- or a good researcher or a good teacher.[10]

Unlike their corporate counterparts, physicians seldom view management as a natural career path-- at least not early in their career. As one doctor put it, only recently "have issues forced the words doctor and manager to be used in the same sentence with no pun intended." Why indeed would someone abandon a successful clinical practice, achieved at great expense and personal sacrifice, to take on managerial work?

It turns out there are at least six pathways from medicine to management: evolution, stardom, default, choice, takeover, and cultivation, roughly in that order of frequency.[11]

Management by evolution. Many doctors never really meant to become serious managers. Like slowly sinking in quicksand, they found themselves more and more committed the longer they stayed in it. Through a slow and often

painful process, time brought them to grips with giving up clinical practice-- which most of them loved-- so they could devote the necessary time and energy to increasing managerial responsibilities. Eventually, their clinical practice was all but gone and they were full-time managers. The gradual evolution usually started with very small scale administrative duties (supervising interns or a small group, heading up a small department) and slowly grew (often over many years) to increasingly larger dimensions. In essence, it was a progression through a series of slightly larger managerial jobs, or increases in responsibility in the same position as the organization grew beneath them.

Management by stardom. The second most common path was being chosen for management on the basis of outstanding accomplishments or skills, almost always non-managerial. Depending on the organizational setting and the needs at the time, doctors might be chosen for a managerial role because of their national reputation, specialized medical credentials, entrepreneurial inclination, network of contacts, research or teaching track record, ability to attract grants, or some other outstanding characteristic. Only rarely was the outstanding characteristic related to managerial or leadership qualities, and often, as we shall see, the admired characteristic was even antagonistic to effective management.

Management by default. Another route to management was by virtue of a shortage of physicians willing to take on a managerial role. As organizations or practices grew, the need for managers increased but available talent didn't. As a result, managerial roles were filled by coercion or seduction, and physicians found themselves managing as a way to get resources, status, "to help out", or even just to keep someone else from managing them.

Management by choice. There were a number of reasons that physicians chose a managerial path. For some there was an early realization that they were good with people or enjoyed building things or had a knack for business. For others clinical practice burned them out, or they tired of it, and medical management offered them new challenges. For still others came a realization that, while they were helping individual patients as a physician, they could make a larger contribution to more patients and even society through a leadership role. Less nobly, for a few it was the lure of anticipated status or power or office. Given the often open door to managerial positions, any of these reasons might cause a physician to step through it.

Management by Takeover. Everyone knows that the corporate world has been wildly turbulent for over a decade, continually turned upside down by mergers, acquisitions, bankruptcies, divestitures, takeovers, and threats of takeover. Few realize the degree to which health care has joined the fray, with insurance companies snatching up and spitting out HMOs, group practices being taken over by larger organizations, hospitals and HMOs going red or belly up, and the other drastic convulsions of the last few years. These organizational changes have resulted in dramatic moves for physicians-- especially owner/mangers-- who have found themselves propelled from one kind of managerial job in one kind of organization to very different levels of responsibility in different kinds of organizations. Legal and regulatory considerations have led some organizations to recruit physicians into certain roles solely because of their credentials-- placing them almost overnight into high level but ill-defined managerial roles. The result of all this turmoil has been substantial movement of physicians into managerial roles, and drastic shifts in responsibilities and organizational settings for physician managers.

Management by cultivation. Only rarely did we encounter physicians-cum-managers who were cultivated deliberately for management by a mentor or by their organizations. Unlike the corporate world, where management development is often a deliberate (if rarely well executed) strategy, health care organizations have not put a premium on preparing physicians for managerial responsibilities. While mentor relationships appear common, especially in academic medicine, and while many physicians who become managers are profoundly influenced by a mentor-like figure, deliberate management development is a rather isolated phenomenon. As one physician described it, "I had lots of support on the medical side, but no one tried to help me be a more effective manager. It's a very non-nurturing environment."

In these six pathways lie fertile soil for failure. Overwhelmingly, physicians enter management for irrelevant or wrong reasons. As one physician manager put it, "they can't find a good candidate, so the person they choose may be incompetent to start with." Scant attention is paid to leadership and managerial qualities as conditions for entry to management or even for promotion to more significant responsibilities. And, if the route to management is fertile, the seeds for failure are plentiful in the physicians themselves. Physician managers are the first to admit that they are ill-prepared for the demands of management. Our first conclusion, then, is that the flaws that will eventually do them in walk in with them.

The high potential for derailment from the very beginning of a managerial career has been documented in corporate settings as well. Morgan McCall and Mike Lombardo looked at why senior executives who later derailed had been successful in the first place. They report that almost all "...derailed executives were identified early as having "it" and ran up a string of successes

in engineering, operations, or project management assignments.... About half the time they were seen as technical geniuses... or brilliant problem solvers.... They were less often well-liked or considered charming.... Some executives who eventually derailed moved up during mergers or reorganizations.... Others were exceptionally hard-working and loyal, managed their careers well, or were excellent at motivating and supporting their subordinates."[12] Roughly translated, even corporations reward accomplishments in a specialty with managerial roles, confuse brilliance with ability to get things done, and make promotion decisions on incomplete or irrelevant criteria.

The Flaws of Physician Managers

> [Physician managers] don't fail because of a lack of skills in their specialty. They run on instinct, gut, emotion-- they are not detail oriented. They are naive financially. They love to diagnose and tell people what their problems are, but they're not so great at action.
>
> If I could tell a new physician manager the foremost requirement, it would be to wrap up your ego and put it on a shelf. You've got to do what the institution needs or you'll not succeed. We have created the superman physician of today. They bring that to management.

As this hospital chief executive observed, it's not their shortcomings as doctors that do physicians in as managers. The ten kinds of flaws that described failed physician managers have surprisingly little to do with a lack of technical knowledge and everything to do with getting things done through others in a complex organization. Whatever the setting, managing is different than technical work, and it requires its own unique set of skills, knowledge, attitudes, and values.[13] Seemingly unaware of this reality, some physicians think, for example, that their experience in dealing with patients has prepared them for dealing with all managerial relationships (one physician manager quipped that pediatricians were especially well prepared for management because

they had learned to deal with childish behavior on the part of both adults and children). But even if a physician has a "good bedside manner" that is no guarantee that the same skills generalize to other kinds of relationships. The fact is, however, that the main reason physician managers fail is their inability to deal effectively with people-- subordinates, bosses, peers, or themselves. As a senior physician executive put it, "It's almost always people management that does them in."

The ten deadly flaws (in no particular order):

1. Insensitivity and arrogance
2. Inability to choose staff
3. Overmanaging (inability to delegate)
4. Inability to adapt to a boss
5. Fighting the wrong battles
6. Being seen as untrustworthy (having questionable motives)
7. Failing to develop a strategic vision
8. Being overwhelmed by the job
9. Lacking specific skills or knowledge
10. Lacking commitment to the job

Insensitivity and arrogance. Failed physician managers share this most common flaw with corporate executives. Variously described as egocentric, humiliating or insulting to others, or unable to build and maintain constructive relationships, insensitive managers inevitably alienated others upon whom their ultimate success depended. "He was never any good at dealing with people," said one medical director of a failed physician manager, "and a managerial position creamed him." A physician department head noted that, "Some people walk in as cowboys. They love to intimidate people."

Among the many endearing charms of managers thus flawed were such practices as insulting people in front of others, showing impatience, failing to listen to others, and acting as if they could do anything. The net result was that no one wanted to be around them or work with them, or, in the last analysis, help them out when push came to shove. As one experienced physician manager remarked about his brethren, "Doctors only talk to God."

Insensitivity and arrogance can be a particularly thorny problem because individuals are often blind to such qualities in themselves. Take for example the experience of a head nurse describing a doctor-nurse relationship:

> The doctors will come to me and say they're trying to get something accomplished and the nurse keeps butting in. Then the nurse will come to me almost in tears, and say, "This doctor is being a real horse's rear end. He won't answer his beeper. I can't get hold of him, and this is going on. Then he came to the desk and really worked me over in front of everybody.
>
> Doctors take criticism very poorly from their peers, let alone from a nurse.... The nurse has already been put down so much that she won't confront the doctor.[14]

Not all physicians treat nurses this way, but many who do are unaware of their impact, or dismiss it as necessary for the good of the patient. Judging from the reported frequency of such events, physicians can act this way almost with impunity. But the data suggest that bringing such behaviors into management, where "if you can't develop useful working relationships you can't get anything done," is a sure ticket to derailment. In spite of the wide-spread belief among non-managers that managers have great unilateral power, one of the first managerial lessons is that superiors, peers, and subordinates respond negatively to insensitive treatment and can be extraordinarily effective in blocking whatever a manager wants to do.[15]

Inability to choose staff. Many physicians made basic and costly mistakes in hiring or selecting people to work for them. Sometimes they viewed the position they were hiring for as insignificant, until a poorly chosen secretary or office manager turned their daily life into a nightmare. Others failed because they played favorites, surrounded themselves with cronies, paid little attention to screening, or otherwise staffed with less-than-effective people in key roles.

People witnessing these poor staffing practices attributed the errors either to the manager's insecurity around talented people, to playing politics, or to poor judgment. Whatever the attribution, two negatives resulted: the manager was viewed as ineffective, and the manager ended up with an ineffective staff.

Overmanaging (inability to delegate).

> He was one of the smartest people I've ever known. He could assess organizational dynamics and lay out a plan. He was charismatic. But he derailed because he was too controlling. He attracted talented people, then strangled them.... He needed to control others. They should have made him a policy maker and put him in a back room somewhere.

Thus did a medical director describe the derailment of a physician manager peer, graphically demonstrating the consequences of overmanaging. It is not surprising that physicians, who are used to being in charge ("You don't want your surgeon taking a vote at the operating table"), often have difficulty letting go. Used to hands-on and even dictatorial control, managers with this flaw have trouble building consensus behind their decisions, getting people to take initiative, generating ideas from their people, and building an effective team. Not only do such a managers alienate subordinates, they may eventually

face a job bigger than they can handle all alone. Inability to effectively delegate insures failure as the scale of the managerial job increases.

Inability to adapt to a boss. For many physicians, the very idea of having a boss is bizarre. Even bosses who are physicians themselves are suspect: "Physicians do not like being told how to treat patients by [physician managers] who have not seen their patient and may not have seen any patients for sometime." But if physicians don't like having a boss, physician managers quickly learn that they have to live with one. This is often not an easy marriage. Even when the boss is also a physician, some managers ignore or fight expectations and otherwise bristle at the subordinate role. One physician manager put it well when describing his perception of the physicians reporting to him. "Physicians are very independent," he observed, "and they like a lot of rope. Just once, though, I'd like someone to accept a <u>subordinate</u> role!" He meant of course that behavior he admired (and maybe even engaged in) when he was a physician-subordinate was harder to tolerate in his subordinates now that he was the manager. Unwillingness of a subordinate to work on a team, to do things he or she doesn't want to do, or to cooperate for the larger good at some point outweighs the positives associated with rugged individualism. A superior can tolerate obstinateness (or outright defiance, as we saw in some cases) only to a certain point, especially from a subordinate manager. Neither physicians nor physician managers in subordinate roles are always sensitive to where that boundary lies.

The greater the chasm between boss and subordinate in style, values, objectives, the harder it was for some physician managers to adapt to the boss. The ultimate test for many who failed, however, came when their boss was a "lay" administrator. As one medical director put it, "Once you've played God, it's

THREE DERAILMENTS

A Changing World

He was entrenched in the philosophy of the "good old days" and the institution was changing. There are a limited number of top positions, and he was caught up in the day-to-day. He couldn't see how the institution was changing: the climate was different, the staff was different. He wasn't prepared to cope with the massive job, and he couldn't adapt fast enough. People lay in wait for him to make an error, and he did.

From Entrepreneur to Manager

He founded and built an effective group practice-- so effective that [a major managed care organization] bought it. He stayed on to manage it for the corporation. He was a martinet and could not deal with people. He couldn't keep his mouth shut, he insulted people in front of large groups. They tolerated him as long as he made money, but when things got rocky he was in trouble. He couldn't deal with lay management or sublimate his ego. He angered someone in the corporate office and he was gone overnight.

The Best and the Brightest

He was selected because he was a terrific independent investigator who landed government grants. He was a good researcher and a good teacher. But as medical director he was unable to give up direct power. He was unwilling to delegate and felt he had to make all the decisions himself. He didn't select good people-- he was threatened by bright subordinates. He did fine for a year or two, but he couldn't adjust.

hard (or impossible) not to feel good about yourself. Then a lay guy tries to tell you how to do your job." We heard stories of derailments caused by bright, aggressive physician managers running afoul of quiet, actuarial types of bosses; by medical directors who lost patience with or failed to understand the perspectives of home-office executives; and by blatant intolerance on the part of the physician manager for non-medical executives above them.

It wasn't just the physician managers who found it difficult to handle physician subordinates. A non-physician administrator averred that "a physician's ego is tough for lay managers to deal with." There was, then, some tension for any change in bosses, but the change to a lay boss for the first time was a particularly significant event. The bottom line, of course, was that when a clash became a war, the boss usually won. While these battles were often dignified by their connection to fundamental health care issues, the truth is that they most often centered on style and personality differences. McCall and Lombardo's study of derailed executives found that both successful and derailed managers ran into conflicts with their bosses. The successful "didn't get into wars over it, fought problems with facts, and rarely let the issues get personal. Derailed managers exhibited a host of unproductive responses-- they got peevish, tried to shout the boss down, or just generally sulked around."[16]

Fighting the wrong battles. Some physicians in management had trouble distinguishing between issues worth fighting over and things to let go. In several cases, physician managers routinely went to war over procedural issues or relatively trivial matters, ultimately paying the price of belligerence by later losing on something important. Some carried attitudes into management that they had gotten away with as clinicians, for example seeing "administrators and nurses as natural enemies." The stories we heard reminded

us of Robert Heinlein's observation that "if a grasshopper tries to fight a lawnmower, one may admire his courage but not his judgment."[17]

Errors of judgment came in several forms, such as starting wars over minor disagreements, horrendous timing of remarks and actions, and blind reliance on (inappropriate) instincts. Repeated clashes resulted in the physician managers becoming thorns in everyone's sides. Worse, in all the commotion they often lost sight of what was really important.

Being seen as untrustworthy. Learning to act for the good of the institution rather than in one's own interest is a major transition faced by physician managers, and some we were told about never made it. Fearful of making mistakes, one manager faked data to make it look better than it was. Another "played one department off against the others" in decisions about staff and equipment, subsequently losing the trust of all concerned. Yet another always acted to benefit his particular group, yet made his arguments sound as if he supported larger institutional goals. Whichever the game, the play was self interest ahead of the institution and the result was a loss of trust. The manager's motives became suspect, and people no longer believed the promises.

Lay administrators and non-medical staff were not the only ones who lost trust. Physicians themselves sometimes grew disillusioned with other physicians when they had to manage them. One such manager described his job as usually challenging and fun. But, he noted, "There are days when I question myself and why I'm in this position. I don't understand why physicians are so hard-headed-- why they do things for themselves [and are so unwilling to do things] for the group and the patient." To some degree a physician-cum-manager started out suspect: To the extent that self interested behavior confirmed the suspicion, physicians in managerial roles were headed for a fall.

Failing to develop a strategic vision. The inability to think strategically, to get out of the day-to-day and see a future, plagued physician managers just as it did corporate executives. Used to the immediate feedback and quick results of clinical practice, many doctors simply couldn't step back to get a bigger picture with a longer time frame. In part because of their narrow background, restricted largely to dealing with other physicians and direct patient care, doctor-managers sometimes had considerable difficulty integrating issues involving other parts of the organization; financial, political, and social forces; and the realities of marketing, capitalization, and construction.

The higher the level the more salient this flaw became, but like other flaws it could be damaging in any managerial position. Some physicians were so narrowly focused on the medical aspects of treatment that they couldn't, as managers, visualize how the totality of forces impact upon a patient's (a customer's) experience. Even though state of the art treatment may be offered, patients like Margo Kaufman still write of their experience: "Cancer patients frequently seem to be treated like airline baggage: checked in, weighed, X-rayed, tagged, thrown on a conveyer belt and forgotten unless it gets lost.... Why was any human reaction I had to their ministrations considered an irrelevant annoyance of no medical interest?"[18] The ability to recognize how the customer experiences health care-- from how telephones are answered to reception to the waiting room-- is crucial to developing what corporations call "customer focus", and is one example of strategic organizational issues some physician managers have trouble getting their arms around. Quality, cost effectiveness, and competitiveness are all objectives that require strategic, integrative thinking.

For some physicians coming up with a strategy was the easy part. Making it workable or putting it into terms that others could understand, however, was a different matter. No matter how intellectually elegant the plan, it came to nothing if other people didn't buy into it. Sometimes physician managers forgot to or were unable to sell up, only to have their ideas unplugged by a boss or a senior manager who wasn't on board. Some had trouble selling their visions to peers or subordinates (or, commonly, to physicians on staff who felt little allegiance to organizational initiatives), and discovered that nothing happened without their commitment.

Being overwhelmed by the job. Perhaps because entre to managerial jobs is so uncontrolled for physicians, some of them are overwhelmed by the demands of management. In some cases the derailment was less the fault of the manager than of a situation that overwhelmed him or her with its scope, the foreign nature of its demands, or, in one or two cases, an impossible mission. (These conditions sometimes resulted from organizational chaos, induced by rapid growth, bankruptcy, or acquisition, that generated managerial jobs with unclear expectations and muddy structure.) In other cases physician managers buckled under the stress of managerial jobs, characterized as they are by ambiguity, few clear endpoints, stressful interpersonal relationships, and time-forced decisions under uncertainty. Lacking self-confidence in a managerial role, some physicians took their setbacks personally, became indecisive or withdrawn, ignored their managerial duties in favor of the laboratory or ward, or even turned to drugs or alcohol. Such reactions stand in stark contrast to the image of the physician as confident and decisive in dealing with patients.

Lacking skills or knowledge. Physician managers seldom failed for lack of needed technical skills or specialized knowledge. When it was a major

factor, it most often involved ignorance about budgeting and finance, or lack of basic knowledge about how business and organizations work. Occasionally we heard of failures caused in part by undeveloped negotiation skills (required for negotiating contracts or dealing with unions), or by an inability to deal effectively with governing bodies, like boards or elected officials. While knowledge shortfalls certainly contributed to derailments, they tended to be viewed as more easily correctable than the other flaws. It wasn't ignorance so much as how the physician handled ignorance that played a prominent role in derailment.

Lacking commitment to the job. A final flaw, traceable to the ways physicians become managers in the first place, was a lack of commitment to managing. People who viewed managing as secondary to research or clinical practice, who ignored expectations of the organization or superiors, or who got bored with administration frequently ended up on the rocks. One specific case, for example, involved a "superb person and surgeon. Management to him is a paper pushing desk job-- it's not in his heart. Even though he was a good leader, he was bored to death."

Successful executives come to grips with what they want to do and find excitement in management itself.[19] Even though most managers begin with a functional or technical specialty, they come to see that managing is important, that doing it well requires commitment to it and leaving the specialty behind, and that managing well means learning new skills. Many physicians believe at first that management is something they can do on the side, or handle easily while doing other things. They find eventually that you can't manage part-time, and here they face a crucial transition. Those enamored of technical specialties or hands-on patient care, or research sometimes had trouble dealing

FIGURE 1

EXECUTIVE DERAILMENT:

THE TEN FATAL FLAWS[1]

Specific performance problems with the business. A series of performance problems in which a manager runs into profit problems, gets lazy, or demonstrates that he/she can't handle certain kinds of jobs (usually new ventures or jobs requiring using lots of persuasion). More importantly, by failing to admit the problem, covering it up, and trying to blame it on others, the manager displays an inability or refusal to take responsibility for his/her actions.

Insensitivity to others: An abrasive, intimidating, bullying style. The most frequent cause for derailment was insensitivity to others. This often shows when managers are under stress.

Appearing cold, aloof, arrogant. Some managers are so brilliant that they become arrogant, intimidating others with their knowledge. Descriptive of such managers is the remark: "He made others feel stupid...wouldn't listen, had all the answers, wouldn't give you the time of day unless you were brilliant too."

Betrayal of trust. In an incredibly complex and confusing job, being able to trust others is an absolute necessity. Some managers commit what is perhaps management's only unforgivable sin-- they betray a trust. This rarely has anything to do with honesty; it is a one-upping of others or a failure to follow through on promises, which wreak havoc on organizational efficiency.

Overmanaging: Failing to delegate or build a team. After a certain point, managers cease to do the work themselves and become executives who see that it is done. Some never make this transition, never learning to delegate or build a team beneath them. Although overmanaging is irritating at any level, at the executive level it can be fatal because of the difference in one's subordinates.

Overly ambitious: Thinking of the next job, playing politics. Some, like Cassius, are overly ambitious. They always seem to be thinking of their next job, bruising people in their haste, and spending too much time trying to please upper management.

Failing to staff effectively. Some managers get along with their staff but simply pick the wrong people-- staffing in their own image with technical specialists, or picking people who later fail.

Inability to think strategically. Preoccupation with detail and a miring in technical problems keep some executives from grasping the bigger picture. They simply can't go from being doers to being planners.

Unable to adapt to a boss with a different style. Failure to adapt appears as a conflict of style with a new boss. Although successful managers have the same problem, they don't get into wars over it, fight problems with facts, and rarely let issues get personal.

Overdependence on a mentor or advocate. Sometimes managers stay with a single advocate or mentor too long. When the mentor falls from favor, so do they. Even if the mentor remains in power, people question the executive's ability to make independent judgments. Can he stand alone, or does he need a mentor for a crutch?

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[1]Adapted from M. W. McCall, Jr., and M. M. Lombardo, Off the Track: How and Why Successful Executives Get Derailed, Technical Report No. 21 (Greensboro, NC: Center for Creative Leadership, January 1983).

with the people side of managing. They were unwilling to invest the time in managing people that they willingly spent on other things. As one manager said, "You know, to be a good manager you really have to like people."

As we look at this set of ten fatal flaws for physician managers, we are struck by the similarities between them and the flaws that derail corporate executives (see figure 1). As McCall and Lombardo observed in their report,

> Some of those who derailed found themselves in a changed situation where strengths that had served them well earlier in their careers became liabilities that threw them off track. Others found that weaknesses they'd had all along, but which had been outweighed by certain assets, were precisely the things needed as strengths in a new situation. Yet others became captives of their own success or of events outside their control.[20]

INSERT FIGURE 1 ABOUT HERE

What differences there are seem more in emphasis than in substance. Corporate executives are somewhat more likely than physicians to do themselves in with ambition or by overdependence on a mentor. Physicians are more likely to be overwhelmed by the job, lack commitment to it, or lack a specific skill-- all perhaps the result of managerial careers that are foreign to them. But these differences are small relative to the overwhelming centrality of two themes: the inability to handle relationships effectively, and the inability to have a vision of where the organization can go and what it can be.

Surfacing Fatal Flaws

The situations which surfaced physicians' managerial flaws were closely related to the flaws themselves. As the scope of managerial jobs increased, so did demands to deal with more people and more different types of people, to

handle effectively functions and specialties unknown to the manager, and to deal with broader strategic issues. The broader the scope, the broader array of skills required to handle the job and the broader the array of potentially fatal flaws.

Job changes often brought with them changes in bosses, and the subsequent demand to adapt to a different style. A particularly crucial point occurs when a physician manager gets a "lay" boss, an event frequently precipitated by acquisition of a medical group by a corporation.

Changes in type of health care organization sometimes surfaced flaws, as physician managers crossed boundaries from one kind of hospital to another, or from a university to another setting, or from a group practice to an HMO. These kinds of shifts amounted to major changes in the corporate culture in which the manager was embedded, and were severe tests of ability to adapt.

Another dynamic involved a slow accumulation of enemies. In several cases, derailments occurred after years of abuse. When the manager got into trouble, no one was there to help out. One medical director, for example, slowly alienated the entire medical staff. Because he was entrenched and supported by the board, he stayed in power for years. Eventually the institution got into a bad cash flow problem, and the director got in trouble with the board. At this point, the medical staff united against him and threatened to resign if he wasn't moved out. He was. As Hugh Menzies noted in an article on tough bosses, "the revolving door also waits for the boss who fails. And when a tough boss fails, there are plenty of willing hands to help give that door a spin."[21]

The essence of each of these situations is change. Flaws emerge and become fatal as situations change.

Preventing Fatalities among Physician Managers

The similarities between professionals in general who make managerial transitions, the dynamics of derailment in corporate environments, and the reasons for derailment of physician managers strongly suggest that strategies used to develop executives in corporations might be useful for physicians in managerial tracks. Two basic practices are particularly promising: 1) closer control over entry and promotion in management, and 2)use of experience to develop leadership skills.

1. Closer control over entry and promotion. The reasons physicians become managers are diverse and in many ways unrelated to the skills and abilities required of managers. A first line of defense, then, is to pay more attention to who becomes a manager in the first place. That is, physicians put into managerial roles should be chosen on the basis of their demonstrated or potential managerial skills. This means development of criteria for choosing physicians and creation of a mechanism for assessing individuals on those criteria. With this approach it is unlikely that people will be chosen for management on the basis of their track record in research, teaching, clinical practice, grant procurement, or other accomplishments if they are unrelated to the managerial expectations.

In addition, we saw that many mistakes might be avoided if physicians had a better idea of what to expect in a managerial job. In industry some success has come from realistic job previews in which candidates are given a simulated job experience or are exposed to the pros and cons of the job they seek. This preview improves the self-selection process, eliminating some candidates who would end up disillusioned and unhappy.

2. Use of experience to develop leadership skills. A glaring deficit in the development of physician executives is the virtual absence of the kinds of experiences that develop leadership skills.[22] It is ironic that a profession that is so thorough in its preparation of people for the practice of medicine is so primitive in its preparation for management. In fact, when we asked our medical interviewees what they thought should be done to prepare physicians for management, they usually recommended courses. This, in spite of the Medical Profession's emphasis on learning on the job and apprenticeship.

Successful corporations develop their executives primarily through on the job experience,[23] systematically moving them around to give them an opportunity to develop leadership skills. They supplement this activity with strategic use of courses, but the emphasis is on learning on the job. As we look at physician manager career experiences in comparison to those of corporate managers, the differences are staggering. Physicians are seldom given meaningful managerial experience early, exposed to effective managerial role models, moved through different kinds of leadership challenges, or exposed to key organizational functions. While these kinds of experiences may not improve clinical practice, future physician managers need them desperately. Perhaps the hardest lesson of all for physicians is that managing <u>is</u> a different profession and requires different training. Health care organizations could profit from identifying experiences that foster leadership development among their physicians, and from thoughtful identification and selective movement of their high potential candidates.

Finally, classroom training for physicians can be an important complement to on the job experience. Just as many corporations gear the classroom to key managerial transitions, physician managers might benefit from courses designed

to help with transitions from professional to manager, to manager of managers, and to executive ranks.

Some Closing Thoughts

The similarities to corporate management development should not overshadow some profound differences. First, most corporate managerial candidates-- even professional ones-- are coming out of a culture where managerial careers, if not wholly respectable, are common and often actively pursued. The transition from physician to manager may be much harder, due to the length of training and the strangeness of organizational culture. Organizations need to be more sensitive to the size of this transition, its nuances, and the risks and fears associated with it.

Second, the turmoil in health care has resulted in many health care organizations characterized by ill-conceived organizational design, badly constructed jobs, unrealistic expectations, poorly designed reward systems, and misunderstandings of medical needs and values.[24] The mangled managerial jobs physicians try to fill remain a major force in the subsequent failure of physician managers.

Learning to lead is no small undertaking. Physicians, as bright, well-trained, and dedicated as they may be, are no better prepared to lead than anyone else. In a sense, choosing a managerial career is, for a doctor, starting over. It means, sooner or later, leaving clinical practice behind. Unlike potential managers in exemplary corporations, physician managers seldom operate in an infrastructure designed to identify and develop leadership talent. They are left largely on their own, to sink or swim. On the one hand, this is exactly how many successful corporate executives developed-- taking on challenges and learning on the run. But bad managerial selection wreaks havoc

on the organization, the people dependent on the manager, and, ultimately, on the patient. We can do better, we know how to do better, and we can't afford not to.

ENDNOTES

1. The authors gratefully acknowledge research support from the American College of Physician Executives and from the Center for Effective Organizations at the University of Southern California. Ron Pickett, formerly with the A.C.P.E., and Dr. Robert Spears of the School of Medicine at U.S.C. were invaluable in helping design the study, identifying physicians to participate, and interpreting the results. Dr. David Molthrop provided us with extensive background in how medicine has been changing and the residents' view of the physician manager. We are indebted to Esther Hutchison for her many useful suggestions on the early version of the manuscript. Last but not least, we thank the physician managers who shared with us their experiences, good and bad, and provided us with the insight that made this paper possible. We are especially appreciative to those among them who gave us constructive feedback on earlier versions of the manuscript.

2. All unreferenced quotes came from physicians, usually from the interviews but occasionally from written comments. Some interview quotes had to be reconstructed from notes. Some specifics have been altered to protect confidentiality, but the essence of the comments has been preserved.

3. Several streams of research have documented the potential psychological impact of failure at a job, for examples see work by Craig Mellow (1986), Murray Finley & Terence Lee (1981), and Richard Sprague (1984). Being fired or demoted are among the most significant life stressors on the Homes & Rahe (1967) stress scale. Losing a job (even voluntarily) is a major "loss" and therefore can be a psychological event akin to divorce, death of a friend or loved one, or other significant losses.

4. Regina Herzlinger, "The Failed Revolution in Health Care-- The Role of Management" (1989), has documented many of the problems. The sense of desperation is clear in the headlines of business and news publications: "Our Health Care is Sick", "The Prognosis on Health Care: Critical-- and Getting Worse", "A Crisis in Care", etc.

5. See Morgan McCall, "Leadership and the Professional" (1978); Jay Lorsch & Peter Mathias, "When Professionals have to Manage" (1987); Mary Ann Von Glinow, The New Professionals (1988).

6. Morgan McCall & Michael Lombardo, "Off the Track: How and Why Successful Executives Get Derailed" (1983).

7. The fifteen people interviewed included 14 physicians and 1 hospital administrator who was not an M.D. Of the physicians, all but one held a managerial position at the time of the interview (the one had recently returned to clinical practice after holding a managerial job). Titles represented included Medical Director (4), Associate Medical Director (1), Chief of Staff (2), Associate Dean (2), Department Head (1), Director (1), Assistant to the Associate Medical Director (1), and Chief Executive Officer (1). Organizations represented included four hospitals (private community, public, and university

affiliated), two national managed care organizations, three group practices, and a medical school. Most of the physicians had held multiple managerial positions in their careers.

8. Unlike the executives interviewed in the earlier study, physician managers were reluctant to discuss failure among their colleagues. Some of the physicians were more open to discussing their own flaws and setbacks than they were to talking about a someone else's.

9. Sponsored by the American College of Physician Executives, the three workshops involved a total of almost 200 physician managers. The workshops generated a variety of information, including lists of reasons physicians became managers and of flaws that derailed them.

10. Physician chief executive of a community hospital who had one career in clinical practice, a second career as a medical school dean, and was starting out on his third as a CEO.

11. Unfortunately the nature of the data from workshops and qualitative interviews precludes an exact frequency count.

12. "Off the Track," p. 3.

13. See Morgan McCall, Michael Lombardo, and Ann Morrison, The Lessons of Experience (1988), for a comprehensive discussion of 34 such characteristics.

14. Jim Wall, Bosses (1986), pp. 101-102.

15. For more on the early lessons of management, see pages 18 through 29 of The Lessons of Experience (1988).

16. "Off the Track," page 8.

17. Robert Heinlein, Farnham's Freehold (1964).

18. Margo Kaufman, "Cancer: Facts Vs. Feelings," Newsweek, April 24, 1989, p. 10.

19. See The Lessons of Experience (1988), Chapter 4.

20. "Off the Track," p. 1.

21. Hugh D. Menzies. "The Ten Toughest Bosses". Fortune, April 21, 1980, 62-69, page 69.

22. The Lessons of Experience (1988).

23. John Kotter documents the practices of well-managed firms in The Leadership Factor (1988).

24. Paul Starr, in The Social Transformation of American Medicine (1982), attributes the poor design of health care organizations in part to the fact that, until recently, they haven't needed effective design.

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