RESIDENT VOICE

Countering the Rise of Administrators: Overcoming Cultural Disconnects and Optimizing Patient Care

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A seminal analysis by Goodall demonstrated the positive effect of physician-leaders on hospital performance, as evidenced by *U.S. News and World Report* scores. The presence of physician leadership significantly increased quality scores when examining top institutions in cancer, digestive health, and cardiac health. Additionally, a significant majority (16/21) of high-performing institutions in the "Honor Roll" were also led by physicians.[1]

Despite the historical norm of physician-led hospitals, increasing complexity and paradigm shifts toward business-like models in the 1980s gave rise to clinical directorates. Although many physicians entered these roles, this signaled the rise of administrators.[2] The increasing "metrification" of health care that accompanied these structural changes, shifting administrators' focus away from patients, has led to loss of physician autonomy, exacerbating a cultural disconnect. At the same time, administrative costs have ballooned from $294.3 billion in 1999 (representing 31% of total health care expenditures)[3] to $812 billion in 2017 (representing 34.2% of total expenditures).[4] This was over 4% of our entire nation's GDP in 2017.[5]

In such an imperfect system, truly optimizing patient care requires systemic change. A full inventory of such solutions is beyond the scope of this piece, but increasing physician knowledge and skills in emotional intelligence and leadership is a critical first step. Some physicians perceive mismanagement from nonclinical administrators and either seek or are thrust into these roles. On the other hand, many administrators feel that clinicians lack management and leadership skills. Despite awareness of these shortcomings, clinicians feel that resources are lacking to acquire these skills.[6]

Nevertheless, physicians who have succeeded are able to wield these skills to benefit patient care. Shanafelt et al also demonstrated reduced burnout and increased satisfaction with more effective physician leadership.[7] Another meta-analysis conducted by Clay-Williams et al recapitulated some evidence of this benefit. They noted that multiple studies analyzing institutional board compositions showed better service quality and lower morbidity rates with more physicians taking part. Other studies showed better outpatient care with physician-led accountable care organizations, but also a harder time fully adopting managerial roles.[2]

Throughout our training, emphasis has centered on individual accomplishments and has not traditionally highlighted leadership and managerial skills, despite leader-

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ship roles inherent in being a physician, both perceived and actual. Even without official leadership roles, we as radiation oncologists lead a team of dosimetrists, physicists, nurses and other allied health professionals with the patient at the center. Other pieces have highlighted leadership programs within radiation oncology resdiency,[8] and we are doing our part. At Moffitt Cancer Center, we recently completed a unique longitudinal, case-based leadership development course exploring topics such as emotional intelligence, conflict management and negotiations, with practical application and guest lectures from executives.

Although more widespread efforts for formal training and opportunities for leadership growth are lacking in radiation oncology, offerings like the Foundations in Leadership course through the European Society for Radiotherapy & Oncology (ESTRO) have begun this process.[9] Organizations such as the Association of Residents in Radiation Oncology (ARRO), American Society for Radiation Oncology (ASTRO), American College of Radiation Oncology (ACRO), and Canadian Association for Radiation Oncology (CARO) should follow suit and create content to provide practical skills and knowledge valuable to radiation oncologists at all stages of their careers.

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