Physician Leadership during COVID-19

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In life, we are often faced with discordant information. As a physician-leader, I have been struck by those who suggest that physicians are insufficiently trained to lead organizations. In the Harvard Business Review in 2018, Rotenstein[1] stated that "nearly all physicians take on significant leadership responsibilities over the course of their career, but unlike any other occupation where management skills are important, **physicians are neither taught how to lead nor are they typically rewarded for good leadership**."

Yet, in my career as executive dean of the University of Kansas School of Medicine and now as the executive vice chancellor of the University of Kansas Medical Center, I have worked for a physician who has served as chancellor (Douglas Girod) in a state in which the governor (Jeff Colyer) and a United States senator (Roger Marshall) have also been physicians. Furthermore, there are a dozen or more physicians who direct large universities and pharmaceutical companies, as well as the European Union and the World Bank. So, how can a group that has not been trained to lead so commonly rise to leadership positions? Furthermore, how can they be successful in doing so?

The central thesis of my book, *A Prescription to Lead*, is that medical school and training is solid preparation for organizational leadership. Together with the skills and achievements required to get into medical school, doctors are trained to define and solve problems and learn to work collaboratively and communicate clearly. While medical training is not sufficient for all doctors to lead, I believe it is a sound basis for those inclined to do so. I further believe that never before has medical training been more applicable for the physician-leader than during the COVID-19 pandemic.

In spite of widely divergent strategic goals and plans, almost all organizations faced similar challenges in early 2020. These challenges focused the immediate needs of the organizations on two immediate goals. It became essential to protect the health and safety of their employees (and customers and patients) and to ensure the continuity of the organization regardless of the challenges that they faced. With these goals in mind, I believe physician-leaders had advantages over leaders who were not physicians.

Physician-leaders share a knowledge base provided by their training that allowed them a greater understanding of the challenges presented by COVID-19. These advantages included an understanding of: (1) the basics of virology, (2) the basics of viral testing, (3) the tenets of epidemiology, viral spread and prevention, and (4) the importance and challenges of vaccine development. They also shared important contacts within organized medicine and, in many cases, local healthcare systems.

Physician-leaders were trained to develop skill sets that allowed them to successfully lead their organizations. These included: (1) sharing a work ethic to meet the demands of the pandemic, (2) the ability to work within and to lead teams, (3) a commitment to serve others, (4) communication capabilities, and (5) the ability to maintain and provide hope to individuals within their organizations. Each of these skills was modeled and cul-

tivated during their many years of medical training.

During COVID-19, physicians in academic medical centers (AMC) were asked to play diverse roles inside and outside of AMC. Many physicians were asked to serve as county or community healthcare leadership or to serve on school boards as they struggled to deal with the novel coronavirus. Physicians were providing emergency and inpatient care throughout their healthcare systems. Testing centers were being established as diagnostic capacities evolved and many centers were run by physician-leaders. Vaccines were developed by teams of MDs and PhDs throughout the public and private sectors.

One of the major roles for physician-leaders during the pandemic was in the leadership of pandemic emergency management teams. At the University of Kansas and empowered by Chancellor Girod, a Pandemic Medical Advisory Team (PMAT) was led by Dr. Steven Stites, vice chancellor of clinical affairs at KUMC and senior VP of clinical affairs at the University of Kansas Health System. PMAT consisted of medical and public health experts, members of the emergency management team, and communications and campus leaders. PMAT met biweekly for over 12 months and weekly thereafter.

The goals of PMAT were the goals of the university: safety and continuity. At the end of each meeting the safety level for the university was determined. From that determination, its impact on activities and campus protocols were determined. Each meeting included reports from campus testing and vaccine sites, data from county (including wastewater) and community partners, and reports from each of the local health systems. As individual members were also on regional and national calls, PMAT provided a one-stop for COVID information gathering.

The challenges for PMAT were real. Recent studies suggest there were important effects of behaviors and policies on college campuses that impacted their broader communities. At the beginning of the pandemic, PMAT had to quickly consider whether students should return to campus following spring break. Mangrum and Niekamp demonstrated that university students who returned from spring break contributed to the growth of cases and deaths in the community.[2] Similarly, opening of campuses in the fall of 2020 and 2021 led to increased COVID cases.[3]

So, did campus policies impact the spread of COVID in the community? A provocative manuscript by Acton and colleagues used a variety of sources to conclude that campuses with vaccine mandates reduced COVID cases and deaths in surrounding communities.[4] They concluded that these policies were associated with 7,300 fewer deaths in the U.S., or 5% of deaths, during the 13-week period studied.

As a scientist, I would ask whether there are data to support my contention that physician-led organizations might have performed better through the pandemic. Unfortunately, I do not believe such data exist. First, many large member organizations try to avoid comparisons of their membership as to avoid making some look inferior. Second, it is plausible that all such groups included physicians given the nature of the crisis. Likely control groups would be difficult to find. Finally, politics may have prevented some physician-leaders to implement preferred public health policies. In the absence of such data, I would posit that physicians were a required part of all such emergency management teams regardless of the nature of the organization. Whether these doctors were procured internally or externally, I believe they were universally required.

The critical role of physician-leaders during the pandemic raises a question also addressed in the Harvard Business Review: **Does your company need a chief medical officer?**[5] Neely suggests that the CMO can play a tripartite role protecting the safety of employees and of customers while creating a culture of global compliance. This is not to be confused with employee health and certainly not limited to healthcare organizations. The combination of employee and customer safety and compliance create a likelihood of business continuity and success.

A former colleague of mine at Mayo Clinic, Dr. Henry Ting, was recently named the Senior Vice President and Chief Health Officer for Delta Airlines. At his hiring, Delta stated that Dr. Ting is a voice for Delta *"as we work to protect the health and safety of our people and customers and emerge stronger and better prepared for the future."* Perhaps there has never been a time in the history of the airline that medical knowledge and training were more important.

I believe that the selection and training of doctors results in competencies, expertise, and skills that support the assumption and high-level performance in diverse leadership roles. Evidence to support that contention comes for diverse and global organizations choosing physician-leaders and the importance and performance of these organizations both public and private and inside and outside of healthcare. Furthermore, COVID-19 made it crystal clear that in cases where the health of the community is at risk, physician-leadership is a necessity. With the likely impact of pandemic and global warming on human health, organizations of every kind should strongly consider a chief medical officer in the c-suite.

References

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