INSTRUMENTS OF CHANGE: THREE MEDICAL DIRECTORS DESCRIBE THEIR EVOLVING ROLE

Kyle J. Kircher, MD, MBA, with comments from Victoria McEvoy, MD, and Macaran Baird, MD

Nearly everyone has been affected by the forces of change that are reshaping the health care landscape in the United States. Relationships have formed and then formed again among patients, physicians, hospitals, and health insurance companies. During this time, physicians have sought refuge in a variety of group practice settings to better manage the new administrative burdens that have come with these changes [1]. New organizational and management structures have arisen in response to the need to contain costs while maintaining or improving quality. Because of these changes, demands for new and dynamic leadership have led to the emergence of an important new player: the medical director.

Within a health care organization, medical directors bear responsibility for both managing resources and monitoring the quality of care provided. Physicians in full-time clinical practice may not fully appreciate the skills and knowledge required to be effective in these functions. Medical directors may appear removed from direct patient care; thus, practicing physicians may not appreciate the relationship between managing the health of an individual patient and managing the health of the patient population to which the organization provides care.

Although a survey of the functions, career paths, and commonly held beliefs of 50 managed care medical directors was recently conducted by Bodenheimer and Casalino [2,3], in general, the medical literature offers little information about this professional role. Because objective data are limited, this article draws upon the experience of 3 medical directors to provide additional insight into the role and responsibilities of medical directors. Specific comments were sought from 2 of the authors to further highlight real-life experiences within different organizational settings. In addition to delving into the medical director's dilemma of balancing the needs of individual patients with those of the overall population served by an organization, this article highlights the unique skills, knowledge, and attributes needed to be an effective physician leader, as well as the value that medical directors may offer to individual physicians as they seek to provide quality care for their patients in a turbulent time.

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The Evolving Role

Medical directors are physicians with specific management and leadership responsibilities for the organizations they represent. The current medical director role has evolved from earlier leadership positions held by physicians. In the past, physicians served in 2 major leadership roles: the group practice medical leader and the hospital physician leader, a position formerly titled "vice president for medical affairs."

Classic examples of group practice medical leaders were chairs of clinical departments and leaders of single or multispecialty group practices. This leader attempted to address reimbursement issues, sought opportunities to build the patient base, and attempted to maintain the practice's profitability.

The hospital physician leader often was a well-regarded, senior member of the local medical community who was involved with credentialing, quality assurance, and utilization management for that hospital. This physician leader also dealt with conflicts among individuals and departments, managed disciplinary actions, and generally tried to keep the hospital medical staff moving in a positive direction.

In the current managed care dominated environment, financial resource constraints, administrative involvement, and organizational growth have challenged physician leaders to respond, resulting in the emergence of the medical director as "change agent." This is the primary role of today's medical director, who must work to improve care while providing greater stewardship of an organization's resources. In this new position,

whether within a health plan or a provider group, physician leaders may need to challenge established standards of care. By using clinical outcomes data, medical directors may encourage physicians to find ways to improve both the quality and efficiency of patient care. In addition, medical directors may need to build collaborative partnerships with providers of patient care (eg, hospitals, medical groups, individual clinicians) as well as with those who fund patient care (eg, employers, employer groups, Medicare, Medicaid).

The Diverse Experiences of Medical Directors

The survey by Bodenheimer and Casalino [2,3] suggests that the specific role and responsibilities of managed care medical directors vary depending on organizational setting. The reader is referred to Kongstvedt's text [4] for more information, as a detailed description of each setting is beyond the scope of this article. At a very basic level, organizations can be considered to be provider (ie, physician or hospital) based or health plan (ie, insurance) based.

A simple example illustrates how different types of organizations might require different functions of medical directors. An independent practice association (ie, a provider-based organization) is a network of physicians and/or medical groups that has formed to enhance the collective negotiating position of its individual members within the local marketplace. Network management, or maintaining this network arrangement, is an essential, ongoing function for a medical director within this setting. However, in a staff-model health maintenance organization (HMO), the health plan employs the physician staff; thus, network management is not needed.

Real-Life Examples

A brief look at the work settings of 2 of the authors reveals important areas of similarity in the role of medical director as well as important differences. Both Dr. McEvoy and Dr. Baird note having primary responsibility for ensuring the delivery of quality care by the physicians within their organization. However, Dr. McEvoy's role in a provider-based organization involves significant face-to-face interaction with physicians and leadership through information sharing and collaborative problem solving. Dr. Baird's former position at HealthPartners was a more commanding role, which is characteristic of the employer-employee relationship in a staff-model HMO.

Provider-based setting. Dr. McEvoy is the Medical Director of General Medical Associates and Massachusetts General West, a 2-site, multispecialty group practice owned by the Massachusetts General Hospital in Boston. The practice consists of approximately 40 clinicians and 27 support staff members. The practice serves roughly 8000 patients and had approximately 36,000 patient visits in 1999.

At the most basic level, Dr. McEvoy's responsibilities to the practice are to ensure the provision of quality care and to oversee the health of the group. This role entails serving as a liaison to the hospital administration and to HMOs, conducting peer reviews, serving as a conduit for complaints (from patients, staff, or physicians), and conducting meetings on a wide range of issues (medical management, business, quality of care, operations). The hospital (Massachusetts General) expects the practice medical directors to have the support of the physicians within the group. Thus, when an issue needs to be resolved, Dr. McEvoy must inform the physicians, provide objective and timely data, and then lead the group to consensus.

Dr. McEvoy's job is split between patient care and administrative duties. She spends roughly 16 to 20 hours per week seeing patients and has the same responsibilities as the other physicians in the group. A wide range of administrative issues may develop during a given day without respect for time allotted for patients. Examples include listening to a specialist's side of a patient complaint, fielding an angry call from a patient who could not get through to the practice over the weekend, making a physician aware of how stockpiling charts in her office is affecting the rest of the practice, sharing data from an HMO that has identified high pharmacy costs with the group and devising possible solutions for the problem, and meeting with a hospital administrator and lawyer on a case of a former employee who filed a discrimination suit. Although these issues can be delegated somewhat to others who work with Dr. McEvoy, they all cross her desk at one time or another.

Plan-based setting. From 1995 until 1999, Dr. Baird was the Associate Medical Director for Primary Care for HealthPartners, a staff-model HMO in the Twin Cities. During that time, the HMO had 20 clinics, employed approximately 300 primary care physicians, and served 240,000 capitated members. Each clinic had a director or, if it were small, shared a director; these individuals reported to Dr. Baird. In addition to Dr. Baird, other Associate Medical Directors oversaw medical specialties, surgical specialties, behavioral health, network management, and quality assurance and utilization management. The Associate Medical Directors worked with nonphysician administrators, which created a team effort at all levels of the HMO.

As the Associate Medical Director for Primary Care, Dr. Baird was responsible for meeting the HMO's practice expectations for productivity, quality, and access across all primary care departments at HealthPartners. Thus, his role involved both "managing down" and "managing up." "Managing down" the administrative chain meant working collaboratively with the department chairs of internal medicine, family medicine, pediatrics, and obstetrics/gynecology as well as the midlevel providers within several departments. Dr. Baird also worked with regional medical directors to promote better contact with each local medical director in HealthPartners' network of owned clinics to ensure that each site did its best to provide the quality and cost-efficient care that was expected. Dr. Baird's duties included representing the entire primary care system during leadership discussions that affected both primary and specialty care. "Managing up" the administrative chain meant representing the interests of all those who worked with the primary care clinics and providers; Dr. Baird was the voice of primary care in strategic discussions and long-term planning. Finally, together with the other Associate Medical Directors, Dr. Baird worked to ensure that population-based improvements in care and health outcomes were achieved.

Attributes of Effective Medical Directors

Early surveys of successful medical directors suggest the importance of clinical credibility as well as skills in communication, leadership, team building, and negotiation (Table) [5–7]. Many of these attributes are not unique to leaders within the health care field, but Dr. McEvoy believes a medical director cannot succeed without them:

> To weather the storms that plague any practice, a medical director first must see the problems as challenging, not daunting. Then, to meet the challenge head-on, a medical director must be a credible, skilled clinician; an organized, effective leader; and an effective communicator. Physicians do not respond well to leadership by fiat, and a consensus-building style based on good data and communication often works best in leading other physicians.
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> Most medical directors are regarded as colleagues by other physicians in their organization, and, ideally, the clinical skills of the medical director are such that he or she has earned the respect and credibility needed to be an effective leader. At times, however, a medical director must assume an authoritarian role to produce changes in the practice or behavior of a physician in the group. A physician who loses her temper with patients or staff members, who keeps patients waiting chronically, or whose bedside manner generates many patient complaints may require the medical director's attention. With effective communication, changes usually can be made so that the physician can stay in the group. However, if a physician is unable or unwilling to meet the group's standards, the medical director may need to ask that physician to leave. This is a difficult task that may negatively affect the medical director's relationship with other physicians in the group, but it is an important responsibility of the medical director.
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> The best way to overcome these difficult situations is to hold open, regular meetings during which each physician is kept aware of the issues involved and can

Table. Attributes of Successful Medical Directors

Clinical credibility
Communication skills
Listening
Speaking
Writing
Leadership skills
Articulating a vision for the future
Creating an environment of shared responsibility
Developing the skills of others
Framing and facilitating critical conversations
Team-building skills
Embracing a participatory leadership style
Developing a common goal or purpose
Creating a climate of communication and trust
Effectively leading meetings
Recognizing and encouraging synergy
Negotiation and conflict resolution skills
Striving for "win-win" solutions
Focusing on interests rather than positions
Encouraging others to communicate and resolve conflict
Serving as a facilitator
Quality management skills
Articulating a philosophy of continuing improvement
Embracing the "best practice" approach
Focusing on processes as the cause of problems
Empowering the people who do the work to solve problems
Using data to gain insight into problems

Adapted with permission from Kouzes JM, Posner BZ. The leadership challenge. San Francisco (CA): Jossey-Bass Publishers; 1987:27.

offer his or her input. A medical director who acts preemptively without the input of the physician group does so at his or her own peril.

Credibility as a Clinician

Fundamental to performing the role of medical director is a solid base of clinical training and experience. A medical director needs confidence to stand among peers and lead. In the authors' opinion, a medical director must have demonstrated clinical competence in his or her area of training to be credible with professional colleagues.

It is also important to have an accurate assessment of one's own limitations; knowing when to seek help is as critical to medical directors as it is to practicing clinicians. Medical directors are asked for input on many diverse issues, from ethically based decisions on providing novel and untested therapies to more practical questions such as adding nursing or medical staff at an expanding clinic. Medical directors must assess their comfort level with providing requested input and may solicit additional information or analysis before moving forward on a particular issue or decision. Medical directors often develop a network of colleagues to consult on clinical or administrative issues that lie beyond the scope of their expertise.

Communication and Consensus Building

A medical director serves as the link between practicing physicians and the planning and decision making on diverse issues that affect physicians. Because effective physician leadership requires extensive communication and interaction, medical directors must have good listening, negotiating, consensus-building, and team-development skills. As Dr. Baird has learned, clinical training is the first step toward developing these skills:

> One-on-one patient interviewing skills learned in clinical training are quite adaptable to the consensus-building skills a medical director needs to lead people into new ways of thinking or acting. During training, physicians encounter patients who are angry or upset or who challenge their authority as physicians. To deal effectively with such a patient, physicians must learn to listen carefully and determine the source of the patient's discomfort, so the patient can leave feeling better and more able to follow through on medical care. These challenging patient situations parallel the emotionally charged environments in which a medical director often functions, such as when trying to lead colleagues onto a new path when they want to continue doing things as they always have.
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> To be an effective leader, a medical director must help others understand why there is a need to go in a certain direction—either to stay the course against some pressure to change, or to change when there is pressure to stay. The physician leader must facilitate an open discussion and encourage all to voice concerns. Then, he or she must listen carefully, learn what the core themes are, identify the principles that need to be maintained, and not jump too quickly to consensus. Making sure that as many sides of an issue as possible are discussed helps to move toward consensus because individuals feel that their contribution is valued. In these situations, a medical director must be able to listen and learn from a physician who challenges new ideas, even when he or she fundamentally disagrees with the challenger.

Effective Use of Data

Medical directors are exposed to many different streams of information from across the organization, and they must interpret this information to identify important themes or patterns of care that suggest a need for change. This means recognizing the opportunities for improving care across the organization and identifying the potential threats to patient care. This skill requires experience to know when to trust information and when to investigate further. As Dr. Baird notes, skills developed in clinical training are again useful:

> Often medical directors are bathed in information that is not useful or that seems interesting but will not provide new insights. It is similar to the clinician early in training who is bewildered by a long patient history full of details, and who tracks every detail because he or she cannot pick out the 1 or 2 important ones that might be a threat to the patient. It takes years and thousands of patient interactions to learn what represents a real threat.
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> Similarly, a medical director sees thousands of data bits fly by each day; it is easy to get bogged down in the details. A medical director must learn to judge which details are important, to avoid immediately jumping to the conclusion that something must be fixed when it could just be a random variation. If every stream of data is investigated, resources will be exhausted and no change or action will likely occur.

One example from Dr. Baird's experience at HealthPartners involved data on problematic prescribing patterns, which suggested a need to reevaluate the organization's approach to pharmaceutical detailing. To simultaneously improve care and reduce costs, HealthPartners established practice guidelines that emphasized the use of

equivalent generic drugs or preferred brand name drugs rather than more expensive medications.

Types of data. Vast amounts of clinical data are gathered at an organizational level to monitor and improve the care provided. Examples include data on average lengths of stay by different diagnoses and data on outpatient use of ancillary services (eg, diagnostic imaging, laboratory services). In addition, many organizations now have their own formulary, or preferred medication plan, which is tracked to determine whether physicians are using drugs identified by the organization to be most cost-effective. These types of data often are collected from billing codes and require retrospective review. Subsequently, the medical director may identify and report trends to physicians within the organization. In these discussions, data for an individual physician or a group of physicians may be compared to benchmark data from colleagues or from a similar practice setting elsewhere in the organization. The medical director may then suggest improvements, such as reminders for preventive services (eg, influenza vaccines).

The medical director also reviews financial data on a regular basis, which includes monitoring the progress of the organization in terms of revenue generated from patient care activities and funds expended for personnel and supplies. Certainly, every organization must carefully control its budget, but the medical director must ensure that appropriate care is given and that quality of care is balanced with the need to control expenses across the organization. Short-term budgeting and long-term financial planning occur regularly, and skills such as basic accounting, as well as knowledge of how to interpret an organization's financial records, help the medical director analyze and participate in the financial operation of the organization [6]. Dr. McEvoy notes a few ways medical directors might develop their business skills:

> Finances are an important part of the position. For the most part, the skills can be acquired on the job if one is willing to learn and master the business side of a practice. Some physicians who are interested in medical administration may seek specific training to shore up financial skills. Master's degree programs in business administration or public health and courses in medical management can be helpful. In addition, a wide array of medical journals offer useful discussions and information. Finally, a good mentor from another practice or hospital can be a real asset.

Functions of Medical Directors

A medical director is responsible for the care provided to the entire population of patients served by the organization. This means setting and maintaining standards for quality patient care and service, assuring that the health needs of the patient population are met, and striving to meet organizational goals and objectives.

Recognizing Inappropriate Variations in Practice

Unexplained or inappropriate variation in physician practices have been reported extensively in the literature [8–11]. Quality problems arising from inappropriate variations in clinical practice also are well documented [12], and evidence now suggests that such variations can lead to errors in medicine [13]. Organized approaches to identify these errors and then systematically examine the process of care involved have been developed and refined [14]. Use of evidence-based guidelines is a good example of how many practices are attempting to help physicians recognize and limit practice variation.

An important way that medical directors contribute to a health care organization is in leading efforts to identify and decrease inappropriate variations in practice. Although the initial focus was on utilization management, or identifying individual physicians whose resource use strayed outside a predetermined guideline, the focus has broadened to include medical management, or looking for individual physicians whose clinical care practices are not in line with certain guidelines. More recently, as a result of improved information system technology, medical directors have begun to focus less on individual physician decisions and more an individual physician's or a group of physicians' *patterns of care*. This new strategy recognizes the reasonable degree of variation in how individual patients present and tolerate treatments as well as in how individual physicians make decisions case by case. Over time, however, the practice of the organization as a whole should move in a well-recognized, quality-assured pattern.

Dr. Baird provides some insight into the challenge medical directors face in trying to change an individual physician's approach to clinical care decisions and why the trend is moving toward pattern recognition:

> A medical director's job is to help create change, but change that is typically seen as important from the point of view of population-based care, not just individual patient care. A tough part of this job is confronting a clinician who proposes or is already down a path of care for an individual patient on the question of whether that path is well supported by evidence. In the past, individual clinicians often decided in their best judgment, not on the basis of any group consensus, what was best for their patients, with a rather

large degree of variation in quality and outcome. And these were big decisions, such as, whether to treat medically or surgically, not just whether to use medication A or B.

When a medical director raises such questions today, it is often in the context of a decision made by a good clinician who is quite dedicated and convinced that he or she is headed down a helpful path. So if a medical director now asks, "Is this care path appropriate? What evidence do you have that it is the best treatment?," the questions can seem quite intrusive to the physician, even if asked gently. The situation can easily become confrontational. This is one reason I believe medical directors are increasingly turning toward identifying patterns of care for physician groups as well as individual physicians, rather than trying to question on a case-by-case basis what someone is doing for an individual patient.

Quality Improvement

As information system capabilities improve, medical directors are better able to identify trends across a population and to scan for improvement opportunities. When these opportunities are revealed, it is the medical director's job to determine what can be done to address the issue and to what extent resources can be expended in the effort.

Quality improvement has become an important strategy in the competitive health care industry, as evidenced by the increasing emphasis placed on meeting quality standards set by the National Committee for Quality Assurance (NCQA) for accreditation of health plans and for achieving high scores on HEDIS (Health Plan Employer Data and Information Set) measures [15]. As the industry evolves and employers and consumers demand greater accountability for quality care and service, health care organizations are demonstrating greater commitment to continuous quality improvement (CQI). CQI is used throughout the industry as a tool to achieve desired results (eg, improved clinical outcomes, better patient satisfaction, reduced costs) through data-driven interventions. CQI efforts often follow the PDCA model—Plan, Do, Check, Act [16], where the analysis of data helps physicians locate a need for improvement and initiate improvement efforts. After implementation, the intervention is monitored and modified where necessary according to statistical results.

Initiatives to improve the quality of patient care often are set in motion by a medical director. Medical directors spend a considerable amount of their time in quality improvement activities, with the highest priority given to addressing NCQA and HEDIS issues [1,2]. One example of a quality initiative involves the effort of many primary care clinics to enhance their service by improving access to physician appointments through scheduling changes [17]. Older computer scheduling programs often employed strict rules for the number and defined types of appointments that could be scheduled on a given day. With these programs, a patient with an acute care need could be prevented from making an appointment because the need did not fit the type and timing of appointment available for that particular day. These computer scheduling programs were identified as an impediment to care, and software improvements—in conjunction with physician flexibility—were needed to improve access and lower wait times for patient appointments.

An example of a broader based quality improvement initiative is the effort Dr. Baird led at HealthPartners to integrate behavioral health care with medical care. As he explains, the medical director plays a critical role in facilitating such efforts:

Before leaving academic medicine, I realized that large systems of care—not individual clinicians—were shaping medical practice and that I needed to understand these systems to continue improving clinical practice. As an example of this commitment to "systems thinking," I have pursued 1 goal along the way: to integrate behavioral health care with regular medical care. At HealthPartners, achieving this goal took about 3 years and a large team of people.

In the new system, almost all of the 20 primary care sites in my charge had on-site mental health clinicians. Any patient with a psychophysiologic diagnosis was likely to have a consultation with a mental health professional, with the goals of decreasing hospitalization and medical visit rates and improving satisfaction among both patients and primary care physicians. This integration required moving the mental and behavioral health clinicians into the primary care physicians' offices, allowing for occasional 15-minute mental health consultations along with regular 50-minute visits, implementing a shared charting system, and modifying the accounting and billing systems to reward therapists for consulting about patients even if the patients were not present.

The primary care physicians wanted to help their patients who needed behavioral support, such as coping with chronic illness or dealing with depression, but making such changes requires more time and skilled intervention than the average physician can deliver. The image that comes to mind is of a group of people who are frustrated because they cannot cross a river.

> Someone needs to realize the possibility of crossing the river and then initiate a plan and organize the group to build a bridge. This is the job of the medical director.

Disease Management

Disease management is a form of quality improvement focused on clinical conditions that account for the majority of costs and resource use across an organization's member population. These efforts target chronic, often progressive conditions that can have serious clinical complications (eg, diabetes, congestive heart failure, asthma). Disease management encompasses all settings of care and strives to minimize financial risk, optimize care processes, and achieve the best clinical outcomes for patients with targeted conditions. The disease management strategy typically places a heavy emphasis on prevention as well as on tracking specific, predefined outcome measures, such as the percentage of diabetic patients with glycosylated hemoglobin levels below 7% or the percentage of patients with congestive heart failure being treated with angiotensin-converting enzyme inhibitors.

Clinical leadership is key to the successful launch of disease management programs. The medical director often contributes importantly to this leadership, but the involvement of a clinical expert in the disease area (sometimes called a "champion") may also be needed to help reach consensus on matters of program design, development, and implementation. In the authors' opinion, individual physicians are much more likely to accept a disease management program if they actively participate and feel valued in the process.

Managing Organizational Resources

Organizational leaders, including medical directors, are ultimately responsible for balancing the organization's need to pay the bills with the individual patient's need to receive the best care money can buy. The challenge to manage organizational resources, both financial and intellectual, highlights the tension between population and individual patient perspectives. Examples of strategies used in an attempt to overcome this tension include: 1) clinical guideline development and implementation to reduce practice variation that can lead to increased costs; 2) resource utilization programs, such as hospital and outpatient formularies to control pharmacy costs; and 3) supply and demand programs that attempt to lower prices for equipment and supplies through higher volume purchases.

Dr. Baird relates a lesson learned when implementing an evidence-based guideline at HealthPartners, which emphasized greater self care and less aggressive early intervention for patients being seen for the first time with low back pain. The lesson: it is important to listen when physicians strongly disagree, because sometimes they are right.

> At HealthPartners, we developed a guideline based on evidence from the literature that suggests that physicians order too many x-rays, prescribe too many medications, and do not emphasize the value of staying active, stretching, and self care for patients with back pain. But data analysis after initial implementation of the guideline suggested that most of our physicians were using too many spinal x-rays and CT scans for patients on their first visit for back pain.
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> When we presented this data, the physicians argued that the data were not credible and that it appeared they were noncompliant with the guideline because their patients were more complex than might be apparent from the initial data. At the physicians' request—and as our plan called for—we did extensive individual chart reviews and found that the physicians were exactly right. Rarely were they seeing a patient who was on a first visit for back pain. Most patients had had years of back pain by the time they saw these physicians, and the doctors were responding per protocol for patients with more complicated histories. When we more carefully tracked new patients versus those seeing a doctor for the first time for long-standing back pain, we found that the physicians were following the back pain guideline quite well.

Meeting Standards for Care

Another responsibility of the medical director is to be knowledgeable about pertinent regulations that govern accreditation and credentialing processes. State and federal legislation guide organizational activities surrounding maintenance of standards related to provision of clinical care.

Accreditation is the process by which health care delivery is evaluated against predetermined standards established by accrediting bodies. Two of the most important organizations involved in accreditation are the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and NCQA. Both JCAHO and NCQA are nongovernmental, not-for-profit organizations that seek to assist health care consumers and purchasers in making informed decisions about health care on the basis of quality and safety. JCAHO accredits hospitals and other health care facilities, whereas NCQA accredits managed care organizations. Both NCQA and JCAHO accreditation are performed on an ongoing basis at regular intervals.

Accreditation is a voluntary process. To remain competitive in the current health care marketplace, however, most health care organizations seek accreditation as a means of demonstrating their commitment to providing quality care. Achieving accreditation requires that the organizations seeking accreditation have established, system-wide policies and procedures to monitor, maintain, and improve the quality and safety of the care they provide. For example, JCAHO accreditation requires that patient care decisions and procedures are documented clearly in the medical record and that all care providers are competent and meet credentialing criteria. NCQA accreditation requires that health plans provide preventive care to members with certain chronic conditions such as diabetes and asthma. Medical directors often are responsible for overseeing accreditation efforts and ensuring that such policies and procedures are in place and functioning appropriately.

Credentialing refers to the process whereby the professional documentation for health care providers within the organization is obtained and reviewed. Documentation includes such information as licensure, certifications, insurance, and malpractice history. The credentialing process includes verification of information obtained to ensure accuracy. Similar to accreditation, credentialing is an ongoing process for any health care organization and typically involves the leadership of 1 or more medical directors.

Career Satisfaction of Medical Directors

Few studies have examined the career satisfaction of medical directors [18,19]. An interesting question is whether medical directors can maintain a meaningful and stable professional commitment to management at their organization during times of significant change in the health care environment. Data suggest that younger physicians are now assuming medical director roles and developing their careers in administration [20]. Only time will tell whether today's new medical directors, who are entering a rapidly changing health care environment, will be able to create and sustain a fulfilling, long-term professional career.

According to Dr. McEvoy, finding satisfaction in the role of medical director may depend more on one's attitude about the job rather than external forces:

> Whether or not a medical director enjoys job satisfaction probably depends on how or why that physician ended up in the position. I took the position by choice as a way of serving in a leadership role to help bring about constructive changes in the difficult medical environment in which we work today. I also chose the career path to learn new skills and to grow as a person and a provider. Many days are difficult and unrewarding, and, at those times, it is important to step back a little to gain the perspective I need to appreciate that I have had an impact on the practice—hopefully a positive one.
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> Improving the care of patients as well as the professional lives of providers are worthy goals. The role of medical director is not for everyone. If a physician views the job as a string of problems, rather than a series of opportunities to have a positive impact, that physician is not meant for the role. However, it is important that the position appeals to a few good clinicians. The more that physicians take on these responsibilities, the less likely that solutions will be imposed by a nonmedical person.

Dr. Baird offers some recommendations to young physicians considering making the transition from clinical practice to management:

> The role of "change agent" can be a politically hazardous one, as evidenced by a fairly high turnover rate among medical directors, especially within larger organizations. A particular risk for young physicians who have made the transition from practice to management is the inherent frustration and instability caused by frequent role changes and job shifts in an ever-changing managed care marketplace. Young physicians who assume these politically sensitive roles early in their lives risk making many transitions over the course of their careers, which may significantly erode their sense of job satisfaction. This is a real dilemma throughout the entire health care system. From education to the delivery of service, tremendous changes are occurring in modern medicine. Young physicians who take on the medical director role today are in a vulnerable position and will need support during this transition and thereafter. The road gets pretty bumpy when it is your job to help bring about big changes. I recommend peer support among medical leaders and continued development of a supportive network to provide encouragement for courageous leadership. We all need to continue learning from each other.

Organizational Value of Medical Directors

The role of medical director remains separate and distinct from that of clinician in the minds of most practicing physicians. Like the clinician, the medical director aspires to improve clinical care. The focus of the medical director, however, is not the individual patient

encounter but the overall health and well-being of a population of people served by the organization. The tools of improved care, thus, have broadened from the stethoscope and the microscope to include the spreadsheet and the improvement project.

It is the authors' belief that the value a medical director brings to the caregiving process comes from the broad, population-based perspective inherent in the role and responsibilities of the position. This perspective facilitates improvement and collaboration across the organization that can ultimately improve patient care. For example, implementation of systems across different clinic sites (eg, programs aimed at improving use of formulary medications, decreasing use of unneeded ancillary services, improving patient satisfaction, or decreasing patient wait times) allows the medical director to learn from each successful improvement initiative and then apply those lessons to other efforts.

The authors hold that this organizational value of the medical director can be translated into improved patient care only by working closely with individual physicians across the organization. As noted, however, organizational constraints and individual personalities may lead to differing leadership styles as medical directors seek to influence individual physician behavior. Although this article presents examples that illustrate the potential for medical directors to improve patient care, the future undoubtedly will present additional and yet undetermined opportunities for medical directors to contribute to their organizations. Through education and communication, medical directors and physicians can move toward a closer working relationship that will benefit patients through improved clinical processes and care systems.

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