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Interview with Dr. Tom Oliver

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Lessons In Leadership

During his time as president of the medical staff at Winchester Medical Center, Dr. Tom Oliver helped his organization successfully navigate a variety of challenges. But none would test his leadership skills more than an on-call compensation crisis. The hospital was on the brink of losing a service line when MaxWorth was brought on board to lead a collaboration between the hospital's administration and physician leaders. The result of this collaboration would become known as the Call Pay Solution®.

We recently talked with Dr. Oliver about his time as president of the medical staff, and how a group of physician leaders were able to bridge the divide between a medical staff demanding to be paid for call and an administration that refused.

Maxworth: Dr. Oliver, thank you for joining us today. Why don't we just get started? So when did you become interested in medical staff leadership?

Dr. Tom Oliver: I first got interested in it the same way most people do. I was a new physician on staff at Winchester Medical Center and one of the senior urologists said it was my turn to be the division chief and so my first medical staff position was the division of urology chair and I enjoyed doing that and after a little while was the department of surgery chair and then got involved in the staff executive committee, surgery center boards, and eventually just persisted through medical staff leadership and ended up as medical staff president in about 2005.

MW: As president of the medical staff, what do you think your most challenging issue was during your tenure?

TO: Well the one that I remember most clearly was when one of our surgical specialties stated they were going to no longer take call after a certain date and we had a bit of a gap between our hospital CEO who stated he would categorically refuse to ever pay for call and a group of physicians who stated they were going to stop taking call unless they got paid and this was at a time when there were some physicians getting help with call. Some of the internists were getting support from the beginnings of our hospitalist service at the time. Some physicians had left staff and were replaced by employed physicians such as the employed psychiatrist and as a result we had a small number of people having call relief and most of us not. They also started a trauma program and a small number of specialties were getting paid to take trauma call. So the number of people who were getting paid for call was small and very well noticed by all the other people who were taking call and not being paid. That caused a great deal of— it caused big rift amongst and between the physicians and between the physicians and the administration. And that came up while I was medical staff president.

MW: What impact do you believe physician leadership can have on healthcare organizations or the industry itself?

TO: Well obviously physician leadership can happen at two levels. The national level that I don't think we're talking about today where medical leadership is very important in national organizations, but even at your hospitals, medical staff leaders can influence the local provision of care and how their hospital culture operates because they can build and lead the culture. It doesn't happen rapidly, but you can do that. I think medical staff leadership is essential to building and maintaining a satisfactory culture of care at your facility. For our hospital, the problem back then was maintaining a roster of physicians available on call for our emergency room.

MW: How would you say, perhaps for those physicians who don't hold official leadership positions, in what ways can they demonstrate leadership in their every day practice?

TO: Most physicians are aware that there are quiet leaders all throughout the medical staff. There are the designated official leaders in the medical staff executive committee and department chairs and so forth and there are physicians who quietly go about doing their jobs well. I think that first and foremost medical staff leaders tend to be good clinicians and secondly they're respected by their peers both for their critical skills, their steadfastness, and dependableness. And those physicians are very useful to medical staff leaders. The official leaders can tap into those reliable, respected physicians. If you don't have their support, whatever program you're planning to start isn't going to fly. For us, when we started our path towards a deferred compensation for call program, it was essential to have buy-in by those other physician leaders.

MW: So how would you say physician leadership played a role in the creation of your call-pay program?

TO: Well physician leadership was essential to the development of our call-pay program. We had the huge gap between administration and physicians and we had a rift between the physicians themselves with different specialties and different groups having different ways of taking call and some of them being compensated for call. It took medical staff leadership working between the two sides to get everybody to realize that both groups of people were well intended. Administration wasn't evil and physicians were greedy, horrible people. Because there was a wide space between them and it meant that the medical staff leadership at the time had to have a good working relationship with administration and with our fellow physicians and also to have a relationship with our board members. And we were very fortunate at the time. We had a very forward-thinking, innovative board for our hospital

and our board leadership was also directly involved because they were concerned about what was happening with our call roster. The short of it was that it took a small group of medical staff leadership physicians working with that previously mentioned wider group of involved, respected physicians from a variety of specialties to realize that it would do everybody better in the long run if we found a way between the different points of view. And our plan wasn't built by one person or two people, but by a small group of people working with expanding circles of other people. I remember the first meeting we had, we sat down, we had about fifteen people around the table, somebody from every specialty, physicians only at first, hashing out their differences of opinion and how we can resolve it so that everybody's points of view are respected and then we took that message to administrators, went over it again, and eventually got both sides in one room at the same time working around what turned out to be a very innovative plan.

MW: What role has your physician leadership played in sustaining the plan? From what I understand, you created this back in 2005 or 6, so how has it grown and how has it been sustained over that time?

TO: You're right. It took eighteen months minimum from the first time we started seriously building the plan to when it went live in January of '06 and it has required attention every year since then. In our first five years it took a lot of attention with both administration and physician leadership paying a lot of attention to making sure the plan worked the way we wanted it to. The documents we laid out in the beginning were good but obviously not perfect and we tweaked documents as we went along. We changed some our preconceived notions of how things should work. And that's just the evolution of any program. We changed our rules and we changed our policy to reflect changes in how things were done and reflect changes in the culture within our hospital and how health care is provided in our hospital and in our emergency room. So it took and continues to take involvement by physician leaders and administration to modify the plan and adapt it at intervals as needed to reflect current needs. Those physician leaders are involved officially through two groups of people. First is our call committee, which is small group of five physicians who meet basically once or maybe twice a year and then a larger group comprised of board members, administrators, and a second group of physicians called our advisory board that acts on behalf of the hospital board to maintain the plan. That group meets, again, once or twice a year. So we've gone from needing to meet every month to only having to meet once or twice a year to keep the plan effective and moderated and of course there is the continuous background support from the professionals at Pangbern and Maxworth.

MW: It sounds like you've had a lot of experience growing your plan and at least addressing different concerns that might have come up through the years. A lot of our folks that may be listening have actually read your white paper that you wrote on the AFP as it was called at that time so how has the program evolved since that white paper was written, I think, in 2010?

TO: It has changed. The biggest change was to shift from a 457(f) to a 409A plan. The 409A has proven to be much more physician friendly for the two or three years that we've had it in place and I think it's a much more physician friendly set up than the 457(f). It is harder to operate, harder to understand, and a more complex structure, but it ends up being more advantageous to physicians than the 457(f). And that was the biggest single change that we've made in the ten years since we've had the plan. We've made smaller changes along the way, changing some of our basic ground rules for who's in the plan and who's not in the plan. We have physician participants in our call-pay plan that were not permitted in the plan when we started ten years ago. But how we cover the emergency room and how the physician culture operates has also changed in the last ten years so people who were previously excluded by ground rules are now included. Our plan is now much more inclusive than it was before. Part of the reason for that is that the hospital is now using the deferred comp for call plan as an alternative to the myriad of little side deals they had, medical directorships and stipends that went to a variety of specialties to keep physicians involved in the hospital. Those side deals so to speak have been largely supplanted by a larger, more organized deferred comp for call plan.

MW: What do you think the plan has meant to the physicians who have participated in the program?

TO: That's a harder one to answer because most medical staff leaders know that silence usually means everybody is happy. The only time you hear

anything is when they're disgruntled and there was a lot of disgruntlement over ten years ago and that disgruntlement has largely disappeared. Complaints about call have largely disappeared from the medical staff executive agenda. That's the biggest thing that's happened, is we just don't hear people complain about it as much so I think what it's meant to the staff is a lower level of grief in general. Nobody likes taking call, but when you know you're being recognized for it in some way then you're just a little bit less unhappy about taking it. It hasn't made us all happy physicians every time we're taking call. We're just less unhappy if I can put that in a positive way. I think that's the biggest thing. The compensation that they've received from call I think has been significant. And some physicians who've had heavy call burdens in well-compensated specialties have received very large checks from time to time. I think that's made meaningful differences in their life activities and meaningful differences in their life planning.

MW: That's great. In closing Dr. Oliver, in what ways do you think physical leaders can impact the culture of call-pay at their own facilities? They're listening to us talk today, what do you feel they can possibly do to have an impact at their own facility?

TO: The first thing for the physician leaders to do is discuss it among themselves with their other physician leaders and then involve key physicians from each specialty that's involved with taking call. Go ahead and invite everybody in. Discuss it among yourselves and then bring in administration early and get them involved in the conversation. The administrators need to know what your call burden is. The physicians need to know what the financial restrictions of the hospital are. They don't have an unlimited budget. And between the two groups, you can find a way to find a functioning deferred comp plan that'll work for everybody involved. Hardest part is going to be recognizing the differences in call burden between different specialties. Not everyone's call burden is the same and you'll need to figure out a way that suits your own hospital culture how you're going to recognize that the call burden of the orthopedic surgeon or the neurosurgeon is greater than that of the ophthalmologist or the pathologist. And everybody knows that difference is there. There is a basic cost to simply being on call whether you're called in or not, but being up all night is a whole lot more painful than staying at home. Those differences need to be recognized with a set of ground rules and you can write those rules however you like to recognize your local needs and culture.