Non-Clinical Career Opportunities for Physicians in Medical Administration

Edited Transcript from SEAK's 2025 Virtual Non-Clinical Careers for Physicians Program

Moderator: Our next talk is going to be on opportunities in medical administration, and we're very pleased to have back **Dr. Tom Whalen** as our presenter. Dr. Whalen, spent years as the chief medical officer of Lehigh Valley Health Network, retiring in the pandemic. Prior to transitioning to administration Dr. Whalen practiced as a pediatric surgeon, with extensive experience in national leadership roles and in academic medicine.

He earned his BA and MD from Boston University and his master's of medical management from Carnegie Mellon University. **Dr. Whalen currently is a very busy, retired physician, but also serves as a physician Executive coach as well on as well as on multiple boards.**

Welcome back, Dr. Whalen. Thanks for coming.

Dr. Whalen: Thank you, Jim. It's a pleasure to be able to give this presentation.

When I 1st constructed this presentation for one of the SEAK meetings in Chicago, my subtitle was shifting to the dark side without the question marks. And so let me pause for a moment and explain why I did that. Traditionally, if a busy practicing physician surgeon decided to make the transition into a leadership opportunity it was regarded as shifting over to the dark side, which variously was applied to going into either the insurance industry or into administration of hospitals and health networks.

The demand among physicians for going for these [non-clinical] opportunities have swelled markedly. If that many people are aspiring to go into careers in leadership and medical administration, I would suggest that it's no longer nearly as negatively viewed as it once was. And so that's why I added those question marks to it, and you can interpret that on your own with the experiences you've had with other physicians.

So just to give you a brief background on me. I was fortunate to receive when I was in medical school a health profession scholarship from the United States Navy. That was very key to my formative evolution as an individual and as a physician. Obviously, the military aspires and necessarily aspires to inculcate leadership into every one of its members, **and it was those experiences and opportunities for formal leadership training that I had within the Navy that really planted the seeds [for my transition from practicing surgeon to hospital administration.]** I was a pediatric surgeon, which was a marvelous field, and I thank the good Lord for having that opportunity to have practiced as a pediatric surgeon. It's a wonderful surgical field.

I, post-fellowship, turned my non-clinical attention towards graduate medical education. I, for years, was a program director of a general surgical residency, and that was a wonderful experience as well. Working with surgical residents.

I probably have some form of undiagnosed attention deficit disorder in that, despite the plethora of experiences in pediatric surgery and then in graduate medical education, I wanted to do even more different things, and that led me to begin to seek a master's of medical management degree.

When I left active duty in the Navy and transitioned to the reserves, I joined Academia and had wonderful years there. But then, as my leadership desires went even higher, I sought an opportunity at a hybrid health network in Eastern Pennsylvania, Lehigh Valley Health Network, which led me to be for the last years executive vice president and chief medical officer. Just an asterisk on Lehigh Valley Health network. They were in the past year acquired by Jefferson Health and are now part of a mammoth health network throughout Pennsylvania and New Jersey.

When I first transitioned into a major leadership opportunity as a chair of a surgery department, I was having my cake and eating it, too. I was still practicing pediatric surgery. [That] opportunity allowed me to have credibility with those I was leading and I think that's something very important, even to this day. **If you have not established your creds as a clinician it may impair your ability to lead other physicians.**

So I would suggest to you that you want to seek an opportunity of leadership where you are currently in clinical activity or a leadership opportunity elsewhere that allows you to have some degree of clinical activity, and there are many of those that exist when you land into your 1st leadership job. The first days are overwhelmingly important, and there's a book by the Harvard Business School Press that I would highly recommend to you. I don't receive any kickbacks from it, but it gives you a lot of great actionable information on what you should do in those first days. If you want to distill that book down to bullet points, listen attentively and carefully, and listening is a hard to develop skill and probably ever harder for most of us, as physicians studies have shown, it's like seconds at a normal clinical setting between doctor and patient before the doctor interrupts the patient when they're explaining why they've come in. So we like to talk. We don't like to listen. **But a new leadership opportunity - that active, vigorous, attentive listening is key.** So you can drink in as much information as possible**. The second is to the extent possible do not make major decisions that may be viewed negatively by constituents that you are leading a cruder way, that I used to say that to people I was leading was, try very hard in the first days not to piss somebody off.**

The corollary [is if] you're not pissing somebody off, you may not be doing your job because it's in the nature of leadership that you're going to make decisions that somebody doesn't like. And my [next] bullet point there relates to my loving bride of years. When I first became a chief medical officer, and [we] would be going to a hospital social event, she would say to me, now, is there going to be anybody there tonight who doesn't like you? That evolved over the next year or so, when we were going to similar events which she would say to me, Is there anybody there who likes you at all? **So you are going to make some enemies. You try to do it with the greatest degree of emotional intelligence that you can. But it's something that's in the nature of the job itself.**

Compensation is important to everybody in life and certainly, as you're making a transition, you may well know the market data for whatever your specialty is, but you may not know what the market data are for the leadership opportunity you're aspiring toward.

There are clearly ways that you can learn what those data are. I never really investigated because I wasn't in the for-profit industry. But I'm sure there are SEC filings and other available public entities. And so you could go for Jefferson health since I mentioned them acquiring Lehigh Valley Health Network and see their [SEC disclosures] and see what their CEO, who's a physician, and what their CMO and others are making, because they're at the top of the heap in terms of compensation. **As a general rule, when you're transitioning into lower level leadership opportunities [in medical administration], if you're in a primary care field you will generally see at least some increase in your compensation. If you are in a procedural field, you can anticipate lowering your compensation.**

The next [thing to consider when considering transitioning from practicing physician to medical administration is] job stability. **So if you're a family physician, if you're an internist, if you're a general surgeon, you have enormous job stability. That's not true when you go into leadership opportunities.** You're now in a job where you are going to be serving at the will of the person you report to, or whoever she reports to and so you will be entering into a contractual arrangement, and there will probably be clauses, and you will need a professional attorney to review them for you before you execute the contractual agreements.

But there will usually be, both “for cause” and “not for cause” termination provisions in a leadership [physician medical administration] contract. For causes is just as it means. If you did something that may be stipulated in that paragraph - Medicare fraud is a common one in your clinical Billings - then that's a for cause termination**. Not for cause, is exactly what it says. We are going to give you [x] days’ separation & compensation, and we're going to say goodbye to you, and we are not going to offer you a reason for it. And that's just a harsh reality of going into leadership opportunities.** So having separated people as a leader I always opted to go for not for cause termination, even if it meant months or one year of

compensation. The reason for that is, you really have a very hard time, if at all, litigating termination for cause which can always be expensive and prolonged.

So if that were to happen to you, or if you went into that [physician] leadership opportunity [in medical administration], and after years or more you said, I really don't like this anymore. The question arises, **can you ever go home again? And in procedural fields and in cognitive fields that can be very difficult, and it may involve retraining. Seeking and gaining those retraining opportunities is very difficult, and so that has to be weighed in your calculus as well if you're going to try to make the transition.**

Now in preparation for [physician] leadership [medical administration roles], what can you do? I like to say to people who were early in their careers or somebody I'm coaching who's early in their career you just say yes, that's the counterpoint for those who are old enough to remember the Reagan administration. When the first Lady Nancy Reagan had a just say no button which had to do with drugs. **Just say yes means, if opportunities arise, you say yes to them.** So that if you want to go to a meeting that is, like AMA Meetings are usually like days, days and be a delegate and get some training and some experience in leadership. There you may take a hit on your [compensation], and that's just something that you either have to negotiate with, whoever you report to, or you have to accept, that you won't necessarily be gaining the same amount in that period of time of clinical compensation that you ordinarily would have in specialty societies. **Whatever your discipline may be, there are always opportunities for leadership and in medical education**, which again goes back to what my fondness was in terms of what I did when I was coming up as a leader.

Medical quality has been and forever will be a critically important component of healthcare in general and the opportunities at your local Hospital Health Network [or] Clinic. I mentioned I came up in the United States Navy. If you happen to be in the military, either on active duty or in the reserves you know that the military provides an enormous amount of leadership opportunities for you in a more stable compensation environment. And that applies as well in government opportunities such as the VA.

In whatever situation you may be in a health, network or hospital or clinic. Any one of these opportunities may exist for you. And so you want to again be able to say, yes. A division, chief or department chair at a local level would be such an opportunity.

If you're in an employed physician group or your health network has such an employed group, there are numerous opportunities. I mentioned quality already, and **so, being a chief quality and/or patient safety officer can be very important.** Chief academic officer, which subsumes both education and research physician documentation, improvement.

And **so leadership and physician documentation, improvement is a burgeoning field.** It may not be for everybody, but it can be important in terms of the economics of where you are presently employed.

If it floats your boat should you get a degree? Probably the answer is, yes it is not absolutely essential, but it is obviously a market differentiator, and the most common one is a master's in business administration, and that's a great degree. You need to consider the value of what you're going to obtain. And do you want to simply seek the knowledge which is key in gaining the Mba? Or is it also important to seek the brand. What do I mean by that? **Here in Pennsylvania everybody knows, and well beyond Pennsylvania, the Wharton School at the University of Pennsylvania, a very famous business school, and a Wharton degree is a differentiator and especially so if you're you have your bachelor's degree, and you want to gain an MBA to gain a brand. MBA, like a Wharton degree, is probably key for that individual.**

If you're already a physician do you really want to spend, I don't know what their tuition is right now to gain an Mba. Whereas you could probably get an MBA at another university that will gain you the knowledge that you need, but at a fraction of that cost.

And so you need to consider that in terms of your personal pocketbook **I have a master's in medical management that is, a degree that is still offered through Carnegie Mellon and through University of Southern California in conjunction with the AAPL. I like to think of it as an MBA that's specifically tailored for physicians,** and so the knowledge that you gain is more tailored to what you are as a physician.

An interesting degree that's offered nearby to me at Lehigh University is a master of science in healthcare engineering. It's an engineer's perspective. And many physicians are engineers. So you know what I'm talking about. It's that analytical approach to problems in healthcare. It's a more rigorous degree to be gained because of the amount of mathematics that are involved within it. But that has been a degree that has been appreciated by a few people that I know. **There are master's degrees in quality and patient safety**.

There's a master's in population health offered by Dartmouth and other universities that can be key to your future. If that's what is your interest, and many physicians aspire to gain a JD or a law degree which obviously can be a ticket to multiple entries into positions for you as well.

So **I was a chief medical officer, and if you want to be a chief medical officer, the saying is, if you've seen one CMO Job, you've seen one CMO Job. They vary significantly from opportunity to opportunity.**

The Vice President of Medical Affairs is probably going the way of the dinosaur. It was a key position in hospitals years ago. There are some that are still around, but they've almost all been replaced by a CMO or a CMO lookalike like a CCO. **You can be in one of these leadership positions at any one of a multitude of different levels, in medical groups, in clinics, hospitals, and in health networks.**

What's a typical CMO [Chief Medical Officer] day, or what was it for me?

When I first had become a chief medical officer, I was reporting to the chief executive officer who had been the chief medical officer until he was elevated to the corner office. After I had been doing it for a few months he said to me at one of our weekly meetings, How's it going so far? And I said, well, I love it. I love it because it satisfies my desire for a multitude of different things. **But I had to tell him that every morning after I worked out and I showered while I was in the shower, I thought, what are 2 things that I absolutely have to get done today. What are those most important things, and that thus far to that point in time, now, months into the job I had never gotten to even start number 2 because something came up as I was dealing with number 1, and I loved that. If that's not your idea of fun. You may not want to be a chief medical officer, so you just need to think about that.**

So to tell you what my situation was like a large employed group of physicians and advanced practice clinicians reported to me when I left the position in 2021 we had 2,000 in our employed group. **And obviously, if you have that large of an employed group, you're always going to have a few people that you may have to deal with [as a chief medical officer] on a one on one level for either clinical issues, or even somewhat more of a demand upon your time, personal interaction issues. [Personal interaction issues] can be difficult, but they require your attention and occasionally you have to separate some of those people for either quality issues or for their not being cut out to be a team player.**

Medical staff affairs reported up to me which was key in terms of the credentialing activities of getting people onto the staff.

All of education reported to me so not just graduate medical education, which was my passion over my career, but undergraduate medical education.

Lehigh Valley Health Network was a clinical campus for the University of South Florida School of Medicine, the Marsani College of Medicine, and so that reported, but also nursing education- education of the staff that all reported up to me research at our health network was exclusively clinical research. There are quite a few demands that have to be very fastidiously followed in terms of being clear that the research is being conducted in an effective fashion and that the reporting requirements are being met. [As a chief medical

officer I also worked on] quality and patient safety across the entire health network, both in the ambulatory environment and the inpatient environment reported up.

I already talked about clinical documentation improvement. The Chief Medical Information Officer [was who] was clearly most involved with analytics and with our electronic health record. At each of the hospitals there was a hospital chief medical officer that reported up to me.

All of organizational development and improvement reported to me

If you're in a leadership opportunity you are going to be either a coach or a mentor, and I, in my retirement, obtained an executive coaching certification, and still do some executive coaching for physicians and other healthcare leaders who aspire towards leadership opportunities. When I took my first course in that graduate certificate, I naively thought that coaching and mentoring were one in the same thing, and it was pointed out that they are very different activities. **And so mentoring is something you do when you have had significant experience in a field, and you want to impart that knowledge and those insights to someone who is more junior to you, so they can benefit. As they're rising up within your organization.**

Coaching is not imparting your knowledge. It is trying to draw out from the person to be the very best that they can be. You help them with smart goals, and you help them in terms of accountability, and you try to draw out from them, and even have them evolve in their emotional intelligence. If you're a leader you need to realize that you can be both a coach and a mentor to those in your organization who either report to you or who seek you out

I did not have good mentorship nor coaching as I came up over my career, and a lot of what I happened upon was serendipity rather than intent, and I always wonder in retrospect. You know the road not taken of Robert Frost. Could things have been different if I had had someone to help me in that regard?

Moderator: Thank you very much Dr. Whalen. Fantastic presentation. I think that you would be a superb coach or mentor just from listening to you. Very, very impressive. I did have some questions I'd like to ask on behalf of our viewers.

Q: Intellectual stimulation [as a physician working in medical administration] Could you give me a numerical comparison, if you can, between you know, doing, taking care of kids, doing your procedures, doing your clinic, talking with the parents, and doing your organized chaos of a medical director and a CMO [Chief Medical Officer].

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A: So thanks, Jim, and if I may, I'm going to answer it in ways for you. **The intellectual stimulation, and also the stress level of it.** So I'm now retired for years. I haven't operated [since before I became a CMO] because I when I was chief medical officer I had to give up surgery because of the demands of it. **I still on a very regular basis have a dream that I'm in the operating room and something's going wrong. I never have a dream that I'm in my chief medical officer office, and something's going wrong that says a lot. And even though decisions I made as a chief medical officer had millions of dollars of consequences, lives were not at stake.**

Pediatric surgery was a marvelous field and there were cases on a weekly monthly basis that would really get your juices going intellectually. **For almost everyone that I know of in clinical activity, pediatric surgery, or otherwise a lot of what you do becomes rote.**

Q: Fantastic. A related question. Bad days versus good days. What was that ratio as a practicing pediatric surgeon? What was that ratio when you were [a physician serving in medical administration]?

A: When I was in Camden, New Jersey, we had an incredibly busy pediatric trauma center there and there were some devastatingly bad days with trauma. Not from anything I did. It was from what I wasn't able to do. The helicopter would fly in with the gravely injured child who would succumb before the parents would ever arrive by ground at the hospital. Those were bad days, the pediatric oncology that I was involved in some great satisfactions. You could take out gigantic tumors and kids would do just marvelously well. But there would be the occasional neuroblastoma that there was no hope for. Those were bad days but the overwhelming majority, even with major hepatic resections or repair of tracheoesophageal fistulas, the overwhelming majority of those days were great days.

I don't mean to stipulate here that there are a multitude of bad days in being a chief medical officer or being a medical leader, but the ratio is higher in in terms of a chief medical officer. When I had to separate a physician especially from a leadership opportunity you know, and to see the look in their face when I had to tell them that even if they kind of anticipated it's coming, those were bad days. **The good days clearly far outnumbered the bad was better in terms of my clinical days.**

Q: So you mentioned separation, and that's no fun. Let's talk about the other side of the coin hiring the administrators underneath you. What do you look for in hiring? Which is what our audience would be - entry level [physician administrators]?

A: So I'll start with saying that that you know the raw material you're working with when hiring a physician leader is pretty darn good. There aren't too many intellectually unmatched individuals who go into clinical activity.

So you're dealing some pretty smart people now, there are some that are smarter than others, of course, and so to the extent you can identify them. That's great. **But for me it was far more important to look at their emotional intelligence.** And that's a lot more difficult to discern in the evolution of the brief snippets that you get of a person in hiring, **but talking with their [references] is key.** A little bit of a parable. So when I joined Lehigh Valley Health Network, I first t joined in as chair of the Department of Surgery. The reason I went there was, it was a highly emotionally intelligent organization, and they valued and prized that emotional intelligence, and they used to tell a story, a true story, that someone was being hired, a non-physician leader. And I don't mean to say that that's a critical difference in this story, but a non-physician leader who blew away everybody who interviewed him and they thought, This is the great person and the right match for this big, important leadership opportunity that we have.

They used to use security people from the hospital to drive candidates to and from the airport. And in this case they weren't going to the small Allentown airport. They were going to the Philadelphia airport, so it was a longer encounter between the Security Guard and the candidate the CEO of the health network. The day after this candidate was interviewed, I encountered the Security guard that had shuttled this person to the airport and said, Hey, you know you drove so and so yesterday to the airport. How did it go? And the Security Guard felt empowered in this organization to say to the CEO, well, thank you for asking me. **That person was an absolute fill in the blank, and I don't mean something positive. Here's what he did to me. Here's what he said to me, and that person wasn't hired because they had shown their dark side of their emotional intelligence.** So to the extent that I'm able to discern someone who's highly emotionally intelligent, that's someone I want in that leadership position.

Q: Let's talk about going up the food chain from you know associate medical director, medical director to some of the higher positions. How does that comp can compare? You know I know it became some variations to the you know, to the benchmarks that you were stating before.

A: Sure and that obviously has changed over the last several years. **Executive compensation for a position like a chief medical or a chief clinical officer in a reasonably sized health network is now very generous.** But to give you an idea of what my compensation was. So I had a base compensation, I had incentive compensation goal. Also, in addition to the regular contributions that everyone in the health network would have to their defined contribution plans I had a SERP plan, a special employee retirement plan, which is usually like top hat plans that you can give to the leaders of the network, which was an additional put aside.

[A] % of my annual compensation went into my serp plan that was then paid out upon my retirement. **And so, when you looked at the entire compensation package, it was very, very**

generous. When you get to those high levels [in medical administration] to try to put it into a comparative metric you get into the stratosphere of orthopedic and neurosurgeons in your total compensation package. When you're at the highest levels. If you're at the CEO level, you're leaving even the neurosurgeons in the dust. If you get to the top of the heap [physician executive compensation] can be very generous indeed.

Q: Interviewing advice [for physician positions in medical administration]. Somebody's preparing for an interview for an associate medical director type position or whatnot. **Any advice for them on how to prepare for that?**

A: Do your homework. Whether you're in the organization or not, try to investigate both the situation you're going toward and the organization in particular, so that you learn some key things. But also, if you know who's interviewing try to learn a little bit about who is interviewing you.

I **always used to like asking the question, particularly when I was interviewing Residency candidates coming out of medical school, going into general surgery. What is your key weakness?** Define your biggest weakness to me and my idiosyncrasy was if someone tried to answer that with a positive, the most common one I got medical students was I worked too hard. Yeah, thanks, that's great. I've never heard that one before. **The last perfect person walked the earth [many] years ago, so we all have something that we wish was better within us that isn't going to lead to your not getting the position, but be transparent about it.**

So. I know it'll vary on the type of position. But can you give us a sense of hours? Weekends calls, remote opportunities for both junior people and kind of higher up the food chain.

So. **I taint my answer with the fact that I've always been a workaholic and I'm far from unique in among physicians and among physician leaders I would always work a number of hours on the weekend both as a clinician and as a physician leader. With this incredibly important distinction. When I was a clinical surgeon, pediatric surgeon, the weekend hours that I worked were determined by my patients**. **When I was a physician leader, the weekend hours that I worked were determined by me**.

Moderator: Dr. Whalen. Thank you very much. Excellent, superb, excellent talk. Thank you so much, sir.

Dr. Whalen: It's been a pleasure. Thank you, Jim.