

CMO — The Best Job in Medicine

Michael J. Sacopulos, JD, and Mark D. Olszyk, MD, MBA, CPE

In this *SoundPractice* podcast episode, host Mike Sacopulos interviews Mark Olszyk, MD, an experienced emergency medicine physician and administrator, about his new book, *The Chief Medical Officer's Essential Guidebook*. Olszyk draws parallels between the responsibilities of a chief medical officer and President Harry Truman's famous desk sign, "The Buck Stops Here," emphasizing the significant accountability that comes with the CMO role. He shares insights into what makes an effective CMO and the importance of building strong relationships within the healthcare system. Olszyk passionately argues that being a CMO is the best job in medicine because of the unique opportunity it offers to engage with all aspects of hospital operations and personnel.

KEY WORDS: Chief medical officer; administration; career path; healthcare system; physician leadership.

President Harry Truman famously had a sign on his desk that read: "The Buck Stops Here." It was an acknowledgment that he was ultimately responsible for the actions of his administration.

Chief medical officers can relate to Truman's position. Being a CMO comes with significant responsibilities. My guest today believes being a chief medical officer is the best job in medicine. He is about to defend that position while offering advice to current and future CMOs.

This transcript of their discussion has been edited for clarity and length.

Mike Sacopulos: My guest today is Mark Olszyk. He is an emergency medicine physician with deep experience as an administrator. Mark is the author of the newly published *The Chief Medical Officer's Essential Guidebook*. Dr. Mark Olszyk, welcome to *SoundPractice*.

Mark Olszyk, MD, MBA, CPE: Thank you very much. It is a joy to be here.

Sacopulos: As you know, this is the podcast of the American Association for Physician Leadership. So, before we talk about your new book, can you please tell me about your career path?

Olszyk: Well, as you mentioned, I am board certified in emergency medicine. I grew up in New Jersey and went to school in New Jersey and New York City. To pay for med school, I joined the U.S. Navy. I spent about eight and a half years in San Diego and overseas with the Marines, which was very much an education in itself.

When I came back, I ran the emergency department at Great Lakes, and that whetted my interest in becoming a better administrator, since I found myself in charge of

personnel and equipment. I got my MBA, and then I continued to get other certifications and took other opportunities for training along the way.

I worked in the VA for a while as the chief of emergency medicine, then, as a deputy chief of staff, went to the central office in Washington, D.C. For the last almost 10 years, I have been the chief medical officer at Carroll Hospital in Westminster, Maryland.

Sacopulos: Excellent. Let's talk about your book, *The Chief Medical Officer's Essential Guidebook*. Why did you write it?

Olszyk: The germ for the book came about when a colleague became a chief medical officer. I must have given him a top 10 list or a little guidance of things to do and things not to do. About a year later, he asked me for that list again. I totally forgot I even came up with it. I looked and could not find anything.

I went on Amazon to buy him a CMO primer, but did not see anything. I thought maybe I can get some folks together and we could share our stories, and other people could benefit from our experience. And that is how we got started.

I met Nancy Collins, who is the publisher at AAPL, and we got the ball rolling. Within a year, the book was published.

Sacopulos: Well, it is a great book. I am interested, what makes a good chief medical officer?

Olszyk: Curiosity, advocacy for the team. And that team can be defined in different ways. It can be just the medical staff, it can be the hospital associates more largely, and certainly can include the patients and the community at large, the folks that we serve.

It takes humility. Every two weeks, we have an orientation for new associates where I tell them that healthcare is a calling unlike any other. We see people at the highest points in their lives and at the lowest. We take care of them when they are being born and when they're dying.

We take care of them when no one else is able to take care of them, and we do so regardless of their shape, size, color, ability to pay, ability to communicate or be grateful. That just shows the awesome responsibility society has given us, and we have to be humble to exercise that authority.

We have to be curious. We have to be advocates. A good chief medical officer is somebody who understands the importance of relationships, knows the fundamentals of the job in regard to quality and safety and patient experience and contracting and all those sorts of things, but is somebody who always wants to learn more, knows that they don't understand everything and they certainly can't do everything. That is why they have to build a team around them and surround themselves with folks who are smarter and more capable and more experienced, but just as passionate about patient care and healthcare.

Sacopulos: Sometimes we learn from the mistakes of others. Your book has some great anecdotes. Does one come to mind?

Olszyk: One of my favorite anecdotes refers to a time when I was working in the VA, and I did not know what compensation and pension was. It is an extremely important function in the VA — it is where you evaluate veterans for service-connected injuries or ailments they might have sustained while on active duty. The healthcare administration does so for the benefits administration.

One day I learned that I was in charge of compensation and pension because we were not performing very well. I did not know the least little thing about the procedures and the protocols, so I simply drove down to where the exams were being conducted and asked the staff, "How can we do better?"

They knew how, and it was simple things. One lady who did most of the processing said, "Gee, if I just had a fax machine in my office." She struggled to walk down the hallway, so she would only do it once a day. She said, "If I had a fax machine in my office, I could cut off a couple of days. Or if they would just give me some stamps."

She explained that the department relied on interoffice couriers to get the papers and the forms and the mailings from that location to where they were mailed out. "If we had our own stamps," she said, "we could save three days."

These were small, simple things, but one by one, by listening to the folks who actually did the job day in and day out and by celebrating the small victories, we went from a turnaround time of 45 days past the desired 30 days into single digits. We were in the top three in the country.

It shows that you do not always need a consultant. You do not need to have some fancy strategy. You just need to listen

to the people, be curious, be humble, and ask them what in their daily experience and in their own judgment could help them out, and then be willing to try it.

Not everything will succeed, but I think empowering the team and showing that you really have their back and are willing to take their suggestions seriously is energizing and actually quite refreshing. In many cases, it will pay dividends.

Sacopulos: That is a good point. We are coming off of a pandemic, and many healthcare systems are chronically understaffed. Being a CMO in recent years has certainly not been easy. How have CMOs been impacted?

Olszyk: COVID was scary. We did not know what to expect at the very beginning. In some ways, it was exhilarating, because we had to invent policies and procedures and do things that we never anticipated, and the entire world was watching. People would come out in New York City, and they would bang pots and pans and cheer for the healthcare workers. That was really rewarding.

A lot of clinicians were given more autonomy and more responsibility than before. It was a lot of work, but at the same time, it was really energizing.

Now that we're coming off of that, a lot of the folks who were getting close to retiring or were thinking about it, said, "Okay, that took the last bit of energy I had, and now it's time for me to retire or try something different or cut back."

We are seeing that reduction in the workforce. At the same time, we saw a lot of demand from patients increasing our volume, or folks who had stayed away from healthcare because of the pandemic and all the myriad reasons why they could not access their providers or healthcare system, but they might've gotten worse. Their chronic diseases might have been less than optimally treated. They came in with more complications, with long COVID.

A decline in the experienced workers, an increase in the demand, and uncertainty about the future — seeing all that come together has been an unanticipated force in just the last year or so.

We're trying to figure out how to keep clinicians from losing heart, prevent them from getting burned out, but to make the job as exhilarating or as rewarding as it had been in the past, while at the same time trying to educate patients and reduce readmissions, reduce complications, and all this in the face of tighter budgets, more financial constraints.

Every day brings a new challenge for the chief medical officer, whom I describe as a bridge builder. They're the clinicians who can translate what the financial officer or the chief executive officer or the board or even the community is trying to say into a language that the clinicians can understand, then taking what the clinicians are voicing and their concerns and their fears, their challenges, and being the bridge builder or the translator to the other parties I mentioned.

You are constantly relaying communications, making connections, trying to be an interpreter for parties who do not always see eye-to-eye or do not always communicate on a daily basis. It is rewarding, but, yes, it has been challenging.

Sacopulos: In the preface to *The Chief Medical Officer's Essential Guidebook*, you write that "All success depends upon alliances and partnerships. So, it is essential to hear from our counterparts, vendors and clients." How do you go about building these alliances?

Olszyk: I find that the room in the hospital where I have gained the most insight over the past decade is the physician's lounge. Sometimes I will go in there and just be a fly on the wall. I hate to say I am an eavesdropper, but conversations take place and people let their guards down. You can hear folks express in an informal setting, in their own words, what is going on.

Taking that to the next level, just let people talk. One of the philosophers or early psychologists said, "Life is nothing more than the battle for the ears of others." Everybody wants to tell their story, and there is no sweeter word than someone's own name.

Allowing someone to talk and showing that you are listening, actively listening, and trying to understand, makes a huge difference. But to be able to get to that level, you have to have a lot of contact.

Very few people are going to open up on the very first encounter, so you have to become familiar with folks. You make small talk. You make gestures: bringing them some food, telling a joke, or letting your own guard down, making frequent rounds in the hospital, participating sometimes in extracurricular activities, whether it is a meal or an event or something off campus, just building those bonds and then letting people talk.

When they do express a concern, use whatever authority or power you have to address that concern and get back to them; follow up is incredibly important.

In the book, I talk about all the different relationships that someone has, but I wanted to make sure we did not just get the CMO's perspective on their counterparts. I wanted the counterpart's perspective on the CMO.

I used a framework from a book about 1,900 years old, Plutarch's *Parallel Lives*, in which he compared one figure from Greek history to one from Roman history. I said, "That's what I want. I want parallel lives. I want what the CMO thinks about and how they interact with the CEO, but I also want the CEO to talk about how they see the CMO and their role and how they interact with them." The same thing for the chief nursing officer, chief financial officer, board member, president of the medical staff. We have this parallel structure that was really the heart of the book, the relationships.

Sacopulos: It is not often that I hear Plutarch mentioned on this podcast. You, sir, are in the right place. Thanks for that reference. So, over the course of your career, you must

have noticed that physicians have changed. How does that impact being a chief medical officer?

Olszyk: When I first got to this hospital, about one-third of the medical staff were contractors, vendors. We would contract with a company, an agency, and they would staff whatever area we needed. About one-third were employees of the hospital, and about one-third were independent.

Those used to be the majority of providers, decades and decades ago. That was the older breed. A lot of the primary care providers had an office in the community. They would come in, they would make rounds on their patients, or they would cover for other physicians in the hospital, then they would go back out to their practice and come back to the hospital at the end of the day.

They were some of the most dedicated and hardworking physicians; some would work 16- to 18-hour days. That is what they grew up doing, that is what they expected to do, and sometimes they sacrificed what we now call a work-life balance. They were the ones who actually participated very passionately in hospital politics at medical staff meetings.

But the flip side is they were not always aligned with hospital goals. They were not opposed to them, but they were working in parallel, not under the same tent, because the incentives were not common. At times there could have been a little bit of friction, but often the interplay was dynamic, and it could be very beneficial.

But to really tackle the EMR and all the regulations, physicians found that if they wanted to work in the hospital, they had to work only in the hospital. It was too hard to have a foot in both canoes, inpatient and outpatient.

We have seen the rise of hospitalists who only work in the hospital, and their goals are given to them by the contractor, by the entity that sets up the contract. The hospital will then say, "Readmissions are important, discharges before noon are important, and we're going to incentivize you or disincentivize you based on your performance."

I think we've achieved good results overall over the years, but I have seen those physicians with an attitude less passionate about hospital politics, more of, "I'm going to come to work, I'm going to do what's expected, I'm going to do it well, but then I'm going to go home."

We have seen the attendance at medical staff quarterly meetings go down, although there are still some who are very involved, very passionate about the hospital governance and executive committee, the medical staff structure.

I guess painting with a very, very broad brush, we've seen the change from independent physicians to those who are contracted or are employed, and kind of a decrease in the involvement of that latter group in a lot of the things that the older physicians had traditionally been more involved in. It is a distinction. I do not think that it is better or worse, but I make that observation, and I think others have as well.

Sacopulos: It also strikes me that maybe things have changed not just with physicians, but the general public. The general public seems less trustful and satisfied with healthcare than they were 30 or 40 years ago. Why is that?

Olszyk: You cannot ignore the elephant in the room, and that is the recent pandemic. There were a lot of voices with varied opinions, and that can be confusing. Patients, consumers, and the general populace have a lot more access to medical knowledge than ever before. As you say, 30–40 years ago, there was not an internet; they had to rely on a healthcare professional. Now, a healthcare professional might just be one more voice crying out in the forest. I think that does confuse the issue.

Certainly, patients on average have gotten older. They have had more chronic diseases, so they come in with more complexity than ever. I think that medicine is moving to value-based care. We are very much interested in results now and looking to longitudinal care and keeping people healthier.

But I do not think that we have fully moved on to full prevention and using some of the almost common sense or actually historically tried-and-true methods. Physicians are sometimes constrained by time, so we rely a lot on pharmacotherapy or consultations.

It would be great if we had the time or the manpower to really educate patients and to instruct them on nutrition and the importance of exercise. We know as you get older, you lose muscle mass, you lose coordination. So, the more muscle, the more strength, the more power you can achieve as early as possible in life, the more of a reserve you have.

We see older folks who come into the hospital for care of their acute event, but I'm not sure we do a great job yet of preventing readmission or really setting them up to get healthier or stay healthier, because that involves tackling a lot of issues, including socioeconomics, nutrition and exercise, well-being, and de-stressing.

We want to increase people's health span as much as their lifespan. That is going to take new thinking. A lot of us are looking into that, but I think the patients are a little bit ahead of us. They really want that, and it takes a while for the battleship that is hospital healthcare to begin to turn, especially as we are constrained by finances and by manpower and by all the other challenges. The good news is that there's plenty of opportunity. It is an exciting time to be in medicine.

Sacopulos: Absolutely. If I wanted to evaluate the quality of a chief medical officer, what metrics should I use?

Olszyk: I would say that you would need to do a 360 evaluation, but an in-depth one of everybody they work with. I would not just look at the metrics of the hospital, because the chief medical officer can be a force multiplier, but is not the only one responsible for all those metrics. If the metrics are good, we would like to take credit for them,

to be sure, but more importantly, as I mentioned, it is all about relationships.

You need to ask all of the service chiefs, the head of credentialing, the head of the bylaws committee, the president of the medical staff, the chief nursing officer, the CEO, the other C-suite executives, and then all of the medical staff and the hospital associates: "What do you think about this person? Do they make you feel unique, like an individual? Do they make you feel valued? Do you look forward to seeing that CMO, that person?"

If they treat you with respect and you really believe that you are on the same team, you are much more likely to believe what they say or to understand the goals that they are trying to achieve.

There is not an easy metric you could apply, but you would need to ask everybody they come in contact with whether they are somebody who treats their colleagues and their subordinates and the staff and the patients with respect and with humility and with curiosity.

Sacopulos: Excellent. As our time here comes to an end, I want to ask you about a bold statement that you make in your book. Here it is: "Being a CMO is the best job in medicine." All right, defend it.

Olszyk: It is. I loved being a medical student because I got to rotate in every specialty, spend a month in pediatrics and a month in medicine, a month in surgery. As an emergency medicine resident, I got to do some of that.

But for most physicians, after you have completed your residency, you live in one area, like the radiologists tend to live in a dark room looking at images. The pathologist lives in the laboratory looking at slides and overseeing the blood bank. They all find that very rewarding, of course, but they do not get the opportunity to see the rest of the hospital interact with all their other colleagues in the house of medicine.

I have actually taken the president of the medical staff on field trips. I took our emergency medicine president up to the behavioral health unit. He had never been inside. In fact, he had never seen the radiology reading room, but he talks to the radiologist every day.

As chief medical officer, I am basically given a universal passport and a visa to go anywhere I want to in the hospital. If I want to observe a surgery, I can do that. If I want to go into the family birthplace and see what is happening there, I am not going to go into a delivery, but I can go into the family birthplace and get a feeling for the morale of the staff. I can wander through the emergency department.

I can go anywhere in the hospital, including the boardroom, the boiler room, walk the hallways, talk to the maintenance staff. The environmental services and the food workers and the transporters probably spend more time with patients than the clinicians do, and they have valuable insights, and they know the hospital inside out. As the CMO, I feel like I can talk to anybody. I get to interact with everyone in the hospital and listen to their stories, which I find

endlessly fascinating. That is a privilege, and that is why it is the best job in the hospital.

Sacopulos: You have convinced me. The book, which is an excellent read, and one of the best examples of helping a friend that I have ever heard, is *The Chief Medical Officer's Essential Guidebook*. Mark, I really appreciate your time. My guest has been Mark Olszyk. Thank you so much, doctor.

Olszyk: Thank you very much. It has been a real pleasure.

Sacopulos: My thanks to Mark Olszyk. His new book, *The Chief Medical Officer's Essential Guidebook*, is a must read for CMOs. My thanks also to the American Association for Physician Leadership for making this podcast possible. Please join me next time on *SoundPractice*. We release a new episode every other Wednesday. ■■

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