

■ Physician leadership

R/X for leadership success—part two

The interpersonal skills physician leaders need

Not too long ago, physician leaders embraced a leadership style that executive coach Diane Brennan¹ calls “command and control.” Physician leaders made decisions about the future of their practices, then went to their staff and said, “This is how I want it done, so do it.” But in the last 10 years, physician leaders have shed the dictatorial style in favor of a style Brennan calls “commitment and learning.” These kinder, gentler physician leaders are asking for input from their staff on the front lines so they can make informed decisions about what the practice needs.

As part of her presentation for the 2003 Medical Group Management Association (MGMA) conference in Philadelphia, Mindi McKenna,² an assistant professor of health care leadership in Kansas City, MO, unveiled results from a survey of about 160 physician leaders, physician educators, and medical students about what makes an effective physician leader. Overwhelmingly, the survey respondents said a successful physician leader must have solid interpersonal skills.

The interpersonal skills most important to leading your practice effectively fall under four broad categories: communication, trust, commitment, and acknowledgement, say Brennan and McKenna.

Communication

In the days of “command and control” physician leaders, the message of what to do and how to do it may have come through loud and clear, but today’s physician leader needs more than just clear language to be a good communicator.

“A good communicator has a willingness to listen and not judge or dictate the solution,” Brennan says. Good listeners make eye contact, smile, and nod. If a staff member has an idea that needs some tweaking, good communicators don’t say it wouldn’t work—they acknowledge that it’s a good idea, then pull the staff member in on ways to build on the idea so it fits the practice’s needs.

Although these little nuances of emotional intelligence may not be on your radar right now, McKenna says it helps to start thinking about them every time you’re the one doing the listening. And good communication is regular communication, adds Brennan. “It could be a weekly meeting, a telephone call if you’re working from different sites, or e-mail,” Brennan says.

However, she recommends meeting face-to-face whenever possible. “E-mail is really great, but it’s still good to have that conversation because a lot of times people think through ideas or obstacles by just talking. A lot of us are more verbal than what we realize, and the light goes on.”

Physician leaders can use weekly meetings with staff to help them gauge their effectiveness by asking for feedback about their practices, their management styles, and the staff’s ideas for improvement.

Trust

“Good physician leaders really walk the walk and do what they say they want to do,” Brennan says. “They’re willing to take risks and make mistakes and learn from those mistakes and to allow others the same latitude.”

Trust is particularly important because patients no longer simply go to their doctors, listen to what they say, and turn around and do it, McKenna says. Patients are seeing a team of caregivers—doctors, nurses, therapists, nutritionists, social workers, etc.—and it’s important that physician leaders trust their staff enough to feel comfortable being part of the solution instead of the last word.

“This notion of ‘I’m the expert, and I’m going to share and convey knowledge, and then someone is going to adhere to that and comply and go do what I tell them’ is gone,” McKenna says. “Now it’s much more about influence and making sure that [the physician leader’s voice and] professional expertise are heard and respected in the context of a bunch of other considerations. And that requires a level of relationship building, interpersonal skill, trust, camaraderie, and collaboration that is not really compatible with the traditional model of medical education.”

Commitment

The best physician leaders are the doctors who had such a vision for the practice that they chose to lead, rather than being strong-armed into the position. They seek to grow the practice by reaching out and cultivating relationships with other doctors and professionals in

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their communities. If they know that a bank represents other practices, physician leaders can take key bank staff to lunch and pick their brains, McKenna says. Bankers won't be able to name names, but they may be able to give some tips about what their other clients are doing that your practice hasn't even considered yet.

Physician leaders also need to internalize their commitment. "Lead with integrity and consistency to build relationships and trust," Brennan says. "Know your strengths, surround yourself with good people, encourage and develop those people, and seek assistance where you need it—whether that's through a professional association, management education, or connecting with a coach or mentor."

Committed physician leaders should be inspiring commitment to the practice from each of the physicians in the group by reminding them that by the very nature of being physicians, they are all in leadership roles. "They're clinicians, they motivate the staff, they're educators, they direct the patient flow," Brennan says. "Physician leaders need to remind [physicians] that they

are definitely leaders."

Acknowledgement

In a hopping practice, it's easy to get so busy that you forget to look at the progress your staff makes en route to a larger goal. But stopping to acknowledge and celebrate success—no matter how small—can go a long way toward creating good faith between you and the staff you lead, Brennan says.

This can be particularly important when a group has a long-term goal. When the group gets wary about all that remains to be done, the physician leader can be there to remind them of what they've already accomplished.

"In the past there's been more of a focus on the negative—on what's not been done," Brennan says. "Today, we're looking at the positive and what has been accomplished, and it allows people to stretch and accomplish even more than what they thought possible." ■

Editor's note: Next month, look for information about advanced training options for physician leaders.

■ Group strategies

Patient satisfaction surveys: Customize for best results

Editor's note: In the January GPS, we discussed the benefits of measuring patient satisfaction through surveys. Here, we take a look at how different survey methods impact the data you receive.

Once your practice has decided to survey its patients, determine how to distribute surveys, how often, and whether to hire a contractor or develop the survey in house.

Response rates

Your response rate will certainly depend on the decisions you make. "If you're doing a survey in the office where the receptionist hands [a form] to an arriving patient, you can expect between a 40% and 45% rate of response on average," says consultant Kevin Sullivan¹. "If you mail the survey, the response is usually between 20% and 25%. So to get a [large enough] sample size for each doctor, you would have to mail more surveys than you would hand out over the counter," he adds. Mail is the more expensive of the two methods.

Distribution methods

A survey can be conducted on paper, over the phone,

or online. But according to Sullivan, written surveys are the most successful. "Phone surveys are very expensive, and they don't [truly] get a higher response rate because the phone systems have the ability to dial multiple times. It takes four to five attempts to complete one survey, so to claim an 80% response rate with phone surveys can't be true," he says.

In terms of cost and convenience, the Internet might seem the way to go, but there are pitfalls. One is that people hesitate to open e-mail that doesn't look familiar for fear of infecting their computers with a virus. And if you use a paper-based survey one year and an Internet survey the next, the two groups of respondents might not be directly comparable, compromising your ability to analyze trends—one of the most valuable aspects of a survey program.

To compare a print survey with an online one, you may have to "do some tricky math to norm the two databases," according to Sullivan. "It could be complicated—and expensive," he adds.

Frequency

For most practices with a stable patient base, an annual survey is sufficient. But there are three instances when you may want to survey

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