Leadership to Transform Practice: How Do We Wear Our Words?

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How do we describe our desired practices of the future? Words like teamwork, collaboration, outcomes, patient focused, culturally sensitive, excellence, and community-based are frequently occurring terms. These words denote positive value and are relatively easy to recite as inspiration for how we are trying to transform practices to provide better care for patients and families and more effectively teach students and residents. These are such positive terms that they can be easily recited, just as we do with the pledge of allegiance, for example, without examining whether we are simply stating words, or seriously trying to make them reflective of our practices.

I was inspired to think more about how to walk the talk of practice transformation when in December 2011, I had the opportunity to attend the Conference on Practice Improvement, jointly sponsored by STFM and the AAFP. I knew of the conference, not only because of the STFM description, but also because a leadership team from our department had attended the year before. The interdisciplinary team included a faculty physician, the nurse manager, the director of behavioral science, the department administrator, and the administrator responsible for health information technology. From stories of dinners together and descriptions of local adventures, it was clear they had fun getting to know one another in a different environment. They came home with information, ideas, and inspiration. Most important, they returned home with confidence and a shared commitment to speed up the transformation of our practice.

When I attended this year’s meeting, I did not have the benefit of being there with a clinical team. So I listened and observed. I noticed that teams generally sat together at meals and checked in with one another frequently. There were many coordinating conversations about who would attend which presentation so they could cumulatively be exposed to the material they desired. When teams presented, generally there was excellent choreography and time management so that the contributions of each presenter were recognized. And like our department team the year before, teams seemed to be having fun together. Hmm, I thought, this looked a lot like how huddles could function.

When it was time to make presidential greetings, I described some observations about the teams and about the experience and outcomes of our department’s team the year before. In terms of language and words, I also identified what I mostly did not hear at the meeting. In most interactions, I did not observe physician leaders dominating conversations. I saw them introducing and highlighting work of team members. I did not hear comments about “my nurse” or “my administrator.” I heard many more collective words about our office and identification of the administrator or chief nurse.

Nuances of language may appear trivial. But we know that groups who feel under-recognized are attentive to the language of those who have more power. We all probably can cite personal examples of hearing something that made us doubt the speaker’s true
commitment to change or collaboration, and we all probably have examples of how we have stressed a relationship because of poorly considered words. When a relationship has much mutual trust, it can withstand some lapses, but language reflects beliefs and culture. Inclusive language is important. So too is personal reflection about whether our values are truly aligned with the inclusive words.

Leaders create an organization’s culture. This happens not only by what leaders say or even how they include others to help create the formal norms and rules. Culture is created by how leaders behave.

In my comments to the conference, I encouraged the teams to be attentive to how they would behave when they returned home. I encouraged them to think about how they would inform the other members of their practices and departments. I reflected how our department’s team had returned the year before and how they were moderately successful in sharing the information as a team. They were moderately successful not because they were not committed to shared leadership but because changing communication patterns and forums is hard work. Even with conscious attention, the culture of a system tends to resist change.

We all know how the realities of clinical time make it hard to reach a team goal, for example, of team presentation of content. We also know that team members notice if the head nurse encourages a medical assistant (MA) to report her own transformation idea to the practice management team or if “because of time,” the MA couldn’t attend the meeting. Who makes the report can often be as telling as what is said.

Returning to the team from my department—their shared commitment, enthusiasm, and preparation were contagious. In less than a year, they led our practice to National Committee for Quality Assurance certification as a Level 3 Patient-centered Medical Home. I am certain that they and we would not have been as successful had they not had the shared training and collaboration that occurred for them at the Conference on Practice Improvement. Other forums may serve this role for different groups, but this is a resource for our discipline that enables teams to take the time to begin to do the work necessary for practice transformation.

Effective teams create opportunities to learn, communicate, plan, and play together. Stephen Covey, in his widely read books on “Seven Habits of Successful Leaders”, describes these as Quadrant 2 activities. They are not urgent but very important. Teams that don’t prioritize and make time for team communication, planning, reflection, and joy may be able to run on luck alone. But our work is too important to risk to luck. The importance of well-functioning teams means that attention to team development must become an urgent activity. And, leaders create the cultures that prioritize the teams.

Family medicine educators have the opportunities to help lead the needed transformational changes in clinical practices, in medical education, and increasingly, in larger health care delivery systems. The urgency for change is high, and the opportunities for leadership are equally high. Even if we don’t consider ourselves to be traditional leaders, as faculty we are perceived as leaders. Trainees and staff look to us to see if our words about collaboration and teamwork are reflective of our beliefs and actions. Patients look to us for behaviors that demonstrate we are interested in negotiation and becoming more patient centered.

How do we stand up to their scrutiny? What behaviors do they see that demonstrate that we value their opinions and are willing to change our actions based on their new information? How can we share leadership within our clinical teams, not only when in clinical practice, but as we experiment and learn about new models of care? Reflecting on these questions may take time. So too will any changes in our normal operations to demonstrate that we behave as teams, not only talk about them. But the time is a necessary investment. The need for transformed and effective teams is urgent. Our work is too important to go it alone.

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