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*Foreword by Marshall Goldsmith, Ph.D.*

# Civil Leadership

*The Final Step to Achieving Safety, Quality, Innovation,  
and Profitability in Health Care*

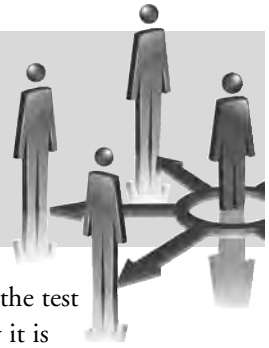


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# Introduction



Many authors desire to create material that withstands the test of time, as relevant in 50 or 100 years as it is the day it is penned—a legacy in print, forever marking their contribution, communicating their passion for an eternity. It is my sincere hope that the publication of this book is, in fact, the beginning of its irrelevance, a literary phoenix that will spontaneously burn up but not have the expected rebirth.

The reader may find this odd, but if this book were to be successful in creating a gut-level, inflamed desire within the health care industry to achieve—in fact, demand—civility and a commitment to relationship-based principles and communication, and the pervasive, visible practice of the concepts—actually *living* the principles—it would make reprinting or future editions of this book unnecessary. I would gladly give up any associated legacy if such an outcome could be achieved. If this were accomplished, the health care industry, one sixth of the entire U.S. economy, would witness unparalleled improvement in quality, safety, and profitability.

I seriously doubt such transformational change will happen. Changing anything that is so big that it accounts for nearly 17% of the gross domestic product, the largest segment of the U.S. economy,<sup>1</sup> can't be done very fast. Clearly, health care is a major driver in the monetary world. But I would argue that the suppliers of health care—providers—unlike suppliers in virtually any other industry, have not responded to patently obvious market forces. There is an ever-expanding demand for health care services, yet we have a consistently declining critical resource to deliver and meet need: providers. Pair this undeniable reality with declining provider reimbursement and increasing overhead and regulatory pressures by state and federal agencies, and the outcome is almost certainly total industry failure—at least without significant, radical, sustained changes in the structure of the system and industrywide innovation.

Saying health care is complex is a laughable remark; it is beyond complex, affecting every citizen and every institution or business. Regardless of the topic—the economics of health care, the payers, providers and their training systems, the myriad state and federal governmental agencies, lawyers, hospitals, pharmaceutical companies, insurers—no one is immune to justified, well-deserved criticism. This complexity paradoxically, and somewhat disturbingly, inoculates each of the above-noted participants from sole responsibility of having created the complex morass that is rightly maligned by just about anyone who knows anything about health care and *everyone* who has had the need to access the industry as a client—that is, patients.

Yes, the number and magnitude of issues the industry faces are daunting. Those issues have and will continue to be examined and discussed for many years to come. But this book's focus is on the ways we, as providers—the ones closest to the action—can affect change *directly*.

Leadership from providers must drive the needed change, and it must be guided by very straightforward concepts such as civility, with an accurate perspective of the complexity of the challenge. One important factor is our behavior. Importantly, the first step we must take is to be *willing* to commit to the kind of change we as providers would like to see. Creating change, however, isn't enough. We need to *sustain* the effort and fix the outcome firmly into place by walking the talk—through personal demonstration to young providers, those in training. We need to teach them that acting with civility is not just important to getting along with our coworkers and patients, but it is *critical* to creating and optimizing the quality and safety initiatives that everyone in the industry desires. In fact, we can never achieve the kind of quality and safety we should have without such commitment to civility. They need to understand that there is an economic benefit to civility that is unavailable to those who do not live its principles—better employee and customer retention, higher patient satisfaction, and lower liability.

The respect we will regain as providers by focusing on the right things—relationship driving civil leadership, for one—will enable us to reclaim the profession. The credibility we will build through those relationships, from patients to the C-suite players, will allow us to have a more direct effect on what is happening and to promote the kinds of radical innovation needed to save the

industry. We will no longer be sitting by idly, being acted upon. Rather, we will be the instruments of change in health care. Thomas Paine perhaps said it best in his manifesto, *Common Sense*:

*Perhaps the sentiments contained in the following pages are not yet sufficiently fashionable to procure them general favor; a long habit of not thinking a thing wrong, gives it a superficial appearance of being right, and raises at first a formidable outcry in defense of custom. But the tumult soon subsides. Time makes more converts than reason.*<sup>2(p. 5)</sup>

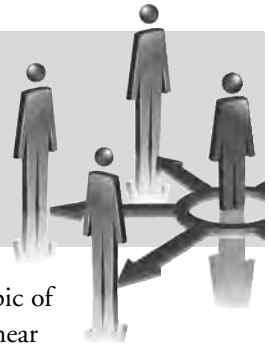
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# Chapter One

## Relationship-Based Civil Leadership



At one time, I thought I knew a great deal about the topic of leadership, personally falling prey to the very sort of linear logic that hamstrings thinking and innovation in health care. I have read Stephen Covey, John Maxwell, Warren Bennis, Kevin Cashman, and myriad other well-known leadership authors. After studying each tome, I thought I understood what I needed to do to become a better leader . . . that perhaps some formulaic approach—*The Seven Habits of Highly Effective People* or the like—would be the magic potion leading to my nearly assured success as a leader. All one needed to do was learn the material and show up.

Many of us in health care have an inherent discomfort with concepts that do not have nice, neat, nailed-down definitions. After all, great comfort comes to those of us who regularly feed at the trough of linear, logical thinking when rigid definition—even if only partially accurate—can be assigned to nebulous concepts. Witness the recent attempts by the Accreditation Council for Graduate Medical Education (ACGME) and The Joint Commission to instill the six competencies into medical practice (see Box 1-1, page 2). At least three of the competencies defy neat definitions: *professionalism*, *communication skills*, and *interpersonal skills*. *Leadership*, as I have come to learn, also defies definition. This is highlighted by the fact that one often sees definitions of *professionalism*, for example, that describe it in terms of recognized anti-traits, such as yelling, berating, belligerence, arrogance, harassment. . . .

ACGME is requiring residency training programs to document that their graduates are competent in these items, and the Joint Commission has adopted the same expectations for hospitals in its “Medical Staff” chapter of the comprehensive accreditation manual.

When one tries to place definitions around nebulous concepts—concepts such as strategy, leadership, communication, interpersonal skills, and professionalism—to “academize” the terms and tame them, mold them into understandable bite-size

**Box 1-1. The Six Competencies, as Defined by the Accreditation Council for Graduate Medical Education and The Joint Commission**

1. Patient care
2. Medical/clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal communication skills
5. Professionalism
6. Systems-based practice

pieces that are so auto-digested that we don't even need to chew, a strange but reproducible phenomenon occurs: The very process of definition results in the concepts losing "their emotional resonance, no longer expressing the reality that practitioners originally tried to capture."<sup>1(p. 17)</sup> In trying to define each of these concepts, and perhaps particularly leadership, in the attempt to "dissect a living phenomenon, the skeleton may be revealed while the specimen dies."<sup>1(p. 17)</sup>

It has become increasingly apparent to me that the type of leadership needed from situation to situation is never the same, and, therefore, leadership is resistant to generic definitions and formulas. The same can be said, by the way, regarding communication, interpersonal skills, and professionalism. These concepts are made up of a collection of behaviors that manifest differently at different times, tailored to the specific situation, with a broad range of individual competence, creating an unreproducible whole. To illustrate, take the concept of integrity—the "sense of being truly genuine—which proves crucial to visionary leadership, and makes it impossible to translate into a general formula."<sup>1(p. 21)</sup> There will never be another Dwight D. Eisenhower because the situations he confronted will never be the same. We can study how he was and what he did, and we can codify his skill set, but we will never be able to convert his leadership into a reproducible formula for broad, generic application.

While acknowledging that there will never be another Eisenhower, it is worth noting that the great general and president wrote his son John, at the time a West Point cadet, "The one quality that can be developed by studious reflections and practice is the leadership of men."<sup>2(p. 214)</sup> I believe what Eisenhower was

communicating to John was that the *skills* needed to lead effectively *can be learned*. How an individual applies those lessons, however, and whether he or she is effective in applying the learnings will differ based upon the situation *and* the individual. In other words, leadership and the application of the aggregate of those things that make up effective leadership is *situational*, assuming that the individual has acquired a set of baseline skills.

Peter Drucker, the late management guru, widely considered the greatest thinker on this topic of the twentieth century, thought that individuals can lead through virtually any set of circumstances and challenges, using four basic competencies (see Table 1-1, page 4).<sup>3</sup> For each of the competencies Drucker described, I have used a single word (in bold) to assist the reader in remembering the concept.

Drucker felt quite strongly that “pettiness and ego [are] the enemy of effective leadership.”<sup>3(p. 202)</sup> Health care providers are often justifiably accused of both of these transgressions, and unfortunately, those accusations are often driven by financial or protectionist turf battles, thinly veiled as concerns for patient quality or safety.

## The Importance of Self-Knowledge

Drucker’s four simple competencies—*listening*, *clarity*, *accountability*, and *stewardship*—are critical to all individuals in leadership roles. Self-monitoring of one’s behaviors is important in the development of such skills. In other words, leaders become increasingly effective by having a very deep understanding of *themselves*. Leadership isn’t about being perfect but creating a pervasive awareness, of self and the organization (that is, the culture), that allows one to *pause and self-correct*. In essence, it requires deep, committed self-awareness and personal knowledge.

Warren Bennis, distinguished professor of business at the University of Southern California, found in his research that some of the best leaders stress the importance of *self-knowledge*. He notes, “All of the leaders I talked with agreed that no one can teach you how to become yourself, to take charge, to express yourself, except you.”<sup>4(p. 51)</sup> From extensive research on leadership and what makes leaders, Bennis distilled what he calls *The Four Lessons of Self-Knowledge*<sup>4</sup> (see Table 1-2, page 5).

Gaining self-knowledge requires openness to change and feedback from external sources and is critically important because we often have inaccurate views of the

# Chapter Eight

## One Foot Out of the Box and Into the Future



***It is also possible that the very identity and vision of a company must be dramatically shifted, forcing leaders to change direction in ways that were never predicted.***<sup>1(p. 2)</sup>

—Larry Levin, Ph.D.

Relationship-based civil leadership is important on both individual and organizational levels. It is a crucial component if we are to achieve the greatest degree of collegiality, quality, safety, risk management, and financial success possible in today's health care environment. It alone, however, is insufficient for saving the U.S. health care system. That will require good-old-fashioned, roll-up-your-sleeves, a little in-your-face, rock-the-boat-type leadership, couched in civility.

I heard Ann Richards, a past governor of Texas, once say, “If ya always do what ya always done, ya always get what ya always got.” No other industry is more prone to continuing to do what doesn't work than health care. When we do try something different, it is usually an incremental tweak and not a potentially transformative solution. Working harder within failing paradigms just accelerates the pace of our failure. As a friend of mine, Paul Summerside, M.D., M.M.M., of the Aurora Baycare Clinic in Green Bay, Wisconsin, likes to point out, “If you are losing money on every patient, you can't make it up in volume.”

Our industry is the master of ignoring the successes of other industries and resisting the adoption of solutions created for similar challenges. We repeatedly try to re-create the wheel instead of going down to Big “O” Tires and just buying what is already there, waiting to be put on the car. Solutions to health care's woes do not reside in the same ways of thinking we've used for the past 30 years. It's time to try a few new things driven by bold, Eisenhower-like leaders who can operate in complex environments, push the right buttons, and do it all within the paradigm of relationship-based civil leadership. Civil behavior is the driver of leaders at this level, too.

In this chapter, I highlight a few of the challenges our industry faces and suggest a few things that might trigger some reader out there to create solutions to some of

our perennial issues. Pay particular attention to Jennifer James's work, discussed later in this chapter,<sup>2</sup> and how to create a road map to examine opportunities. Space is provided for you to write in some ideas for solutions of your own. Who knows? Maybe even some of our political leadership will adopt some of these commonsense suggestions and make the practice of medicine both easier and more enjoyable. Hey . . . one can always hope!

## **Innovation and Novel Solutions in Health Care**

If you don't think *radical innovation*—really, truly out-of-the-box-thinking—is needed to solve the challenges health care faces as an industry, then, quite frankly, you are part of the challenge. To keep the industry from being crushed under the weight of rampant costs, ever-worsening access, increasing regulation, and the rigidity of “that's the way we have always done it” thinking of our academic institutions, I offer some potential considerations for the future. I suspect some readers will chuckle at these suggestions. Others will put their head down and implement them or improve on them! Whatever happens, the change will take decades and will require change at multiple levels throughout the system. We should start now.

This chapter's goal is to suggest some novel, perhaps even innovative, solutions to some of the challenges faced by the health care industry today. There is virtually no segment of the industry that wouldn't benefit from some form of meaningful change, and in some instances, tectonic shifts, in the way things work. Everything should have the target of change placed squarely on its chest, and we should fully load our quiver with arrows.

## **Understanding Where We Need to Go**

It seems that we need to develop a road map for innovation targets. We should be looking to define the theoretical ideal whenever possible, instead of, as we so often do in health care, pasting together half-crafted partial solutions. Jennifer James is an urban anthropologist and one of my favorite authors and speakers. She has suggested that any industry seeking to understand itself can do so by evaluating its current situation.<sup>2</sup> Importantly, James notes that it also allows one to predict where things are going in the future. She notes that if one understands an industry in terms of four criteria—its current technology, economics, demographics, and culture—one can begin to craft a new direction for the future of the industry. Think of using those four measures as tools for drawing a road map for change by understanding the current territory.