Managing Medical Groups: 21st Century Challenges and the Impact of Physician Leadership Styles

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Physician group managers and administrators charged with leading medical groups in the 21st century face a set of old and new challenges and opportunities. Leadership is assumed to make the difference between a successful and not-so-successful medical group. Yet, there is little research about how physician manager leadership styles contribute to the success of medical group practices.

This article is a study of physician leadership styles using the DiSC, based upon a sample of 232 physician managers. Dominance (D) and conscientiousness (C) were the two dominant styles found in this study. Moreover, the two dominant combination leadership styles fall under the categories of the "creative" and the "perfectionist."

The article formulates practical recommendations for both physician managers and administrators for leading medical groups to respond more effectively to the challenges and opportunities facing medical groups in the 21st century.

Key words: Physician leadership; physician leadership style; physician management style; DiSC and physician leadership; attribute flexing.

Many challenges face contemporary medical group practices. To note a few: more demanding patients, increasingly complex reimbursement schemes, continuing litigation threats, ever-challenging illnesses and diseases, and ever-increasing pressures to provide high-quality medical services, while at the same time exceeding the expectations of patients. Medical group practice leaders, regardless of their formal roles and titles, are on the front line of the battle to manage the sometimes competing demands of high quality, service excellence, higher productivity, performance against measurable standards, and sensitivity to the ethical practice of medical care.

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These challenges often fall on the shoulders of the physician manager in the medical group, as well as on the seasoned administrator. Given this practice and leadership challenge, it is important for physician managers and administrators to get the most from their employees. Understanding their leadership styles can help them lead and manage others more effectively.

Medical group practice leaders . . . are on the front line of the battle.

Leadership does matter significantly, and leadership makes a crucial difference during times of chaos and uncertainty (are there any other times?). Understanding one's own leadership style as a physician group manager is critical. This realization allows you to learn how to flex your leadership style to changing circumstances. Kouzes

and Posner [1] admonish leaders about the importance of being prepared:

> "Stuff happens in organizations and in our lives. Sometimes we choose it; sometimes it chooses us. People who become leaders don't always seek the challenges they face. Challenges also seek leaders. It's not so important whether you find the challenges or they find you. What is important are the choices you make when stuff happens. The question is, when opportunity knocks, are you prepared to answer the door."

The purpose of this article is to present insights and recommendations on effective strategies for leadership for physician managers and administrators of medical groups. These insights are drawn from empirically based findings combined with years of experience teaching, consulting, and coaching physician managers.

MANAGING AND LEADING: THE ART OF LEVERAGE

One of the more long-standing definitions of leadership is: to influence others to work toward achieving an organizational goal. This definition strongly suggests that physician managers and administrators should focus on leveraging the talent, experience, and discretionary effort of the entire medical group staff, including other physicians. To do this, they need to align the objectives of the group with the personal, family, and professional objectives of others in the entity.

PHYSICIAN MANAGER LEADERSHIP PREFERENCES

Little published research exists on the management styles of physician managers and health-care managers. Of the few published empirical studies in this area, however, some have suggested that leadership and management in health care is qualitatively different from that in other industries.[2] On the other hand, more recent research has found the opposite: hospital CEOs and general business CEOs are more alike than they are different, except for two qualities:[3]

- Hospital CEOs are not as "interested in working with details."
- Hospital CEOs have a "lower need for rules and supervision" than general business CEOs.

SETTING OF LANDMARK STUDY: TULANE UNIVERSITY

The origin of this empirical investigation began in 1996 with the launching of the master of medical management (MMM) degree program in the department of health systems management at Tulane University's School of Public Health and Tropical Medicine in New Orleans. The degree is designed for physicians who are assuming executive and leadership roles in the delivery of health services and who are committed to management as a major element of their professional careers. The Tulane MMM demographics parallel the demographics of the overall physician manager population in that the majority of the students in the program are white, male, and in their 40s and 50s. To date, 232 physician managers or aspiring physician managers have participated in the program.

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One of the required courses, managerial communication, includes an assessment of management style using the DiSC "instrument" (this will be reviewed in detail in the next section). Upon completing the DiSC, individual physicians receive both written and verbal feedback about their management style and the resulting strengths and weaknesses of that style, with specific recommendations to increase their effectiveness at managing and leading others.

DISC: BEHAVIORS BEHIND THE STYLES

The instrument selected to survey the leadership and management styles of the MMM students was the Personality Profile System developed by Carlson Learning.[4] This style indicator survey is based upon the work of William Marston, who described a model of human behavior in the 1920s.

The DiSC is a reliable and valid instrument and significantly correlates with other well-known instruments in leadership and management such as the Myers-Briggs Type Inventory (MBTI). The DiSC is a 28-item, forced choice instrument that requires the respondent to select words that are "most like me" or "least like me" from 28 sets of four words each.

In this model, behavior or characteristic leadership preferences fall into four categories:

- Dominance (D)
- Influence (i)
- Steadiness (S)
- Conscientiousness (C)

The DiSC describes the four dimensions of behavior as illustrated in the accompanying sidebar.

FINDINGS: INSIGHTS TO IMPROVE PHYSICIAN MANAGER EFFECTIVENESS

Individuals tend to have a preference for a "primary" style, or preferred behavioral pattern, and a "backup"

Categories of Leadership Characteristics Derived From Disc Survey

Dominance (D)

The behavioral characteristics associated with this style include being motivated by control over the tasks and work environment, directing others, and achieving specific, stretch goals.

In general, those medical group physician managers and administrators who score high on dominance (D) *tend to be results-focused, fast-paced, and value autonomy.*

Influence (i)

The behavioral characteristics associated with this style include being motivated by interacting with others, giving/receiving immediate feedback, and acknowledging emotions, as well as facts.

In general, those medical group physician managers and administrators who score high on influence (i) *tend to be recognition-seeking, fast-paced, and search for creativity and variety.*

Steadiness (S)

The behavioral characteristics associated with this style include being motivated by job security, predictability, and clearly defined expectations.

In general, those medical group physician managers and administrators who score high on steadiness (S) *tend to be security-focused, patient, and value consistency.*

Conscientiousness (C)

The behavioral characteristics associated with this style include being motivated by needing to be right, working alone, and preferring to work on tasks rather than dealing with people.

In general, those medical group physician managers and administrators who score high on conscientiousness (C) *tend to be quality-focused, detail-oriented, and value logic.*

Adapted: Straw J. The 4-Dimensional Manager: DiSC Strategies for Managing Different People in the Best Ways. San Francisco, Berrett-Koehler Publishers, Inc., 2002.

style, which they may use when their surroundings dictate a change. Most of us, however, have a strong preference for our "primary" style, and we tend to use that style when we interact with others.

Individuals tend to have a preference for a "primary" style, or preferred behavioral pattern . . .

The results from this first empirical investigation of the management styles of physician managers reveal that:

- Dominance was the highest-scoring category, accounting for 49 percent of the 232 physicians surveyed.
- Conscientiousness followed, comprising 29 percent of respondents.
- Influence accounted for 15 percent.
- Steadiness accounted for 7 percent.

TWO PREDOMINANT PATTERNS: CREATIVE AND PERFECTIONIST

The four dimensions of the DiSC are subdivided into 15 patterns that are named according to a "library of classical patterns." Each of the 15 patterns indicates the respondent's preference, ranging from a strong preference for a single dimension of the DiSC to a preference for a combination of the dimensions.

Further analysis indicates that the majority of physician managers in this study score high on the combination of dominance and conscientiousness. This majority also includes sub-character types: classical patterns classified as "creatives" and "perfectionists. Indeed, the study found that these two of the 15 patterns accounted for 47 percent of the total: 32 percent creative and 15 percent perfectionist.

Creative Pattern (32 percent)

The term *creative* suggests that unlike the 14 other patterns that have a primary style and a backup style preference, this style has *two equally* strong preferences of the DiSC dimensions: dominance and conscientiousness. Creative is used to describe those who prefer to get things done while at the same time being careful to do things correctly. This style is often subject to the competing needs of accomplishing tasks quickly and accomplishing them with precision. Speed and perfection vie for equal energy. These competing needs often set up a dynamic tension that is difficult to sustain and, therefore, causes some internal stress.

Perfectionist Pattern (15 percent)

Although the perfectionist pattern includes much of the creative's need for precision and exactitude, the perfectionist lacks the need for quick action. On the con-

trary, these individuals take their time and are quite deliberate. They have a strong need to avoid errors in speech and action and may appear to others as slow and ponderous when it comes to getting things done.

KEY LESSONS: ENHANCING PHYSICIAN MANAGER EFFECTIVENESS

Given that such a large proportion of responding physician managers received their highest scores in two of the four dimensions—dominance and conscientiousness—we can draw two conclusions from this study:

- First, physician managers tend to prefer short-term tasks over which they have a great deal of control.
- Second, they need to stretch their interpersonal skills to gain the cooperation of others to accomplish those tasks.

The point of this study is to further identify for physician managers where their most natural strengths lie and where they will need to expend effort to meet the various requirements of their tasks.

The majority of physician managers in this study score high on dominance and conscientiousness.

The *strength* of the dominance dimension is the ability to make quick decisions, while the strength of the conscientiousness dimension is attention to detail and accuracy. The role of the medical group physician leader, on the other hand, often requires patience and tolerance for ambiguity, which are the *weakest attributes* of these two dimensions. Physician managers should understand the value, as well as the limitations, of their natural strengths. As in bridge, while they may play to their strongest hand, they need to be cognizant of their partner's bids and the bids of their opponents. They must then adapt to the ever-changing circumstances of their dynamic environment.

MODIFYING PHYSICIAN BEHAVIOR

Modifying physician manager behavior represents a daunting challenge: in large measure the training that physicians receive in medical school and in residencies focuses on the development of a skill set that does not complement that of leading and managing a medical group.

Physician managers should understand the value, as well as the limitations, of their natural strengths.

For example, in clinical practice, physicians must see many patients in fairly quick succession and then be able to make a series of accurate diagnoses based upon data and experience. Each diagnosis, in almost all cases, is confined to a single patient. In contrast, the medical group physician manager's role is to make a diagnosis of the provider's problems, group/team problems, and/or organizational problems using data that is often diffuse, tainted with opinion, and requiring a deft political understanding of the multiple parties and perspectives involved.

. . . the training that physicians receive . . . focuses on the development of a skill set that does not complement that of leading . . . a medical group.

This is not to say that physicians will have difficulty being effective medical group physician managers. They can be effective if they make an effort to *flex*—to include those attributes of the other two dimensions: influence and steadiness. We call this effort *attribute flexing*. The following are two illustrations of such flexing:

- The strength of the influence dimension is the ability to make a favorable first impression and to interact with others in an easy, cordial manner.
- The strength of the steadiness dimension is the ability to weigh multiple factors of a situation and look at the long-term consequences.

The combination of understanding one's primary dimension and being aware of the need to flex to a backup dimension will create a powerful internal source for leadership skills in medical group practice settings.

ATTRIBUTE FLEXING

To accomplish attribute flexing, medical group physician managers may at first need a relatively significant amount of energy to flex from the dominance or conscientiousness domains to the influence or steadiness domains.

In time, attribute flexing becomes second nature. It is a clear sign that the medical group physician manager has achieved command . . .

The amount of energy necessary for attribute flexing will depend on how strong the individual's preferences are for a single dimension. The need for that energy, however, decreases with practice. In time, attribute flexing becomes second nature. It is a clear sign that the medical group physician manager has achieved command not only of natural strengths, but also of the supplemental strengths that are required for organizational success.

RECOMMENDATIONS FOR WORKING WITH THE CREATIVE STYLE

The recommendations for medical group administrators who work with creative medical group physician managers are based upon the recognition that, in general, the creative style is highlight-oriented rather than detail-oriented. Too many details tend to complicate their ability to use their strength, which is quick decision making. Because taking action is a strong point for the creative style, the formation of action-oriented recommendations is key. As a matter of fact, the creative style tends to avoid people who use a lot of social preliminaries. In this case, a little conversation goes a long way.

. . . the creative style is highlight-oriented rather than detail-oriented.

In short, when dealing with a creative style, it is critical to approach the medical group physician manager in the following way:

- Skip the preliminaries and get to the point.
- Use bullet points or an executive summary and prepare a full report as a backup.
- Suggest a few steps that can be taken right away to address the issue.

RECOMMENDATIONS FOR WORKING WITH THE PERFECTIONIST STYLE

When dealing with a perfectionist style, it is critical to approach this medical group physician manager in the following way:

- Use a lot of structure to show how you have organized what you are about to say.
- Rely upon data and facts in formulating your arguments, not emotion and opinion.
- Do not rush the perfectionist medical group physician manager to make a quick decision.

In general, the perfectionist style is focused on organization, logic, and thoroughness in decision making. These physician managers tend to look poorly on arguments that are based on personal feelings. Because the perfectionist managers take comfort in organized information, do the organizing for them. Do not expect the perfectionist to make a quick decision, as you would those with the creative style. The perfectionist will prefer to select from a number of choices in a more methodical way.

CONCLUSION

It is important to remember that no style is good or bad. All styles are valuable. For medical group practice leaders, however, it is especially important to become aware of their own style preference so that they can flex to the styles of others when necessary. Attribute flexing, as described here, enhances the ability of medical group physician managers and administrators to interact with others. It suggests a practical method for more effective leadership.

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The intent of this article is to establish a base of information on which to build a reliable and successful method for making significant improvement in group practice management. The results of this study suggest that administrators can improve their effectiveness by learning how to flex to the management and behavioral styles they encounter.

The combination of understanding one's primary dimension and being aware of the need to flex to a backup dimension will create a powerful internal source for leadership skills in medical group practice settings. ■

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