Physician Leadership: Is it Really Improving?
Kevin O'Connor

Pat: Hi, this is Pat Iyer with Legal Nurse Podcast, and today we're going to be talking with a guest who has a deep insight into how the healthcare system works. He's not a physician. He works with physicians. He's a certified speaker, which means a certified speaking professional. This means that he has achieved a designation that is quite rare within the speaking industry. He's a consultant, he's an educator, and he specializes in working with medical and scientific personnel who are charged with leading their peers. Kevin O’Connor has graduate degrees in education, counseling, psychology, and spirituality. And he focuses on the challenges of leadership, business relationships and team effectiveness.

I met Kevin through the National Speakers Association and have purchased his books in the past on presentation techniques. I knew he had a lot that he could bring to you. So, Kevin, welcome to the show.

Kevin: Thank you. Thank you, Pat.

Pat: We talked when we met about the focus of your expertise. The legal nurse consultants who are listening to this program, and there are listeners in 72 countries at this point, they know the clinical world of working with physicians, and they also know the legal world. And we get involved in a case if it's a medical malpractice case. It's because the team has broken down, the communication has broken down, something has happened. We're seeing not all the success stories, but we're seeing the problems, and I thought you might be able to give us some insight into the dynamics that occur in a team when a problem occurs. What are some of the factors that you've seen, and you've worked with that helped to lead to patient safety errors?

Kevin: In my view there are three things.
1. There's employment, and that's when I have a job and I'm doing my role. You ask somebody, "What do you do for a living?" and they tell you what they do for a living. "I'm a nurse. I'm a doctor."

2. Then there's management, where we're supposed to be in control of a team and we're moderating, and we're working.

3. And then there's a third one called leadership, and leadership is different than the other two.

And when we think about our role when dysfunction is happening or when we're called into a difficult situation, if we go in not as someone who has a job to do this, not as someone who is managing these people, but rather as someone who is being called to lead these people, that means I'm going to come in fully aware of my ability to help this situation get better. It doesn't mean I have all the answers, but it does mean I'm going to try to make things a little better here. I'm coming in with the full force of my solution, my inner expertise, and I'm going to bring that to the table.

So, I think one of the things that's really, important, and I've listened to some of your podcasts in the past that seemed to have the same theme, is it really has to do with us.

"What's my role in this and am I going to step up to the table?"

A doctor told me once that he was attending a meeting. He said, "I don't have to attend the meeting." He had just gotten employed as a physician after 30 years in private practice. He sold it to the hospital. I said, "How's it going?" He said, "Well, it was great for about three months." He said, "But then they started treating me like an employee." I said, "Oh my goodness, really?" He said, "What's worse is, I started acting like one." And he said, "I'm at tonight's meeting because I've heard you're either at the table or you're on the menu. I don't want to be on the menu. I want to be at the table."

And I think when we come to these meetings and we say, "I don't know what's going on, but I'm at the table. I am fully present," it's a big deal.

One of my students is a nurse lawyer and does mediation in the juvenile court system. She said, "I used to ask a lot of questions. Now I'm learning that if I listen first then the questions are easier to answer.
for them later." I think sometimes if we come in thinking we must ask a lot of questions, we're better off if we listen.

I think the keen insight that I've gotten from nurses and from physicians in the past is when they listen, they engage. When they start asking questions, distancing can happen if it's done too early.

**Pat:** When I first got hired to work as the staff development coordinator of a large hospital, I decided to spend a week working on each one of the nursing units in that first six weeks that I was an employee. And my peers who were working with me said, "Why are you doing this?" And I said, "I like to get to know people." I had learned in graduate school about the concept of being a change agent and realized that the best way that I could develop relationships and establish my credibility was to show the nurses in that hospital that I could do their job.

I spent six weeks in that role, and it was probably the best six weeks that I could have ever spent demonstrating my commitment to the people that I would be teaching for the next seven years. And in that process, I learned how the hospital really worked. "Oh, we don't really fill out incident reports if we give Tylenol by mistake. It's not necessary to do something like that." That was one of the things that I recall a head nurse telling me and several other eye-opening experiences, the kinds of things you hear when you're listening and not coming in and acting like you're in charge.

**Kevin:** That's right. There's a physician, I think he's still at Stroger Hospital which used to be Cook County Hospital in Chicago, which gets a little bit of everything. And he said, "Every Thursday afternoon, I round to all of the nurse stations and I ask them, "What do you know that I don't know that I should know?"

**Pat:** That's a good question.

**Kevin:** That's a great question. And he said, "And then I also asked them, 'What is it that I can do that would make your job more about what you want your job to be for these patients?" And he said the first few weeks they looked at him like, "Yeah, what's this all about?"

He added, "But once they trusted me and they knew I was not going to stop doing this every Thursday afternoon, they were ready for me. I
learned all kinds of stuff that I would not have learned if I'm in my office or even if I'm rounding and saying, 'How's everything going?'" He said that's not a question that's useful. He said, "If you ask a question that pinpoints something inside of them, and they trust you, trust is a big deal, then that comes out. Then you learn a ton of information."

A lot of physicians who are administrators and leaders say, "Well, I have to practice a little bit to gain credibility with the other doctors because I don't act like a real doctor sometimes." I say, "Well, what do you do?" And they say, "Well, I met the charity clinic two hours a month." I said, "Geez, are you still safe?" He said, "Oh yeah. I asked the nurses if I'm making any mistakes."

Then I ran across a female doctor who said, "I have not done any clinical practice in 15 years." Very, very successful. Very popular among the doctors. I said, "How do you do that? You're not doing any clinical practice." She said, "You know if they don't trust me as a leader, then I'm not doing a good job as leader. My job is not to be a clinician anymore. My job is to be a leader of clinicians."

I thought that was interesting. She has a different kind of mindset. And in a different way in today's paper in Chicago, they recounted a story of you know, Jon Bon Jovi, the rock star that goes around the world. The group, Bon Jovi. He was on a cruise in Spain.

**Pat:** I think he's from New Jersey actually.

**Kevin:** Okay, all right. Okay, so he's one of the most profitable rock groups. He owns the band and then he gave it his name. They make a lot of money. They're very popular. So, he was doing a cruise in Spain, and one of our local women who has cerebral palsy for the last 40 years went with her caretaker. And Bon Jovi said, "I want to have somebody come up and sing a song with me, but you got to know the words. You've got to be a singer and I don't want you to try. I want you to do it."

And suddenly, her caretaker raised her hand and got up there and I guess had the memory of a lifetime. I thought it was very interesting. He said, "I don't want you to try to be good. I want you to be good."
I think when we bring ourselves to the table, it's so important that we come with that full sense of ourselves. I think it's something that you feel from someone, and I think a doctor feels it from a nurse and wants to feel it from a nurse. When I have students who say, "I'm going to try to do this," I tell them, "I don't want you to try. I want you to do it." Sudden, they take on a kind of different persona.

Dr. Driker is the famous psychiatrist from Chicago. He used to say to his patients, "Try to get out of your chair." And so, they would start to get out of the chair, and he said, "I didn't tell you to get out of the chair. I told you to try to get out of the chair." And suddenly, it became obvious the difference between try and do.

When you're a nurse, regardless of your capacity, but especially when you're advising in difficult situations or you're involved in difficult situations, don't be a bystander. Don't lean back in your chair. Come at it with the full force of your knowledge. You are important. If you weren't important, you wouldn't be at the meeting. And when you're at the meeting, you shouldn't be on the menu. You should be at the table.

**Pat:** I think sometimes nurses get on the menu because even though they're supposed to be patient advocates, it's extremely intimidating to challenge the chain of command and to carry a concern to a physician department head who could be understanding and accepting and concerned or could be dismissive and punitive for exposing a problem. That's the stress that nurses face every time there's something clinically going south, as we say.

**Kevin:** That's true. It doesn't mean that you must be the irritant. It doesn't mean you have to be the voice of doom or a Debbie Downer when you're walking in. It does mean that you are walking in as a coequal. "I know some stuff and you know some stuff, and I want to collaborate with you."

Sometimes you're going to say, "Do we want this on the front page of the Daily Herald in Arlington Heights, Illinois?" "Are you sure this is the right decision that's good for all of us? I want to collaborate with you." So, if we continue to do the collaborative technique, and we continue to offer our expertise, but first listen to the other person. They must feel that you have listened to them to make a difference.
Here's an example. I was talking to a fellow a few weeks ago, a very, very bright guy, not in my area. And I was talking to him about an issue of something that he volunteers at. And it was very clear in the beginning that he was feeling a little defensive. He was coming at me with all his arguments and all that kind of stuff. All I started doing was paraphrasing him. And I tried to do it not by repeating what he said, but by paraphrasing to the core of what he was saying. So, I was using my words, but I was mirroring his ideas.

Later I took out a piece of paper and I started drawing a little diagram about it, and it was very interesting. At the end, I offered him the diagram, which I do all the time. I usually do it on a paper napkin because we're at a restaurant or something, and then I offer it to the person. I say, "Do you want to keep this as a reminder?" and everybody grabs this napkin.

It's hysterical, and later when I'm in their office, I see it pinned to their bulletin board. You know, "Is that the napkin from two years ago?" "Yeah, wasn't that a great meeting?" So, it's a visual reminder to them. So, I offer it to him. He said, "No, I'm okay" and I thought, "Really, you're going to be the first person in the world not to take my important diagram." So, I left that day feeling I didn't think I really nailed it.

Later, two weeks later, he's talking to another person about that meeting whom I know. That person came to me and said, "You know he showed me this diagram." I said, "He doesn't have the diagram. I have the diagram." She said, "He reproduced the diagram as we were talking and told me, "You know what I like most about that lunch? I felt heard." Interesting. Very interesting.

Now I was blown away by that, and it reminded me again of the importance of feeling heard. As soon as he felt heard, we were coequals. I know stuff, he knows stuff. And I think it's important for nurses to think this way, especially around what might be dominant or authoritative or bossy bosses. Even bosses want to be heard, but sometimes what they get are questions, or they get statements, or they get judgments, or they get advice. Really, what they want is somebody who will listen. And when you're listened to, that's the beginning of change.
The American Psychiatric Association said, "Change happens when I feel listened to, when I feel like you're interested in me, when you help me focus, and when you encourage me." That's when change happens, and it happens in our marriages as well.

Sometimes we want to give advice to our spouse. Sometimes we want to point out the problem they had and all that sort of stuff. When in fact, if we do those things, they're closer to us. They're much more likely to change. In fact, Drikker used to recommend that when you're arguing with your spouse, you should hold hands with your spouse while you're arguing. Because you can't possibly say all the bad stuff you were thinking of saying because the connection is so strong, right.

You can't do this with your boss, you're not supposed to. But you can remind yourself of how important the connection is. The connection is not going to happen because you barge into somebody's office and tell them what the real deal is. It's not going to happen when we go in and think that we know more than they know. It is going to happen when we bring our full understanding of what we know with the skills that I think everybody ought to have, nurses, lawyers, grocery store clerks, which are the skills of paraphrasing, empathy, understanding.

Pat: They certainly can be skills important for us as businesspeople when we're interacting with our clients, who are all attorneys as well.

Kevin: Correct.

As a legal nurse consultant, you play a crucial role in helping attorneys identify medical malpractice cases that are meritorious. There is a lot at stake in a medical malpractice case – the costs, the potential recovery for the plaintiff and the reputations of the defendants.

Using your medical knowledge and analytical skills, you are in a prime position to help attorneys understand the merits of a medical malpractice claim. You can be the light that guides the attorney to the meritorious claims.
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Obtain the details about this program at the show notes for this podcast. You’ll find them on podcast.legalnursebusiness.com. I’ll give you a 25% discount if you use the code Listened in the coupon box when you purchase the training. You may also get information about this training when you listen to this podcast on our mobile app called BizEdu. Obtain the app by going to legalnursebusiness.com/bizedu. Now let’s return to the show

**Pat:** I thought maybe you could give us a little perspective, Kevin, on the changes in health care because many of us came into health care at a time when there was a very authoritarian model in the medical model of the doctor is in charge and the nurses were those who took orders. All of that has changed to much more of a collaborative team model. We see, as I mentioned earlier, the situations where the communication breaks down. Can you give us some insight about what has been done within the physician world to help physicians give up that top down approach and are they getting it? Are they understanding?

**Kevin:** Right. Well, I think they are. The ones who are becoming leaders in a formal way, I think they not only get it, but they must get it because they're employees. And they're not going to last long on a team if they try to pull the authoritative thing. And sometimes surgeons and
cardiac docs and all that get a bad rep because of what happens to them.

And I think what happens is, what we get from them is not them demeaning us. What we get from them is their anxiety. They have been told they have to be perfect since probably high school, right. Certainly, they're supposed to be perfect when they're doing a procedure and they know the full weight of that procedure is on them. They think the full weight of that procedure is on them. And so, can you imagine? Try to imagine for ourselves what's that like, the full weight of the procedure. Even though I have a team, it's on me. And I think then the collaboration piece to them is kind of hard to figure out a little bit.

One of the doctors I was working with in a surgery situation, I was observing some of the surgeries. And in this hospital, maybe they do it everywhere, they don't just do a timeout for what leg are operating on. They introduce each other even though they've been working together for nine years. "I'm so-and-so, I'm the surgeon. I'm Bob, I'm the anesthesiologist. I'm Cindy, I'm the OR tech." It goes around like that. And this guy was the stereotypical problem surgeon. My job was to see if we could change things.

He actually introduced me, and he said, "That's Kevin. He's my anger management coach." So, he knew what was going on. He just didn't know what the skills were. So, we come out of the first operation and he said, "How did I do?" because he knew I was observing him. I said, "It was good. The thing that I noticed, though, was, everything we talked about for the last hour was about what you wanted to talk about. Nothing was about them. And so, everybody responded to only what you were talking about."

He said, "I didn't notice that." I said, "Well, FYI." We go into the second operation and suddenly, he becomes Mr. Dale Carnegie and "Bob, how are you" and "Cindy, what's going on with you" and blah, blah, blah. We went on like this. They're looking at me like, "What the heck did you do to this guy, right?"

We come out of that operation and he said, "How did I do?" I said, "It was certainly different than the first one." He said, "I've never done anything like that before." I said, "I know." He said, "I didn't know
Cindy was getting married next month." I said, "How long have you worked with her?" He said, "About nine years." I said, "Really, don't think you're getting an invitation to the wedding."

Now in school, we call this a corrective emotional experience. He had never had the experience of what is it like if suddenly "I" as the physician decide to listen to my staff. And for him, that was a huge moment that allowed him to say, "Oh my gosh, I've never even thought of that."

Last night in my class a student would say something of what they learned or what was important to them. And my co-teacher said, "Before anybody else offers an idea, I'd like you to tell so-and-so what you liked, learn or appreciate (this is the skill of encouragement) about what they said." We had a sub-discussion about what the person said, and as soon as they started hearing what other people liked learned or appreciated, suddenly you could see a corrective emotional experience happen.

For some, it bonded them a little bit better. If you say to anybody, and I mean anybody, "You know what I liked about what you said?" they never say, "No, I don't want to know what you liked about what I said." They always lean forward. And this is not sucking up, this is called encouragement. You must find something you really do like about them. And when you do that, they bond closer to you. They're more likely to hear. They're more likely to then take the next right step with you.

**Pat:** Those are such important communication skills. Your story reminded me that one of my podcast guests told me about working in an emergency department with a new ER director who within nine months took a perfectly functional team and created turmoil with people wanting to leave and calling in sick when they knew he was on the schedule.

She confronted him after he chastised her publicly in front of two shifts for something that she had said or done. She pulled him aside and said, "Look, you got to get this straight. You are the leader of this department, and people want to leave, and they're looking for jobs. And even if you go somewhere else, you're going to take your mouth and your personality with you. You have to learn how to fix this." So,
the next day he brought ice cream and donuts for the team. That was corrective action. She has recently resigned her position and you know, clearly, he hasn't fixed the problem.

**Kevin:** Yeah, yeah. Nobody taught him. You know nobody teaches them how to do. And this is not only in that profession, there are some nurses, there are some maintenance people. Nobody really onboards them, tells them what is it that must happen. They don't give them an experience of themselves. They just say, "You're hired. Go do this. Lead the team. You're in charge of this team." And I think many of us take this old European model of superiority and inferiority. It's called a vertical way of looking at things instead of a horizontal way. "I'm important in my own way. You're important and we can work together."

The medical schools now are trying to do a little bit more of that. I think the generation they're working with is much more used to working. Some of these young doctors have been in Montessori schools. Some of them have been in schools where a team is the deal. Maybe some of them have gone through their MBA. Some doctors now have gone (to school) 10 years. They've been engineers, and suddenly they go back to medical school.

One doctor said to me, he said, "Anybody can be a doctor if you just give them eight or 10 years to do it," eight or 10 years to do medical school. He said, "It's a data dump," and he said, "If you think about it, he said, most of medical school is self-taught." He said, "If I have to rely on the lecture, I won't pass any of the exams." Now some of them say it was terrible, some say they loved it, but they said it's just a constant barrage of data and tests.

Now if I put myself in that mindset, when would I have time to learn about my interpersonal skills? When would I have time to learn what the difference is between managing change and leading change? When would I have the ability to know how to present to a group of people, so I don't just dump data on them too, but how do I make it more interesting? How do I make it stick more?"

These skills are things they don't know, and when they emerge, many times it's the clinical nurse that's going to teach those new doctors for a while. They're going to rely on him or her to help them. The place I
love to go to in a hospital is the ICU because there it's really a team. It seems like it's really a team sport. The doctors are relying on the nurses, nurses on the doctors, the techs are involved. Even housekeeping is an important piece there in a team way.

I think if that can become the standard that we work as a team, and we give feedback to one another, and we start the feedback with what did I like, learn or appreciate, I think that helps people start to understand. "Yeah, I see what you mean by that" it becomes a corrective emotional experience, not a corrective experience that's kind of a slap on the hand. We don't want to insult the ego. And you know, I don't know if it's still true, but I have heard that older nurses are not always real nice to the newer nurses. That many newer nurses wind up leaving, not because of doctors, but because of the senior nurses.

**Pat:** Yeah, I think that's been an issue in nursing for sure.

**Kevin:** So, the superiority inferiority is a model that can go anywhere and even in parenting. So that we say, "I'm the boss. Children should be seen and not heard," all that sort of stuff instead of a more collaborative model that talks about really helping children learn the skills of conflict resolution and what does cooperation mean and what does it mean to be treated with respect? You know, if we're treated with respect, usually we can stay in the same room with each other. As soon as I'm disrespected on either end, I am mentally out of that room. And that's what we must be careful of. Sometimes people say, "Really, I'm out." They don't physically leave, but mentally they're gone because they've lost trust.

I think we start helping all teams understand some of those concepts and not just think of them as, "You have to do this, that, and the other thing." My attorney in my class who works with juvenile mediation - it was very interesting to watch her just come to an awareness last night of, "When I listen, I get more. When I ask questions, the defenses raise unless I've established trust." We establish that by listening.

**Pat:** Those are communication lessons that apply everywhere, don't they?

**Kevin:** Yeah and I think you know I did it today, and we recommend people do it in their interviews. And I'm recommending people also do it in
their jobs. I'm not a sports person so I don't know who this man is, but apparently there's a football coach named Bill Belichick, and Belichick has a card that he uses. And when he does the plays, he puts it in front of his mouth so you can't lip read and see what the play is. On the card are all the plays that he plans to use for the first quarter of the game. So, as he's looking at it, it's covering his mouth, but he's also looking at, "Oh yeah, we have to do a number of 68 today and we have to do number 27."

I'm recommending when people go for a job, especially our doctors, that they make a play card. And there are some stories they're going to tell in that interview. There are some statistics, there are some personal stuff. There's, "How do I handle this situation?" And, of course, you can't take it in the interview, so we ask them to memorize it. And when they go in, they are coming in not as just a receiver of questions. They're coming in as experts.

And so, what would happen at meetings? Instead of coming in with an agenda, you and I and all our colleagues come in with their play card for that day. "Here are the three things I'm going to say at this meeting, regardless of what the agenda says." "Here's a story I'm going to tell about something that just happened." We're not relying on our memory. We have it. My play card is right next to me right now. Now I've memorized it. I don't have to look at it very often, but occasionally I might glance at it. And because I don't know what questions you're going to ask me today—isn't that life? None of us knows what the next question is going to be.

**Pat:** That's true.

**Kevin:** Yeah. But if I have a play card, I know what I'm going to say regardless of what's asked of me. I think it was Robert McNamara, wasn't it, the Secretary of Defense under Kennedy and Johnson, who said, "Don't answer the questions they ask you, answer the questions you wished they had asked you."

**Pat:** Yes.

**Kevin:** He knew in the 60s what a soundbite was.
Pat: Yes, I learned that in media training. I'm going to ask you one question that you know I'm going to ask you, which is how can our listeners find out more about you and what you offer?

Kevin: Okay, so my website is kevinoc.com and the books that I have are coauthored with Cindy Maxey, M-A-X-E-Y, so her name always comes up first alphabetically. We've written four books on presentation skills, one of them specifically for women who are in scientific positions. We interviewed a lot of doctors.

Our first book was based on regional medical liaisons who work in pharmaceutical companies, doctors, PhDs, PharmDs. Our editor in New York was a woman and she said, "Why don't you write a book for presentation skills for women executives?" And I said, "Is there a difference between when a woman presents and when a man presents?" And she said, "Go find out." So, I interviewed a bunch of nurses, PharmDs, PhDs, MBAs who were women in executive positions, doctors too. All of them said, "Oh yeah, there's a big difference," so then we wrote a book on that.

So, most of my work, I do about 80 presentations around the United States and in Europe per year. I've done some work at the Magnet Conference, as well as working with physicians and the American College of Healthcare executives. And then I teach six classes at Loyola University in Chicago, and I'm happy to talk to anybody. My email is kevin@kevinoc.com. Happy to talk to anyone that wants to say hello.

Pat: Thank you Kevin, and I appreciate the work that you're doing with the healthcare system to help improve communication, which can lead to better patient outcomes and less work for the medical legal system.

Kevin: That's right. I think we must to remember we're saving lives when we do this. I was just at the Health Executive Briefing Conference for the Joint Commission. The theme this year for those is to save lives. That what we do with safety and in hospitals, and I think we do it in the legal nurse profession, we do it in the courtrooms. We save lives and if we can keep that in our mind, that's why we went into this business in the first place. Yeah.

Pat: Thank you Kevin, for being a guest on the show.
Kevin: You're welcome.

Pat: Thanks to our listeners who are soaking up the knowledge from Kevin. I know, Kevin, that there will be people listening to this who are saying, "Why does it have to end? We want more...." So, I appreciate you sharing your expertise.

Kevin: Thank you. Thank you.

Pat: And thank you everybody for listening and we'll be back next week with a new interview.

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