ON THE LEARNING CURVE

Leadership Skills, Part VII

A leader must always be able to focus on the "big picture" and help the group work toward a common mission. The dreaming is fun. It is exciting to think about how things could be, and imagine yourself there. However, along the way there are many details to be attended to.

BY LEE SAVIO BEERS, M.D.

The only way your team will ever succeed is if you are able to talk with them about how they are progressing toward their goals, and advise them on how to build on their strengths and address their weaknesses.

As young physicians, we are probably all familiar with the term "feedback." We were all expected to receive regular feedback on our performance as residents and fellows. However, most of us also have experienced great variability in the quality of the feedback we received. Some attending physicians sat with us and talked in detail about what we were doing well, and what specific things we could do to improve. Others said, "Good job this month," as they passed us in the hall. Some written evaluations were comprehensive with thoughtful comments. Others just said, "Great intern," with a line drawn through all the "5's" on the Likert scales.

Although we enjoy positive evaluations and comments, they are less meaningful if it doesn't seem like much thought has gone into them. Feedback also is not very helpful if it does not give specific examples of what was done well, and give concrete suggestions for improvement. Not one of us is perfect, and so there is always something we can improve on. The way we learn and grow is to hear those things and think about how we can do even better the next time.

A common mistake in giving feedback (and why it doesn't happen as much as it should—I certainly am guilty of this myself) is to think that it has to be a formal, sit-down, set up an appointment kind of event. Formal feedback sessions can be very helpful, particularly at regularly scheduled intervals, such as at the end of a rotation, at the midpoint of a project, or during an annual review. However, every day there are countless opportunities for giving feedback. For example, you could tell one of your front desk staff, "You did a nice job with that parent who was angry about waiting. You stayed really calm, and that helped the parent to calm down, too. One thing that might help prevent this sort of thing from flaring up in the future is to remember to let families know if the provider who is seeing them is running behind. You are always very good about communicating with us, so I'm sure you would be really effective at letting the families know why they are late being seen for their appointment."

There are a couple points to be illustrated by this comment. First, it takes about 10 seconds to say—most of us can spare that time in our day. Second, you don't have to make a big deal about finding a moment to say it. Just walk by the desk in between patients and say, "Can I grab you for 1 minute about something?" Stand over to the side where you have some privacy and give your quick feedback.

If it turns out there is more to the story, and the conversation is going to take longer than anticipated, you can say "I'm really glad we are talking about this. … We both have patients to take care of now, but why don't we touch base in my office after clinic or first thing in the morning tomorrow. Then we can talk about it in more detail." Obviously, this is not a good strategy for something very serious or that you know is going to lead to a long discussion, but for most things it will work quite well.

Third, it illustrates the "feedback sandwich"—a constructive comment sandwiched in between two positive ones. No one wants to hear only what they are doing wrong, and almost everyone will be more receptive of perceived "negative" comments if they hear some positive ones as well. The comments also were focused and described specific actions and events (not, "You don't communicate with the patients well"). Lastly, if you address small issues as they come up, they will be less likely to turn into big ones.

A minute or two scattered throughout your day can save you time, and more importantly, improve the performance of your team, in the end. ■

DR. BEERS *is an assistant professor of pediatrics at Children's National Medical Center in Washington, D.C. She also is a member of the* PEDIATRIC NEWS *editorial advisory board and the American Academy of Pediatrics Committee on Residency Scholarships. To respond to this column, e-mail Dr. Beers at pdnews@elsevier.com.*

Small Proportion of Kids Have Many Subspecialty Visits

BY KERRI WACHTER

BALTIMORE — Five percent of children in one network of private primary care pediatric practices accounted for almost a third of pediatric subspecialty visits over a 2-year period, based on a study of more than 35,000 children.

Although roughly 60% of 35,487 pediatric primary care patients had no subspecialty visits between May 2006 and April 2008, 5% of children accounted for 32% of 40,487 subspecialty visits, Dr. Louis Vernacchio and his colleagues reported in a poster at the annual meeting of the Pediatric Academic Societies. The findings may soothe concerns about the overuse of subspecialists in the management of common conditions.

Although roughly 60% of 35,487 pediatric primary care patients had no subspecialty visits, 5% of children accounted for 32% of 40,487 of those visits.

The researchers analyzed data on paid claims from a single large health plan for subspecialty visits for a 2-year period for all primary care patients (aged 0-20 years) of the Pediatric Physicians' Organization at Children's, which is a network of private primary care pediatric practices affiliated with Children's Hospital Boston. The network consists of 72 practices with 182 pediatricians. All visits to subspecialty physicians were included in the analysis, except for mental health visits, wrote Dr. Vernacchio, who is a member of one of those practices.

Patients were followed for a median of 14 months and were evenly split between the sexes (49% female). The top seven subspecialties—ophthalmology, orthopedic surgery, dermatology, otolaryngology, allergy and immunology, gastroenterology, and neurology—accounted for nearly three-quarters (72%) of all visits.

"Within subspecialties, there are common diagnoses/procedures which can be targets for primary care–based quality improvement or research initiatives aimed at enhancing primary care management and reducing unnecessary referrals," the researchers noted. These include office vision screening, scoliosis screening and nonoperative management, acne management, and otitis media management.

The study was funded by internal funds of the Pediatric Physicians' Organization at Children's. The authors reported that they have no relevant disclosures. ■

Shortage of Pediatric Dermatologists = Long Waits

BY KERRI WACHTER

PHILADELPHIA — A quarter of pediatric dermatologists report that new patients have to wait more than 12 weeks to get an appointment, and the average overall wait time for pediatric dermatologists is 6-8 weeks, according to a survey of 243 pediatricians, general dermatologists, and pediatric dermatologists.

In comparison, the reported median wait time for a new-patient visit is less than 2 weeks to see a pediatrician and less than 5 weeks for a general/adult dermatologist, Dr. Kristen Cam said in a poster presented at the annual meeting of the Society for Pediatric Dermatology.

"A significant shortage of pediatric dermatologists is perceived by pediatricians, dermatologists, and pediatric dermatologists," wrote Dr. Cam, a dermatology resident at the Children's Hospital of Philadelphia, and her colleagues.

They conducted the survey to assess anecdotal evidence that patients experience long wait times to see a pediatric dermatologist. The researchers asked approximately 800 physicians from the American Academy of Pediatrics, the American Academy of Dermatology, and the Society for Pediatric Dermatology to complete a 45-question online survey. In all, 243 completed the survey. Of these, 19% identified themselves as pediatricians, 28% as general or adult dermatologists, and 53% as pediatric dermatologists.

More than 90% of the survey respondents perceived a shortage of available pediatric dermatology services. Almost half of the pediatric dermatologists reported that their practices are actively recruiting additional pediatric dermatologists. A quarter of them reported actively recruiting for more than a year, the investigators said.

Almost two-thirds of pediatric dermatologists practiced in urban areas. More pediatric dermatologists practiced in academic and hybrid academic/private practice settings than in private practice.

Slightly more than half of the pediatric dermatologists had completed a categorical pediatrics residency and almost half had completed fellowship training. Median salary ranges were comparable for pediatric dermatologists and general/adult dermatologists—$200,000-$250,000—despite additional subspecialty training. In comparison, the median salary range for pediatricians was $100,000-$150,000.

"Salary was perceived to be the strongest factor deterring physicians from entering pediatric dermatology," Dr. Cam and her associates wrote. ■