Management and Leadership Skills for Medical Faculty

A Practical Handbook

Anthony J. Viera
Rob Kramer
Editors

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ISBN 978-3-319-27779-0 ISBN 978-3-319-27781-3 (eBook)
DOI 10.1007/978-3-319-27781-3

Library of Congress Control Number: 2016935322

Springer New York Heidelberg Dordrecht London

Printed on acid-free paper

Springer Science+Business Media LLC New York is part of Springer Science+Business Media (www.springer.com)

Foreword: Why Lead Now?

This unique book is designed to bring hard-learned lessons, from within and beyond academic medical centers, to medical faculty seeking to be efficient and effective leaders in academic medicine. It is a book of "hows" that will help the reader negotiate barriers and avoid pitfalls. We humbly offer our thoughts on "why" this topic is so needed in academic medicine, including some observations on "why lead now?"

People come to leadership with at least one reason to lead, if not many. So please take a scrap of paper, right now, and scribble down on it your reason(s) for being or becoming a leader. Make two columns—a list of reasons you are doing this "for self" and a list of reasons you are doing this "for others." Take as much time as you need making this list. We think it is important.

If you are like most people, like most leaders, there will be entries at least in the "for self" column. There is nothing wrong, per se, if your mind first went there and sort of got hung up thereafter. We are complex creatures in whom mixtures of public spirit and self-interest always coexist. But we think you will be a more successful leader, a happier leader, and a leader more readily followed if you are able to add to the "for others" column.

To help you add to that column, consider how much angst and dissatisfaction exists in healthcare right now. Much of it is reflected in troubling data about the medical field. Because medical schools and academic medical centers, at least in theory, exist to lead the field forward to a better place, there is much opportunity right now to make a difference through leadership.

Here are just five of the many challenges facing medicine right now. Addressing any of them might help you quickly identify a meaningful "why" that you can place in your "for others" column.

1. **Healthcare wastes too much money.** There is general agreement that roughly 30 % of total healthcare cost is waste, that is, over $800 billion dollars a year. Of every dollar spent in this country for any reason, 5 cents is for healthcare waste. Meanwhile, the disparities between wealth and poverty are widening, and the country's decaying infrastructure is being neglected.

2. **Healthcare is not safe enough.** Estimates of deaths in hospitals from errors run as high as 187,000 each year—that is, inpatient deaths alone. There is no credible estimate for outpatient deaths, which some experts guess to be higher. After 15 years of regulatory attention and effort, healthcare is not much safer.
3. **Crucial research is not reaching patients.** Over 15 years of data collected by the Centers for Disease Control and Prevention now suggest that adverse childhood experiences are major contributors to adult diseases. This process likely affects tens of millions of Americans, and there is research showing how to provide relief. We know things about childhood adversity and later health that we have not acted on, leaving millions suffering unnecessarily.
4. **Crucial research is not being done.** We spend far more on research that examines how to treat diseases than on how to prevent them and on how to develop new therapies than on how to disseminate ones that we already known are effective. These research priorities are often driven by the prospect of making money rather than saving it, leaving crucial research unfunded.
5. **Healthcare organizations suffer from too much top-down leadership.** Across healthcare, only half of employees in an anonymous national survey felt comfortable speaking up if they saw an error or bad behavior [1]. Yet modern leadership theorists endorse creating bottom-up safety in which the initiative and commitment of employees can revolutionize organizational culture and performance (i.e., creating leadership "at all levels").

In making the "why" list, we encourage you to take an opportunity to look inward, into your soul, into what you really care about. This process is one of self-reflection and self-awareness in which you can examine your gifts in relationship to your work. In doing so, you may identify a clearer purpose and meaning in being a leader.

No matter who the leader, no matter where or when, it can be hard for that person to hold in a safe container those "whys" for leadership that are "for others." The danger of being harried out of the "for others" column is high, and the challenge of maintaining inspiration is great. But some day, you will step down from your formal leadership role. The battles, the rationalizations, and the likes and dislikes will slip out of your consciousness. You will be left with this question: What did I do? Did I make a difference?

The answer to those questions starts today and ultimately will lie on the scrap of paper in your hand that has two columns. So too does the likelihood of your success, as well as the opportunity to look back some day and smile peacefully about what happened under your leadership.

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Preface

According to the Association of American Medical Colleges (AAMC), there are 141 accredited US and 17 accredited Canadian medical schools; approximately 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, there are 128,000 faculty members who are responsible for educating and training 83,000 medical students and 110,000 resident physicians.

The primary aim of this handbook is to provide these faculty and similar professionals with a contemporary, directly relevant resource about personal career development, executive skills, and leadership principles, topics that are usually not covered in medical school or residency training. Our emphasis is on practical skills advice and leadership development, including personal improvement, which can be used at any stage of one's academic medical career.

Books and resources about general leadership abound, but we hope this handbook, tailored to medical faculty, will fill a niche that is increasingly important in a climate of accelerated healthcare change, competition for available research funding, and increasing momentum for medical education transformation.

Chapel Hill, NC, USA

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About the Editors

Rob Kramer is an executive coach and leadership development professional with significant experience in healthcare and teaching hospitals. He has served more than 15 years in higher education, including as the director of Training & Organizational Development at the University of North Carolina (UNC), where he oversaw management, supervisory, and leadership development for the University's 12,000 faculty and staff. He then founded the Center for Leadership and Organizational Excellence at NC A&T State University. Rob continues working in faculty leadership development at UNC, where he co-facilitates the Academic Leadership Program and the Chairs Leadership Program. He is the author of *Stealth Coaching* and contributes a leadership column for *Advance* healthcare magazine. Rob is an executive coach for the Center for Creative Leadership, an organization ranked among the best executive education providers in the world, and is an adjunct faculty member at the Federal Executive Institute, the premiere executive development provider for the federal government.

Anthony J. Viera is associate professor and the Charles B. Wilkerson Distinguished Scholar in the Department of Family Medicine in the School of Medicine at the University of North Carolina at Chapel Hill. He is a practicing physician and prolific writer, with over 135 indexed articles, 3 books, numerous book chapters, and several monographs published. He is also an accomplished researcher and teacher. He has held grants (totaling millions of dollars) from NIH, HRSA, and other organizations. Additionally, he has been the recipient of multiple faculty awards. Dr. Viera serves as the director of the MD-MPH Program, one of the nation's oldest and most well-regarded of such programs. He was selected to be one of the UNC Academic Leadership Fellows from 2012-2013, during which time he met Rob Kramer.

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Part I
Tools of the Trade

Chapter 1
Developing Yourself

Rebecca Bradley

"Physician, heal thyself."
Luke 4:23

Introduction

Meet Clint Reed, the director of the fellowship program in pediatric cardiology at a venerable teaching hospital. The first time we met, he greeted me with a sheepish smile and a twinkle in his eye, and welcomed me to his office. The source of his chagrin was immediately apparent from the stacks of files and papers covering every surface. I had been selected as Clint's Executive Coach in the leadership development program his organization offers to high potential leaders, and was given the charge of demonstrating ROI (return on investment) for coaching dollars spent. In plain speak, Clint was expected to either save the organization money or increase revenues as a direct result of our coaching engagement.

Clint explained to me that he was responsible for ensuring the fellowship program would graduate world-class physicians and continue to attract top-notch candidates. In addition, he was also responsible for departmental fund raising, publishing regularly, presenting papers at conferences, and not least of all, providing the best possible care to the children the hospital serves. It was easy to see that, undaunted by an overwhelming list of responsibilities, Clint loved his job and was clearly fulfilled by the knowledge that he was making a difference in the lives of his patients and fellows.

As we talked about his development and what he wanted to improve, Clint confessed that he was very late on a publishing deadline, that he had some important design changes he wanted to make to the fellowship program, and that his feeling of always playing catch up was beginning to wear on him. One final awareness

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_1

Clint shared was that he avoided tough conversations with colleagues and fellows until the situations became dire, and when he finally addressed them, he didn't feel he handled them very well. He had a family he loved, yet sometimes felt he wasn't present for his wife and children at home because of the preoccupation he felt with his myriad work responsibilities.

He wanted to be more effective in his role as leader (positively influence the fellows program), learn to work smarter (planning and prioritizing), consistently maintain a simple organizational system (find things easily and actually see his desk), and have a system for reaching out to donors (maximize fund-raising efforts). He also wanted to have his work life under control so that he could enjoy his family, fully participating in the kids' activities and supporting his wife.

Does any of this sound familiar to you? We will come back to Clint later, but let us talk about you now and why you chose to read this handbook. Like Clint, you may have reached a turning point. Without some kind of change, you know you are going to fall hopelessly behind, burn out, or in some way negatively affect those you are dedicated to serving. You may just be curious about leadership and management skills and hope to find some tips for better ways to approach your work. Either way, you have come to the right place.

Five Components of Self-Development

Being a medical faculty member is a privilege, and, of course, with privilege comes responsibility. Faculty members not only have the responsibility of tasks such as educating and equipping medical students, interns, residents, and fellows to diagnose and treat disease, but, increasingly to teach them to partner with their patients to help prevent illness and live lives of overall wellbeing. Like Cliff, your responsibilities may include effective time management, publishing and speaking, supervision of students, and possibly managing or influencing other faculty, and fund raising. In order to successfully meet these challenges, you must be a leader and role model, and, in turn, help others learn how to be positive influences in the lives of their patients—not an easy task!

Take heart, you have already made the first and most important step, which is what this chapter captures: developing yourself. There are five essential self-development components we will explore (Fig. 1.1). Each component greatly influences the likelihood of developing effective new habits and behaviors.

1. Awareness: The Essential Awakening That Things Could Be Better
   We all live on autopilot at times. We tend to move from activity to activity without much reflection on how we are engaging with the people and world around us, even when situations are going poorly. However, the moment our awareness is raised that things are not working well or that there might be a better way, our struggle and frustration cease, and we are now at choice. We now have the opportunity to try different actions or make alternative choices to what we have routinely, unconsciously done. Without awareness,

Fig. 1.1 Components of self-development. (1) *Awareness*: the essential awakening that things could be better. (2) *Intention*: commitment to make a change. (3) *Focus*: daily attention directed toward personal effectiveness. (4) *Action*: doing or behaving in new/different ways. (5) *Hardwiring*: repetition of new actions until new neural pathways are connected permanently

we are destined to continuously repeat habitual behaviors that prevent us from getting the results we want.

In the 27 years I have coached executives, one of my most significant roles has been to help leaders *accurately* see themselves and their performance. Keen self-awareness is a rare trait, and getting accurate and timely feedback when in a position of power is extremely difficult.

So how can you develop awareness? Here are several suggestions:

- On a regular basis (monthly, if not weekly), take a personal inventory of (1) what is working well in your life, (2) what is not working as well, and (3) what, if done differently, would create better results.
- Regularly seek feedback on your leadership behaviors from key stakeholders: peers, more senior leaders, staff members, and students. A good way to get started is to tell them you are working on your own development as a leader, and then ask them what they think is working well and what they would suggest you do differently going forward to be more effective in your role. Always thank people sincerely for their feedback (even feedback that may be difficult to hear). For a more formal, and perhaps more robust process, there are many 360° assessments instruments (Boss, Peers, Direct Reports) available today [1]. This type of assessment identifies essential leadership competencies and gathers anonymous feedback from key stakeholders, including written comments on perceived strengths and development areas. The data are compiled and presented to the leader as the basis for a developmental planning process, commonly augmented by Executive Coaching.
- As you go about your day, notice areas of frustration, struggle, and efforts that don't seem to be effective. For each one, ask yourself, "What is the root cause of this issue? What would be the ideal outcome? What could I do differently?"
- Develop an awareness of your strengths and assess whether you are using them regularly to help you be more effective.

- Reflect on what you want in your "heart of hearts" and avoid the temptation to dismiss it as impractical or not possible. With focus and action you may be able to take the first steps toward your vision.

Pause for a moment and consider the following awareness raising questions. Perhaps rate yourself on a scale of 1–10, where 10 is maximal level:

1. What is my level of effectiveness at getting the results I want?
2. What is my level of satisfaction and fulfillment at work?
3. What is my level of presence and enjoyment away from work?
4. What is the level of my overall wellbeing?

Be brutally honest with yourself. Thinking about your answers may reveal that you have room for improvement in living a personally and professionally productive and rewarding life.

2. Intention

Intention is the marshaling of energy toward an end result, whether a goal, objective, mission, or outcome. It is always the point at which a commitment is made to a new path. Building self-awareness is the fertile ground, and intention is the planted seed of new growth. Gary Zukov, in his book, *Seat of the Soul* says, "Every action, thought and feeling is motivated by an intention, and that intention is a cause that exists as one with an effect. Your intention creates your reality." [2]

The clearer you are about what you intend your life to look like, feel like, and be like, the easier it is to stay committed to attaining that vision. If you cannot picture it clearly, it becomes harder to maintain focus.

Once Clint and I were satisfied that he had a clear and accurate picture of current reality (awareness) both professionally and personally, we established his intentions. Realizing he was too busy to focus on more than one thing at a time, we prioritized and he made the decision to address the most critical area - organization. His intention was, "Within 90 days, I will have, and consistently use, a system of planning and organizing my work and life that enables me to be an effective leader and enjoy my free time with my family." Clint knew if he could master this one foundational element, mastery of other intentions would become possible.

The final step before moving forward was to do a gut check. I asked Clint, "On a scale of 1–10, what is your level of commitment to this intention?" Remember, intention is a commitment to oneself to make a change. If the answer to this vital question is not a 10, then the question needs to be asked, "What would make it a 10?" The answer to this question reveals how, what, or why elements of the intention statement need to be adjusted. For example, the intention may seem overwhelming and needs to be broken into smaller chunks, or the time frame may be too ambitious. Until a wholehearted commitment can be made, the intention doesn't have the power necessary to stay the course.

Here are the steps to formulate a powerful intention statement:

1. Current reality: As a starting point, use the awareness you have gained about what is not working or how you would like to grow or improve.

2. Desired future: Now imagine what it will be like when you reach an ideal life state or goal. Imagine a scene in which you experience a great sense of accomplishment or satisfaction. Allow yourself to feel this sense of mastery.
3. Write it down[1]: Take the time to write a succinct statement of your desired future state. Write it in the present tense as though it is already done; this gives your mind a completed picture (which is also part of our next step, focus). Adding a time frame adds additional "pull energy" toward reaching the desired future state. Pull energy is that sense of urgency that compels us toward completion of a goal we want very much and have declared to ourselves and others we will complete by a certain date.

3. Focus

Every day, and perhaps even moment-to-moment, you make choices about where to place your attention. At the end of the day, your productivity, achievements, and even your enjoyment and sense of satisfaction are directly correlated with the choices you've made regarding where to place your most powerful achievement tool, your focus.

Once you are aware of the need to make a change, and have a clear intention, you have a point of focus on which to place your attention and energy. Yet, how is it possible to maintain focus on anything with the constant pull of seeing patients, teaching, working with faculty, managing research projects, and working with students, not to mention the distractions of email, texts, phone calls, and back-to-back meetings. The best way to maintain focus is through awareness, and an efficient way to increase awareness is to ask yourself focusing questions. Here are some examples:

- What is the single most important thing I could focus on today that would help me _____ (fill in the blank): for example, be a better listener, be more organized, take time to connect with my staff, or use my communication skills more effectively?
- What is happening right now to distract me from getting the results I want today?
- What one step might I take to give my full attention to this area of development today?
- What would it take to commit fully to this area?
- What competing commitments are hampering my ability to focus on this area?
- What might I do to manage both commitments?

Developing the ability to focus is like working a muscle to strengthen it over time; unless we are fully committed and build structures for focusing, it won't just happen. Here is an example of building a structure for focus:

[1] Mark McCormack, What They Don't Teach You in Harvard Business School, Bantam Books, New York 1994. McCormack sites a famous study done with graduates of the 1979 Harvard MBA program in which the 3 % who had written goals were earning, on average, ten times as much as the other 97 % of the class combined, 10 years later.

Commit to writing a brief journal entry (10 min max) every morning, establishing three outcomes you would like to achieve that day (intentions). Many people find it helpful to do this activity *before* having any electronic interaction (to avoid distractions that may pull focus from doing the activity). Two of your outcomes can be from your to do list, but the third should address your primary development area. In addition, add comments on progress made to your three intentions from the day before.

Let's review Clint's experience of commitment and its role in his focus. Once he had begun to make progress with his organizational skills, he decided to address his tendency to avoid uncomfortable conversations. He made the decision that he was going to address difficult conversations sooner rather than later. He began to focus on opportunities and the desired outcomes rather than his own discomfort and impulse to avoid the situations.

4. Action

Taking action and changing behaviors is ultimately where the rubber meets the road. Designing actions that help move us from where we are to where we want to go is key. Thinking alone won't foster a new way of being. You have to move through the "discomfort zone" of practicing new behaviors until they become habitual.

In Clint's case, his first area of development was organization. While he was committed to improving the other areas of his life, he chose to focus first on actions to gain control of his schedule, planning, prioritizing, and file/paper management. He started changing his daily routine by committing to coming into the office every day 30 min earlier. He used this time to plan and prioritize for the day's activities and follow up from the previous day. Clint also added regular weekly and monthly planning time to his schedule, to ensure that he was looking ahead and thinking strategically, rather than just being reactive in his daily "to-do" list. Lastly, he scheduled protected time on his calendar for writing and administrative work. Within two months, Clint had started to see real improvements and felt significantly more in control. In a recent conversation, now seven years later, he said he would never have been able to accomplish his other objectives of meeting publishing deadlines, increasing contributions, improving the fellowship program, and effectively handling difficult conversations, if he hadn't first improved his organizational skills.

To begin making action changes, ask yourself:

1. What one action, if done consistently, would make behavior change possible?
2. What is the potential payoff for doing this action consistently?
3. What is getting in the way of committing to this new action?
4. What can I do today to overcome that obstacle?

5. Hardwiring

Changing behaviors entrenched over many years is difficult. We have to create new neural pathways for new behaviors to become automatic and comfortable. Fortunately, modern neuroscience has contributed to the field of personal and

professional coaching and self-development tremendously, providing evidence-based tools and techniques that support re-wiring the brain to make change possible and permanent. Neuroplasticity, the capacity of the brain to re-wire itself, enables people to learn new languages, improve their golf games, and even enable those with Obsessive Compulsive Disorder to control undesirable behavior without the use of medication.[2]

Ideas to hardwire changes:

- Choose only one area of improvement at a time.
- Work on that area for at least 90 days (a few days or couple of weeks will not suffice!).
- Have at least one person to provide support and, if possible, work with a coach.
- Expect to hit a wall about half way to the finish line—resistance is a natural part of change. Keep going!
- Practice does not make perfect; practice makes permanent! Make sure you are hardwiring the desired behaviors by asking for feedback from others and repeating what's working well consistently.
- You will know when the "cement is dry" in the area of change you have been addressing when you no longer have to consciously focus on getting it right. If you've ever learned to ride a bike, drive a car, ski, or swim, you know what its like to have muscle memory and be able to perform the function automatically while talking or thinking about something else. Don't stop until the "cement is dry!"

Conclusion

The five components of self-development and recommended tools are practical and effective when applied consistently and long enough to allow the "cement to dry," Leading by example is, of course, the ultimate leadership competency. The payoffs are considerable both personally and professionally, not the least of which is the inspiration you will provide for students, physicians-in-training, and fellow faculty members. When others see you expend the effort required to improve yourself, you will garner their respect and ultimately their followership … and that, after all, is what leading is all about.

[2] … Applying this concept to the principle of change, if we shine our spotlight on something new that represents the change we wish to make, our brain makes new connections. This is not just a theoretical possibility: That the brain makes new connections in this way, "has shown to be true through studies of neuroplasticity, where focused attention plays a critical role in creating physical changes in the brain" (Rock & Schwartz, 2006, p.36). David Rock and Linda Pane Ph.D., *Coaching with the Brain in Mind*, Wiley and Sons, 2009.

Pearls and Pitfalls

- Ask for feedback from people other than your raving fans. Ask what you can do more of/less of to be a better leader.
- Be aware of your effects on others, and don't assume your intention is obvious. People judge your leadership ability by your actions; your intentions may be misinterpreted.
- Understand that perception is reality. If you are perceived by those around you as abrasive, even though you consider yourself direct, you can be certain that their reality is that you are abrasive.
- One of the most important aspects of the process of personal development is structure. Create structures that will set you up for success. Examples of structure are:
  - A support structure such as a coach, mentor, trusted adviser or accountability partner
  - Written goals
  - A daily focus time each morning to plan and prioritize
  - A journal in which you regularly record insights and accomplishments
- Don't assume that a lack of feedback from others means they are happy with your leadership; seek accurate honest feedback from others and reward them for giving it.
- If you try to change several things at once, your efforts will be diluted for any one thing and you will work against how your brain hardwires changes. Choose one thing on which to focus and stick to that one area until it is automatic.
- Never underestimate the power of awareness—awareness of self, of others and your impact on them. Without awareness, no amount of action or behavior change will succeed.

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Additional Resource

Mindtools website: https://www.mindtools.com/

Rebecca Bradley ICF Master Certified Coach, has been coaching Executives and their teams for 27 years. Through her work in the private and public sectors in the United States and Singapore, she has taught over 7000 managers her proprietary Partnership Coaching model. Rebecca is passionate about helping leaders optimize their strengths and talents and deepening their self-awareness.

Chapter 2
Communicating Effectively

Chris Hamstra

Introduction

Communication is one of the most talked about subjects in all of human history … and one of the least understood. Realistically, humans have been trying to communicate since the dawn of time. From early humans sitting around campfires and writing on cave walls to modern humans sitting around conference tables and writing text messages, the enduring question remains: what is effective communication? Within the constantly changing health care and academic medical environment, how can individuals practice effective communication?

Balancing Content and Connection

Effective communication is a balancing act between ***content*** and ***connection*** that develops shared meaning. Remember the old playground see-saws with one person on each side? In order to have effective "see-sawing", you had to achieve a certain balance with the person on the other side. This idea is similar to the balancing act of effective communication. One side of the balance beam is *content rich messages* that are quick and concise to share. The other side of the balance beam is *connection*

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_2

and building relationships with individual personalities. Whether communicating with colleagues, staff members, senior leadership, or patients, it is vital that these areas are balanced.

Think about what happens when a see-saw is out of balance. One person is older or bigger than the other and the see-saw does not work. Even with maximum strength and effort the balance beam crashes back down because there is an unequal balance. Similarly, communication can "crash" when content and connection are out of balance. Multiple stories exist about doctors or nurses who walk in a patient's room, deliver a diagnosis, and leave without making a connection. Think about the medical school professor who rushes through jargon, technical details, and academic content but fails to consider different learning preferences and connect to the personalities in the classroom environment.

The following humorous story emphasizes what happens when content is emphasized over connection. A medical professional is treating a patient who is diagnosed with an ear infection. The prescription order is written for two drops of antibiotics at night for the next 10 days. When a family member calls later for confirmation, the doctor does not listen to the clarifying question. With a harsh and dismissive attitude the reply is growled over the phone "… to complete the orders as written." The doctor was surprised to find an upset patient later that week who still suffered from the ear infection. The doctor learns that family members were using the medicine and following the orders as directed. The two drops for the ear infection were placed "as written" in the ***R ear*** not the *R*ight *ear* as the doctor had planned. When content is out of balance with connection, miscommunication frequently occurs.

Messages rich in content are not always effective, but the opposite is also true when solely focused on connection. Consider the interaction with a physician who is very nice but may not effectively share the knowledge needed to adequately help. Medical educators and practitioners focused only on the connection piece can miss important content that is vital for proper diagnosis and treatment. The bottom-line is that it is important to balance the need for *content* and *connection* when reaching for the goal of effective communication.

Quick Activity and Discussion: Balancing Content and Connection

One easy way to balance content is to consider the language and terms used. What are some of the technical terms and jargon that are typical of your daily activity with your peers but others may not understand? Make a short list of those terms that may seem common sense to you. How can you balance your work place content to help those outside your group connect with the common understanding for effective communication?

List five common terms or phrases that you know and use in the first column. When communicating with others, how can you explain these terms to someone who might not understand? Enter these into the second column.

Jargon/Slang/Official term	Common understanding
Example: “EHR”	Electronic health record

Why Effective Communication Is Important

A set of shared expectations in the academic medical environment is vital for successful patient care, communication with peers, and teaching. Effective communication in healthcare was addressed by the Joint Commission on Accreditation of Hospitals in their report, *A Roadmap for Hospitals*. The report suggests "No longer considered to be simply a patient's right, effective communication is now accepted as an essential component of quality care and patient safety" (p. 1).

The Joint Commission suggests using the SBAR formula for effective communication. Used initially in the military and eventually gaining a foothold in medicine around the 1990s, SBAR was used initially to facilitate effective communication between physicians and nurses. This template can be used in any area of healthcare and even in other industries. It provides a framework to communicate important information from one person to another. SBAR is a mnemonic to help remember four critical elements of communication:

Situation—What is the problem or reason for the communication?
Background—What background data and information is being used?
Assessment—What are the behaviors or areas of concern? Summarize the facts.
Recommendations—What is the next step? What do you think needs to be done?

Let's look at an example in the workplace. A research faculty member needs to give one of her students (Mark) feedback on his behavior in the lab:

Situation: "Mark, I need to talk with you about your behavior working in the lab. You have typically been very high performing, but as of late there has been a change."
Background: "I have reports from numerous colleagues in the lab who work with you, as well as my own observations."
Assessment: "The reports are all basically the same—that when others ask you for help you become defensive or resistant. I have also experienced this with you multiple times in the last 4–6 weeks."
Recommendations: "The behaviors need to change so that the lab can perform better. Is there anything going on I should be aware of? How can I help you? I'd like to create a plan with you to help you get back on track."

The SBAR guide is an important formula for quick, concise information sharing. The SBAR guide also allows the flexibility to connect with different individual's varied communication styles.

Activity and Discussion: Using SBAR

Pick one recent situation from your life where you needed to present information to another person. Any situation is fair game: at home with your significant other and family, in the workplace, or with a friend. Pick a partner and practice using the SBAR formula to relay the important information through speaking.

Tips for Speaking with SBAR

1. To effectively speak with another individual using SBAR, consider the verbal and nonverbal elements in the communication process. Think about and follow the alphabet 'ABCDE' of effective speaking:

   (a) **A**ppropriate eye contact
   (b) **B**e simple and be clear when speaking
   (c) **C**alm tone of voice and volume
   (d) **D**one speaking—be quiet and listen
   (e) **E**nd with clarifying questions and summary

SBAR can also be used when writing, as it clarifies important information that is necessary to share.

Tips for Writing with SBAR

1. To write using the SBAR formula, consider the following tips:

   (a) Always be concise but full of detail and information
   (b) Use accurate words and phrases that describe the situation—avoid jargon
   (c) Write in active voice

   – A passive statement complicates and deadens the writing. For example: *The patient was feeling nauseated after taking the medicine* is a passive statement.
   – Using an active voice helps to provide information and comprehension. Consider the previous statement in an active voice: *The patient took the medicine and immediately felt nauseated.*

   (d) Check spelling and grammar

Effective Communication: Navigating a Complex Process

As academic medical professionals, acronyms and templates are a way of life and provide an easy short hand. The tips and tricks using SBAR for effective communication in speaking and writing (above) also make information transfer easy and efficient.

Unfortunately, though, following a template does not always work in a healthcare or learning environment. The reality is that effective communication is messy and rarely follows a prescribed formula. What road should be followed in the middle of a chaotic and pressure-packed situation? Sometimes effective communication

requires additional tools. Similar to a GPS system when driving a car, there are many different ways to get to a communication destination, and reaching the goal of effective communication may require a 'recalculation.' It is important to consider two additional "road map" items: (1) communication is a *complex process* and (2) communication is fundamentally a *human* activity.

The primary challenge is that the seemingly simple act of communication is surprisingly multifaceted. Miscommunication occurs throughout daily activities, both externally in behaviors and internally through preconceived assumptions. Imagine making eye contact and waving to a colleague across a crowded room and getting confused looks and puzzled waves back from complete strangers who think you are waving at them. Humans are not always clear, and what may seem like a simple communication strategy can require more complexity than first realized.

Miscommunication: External

This communication strategy of you waving 'Hello' to your friend across the room is complicated by several external factors including: the different channels the message travels, the various verbal and nonverbal interpretations and behaviors of the individual (you) and others (your friend).

Think about the complexity of communication and the different roads your message of 'Hello' can travel. In the nonverbal waving to a colleague described above, a seemingly simple message of 'Hello' from one individual to another is picked up by several others. While the message is not intended for them, your message of 'Hello' is picked up and understood by others sitting near your colleague as well as by others in the corner of the room, far away from your intended target.

The complexity of communication continues when thinking about the meaning of your nonverbal gesture. The wave can be understood in a variety of different ways. Is your wave the *'Look at me, I am here'* message with the smile, or the casual flip and of the hand with little eye contact? These different nonverbal gestures create a different meaning. What is the meaning you are trying to convey? The seemingly simple message and wave of 'Hello' is surprisingly complex. The intricate nature of communication is typically not considered by the communicator until unintended feedback occurs and a 'recalculation' is needed.

Think now about the human element of communication when you walk in the room and offer the wave to your friend. The meaning of your message varies greatly depending on a person's background, their culture, the context of the situation, and other diversity challenges. For example, someone may perceive a lazy wave their direction as a "gentle, friendly hello," while someone else may interpret it as an inauthentic gesture—"they don't really mean it, they just waved because I caught their eye."

Activity: Search for Common Miscommunication Errors

Using the internet, spend a few minutes searching for common forms of miscommunication in your field of expertise. For example, a quick Google search may provide websites that list examples of communication errors when educating patients on ailments, or common dosing errors between medical staff. Find five (5) different spoken or written forms of miscommunication, write them down, and examine them. What possibly happened that made this error possible? What steps could you take to 'recalculate' the message?

Miscommunication: Internal

While external factors contribute to miscommunication, the more severe form of miscommunication is internal and occurs through assumptions and preconceived ideas. An assumption commonly made is to accept something as fact, typically with little or no proof. Medical faculty members and clinicians frequently use four of the five senses almost constantly. In front of the classroom or in the clinical setting these senses provide input through sight, smell, sound, and touch. Think about the external and internal elements of miscommunication. Consider the assumptions from those involved, and the sources of information used to 'recalculate' for a better outcome.

Listening: An Important First Step (Listen to Speak)

An important first step to 'recalculate' for effective communication is to listen with your ears and your eyes. There is a fundamental difference between hearing and listening. Hearing is passive and usually a reaction to stimulation. Listening implies an active search for meaning. Individuals rely on listening skills more than any other communication activity, including reading, writing, and even speaking.

When an academic physician walks in the clinic or approaches a class without listening, miscommunication frequently occurs. Listening is a full-time and full-body activity that uses the ears, the eyes, and a third component, "the heart."

Consider the HEART acronym:

H: Have and open-mind and closed mouth—Be prepared and aware that someone is seeking to communicate with you. It is important in this step to create a space where you are internally ready to listen. Stop your mind from wandering, and listen. Do not just hear but really focus in and listen with intent to understand.

E: Eye contact—Set up your nonverbal behavior. Make good eye contact, face the speaker, provide good nonverbal cues that you are listening (such as head nods).

A: Ask quality clarifying questions—Actively search for meaning and useful information based on what you have heard. Clarify any misunderstandings or assumptions that you may have.
R: React with empathy and honesty—Engage fully with the person and watch out for your personal biases getting in the way.
T: Trust—Develop this vital area of relationship building by following up. Remember what is being said and take appropriate, timely action.

Effective Communication: A Human Process

A second challenge is remembering that communication is a distinctively *human* process. Communication can be messy and may take time. It is vital for the health and well-being of everyone to understand that effective communication is a process that is co-created between individuals with different bodies, minds, and values. Effective spoken and written communication is a process that is continually shaping and being re-shaped over time, in different environments, and between different people. A balance should be maintained between content and connection, and recalculations often need to occur to reach the desired destination.

Best Practices and Summary

Communication is a challenging process. As much as communication is a skill, communication is also an *art* that needs to be acknowledged and cultivated. Quentin [1], in his book *Communicating for Life*, offers that "the study of communication should take us beyond the ordinary in life to ultimate matters of life and death" (p. 14).

Communication is a *skill* that is often only perfected in reflection. Take to time to consider your communication with others each and every day. There is always the wonderful potential to change a course of action for future success.

Effective Communication: Pitfalls and Tips

Pitfalls	Tips
Using jargon and acronyms	Get to know your audience. Balance content and connection
Using a Passive Voice	Use an active voice
Speaking before listening	Listen first—Use HEART
Rambling thoughts	Use SBAR

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Chapter 3
Giving and Receiving Feedback

Ellen Mohr Catalano

Introduction

Giving feedback in an academic medical setting is a critical part of developing students, interns, residents and other faculty colleagues, and takes many forms, from a casual conversation to just-in-time feedback to annual performance reviews. The best time for effective feedback is not in a crisis situation, where actions need to be carried out swiftly and with little time for conversation. However, by default, managers and leaders tend to habitually give feedback too early, regardless of whether it is an emergency or not. The quality of such feedback is often not thought out well or delivered artfully. Spending a little extra time to listen carefully and ask good questions pays off in quality flow of information, and helps to build trust and rapport with others.

Feedback best practices include listening, asking open-ended questions, delivering comments with clarity, self-management, the use of acknowledgments and the use of "I statements." Although some teaching hospitals focus on the practice of conducting feedback sessions post code or critical situations, this chapter's focus is providing ongoing feedback (also known as developmental feedback) in the office or learning environment. In either case, effective feedback best practices help to build trust in relationships and as a result, a more motivated workforce.

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_3

Use Active Listening and Powerful Questioning as the Foundation for Feedback

Timing Is Everything

In the press of the moment, it can be tempting to jump in with feedback right at the start of a conversation. This habit invites problems as it often creates defensiveness in the other person, leading to potential shutdown of the conversation. Unless it is an emergency situation where instructions must be given swiftly and followed immediately, it is worth taking the time to ask the other person a very basic and often overlooked question: "What did you think you did well and what could be improved?" With such an approach, people can identify the area(s) that they need to work on. As a result, their motivation to change their actions or behavior is higher because it is based on *their* idea rather than yours.

The Sandwich Technique

Dr. Mary Preston, who retired after a successful career in geriatrics at the University of Virginia Medical Center, continues to work with first year medical students. Her typical group of six students meets once a week, four hours each meeting, for a total of eighteen months. This structure gives the group members plenty of time to get to know each other and establish a comfort level conducive to giving and receiving feedback. They role-play case studies with a group member playing the patient and another playing the physician. Then, they give and receive feedback not only on the medical aspects of the case, but also on the rapport they are able to establish with the "patient." They give and get feedback on physical exam skills (e.g. putting the blood pressure cuff on correctly) and interpersonal skills such as how well they exhibit genuine engagement and interest in what the patient has to say.

As the year progresses, Dr. Preston notices that the students typically become more facile and comfortable with giving and getting feedback, and more adept at treating it as "neutral data" rather than attacks on their character. It is also evident to her that peer feedback can have a more powerful effect on performance than professorial comments. How does she train them to take such an open and curious approach, especially where she is seen as the expert?

From the very beginning, she sets the stage for feedback, saying that she will be picky in spotting needed improvements in their oral and written presentations. Her regular session process is:

1. Role play the case.
2. She asks the person playing the doctor the opening question: *How did you think it went?*
3. She asks the person playing the patient to give feedback.
4. The rest of the group then weighs in with their feedback. Dr. Preston says that at the beginning of the group's life together, they are very "nice" to each other and

hesitate to give constructive feedback. However, as the group establishes trust, feedback becomes forthright.
5. Dr. Preston speaks last as she is the most experienced and has the most "power". She uses the "sandwich technique" where she names strengths she observed, then suggestions for improvement, followed by a summary strength.

Dr. Preston reiterates that the feedback process should be made clear and handled carefully, as there are fragile egos at play. While first year students may be accustomed to critique, they come from a "straight A's" background and may be unused to corrective criticism. Residents and interns may be devastated by making mistakes, because they can be writing orders in a life or death situation.She goes on to point out that regardless of someone's level in the hospital system, you can help manage potential defensiveness by using the sandwich technique (positive, negative, positive) and by not comparing them to their peers (implying favorites).

Self-Manage

Assumptions and Intentions

Test your own assumptions and intentions before entering into a feedback conversation. In examining your intentions, what do you hope to gain by giving this person feedback? Be very clear with yourself and take an honest look at your motivation. Is this person so annoying to you that you would like to "put him in his place?" Is the feedback for the ultimate safety of a patient? Is it given to help teach new behaviors or action steps?

Next, take a look at the assumptions you hold prior to giving feedback. Do you think you already know how the issue should be handled? The problem solved? By tabling your thought of "already knowing the solution," you can instead promote a sense of curiosity and exploration of the problem to be solved or the behavior to be changed. This strategy in turn promotes a power *balance* in the relationship between you and your students, employees, or colleagues. You are allies and partners in solving the problem.

Students especially may resist this notion of partnership with their professors. However, it is worth the time to instill this sense of partnership. Management gurus have for a long time extolled the virtues of creating durable, sustainable solutions by moving away from a "command and control" attitude toward a more transparent conversation where ideas flow freely.

Avoid Attribution

If you catch yourself saying "I know why you did it that way" you are automatically assigning motivation and meaning to the person's behavior. This stance is a recipe for disaster. It is best to have the other state the reasoning. Ask the following open-ended questions:

"What led you to that decision/action?"
"What was your goal/intention?
"What were the underlying forces beneath your decision/action?"
"What data did you have to move in that direction?"
"What conclusions have you drawn from this course of action?"

After listening carefully to the responses (and perhaps learning something new for yourself in the process), you are in a better position to give well informed feedback in the form of an "I" statement.

"I see it that way as well."
"While I see how you were thinking about this, I would have made a different choice because…"
"After hearing your view on this, I better understand where you are coming from, and I have some feedback for you that I believe will help you with your goal/intention.

A Word About Open-Ended Questions

You will notice the questions in the above section begin with the word "what." A hallmark of the open-ended question is it prompts further conversation and is a useful way to diffuse defensiveness. A closed ended question such as "Don't you think that …. ?" Is really a leading question and implies that you already know the answer.

Angry Feedback

Feedback given in anger almost always erodes trust. For example "You should have known better" or "You always do that" brings out fear and distrust in others. It is better to wait until you are calm and can focus on the problem, not the person. Feedback given to demean someone derails trust because people will be afraid to make a mistake around you, and will hide their failures. Worse, they will avoid consulting with you in the future. Additionally, watch out for sarcastic feedback. Your intention may be wry humor, but it can backfire because it can elicit embarrassment, or the receiver can feel awkward and unsure what to do with it.

Spot the Strengths

Weaknesses and failures jump out at us. It is often far easier to spot the mistakes than recognize and acknowledge the strengths. Research in the field of management psychology reveals that anybody learning a new skill will perform better with praise and encouragement rather than judgmental corrections. Some experts suggest approximately five "praises" for every one "negative." [1] The effective manager will need to be the best judge of the amount of praise to offer given the culture of the organization. For example, the military tends to be stingy in giving praise as

their culture prizes tough soldiers. The elementary school teacher may double up on praise with his or her young children. Whatever the climate of the organization, the bottom line is that employees and students need feedback on their performance. In the absence of any praise whatsoever, they will have a tough time sustaining motivation to improve; or worse their confidence may erode. Zenger and Folkman in their Harvard Business Review article [1] on the ideal praise to criticism ratio state that "Negative feedback is important when we're heading over a cliff to warn us that we'd really better stop doing something horrible or start doing something we're not doing right away. But even the most well-intentioned criticism can rupture relationships and undermine self-confidence and initiative. It can change behavior certainly, but it doesn't cause people to put forth their best efforts."

If praise is over-used or not genuine, however, the receiver will likely be suspicious, especially if the feedback is too vague or broad sweeping:

> "You all are wonderful" is a saccharine statement unless coupled with a specific behavioral observation. It would be better to say "You have done a great job here with your commitment and attention to detail, which helped us formulate a better course of action."

If you find it hard to spot any positive behaviors and you fear your praise will sound hollow, pick a neutral behavior you can honestly support:

> "It's obvious to me that you did a good job getting sufficient information from the patient (acknowledgment). What you need to work on is organizing it for the presentation: put it in a logical format that will be easily followed by the attending physician" (corrective).

"I" Statements

"I" statements are comments made from your own perspective and/or observation. A common mistake in giving feedback is to use a third party as intended validation of the feedback. For example, "Others have told me that…" or "It is commonly known in the department that…." This use of third party typically backfires because it elicits defensiveness. The receiver of the feedback usually begins to debate "I wonder who the others are" or "The rumors are flying around the department," rather than focusing on the feedback they need to hear. If you suspect an issue is a concern, or someone has in fact brought it to your attention, it would be much better *not* to attribute the feedback to a certain person but again, make an "I" statement. "I saw you excel in this area at last week's rounds" or "I observed you rushing through that appointment" are much stronger statements because they are more direct and based on first person data.

Because I Said So

Sometimes, you will find yourself in a position of needing to help develop someone who has limited insight in changing his or her behaviors. Anyone with teenagers will tell you that quality feedback delivered with care and empathy still may have its

limits. After trying the approaches mentioned in this chapter, you may need to clarify (or re-clarify) expectations. "What I need you to do is _____ and the consequence of you not doing it is _____." Take a deep breath. Do not beat around the bush, and stand firm without apology.

Receiving Feedback

As a receiver of feedback, especially critical feedback, allow yourself to relax and listen. Treat the data as neutral and not a personal attack. It can be difficult for any of us to hear negative criticism, especially if we feel it is not deserved or ill intentioned. When faced with criticism, take a deep breath and repeat this mantra: *I am open to ideas from others*. Catch yourself if you begin to rationalize or place blame on others, which may give the impression that you are blocked by self-defensiveness and not really ready to learn.

Additionally, if the feedback is complimentary, don't excuse it away. Instead, let the accolade in. You did a good job. Be sure to thank those providing the feedback, and let them know that you heard it. When people see you taking their input seriously, it not only inspires them to trust you, but it also creates an environment where this kind of conversation is encouraged.

Conclusion

When you listen well and ask clarifying, open-ended questions *before* you give feedback, you stand a much better chance of motivating the receiver to change problem behavior or continue on a path of good behavior. Always acknowledge demonstrated strengths whenever and wherever you see them. This approach paves the way for engagement and motivation, and a much greater likelihood of creating sustainable and durable solutions.

Feedback pearls	Feedback pitfalls
Set the context for regular and timely feedback	Ambush others with negative feedback
Internally check your intentions	Give feedback when angry
Self-manage	Overreact
Use "I" statements	Use a third party, as in "People tell me that…" which backfires because it elicits defensiveness
Start with open-ended questions	Use closed-ended questions
Look for the strength(s)	Over-use praise
Insert a positive comment somewhere in the conversation	Lie
Listen carefully before giving feedback	Assume you know the details/solution/answer

Feedback pearls	Feedback pitfalls
Use formative statements	Use evaluative statements
	Start a conversation with “Can I give you some feedback?”
Be hard on the problem, but soft on the person.	

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Chapter 4
Navigating Conflict

Leilani Raashida Henry

"Peace is not the absence of conflict but the presence of creative alternatives for responding to conflict—alternatives to passive or aggressive responses, alternatives to violence."

—Dorothy Thompson, Journalist and Time Magazine Woman of the year 1939 (with Eleanor Roosevelt) [1]

Introduction

Conflict Is Integral to Life

Organizations minimize or maximize conflict by the health of their environment. Healthy environments are like healthy water. The greater the condition of the water, i.e., clean, clear, pH-balanced, the greater tool the water becomes to sustain life. The health of the ocean (and our bodies) depends on the perfect acid-alkaline balance. At optimal ocean pH, diverse life forms thrive. If the pH is off by just one-tenth, coral dies and aquatic life suffers. It's the same for individuals, relationships, and organizations. When workplace environments are at their 'optimal pH', expectations are clear, responsibility is taken, and the environment brings out the individual and collective best. This balance unlocks gifts of breakthrough, learning, and innovation. Our workplace is one main environment in our lives. When conditions are outside the 'normal pH range' we see an increase of undesirable behaviors, poor outcomes, and greater conflict. Unhealthy conditions demotivate, slow progress, and perpetuate a toxic work environment. Physicians, students, staff, and patients suffer.

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_4

What Is the Key to Minimize or Navigate Conflict?

Think coherence. Coherence is being in sync, in harmony. From the state of coherence, people and systems can better handle conflict. Especially in an academic medical setting, people often choose to work in that environment for reasons other than salary alone. Most people want to contribute their talents and make a positive difference. If the organization removes barriers to the work and supports the diverse ways faculty engage, people and systems can then move from defensiveness or conformity to coherence.

Indicators in Organizations

When the "pH" of an organization is too acidic, it leads to hostile, passive-aggressive, undermining, or antagonistic communication. Passivity, indifference, or lack of engagement emerges in overly alkaline conditions. An optimal pH range fosters a willingness to accept responsibility and to focus on continuous learning.

Regardless of why conflict occurs, time and attention must be paid to redirect the situation back on course. The challenge is to recognize disagreement as early as possible, determine its source, and commit to growing from it in healthy, productive and harmonious ways. Create the conditions for healthy conflict in yourself and in your organization. Extraordinary results are born from organizations that give people choices and expect them to own their choices.

Anatomy of Conflict

> *"It is a fact that the bitterest contradictions and the deadliest conflicts of the world are carried on in every individual breast capable of feeling and passion."*—Joseph Conrad, Author [2]

It takes effort and rigor to overcome the apathy that comes with negativity. Conflict can be directed within ourselves or outward towards others, or to the entire organization. It can escalate from resistance, disagreement or opposition. What are the collective assumptions we hold that prevent us from successfully dealing with conflict? Which of these assumptions about conflict sound familiar?

- It's too difficult, painful, draining and time consuming.
- Resistance is ongoing; once it starts, it is hard to stop. Habits are hard to break. It will never get resolved.
- Judgments or decisions are made, policies are set, and they can't be reversed.
- We like it this way, why change?
- We don't need any more awareness or dialogue. If we ignore it, the conflict will go away or resolve itself.

- It's the wrong time to test this new idea; we're too busy doing more important things
- It's not a priority-we need to focus on higher priorities.

It's easy to develop aversion to conflict. Unhealthy conditions for conflict are pervasive in organizations. The culture can make it hard for practitioners, researchers, administrators, and staff to function. We make things more complicated by hiding the "elephant in the room" or "sacred cows"—ideas protected from criticism or comment.

On the other hand, provoking conflict in some organizations is a value or norm. For example, when competition between departments is desired over collaboration, chaos and fighting are heightened. With employees, hurt feelings may arise from unintended consequences such as lack of recognition, awards, or bonuses. For some, this could easily result in demotivation.

The following pitfalls exacerbate conflict and defensiveness. Which ones do you recognize?

- Find blame or fault for one individual, instead of checking the team, system, or process.
- Lack of trust creates the fear of speaking up. Employees don't believe their ideas will be considered, or they feel indifferent.
- Lack of transparency or inclusion. Decisions are made at the top of the organization with little or no input from lower levels (faculty, staff, and administrators). What goes into the decision is hidden or unexplained. It becomes 'do it' rather than 'let's do it.' Employees are not considered key stakeholders. Consider this example:

  In a community hospital, management is concerned about biohazards. A rule was made not to have water bottles on desks, but rather be stored in one central location to prevent the spread of germs. During the first implementation of this rule, a nurse left her bottle on her desk and it was removed. The nurse asked her supervisor, "What is the true purpose of this new policy? Why would someone be touching my personal water bottle on my desk anyway?" Her supervisor refused to engage in the conversation and said, "Because I said so."

  All water bottles were required to be stored together in the designated, appropriate place. A week later, the whole department got the flu. The people who did not store their bottles in the designated place did not get sick. Eventually, management concluded the policy wasn't useful.

- Unwillingness to have mediation or facilitation. Chronic conflict sometimes requires intervention from a third party. Often organizations and leaders deem this unnecessary or not valuable. The attitude is "I can fix it" or "the conflict will fix itself." Consider this example:

  An academic department has ignored a situation for more than two years. Two distinguished faculty physicians have an interpersonal conflict that has now created factions within the department. The two sides barely speak to one another. Even if people agree that something needs to be done, they won't speak up in faculty meetings or other public venues. The department chair recognizes the conflict but refuses to seek support to work on the situation. Everyone is miserable, the conflict is unresolved, faculty morale is poor, and the quality of clinical care is suffering as a result.

- Lack of accountability or follow through on deliverables or time frames.
- Micromanagement. There is constant "looking over a person's shoulder," making decisions for others that they need to make, and speaking for others.
- Power plays. Some people take all the credit behind the scenes; others put the focus on games of guilt, blame or shame. Sometimes people don't share information because it undermines their value to the organization or to their position of authority. Competition is rampant and built in to the environment.
- Differences of opinion, perspective, education or experience handled as, "I'm right and you're wrong" or "this is nonsense," creates conflict. Sometimes visible differences provoke discomfort and lead to conflict. Some of the ways we are visibly different are race, gender, culture, sexual orientation, physical ability and age. Assigning labels instead of building relationships causes harmful conflict (see Chap. 10.)
- Organizational conflict. "Over-acidic" environments create undue conflict by the type of rules, structures, and management styles present. How rules are implemented may also cause conflict.

Dealing with Conflict

Establishing healthy conditions for dealing with conflict requires commitment to take measures to reduce unnecessary confrontations. Sometimes acting to reduce the frequency or intensity may be the first line of response. You need to learn the skills to navigate as conditions change. Ultimately, you need to be proactive. To what underlying issue or challenge is the conflict pointing? Discover the source. Become clear about the what, how, who, when and why of the situation. Make and keep agreements, with all participants in the conflict, regarding how to operate in the future. When the actions of others don't coincide with stated fundamentals, take a chance at being vulnerable.

Be willing to share your experiences and feelings with others. Ask questions, and state opinions for clarity. Providing consistent clear communication and stating desired objectives to key stakeholders are of key importance. Avoid complaining and distracting side conversations. Take time to make the fundamentals clear through conversations, meetings, and written expectations.

Organization Conflict

Organizations set the tone for healthy conflict when they maintain a 'healthy pH' within the work environment. The following are apparent in a healthy organization climate:

- Roles are clear; people know how they fit into the larger whole (organization's vision and values).
- Leadership models the desired organization principles/environment/agreements.

- Everyone is held accountable for the same rules and standards. Accommodations made are clearly communicated.
- Communication and trust between all levels is optimized.

This kind of climate can be achieved by creating inclusion, streamlining processes, and shedding light on conflicts, through dialogue.

Create inclusion. Lack of agreement doesn't mean it is ok to ostracize a member or encourage gossip. Leaders need to establish rapport with everyone to increase collective synergy. Even the scapegoat or outlier has something valuable to add. The leader may not resonate with the messenger, but the message may be important. Do young residents feel combative? Are tenured faculty acting superior? Do faculty or colleagues second guess female physicians? Do medical staff, who are not in the majority, feel unwelcomed? If any of these are present, there may be underlying patterns to address. When differences are welcomed and encouraged, a positive foundation for conflict resolution is built.

Streamline processes. Where are the blockages or duplication? Anger or disengagement occurs when people disagree about "who needs to do what by when". For example, who can step in to answer certain questions in lieu of the attending physician? Which shift turns the patient over? Whose budget pays for expenses or expansions? Leadership can facilitate and resolve competing priorities and financial overlap.

Shed light through dialogue. In what ways or areas has your organization stopped learning? How is the quality of communication between groups/departments? How well does the team recover from mistakes? Acknowledge what makes the collective successful. Reinforce what's working. Listen and ask for ideas to improve organizational conflict. Go slowly to gain more understanding of the collective challenges and opportunities as a group. Unveil deeper questions and ideas that need to surface. Use the Inquiry Circle dialogue exercise (Table 4.1) to gain needed insight.

Interpersonal Conflict

> *"We judge others by their behavior. We judge ourselves by our intentions."*—Colonel Montague Jocelyn King-Harman, Author [4]

Once the conditions for healthy conflict in the organization are in motion, it's easier to work with interpersonal conflict. We must unpack the distance we feel toward others. Through empathy and compassion, seek to know what is unknown. Connect with the thoughts, experiences, and feelings of others. Check for understanding. Identify assumptions by listening for what's not being said. What's behind the question? Consider the intent of others as valid. This strategy may reveal what is blocking harmony. Where does this conflict fit into a larger pattern? Elevate your perspective to see the connections. Consciousness and awareness replace ignorance and stagnation. By discovering the whole story, common ground emerges.

Table 4.1 The inquiry circle exercise [3]

1. In small groups of 5–6, or with a partner, pick a general topic, such as *conflict at work*. The goal is to build collective intelligence through dialogue. One person starts and asks an open ended question that is on his or her mind. Choose a direction to go around the circle, either clockwise or counterclockwise.
Sample Questions—*What difference would it make if we could see the thoughts of others, like a thought bubble over the person's head? What difference would it make if we had 100 % agreement on the direction we need to go?*
2. The next person responds with a thought, feeling or what comes up for her as she hears the question. There is no need to search for the perfect "right" answer. All responses, feelings and thoughts are valid.
Sample Responses—*I think people would be more honest and reveal more about themselves and their perspective. We might stop bumping into each other, be more productive, and have fun at work*
3. Then, that same person ends with a new open-ended question.
4. The next person responds. They can take their question in any direction, whether or not it links to the prior question to which they responded.
5. Continue for 3 rounds. It's important for each person to only respond to a question when it is his or her turn. This method builds listening and creative tension.
6. After the last person gives a response, he or she poses one final question, to which no one responds.
7. Debrief on the themes, insights, and observations that surfaced. This process will naturally open dialogue. New ways to view issues and resolve challenges will unfold.

Be willing to engage**.** At times, navigating conflict requires strong interaction. Sometimes tempers rise before they cool. Escalation could be an adequate, temporary outcome. Things that have festered need an outlet. Stop being an intentional agitator of conflict. Break the cycle by being conscious and responsible for your feelings and actions.

Remember that when you interact with others there is much below the surface, like an iceberg. If we stay on or near the surface, we may react, instead of respond. When we respond, we unravel the whole story. The "Iceberg Model" (Fig. 4.1) is a healthy way to go below the surface and take a learning stance. With a learning stance, conflict becomes information which can be used to effectively address change. Use the Iceberg Model to navigate interpersonal conflict.

Case Study: Using the Iceberg Model and Inquiry Circle Effectively

I was hired to work with Sarah who leads a large nursing unit at a university. The university is aware of the extreme conflict on her team, and her provost wonders about the continued attrition in her department and the poor feedback from internal customers. There's backbiting, undermining, blame, and lack of trust in the environment. Ideas aren't shared; information is hoarded; inefficiencies abound and responsibilities overlap. Employees report feeling micromanaged. No one has stopped to address the myriad of problems. The strategy

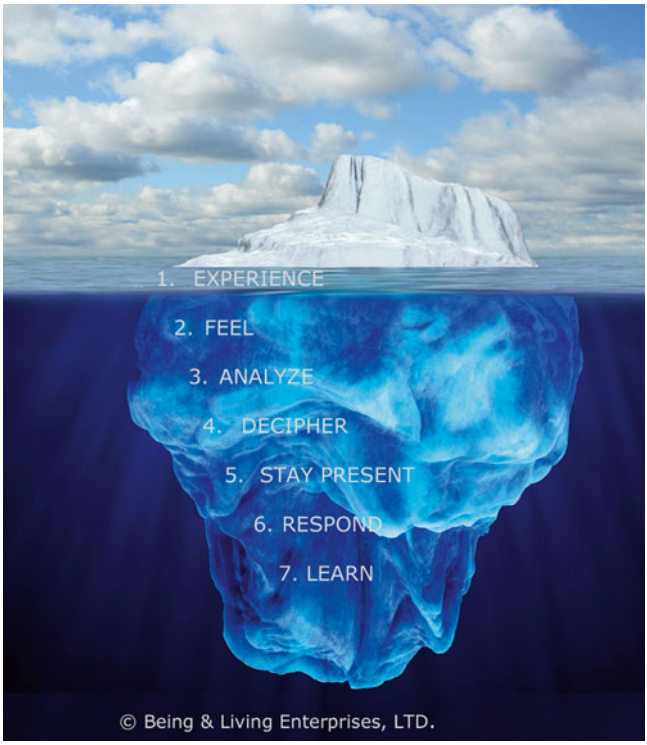

Fig. 4.1 The Iceberg Model [5, 6]. (1) EXPERIENCE: Something happens. e.g. "*I'm accused of racism".* (2) FEEL: Emotion arises. There is discomfort or comfort. Avoid judging the feelings to make them good or bad. e.g. "*I feel victimized".* (3) ANALYZE: The mind searches for a belief or assumption to make sense of what happened. Be unbiased. e.g. "*Even good people make mistakes".* (4) DECIPHER: Keep neutral, as you compare it to another experience or look for analogies. e.g. "*It's like stepping on someone's foot on the dance floor, and the person is limping from the pain.*" (5) STAY PRESENT: In spite of the past, remain open to what is happening in the moment. e.g. "*I feel beat up and helpless.*" (6) RESPOND: Communicate what happened. Stay curious about intent and be open to possibilities. Let go of assumptions that no longer serves you. e.g. "*I've come a long way with respecting those who seem different. We, collectively need to be sensitive and aware of the past, while staying present and engaged to create what we want together.*" (7) LEARN: Allow for unexpected ideas and insights to surface through reflection with yourself and in dialogue with others. e.g. "*Let's train everyone in using healthy dialogue and practice the skills daily"*

Sarah developed to fix the issues was for the department to work on relationship building by having parties. The latest party (for Halloween) was the last straw for the departmental dysfunction to explode.:

Sarah and her leadership team performed a skit in blackface. Though they claimed it was not done to hurt anyone and seemed to them an innocent Halloween gesture, the skit went sour. Many of the employees were disgusted by the costumes and makeup. The leadership seemed unable to acknowledge or care that students and faculty were outraged by their actions.

After sharing the Iceberg Model with Sarah, she agreed to participate and train the whole department on the skills of dialogue (i.e., inquiry, advocacy, deep listening and

challenging assumptions, as reflected in the Inquiry Circle and Iceberg Model). The goal was to surface trauma many people had been feeling for years. Through various weekly exercises, we walked through the Iceberg model using the Halloween experience as a case study. Employees started to become vulnerable with one another, sharing stories of their experiences. Sarah recognized, owned, and apologized for her mistakes. Empathy and forgiveness became more common. Relationships were repaired, and team work improved. By mapping the work flow, issues of redundancy that had fueled conflict were uncovered. Arguments about tasks were significantly reduced. Agreements about how to move forward were designed and kept. The work environment returned to a healthy balance, and the nursing unit reestablished its top rated reputation in education.

Personal Conflict

"Everything that irritates us about others can lead us to an understanding of ourselves."—Carl Gustav Jung [7]

We have the most control within our internal environment, our inner selves. Through the quality of our hearts and minds we may influence our organization's environment. Each of us has 100 % responsibility for how we show up at work (and in life). If we lack coherence, we risk fueling conflict. Ever start your day rushed, or irritated, or without coffee or breakfast? By the time you get to work, you may be ready for a fight. Under stress, we are preoccupied with our own problems, our own drama. It is difficult, if not impossible, within this mindset to empathize with others.

To minimize the destructive aspect of conflict, inner coherence is the key. When we are at ease, centered and focused, people around us are affected positively by our presence. Also, we become resilient when we own and communicate to others our contribution to conflict (see Chap. 6).

When we practice self-reflection, we become better at disseminating choices and making conscious, well thought-out changes. Inquiry helps us recognize our shortcomings and our strengths. Ask yourself: What does the conflict trigger within me? What am I missing? What do I need to unlearn? Take responsibility for your feelings, thoughts, decisions and actions. What do you need to heal within yourself? What is triggered in you? "Heal thyself," as you reach out to others and stay balanced in the face of conflict with others. Identify what drives you to build relationships.

Seek advice from a mentor or confidant. This process can help smooth the rough spots so you can clearly see what and how you need to respond to a conflict situation. Sense the inner and outer signals for when it's time to respond. For example, notice others' tone, face or body language that doesn't match their words. This discordance may indicate that space is needed for them to more fully process, rethink, or rephrase their statement. Prioritize what's important. Some conflicts take more time than others to resolve or process. Welcome feedback from others. Compliments and constructive critique helps you stay connected to yourself and your abilities.

Internal conflict can act as a mirror. When we acknowledge this paradox, we are closer to forward movement. When you recognize a conflict within yourself,

stop—breathe and reflect—and then act. Have patience with yourself. The absence of 'inner peace' creates discomfort and can result in a lack of acceptance toward others. This pattern can ignite the cycle of conflict with others. Turn your own resistance into curiosity. With heightened awareness, you can shift more easily.

Body-Mind Exercise [8]

Often we have two opposing feelings about the same situation. For example, "I love my profession" and "I feel drained by the lack of cooperation at work." What does your body feel like with each statement? You may switch from an open posture to a closed posture respectively, with each statement. Notice: How do you carry your head? Is it held upright, as you state "I love my profession"? Do your shoulders slump when you say, "I feel drained by the lack of cooperation at work"?

What body part is holding the most tension? Explore that tension by feeling its intensity. On a scale of 1–10, (10 is high tension), what number do you give the discomfort? As you think about each statement, what colors, shapes, sounds come to mind? Breathe deeply from your belly, three times. Then, pick one of these five environments to work with:

- the ocean;
- an emerald green forest;
- a favorite cultural event or restaurant;
- the blooming desert with a beautiful sunset;
- a gorgeous mountain top vista.

Put yourself in the environment you have chosen. Feel your heart soak up the experience of the smells, tastes, sounds, uplifting feelings, textures and sights. Take three more deep belly breaths. Repeat the statements, e.g. "I love my profession" and "I feel drained by the lack of cooperation at work". Then ask yourself again, what number do I give this tension now? Discover any changes in your state of mind and body.

As a practice, is best to move stuck energy in your body by acknowledging and releasing, rather than ignore it or push it aside. Our body-mind connection is stronger than we think.

If a primary outcome is synergy - the synergy within us, in our relationships, our teams and our organizations, then it is our thoughts and feelings that hold the key to navigating conflict. Dr. Masuru Emoto, distinguished water researcher and author said, "The message from water is to look inside ourselves." [9] Dr. Emoto took the very first images of frozen water crystals. His healing effects of water research with over 10,000 patients recognized the power of water. Famous for measuring the effect of words on water containers and natural bodies of water, he took pre and post pictures of frozen water crystals. In his lab, he put water in glasses and wrote different words on the side of each, then froze the water into crystals.

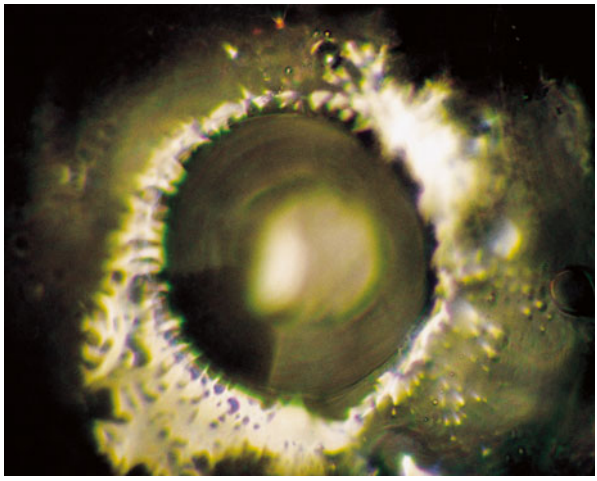

Fig. 4.2 "Do it" frozen water crystal

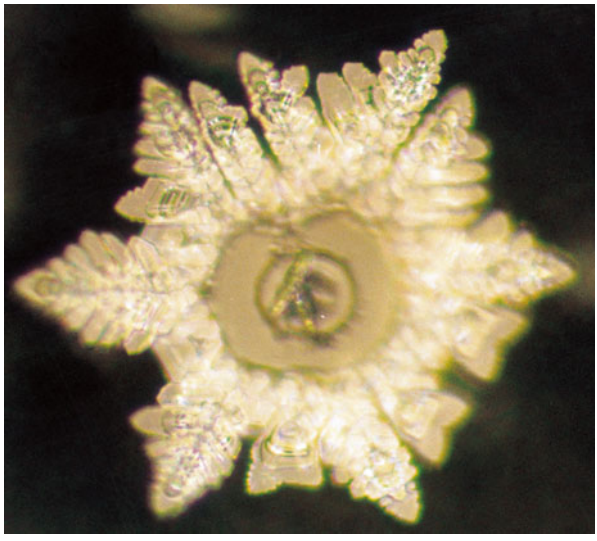

Fig. 4.3 "Let's do it" frozen water crystal

What is the difference between the words "Do it" and "Let's do it"? Typically, the first phrase is a directive. The second phrase is an expression of unity or support (Figs. 4.2 and 4.3).

Notice the visual complexity and appeal in the two images. Through his renowned frozen water crystals research, Dr. Emoto has captured a visual representation of the power of words and intention. Often conflict arises from a lack of cooperation, presence or connection. Saying "Let's do it" and "Thank you" reveal the beautiful, balanced crystals created from respectful communication. Dr. Emoto concluded, "Water is a mirror reflecting our mind." [10] (Fig. 4.4)

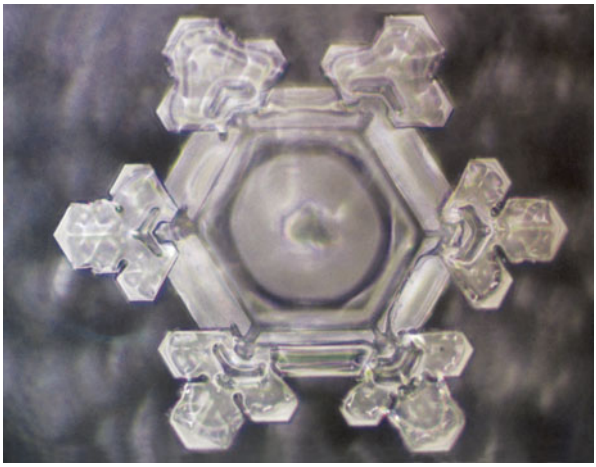

Fig. 4.4 "Thank you frozen water crystal". Frozen crystal examples of "Thank you", "Do it", and "Let's Do it". Courtesy of Office Masaru Emoto, LLC [11]

Conclusion

Our presence and skills make the difference in how well conflict is prevented, reduced or navigated. Practice the following skills [12] to build leadership coherence.

Promote Dialogue: Conversation Fosters Change:

- Notice and unravel thought processes, assumptions and beliefs
- Give full attention to all parts of communication, including feelings and nonverbal messages
- Escalate and de-escalate conflict appropriately
- Use disagreement as a tool for learning
- Engage in storytelling. It draws out people's interests and views. Telling stories makes people think.

Handle Differences: Conflict Is Easier if You:

- Invite feedback from others
- Ask questions to ensure understanding
- Negotiate for mutually beneficial solutions
- Appreciate the value of silence to let things sink in

Balance Your Inner pH:

- Deal with stress easily and quickly
- Integrate physical, emotional, mental and spiritual parts of the self
- Be honest with yourself and others
- Practice emotional intelligence, be aware of your own and others' feelings

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Chapter 5
Managing Your Time

Anthony J. Viera

Introduction

A career in academic medicine is challenging. Success generally requires achievements in multiple domains: clinical work, teaching, and scholarship. In addition, a faculty member is expected to be of service to her department, university and discipline. Given the large number of demands, expectations and opportunities in academic medicine, it is exceedingly easy to become overcommitted.

Striking the right balance between work and non-work (e.g., leisure time or family time) is also critically important to overall health and to avoid burnout. In the pursuit of academic goals it is important not to constantly sacrifice time away from loved ones or relinquish other activities that bring personal fulfillment. Yet, the successful pursuit of academic medicine often requires working beyond "regular" work hours.

When asked about barriers to work goals or new initiatives, "lack of time" is sure to be commonly cited by faculty members. Of course, time is a zero sum game. You can never get more of it. A commonly assumed myth is that there will be "more time later." The skill to be productive is to be able to *manage* your time effectively.

Time-Consumers vs. Time Traps

Some academic medicine activities require a good deal of necessary, time-consuming attention, such as patient care and teaching. Major portions of these activities (e.g., the actual time seeing patients or teaching students) are often on a

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_5

strict schedule. On the other hand, there are many non-scheduled activities that consume much more time than they actually should. Examples of these traps include responding to emails, dealing with interruptions, or meetings that run long. These two broad categories of activities, scheduled and non-scheduled, require different strategies of time management. Generally speaking, you want to maximize efficiency for the time-consuming activities and minimize (or eliminate) time traps. Doing so will permit more time to devote to other academic pursuits such as writing scholarly articles, conducting and pursuing research projects, or developing new curricular materials.

Patient Care

Clinical time is generally the most fixed time in a faculty member's schedule. The amount of time allotted to clinical work is almost always less than the amount of time it takes to complete all of its tasks. Given an ever increasing list of responsibilities such as completing electronic health record documentation, call-backs, electronic communications with patients, and filling out forms, it is important—to the extent possible—that you complete clinical tasks during allotted clinical time. To help preserve precious minutes, become as efficient as possible completing documentation in the electronic medical record (EMR) system. Use templates and other built-in shortcuts to reduce documentation time. If necessary, *invest* time to receive tutoring from someone skilled with the EMR. Choose a certain block of time per day that you will use to respond to patient phone calls and electronic communications, and complete forms and other peripheral tasks. Make sure your support staff know your preferred procedures for handling these so as to minimize interruptions to your schedule.

It is recognized that physicians generally rely on clinical work for a portion of their salaries, and financial incentives tend to favor clinical work. Gravitation towards a large amount of clinical work, however, will likely come at the expense of other academic endeavors, especially those that require a significant amount of writing (scholarly manuscripts or grant proposals). Be mindful where you may overextend your clinical time investments.

Teaching

Many physicians are drawn to academic medicine for the opportunities to teach medical students, residents and fellows. It takes substantial time to develop a well-organized lecture. It takes even more time to develop a lesson that involves active learning or an engaged classroom. If you are a course director, you have the additional tasks of organizing all of the content and coordinating the teaching faculty.

To maximize time savings, it is useful to align, as much as possible, teaching with other scholarly activities. For example, develop courses that overlap with your research, or author a clinical review on a topic that you teach the residents. These allow one of your time-invested activities to support another.

Time Traps

Electronic mail (e-mail) is probably one of the most common, and overwhelming, time traps. Given the ease with which communication is accomplished via e-mail, it is both a blessing and a curse. It's efficient on one end, and yet it is easy to see why a faculty member may receive 150–200+ email messages per day. Thus, it is easy for an important message that requires timely action to get lost in the sea of non-critical email. It is also very easy to "get behind" on e-mails. To minimize its effect on your time, you need to have a strategy for handling e-mail.

The first option (and no doubt everyone's favorite) for handling an e-mail message is to *delete* it. This option is appropriate for the many informational, irrelevant, or junk e-mail messages. If an e-mail message requires action but someone else can take care of it, then *delegate* it (i.e., forward it with instructions) to that person. If a message requires your response and you can type it succinctly and clearly, then go ahead and *deal* with it, ideally, as soon as you read it. If you cannot deal with it immediately, mark it to come back to as soon as you can. When an e-mail communication requires a lengthier explanation (or is about a sensitive issue) or will undoubtedly lead to ten other emails, you should probably *defer* it to a phone call or in-person meeting. Using one of these Four D's (Table 5.1) to handle e-mail can help make it more manageable.

Perhaps the time when you are most vulnerable to e-mail overwhelm is when you come back from vacation, especially if you opted to truly unplug and not check e-mail. To wade through the 1500 emails in your inbox upon your return can easily take a full day (or more). An alternate strategy is to have a few times during your vacation when you check your e-mail, with the idea that you benefit by not having such a volume to handle when you return. Perhaps the most aggressive strategy is to set your auto-reply to say something like, "I am out of the office for the next two weeks and all e-mails received during this time are automatically deleted. If you need me to see your message, please re-send it when I am back in the office."

From the manager/leader perspective, it can be valuable to provide guidance to faculty and staff about best practices using e-mail. For example, you can instruct people to put "time sensitive" in the heading if something truly requires a quick

Table 5.1 Handling electronic mail

Delete it
Defer it
Delegate it
Deal with it

response. When someone has a heavy workload week or is on travel, an auto-reply letting others know responses may be slower that week may be helpful.

Meetings can also be a time-trap, especially if they are informational-only. Try to avoid scheduling full days of meetings, which leaves little time to attend to other tasks. If you have to build in travel time to get to meetings, consider whether you can attend by phone. Not only will you save the travel time, but you may be able to participate in the meeting and get some other tasks done while at your desk. From a manager or leader perspective, consider delegating a meeting's attendance to another faculty or staff member. Such an approach not only can save you time, but also can be good professional development for the person who attends the meeting on your behalf.

The Four P's of Time Management

Nearly every book on time management covers the same basic principles centered on organization and prioritization. To summarize the critical tasks of time management, use the Four P's: plan, prioritize, "pack" for productivity, and persevere.

Plan

The first step in managing your time is to plan how you will spend it. Planning needs to be specific and task-oriented. In other words, plan what you will do—the actions you will take, the items you will accomplish. It is helpful to have lists that are organized around what will be done by the end of the day, end of the week, and end of the month.

A must-have is a calendar that can be viewed easily, every day. It may be useful to keep a paper planner/calendar to keep daily, weekly, and monthly tasks. The ability to quickly (without any wi-fi or electricity) glance at an entire month will help you plan most efficiently and effectively. If you prefer an electronic calendar, it may be useful to keep a printed copy of it on hand, to amend and refer to it anytime. Additionally, if you have an administrative assistant who has access to your calendar, it is vital to train and educate that person on your preferences for scheduling meetings and commitments as well as to what requests they can say no. It can be very alarming (and time consuming) to find surprise items on your calendar.

Prioritize

The Four Quadrants Framework, popularized in Covey's *The 7 Habits of Highly Effective People*, is one strategy to help you prioritize [1]. Using this framework, you consider the tasks on your to-do list in terms of their urgency and importance

Table 5.2 Example of using Covey's Four Quadrants Framework for prioritizing

	Urgent	Not urgent
Important	I	II
	Many patient care issues (e.g., critical lab value)	Clinical quality improvement
	Grant (deadline) writing (a reality, though it's better if can be in quadrant II)	Mentoring
	Student grades (deadline) or issues	Brainstorming
	Current research project enrollment	Manuscript writing
	Crises (e.g., personnel issue)	Book chapter (might be quadrant IV depending on career stage)
		Spending time with spouse/partner, family and friends
		Exercising
		Long-range planning
Not Important	III	IV
	Most phone calls	Most e-mail
	Many meetings	Most paper mail
	Most interruptions	Trivial tasks
	Informational reports	Social media
		Catching up on television shows (especially binge-watching)

(Table 5.2). Covey notes that that activities in the urgent half of the table are things that "act on us." [1] Instead, you want to be doing things that get you closer to your goals.

The key is to prioritize so that you can spend as much time in quadrant II as possible. Quadrant II is where you are typically most creative, most productive, making your most valuable contributions, and hopefully, where you are most fulfilled.

Delegation is a good strategy to allow you to spend more time in quadrant II. Tasks that do not require your personal handling should be delegated to someone else, as much as possible. Another key strategy for minimizing the non-important activities is the ability to tactfully set boundaries with others on phone calls, interruptions, or chatting.

Pack for Productivity

When you are at work, be fierce with your time, and try to make every minute count. Your day likely includes transit times (e.g., from hospital to clinic, or clinic to lecture room), "down-time" waiting for something (e.g., a meeting or lecture) to start, a few minutes to eat lunch, and "in-between" times (e.g., between patient visits or between one meeting and another). Certainly, some of these moments are appropriately used to chat with colleagues or to catch a quick breather. But it has been estimated that up to

20 % of the physician's day is spent in these moments [2]. With your backpack or carrying-case packed with the proper items (e.g., article to read or peer review, smartphone or tablet PC, paper to grade, voice recorder, slides to review), you might be surprised what you can accomplish with small bites of time spread over the day.

Robert Jackler, an otolaryngologist at Stanford Medical Center, calls this strategy making use of the "interstices of the day." [3] Applying one of the Four D's above to e-mails is a good use of one or more of these interstices. You may be able to accomplish a phone meeting during one of your time gaps. You might even be able to write a paragraph for a manuscript or grant proposal. The idea is to make use of the interstices to gain productive time.

Persevere

Ultimately, the key to being productive in academic medicine will stem from perseverance. There will no doubt be times when you simply do not succeed at being productive. Think of that most recent day that began with very good intentions, setting aside a block of time to work on your proposal, manuscript or book chapter, but you became distracted (probably mostly by quadrant IV with a little quadrant III mixed in), and 3 h went by with no progress. It is your perseverance that overrides the desire to give up and brings you back to working on your quadrant I or II task.

Perhaps you have had the experience of finally piecing together (over several months) the 60 h it took to write a paper, only to have it rejected on its initial submission. Here too, you must persevere. You have already invested a lot of time in the project. You need to identify if there are ways to improve the paper, revise it, and submit it to another journal. The same goes for grant proposals, which go unfunded far more often than they are funded (see Chap. 6 for more ideas).

Perseverance is not only about sticking with your plan to complete your projects; it is also about eliminating, or minimizing as much as possible, the tendency to procrastinate. The prioritized to-do list and the organized calendar only work if you stick to them. If you find yourself frequently putting off the tasks you set out to accomplish, reflect on what is happening that leads you to procrastinate. Lack of necessary skills to do the task? Seek a mentor who can provide guidance. Putting off the tasks you hate doing (but you nevertheless have to get them done)? Consider mixing some time to completing undesirable tasks with a reward: some time devoted to a task that you prefer. You may not get the undesirable tasks done as quickly, but at least you will get them done.

Maintaining an Overall Balanced Life

People often use the term "work-life balance" to denote a separation between time spent doing work and time spent not doing work. Indeed, it is very important for one to spend time with family and friends, as well as on hobbies, exercise, and

enrichment activities. A problem with the term "work-life balance," however, is that it implies that "life" is all the non-work stuff. The fact is that work is a part of life, and ideally, a very important and defining part. Hopefully, you enjoy (most of) your work and it brings pride because of the contributions you are making. As such, there should be nothing inherently wrong with doing some work while at home.

Robert B. Taylor, in his book *Academic Medicine: A Guide for Clinicians*, lists several myths about academic medicine. Among the myths he lists is the following: "Your job description includes a lot of time to think, do research and write." [4] The reality is that most academic physicians do much of their scholarly work during evenings and weekends. Thus, work at home becomes commonplace for the academic medical faculty member. The key is knowing how and when to make adjustments.

There will be times—perhaps many—when it is appropriate that work time tips the "balance scale." For example, if you are up against a writing deadline (e.g., a grant proposal), you will devote extra time to work until the proposal is submitted. At another time, you may have a particularly busy clinical week (e.g., inpatient service) with several call nights. There will be other weeks when you can work fewer hours, and devote more time to non-work activities. Vacations, of course, should tip the scale completely in the opposite direction. In between tipping the scale completely toward work and completely toward personal time, the goal should be to maintain the harmony that is right for you and your loved ones.

When you feel the balance is too far tilted toward work, a helpful strategy is to add things to your non-work life. Structured non-work activity helps keep work from driving everything else out. For example, have scheduled exercise time, or make Saturday afternoons family picnic/game time, or take dance lessons with your spouse/partner. Balance, then, has nothing to do with a division of clock-time, but rather is about whether you are spending time meaningfully as judged by you and others in your life. To use an old cliché, it is important to take time to smell the roses.

When You've Stretched Yourself too Thin

One very powerful tool that you should have in your time management toolbox is the ability of kindly saying "no." When you first join an academic department, and your plate is relatively empty, it is not the time to use this tool. In fact, saying "yes" early on to the many opportunities that come your way can be a valuable way to build your portfolio of activities. Doing good work is also how you make a name for yourself and become the person who is asked to do more (it is the paradox of the busy academician). When you are feeling stretched thin, however, the ability to say "no" is important. By virtue of being a busy person, you also have more legitimacy in doing so. Saying something like, "That sounds like a great opportunity, and I know the work is important, but if I take it on I will have to give up…" (something else that you are doing that is important such as your research, your teaching or a service activity). In the end, it is better for all involved that you are not so over-committed that either your work or well-being suffer.

Table 5.3 The investment-productivity matrix

		Productivity or positive yield	
		High	*Low*
Investment of time or energy	*High*	Star	Problem child
	Low	Cash cow	Dog

When you are at the point that you need to scale back your activities or commitments, it is advisable to take a systematic approach to the decision. One method is adapted from the business world's growth-share matrix (also known as the Boston Consulting Group matrix). Here, let's call it the Investment-Productivity Matrix (Table 5.3). Think of your "portfolio" of academic activities and projects. Place them into one of four categories:

- *Cash cows*—these activities require little investment or commitment to keep them going and they generate some level of productivity (or positive yield) for you
- *Stars*—these projects are ones that are growing; with some additional or ongoing investment they could turn into cash cows
- *Dogs*—these activities are not resulting in any "productivity points" for you; they require investment without much (if any) yield; these are often older activities
- *Problem children*—these are also called "question marks" because it is difficult to tell whether (with the right investment) they will turn into stars; these are usually newer activities and could be thought of as "risky"

You probably want to keep your cash cows and devote your energy to the stars. In the business world, the "dogs" would be sold; these are the activities you should consider dropping or delegating away. Your "problem children" are the ones that may require more thought. You might consider some too risky, whereas there will be others on which you want to take a chance.

Conclusions

Ultimately, there is only so much that you can control. The key to being as productive as you can be—while minimizing related stress—is to manage your time well. It is truly your most valuable resource. When skilled in this area, you will achieve greater success in all the domains of academic medicine. Most importantly, good time management also helps you have an overall balanced life.

Pearls and Pitfalls

- Evaluate and monitor how you are spending your time
- Use the Four P's to be productive with your time: plan, prioritize, pack for productivity, and persevere
- Spend less time on the unimportant; get in quadrant II
- Delegate; even seemingly small, repetitive tasks can add up to a good deal of time
- Kindly say "no" when appropriate
- When overcommitted, drop activities that are requiring your time without much yield ("dogs")
- Don't neglect yourself or your loved ones
- Add structured (protected) time for non-work activities

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Additional Resources

Allen D. Getting things done: the art of stress-free living. New York: Penguin; 2015.
Covey SR. The 7 habits of highly effective people. New York: Free Press; 2004.
TED Talk on work-life balance. http://www.ted.com/talks/nigel_marsh_how_to_make_work_life_balance_work?language=en

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Chapter 6
Developing Resilience

Doug Silsbee

Introduction: The Need for Resilience

A central question is now in front of us: How can the academic healthcare leader intentionally build resilience as a leadership capacity?

In an effort to answer that question, my colleague Bev Wann and I have spoken with scores of individuals over many years. These conversations have included dying patients, nurses, physicians, and Chief Executive Officers (CEOs). More far-reaching interviews have also included grass-roots development leaders in Africa, Special Forces trainers, people who thrived despite growing up in desperate slums, and remarkable people from many walks of life who seem able to maintain their focus, energy, and commitment no matter what is going on around them. From these conversations, we have identified five core elements that have surfaced, over and over, as essential to resilience.

We have taught these elements to health care, business, government and non-profit leaders, internationally and throughout the US. Consistently, the feedback has been that these lessons, drawn from extraordinary people at the edges of human experience, are also relevant to the rest of us. We have seen that, with this map of the territory, a reasonable on-going commitment to developing resilience has tremendous pay-offs in effectiveness, energy, optimism and persistence.

Physicians, healthcare leaders, and hospital administrators are buffeted by changes as the industry undergoes seismic shifts in response to ballooning costs, the Affordable care Act, accelerating competition and consolidation, new technologies, and new threats such as pandemics and antibiotic resistant bacteria. Stress and overwhelm can seem the order of the day.

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_6

Developing a personal capacity for resilience, while it does not immediately change the context that produces the stress in the first place, must be an essential component of any leader's strategy for staying effective in a tumultuous environment.

Elements of Resilience

The central elements (Fig. 6.1) that can serve as focal points for developing resilience are: Purpose, Perspective, Partnerships, Pro-activity, and Practice. Each covers a lot of territory. The power of each element is enabled by a sixth: the inherent capacity to choose where to focus and direct one's attention. Energy and action follow attention and awareness. It follows that choosing where a leader places his or her attention is at the core of maintaining a capacity to be resourceful and creative.

Resilience can be defined as "*the capacity to be resourceful and creative, to make choices, and to take effective action, no matter what is going on.*" In essence, this capacity involves making a conscious choice to exercise agency and to manage our attention independently of our context. In the language of Jewish psychiatrist and author Viktor Frankl, "the last of the human freedoms is to choose one's own attitude, regardless of the circumstances." [1] While Frankl came to this realization while surviving 3 years in a Nazi concentration camp, his hard-won and liberating insight is universal, and applies in today's complex and pressure-laden academic medical center. Resilience is, in effect, the cultivation and maintenance of this sometimes elusive but always relevant understanding.

The academic healthcare leader is working in a context of competing commitments. Clinical, teaching/mentoring, administration, and research responsibilities

Presence Developing the capacity to direct and focus attention.

Purpose	Maintaining a clear and unwavering focus on who and what the work serves.
Perspective	Choosing, from a range of possible perspectives, the ones that are maximally freeing.
Partnerships	Creating alliances with those who share value s, goals and purpose, and can advance the work.
Pro-activity	Focusing on what can be done, rather than on obstacles, and staying in action.
Practice	Engaging in consistent and supportive physical, fun, and body-mind practices that are restorative.

Fig. 6.1 The elements (Six P's) of resilience

each provide unique challenges. Each is demanding; collectively these challenges can feel overwhelming.

A traditional stress management approach offers tactics such as breathing, exercise, conversations, time and priority management as ways to reduce and manage stress. While useful, these are often responses to specific symptoms of overload and stress. Stress management is most often a set of competencies targeted at the squeakiest wheel of a busy professional's work-life. This approach is different from a comprehensive and lifelong strategy for building the underlying capacity for resilience itself.

Developing the meta-competency of resilience enables the leader to respond to life's curveballs with consistent creativity, resourcefulness, and leadership presence. Like a health care intervention focused on underlying causes rather than treating symptoms, a resilience strategy is profoundly developmental, rather than tactical. It produces long-term effectiveness and satisfaction, rather than simply short-term comfort and relief.

Resilience requires practice. The five elements are entry points. Developing a personal strategy that incorporates these multiple elements will much more reliably support a leader's capacity to stay creative and resourceful.

Purpose

It is time we steered by the stars, not by the lights of each passing ship.

—Omar Bradley

As a consultant I worked for years with the American Red Cross blood collections organization. Frustrated by demanding and unpredictable schedules and by detailed, technical, and constantly changing regulations, nurses and other staff would often vent their feelings to me.

Yet, when I asked people why they did what they did, their eyes came alive, and each said "I save lives." It was very clear to each person at the Red Cross that, while their specific job might be drawing blood, working on a loading dock, recruiting blood drive sponsors, or testing blood in a lab, ultimately they were providing life-saving blood to people in real need.

When we talk with people from all walks of life about <u>who</u> or <u>what</u> is being served by their work, as distinct from talking about the work itself, they become more energized and passionate, they light up, and a new vibrancy comes into their voice. The difference is self-evident.

Resilient leaders are connected to purpose. They have identified a purpose that is personally meaningful and resonant, and they find ways to embody that purpose by putting it into action on a daily basis. Purpose becomes an organizing principle that energizes and guides them. Ask yourself:

- What is my purpose?
- For the sake of <u>what</u> do I do what I do?

- How intimately can I articulate the connection between what I do, and who is being served by what I do?
- What do I do daily to remind myself of that connection? *(e.g., In the Ronald Reagan Building in Washington, DC, senior leaders for the US Agency for International Development have large photos of the children in poor third world villages that their efforts ultimately serve.)*

Perspective

We can't control the world, but we can control how we think about it.

—Walter Mischel

Resilience results from the recognition that our understanding of our worlds, no matter how real and solid it appears to be, is largely subjective. To be sure, there are stubborn facts with which we must engage in the course of our daily life. Yet, we have much more flexibility in how we engage with those facts than we often recognize.

Lucy, a friend of mine, had ovarian cancer. She came to see her illness as a "training partner." In this perspective, the difficult decisions, physical pain, and fear she faced every day became opportunities for Lucy to practice self-awareness and active engagement in her own healing process. Recognizing that her time might be very short, she began doing things she had always wanted to do and speaking more honestly to the people she loved. She repeated over and over that her life-threatening illness helped her discover a great vibrancy and joy in life that had not been nearly as accessible before her illness.

Our attitudes, and the filter or lens through which we see and interpret what is in front of us, are enormously subjective and open to change. Resilient leaders actively choose liberating and energizing perspectives over ones that are disempowering and constrictive. With discipline, time, and practice, we can internalize liberating perspectives so that they become our truth. Out of this newborn resilience come optimism and the ability to see creative opportunities in the dimmest of circumstances.

Frankl's resilience, derived from the internal locus of control that his wisdom represents, was instrumental in his inspiring transcendence of one of the most traumatic experiences that a human can endure. Lucy's resilience was drawn from her discovery of fortitude and engagement, but derived from the same principles. Any set of challenges can, if seen as such, serve as the practice opportunity for a choice of perspective. Resilient people understand that a generative perspective is theirs for the choosing. A leader must select his or her perspective wisely, as over time it becomes truth. Ask yourself:

- What perspective do I currently have on a situation that I experience as limiting or frustrating?
- What alternative perspectives are available for this same situation?
- What evidence can I find to support each of these other perspectives?
- Which perspective is the most liberating, energizing, and irrepressible?

Partnerships

If we are together nothing is impossible. If we are divided all will fail.

—Winston Churchill

Humans are by nature social animals; we function in relationships. Working skillfully within the web of relationships in which we exist is key to getting things done and to leading a fulfilling life. Resilient leaders cultivate partnerships that help accomplish goals and support their energy and optimism. Resilient leaders also find strategies for minimizing the negative effects of relationships that are draining.

Rick is a Chief Medical Officer in the late stages of a long career in a large Northeast US hospital system. He was tiring of the unrelenting administrative load, and his clinical work was no longer fresh. With the encouragement of his CEO and several other clinicians, and based on observations that many system leaders were high individual achievers with poorly developed leadership and interpersonal competencies, they established a pioneering Physician Leadership Development Program (PLDP), focused on cultivating the capabilities of up-and-coming leaders.

Rick describes the process as providing rich learning. Facing initial stiff resistance, he found common cause with other key leaders and built partnerships of shared interests. With more widespread ownership, other influential leaders came on board, including some high profile clinicians who initially disparaged the initiative on the grounds that the medical meritocracy was a proven means for determining future leadership. Having shared "skin in the game" for this initiative built a collective ownership of the PLDP process and catalyzed a much more dynamic and collaborative culture. The PLDP has been a model that has since been replicated elsewhere.

With respect to his own leadership, Rick has also benefited personally from this inspiring late career initiative that was both challenging and developmental. Ask yourself:

- Who shares my interests in a challenging situation?
- Which relationships provide support and increase my energy?
- What helpful support or resources could I request?
- Of whom might I make this request?

Pro-activity

God, grant me the serenity to accept the things I cannot change,
the courage to change the things I can, and the wisdom to know the difference.

—Serenity Prayer

Charles, now in his late twenties, grew up in the slums of Nairobi. When he was a young child, he lived with his four siblings and parents under a few sheets of plastic draped over sticks wedged into the dirt. Later, they moved to a corrugated

iron shack. When his parents died from AIDS, he had to take care of his siblings by whatever means available. Over the years, starting with cutting hair in a tiny barbershop at age 11, he found ways to bring in money. Friends and one brother didn't make it, dying violently or through endemic addiction, prostitution, and crime. Through grit and persistence, Charles transcended his conditions, and now supports his siblings through an entrepreneurial mashup of making jewelry, driving taxis, fixing electronics, selling rugs, and hustling odd jobs.

Staying in action as an active participant rather than an inactive passenger is a key to resilience. Pro-activity requires identifying actions that are most likely to bring about results, and then taking them. As many cancer patients can testify, maintaining some sense of control is key to their spirits, and ultimately to healing.

Pro-activity is the antidote to "learned helplessness [2]," a debilitating psychological state in which a person comes to believe that whatever she does will not make a difference. We see this condition on the factory floor, in highly regulated health care environments, in resource-deprived communities around the world, and in the faces of both cancer patients and their physicians who sometimes feel overwhelmed by their ability to make a real difference.

Pro-activity requires accepting the things we cannot control and maintaining the attitude that in any situation, we can find something that we can control, i.e., some action we can take. Focusing on what we can do is far more empowering and enjoyable than paying attention to all the reasons we cannot do anything. Ask yourself:

- Which facts of my challenging circumstance is it time to simply accept?
- In what circumstance do I tell myself there's nothing I can do, when in fact I do have real choices?
- What is a simple action, right in front of me, that I haven't let myself do?

Practices

> *To keep the body in good health is a duty…*
> *otherwise we shall not be able to keep our mind strong and clear.*
>
> —The Buddha

I spoke recently with Ruth, a 65-year-old academic clinician in a large hospital system. Ruth is a marathon runner, completing some three or four marathons a year. She has no interest in breaking records, but clearly recognizes that her extraordinary health, vitality, and resilience are direct benefits of the rigorous training that marathons require. She also speaks eloquently of the perspective shift that is required at about the twenty mile marker when every muscle in her body wants to quit, and where she finds deeper wells of persistence from which to draw. This perspective shift serves her equally well when her combination of clinical, teaching, and mentoring responsibilities becomes overwhelming. In fact, when this happens, she thinks about her running, taps into the same well of determination, and remembers that all marathons have an ending.

Some practices are self-evident. Regular exercise; time to read, relax and play; and a decent diet are widely recognized as being restorative. Other practices such as weekly quality time with grandchildren, dates with loved ones, or walking the dog also can recharge the emotional batteries. The key for health care leaders is to recognize that their capacity to lead well and to heal others depends largely on maintaining their own health, stamina, and resilience.

Resilient leaders have a strong set of self-care and health maintenance practices that are habitual. Ask yourself:

- What do I do on a regular basis that is restorative?
- What routines have I used in the past that were consistent, released stress, and increased my vitality and energy?
- What practice can I engage in, starting now, that will support my resilience?

The Sixth Element: Presence

The mind is everything. What you think, you become.

–The Buddha

I spoke with Frank, an F-16 pilot, about resilience. The joystick in an F-16 cockpit carries out more than 100 different functions, depending on combinations of stick motions and buttons. Training includes aerial dogfights where the pilot takes on up to 17 "enemy" aircraft simultaneously. There is no time for thinking: a pilot must become so intuitive, present, and at one with his extraordinary machine that the plane is an extension of his body. In a very real sense, the nervous system of the pilot and the controls of the plane become one interconnected system. The pilot's quality of presence coupled with the extraordinary maneuverability of the F-16 design allow the pilot to get inside an enemy pilot's decision loop, creating such confusion that he quickly has the upper hand.

Neuroscience research is showing that repetition of a behavior or action, with full attention, leads to a rewiring of the brain. This neuroplastic change results in the embodiment of new neural pathways associated with habits, behaviors, and resilient states that then become increasingly available to us. The more we repeat a particular action or behavior, like calming ourselves in the middle of chaos, or choosing to speak up when we are afraid, or exercising a new action in a difficult situation, the more that behavior becomes part of our repertoire, becomes part of what is "normal" and available to us.

Similarly, resignation, overwhelm and learned helplessness are in fact trained habits. They are perspectives based on a story about the world, rather than an objective description of the world. Repeatedly telling ourselves that we have no choice embeds this belief more and more deeply until it becomes an unchallengeable truth; our very habits then prevent us from seeing the options that are available.

We can identify and practice that which builds resilience, creativity, and resourcefulness. Just as we can build our abdominal muscles through crunches, we can build resilience through practices that exercise and develop our attention and that enable

us to be increasingly self-generative in work and in life. We can practice a particular perspective that is enabling, or practice making requests to build stronger relationships and support. We can practice directing our attention to something that is calming in the midst of conflicting demands.

This capacity for presence, for choice in the heat of action, is trainable. A tremendous body of research has been developed over many years about the physiological and resilience benefits of mindfulness [3] and body-mind [4] practices, such as meditation, yoga, tai chi, and martial arts. These practices, through repetition, build a new capacity to steady and direct our attention to reliably lower blood pressure and reduce symptoms of stress [5] and to develop the inherent capacity to access creativity and resourcefulness.

Further, since the human nervous system is capable of tremendous change and growth throughout our entire life span, these practices establish new neural pathways and default areas of activity in the brain. In essence, body-mind practices are reliable ways to build the underlying physiological support for resilience that allows a physician or first responder to stay calm and effective in the face of overwhelming trauma, an administrator to artfully and effectively facilitate a contentious strategy meeting, or a nurse to calm a panicking patient through her reassuring voice.

Body-mind practices will have benefits when done consistently for as little as a few minutes a day [6]. Body-mind practices result in present-moment awareness, central to the meta-competency that leverages the previous five elements. Presence reliably increases our access, over time, to greater resourcefulness and creativity, awareness of new possibilities, and increased energy and aliveness. In short, presence directly produces resilience itself. Ask yourself:

- If these claims might be true, what are the potential payoffs for me?
- What experiment might I design to research this for myself?
- How can I integrate a simple body-mind practice into my daily routine?

Conclusion

The bottom line? Resilience is a birthright. No combination of complexity, urgency, or competing commitments can deprive an academic physician, hospital administrator, or clinician of this inherent capacity. Certainly some circumstances are more challenging than others. Yet the human is well-designed to be resilient, creative, and resourceful, and these challenges can be seen as the very playing field upon which resilience can be developed.

Pearls and Pitfalls

- It is a trap for the leader to think that current stressful circumstances will pass and things will "go back to normal." More likely, the current situation *is* normal, and the leadership context is highly likely to get more chaotic and stressful in the

future. The pitfall is to simply endure or manage stress symptoms "for now," postponing a more fundamental approach.

- Leaders cannot manage themselves through developmental challenges. New technical skills and more efficient processes can alleviate immediate conditions. However, these are short-term fixes. The deeper developmental questions will remain, and the leader can choose to take on the developmental work of building capacity now, or wait until even more challenging circumstances make it even more difficult. Sooner or later, the investment must be made in the development of the self.
- A powerful perspective is to see that the very challenges and stressors that can seem overwhelming, in fact, create the rigorous conditions that require the leader to evolve, to develop, and to move to a new level of leadership presence and resilience. It is possible to reframe these challenges as catalysts for development.
- Recognize that the investment in resilience is a lifelong process, not a short term response to a crisis, though it might begin with the latter.
- Develop a strategy that includes several of these elements, and includes at least one body-mind practice that will be consistent over time. Revisit and update this strategy periodically so that it stays fresh and front of mind. The payoffs are enormous, but it will also take some investment in conscious attention.

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Additional Resource

You can subscribe to a free series of emailed resilience practices at http://presencebasedcoaching.com/subscribe or view resilience videos and find more information on Doug's website at http://presencebasedcoaching.com.

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Part II
Management

Chapter 7
Principles of Management

Warren Blank

Introduction

Manager and leader are two key organization roles. Managers are assigned their role and rank and a set of staff (i.e., "direct reports," or "subordinates"). Leader is a role one "takes" to meet a need with the goal of gaining willing followers. Effective managers know how to also take the lead. Leaders do not have to be managers. Effective managers understand their role. They also are aware of their managerial style. Perhaps most importantly, they know how to demonstrate a high level of "managerial intelligence."

The Manager Imperative: What It Means to Be a Manager

Lane manages a lab of research scientists. Every day while commuting to work Lane considers the question, "What do I need my staff to do today to accomplish our goals?" Lane understands the "imperative" that managers demonstrate: the capacity to "get work done through assigned staff."

The "Managerial Imperative" has three important elements:

1. The work or tasks—For a research lab manager like Lane, this includes directing staff to create research protocols, conduct clinical trials, prepare research reports, etc.
2. The goals, outcomes, or desired results—Lane set goals for staff, such as enrolling specific numbers of clinical trial participants by certain dates.
3. Assigned staff—Lane recognizes that managers direct and staff "do."

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_7

Application Ideas

1. Set clear goals with your staff so they understand what must be done.
2. Clarify specific tasks and establish work schedules with staff so everyone knows their assigned tasks and how they lead to goal achievement.
3. Remember a manager's job is to direct staff to do the work. Engage staff in a discussion about how much direction they need, and when they want you to support their work without being a micro-manager.

Managerial "Style:" What Kind of Manager Are You?

Managerial style refers to the overall manner, approach, or a fairly consistent pattern of behavior managers take when interacting with their staff. There is no one "best way" to get things done through staff. Effective managers are adaptive. Just like a clinical professional knows how to assess a patient to make a diagnosis, successful managers know how to assess situations to determine more effective approaches. Such assessment means they take into account the requirements established by organizational guidelines (e.g., defined protocols for specific medical procedures), recognize the boundaries of time limits that affect goal achievement, and understand their staff's individual work preferences, needs, and motivations.

Managerial style varies on two key dimensions: the way managers direct staff to accomplish tasks, which can be labeled the "performance management style;" and the way managers relate to staff in any and all interactions, which can be called the "people management style."

Consider Terry, who manages a medical team in a large teaching hospital. Terry relies on a "tough" performance management style: "Do it this way and do it right," is a common remark from Terry. Compare this with Kerry's performance management approach. Kerry also manages a team in the same hospital. "Let's work together to determine how to get this job done," is Kerry's typical approach.

People management styles can also vary. While tough on performance, Terry takes time to build positive interpersonal bonds and show sincere concern for staff needs. Terry does care and respect the work of the staff team. Kerry takes a lower involvement people management approach. Kerry is more aloof with and does not get too involved with staff outside task activity discussions. What impacts a person's performance management versus people management styles?

A manager's style develops based on many factors. Personality traits affect a manager's manner. For example, more introverted people display a different style than those who are extroverted. Kerry is easily drained by too much interaction with staff that is not work related. Kerry's introversion, the need for "me time," limits his social interaction with others. Terry is an extrovert who enjoys and gets energized by the comradery created through non-task related interactions with staff. People with a high need for achievement might lean towards a more performance focus. Such a need might partly explain Terry's more forceful performance management style.

Table 7.1 Best and worst boss styles

Best boss	Worst boss
Trust Honesty Integrity	Controlling Micro-manager Dictatorial
Respect Compassion Empathy	Abrasive Cold Liar Disrespectful Uncaring Angry
Commitment Coach Courage Visionary Strategic Fun	Abusive Overly Emotional Abrupt
Approachable Passionate Energetic	Distrustful Dishonest Yells
Knowledgeable Responsive inspiring	Manipulative Arrogant Distant
Hard worker Clear goals Mentor	Lacks Knowledge Noncommunicative
Good communicator Politically Savvy	Unapproachable Apathetic

Style also evolves based on the way people have been managed by their parents, teachers, and previous bosses. We model what we experience and adopt a mindset, "This is the way to approach others," because it is the dominant model we experienced. Most of the bosses Terry admired and excelled under were very demanding on task while also being more personable. Kerry's style mirrored the managerial style of those who made a difference during her formative work years.

While there is no one best style, research from the staffs of over 5000 managers reveals a consistent overall portrait of "best" and "worst" boss styles that have a more positive effect on staff performance, morale, and engagement (Table 7.1) [1]. This research reveals that more effective managers tend to be firm and focused regarding performance (e.g., set clear goals and measure results) as well as cooperative and congenial with people (e.g., demonstrate respect and show empathy). Less effective managers approach performance demands with the "hammer" (e.g., dictatorial, "Do it my way, or else!") and do not show sincere concern for staff needs (e.g., cold and abrasive, "My job is not a popularity contest.").

Effective managers realize their style is not fixed. They cultivate "best boss" style and know when to alter their specific approach to maximize fulfillment of the managerial imperative: i.e., "get work done through assigned staff."

Application Ideas

1. Assess yourself using the best-worst boss list. Think of the last few performance interactions you had with staff (e.g., you directed them to do work). How would you describe your manner with staff? If you moved into the worst boss list in some way (e.g., you became overly controlling), what caused that behavior? Think also of the last several exchanges with people that were not directly performance related (e.g., a staff member struck up a conversation with you while waiting for an elevator or while walking down a hallway). To what extent and in what ways did you demonstrate interest and concern during these encounters? What may have caused you to be somewhat distant or to demonstrate a limiting interaction?

2. After reviewing your self-assessed style in these situations, congratulate yourself if you were consistently best boss style based. If necessary, consider how you could have altered your manner. What could you have said or done differently?
3. Ask trusted allies to review the best-worst boss list to give you specific feedback on your actions. Use their feedback to modify aspects of your style to match circumstances.
4. Accept that examining, refining, and adapting your style is an on-going process based on changing circumstances. There are situations when being more directive (even tending towards being very directive) is needed. For example, consider an emergency room where the medical team faces a life or death situation. A directive approach in that setting may be very appropriate. However, recognize that applying such an approach broadly (e.g., always being a "hard-nosed," grueling task master) may limit your managerial effectiveness. Consider managing a ward made up of highly qualified personnel who know what to do and how to do it. A very low directive, hands off performance management style might yield better results. On the other hand, taking a high people, low performance approach may not always be the most useful way to deal with staff. Consider a team of young, inexperienced research assistants who are not precise in carrying out experimental protocols. A more firm, even demanding approach might be necessary and add more value than being "warm and fuzzy." Adjusting and adapting to your situation requires "Managerial Intelligence."

Managerial Intelligence

Managerial Intelligence (MI) is the capacity to fulfill the managerial imperative (get work done through assigned staff) with an adaptive style. MI stems from understanding one's self and others so you can take action to implement the managerial imperative. MI is also a function of "grit," which is the capacity to work hard, to persevere in the face of difficulty, and to ultimately make things happen. MI is an on-going developmental challenge. Effective managers continually hone their craft just like an effective medical professional continually works to be a more competent doctor, researcher, or teacher.

A high level of MI results from mastery of two foundational skills: building positive relationships (which relates to your people management style) and clarifying expectations (which encompasses your performance management style). MI mastery also means you understand and know how to take action related to the 3 R's of effective management: clear and agreed upon Roles (the designated position of "manager"), Requirements (i.e., the specific tasks or duties of the role), and Rank (i.e., formal authority). The foundation and 3 R's skills are interrelated and, when implemented well, form a more coherent managerial approach.

The Foundational MI Skills

It's all about relationships. MI begins with relationships (people management style) because every interaction affects the quality of relationships. Whether you are directing interns during rounds or having lunch with staff, your behavior creates a form of relationship with others that leaves an impression and affects future exchanges. At least 50 % of organizational problems stem from poor relationships between and among people [2]. Effective managers build trust, develop rapport, and create respect, more effectively motivating their staff to fulfill their jobs (the managerial imperative). Such managers are highlighted on the "best" side of best-worst boss lists.

Alexi, a hospital senior manager with whom I worked, greeted every staff member on a first name basis without looking at their name tag. Alexi knew each person's job role and could easily chat with any staff member about job and non-job issues (e.g., a professional development course a staff member was taking or the new car a staff member just purchased). I was amazed when I observed Alexi's ability as we would walk the halls while discussing the training program I was scheduled to teach at the hospital. I asked Alexi for the secret to this ability. "It is important that I know my people to help them perform better and to feel more comfortable working here and with me. I memorized their personnel folders when I came on board. I practiced matching their picture and name. I continually ask staff about what's going on so I can make a connection when I see them." What was most amazing to me was there were 1400 people working in Alexi's hospital. Think of the number of people on your staff. Consider how many you interact with on a daily basis. Develop and demonstrate your MI by taking similar action with the people on your staff.

Application Ideas

1. Work on relationship building every day because every interaction counts. You can use each interaction as a way to enhance your relationships and display a best boss-like people management style.
2. Use the brief moments when you see others (e.g., waiting for an elevator, when you sit next to someone in the few minutes before a meeting starts, or when you pass someone's open door and notice them sitting at their desk) to take an interest in staff. If you know your preference is to be more introverted, focus these interactions on a work exchange (e.g., 1–2 min of, "How are things going today?"). If your comfort zone includes being more outgoing, and staff are comfortable with it, use these interactions for non-work exchanges (e.g., "What's going on this weekend?").
3. Carve out longer periods of time to get to know staff's motivations, needs, desires (e.g., a 10 min discussion over lunch or coffee about, "What got you interested

in the medical profession?" or "What are your goals for this job?" or, "What are your career aspirations?")
4. Let others know you! Relationships are reciprocal and people open up with those who open up with them. Find ways to talk about your interests and motivations as part of your relationship building time. Self-disclosure begets self-disclosure.
5. Periodically allot just a few minutes in meetings for "acquaintanceship" discussions. For example, ask each staff person to take 30 s and describe "A unique experience I had today/this week was…," or, "My favorite vacation spot is…," or "My most satisfying job experience is…".

These moments of "relating" establish a bond of community with staff, create a sense of personal commitment between people, and simply make the tough challenges of work and life more enjoyable because they connect us to others.

Expectations guide perception and behavior. "What we expect is what we get" is a well-documented principle. For example, the health of a percentage of patients who are prescribed placebos without their knowledge does improve. This classic placebo effect in medicine is a function of expectations. Similarly, recall a time when you were told a new staff member was, "hard to deal with." In your first interaction, you noticed an aspect of the person's behavior that immediately triggered the comment and caused you to perceive the person as difficult. It is not that we do not have the ability to be more objective and to observe what is actually happening; but given all the data we continually process about so many aspects of our life, we rely on preconceived notions (i.e., expectations) to shape our actions and to guide the actions of others.

A second step in developing MI is to emphasize the importance of setting clear, consistent, and agreed upon performance expectations. This step seems so easy when we think about it. Yet, recall a time when you left a meeting conducted by someone else and you asked a trusted ally, "Do you know what we're supposed to do?" Almost everyone has had this experience. In circumstances like this, people often do not ask for clarification because they do not want to look foolish or like they were not paying attention. They also may have the expectation that they are the only ones who do not fully understand performance expectations. In my research, training, and consulting work, I find that at least 30 % of organizational difficulties originate from unclear, unmet, or unexpressed expectations [2].

Expectation clarification relates to three important aspects of task management: the Must, Could, and Should of performance. Successful managers clarify expectations with staff to be totally clear about what "Must" be done. For example, Leslie, a lab director, meets with staff every day to review specific assignments and outcomes to be completed and the established procedures staff must apply. Effective managers also engage staff to clarify "Could" performance expectations. For example, Leslie mutually develops an approach with staff to conduct experiments and to consider alternatives that maintain research rigor. Finally, best bosses reinforce expectations with staff about what "Should" be done to achieve desired performance standards. This component reflects the values imbedded in expectations. Leslie demonstrates positive values by frequently using specific examples to

remind staff that quality and precision are essential and should always be the standard they use in their work.

Expectation clarification also includes how staff work together as a unit. Managers achieve higher performance levels when they establish positive group norms with staff to define what constitutes appropriate behavior. Such norms could relate to how staff address disagreements about work schedules. Managers must also set expectations about how their style affects the staff. For example, Bennett was a more aloof, hands off medical staff manager who ran into difficulty because the staff expected him to be available and approachable. Their previous manager had functioned this way, so the expectation had been set that, "I can talk to my manager whenever I want." Once this expectation was clarified, Bennett was able to define boundaries of availability that supported both his and everyone's expectations, and identified what behaviors staff deemed as more and less approachable. Bennett and the staff found it much easier and more productive working together after clearing the air about this expectation.

Establishing clear and agreed upon expectations is an on-going process. The standard should be that to always verify that you and your staff have shared and agreed upon performance expectations before taking action. An effective surgical team manager makes sure everyone is on the same page before starting a procedure. The expectation defined by the "carpenter's creed," measure twice and cut once, is essential in such situations.

Application Ideas

1. Always remember that everyone has expectations and people get what they expect. Behavioral economics research reveals how expectations shape biases [3]. Consider how the bias that people get what they expect plays out in a medical setting. Expectations that elderly patients are "fussy and hard to deal with" may negatively affect patient care. The bias that a specific subject, "Is not relevant to what I need to know," reduces motivation to master content, or triggers one to ignore important information. Remember that it is essential to continuously clarify your (and the organization's) expectations about outcomes, tasks, and acceptable methods.
2. Continuously uncover what staff expect so they do not just, "go along to get along," with your expectations. Ask for and verify that everyone understands and agrees to the same expectations.

   Consider concluding interactions with staff in group meetings and one-on-one discussions with an inquiry about what must, could, and should be done to verify that expectations are clear. Use the "two-sided" question to accomplish this:

   One Side: "Does everyone know what to expect about… (e.g., a particular task)?"
   The Other Side: "What expectations are not completely clear about … (e.g., a particular task)?"

The value in the two-sided question is it avoids the problem of people not wanting to admit they are unsure or unclear about expectations (caused if you only use Side One) and it opens the door for more subtle inquiries (through The Other Side question) even if people are clear about Side One.

3. Whenever possible clarify the "Why" or "Because" behind expectations that you set for staff.

The Why factor has been shown to minimize a negative response to managerial direction and to increase commitment to action. For example, doctors who take the time to listen to patients and then explain the "why's" behind their diagnosis and treatment regimen are less likely to get sued (even if the doctor makes a mistake) than those who do not offer such information [4]. Apply this finding. Explain why a decision was made and/or the "cause" behind why action needs to be taken in a certain way (i.e., perform a task, achieve a goal, etc.).

The 3 R's of Managerial Intelligence

Well-honed MI clearly defines Roles (i.e., job responsibilities), clarifies Requirements with precision (i.e., staff accountability standards), and applies Rank (i.e., formal authority) with an equitable and consistent hand. It is the manager's job to insure staff understand their role and the relationship of their role to other staff. Staff should know the answer to, "Who is supposed to do what?" Successful managers establish roles with staff input so task assignments are defined in a mutually determined and agreed upon way. Engaging staff in this process has the added benefit of building positive people management. Staff are more likely to feel valued when they are involved in decision making, especially when it concerns work they have to perform.

Role clarity also creates clear performance expectations because it ensures that staff have the "ability to respond." An open discussion about roles-responsibility can clarify what support to provide staff. Staff may need varying amounts of coaching, mentoring, or training to develop the necessary competence to respond to work demands. Lack of well-established clarity about responsibility almost always creates problems. Think of the chaos that would ensue in an operating room if roles were unclear and/or if the anesthesiologist was "unable to respond."

Managers are expected to define accountability standards and requirements. This process clarifies to staff that they are being "counted on" to perform tasks and to achieve goals, results, or outcomes. Effective managers clarify the what, when, how, and why of performance matters. A doctor who effectively manages interns on rounds would engage them with the intention to verify that they understand the consequences of an incomplete assessment regarding how a patient presents. Successful managers provide clear and agreed upon measures to evaluate how well staff meet requirements. A research team manager would set the key parameters for an experiment and clarify when and how those parameters are to be monitored.

Lack of clarity about accountability almost always results in performance lapses. Think of the results a teacher would get if students were unclear about assignments, did not understand how they would be tested, or if they did not know what constitutes successful performance on an exam.

The managerial role includes formal authority based on rank. Ultimately, the manager decides what the staff is supposed to do. Best bosses know how to apply the "authority continuum" (i.e., who makes the final decision and how). They avoid simply relying on, "I'm in charge so do what I say!" as a standard response.

Degree of Reliance on Manager Rank

To use the authority continuum (Table 7.2) requires "style adaptability:" A manager must "read" the situation, just like a doctor reviews a chart and assesses how the patient is presenting to develop a treatment approach. Several variables come into play when managers determine how much authority they need to exert. These variables include the goal, situational urgency, level of resource availability, and staff experience and expertise. Obviously, a triage situation requires a different approach than one where decisions about the order of treatment are not critical to success. A research team manager might allow a team member to create their own work schedule if the team just lost five people. This strategy would empower the staff to be more responsible to do added work because they had ownership of the decision. Alternately, in the same situation, the research manager might make the decision alone if the staff typically argued and complained about work assignments. In this case, a more firm application of authority might at least minimize inter-staff disagreements.

Naturally, a manager would also use a different degree of authority based on the skill level of the staff. Less experienced, less confident, less competent staff might seek and be positively responsive to a manager being more directive and explaining what needs to be done. A manager's level of knowledge and skill also plays a role in the degree of authority used. A resident working with highly experienced, expert nurses might defer to their expertise and support their decision rather than impose an idea based on his/her formal authority. In contrast, a world-renowned expert physician might explain, based on having more experience than others, why a decision is being made.

Table 7.2 The authority continuum

Very High	High	Moderate	Low	Very low
The manager decides alone, staff implement the decision	The manager receives staff input, the manager decides either using or not using staff input	The manager receives staff input, the manager and staff make a mutually agreed upon decision	The manager directs staff to decide, reviews the decision, and makes modifications with staff input	The manager directs staff to decide and reviews the results of the decision

Staff Person Responsible	Task 1	Task 2	Task 3	Task 4	Task 5	Task 6

Fig. 7.1 Responsibility chart

Application Ideas

Clarify Roles

1. Create Responsibility Charts (Fig. 7.1). This chart is a simple grid that indicates who is assigned to do what. Tasks are displayed in the columns and your staff's names are indicated in rows.
2. Engage your staff to place a check mark under each column that correlates to the primary person responsible; include a secondary person if and when possible.
3. Display the chart where all staff members can actually see it (on a wall, on a web page—for non-time sensitive tasks). The chart becomes an expectation reminder for the staff member assigned to a specific task and a way to clarify to others expectations about who is responsible for specific tasks.
4. Review the chart periodically on your own and with staff to verify that it is up to date and complete. Revise the chart as tasks or task assignments change.

Define Requirements

1. Have frequent discussions (one-on-one and with your entire staff) about "best practices" so that the shared expectation is always, "How can we perform to our highest level of expectations," (a "could" aspect of expectation clarification).
2. Always remember: "What we measure is what matters. Therefore, what matters is what we should measure." "Measure" can refer to anything that you or others bring to people's awareness. For example, you might make a comment to staff about the specific time frame to complete a task. You could track a process via a reporting mechanism; or, you would document results as part of performance plan. All of these provide a measure of something that matters.
3. Never forget that, "What gets recognized, reinforced, and rewarded gets continued."

Continuously shape behavior by using these methods to set your expectations for action.
4. Continually ask questions that focus on agreed upon responsibilities: "What do we agree is important to everyone?" "What will satisfy us all?" How can we both/all get the job done successfully?"

Define Rank

1. Clarify decision-making standards at the beginning. Explain why you must make a decision without staff input. Clarify when you need other's input and provide the "because" in those situations. Let staff know when you want to decide with others or let them decide on their own with a clear description of the "why" or "because." Clarification up front minimizes problems down the road about the decision process and also clarifies accountability and responsibility.
2. Extend authority to others when appropriate. Give staff a chance to make a choice, developing their confidence and competence. Obviously, this action is tempered by the situation.
3. Review decisions with staff to determine how well they met requirements. Discuss with staff when and how you may need to adapt your use of rank along the authority continuum when making subsequent decisions.

Conclusions

Effective management is challenging and fulfilling. Multiple competing task demands, changing patient preferences, resource limitations, and individual differences create the need for managers to fulfill the management imperative by continuously adapting their style to the situation. To succeed for the long-term as a manager involves the on-going sharpening of Managerial Intelligence by enhancing relationships, clarifying expectations, and ensuring clarity and consistency about roles, requirements, and the use of rank. Best bosses do all this to make a substantial difference.

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Additional Resources

Leadership Group: http://leadershipgroup.com/
Manager Tools: https://www.manager-tools.com/

Warren Blank founded The Leadership Group in 1986, a leadership development firm, and has worked with over 75 Fortune 500 companies and 100 government organizations throughout the United States and in 20 countries. He is the author of five books and dozens of articles on leadership.

Chapter 8
Running Effective Meetings

Ellen Mohr Catalano

Introduction

A common complaint I hear as an organizational consultant and coach is, "I go from meeting to meeting all day, and that leaves me no time for _____" (fill in the blank). Or, "If only I didn't have so many meetings I would get some real work done." Or, "How can I get out of that meeting? It is deadly dull, too long, no one says anything, and why don't they just send me a memo instead?"

A meeting I recently attended provides a typical example of the meeting doldrums. I observed a lack of energy, people doodling, and consulting their cell phones or their laptops. Most significantly, the meeting design had attendees reporting out one by one, with no questions, comments or conversation of any sort. I left wondering just what the meeting leader was hoping to accomplish. I suspected the attendees were biding their time until it was their turn to speak. Yet I know these people to be hard working and committed to their jobs. Surely they were considering what productive things they could be doing if they didn't have to sit there.

Meetings often become a familiar habit, and managers sometimes don't stop to consider how they can make the best use of their attendees' time. Rather, it becomes an expectation to attend, regardless of whether or not it is truly necessary to be present. Further, it becomes an organization norm, often unsurfaced, that if you *don't* attend the meeting you will be branded a "non-team player." Consider reversing this damaging habit and help create meetings where people say the following:

"I'm glad I went to that meeting…I learned something important."

"I look forward to those meetings because they are energizing."

"I look forward to that meeting because I usually leave feeling good about the work that I do."

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_8

"These meetings help clarify important issues in my work."
"I feel welcomed and am encouraged to give input."
"I enjoy hearing from and sharing with the other people in the meeting."
"I trust the meeting leader/manager/supervisor/facilitator to start and stop the meetings on time, to make sure all viewpoints are heard, and to make the meeting a safe place for differences of opinion to be aired."

Hallmarks of Ineffective Meetings

The following are commonly observed behaviors when a meeting is not relevant to attendees or underlying issues are present in the group that are not being addressed.

- People show up late and leave early
- People are on their cell phones/laptops during the discussion
- There is prolonged silence when the meeting leader asks for discussion
- Sidebar conversations are allowed to go on
- Differences of opinion are discouraged, or if someone offers a differing viewpoint they are summarily dismissed
- People focus an inordinant amount of time focusing on details of an issue (drill down into the weeds) which do not concern all or most of the meeting participants
- One person is allowed to drone on or dominate the conversation
- The agenda for the meeting is not clearly stated
- The meeting is allowed to go on past its end time without acknowledgement or request from the leader to extend the meeting time

Types of Meetings

Before the leader decides to make a change in his/her meeting management skills, it is useful to consider the type of meeting that needs to happen.

1. The Check-in:
   The check-in meeting is appropriate for projects that need to be shared because they are relevant to *all* of the participants. For example, the team shares a timeline for the work to be completed or the status of patient care. Simple report-outs may be the best use of time, with time allocated for any clarifying discussion. While standing meetings are useful for staff time management (i.e. can be put on the calendar well in advance), look closely, however, at the need/value for a check-in meeting. As Neal Hartman of MIT Sloan School of Management writes, "Standing meetings with vague purposes, such as' status updates,' are rarely a good use of time." He goes on to say that "When people feel that what's being discussed isn't relevant to them, or that they lack the skills or expertise to be of assistance, they'll view their attendance at the meeting as a waste of time." [1]

2. Inspirational:
   The sole purpose of some meetings is intended to be inspiring. For example, a new product is being revealed, a new manager/leader is being introduced, the team needs to welcome new members, or the team needs to celebrate its accomplishments. When the meeting convener may be introducing a change in the workplace, omit routine items and run a longer meeting to take care of the many questions, emotions, and reactions that change can bring. For example, conduct an exercise where attendees state a past successful strategy for coping with change. This exercise helps to set a positive tone for addressing the range of reactions that change can cause—from negative to positive.
3. Information sharing and/or problem solving:
   This type of meeting occurs most frequently in the workplace. It deserves careful scripting so that employees know what to expect and come fully prepared to participate. First, set the meeting agenda ahead of time and disseminate to the appropriate people. Make sure you, as meeting leader, are clear about the objective(s) you hope to accomplish. Once you've determined *who* needs to be there, create and disseminate an agenda at least a week in advance which lays out the timeframes for the meeting topics. Marsha Green suggests in Duke Today [2] to write an agenda with discussion items and updates, including whether action is necessary. Creating that agenda is also a test for whether a meeting is needed.

What follows is a template based on a one hour meeting. Many experts agree that 60 min is the limit for the most productive meetings. If the agenda can be accomplished in less time, so much the better. If the meeting begins to run over the stated end time, people begin to look at the clock and generally tune out the unfortunate speaker or topic left at the end. If this begins to happen, call a time out, remark on the status of the time and check on the interest of members to remain longer, and if so, how much longer. A suggested 1 h meeting template shown below can serve as a guideline for these meetings.

1 h meeting template		
A.	Gather, greet and agree to norms	5 min
B.	Restate agenda, get agreement, make adjustments to agenda (if needed)	5 min
C.	Routine items (if needed)	10 min
D.	Topic discussion: All ask clarifying questions first before giving opinions and solutions discussion could be 40–45 min if agenda adjustments and routine items are not needed	30 min
E.	Summarize, next steps, and wrap-up with evaluation	10 min

Breakdown of the above template:

A. Gather, greet and agree to norms: It is important to spend a few minutes at the start of any meeting to greet each other.
   Allow a couple minutes at the start to encourage people to chat informally. Oftentimes people are sharing important information or building rapport. If the team is newly formed, allow more time for this so that people can get to know who is in the room and begin to build trust.

Useful questions to ask at the start of meetings: (use only one)
Let's go around the table and hear from each person….

- Any good news or challenges we should be aware of?
- What word would you choose to describe your energy level right now?
- What do you hope to get from this meeting?
- What interests you in today's topic?

(Be careful not to encourage further discussion at this point; this is a warm-up segment and could easily derail the meeting if you begin problem solving too early).

Norms are also known as team guidelines, ground rules, or covenants, and serve as useful reminders of how to do business together. Typically set early on in the life of a group, they can be revisited as often as needed to evaluate meeting performance and make corrections.

Examples of norms are:

1. Timeliness: start and stop on time
2. Be fully present to the conversation: cell phones on silent or turned off
3. Listen fully before judgment
4. Invite others to participate
5. Make remarks concise
6. Allow differences of opinion to be surfaced
7. Honor confidentiality
8. Silence pagers unless absolutely necessary; inform meeting participants at the beginning of the meeting that you may be called away to an emergency
9. Agree to use a meeting recorder or scribe who will promptly disseminate the meeting notes and progress
10. Act on behalf of the team rather on your own agenda; adopt a "we instead of me" approach [3].

B. Restate the agenda and get agreement/adjustments.
Even though the agenda has been disseminated beforehand, make sure it is restated and visibly present on a flip chart, whiteboard, slide, or handout. Get agreement to proceed and check for any needed adjustments, as it is possible that some items may be eliminated or adjusted. Take care to facilitate this discussion, however, so as not to get off course discussing the adjustments. Use the "parking lot" technique to stay focused (recording any unfinished business that may need to be addressed at a future meeting).

The parking lot is a useful way to record and retain information that is introduced at the meeting but cannot be addressed due to time or other factors. A parking lot could be as simple as a piece of flip chart paper taped on the wall where the scribe records the items not to be forgotten. However you keep track of the parking lot items, be careful that they do not get lost in the shuffle, but rather are followed up at subsequent meetings or by emails. If parking lot items are not followed up, people will not take the parking lot system seriously.

C. Take care of routine items, if needed
State that no more than 10 min is devoted to routine items so that the bulk of the meeting can be used to address the pressing topic(s) at hand. Again, use the parking lot to record unfinished routine items.

D. Discuss the topic at hand
Clarify regularly that everyone is encouraged to participate in the discussion and that all input is welcomed. Make sure one person does not dominate the discussion. If necessary, gently interject that other comments are needed before making a decision.

As an example, I know an excellent group leader who runs a meeting of 20–30 people, all of whom have very strong opinions. The meetings run smoothly because he sets a couple of specific rules:

- A certain amount of time is designated for clarifying questions before opening it up to discussion. He firmly guides the participants to rephrase their comments into clarifying questions if they stray into problem solving.
- Once a person has spoken, that person needs to wait until the rest of the group members speak before getting to speak again.

E. Summarization and wrap-up
Summarize any agreements thus far in the meeting, and restate the decision if one has been made. Acknowledge people for their contributions. Don't skip over this step. People want to feel like they have made a positive contribution, whether their ideas were accepted or not. For example, you could say "Thank you for everyone's input; as a result of your participation we definitely had a lively conversation and thus came to a good group decision." Be sure to praise those who model the agreed upon group norms. Also, as part of the summation, ask people what worked well for them at the meeting, and what they would like to improve for the next meeting.

If Conflict Erupts: Look at *Content* and *Process*

In some medical settings, physicians have to make quick decisions. The profession may require that they act fast or a patient may suffer. In other medical settings, decisions can be made more slowly or over a longer timeframe, with options weighed more carefully. This range of decision making styles can produce unhelpful conflict, as one group may exhibit impatience or come to a decision too quickly regarding the issue, or "content," while the other group may feel that they have not had enough input before the decision, or the "process" is faulty. *Content* is the task at hand, the reason the meeting is called. *Process* is the way in which the meeting is held, such as clarifying meeting objectives and making sure people are engaged in constructive conversation before a decision is made [4]. A good meeting facilitator will spot the delicate balance between content (data) and process (style) and

name the potential tension between these two elements that are present in all meetings, without labeling either as "good or bad". For example, the facilitator might say the following as a process comment: "We seem to be moving towards a decision. Are there any comments yet to be shared about this issue?" "Are there any other viewpoints/feelings that need to be shared before we proceed?" (Give time for any responses; don't rush to closure.)

Fun and Other Tips

Don't forget to find ways to have fun at your meetings! For example, look for appropriate ways to poke fun at the rules. A prominent grocery store manager once decided to make a point about employee style of dress. He showed up at the meeting modeling how they should *not* dress by wearing short shorts with holes in them and a low cut tank top over a hairy chest. People at the meeting laughed hilariously and his point was well taken…they remember and dress accordingly. Another example of inserting energy into a meeting is to have people stand and stretch, move around, talk to each other, or play a simple game. Movement works wonders for helping kick the brain back into gear. Also, snacks are always a welcome addition to meetings. People appreciate and feel supported with food and drinks.

Make sure your meeting space is not too hot or cold and relatively free of distraction, or you won't have the full attention of attendees. Make sure people are sitting where they can see and hear each other.

Model meeting effectiveness by starting and stopping on time. This tip is especially relevant for "the boss" or highest ranking official attending the meeting. If this person slips in late and leaves early, it leaves an imprint that the meeting and/or attendees are not that important. Such behavior may be offensive or demoralizing to others.

Conclusion

Meetings do not have to be dreaded. They can be energizing and real motivators in the workplace if you take care of the process as well as the content. You can be both a facilitator *and* leader of a meeting by knowing when you are getting too deep into content and when you need to pull back to run the process. It is ok to say, "Now I am putting on my facilitator hat and calling attention to our time; we need to wrap this topic up in a few minutes. Who would like to summarize our meeting thus far?" Ensure your process success by setting clear agendas and encouraging participation by all members. Ensure your content success by requiring timeliness and succinct comments. Avoid meeting derailers by including the right people in your meeting and by guiding conversations to encourage focused and full engagement.

Acknowledgment Mary Preston, M.D., Associate Clinical Professor of Internal Medicine, University of Virginia.

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Chapter 9
Conducting Faculty Retreats

Rob Kramer

Introduction

Academic leaders' beliefs vary widely on the value of retreats. Some academic departments have annual faculty retreats, while other departments may never have them. It is not uncommon that when a new department chair is appointed, he or she will want to have a retreat to discuss the department's strategy and goals for the coming years. Departmental reviews, key retirements, budget changes, and organizational mandates are also typical drivers for faculty retreats. Ultimately the questions to ask are: will this retreat add value? And how will we know if it did?

Poorly planned, timed, or rolled out retreats can have a damaging effect, lowering morale and buy-in, and creating aversion to future retreats. On the contrary, thoughtfully prepared and administered retreats can re-energize a faculty, creating excitement for current and future plans. The key is to understand the context of the academic medical setting, and to strategize, plan and implement by clearly recognizing that reality.

Start with the End in Mind

In partnering with medical faculty leaders over the years to design, organize, and facilitate countless retreats, I have found the best way to create a strong, effective agenda that will yield solid results is to start with the end in mind. What are the primary goals and outcomes the group would like to achieve? These outcomes are typically tangible, visible, and measurable items (see section "What Topics Warrant

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_9

a Retreat?" below for examples). What would be the optimal results of a great retreat? If those can't be attained, what are the next best desired results? Are there any secondary outcomes or bi-products the group would like to have occur (e.g., a stronger sense of unity or team, better communication, improved trust with higher management)?

Clarity of objectives and outcomes informs a well-designed agenda and design. If the group is not certain what it would like to achieve, or whether a retreat is even warranted ("can't we just do this as part of our regular faculty meetings?"), talking to a mentor or working with an experienced, professional facilitator can help answer these core questions before proceeding.

Timing

Timing is vital for a retreat's success. The academic year is such a compacted, time-pressured period that it can be challenging to find the right time to carve out four to eight hours (or more) for a group of faculty. In my experience, the times I have seen retreats work best are either the start of the fall semester or the start of the spring semester. Other times may seem available but tend to be less effective or poorly attended. The start of the fall semester can be ideal, as you catch people before the craziness of the year has fully kicked in, and people are typically refreshed. The start of the spring semester is also a good time, as people are not yet immersed in the semester's issues and can think about what is currently effecting the department or division.

The actual time of the retreat can also influence the quality of the session. I have facilitated many retreats on Saturdays, as departments are unwilling or unable to adjust the department's weekly schedule, typically because of class or clinical schedules. My experience of weekend retreats is that attendance tends to be lower and people lobby for a shorter session. Both make sense, as few people want to cut into their time away from work and with family. Thus, if at all possible, try to schedule the retreat on a weekday. I have seen some groups enhance the retreat day by including happy hour and/or dinner after the session. It may be appropriate to invite family or spouses to the "after party," as well.

What Topics Warrant a Retreat?

There may be no better way to reduce morale and instill resistance in faculty than to require attendance at a retreat for which no one feels strongly about the reasons to meet. Be very clear about the purpose and objectives before assessing if a faculty retreat is necessary. The best retreats I have facilitated have a clear goal or objective and typically focus on issues affecting the department in the *near term*, over the next six to eighteen months (three years at the most). Long term "strategic planning" is a

misnomer in the current academic medical climate as change happens fast. Why create a five year plan when there is strong probability to revise it within a few years? Faculty can provide more effective input when the issues at hand are concrete, timely, and relevant to their current situation. (Note: one topic that may warrant longer term focus is hiring strategies, when a department can anticipate faculty changes such as retirements, new lines, etc.)

Topics that typically work well for a medical faculty retreat:

- One to three year planning
- Curriculum redesign
- Department reorganization
- Faculty changes, hiring, etc.
- Formulating responses to hospital and/or university requests
- Graduate student/TA allocation

Topics that typically do not work well for a medical faculty retreat:

- "Team building"
- Celebrations (without other agenda items)
- Leaders trying to gain faculty support for ideas they already plan to implement
- Long range planning (beyond three years)
- Managing bullying faculty
- Resolving personality or ideological conflicts

Who to Include

Deciding who should attend a retreat can be a tenuous issue, and it greatly depends on the topics to be discussed. Some faculty may not wish to participate, but does that mean excusing them? Other faculty may have personal agendas they want to push, risking dominating the retreat; so should they be excused to reduce potential problems? Does the topic(s) warrant the entire faculty body or only certain players? Should fixed term and adjuncts be included? Is there a reason to include staff? Or students? When is it appropriate to invite administrators or other decision makers, such as Deans, VP's, or the President/CEO?

Typically, I see departments include the tenured and tenure track faculty at departmental retreats. Sometimes questions may arise about junior faculty, for example if a topic effects them directly (such as tenure decisions, trailing spouses, etc.). In order to determine who else to invite, and for how much of the retreat, start by clarifying the goals and desired outcomes for the session. Do any of the topics have a direct impact on any of these additional groups or individuals? Is it beneficial to have their input? Is it politically savvy to request their attendance? Does their participation build good will or would it be a distraction or hindrance?

Ultimately, ask yourself: (1) Who might be affected by, or have input on, this topic? (2) Are any decisions needing to be made?, and (3) How would it benefit or hurt us to

include these parties? Addressing these questions will help clarify if other key stakeholders should be in attendance. Consider as well that inviting "special guests" at key points during the retreat can build good will and/or provide access to key constituents with whom the faculty may not typically have the chance to interact.

Using a Facilitator

Another common question when organizing a retreat is to determine if it warrants bringing in an outside person(s) to facilitate the session. Answering "yes" to one or more of these questions may indicate a facilitator would be helpful:

- Does the formal leader of the group need to participate in the retreat? Is this person capable of both facilitating and fully participating at the same time?
- Is the agenda full and time short—trying to get a lot done in one session?
- Is the attendance going to be greater than fifteen people?
- Are there "hot button" topics and decisions to be made that may involve the need for a peace keeper?
- Does the formal leader not feel prepared to facilitate the retreat?
- Will there be strong or dominating personalities participating in the retreat?
- Are the scope and/or complexity of the agenda items robust, sensitive, or high stakes?

If it is deemed helpful to use a facilitator, how do you find one, and a good one? The place to start is by asking colleagues, peers, or senior leaders if they know anyone to recommend. Referrals are often the best way to find a good facilitator. Effective facilitators do not have to be experienced in your participants' industry, though it can be helpful if it is deemed important that they understand the culture, common acronyms/language, key players in the organization, etc. A great facilitator can be effective without any prior knowledge of the organization or business. Be open-minded as you conduct your search. Finding the right personality and fit for the group is as important as anything else you consider.

Damage Control

One of the best ways to plan for a retreat is to anticipate and plan for problems. Common damage control issues to consider include:

- Balancing faculty levels, dynamics, and power (Full, Associate, Assistant, Fixed-term, Adjuncts)
- Dominating personalities
- Hot button topics
- Managing loud voices
- Personal agendas
- Staying on time

Having a strategy to manage these potential pitfalls will save a lot time, distractions, and headaches during the retreat. Let us explore how to handle each of these issues.

- Balancing faculty levels
- A common occurrence in faculty retreats is that the Full faculty tend to be the most vocal, informally setting the tone for the retreat's effectiveness. It is often an unspoken norm that the highest ranking and longest tenured faculty wind up shaping the session. Depending on the dynamics of the retreat participants, there are three main strategies to managing this power issue:

    1. Pre-assigned seating—strategy A: mix up the seating chart so that the full faculty are dispersed amongst the group (separate tables or spread out). This strategy prevents any one table or area from being dominated by multiple Full faculty.
    2. Pre-assigned seating—strategy B: put the entire Full faculty in one area or at one table. This strategy isolates their conversations to only themselves.
    3. Use a facilitated process: utilize break out/small group conversations that are short and involve regular seating rotation. For example, present a topic and ask the tables to discuss it for ten minutes. At the conclusion of that time, have all participants separate from one another and join a new table with all new participants who then discuss it for another ten minutes. Do as many rounds of conversations as needed to thoroughly explore the topic, but keep the groups rotating and sitting with new people regularly. This rotation keeps table members constantly in flux and changing.

- Dominating personalities
- The best way to temper dominant personalities is to have as few large group conversations as possible. Small group interactions will limit a dominating personality's scope. Additionally, using the strategies outlined above ("Balancing faculty levels") are helpful.
- Hot button topics
- "Hot button" refers to any issue for which people may have strong thoughts, beliefs, or emotions. The topic may cause heated discussion and/or bring up strong reactions, making productive conversations a challenge. If a hot button topic is indeed going to be on the retreat agenda, a great damage minimizer is to prep the participants ahead of time.

    1. Have the retreat facilitator meet with the retreat attendees in advance (individually or in small groups, as warranted) to share the agenda and discuss the perceived hot button topic. Allow people the space to discuss it ahead of time, so the facilitator can understand their thoughts and concerns, and help them work on strategies to most productively share their thoughts at the retreat. Enrolling faculty ahead of time to make them part of the planning process can be an invaluable strategy. This option takes additional time (and cost if using a facilitator), but may be well worth the efforts to ensure a smoother, more productive retreat.
    2. Share as much data, documentation, and additional information as possible about the topic, so participants are fully informed prior to walking into the

retreat. Surprising faculty with new data on a critical topic, and doing it publically in a large group setting, risks unproductive conversations. Allow faculty to ask questions about the topic in advance, either privately or in faculty meetings.

- Managing loud or dominant voices
- This problem tends to be the most commonly difficult issue for a leader to manage if facilitating a retreat him or herself. Long standing group dynamics, power struggles, personality differences, and sometimes downright belligerence can be present at a retreat. It may be a real challenge for the group leader to manage a room full of personalities, keep the conversations effective and timely, and allow her or himself space to participate. If this is an issue of concern, utilizing a facilitator is a good idea. A skilled facilitator should be experienced in managing this type of scenario and should have a toolbox of tricks to use. When interviewing potential facilitators, ask about their experience in managing loud or dominant voices, and what methods they use.
- Personal agendas
- I often joke that the best way to provoke a group of medical faculty is to tell them they have to take a day away from their research, teaching, and/or clinical hours to attend a departmental retreat. Consciously or unconsciously, the strong majority of faculty will be entering a retreat with a personal agenda. Some may be overt: "I want to make my point when we get to topic X." Others may be covert: "I want this to go as fast as possible to get out of here and get back to doing *real* work." Recognize the room will be filled with personal agendas. To minimize the damage created by personal agendas, make sure the retreat design is crisp, efficient, and very relevant to pressing faculty needs. Keep comments and conversations applicable and focused, capture notes on flip charts or at table papers, and keep the agenda moving.
- Staying on time
- Getting out on time is great. Getting out 30 min early earns brownie points. But getting out late or not getting through the agenda because of poor facilitation breeds faculty contempt. If nothing else, end on time. If topics look like they will run long, stop for a moment and check in with the participants. Let them know it appears the current topic will run long and ask if they prefer staying on the topic and dropping something else off the agenda, or if they prefer to move on. Let the group have ownership of prioritization as much as possible (this strategy assumes no other hard stops on the agenda, such as for guest speakers, etc.).

Designing a Great Retreat

Creating an effective retreat starts with clarifying the objectives, goals, and outcomes first. As described earlier in the chapter, what do you want to come away with in the end? Decisions, documents, ideas, plans? Set realistic expectations about what you plan to accomplish. Understand what you would ideally like to accomplish, and then clarify what is most realistic and most important to accomplish to hone the

agenda. Ask yourself: What do I *dream* to get accomplished? What *could* be accomplished? What *must* be accomplished?

Once objectives and goals have been clarified, consider the amount of work to be accomplished and how much time it will take. Can the group commit this time? Is it non-negotiable? Faculty retreats I have facilitated over the years typically run between four and nine hours. However, at times, a multi-day retreat is warranted. The longer the retreat the more challenging it is to find the time when faculty physicians can disconnect, especially from clinic hours and other deadline driven responsibilities.

Once a time commitment has been established, the agenda should be developed. Go back to the issues that must be accomplished, prioritize them, and set time allotments for each topic. Be sure to build in break and meal times. Recognize what topics could be deferred if you run out of time. Within each topic's time allotment, the design for each is then created. How will the group go about discussing and working on the topic at hand? Are large group or small group conversations better? Will a presentation of data be warranted? How will the results be collected (flip charts, table papers, etc.)? Consider the "damage control" methods discussed earlier in the chapter as a way to avoid problems and keep the session moving along smoothly. A summary of tips and best practices can be found in Table 9.1.

Table 9.1 Tips and best practices for faculty retreats

Retreats typically work best when the topics being discussed affect the next six to eighteen month timeline (and no further out than three years).
Have food and coffee available for when participants arrive, at breaks, and for meals if applicable. Food (and its quality) is the great elixir for better engagement.
Avoid weekends, holidays and breaks. Nothing affects buy-in more or makes people want to end sooner than to schedule a retreat in their free time.
Use tables for seating. It creates a smaller group feel, and you can separate people with pre-assigned seating.
Use breakout groups. Mix and match people to create effective dialogues and more participation. This strategy is especially helpful for the introverts on the team.
Use PowerPoint or visuals only when there is a graphic that everyone needs to see together. Have the data available as a handout, as well, in case there are problems with the technology that day.
Capture data and ideas using flip charts and table papers. Have plenty of paper, markers, pens, and tape.
Use voting/narrowing strategies. Sometimes a conversation leads to lots of ideas being generated. The group may determine the list is simply too long or broad to handle it all. Have the group vote to narrow the list down. A great way to do this is use sticky dots or markers. Each person is allowed to vote for 'X" number of items (typically 3–5). Clarify that they cannot vote for one item more than once (in an attempt to skew the voting)!
Determine if the session would function better with a professional facilitator.
A good location can make a big difference in the quality of the retreat. The group should be away from their everyday environment. The more inviting the location the better. Determine if the session warrants a more business-like atmosphere or whether an alternative site (such as a retreat facility or bed and breakfast) would be more effective. You want the group to feel like they are away from distraction, in a friendly environment, supported with refreshments, and able to easily focus.

Next Steps: After the Retreat

You made it through the retreat, and now what? Typically a list of "to-do's" comes out of the session. As quickly and efficiently as possible determine:

- What specifically needs to be done?
- When do I owe a report or follow-up back to the participants?
- How should we follow up on any points? Another session? Can things be handled in future faculty meetings?
- Do we need to form working groups or committees to complete assignments?

To use a football metaphor, getting from "the 20 yard line to the end zone" can be the hardest part for some groups. Going back into the daily grind of everyday work can easily push the retreat's to-do list to the back burner. This problem fuels the long-standing belief that, "retreats are a waste of time; we come up with all these great ideas and then nothing ever comes of them!" To avoid this error for your own group, consider the following:

- Get a small win fast. Share the retreat report back to the group immediately. Then accomplish one thing from the "to-do" list. Pick an easy one, but get it done within the first few weeks following the retreat. This accomplishment will send the signal that results are being pursued, garnering more patience as the other to-do's are slowly worked through.
- Update the group regularly. Keep them informed with status reports, whether in faculty meetings, regular email communications, or both. The formal leader needs to keep the conversations and momentum going.
- Continually reinforce plans and deadlines. Have working groups and committees provide reports at faculty meetings, clarify expectations for the work being done, and provide recognition and rewards whenever possible.

Conclusion

When considering the amount of time and effort it takes to put together a retreat, it can be easy for a leader to decide it is not worth the hassle. However, when comparing a retreat to the thought of dragging the same conversations out across the course of a semester or year in faculty meetings, suddenly it may become a wise idea. Be mindful to prepare well: know the audience of attendees; shape the agenda to make it a worthwhile investment of time; provide a supportive environment; plan for and minimize damage as much as possible; and consider the help of a facilitator or moderator. A well-organized and implemented retreat can save enormous amounts of time and effort, energize participants, and set an organization on the path to amplified success.

Additional Resources

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Chapter 10
Changing the Faces of Academic Medical Center Leadership: Gender and Ethnicity

Sue Tolleson-Rinehart

The Meaning of Difference: Why Do We Care Who Leads?

When Ann Richards emerged the victor from the crucible of the Texas gubernatorial election in 1990, she was a media magnet. She was among the first eight American women to have been elected governor in their own right. She had won election in a huge state known for the ferocity of its political conflict. She seemed to presage more electoral success for women at all levels. She recognized that she was an oddity—she was the "two-headed cow" of the political moment. She knew that she could not avoid the media attention, and she was determined to use the attention for important public policy purposes.

The late Governor Richards understood three powerful and endearing features of human interaction. First, people see difference even faster than they can consciously acknowledge they have done so. Social scientists have known for decades that sex and ethnicity are among the very first traits human beings recognize in one another—we recognize one another's sex and race so fast we may not be consciously aware of doing so. Recently, cognitive neuroscientists have begun to determine some of the physical mechanics of face recognition [2], but perhaps even more important than the recognition of difference is the cascade of expectations such recognition brings. That is the second thing Governor Richards understood: when we don't look like other members of the group we are in, expectations about who we are and how we will behave are even more sharply focused.

"Everybody wanted to come see the two-headed cow."
—Governor Ann Richards [1]

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_10

Third, Governor Richards understood that the attention we pay to difference and our expectations about it have consequences for leadership and representation. We expect leaders to represent the needs and interests of their institutions and the people those institutions serve. We have additional expectations, though, for women leaders or leaders who are men of color: we expect them also to represent those who may not always have been represented before, and we expect them to represent change. The goal of creating a more diverse leadership motivates the American Association of Medical Colleges, for example, to measure the sex and ethnicity of Academic Medical Center (AMC) faculty [3, 4], or to create reports on women's pipeline to AMC leadership [5]. Advocates for a diversity of leadership believe diversity is right because it seems just, because it makes the leadership group, in the words of one AMC dean, "look like the increasingly diverse faculty and students," and because "… diversity is an important organizational or community strategy in and of itself, ensuring that there will be a variety of ideas available to address the many unpredictable challenges that arise as threats to a group's missions," as stressed by the Vice Chair of a large clinical department. Our expectations of diverse leaders may create challenges for them, but they also create great opportunities.

We assume leaders represent us. Just "running the institution" is a management function. We expect something more from leaders. Political scientists have long considered how the representativeness of leadership is improved by diversity. The most classical definitions of representative leadership say any leader can represent the needs and interests of the entire community. But two other kinds of representative leadership, "descriptive" and "substantive," make important contributions as well. ***Descriptive leadership*** is a direct reflection of the appearance of difference. When an African-American woman is in a leadership position, for example, she increases the legitimacy of the whole system by showing that members of all the system's groups are present in its leadership, just by her descriptive characteristics alone. Her presence makes the system seem more just. On the other hand, groups may differ not only in appearance, but in their interests and needs, as we recognize in our attention to the health care needs of vulnerable populations, for example. ***Substantive leadership*** means that different groups' own members may best understand and represent these *substantive* needs. Adding a variety of perspectives, moreover, may enrich the whole system's problem-solving capacity.

The political philosopher Jane Mansbridge also discusses "***surrogate representation***" [6] as an extension of both descriptive and substantive leadership. In politics, a woman senator from California might be seen as a "surrogate" representative for women in other states. In AMC leadership, our African American woman Dean's surrogate representation may not just be seen as representation of other black women in her medical specialty, or her AMC. She might also be seen as a representative of the needs of black patients, or of other black female health professionals. She is likely aware of these sweeping expectations of her. This example also shows that our expectations are more complicated than we realize, because representation can be "crosscutting" or "coinciding" [7], depending on the question we are trying to answer. That is, sex is a crosscutting category: women are found in every possible stratum of society. We more often think of ethnicity, though, as "coinciding," or

relatively mutually exclusive—someone is a member of one ethnic group but not another—and we may count representatives of different ethnic groups as categories of their own. This complicated interplay of "crosscutting" and "coinciding" representation is at work in all the tables that depict the physician workforce by sex, and then by ethnicity, and then by numbers of men and women in each ethnic group. We count this way because we think it matters, but doing this raises new questions we may find hard to address: Can men represent women? Can women represent men? Can a black man represent an Asian woman? Can all of them represent the entire institution and the patients it serves? Our implicit hope is that the answer to all these questions is "yes," but legacies of sexism, racism, and academic cultures that imposed taxing burdens on their underrepresented members shadow current commitments to progress [8, 9].

Change is inevitable, but its pace is slow. Any internet search uncovers the pioneering women of all ethnicities and men of color who first broke into AMC leadership [10]: Dr. Ann Preston became the dean of the Female Medical College of Pennsylvania in 1866, but more than a century had to pass before Leah Lowenstein became the first woman of any ethnicity to be dean of an accredited co-educational medical school when she assumed the helm of Jefferson University's School of Medicine in 1982. Alexander Augusta and Charles Purvis were the first two African-American physicians to serve on a medical faculty (at Howard University) in 1868, and are considered among Howard's founding leaders. But it took until 1991 for an accredited non-minority medical school in the United States to have an African-American dean, when Donald E. Wilson became Dean of the School of Medicine at the University of Maryland. Two years later, in 1993, Barbara Ross-Lee became the first African-American woman to achieve decanal office in a medical school when she commenced as Dean of the College of Osteopathic Medicine of Ohio University. The past quarter century has continued to witness change, but the diversity of AMC leadership has not yet approached the goal of real representativeness.

Paradoxically, while concerns about AMC faculty burnout are growing, and while men of color and women of all ethnicities continue to report debilitating experiences of discrimination [8, 9], deans of both sexes are dramatically *less* likely to report burnout and *more* likely to report high job satisfaction [11]. Deans appear to have the support and rewards, and the sense of power to act, that keep us engaged with our work and our institutions. Assuring that most, if not all, faculty have those vital resources may be the rate-limiting step to keeping the pipeline of diverse future leadership candidates flowing.

Changing Leadership in AMCs: The Contemporary Picture

Although we have placed increasing value on the goal of achieving a diverse leadership in academic medicine, getting there is not straightforward. Today, about 31 % of the roughly 950,000 US physicians now practicing are white men (author's calculation from data in [3]), certainly a very significant change from the past. In fact this

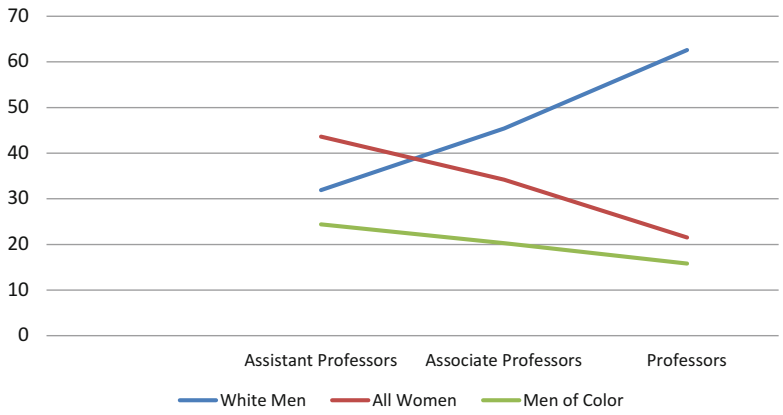

Fig. 10.1 White men, men of color and women by faculty rank. *Source*: Author's recalculation of raw data collected by the Association of American Medical Colleges and reported in Table 11, AAMC Faculty Roster 2014 [4]

means that white male physicians are now proportionately represented in medicine, since white men are 31 % of the US population at present. These numbers alone might make us think that medicine as a profession has achieved much more balance than is true in, say, elective politics, where white men occupy about 65 % of all elective offices. The apparent balance does not persist in academic medicine, though. AMCs have lagged behind the pace of change in the general physician workforce: 40 % of all AMC faculty are white men (author's calculation from data in [3]), and white men's proportion of faculty and leadership positions only increases as we look up the ladder of rank and leadership positions.

Figures 10.1, 10.2 and 10.3 show the current distributions of leaders by sex and ethnicity and suggest that despite great progress in recent decades, the leadership pipeline may still be blocked or obstructed for now. The pool of potential leaders from heretofore underrepresented groups is growing dramatically: women of all ethnicities are almost 44 % of assistant professors; men of color are nearly a quarter of assistant professors [4]. This strong representation does not persist into the highest faculty ranks. Among all full professors, women of all groups are 21.5 % (as of 2013), and men of color hold only 15.8 % of the full professoriate. In effect, white men's disproportionate share of senior faculty positions grows, as Fig. 10.1 illustrates.

Deans of 16 % of the accredited US medical schools are women [12], and although some of the women deans are members of underrepresented ethnic groups, men and women of color are a very small proportion of the top leadership of AMCs. Figure 10.2 arrays all faculty ranks and leadership positions (as of 2014, calculated from data in [12]). Spreading men's and women's share of positions from that of entry into academe to holding its top office gives us another way of looking at women's underrepresentation. This picture may also be telling us another familiar story of women's often halting advancement in academic institutions: the one

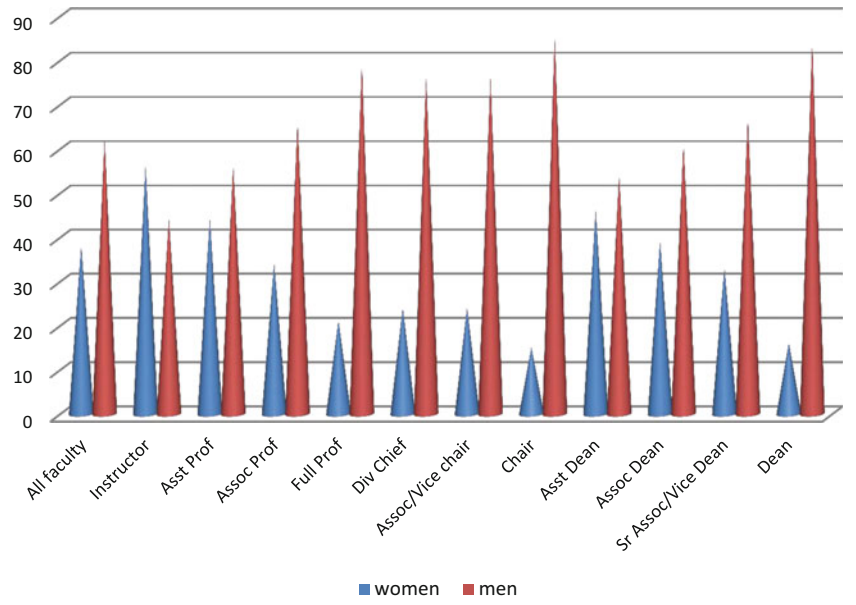

Fig. 10.2 Percentages of women and men by faculty rank and leadership position, in percents. *Source*: Recalculation and representation by author of data reported in Lautenberger Diana M., Dandar Valerie M, Raezer, Claudia, and Sloane, Rae A. The State of Women in Academic Medicine. 2014. Washington, DC: Association of American medical Colleges [12]

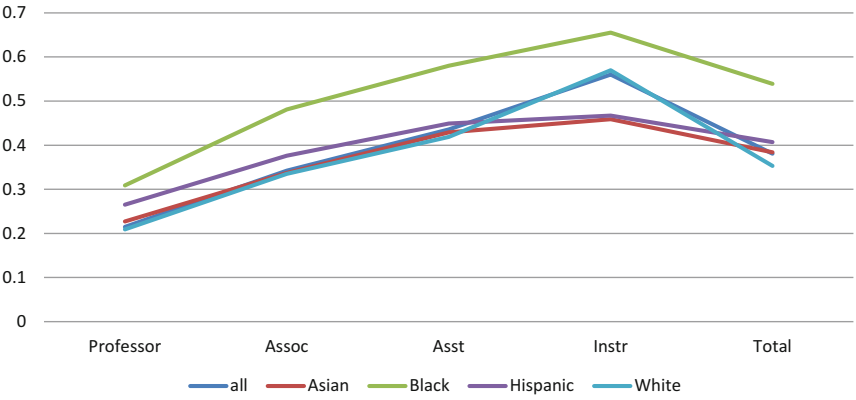

Fig. 10.3 % Women of select ethnicities by faculty rank, 2014. *Source*: Author's recalculation of raw data collected by the Association of American Medical Colleges and reported in Table 11, *AAMC Faculty Roster 2014* [4]

faculty level where women are overrepresented is the rank of Instructor, and the one leadership area where women draw closer to men is in the positions of Assistant and Associate Dean. The story this may tell—and it is one that merits much closer investigation—is the well-known trope of women making much slower progress up the

academic ranks on the one hand (depicted by the large numbers of women in Instructor positions), and on the other, finding themselves asked to perform much more service activity than is proportionately true of men when they reach mid-career levels (illustrated by the larger number of women in junior—and seldom full-time—decanal positions). One obvious place for further study is to examine how, or if, women's positions as assistant or associate deans leads to further career development, or are the pinnacles of their career advancement.

The data suggest one further need for investigation: the representation of women and men faculty members within major ethnic groups is not entirely similar. Figure 10.3 confirms that black women are closer to achieving parity with black men at most faculty ranks. Black women are now 66 % of all African-American Instructors, and they are 58 % of all black assistant professors. Black women's recruitment into the "entry-level" positions of academic medicine seems to be marginally more successful than is the recruitment of black male physicians into these ranks. In fact, though, black faculty members of either sex remain very significantly underrepresented at every rank, as do Hispanic academic physicians. The interplay of "cross-cutting" and "coinciding" representation means that AMCs must be thoughtful about the different dynamics at work in creating and sustaining academic physicians of both sexes and all ethnicities.

What Will Change the Faces of AMC Leadership?

Concluding Recommendations for Institutions and Individuals

Drawing diverse leaders from the pool of academic physicians requires increasing the rich diversity of the pool, and assuring that the pipeline from the pool to the Dean or Vice Chancellor office remains unbroken. It also requires institutional reflection on the culture and processes that may have impeded advancement in the past. The Dean of a large AMC captured the whole process of changing the face of academic medicine's leadership in his response to questions I posed to several leaders:

> *It should be no surprise that when people are selecting leaders for any group or institution, including AMCs, they very much tend to pick people who are like themselves. So we should not be shocked that the largely white and male leadership class of AMCs tends to select other white males. But since the work of medical schools (and other health professional schools) [influences]…and is in service to all of our diverse society, the leaders of AMCs need to "look like America," as Bill Clinton famously said. Beyond that noble goal…our newly minted doctors (and other health professionals) are themselves very diverse…Thus the current and future residents, assistant professors and associate professors will rightly demand that their professors, division chiefs, department chairs, deans, etc., "look like them." Thus we have to push ourselves right now to select a diverse set of leaders—but this will be a time-limited phenomenon. Soon it will be just as "natural" to pick diverse leaders as it has been to pick white male leaders up until now.*

Doing that—making picking a diverse leader "natural"—impels current AMC leaders to be reflective, conscious, deliberate architects of change. Current leaders need to change everything from search strategies to a critical examination of whether

Table 10.1 Recommendations for institutions

1. Search consciously: treat each leadership position opening as an opportunity to evaluate both hidden and obvious contexts that may be hampering institutional growth, and construct a contemplative new approach to identifying the right new leaders
2. Align missions and interests between the medical school and its teaching hospital[s]: be aware that competing financial pressures and differing evaluative and performance standards may contribute to the burnout of the very faculty who should be in the leadership pool
3. "Manage talent strategically:" deliberately recognize that establishing the kind of work environment that fosters engagement, performance, and excellent patient care is also the environment that nurtures the institution's future leaders
4. Collect, share, and report data: although the AAMC and AMCs generally have recognized the need to measure progress toward a diverse leadership, too many holes in the data remain, especially with regard to the career progress of men of color. Make accurate, timely data collection on faculty progress a priority
5. "Teach leadership:" don't offer development programs or didactic presentations of leadership skills alone. Instead, create an environment that encourages reflection on what leadership is in each individual

Sources: Souba [13], Bickel, Wara, Atkinson et al. [9], Fox, Shannon, Sarah Bunton and Valerie Dandar [14], Mallon and Cornice [15]

their missions are aligned with the missions of their health systems. In the words of Dr. Wiley Souba, Dean of the Geisel School of Medicine at Dartmouth, "…unless and until we change the lens through which we understand and exercise leadership, the future will be largely a continuation of the past. If we define leadership as being simply about power and status, our way of being and our actions will reflect that frame of reference." [13].

Table 10.1 lists five areas of institutional change mentioned repeatedly in the literature.

For now, men of color and all women in AMCs, whether they want to or not, represent diversity because their numbers are still smaller than those of white men. In my own institution, at this writing, the senior leadership team in the Dean's office now contains two white women and an African-American man as Vice Deans. The group of clinical department chairs, though, was an entirely white male assemblage until July 1, 2015, when a woman took over as chair of one clinical department. The data show my own institution is far from singular in this regard. This means that women and men of color in leadership positions will be looked to, perhaps unfairly, for different perspectives, and to represent different constituencies, but such will be the reality until their numbers are larger than they are today. Diverse leaders continue to have the triple opportunity of descriptive and substantive representation, the chance to be important change agents, and the chance to be leaders (Table 10.2).

The political philosopher Nannerl Keohane, who was President of Wellesley University before she became the first woman president of Duke University, crafted a synthesis of scholarship and her own leadership experience to remind us that we cannot bring new, diverse perspectives alone to the helms of institutions. Aspiring leaders must genuinely understand the institutions they hope to lead—in Keohane's words, for example, they might reflect on whether they are captaining a single ship

Table 10.2 Recommendations for men of color and all women

1. Recognize that you symbolize and are expected to represent difference even when that is not the first quality you are trying to project, and even when you are focused on other institutional challenges
2. Understand what kind of institution you want to lead: are you the captain of a ship or the admiral of a flotilla? [Keohane 706]
3. Learn to model the kind of leadership you want to create. [Souba]
4. Cultivate your judgement: develop that "distinctive mental faculty…that combines experience, intuition, taste, and intelligence" [Keohane 710]
5. Make and support the kind of change that will make a more diverse leadership seem natural and inevitable

Sources: Mansbridge [6], Htun [7], Pololi, Cooper, and Carr [8], Souba [13], Keohane [16]

or serving as the admirals of flotillas ([16], p. 706). She also urges aspiring leaders to cultivate "judgement…[the] distinctive mental faculty that combines experience, intuition, taste, and intelligence." ([16], p. 710). All leaders need these attributes if they are to lead well, of course. Diverse leaders, because they themselves actually embody change in the most lived way, need these qualities even more. Keohane was not primarily writing for women, or for minority men, but her own experience as a "first woman to…" left her in no doubt about the importance of that added characteristic of difference. She ends her essay this way:

> *Whether you are female or male, you will be a better leader if you do sometimes ask questions such as … 'Where is this path taking us, and is this destination the one we should be seeking? What are the temptations to which I am now subject because of the power that I hold, and how can I avoid them? What are some of the things that stand as "common wisdom" in my organization, and how can we rethink them to the advantage of us all?'* ([15], p. 718)

We know "this path," for AMCs, is toward more diverse leadership. How the institutions and the people leading them follow the path will determine how we change the faces of academic medicine.

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Chapter 11
Managing Managers

F. John Case

Introduction: Management vs. Leadership

Are You a Leader or Manager?

Leaders often do not want the stigma of being called a manager, nor the daily routine and demands that come with the management role. In universities, colleges, Academic Medical Centers (AMCs), and hospitals, this desire for role separation is certainly true. The distinction between a leader and manger is drastic in many ways; however, there are many similarities and they should be recognized by the organization.

People who move up in their career will hear the word "leader" in meetings, evaluations, strategy sessions, and even operational discussions. Faculty members, educators, or researchers who advance to a chairman, chief, center director, or vice president/dean know they will be asked to lead by developing strategies for their department, division, unit, or center. They will be asked to make tough personnel decisions when shaping organizational changes. They will be asked to develop and adhere to a budget and a resource plan. Leading is the ultimate goal in an organization: setting goals and priorities and letting the next levels of management operationalize the faculty and staff to meet the vision. Once the goals are set, the managers must execute daily operational procedures to meet and exceed the goals.

Managers are critical to moving the operational activities of a department, division, unit, or center toward the vision and strategies set by the leadership. Management is not easy, especially in today's environment with such a broad and diverse range of workers. Baby Boomers, Millennials, and Gen Xers all have different

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_11

styles, work ethic, beliefs, and goals, and managers must understand the differences so they can effectively coordinate their teams to accomplish daily activities.

In AMCs, most employees functioning as support staff provide transactional, repetitive activities to accomplish their daily goals (registering patients, measuring samples, completing accounting paperwork, etc.). They support the work of the faculty, chairman, director, vice president, dean, or C-level executive (for example, Chief Financial Officer, Chief Information Officer). Front line employees are critical to the operation's success, and managers have oversight responsibility for these employees. Every professional in an AMC will have to manage people on their way to a more senior leadership role—it usually is a "rite of passage." It is part of the career ladder in many industries, and education and health care are no exceptions.

The Differences and Similarities in Leadership and Management

Following is a list of a few of the differences and similarities between a leader and a manager:

Differences

1. Leaders are responsible for the complete execution of department strategy through people, process, and technology; managers are responsible for teams with specific functions that contribute in their unique way to the operations and strategy of the department.
2. Leaders are responsible for all resources and must allocate them efficiently such that the department's strategy can be accomplished successfully; managers use their share of the budget to operate daily with minimal discretion (usually) for flexibility.
3. Leaders make decisions that can affect department strategy and set the guidance for other decisions during execution; managers' decision-making is usually on-the-spot, reactionary, and often is the result of a customer service issue.

Similarities

1. Effective leaders and managers must understand people, process, and technology decisions and how they contribute to the department operations and strategy.
2. In order to succeed, leaders and managers know building relationships is critical, both internal and external to the organization. Managers must understand their relationship to each staff member just as a leader must understand an external research sponsor or governing body's relationship to the organization.
3. Leaders and managers must deal with personnel issues daily. Leaders may deal with higher-level issues like a reorganization, while a manager may have to make a decision on one person's performance (Fig. 11.1).

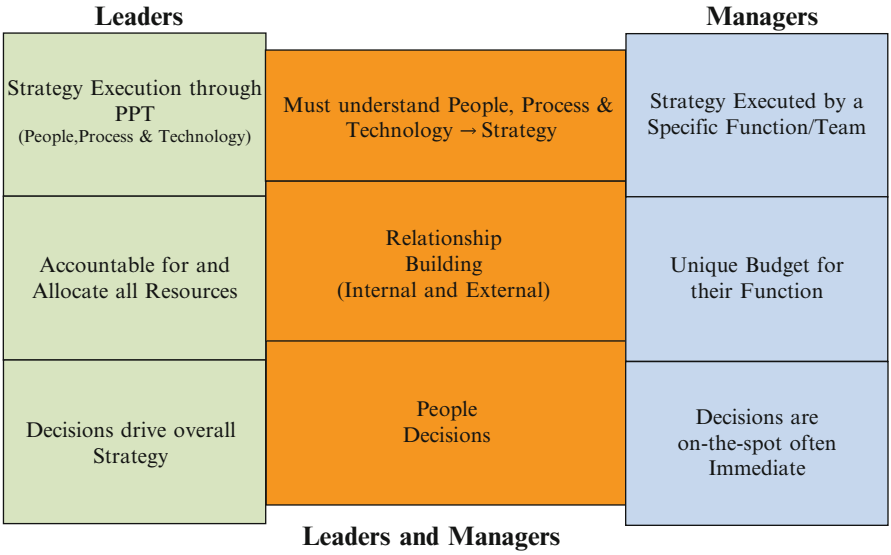

Fig. 11.1 Similarities and differences in leadership and management

The similarities and differences are not unique to any industry; they are common across all industries including education and health care. From many perspectives, they tend to blend together in the silo oriented AMC. Why? In many non-profit organizations like AMCs, there is minimal professional development provided to learn the new skills needed to lead, and promotions to leadership positions are often not based on competencies or required skills for that level. Thus, many managers (or even individual researchers or clinicians) are promoted to leadership positions without the skills, technique, or savvy to needed to succeed in such roles.

As a leader, then, how does one manage managers, and what are the skills needed to do so? It is not easy, and it takes time to develop the skills.

Managing Managers in the Medical Center environment: The Wheel of Attributes

Is there a unique set of tools, professional training, or learned behaviors that will make a faculty member successful in managing others? Is there a specific training or course that gives a faculty member that competency? Does the Association of American Medical Colleges (AAMC) or any other organization have a conference on training medical faculty to manage people? The answer is maybe. There may be occasional workshops, a concurrent session or two at a national meeting, or even a

Fig. 11.2 Medical faculty attributes to manage effectively (managing managers wheel of attributes)

leadership course at Harvard Business School or the AAMC on the topic. They are minimal and as many know, until they are in the position, courses and concurrent sessions only provide up-and-coming physician leaders with tidbits of information to use in their leadership role.

Figure 11.2, depicts attributes that can help medical faculty to manage managers on a daily basis and to help lead them to operational effectiveness of their department.

Effective Communication: The Center of Managing People

The core skill of any successful manager or leader is effective communication. Hiring an employee, firing a staff member, making travel plans, or simply verbalizing the daily goals for the team are actions that, if communicated ineffectively, can create

misunderstandings, hard feelings, and even mistakes on execution of the daily assignments. There is no other piece of the Managing Managers Wheel of Attributes (the wheel) that hinges on success or failure of managing people as much as communication. A faculty member could be non-supportive, not motivate the team, nor provide coaching to a staff member, and usually the operations of that team will continue. These types of actions can sometimes be ignored, but if that faculty member moves into a management position and utilizes the same ineffective communication techniques, it typically will result in failure for both the new manager and the team.

There are several key communication techniques to apply to everyday management (see Chap. 2 for more ideas).

Be timely—the timely communication of any message can make or break a situation or process. There is always a rippling effect of untimely information—actions are delayed, deadlines missed, and resources wasted.

Be direct—just as the saying goes, "the fastest way to travel between two points is via a straight line," information delivery follows the same directive. Provide only the exact information needed. If background is necessary to give context, provide it in a concise and relevant manner.

Be honest—honesty is critical in effective communication: there is no substitute for it, and most of all, people expect honesty. Leaving critical information out of a conversation is not being honest. As kids say, "I didn't lie to you, I just didn't tell you about it." An effective leader and manger will always be honest and use tact (in the delivery), even if the outcome leads to a difficult situation or bad decision.

Be open—an open conversation is an effective interaction. Listen to thoughts, questions, and concerns, respond as needed (not all open comments need a response, be smart in reacting), and most of all, respect the other person's feelings and perspective.

Be patient—in communication patience is needed to fully understand the situation, analyze, and make the best decision possible under the circumstances. Doctors make decisions daily in the operating room, their patient office, and in department meetings. They must not jump to conclusions, quickly react to a statement, nor analyze the situation before all (or as much a possible) information is available.

Most of all … listen—it shows respect for others' views, knowledge, and analytical techniques. Reactionary decisions without full comprehension can lead to the wrong decision, which can lead to a poor outcome.

Managers must understand these elements of communication and use them everyday to effectively manage their operations. Leaders know that a manager with limited communication skills will eventually fail, because they lose the trust of their front-line staff, their peers and colleagues, and especially senior management. Worst of all, communicating ineffectively cannot be overshadowed by timely deliverables, a positive bottom line, or a successful procedure with a patient. The deliverables may be achieved, but ultimately the morale, trust, and commitment of the "team" will deteriorate and be heard louder by the institution's leadership.

Other Attributes Critical to a Manager's Success

While communication is central for effective management, other attributes are essential to develop a team that cares about vision, strategy, operations, and the success of the organization. Without these tools, a manager risks losing the team's faith in his or her abilities.

Support and encouragement—Just like any aspect of one's life, support and encouragement create a relationship between a leader and his or her managers. Just as parents provide their kids encouragement and support in school, so should a leader support and encourage a manager. Such support builds trust, conveying the message that the leader feels the manager is capable, while being empathetic to the manager's many challenges, roadblocks, and details of an activity or project. In some ways, the leader is inspiring managers to 'go forth and be successful,' knowing the leader is there for them as needed [1].

Coaching and development—Leaders are expected to develop high quality and productive results. To meet this expectation, leaders need to coach and develop their managers. Ideally, the leader can make the time and effort to coach managers to succeed (see Chap. 15). If not, then see it as an opportunity to find alternative resources, such as: (1) coaches in the Human Resources department; (2) a coach from another department, one that can develop managers into leaders especially at your organization; or (3) a professional coach hired to help managers be successful in their daily routine. It is very common today for leaders to have some form of professional coach; it could be formal (from an executive coaching firm) or informal (a successful colleague that has risen through the organization). Either way, leaders must understand that the pressures of managing people, processes, and technology will essentially wear out a manager unless properly coached.

Accountability of managers—The Merriam-Webster online dictionary defines accountability as:

> The quality or state of being accountable; *especially*: an obligation or willingness to accept responsibility or to account for one's actions [2]

All managers must accept responsibility for their activities—planning and executing a budget, determining schedules, hiring staff, etc. They must also accept and be able to account for the actions of the team they supervise, as well as their own individual actions. The result is an organization that recognizes success, determines failures, and pinpoints needs for improvement through the accountability of their managers. Leaders must create an accountable environment of clarified expectations for all their managers. Accountability measures need to be realistic, align and strive toward the organization's vision/strategy, and be measurable. Without accountability at the unit level, leaders will carry the load for all activities throughout their department(s). That is not realistic or sustainable, and it dis-incentivizes and dis-empowers managers.

Project management—Managers needs to be able to execute on daily activities, departmental projects, and committee work. Project management is a skill that can be taught, and there are various project management tools to help managers be suc-

cessful. These can be as simple as a Microsoft Excel spreadsheet or a more detailed project management tool as in Microsoft Project. Without an established tool to track and understand progress on activities in the department or organization, deadlines will pass, projects will go incomplete, and a leader will be consistently asking, what happened to the XYZ project? Project management provides another outcome tool for the leader: it creates accountability measures for the managers' activities and unit effectiveness.

Motivation — An effective leader must be able to motivate managers regularly to lead their units successfully. Motivation creates excitement and passion in managers to execute effectively. It brings out the best in managers, makes them strive towards excellence and feel positive about their contributions to the organization. Be authentic, sincere, and caring towards managers, making sure it is understood how they feel and what they need to succeed. Motivating is not about delegating tasks, harping on deadlines, or stressing the importance of outcomes. Those are operational issues. Leaders must create an environment that fosters organizational success, effectiveness, and teamwork to be successful [3].

Decision-making — Leaders will most likely delegate more decision-making to managers they trust. Decision-making is not a talent or trait; it is a process that must be developed by everyone leading an organization. Leaders must review and understand each manager's technique in getting to a decision. Once the leader understands the manager's technique and sees it applied on a daily basis, the leader can begin to form an opinion: either trust the manager's decision making or do not. If the leader can trust it, confidence in that person moving the organization forward independently increases. If there is no trust established, it is imperative to help that manager understand the information, tools, and analytical skills needed to make the best possible decisions. If not, the leader will most likely find him- or herself micromanaging. Eventually the leader risks failing from the lack of delegation and accountability placed on others. In such a situation, the leader fails from not helping others succeed.

Appreciation: All Along the Way

One critical success factor for every manager is to recognize how to appreciate his or her team. Even in our personal lives, people enjoy being appreciated; it supports and fosters a feeling of accomplishment. Appreciating the team, the nurse, the administrator, the boss, and all of the staff will create a positive and pleasing environment for the department, division, or unit.

Rewarding good performance is a vital component of any effective management system. Reward, or appreciation, can directly affect the motivation of an employee. Appreciation can help an employee overcome failures, and with adjustments and corrective actions, success can be achieved. As much as we recognize the need for improvement in an employee's daily effort, recognition and appreciation help promote satisfaction in the workplace [4].

Every physician, senior leader, and effective manager must consider what types of appreciation will be effective for whom and when and where. Often a written note (note card, thank you card, etc.) will show a genuine, concerted effort to personalize the appreciation. Recognition at a department faculty meeting creates a public perception of an accomplishment's importance or impact. In some situations, where applicable (and doable), a monetary reward can be a very effective way to show appreciation. The appreciation ring in the Wheel of Attributes continues throughout your career, no matter what position you find yourself in. Used effectively, appreciation can be the difference between a cohesive unit and a dysfunctional team.

Lessons for Leadership

The successful leader understands the wheel and each element within it. Every day, managers are challenged in each of the areas on the wheel. As a leader, one must provide the environment, tools, resources, and guidance for the manager to be successful. If a leader needs development on any attribute in the wheel, there are typically resources within the medical center to help, such as human resources, training classes, or a colleague/mentor. If internal resources are not available, outside help is an option as well.

Conclusion

Presidents, deans, chairmen, chiefs, vice presidents, and medical faculty need to be able to rely on managers and create an environment where managers feel supported, empowered, and successful in guiding their department or unit. Leadership is not management, and in today's marketplace of changing health care models, affiliations, and reimbursement methodologies, leaders need to be driving success with every manager in their unit. They need to foresee changes in the environment (e.g., a demand for hospital billing coders with the implementation of ICD-10), changes in operations (e.g., new technology interfacing to electronic medical records), and an increase in creating efficiencies in every aspect of their business (e.g., sharing back-office services across departments). Today's leaders need both the hard skills (project management, accountability, decision making) and the soft skills (motivation, coaching, empowering, supporting) to lead and develop their managers to be effective in the ever-changing medical environment.

Not every leader has the ability and competencies to lead and effectively manage managers. Medical faculty and leaders often possess many of the attributes in the wheel, and with development and support, they can become effective at every area in the wheel, essential to effectively lead their operations. The higher education and medical environments are creating pressures for more efficient operations and metrics. Build a unit with managers that people want to work for, and the entire organization's success level will rise.

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Chapter 12
Promoting Professionalism and Professional Accountability

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Introduction

Dedicated leadership, effective planning and teamwork, and reliable implementation are essential elements of successful healthcare initiatives, clinical outcomes and research endeavors. Lapses in professional conduct—whether aggressive, passive-aggressive or passive behaviors (Fig. 12.1)—at any level may undermine teamwork, safety and outcomes. Therefore, healthcare leaders need specific, evidence-based plans and means for identifying lapses and addressing indicators of unnecessary variation in professional performance. Professionalism (including its core tenets of self- and group-regulation) is foundational for identifying and addressing unnecessary variation in performance [1, 2]. This chapter discusses application of self- and group-regulation to a hypothetical faculty member recruited to join an Academic Medical Center (AMC) and create a Coordinated Clinical Care Center ("Center") in his area of medical and procedural expertise. The AMC needs the Center to reduce fragmentation and increase comprehensive ("one-stop") patient care, improve patient and staff satisfaction, reduce cost of care, support translational research, increase department revenue, and routinely deliver excellent outcomes.

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_12

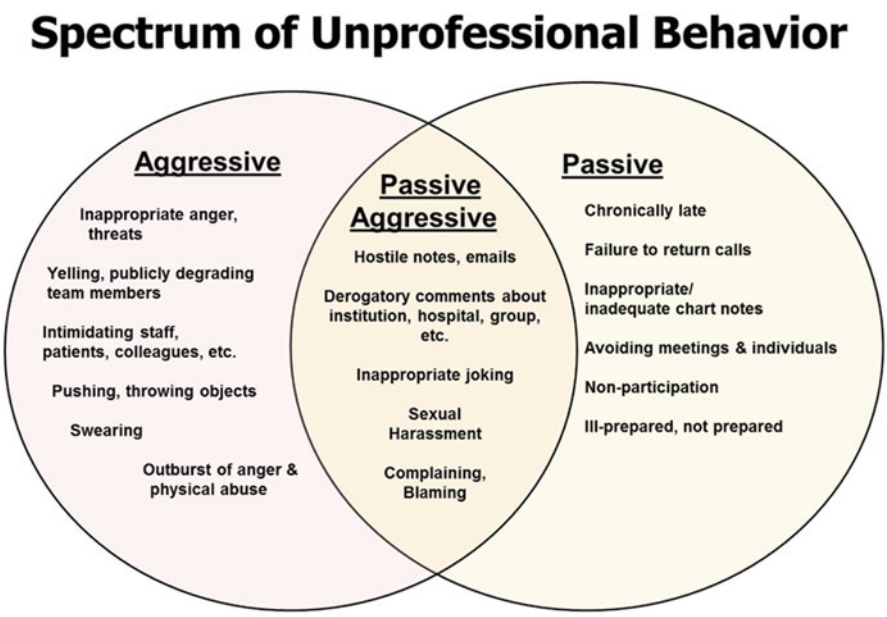

Fig. 12.1 Spectrum of behaviors that undermine a culture of safety and reliability (Adapted from Spectrum of Disruptive Behaviors in Physicians. Swiggart WH, et al. A Plan for Identification, Treatment and Remediation of Disruptive Behaviors in Physicians. Frontiers of Health Services Management, Vol 25. Number 4, Summer 2009, page 4)

While fictional, the case represents a composite drawn from several AMCs throughout the U.S. The chapter's goal is to describe a specific plan and reliable process by which medical group colleagues and AMC leaders may promote professionalism and professional accountability, and restore to full and effective functioning ("redeem") those colleagues who exhibit concerning patterns of behavior.

A Hypothetical Scenario

Dr. A is a well-known surgical specialist recruited from a large, urban, for-profit hospital to establish the AMC's Center. The AMC had undergone leadership changes, and Dr. A's Chair has been charged by AMC leadership to expand her department's influence, reputation, and revenue. She recruited Dr. A because of his reputation for clinical and procedural innovation, and she considered his MBA training an asset. During interviews, Dr. A said he was "looking forward to working in an academic community that valued innovation." Dr. A's recruiting and on-boarding included open, frank dialogue about the resources Dr. A would need, and both sides were satisfied with the outcomes of negotiations. (The brief outline in Table 12.1 highlights other elements that can improve (not guarantee) a recruit's chances of success [3].) Dr. A's spouse did not immediately move to the new location, but he arrived with great expectations, purchased a home, and set about establishing the Center.

Table 12.1 Recruiting and onboarding for success

AMC Tasks
I. Recruiting: Discuss AMC's strategic plans and approval process with physician leaders; seek input from those who will be impacted, both consulting and the consultants. Gain majority support.
II. Initial Contacts with Recruit: Request case logs, patient data, inquire about any barriers to state licensure or medical staff credentials. Involve key medical staff, potential referral sources; Outline the AMC mission, vision, values, and expectations; learn candidate's expectations; State roles, goals, behaviors, and evaluation metrics.
III. Site Visits: Introduce candidate to key medical, nursing and administrative leaders, other physicians and team partners and key potential competitors; host facilities tours.
IV. Confirm Expectations: Determine and obtain required equipment, supplies, etc.; schedule training for candidate and team members. Set timeframes. Confirm candidate has and understands faculty manual, bylaws, credentialing policy, code of conduct, and other governing documents. Discuss role in Core Measures, HCAHPS, EHR, RAC, VBP, and other programs.
V. Welcome to the Community: Introduce key facility directors and department managers; initiate marketing; initiate meet and greet functions with referring physicians.
VI. Implement Performance Measures and Monitoring: Share positives and use accountability pyramid to routinely and reliably share concerns as they arise; employ local, regional, national peer comparisons.
Candidate Tasks
I. Learn about AMC's history, culture: Ask how it is regarded in the community. Is the center seen as a threat or beneficial?
II. Share expectations, needs, concerns: Carefully consider the AMC's proposed goals and metrics.
III. Talk to AMC and community physicians: Aim to learn center impacts on both. Systems may resist change, so monitor for any resistance.
IV. Determine skills and staff training needs: Identify those related to new program; establish resources needed for training.
V. Find mentor(s): Within the AMC to navigate politics, help negotiate unforeseen challenges.
VI. Invite, consider feedback: Use all available resources to address concerns, improve outcomes.

Problems began appearing in the Center's first few months of operation and persisted over the next 2 years. It soon became apparent that far fewer physicians than anticipated were referring patients than the business plan projected.

Additionally, in the first 9 months three complaints about Dr. A from Center team members were submitted via the AMC's online event reporting system. One indicated that Center staff (especially procedure support staff) wanted training in Dr. A's procedures because he publicly berated them for their lack of skills. A supervisor reported Dr. A was especially vocal in criticizing new nurses and humiliated more than one by harshly dismissing them from procedure rooms.

Moreover, one team member complained Dr. A's orders sometimes conflicted with AMC policies in ways that could negatively affect outcomes. The report stated, "When nurses and staff objected, Dr. A raised his voice and replied with mean-spirited sarcasm about 'irrelevant' policies." Finally, early in Dr. A's second year, the Quality Chief reported the Center's first-year metrics compared poorly with national benchmarks.

If Dr. A had been recruited to your AMC, what might your AMC do to help him (and the Center) succeed, and what would your timeline be?

The Project Bundle

Numerous factors influence the success of proposed organizational initiatives. This chapter addresses human factors, but concerns about physician behavior do not rule out system failures. Leaders who focus primarily on systems issues may miss the effects of unprofessional behavior. A focus on an individual's behavior may similarly obscure impacts of systems failures. Therefore, leaders must weigh systems and human contributions, and then determine actions that will address the problems [4–9]. Use of a "Project Bundle" can help leaders focus on and identify both potential system-related barriers and behavioral challenges (Table 12.2) [4, 5].

Table 12.2 A project bundle[a]

Team Name/Unit		**Project**			**Date**
Project Bundle Rating Scale[a]		A. Need (1 point)	B. Developing (2 points)	C. Strength (3 points)	Comments
PEOPLE	**Committed Leadership**				
	Project Champions				
	Dedicated Team				
PROCESSES	**Clear Organization Values and Goals**				
	Enforceable Policies				
	Sufficient and Right Resources				
	Model for Tiered Intervention				
SYSTEMS	**Measurement and Surveillance Tools**				
	Process for Reliable Data Review				
	Multi-Level Professional Training				
Sum Columns		A=	B=	C=	**Project Score Guide**
Project Score (column total (A+B+C))					>23: High likelihood of success
					19–23: Needs additional development
					<19: High risk of failure

[a]Hickson GB, et al. Balancing systems and individual accountability in a safety culture. In: Berman S, ed. *From Front Office to Front Line*. 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources; 2012:1-36, specifically 19-23

The likelihood of achieving meaningful goals will improve if the AMC has a robust infrastructure that supports project development, monitors progress, and facilitates early problem identification. Leaders must demonstrate willingness and ability to reliably address any behaviors that undermine the achievement of intended outcomes [6]. Table 12.2 illustrates the extent to which AMC leaders and implementation teams must evaluate which key elements are in place for important projects: People, Processes, and Systems.

People

Effective leaders consistently articulate, model commitment to, and implement the infrastructure that supports and promotes professional accountability for the organization's aspirational mission, vision, and values. In this case study, the AMC had plans in place for timely identification of and attention to indicators of behavior/performance problems. Dr. A's data suggested problems relatively soon after his arrival. AMC leaders and department colleagues possessed personal courage to address the Center's problems, and they acted to address Dr. A's conduct and provide him with needed behavioral support. The remainder of this chapter describes how.

Processes and Systems

When problems arise and/or progress toward goals fall short, leaders need defined processes and reliable tools for action (Table 12.2). AMCs are better able to align goals and actions if all team members share core values articulated by the AMC's mission, vision and values. Effective AMC leaders routinely connect values to the assessment of performance at the system, individual and team member level. Policies that address expectations for physician conduct are needed, as are a model for tiered interventions and resources to help restore physicians whose performance demonstrates unnecessary deviation from norms or expectations, thereby undermining the culture of safety [4, 5].

Consider the "Accountability Pyramid to Promote Professional Performance" (Fig. 12.2) [7, 8], which provides a way-finding framework for helping leaders decide when and how best to promote accountability. Criteria for action at all levels are defined and more fully described through other resources [10, 11]. For example, suspected or observed "egregious" (intentional, dangerous, immoral and/or illegal) acts at any level of the pyramid must be immediately referred for evaluation and consideration of corrective, disciplinary, or legal action [4, 7, 8, 12]. In contrast, the first time a professional's behavior is reported as inconsistent with organizational values or policies (i.e., unprofessional) and likely due to an oversight may be addressed lower on the pyramid, in a more collegial fashion [4, 5, 7, 13].

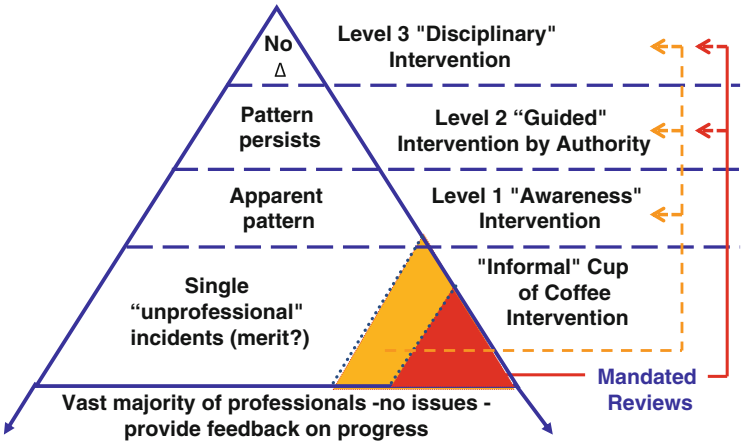

Fig. 12.2 Promoting professional accountability pyramid

For isolated observations of unprofessional performance or conduct, "cup of coffee" conversations will generally suffice [4, 7]. Cup of coffee conversations allow for quick, non-judgmental feedback, a respectful declaration of what was observed and a non-directive expression of concern [7–9, 11]. The tone is collegial and conducted so as to minimize any humiliation or embarrassment. Therefore, in virtually all cases, the conversation includes no guidance or coaching. Dr. A's Chair and Vice Chair had received training and practice in cup of coffee conversation skills as part of the AMC's leadership development training program (for more information, see Chap. 3).

The pyramid's Level 1 Awareness Intervention requires data, metrics, reliable reviews, and AMC professionals with both the right to know the data and training to share it. The purpose of Level 1 feedback is to bring "awareness" so that the recipient can self-reflect and seek to eliminate recurrences. Awareness interventions occur when data exceeds pre-determined thresholds and before the need arises for leadership to impose directive or disciplinary correctives. Evidence suggests that 70–80 % of physicians respond to this intervention level by reducing patient and co-worker concerns [5, 10]. This process has also been employed to identify variation in clinical outcomes and to improve adherence to clinical processes that result in meaningful improvements in clinical outcomes when applied as part of the comprehensive bundle for promoting professionalism and accountability [14, 15].

Application to Dr. A

Shortly following submission of the third staff/co-worker concern, the Vice Chair of Dr. A's department visited with Dr. A, reminded him of their brief conversations about the previous two reports, shared the third, and showed Dr. A data revealing that while 87 % of the AMC medical staff had no staff reports of concerns, Dr. A was among the 2 % of the medical staff

with three or more. With respect to the specific report, the Vice Chair invited Dr. A to recommend changes to policies or protocols that appear inconsistent with best practices—or to adhere to them "because I am aware of your commitment to patient safety and quality." Dr. A expressed surprise and dismay to learn his data compared poorly with that of his colleagues. He excused his behavior by saying his primary concern was patient care and safety. He attributed the complaints to nursing and staff unwillingness to follow his orders, and not to his behavior. He further asserted healthcare had changed over the years in ways that diminished physicians' authority. He was frustrated that he was less able to effect change using the skills he had learned during training and used throughout his career. The Vice Chair returned attention to the comparative data, noting that medical group members, representing a range of years in practice, were associated with few or no concerns, and they all worked with the same or similar staff in the same environment.

The Vice Chair explained AMC and departmental policy, noting additional reports could trigger the need for a structured remediation plan, "but we all want you and the Center to succeed, and I'm confident that won't be needed in your case." Dr. A paused, then added that his spouse's delay in moving to the new location led him to feel more lonely and isolated than he had ever felt before, perhaps contributing to some "misunderstandings."

Dr. A agreed to reflect on co-workers' perceptions of his behavior and ways to address systems issues that undermined the Center's priority on safety.

When Additional Help Is Needed

Should a pattern persist or egregious acts occur, leaders must take active roles in "guiding" the individual (Fig. 12.2, Level 2). If the professional still does not improve, he/she is referred for consideration of Level 3 corrective/disciplinary action conducted in accordance with the AMC's faculty manual, bylaws, contracts, human resources policies, or other governing documents. However, before Level 3 occurs, what resources might AMC leaders use to address an apparent deficiency and help restore the colleague to full and effective professional functioning?

Resources to Help Address Professionals' Needs

Table 12.3 lists potential resources that may be required to help professionals whose pattern persists due to physical or mental illness, substance abuse, significant life stressors, skills deficits, and/or practice management challenges. Most states have a Physician Health Program (PHP). PHP services vary, but all exist to identify or provide expert resources for diagnosing and/or addressing physician needs. Second, an AMC's Office of General Counsel (OGC) can help draft conduct standards, establish just and fair due process procedures, and guide development of other system-wide policies and protocols. OGC's guidance can help avoid costly procedural mistakes. In addition, some AMC employee assistance programs (EAP) and wellness committees offer faculty/physician-specific help for medical, psychological, psychiatric or situational problems that may trigger or contribute to unprofessional behavior [16, 17]. EAPs are also likely to be aware of effective

referral resources outside the AMC. Some referral sources offer comprehensive multidisciplinary physician evaluations (fit for duty) that may identify such issues as early onset dementia, undiagnosed mood or personality disorders, hearing loss, burnout, and depression, among others [18].

Comprehensive evaluations are valuable for providing unbiased assessments and recommendations to address professionals who cannot or will not change performance. When unprofessional behavior seems out of character or appears to be a new pattern, the evaluation can provide clarity and save both the physician and AMC unnecessary confusion.

Other resources such as 360° evaluations [19] are designed to clarify impacts and extent of staff concerns for physicians who otherwise deny or downplay them. These evaluations should be constructed to permit quick completion and be repeated to support ongoing monitoring. Other physicians may benefit from a coach or qualified mentor who observes clinical and team interactions, then provides actionable skills-related feedback [4, 7, 19] (see Chap. 15). Professional development courses and various residential and outpatient treatment centers have particular value for physicians with diagnosed need for skill development or counseling respectively [20–27]. Educational and therapeutic interventions can address core issues and teach new skills and behaviors in supportive environments. Organizational leaders should be prepared to discuss referrals with intervention program directors who may, after receiving a participant's permission, call to learn the organization's reasons for referral, clarify expectations, and address common questions (Table 12.4).

Application to Dr. A

Following Dr. A's awareness intervention, no new complaints were reported for the next 9 months. His interactions with nurses changed rather dramatically. While he didn't yell or use harsh sarcasm, he limited conversations to crisp but superficially polite demands for what he needed. New nurses assisting on procedures were marginalized as he simply worked around them. The less he communicated verbally the more tension grew. Near misses and mistakes increased. Center nurses and their collaborating counterparts grew increasingly afraid to call Dr. A with questions or concerns. The Center's clinical metrics suffered.

One day during a particularly complicated case Dr. A exploded in anger, capped by him throwing an object across the room. Several staff reported their concerns about the "unsafe, frightening, and unprofessional" event.

Consistent with the AMC's adoption of the tiered intervention pyramid, Dr. A now qualified for an authority-guided intervention [8, 9, 28]. Therefore, Dr. A's Chair and Vice Chair met to review the latest staff complaints, clinical data, and other elements of the department's Ongoing Professional Practice Evaluation (OPPE) dashboard. The Chair then met with Dr. A to share the data, concerns and next steps.

Table 12.3 Selected intervention resources[a]

• 360° Evaluations and Continued Monitoring
• Coaches
• Comprehensive (fit for duty) Evaluation Programs
• Consultation with Clinical Practice or Management expert(s)
• Employee Assistance Programs
• Internal AMC Physician Wellness Programs
• Office of General Counsel
• Peer Review of Medical Records
• Physical/mental health assessment
• Professional Development Courses
• QI officers/risk managers
• Residential or Outpatient Treatment Centers with expertise in physician behavior
• Reverse shadowing: shadowing an "expert" in the field
• State Physician Health Program
• The Federation of State Physician Health Programs (www.fsphp.org)
• Therapists and Counselors
• Other options as applicable

[a]These should have demonstrated relevant expertise and a track record of diagnosing and/or addressing physician behavior

Application to Dr. A

Dr. A's Chair began by saying she valued his clinical skills and Center startup, but his behavior, most especially his recent egregious outburst, was inconsistent with the AMC's values. She noted the conduct had affected teamwork and may have influenced both clinical outcomes and potential referrals. She told Dr. A she wanted him to succeed and to model the kinds of professionalism his leadership role required. She added she was prepared to support him in achieving that goal. She said she had reviewed the data and had concluded that Dr. A appeared to "lack some leadership and interaction skills." She continued, "You also don't always seem to recognize how your conduct affects others." She told Dr. A she had informed and consulted with the AMC Dean of Faculty and Legal Counsel, and concluded by directing Dr. A to attend a remedial course for physicians that featured small group learning, skills training, multiple pre- and post-course self-assessment and reflection exercises, and both short- and long-term follow-up. She asked him to voluntarily submit to a series of 360° evaluations and informed him the AMC would share costs. Dr. A replied he was not totally convinced he needed help, but signed an agreement letter that permitted the Chair to discuss reasons for the referral with the course director. When Dr. A called to register, he told the course director, "I was hired to start a program, and now I'm in trouble."

Why was Dr. A "in trouble?" Perhaps he lacked emotional intelligence or insight into how his behaviors affected others? Or because he lacked skills needed to negotiate conflict, effectively solve problems, and lead support staff? His Chair deemed him either unwilling or unable to act on previous feedback regarding his behavior and its effects. The course to which she directed him addressed behavioral deficits,

Table 12.4 Selected Elements of Potential Communications with Referral Agencies[a]

1. History/Background
(a) Description of observed behaviors (may include documents or emails displaying the concerning behavior; state any limitations on sharing)
(b) Mandatory or elective involvement?
(c) Any prior communications about the concerning behavior
(d) Related data, including medical records
(e) Timeline: past and current work record/annual reviews, HR actions, administrative actions;
(f) Is this an acute or chronic issue; when did things begin to go wrong?
(g) Do the agency's strengths match the need?
2. Objective(s) of the referral—But let the professionals do the assessment, diagnosis, recommendations, treatments
(a) Assessment only
(b) Assessment and treatment
(c) Restoration to full practice, Restricted practice, Relocation, Termination
(d) Other
3. Metric(s) for assessing change
(a) How will Dr. __ and leader measure success or failure
(b) Any contingencies (Dr. __ must/must not ___; if Dr. __ does/does not)
(c) Any timeline by which results must be achieved (is change achievable within pre-specified timeline; consistent with expected span of treatment)
4. Resources
(a) Who/what helps are available for Dr. __ (local, regional, national)
(b) Who pays for what
(c) Any agreements (FMLA, Administrative LOA, Medical LOA)
(d) Other
5. Outcome(s)
(a) What feedback does referring leader need/want, and can it be provided)
(b) Who decides fitness for duty and on what basis
(c) Is a Return to Work Agreement (RWA) needed
(d) Other

[a]Appropriate releases should be obtained. Most referral agencies will benefit from having a conversation. Communications may be oral or written; each circumstance is different; not all elements will be available, needed, or appropriate every time; and agencies may be limited in the feedback they can provide to the organization making the referral

taught selected interpersonal skills, addressed personality characteristics, and prompted discovery of ways in which his family background and parental messages had influenced him. For example, through a series of exercises conducted before and during the course, Dr. A came to realize he grew up in a home where emotions were undervalued, achievement was paramount, and healthy conflict resolution was rarely demonstrated. His medical school training reinforced his resulting perfectionism. When he returned to work following course completion, he requested the assistance of an executive leadership coach, which was granted. He agreed to and continued to be monitored with 360° feedback every 6 months for the following 2 years.

Postscript

Dr. A recently completed his fifth year as Center director. The Center has earned a solid referral base and excellent community reputation. Dr. A's coach had employed periodic shadowing and regular reviews of steadily improving 360° evaluation results to recommend specific teambuilding skills. As a result, Dr. A learned essential skills for forming relationships with other physicians, Center colleagues, and patients. These relationships were reinforced by positive publicity about Center research, better-than average clinical metrics, and positive online patient testimonials. In addition, Dr. A sponsored "Cup of Coffee Conversation" training [4, 7] *for all Center staff, during which he personally modeled how he intended to respond to constructive feedback by listening, empathizing, appreciating messages, and responding thoughtfully. Staffing over the past 18 months has been stable, with minimal turnover due only to retirements or relocations. No staff complaints were reported during this interval.*

A few months later, Dr. A is sitting with a mid-career physician faculty member who has been associated with several staff concerns and an adverse event. Dr. A's Chair had recommended he complete the AMC's training on having such conversations. He remembers his own history. He clearly and respectfully shares the concerns and responds to the colleague's questions and challenges. The colleague asks for Dr. A's expectations. Dr. A suggests his colleague reflect on the complaints and consider how the problematic behaviors described in the event reports might have been avoided. The colleague wants to know what to do. Dr. A begins to relate how he acquired new skills, but because elements of the colleague's circumstances differ from his, he instead shares a broad list of potential resources and says he knows the colleague will consider which, if any, may be helpful.

Conclusion: Lessons for Leadership

Does this general approach to promoting professionalism and professional accountability work? Experience demonstrates that high risk professionals can be identified [28–30], and more than 70 % who receive feedback and needed resources improve [10]. To be sure, professionals receiving guided interventions offer more challenges, but they often respond positively as well [20, 23].

Finally, promoting accountability requires leaders (and peers) who are willing and able to address both system and individual performance issues. Such commitment is consistently realized when all AMC faculty and staff are armed with tools that:

- Reinforce personal courage for sharing concerns with a coherent, comprehensive plan,
- Encourage co-workers, patients/families, and professional colleagues to report concerns,
- Provide measures and metrics that indicate threats to teamwork, safety, and quality,
- Bring "awareness" to individuals and systems demonstrating unnecessary variation from norms,
- Permit no exceptions or exemptions from the process irrespective of rank, status, or assertions that their circumstances (e.g., practice, patients, service volume, etc.) differ from others',

- Define and direct tiered interventions to restore excellence,
- Make effective use of relevant internal and external resources, and
- Help the physician reenter the workplace successfully.

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Chapter 13
Medical Legal Challenges

Robert E. Gwyther and B. Glenn George

Background Issues

Teaching physicians practice in complex settings that involve not only the care of sick patients, but also include supervision of resident physicians and medical students. Residency training is carried out under guidelines written by experts from each specialty, overseen by the Accreditation Council for Graduate Medical Education, and reviewed periodically by a "residency review committee". There are also guidelines and recommendations written by the American Association of Medical Colleges and administrated by the Liaison Committee for Medical Education. Added to this are billing rules and regulations for charges submitted to Medicare and Medicaid patients, which are written and enforced by the Center for Medicare and Medicaid Services.

Physicians are educated in biomedical sciences and trained to diagnose and treat patients using deductive reasoning, which involves gathering data, determining a working diagnosis, and treating accordingly. Lawyers are taught to reason inductively, using laws, regulations, and previous court outcomes to advise their clients on required and prohibited actions and behaviors. Sometimes these reasoning strategies conflict, especially when physicians believe that what they have done is "right," while their lawyers believe that they may lose in court if the issue is litigated.

All medical settings have written policies and procedures required for accreditation by the Joint Commission (or another accreditation entity) or written to achieve

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_13

optimal outcomes. As a rule, if providers do not follow their own institutions' written policies (or applicable state or federal regulations), it is difficult to defend subsequent claims if adverse events occur.

The concept of "standard of care" (SOC) arises in most medical malpractice suits. SOC may be defined as:

> *…the watchfulness, attention, caution and prudence that a reasonable person in the circumstances would exercise. . . . Failure to meet the standard is negligence, and any damages resulting therefrom may be claimed in a lawsuit by the injured party* [1].

To prevail in court, a plaintiff must prove both that the providers were "negligent" by practicing "below" the SOC and that the harm or bad outcome was caused by that negligence. There is no definitive resource that describes the "standard of care" because medical knowledge continually grows and changes, and because much of medicine involves judgment calls, rather than proven science. Therefore, SOC in a trial becomes a description of acceptable practice at the time of the incident, provided by experts in a similar field as the defendant.

Case Study for Medical Legal Chapter MA is a 62 year old Caucasian woman whose primary care physician started her on Prempro (conjugated estrogen plus progesterone) in September of 1996, when she was 52 years old. This medication was started in an effort to minimize bone loss because MA weighed just 120 lb and had a family history of osteoporosis. A screening mammogram, done in March of 2002, showed an area in her left breast that was suspicious for malignancy. A needle biopsy revealed adenocarcinoma and a partial mastectomy revealed a 2 cm lesion confined to the breast with no metastases to axillary lymph nodes. She was subsequently treated with radiation and chemotherapy. She has had no recurrence of her cancer.

MA attends a breast cancer support group. In 2003, she heard about results from the Nurse's Health Study (NHS), which demonstrated an 80 % increased risk of invasive breast cancer (compared to placebo) for patients taking Prempro for 5 years or longer [2]. She became very concerned that Prempro might have caused her breast cancer and consulted an attorney to see if this was a case of malpractice.

The attorney reviewed her case and determined that:

1. Prescribing Prempro for osteoporosis prevention was commonplace during the years when MA took the drug and was therefore likely to have been within the standard of care.
2. The NHS demonstrated a correlation between Prempro and breast cancer, but did not prove that it was "cause and effect".

The attorney advised her that she would not win a malpractice lawsuit alleging that her physician's prescription of Prempro caused her breast cancer for two reasons:

1. It did not fall below the standard of care.
2. It is not clear that her breast cancer was caused by the Prempro.

Patient Care Situations

The basis of medical care is the "doctor-patient" relationship. Physicians agree to care for a patient using SOC methods. Patients agree to consider the physician's recommendations and to compensate providers for their services. Patients are under no obligation to do as the physician recommends. Third party payers (e.g. Blue Cross, Medicare) sometimes affect the care provided (e.g., if recommended services are not covered under a patient's policy and the patient decides to forgo treatment for economic reasons).

Consent

Informed consent is necessary for patients to knowingly agree to any care proposed. Physicians are responsible for describing recommended medical treatments and procedures in sufficient detail for a patient to understand what will occur during the treatment or procedure, including risks and benefits as well as alternative options. Listing possible complications in the consent documentation may reduce the chance of a successful lawsuit should any such complications occur.

Some patients may be suffering from conditions that make them dangerous to themselves or others. A medical example is a contagious infectious disease, such as E-bola virus, for which patients may be forced into quarantine until such time as they are no longer infectious. In the case of unstable mental health diseases, physicians may institute "involuntary commitment" of patients, without the patient's consent, to an appropriate psychiatric facility, until such time as a judicial hearing can be held, as required by state law.

Patient Capacity

Patient capacity refers to a patient's ability to understand and make decisions about his or her care. Adult patients may be unable to make their own decisions due to temporary or permanent incapacitation, dementia, or mental illness. Minors are generally represented by their parents or a legally appointed guardian, although some issues (e.g., contraception, pregnancy and substance abuse) may be treated without parental consent under applicable state law. Physicians may also be authorized to treat minors in an emergency when a parent or guardian cannot be reached.

Many patients have designated a family member or friend as health care power of attorney (HCPOA) to make healthcare decisions on the patient's behalf if the patient lacks capacity. If a patient does not have a HCPOA, decisions often fall to family members (as authorized by state law). Care of hospitalized patients with no

spokesperson may be managed by providers (often including a representative with ethics expertise), as permitted by state law and hospital policies, but may require the appointment of a legal guardian.

Any patient with capacity to make his or her own decisions has the right to refuse recommended treatment and may choose to leave the hospital before the provider believes it is medically safe for that patient to do so. When that happens, it is especially important that the physician fully document his or her efforts to explain the recommended treatment to the patient and the patient's decision to refuse that treatment. Most hospitals have a policy and a process for a patient who chooses to leave the facility "against medical advice."

Advanced Directives

Advanced directives are decisions patients make about the treatment(s) they do or do not wish to have in the future. Such questions commonly arise as patients age, and there is also a Medicare requirement for hospitals to determine treatment directives upon admission. Some patients want treatments that prolong their lives; others do not want to be kept alive by artificial means if there is little chance of survival or a return to a quality of life they consider acceptable. Advanced directives may be given verbally or documented in writing.

"Living wills" are one form of advance directives and typically address issues such as "Do Not Resuscitate" (DNR) or "Do Not Intubate" (DNI) orders (although physicians sometimes need to remember that these do not mean "do not treat"). Living wills can be helpful documentation in a patient's records, but may be difficult to apply to unanticipated illnesses or situations.

When a patient has provided verbal instructions to his or her physician, the physician should clearly document those instructions in the medical record, and the physician should honor any clear directives. Sometimes patients expect that "their doctor will know what to do" based on such conversations, but any uncertainty will need to be resolved by the HCPOA or a family member authorized to make those decisions if the patient lacks capacity to make his or her own decisions.

Medical Malpractice Claims, Insurance and Litigation

Medical malpractice issues are commonplace in American healthcare. As mentioned earlier, legitimate malpractice claims require both negligence and harm. In other words, the physician's actions or failure to act must have fallen below the SOC and the patient suffered some harm as a result. It is estimated that between 2 and 6 % of patients admitted to American hospitals have an unexpected adverse outcome due to medical negligence, but only 2 % of those patients file malpractice lawsuits, amounting to about 0.04 % of admissions. Up to seven times that many lawsuits are actually

filed [3, 4], however, because patients sue physicians for other reasons, such as a belief that critical information was withheld from them, a desire for revenge ("someone should pay" for their misfortune), or significant financial burdens (such as caring for a disabled child) [5].

The risk of malpractice suits varies by specialty. Payouts are made on behalf of approximately 2 % of internists, 4 % of pediatricians, 6 % of obstetricians, and 8 % of surgeons [6]. Other correlations of malpractice payouts include (in descending order) higher frequency of unsolicited patient complaints, more productivity [measured in relative value units (RVUs)], and male gender of the physician [7].[1]

Insurance companies provide different types of malpractice insurance policies with different coverage limits (for example, $1 million/$3 million, or $1 million for any individual claim and $3 million for all claims in a policy year). The annual premiums for insurance vary by specialty, reflecting the variations of risk of lawsuits noted above.

There are two different types of malpractice insurance. It is critical that physicians understand the type of policy covering their practice, as well as their reporting obligations under that policy.[2] "Occurrence" policies are based on the date of the event. Any bad outcome arising from care provided during the policy year should be covered, even if a claim is filed in a later year, assuming the provider has otherwise complied with the terms of his or her policy (e.g., reporting adverse events even before a claim is filed). "Claims made" policies cover claims occurring and made during a physician's coverage period. Claims filed after the insurance policy has lapsed will not be covered unless the physician has purchased "tail" insurance. Typically, claims made policies are less expensive for the first few years, but the rates grow higher in future years.

Risk management personnel stress the importance of being notified whenever an adverse outcome occurs. This notification facilitates both a prompt investigation and a quick resolution if the potential claim has merit. The risk management department may even initiate contact with the patient and offer compensation when an error has clearly occurred.

Litigation

Some patients start the malpractice process by submitting a claim or a complaint to the hospital's legal department or to the physician's office. If a claim is judged to be baseless by the physician's attorney or the hospital risk management team, it may simply be denied and the patient can drop the matter or decide to pursue litigation.

[1] Since the other variables are difficult or impossible to change, Vanderbilt University developed a successful peer intervention program called the Patient Advocates Reporting System (PARS), which seeks to identify and intervene on high complaint generating physicians to reduce their risk of lawsuits.

[2] Medical malpractice insurance blog.

When a lawsuit is filed, the injured patient becomes the "plaintiff", while the hospital, physician(s), nurse(s), and other staff become "defendants". Phases of investigation and settlement are outlined in Table 13.1.

Because defendants prevail in over 85 % of medical malpractice trials [8], physicians may believe they are likely to win a trial. These numbers are misleading, however, because physicians and hospitals typically settle cases they consider "risky" or do not expect to win. Cases actually tried are those where the providers (and their attorneys) believe they have a strong probability of winning.

Physicians must report any payouts of $75,000 or more to the National Practitioner Data Bank (NPDB), regardless of whether a lawsuit was filed. The NPDB also collects other information, such as adverse medical board actions, Medicare fraud, and adverse hospital privilege actions. NPDB information is available to hospitals, licensing boards, insurance carriers and potential physician employers, but not to the public at large.

For many years, the prevailing philosophy of approaching potential medical malpractice in healthcare settings was to deny liability and defend cases unless it was certain that they could not be won, resulting in expensive litigation and long delays. In 2001, the University of Michigan initiated a new philosophy of honesty and

Table 13.1 Phases of investigation and settlement of medical malpractice lawsuits

Phase	Activities included
Initial investigation	Physicians and staff work with lawyers and risk managers to review what occurred in the patient's care (may already have occurred if the event was previously reported to risk management)
Determination of validity, merit, and defensibility	Internal (and external when needed) experts review the case and opine on whether the case is valid, has merit, and is defensible
Settlement without a trial	If damages to the patient are determined to be the result of medical negligence or the case may be hard to defend for other reasons, an offer to settle the case without a trial may be initiated. Settlements are generally final and cover both past and future costs
Assessment of value	Each side often prepares a detailed cost analysis to establish the monetary value of the case. Damages may include the cost of medical care; the cost of expected future care, including life care plans for severe injuries; and loss of income." Pain and suffering" damages compensate the patient for discomfort and loss of normal function, but may be "capped" under state law. Jury verdicts or settlements for similar cases in that jurisdiction, if known, may help determine the expected outcome at trial
Mediation/arbitration	If agreement is not reached between the parties, some jurisdictions require mediation or arbitration processes, or the parties may voluntarily agree to use them. In mediation, an experienced attorney or former judge facilitates a settlement to which both parties agree. Arbitration typically involves an individual who actually "decides" the case, similar to a judge, and the parties agree to be "bound" by that decision
Jury trials	If no agreements are reached, the case proceeds to trial, during which both sides present a case and a judge or jury decides the outcome

transparency including "open disclosure with an offer to settle" when the institution believed its providers were at fault. This new approach led to a lower number of claims filed, reduced case processing time, lower defense costs, and lower average settlement amounts [9]. This philosophy is now widely used to acknowledge valid claims and attempt to reach prompt resolutions.

Testifying

If sued for malpractice, physicians are usually required to testify in their own defense about the care they provided to the patient plaintiff. Physicians may also be asked to testify in court on behalf of their own patient(s) as "fact witnesses" to provide information about the patient's condition and/or treatment provided, even in cases in which they are not being sued. Finally, they may be asked by plaintiffs or defendants to testify as "expert witnesses" because of expertise they possess that may help a court or jury evaluate the SOC issue or the extent of the plaintiff's injuries. In any of these situations, physicians testify under oath and are obligated to give truthful, accurate, and ethically appropriate testimony.

Generally a physician's testimony will require the physician to review the patient's medical records and disclose HIPAA-protected information; both require authorization by either patient consent or a court order. The physician should consult with counsel prior to reviewing a patient's record (for any purpose other than treatment he or she rendered) or prior to discussing the patient's care with anyone other than the patient. Except when testifying on their own behalf in a malpractice action, physicians generally may charge reasonable fees for time to prepare for and provide testimony.

Experts may be "non-testifying," hired by one of the parties to provide a candid evaluation of the claim without any intent to use that individual as a witness in the case. A "testifying expert" is identified as a witness to be used at trial and may be deposed prior to trial, in addition to being a trial witness. A deposition involves recorded testimony provided under oath, with attorneys from both sides present.

To qualify as a testifying expert witness, a physician must practice in the same or a similar specialty as the defendant in question and must have practiced coincident with the time the defendant was treating the patient. In general, the court must be satisfied that the witness brings special knowledge about the type of condition and treatment at issue in the case. Experts are often sought from among medical school or residency training program faculty members, who may have a history of teaching, research and/or publication in the field involved. Physician experts should be unbiased and, ideally, should not agree to testify in cases involving their medical staff colleagues because of the internal difficulties and "political" issues that may cause for the institution.

Some physicians may question why one physician would testify against another physician on the plaintiff's behalf in a medical malpractice lawsuit. The important thing to remember is that errors do occur, and if medicine professes to discipline

itself, it requires knowledgeable physicians to give honest testimony on either side of a case. Testifying against local community physicians who agree to precept medical students may create other "political" problems for academic medical centers, however, which commonly depend on community physicians to refer patients and to assist with the education of medical students or residents. So, academic physicians may wish to avoid becoming experts on the other side of cases involving their community teaching faculty.

Legal Issues in the Workplace

The practice of medicine is not a right but a privilege, administered under rules and regulations of both federal and state institutions. Physicians must successfully pass national board examinations while in medical school and practice under supervision, with a training license, for at least a year, to be eligible for permanent licensure. Most physicians complete residencies and fellowships that are 3 years or longer in duration and then must pass examinations and other requirements to become board certified in a medical specialty. Physicians may lose their licenses or their board certifications for cause, including failure to maintain state or specialty certification requirements, substance abuse, inappropriate relationships with patients, or disruptive behaviors. In addition, physicians whose performance is substandard may lose hospital privileges. Adverse decisions/rulings are reported to the NPDB and are available to the same institutions as malpractice payouts.

Physicians accused of disruptive behavior are investigated pursuant to policies required by the Joint Commission, often through a chief of staff's office. When claims of disruptive behavior are substantiated, the institution may attempt internal remediation as a first step. If problems continue, physicians may be referred to external programs that evaluate the physician and recommend an intervention. The physician may well seek legal counsel if his or her privileges or employment are in jeopardy (see Chap. 10 for more on Disruptive Physicians).

Employment in medical training environments is complex and regulated by government, hospital, and university policies. Attending physicians employed by universities may be given tenure track or clinical track faculty appointments. Teaching physicians are tasked with providing patient care, supervising care provided by residents and medical students, and complying with documentation and billing requirements of third party payers, especially Medicare and Medicaid. Physicians may be paid salaries, a percentage of fees based on personally performed services, and/or productivity bonuses. Faculty members are generally evaluated on patient outcomes, patient satisfaction, learner evaluations of teaching, research productivity, and, if applicable, success in securing outside funding. In order to advance through the ranks of academia, faculty may be required to demonstrate proficiency or excellence in patient care, research, teaching, administrative work, or community service. There are generally routes of appeal designated for faculty members who want to

contest their unrealized expectations for promotion, and lawyers are often involved on both sides of such matters.

There are numerous other professional and staff positions involved in running an educational program or a patient care enterprise. Physicians commonly supervise these employees and may be responsible for performance evaluations and disciplinary actions, consistent with applicable institutional policies. Physicians as supervisors may be targeted in internal grievances or external legal action filed by employees seeking to challenge adverse employment decisions.

Regulatory Background for the Practice of Medicine

The practice of medicine and the governance of the medical educational enterprise in the United States are regulated by many entities (Tables 13.2 and 13.3).

Table 13.2 Significant federal regulators governing clinical practice

Major regulators	Organizations and/or activities included
US Department of Health and Human Services	Administration for Children and Families
	Administration for Community Living
	Agency for Healthcare Research and Quality (AHRQ)
	Center for Disease Control and Prevention (CDC)
	Centers for Medicare and Medicaid Services (CMS)
	Federally Qualified Health Centers (FQHC)
	Food and Drug Administration (FDA)
	Health Resources and Services Administration (HRSA)
	Indian Health Service (IHS)
	Substance Abuse and Mental Health Services Administration (SAMHSA)
	US Public Health Service
US Department of Defense	Active Duty and Retired Military Personnel
	Military Health System: Provides healthcare to TRICARE Management Activity (TMA)
US Department of Veteran's Affairs	Veteran's Hospitals
	Veteran's Outpatient Clinics
	Veteran's Community Living Centers
US Department of Justice	Drug Enforcement Administration (DEA)
Joint Commission (or other accreditation entities)	CMS payments depend on accreditation
Accreditation Council for Graduate Medical Education (ACGME)	Members: American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, Council of Medical Specialty Societies, American Osteopathic Association
US Department of Education	Liaison Committee on Medical Education

Table 13.3 Significant state, local, and institutional regulation and governance

Major Regulators	Organizations and/or activities included
State Departments of Health and Human Services	Implement and enforcement of state health laws
	Regulate Medicaid, which is funded jointly with the Federal Government
	Pay Medicaid providers on a fee-for-service basis
	Provide mental health, developmental disability, and substance abuse services for low income citizens
Boards of Medicine, Nursing and Pharmacy	Grant training and permanent licenses to providers who meet requirements
	Administer certification programs for licensees
	Investigate patient complaints and impose sanctions when appropriate
Healthcare Organizations' Administrative Divisions	Hospital privileging and credentialing
	Employment management including hiring, annual review, and disciplinary actions
	Institutional management of policies and procedures
	Billing and collections
	Managing malpractice insurance coverage
Managing Executives or Board of Directors	Establishing and enforcing institutional policies
	Responsible for strategic business decisions and overall budget issues

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Part III
Leadership

Chapter 14
The Leadership Stance

Rob Kramer and Anthony J. Viera

Introduction: Managing and Leading

People aspire to formal leadership roles in their organizations for a multitude of reasons. Some may desire more influence in creating a vision, moving the organization to greater levels of success. Others may aspire to affect policy and resource decisions. For others, weariness of past leaders' styles or mistakes may catalyze them to want a chance to set a different tone, affecting the culture. Discomfort can be a great motivator. In any context, the opportunity to lead in a formal role also comes with great administrative responsibilities.

In embracing the administrative role, managerial skills are important. However, people often confuse being a "manager" with being a "leader." In academia, a common framework is to identify the division chief or the chair as the leader of that group. It is also common to refer to the collective chairs and deans in an academic setting as the "leadership team." Such references confuse the roles and responsibilities that a manager has from that of the leader, which, at first glance, may seem merely semantics. However, two important distinctions need to be addressed in order for both the administrative manager as well as the group "being managed" to succeed.

To begin, in the context of higher education and among medical faculty, the designation "manager" is nearly unheard of, and may actually be seen as an insult. One wouldn't possibly give up the life of an academician to bear the scarlet letter "M." To do so, and by choice, is routinely shunned as a career detailer. If a faculty member is going to put her or his research, teaching, and clinical work to the side for an administrative role, "leader" rings with much more status than "manager." Yet, taking on an administrative role, such as department chair, division chief, dean, principal investigator, or clinic director, comes with a substantial number of managerial

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_14

responsibilities. Thus, recognizing the difference between the roles "manager" and "leader," and when to be strategic in the use of both, is a foundational component of the administrator's success.

The first distinction is that to be a manager is to oversee the work and deliverables for which the role requires. The manager role is vital in academic administration. This role may or may not include a formal job description, formal policies or procedures to learn and be able to enforce, and, ultimately, to oversee the accomplishment of the work for which the position has oversight. Management is hard work, especially when the job requires responsibility for the performance of others. The manager's source of power and influence includes the use of resources, established policies, procedures, rules and regulations to accomplish results; it comes from the manager's formal position of authority. With this role come established organizational methods to support the accomplishment of tasks to be done. When faced with people to supervise and performances to review, resources and budgets to allocate, decisions on strategy to be made, partnerships to build or maintain, and bosses to keep informed and satisfied, the manager needs tools to handle the plethora of responsibilities placed upon him or her.

The second distinction is that nothing in the above description of the manager's responsibilities includes the notion of leading, or instructions on how to be an effective leader. Being a leader is quite distinct from being a manager. While the manager's role is to oversee work, the leader's role is to gain willing followers towards the accomplishment of a vision or goal within a set of given circumstances. A manager uses the formal position of power to exert influence among those who report to that position. The influence may be in the form of recognition and reward strategies (given or excluded), work assignments and the quality or desirability therein, and the overall tone and culture of the department. However, if the manager relies solely on those tools to accomplish the work, she is instilling great limitations to her effectiveness. She can and should also leverage the power of the leader role. Effective leaders need to understand and maximize their functioning in each of its triumvirate parts (Fig. 14.1).

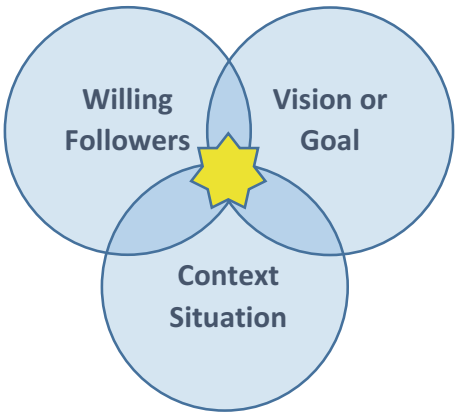

Fig. 14.1 The three intersecting *circles* of leadership

Gaining Willing Followers

The leader first and foremost must be able to gain willing followers. Many people have the ability to share ideas, give input, or even make decisions. However, without support and buy-in from others, these efforts can easily fall on deaf ears.

A person doesn't earn the moniker of "leader" until a tipping point of followers readily, and by choice, supports the leader. The aged notion of using command control methods to enforce followership is akin to having a bank account filled with power. The leader can make withdrawals from that account, enforcing his or her will upon others, until the account is emptied and the followers are fed up. How many times have we heard stories of followers not willingly following at all, but rather behaving with compliance rather than commitment? Once that "power account" is dried up, dissension appears, and in many forms: disengagement, undermine/sabotage, turnover, or all out revolt. The true leader emerges, regardless of a formal role, because of his or her ability to attract others to *want* to follow.

Vision or Goal

Next, leaders have a clear vision or goal that is communicated effectively and inspires others to want to support it. The leader not only stands up for the cause he believes in, but models and embodies the behaviors needed to achieve the goal. This dynamic can be challenging, as the ability to provide an influential narrative and rationale for pursuing a vision, as well as to demonstrate one's deep commitment to its attainment, can be hard to sustain. For example, prior to the events of September 11, 2001, the New York City mayor at the time, Rudolf Giuliani, did not have a high approval rating and was primarily seen as a policy enforcer. However, upon the terrorist attacks of 9/11, Giuliani stepped into the void of uncertainty and grief, providing a clear vision for the residents of the city which resonated locally and globally:

> *"Tomorrow New York is going to be here. And we're going to rebuild, and we're going to be stronger than we were before… I want the people of New York to be an example to the rest of the country, and the rest of the world, that terrorism can't stop us."* [1]

In the weeks following September 11th, Giuliani's approval rating from Manhattan residents was 79%, up from the 36% rating he had 12 months prior [2]. He was *Time* magazine's Man of the Year for 2001. A year following the attacks, Giuliani released a new book. It's title? "Leadership." Suddenly Giuliani is an expert on leadership. A swell of support empowered Giuliani to consider running for president of the United States in 2008. Beginning as a front runner in 2007, he began campaigning and sharing his vision for the country, and people began to see the "everyday" Giuliani appear again; the policy enforcer and by-the-book administrator. Those strategies may have been effective as a manager, but they did not inspire willing followers in his bid to become president. By the time the New Hampshire primary arrived in January of 2008, Giuliani finished fourth with only 9% of the vote [3]. Giuliani was out of the race by the end of the month.

Creating a vision and establishing goals people enthusiastically want to support is only one step in the process. Creating an intriguing story around the vision or goals that sustains willing support is a second important factor. And having a leader who embodies the nature of what is being sought is a third critical component. In this vein, Giuliani was successful for a short time by giving voice to a critical vision that New York City, and the country, needed to hear. He fell short, however, in his bid to sustain his leadership status through his limitations in communicating an effective story and to personify his vision. Being a leader can be an ever moving target, one that is as hard to grasp at its onset, as well as to sustain for long periods of time.

Context or Situation

Leaders must understand and figure out how to effectively operate within the given circumstances they are placed. Another way to consider this is to look at the context, situation or culture in which the leader is operating. Many variables can affect the given circumstances. In academic medicine, examples may include the hospital and/or university managements' style, the philosophy within the department, the personnel working with and around the leader, the amount of resources available, timing and time pressures, the quality and number of medical students, clinic hours, etc. Clearly discerning the given situation or context can offer strategies to meet follower needs. In 2008, Barak Obama, in his candidacy for President, was very clear in his message that he always opposed the Iraq war. He understood that a majority of the U.S. population had grown tired of the U.S. presence in Iraq, and he used that awareness in crafting and embodying his message. He always opposed the war, going back to his days as a state senator in Illinois. This point was non-disputable and one that emboldened his candidacy.

Another example: on March 4, 1987, President Ronald Reagan addressed the nation in the midst of the Iran Contra scandal. He recognized the context, that the country was torn and troubled by the news that the U.S. had sold arms to Iran. Taking the national stage, Reagan addressed the situation head on, saying:

> *I've spoken to you from this historic office on many occasions and about many things. The power of the Presidency is often thought to reside within this Oval Office. Yet it doesn't rest here; it rests in you, the American people, and in your trust. Your trust is what gives a President his powers of leadership and his personal strength, and it's what I want to talk to you about this evening.*
>
> *For the past three months, I've been silent on the revelations about Iran. And you must have been thinking: "Well, why doesn't he tell us what's happening? Why doesn't he just speak to us as he has in the past when we've faced troubles or tragedies?" Others of you, I guess, were thinking: "What's he doing hiding out in the White House?" Well, the reason I haven't spoken to you before now is this: You deserve the truth. And as frustrating as the waiting has been, I felt it was improper to come to you with sketchy reports, or possibly even erroneous statements, which would then have to be corrected, creating even more doubt and confusion. There's been enough of that. I've paid a price for my silence in terms of your*

trust and confidence. But I've had to wait, as you have, for the complete story. That's why I appointed Ambassador David Abshire as my Special Counsellor to help get out the thousands of documents to the various investigations. And I appointed a Special Review Board, the Tower board, which took on the chore of pulling the truth together for me and getting to the bottom of things. It has now issued its findings.

I'm often accused of being an optimist, and it's true I had to hunt pretty hard to find any good news in the Board's report. As you know, it's well-stocked with criticisms, which I'll discuss in a moment; but I was very relieved to read this sentence: "… the Board is convinced that the President does indeed want the full story to be told." And that will continue to be my pledge to you as the other investigations go forward. [4]

Through these words, Reagan recognized his followers' need for trust and that it was violated, expressed that he also found it to be unacceptable, and conveyed what he intended to do about it. In owning his flaws and understanding the context of what America needed to hear from him, he endeared himself to his followers. In 1989, Reagan left the white house with the highest presidential approval rating since Franklin Roosevelt [5].

Thus far, the examples in this chapter have come from politics. This arena was utilized as it clearly demonstrates the direct impact of followership: if politicians do not garner enough willing followers, they do not get elected. Additionally, if an event occurs during a politician's tenure, it can greatly affect his effectiveness while in office. Considering this model, one can draw links to leadership in the academic medical center setting: followers matter, "walking-the-talk" matters, understanding the situation matters, communicating an effective story matters, and, yes, even politics matter. However, there are also many nuances which are unique and specific to higher education, and to medicine. The following is an exploration of leadership. As you read it, bear in mind the distinctive differences between managing and leading, and the core components of what makes a leader: gaining willing followers towards the accomplishment of a vision or goal within a set of given circumstances.

Academic Leadership Case Study: Teresa Sullivan, University of Virginia's First Female President [6]

In 2010, Teresa Sullivan was unanimously elected as the eighth president of the University of Virginia, and took over the office on August 1st of that year. On June 8, 2012, the Board of Visitors (BOV) Rector, Helen Dragas, and Vice Rector, Mark Kington, informed Sullivan that the board voted to remove her from office. What transpired in the subsequent 18 days is a remarkable story, affixed in the struggles of management and administration, and ultimately the vital importance and power of the leader-follower relationship.

In the few days following the vote to remove her from office, Sullivan handed in her resignation, and the BOV made the announcement to the campus community. Dragas stated, "The Board feels the need for a bold leader who can help develop, articulate and implement a concrete and achievable strategic plan to re-elevate the

University to its highest potential. We need a leader with a great willingness to adapt the way we deliver our teaching, research and patient care to the realities of the external environment." It appeared that the desires and strategies of the BOV were not in alignment with those Sullivan had been implementing for the prior 2 years. Immediately in this story we can see a fiasco of both management and leadership. The management situation is that the BOV and Sullivan were not on the same page regarding clarified expectations and outcomes for Sullivan. This is a failure of basic human resources management. Expectations were either not clearly stated or not well enforced by the BOV. On the other hand, the failure of leadership falls in the relationship dichotomy between both parties. What at first was mutual followership, Sullivan willingly following the BOV as she was nominated for the presidency, and the BOV willingly supporting Sullivan as the new president, eroded quickly. Either Sullivan no longer followed what the BOV desired, or the BOV no longer followed what Sullivan was trying to accomplish. *The Washington Post* reported that Sullivan's academic strategic plan, submitted in May of 2012, may have been the impetus for the BOV's decision. As we will soon see, the leader-follower dynamic quickly falls towards favoritism for one party over the other.

Beginning on June 11, 2010, 3 days after the BOV asked Sullivan for her resignation, and the day after the announcement went out to campus, the faculty, staff, and (soon after) students began a campaign of resistance and backlash against the BOV's decision, overwhelmingly supporting Sullivan as president. These groups were angered by the swiftness and secrecy by which the BOV went about their actions. They also were in strong support of Sullivan's vision and goals for the University. If the BOV had willing followership prior to June 10, 2010, it was quickly lost across a strong majority of campus. Sullivan, on the other hand, gained more and more followership in the coming days and weeks, growing stronger as information of the BOV's actions became known. By June 13, an online petition to reinstate Sullivan had garnered over 5200 signatures.

On June 16, the alumni association was heavily involved in petitioning for Sullivan's reinstatement, as was the American Association of University Professors (AAUP), who released a statement saying, "We join in the Senate Executive Council's dismay that due process for President Sullivan and the legitimate interests of the U.Va. faculty have been ignored in the precipitate action taken by the Board of Visitors. We join in calling upon the board to reconsider its decision." In the coming days major donors announced they would pull their funding, the University's faculty senate passed a resolution of "no confidence" in the BOV, and the BOV's student representative asked for more transparency from the board. On June 18, Dragas made a statement saying, "While our actions in this matter were firmly grounded in what we believe to be in the very best and long-term interests of the University, and our students, faculty, staff and alumni, we want to express our sincere regret for the pain, anger and confusion they have caused among many in our U.Va. family." In the face of growing opposition, it appeared that the Board would not back down from their decision.

Dragas' statement above demonstrates the lack of acumen in understanding followers' needs. It is quite in opposition to the tactic Reagan took during the Iran-

Contra Affair, where he acknowledged his failures and pointed towards specific actions to make improvements. Dragas' announcement, by contrast, begins with a self-protective statement ("While our actions in this matter were firmly grounded in what we believe to be in the very best and long-term interests of the University…"). This move undermines her attempts at regaining followers in the second part ("… we want to express our sincere regret for the pain, anger and confusion they have caused among many in our U.Va. family") as she already started with a defensive posture.

As the backlash continued, Vice Rector Mark Kington resigned, following in the steps of Peter Kiernan who resigned as chair of UVA's Darden School Foundation Board of Trustees. The BOV was losing followership at higher and higher levels of authority, and Dragas received growing external pressure to step down as well. Dragas, however, did not adjust her strategy to the changing situation, issuing a statement on June 21 stating that, "While the UVA student experience remains premiere, though our faculty creates dynamic new knowledge every day, and despite the enduring magic of Mr. Jefferson's University, the bottom line is the days of incremental decision-making in higher education are over, or should be." The same day, Marcus Martin became the first UVA Vice President to openly support the reinstatement of Sullivan as President. On June 22, Virginia Governor Robert McDonnell announced that the BOV had one week to make final personnel decisions regarding the matter or he would demand the resignation of the entire Board.

The swell of support had nearly reached its pinnacle, as Sullivan's follower base escalated in grass roots, financial, political, and media markets. On June 25, nine foundations, whose support covered nearly the entire University, wrote the BOV asking for Sullivan's reinstatement. On June 26, the BOV *unanimously* voted to reinstate Sullivan. The BOV *also* voted unanimously in favor of Dragas keeping her role as Rector. Finally, on June 29, Governor McDonnell announced, "Just as I was disappointed to see the lack of transparency and communication surrounding the request for the resignation of the first female president of U.Va., I am also concerned that the first female rector seemed to become the sole target of recent criticism."

The truth in this matter may never be separated from political posturing; however, both Sullivan and Dragas kept their jobs, and have somehow managed to maintain a working relationship, at least within the context of the university setting. How had they both managed to survive such an ordeal?

Sullivan maintained a clear vision, articulating her desire to continue working towards its attainment, and was able to enroll a critical mass of support in her favor. The faculty, staff, students, and funders each provided strong followership for Sullivan; and these respective groups provided critical leadership in standing up for their desires, creating a swell of support and momentum that spilled over to each other and out to the alumni and greater community at large.

How had Dragas managed to maintain her position amidst all this controversy? It appears, at least on paper, that she maintained the willing followership of her most important decision maker, the governor. Some people manage and build relationships with those above them ("up") far better than they manage down.

Medical Leadership Case Study: "Jennifer"

Jennifer is a well-respected faculty member at her university and teaching hospital. She has demonstrated dedication to her field and has maintained outstanding success in her research and teaching. She is also an enthusiastic mentor, helping young doctors and residents with their career progression. She enjoys giving extra time and attention to those around her, often working extra hours in the support of others. Last year the chief of her division appointed Jennifer as the clinical director for an outpatient clinic. The clinic was high functioning and was about to be expanded. Jennifer was excited at the new challenge, as she was ready to take the next step in her career. Having such a strong track record of success leading up to this point would certainly benefit her in this new role.

Jennifer struggled as clinic director for most of her first year. The amount of new responsibilities caught her off guard, especially the demands on her time as an administrator. She worked to understand everyone's roles in the clinic, even spending extra time to learn aspects of each job. She was routinely seen sitting with nurses or staff members, trying to better understand their work. Jennifer found herself in countless meetings and often felt overwhelmed in budget or clinic space discussions. She was routinely stopped in the hallway with questions she felt she couldn't answer. Her email inbox had exploded, and as hard as she tried she could never seem to keep up with it. Still, Jennifer continued to invest in supporting the clinic administrative team. Her dedication to her staff and nurses, however, didn't seem to be paying off.

Email complaints from the clinic team soon began to fill the division chief's inbox. Jennifer's peer, a physician who worked one day a week in the clinic, eventually pulled her aside to let her know she was failing and that changes needed to be made or the chief would intervene. Jennifer knew morale was slipping but couldn't understand how it was her fault. She had always been successful and skilled in getting along with others, especially people in positions that she supervised. What was different now?

Jennifer's lack of awareness is a common trap for leaders who find themselves in new formal roles. That is, Jennifer's natural inclination upon assuming the clinical director role was to use the same skills and methods that were successful for her in the past and apply them to this situation. She likes to mentor and to teach, so she took it upon herself to spend hours better understanding each role in the clinic, and then attempted to mentor the staff and nurses. However, staff and nurses are not young doctors and residents. The way to be helpful to them is completely different from what her typical mentees are wanting. Additionally, Jennifer's focus was in the wrong place. By spending so much time learning her employee's roles, she was not focused on the bigger picture of overseeing the clinic at large. Jennifer was not comfortable with certain aspects of the new role, so she poured herself into using the strategies she was more confident in and had been successful with in the past.

Using the leadership language described earlier in this chapter, Jennifer was faltering by not adapting to the changes in context. That is, she was not seeing the

needs within the clinic as different from situations she had dealt with previously. And by failing to adjust to the new situation, and to the needs of *this* team in *this* situation, she was not able to gain willing followers. Additionally, with her focus being spent too much in employee roles and responsibilities, she wasn't setting a clear vision or goals for the clinic. The team wasn't clear on her expectations, yet rather was feeling micromanaged. Their perception of Jennifer's behavior was not the same as Jennifer's intended actions. Jennifer would do well to: (1) clearly understand the situation—the culture and needs for an already high performing and growing clinic; (2) clarify her own role and responsibilities; (3) assess where she is lacking in the requirements for the new role; and (4) develop her skills while managing expectations for the clinic accordingly.

Conclusion: Lessons for Medical Faculty

For a leader to be successful in a medical faculty world, she needs to be attentive, self-aware, resilient, pro-active, and have a clear sense of when to lead and when to manage. Perhaps the biggest driver for medical faculty, given the intersecting circles of leadership (Fig. 14.1), is the complexity and challenges in the "situation/context" arena. The convergence of healthcare complexities, teaching and mentoring, clinical hours, research, and academic responsibilities provide unique challenges found in no other business sector. As discussed in other chapters, numerous challenges such as dealing with conflict, time management, diversity, ethical dilemmas, personnel and faculty issues, stress and resilience, and one's own career aspirations only heighten the intricacies of this context. The leader's job is to navigate this world, recognize and adjust to its changing conditions, and garner support from key constituents towards the accomplishment of the greatest mission: making the world a healthier, better place to live, and equipping the next generation of physicians to lead the way.

Tips and Pitfalls

- Understand the clear differences between managing and leading. Start to assess when to use which strategy, based on the situation and whose followership is needed. "Command and control" work styles do not serve the twenty-first century workforce.
- Strengthen your skills in gaining willing followers. Become expert at building rapport, clarifying expectations, building trust by maintaining high integrity and honesty, and supporting others' success. Blindly expecting people to follow because of positional authority is short sighted, and ignores followership from peers and key decision makers.

- Understand the vision and goals for the area you are leading. If they are not clear, create or recreate the vision and goals in order to be able to articulate them artfully to your various constituents. Not being able to adapt your message to various audiences greatly hampers your effectiveness.
- Heighten your awareness to your environmental conditions (situation/context) in order to adapt and gain willing followers. It's better to find the landmines *before* you step on them.

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Additional Resources

Kramer Leadership. http://www.kramerleadership.com/. Free Leadership Journal.
Center for Creative Leadership. http://www.ccl.org/Leadership/index.aspx
Harvard Business Review. https://hbr.org/Leadership Lessons from Dancing Guy by Derek Sivers. https://www.youtube.com/watch?v=fW8amMCVAJQ

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Chapter 15
Coaching and Mentoring

Johan Naudé

Introduction

What are coaching and mentoring and how can they be applied in today's complex academic healthcare environment? To set the stage for this chapter, I invite you to reflect on your career development. What has contributed to your success? Beyond intrinsic factors such as intelligence and drive, most successful people name at least one mentor or coach who had a significant impact on their development. Who are the people who really challenged you to think differently, to stretch yourself in unexpected ways and who were there to support you in your journey? What was it that they did that served as a catalyst for your growth and development? This chapter addresses the increasing importance of mentoring and coaching in the academic medical center environment, and why this shift is increasingly important not only with students, but with colleagues and other professionals, as well. We will then explore what coaching and mentoring mean in an organizational context, followed by some practical guidance for you as you mentor and coach others. The intention is to build your confidence in applying these frameworks and tools in your everyday professional life. I hope that you gain an understanding of how coaching supports a broader mentoring relationship, and that you recognize the value of continuing to exercise and build these "muscles." Competence in these skills can have positive effects on medical education, patient care, teamwork, and in supporting the business of healthcare education and delivery. A collateral benefit of applying coaching skills is improved communication in life outside of work.

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_15

Coaching and Mentoring in Medical Education

Traditional physician education has relied heavily on an apprenticeship model. The development of protégés in this model is similar to that found in athletic coaching. Coaches are experts and use this knowledge to help their protégés develop better skills. Technical competence is essential and the focus of coaching is on demonstrating and directing in a competitive context. While this approach can be tremendously beneficial in helping someone master the skills required to be technically proficient, physician leaders often end up over relying on this expert-oriented approach. The expert approach is not sufficient to maximize performance over time. Beyond technical mastery, this "expert" mindset is geared toward producing doctors who are excellent individual decision makers, but fosters an individual approach to work. Michael Yeh, a leading endocrine surgeon, Director of the UCLA Endocrine Surgery Program and Associate Professor in residence at UCLA Medical Center, sums it up this way:

> *"Developing task competence in the ivory tower in one department can result in being locked into one way of thinking. The traditional pathway is "me focused." Physicians need to get a wider view of the value they can bring to patients, their organizations and their communities. This wider view requires a mindset shift. They need to mindfully transition from 'I'm a surgeon' to I am someone to help a patient get through breast cancer. The focus on being part of a team is important."* [1]

When physicians are placed within a multidisciplinary team, an institute structure, or administrative roles, skills like influence, collaboration, active listening and asking for and giving feedback are more likely to yield sustained results that matter. Patterson and colleagues argue that even something as elemental as doctor's "orders" reinforces a top-down, expert oriented model that is at odds with what is increasingly required in healthcare delivery systems: *relying on people to partner effectively* [2]. Due to the evolving healthcare landscape over the last several decades and the accelerating pace of change, a more intentional focus on talent development is required. They note that:

> *"In this (rapidly evolving) context," "… it can be difficult to know if organizations have the leadership talent they need to set direction, create alignment and gain commitment among employees, partners and stakeholders as they seek to provide safe, high quality patient care."*

In 2012 the Mayo Clinic Board of Directors approved a strategic plan that included building internal physician-leader coaching capability and capacity. The project lead, Priscilla Gill, from the Office of Leadership and Organization Development, describes this process:

> *"One component was to build internal capability …. by identifying physicians who had the qualities of a coach. We told them about the vision of a coaching culture and they bought into it, which made it easier to get others excited about it. Coaching has a ripple effect … Coaching builds compassion…. A successful physician-leader coaching program results in less stress and strife and fosters more positive feelings within the organization."* [3]

Gill goes on to explain that Mayo's patient care model relies on teamwork rather than

> *"…the traditional 'individualistic', expert-oriented approach. We need to prepare physicians to coach across several key relationships such as peer-peer, Chair to doctor, and doctor to patient.....Mayo values both patients' primacy and collaboration, which aligns well with a coach mindset."*

Since it is clear that developing physician leaders is critical, what are some of the tools at your disposal? I will begin by addressing mentoring and will share several key functions of a comprehensive mentoring relationship. This content draws heavily from the Center for Creative Leadership (CCL), a global, research-based, educational organization.

What Is Mentoring? How Does It Differ from Coaching?

People often use the terms coaching and mentoring interchangeably, and yet there are key differences. Hart describes mentoring as "an intentional, developmental relationship in which a more experienced and knowledgeable person nurtures the professional development of a less experienced, less knowledgeable person [4]. The focus is on the mentee's career path, and a key element is that the mentor has more knowledge and experience than the mentee. Mentors often provide advice and guidance based on their professional experience or significant experience in the mentee's organization. In contrast, when coaching, one does not need to have more functional or technical expertise than the coachee. Rather than relying on advocacy or taking a directive approach, a coach will seek to understand the coachee's situation and perspective, and then challenge assumptions and perceived constraints through inquiry to help the coachee develop a new mental model. An inquiry-based coaching approach is part of a broader mentoring relationship. We will explore coaching in more depth later in this chapter.

Benefits of Mentoring to the Individual

Whether you are a physician leader tasked with the responsibility to develop residents, junior physicians, or future medical leaders, or you have no formal mandate to develop people, look over the list of potential benefits in Table 15.1 for you as mentor and see which ones are compelling. Keep in mind that organizational structure and culture may affect the degree to which these potential benefits fit your situation.

Table 15.1 Benefits of mentoring others

Personal satisfaction and fulfillment	Increased adaptability when facing new situations
Enhanced creativity and professional synergy	Improved professional identity
Career and personal rejuvenation	Greater professional competence
Development of a loyal support base	Increased career satisfaction
Recognition for developing talent	Greater acceptance within their organizations
Access to leadership opportunities	Decreased job stress and role conflict
Career mobility	Enhanced credibility and influence through association with mentor
Better rewards	

Adapted from Hart (2009)

Benefits of Mentoring to the Organization or Profession

In his "Seven Keys to Successful Mentoring," Hart describes several benefits to the organization from having a mentoring program in place. Organizations that have a reputation for investing in their people are better able to attract talent—whether administrative, physician, academician, staff or student. Those employees who seek out and engage in developmental activities are typically more committed to their organizations, which is good for retention. Beyond technical proficiency, people who engage in developmental activities experience accelerated development and are ready sooner for more responsibility in more complex roles. Organizations benefit from mentoring in that it is more likely to create better alignment between mentee efforts and organizational objectives. There are several implications: better overall patient care, increased adaptability to changing external conditions, innovative programs, and increased collaboration across departments aligned with a shared vision. Utilization of both informal and formal mentoring programs for growth and development helps people adjust to new cultures and new roles. For this purpose, a mentor may be a better resource than a coach.

The Functions of Mentoring

Successful mentors need to pay attention to at least seven key areas (Table 15.2).

1. Develop and Manage the Mentoring Relationship
   Diving into a mentoring relationship without laying out clear expectations can result in frustration and poor outcomes. How intentional are you in creating the infrastructure on which a successful mentoring relationship is built? As you reflect on your approach to mentoring or to the mentors in your life, what kind of preparation or training is useful? Is technical proficiency and understanding the organizational culture enough to serve a mentee's needs? While these are necessary, they are not sufficient for a comprehensive mentoring relationship.

Table 15.2 The seven functions of mentoring

1.	Develop and manage the mentoring relationship
2.	Teach
3.	Survey the environment for threats and opportunities
4.	Sponsor the mentee's developmental activities
5.	Guide and counsel
6.	Model effective leadership behavior
7.	Motivate and inspire

On the other hand, a mentee may look to a mentor for specific functional area expertise and recognize the mentor's limitations to assist in other areas. When considering participating in a mentoring relationship, pay attention to the sense of "fit" for both the mentee and mentor. Are your communication styles compatible, or is it hard work to stay on the same page? Do you have shared interests that can help create a stronger relationship and build the trust that is essential for an effective result? Part of developing the mentoring relationship is to get to know the mentee's strengths and weaknesses. How will *you* flex to be effective for your mentee when your styles are not synergistic (rather than expecting the mentee to adjust to you)? What kind of questions will you ask to understand your mentee's perspectives, aspirations and desired outcomes from the mentoring relationship? It is important to set clear expectations about how you will work together.

2. Teach
   Having a good understanding of your mentee's technical competency and knowing what skills to demonstrate are fundamental in academic medicine. Providing the right training, correcting errors, and giving specific feedback are all part and parcel of effective teaching. Teaching may involve finding the right next challenge to stretch your mentee. Teaching also has less directive aspects such as asking good questions and listening for understanding. These skills can enhance effective teaching, and, as we will see, are instrumental tools in coaching as well.
3. Survey the Environment for Threats and Opportunities
   As a medical faculty mentor, you are on the lookout for opportunities that will afford your mentees the visibility they need for advancement. You may seek out mutually beneficial "win-win" opportunities that positively position your mentee and provide a direct benefit to another department. As someone who knows the organization well, you are in a position to help prepare your mentees to navigate the various hospital, bureaucratic, and political systems adroitly. As you scan the environment for threats and opportunities, pay attention to how your mentee is managing relationships in his or her network. Are there conflicts you are aware of that may need addressing? Look for colleagues who may work well with and benefit from a relationship with your mentee to leverage potential synergies. As faculty, you are likely in a position to hear criticism that is aimed at your mentee. To the extent this criticism is unwarranted, seek to correct perceptions. If the criticism is justified, find ways to support your mentee to avoid repeating potentially maladaptive behavior.

4. Sponsor the Mentee's Developmental Activities
   As a sponsor of developmental activities for your mentees, you have an advocacy role. What are the opportunities in your organization to position your mentees for projects that will serve as a catalyst for their development? Beyond direct patient care, which committees or meetings might they benefit from attending to broaden their knowledge base and professional network? Additionally, there may be opportunities in other departments or in closely related practice or research areas where they could gain useful experience.
5. Guide and Counsel
   You have an opportunity and an obligation to guide and counsel your mentees. It is advisable for you to think about the boundaries that you have drawn, perhaps not explicitly, that inform the topics on which you are comfortable providing guidance. You may be approached by your mentees with personal issues that negatively affect performance and that are not themselves part of the professional healthcare landscape. Given the stresses on medical students, residents, junior faculty, and others in intensive learning environments, you may find yourself discussing how you and others have successfully dealt with family stressors or other personal challenges. Addressing issues in this domain requires patience, support, and respect for the mentees' perspectives. Providing guidance and counsel requires you to be aware of your mentees' biases, attitudes or perceptions that may hinder their development, as well as stylistic issues and problematic decisions they have made. To the extent you have a good grasp of their approach as well as the impact they have on others, you are in a position to provide valuable counsel.
6. Model Effective Leadership Behavior
   People learn from observing others. You may or may not be identified as a formal "leader" in your organization. Yet, to the extent you are setting a *direction* for your students, creating *alignment* around that direction and gaining their *commitment,* you are tending to the key elements required for leadership (see the chapter, The Leadership Stance, for more information and ideas on leading others) [5]. Observe yourself as you wrestle with how to approach a challenging situation. There is clearly merit in being decisive in a clinical situation and in instilling this in your trainees. However, could this become an overused skill that may detract from their effectiveness as future physician leaders? What opportunities do you have to apply this skill in a context appropriate way and not only when a decision needs to be made? A discussion about aligning standards of practice across clinics may not be the time for an "always sure and sometimes wrong" approach. Debrief these experiences as learning opportunities. Admitting mistakes might be rather uncomfortable and takes courage. It also creates an environment where people will be more prone to ask questions. If you are seen as invulnerable and always right, mentees and other learners will not be inclined to share their uncertainties and may shy away from taking appropriate risk for fear of failure.
7. Motivate and Inspire
   What are your mentees passionate about? What drives them?? To the extent you uncover their values and professional passions, you are in a great position to help

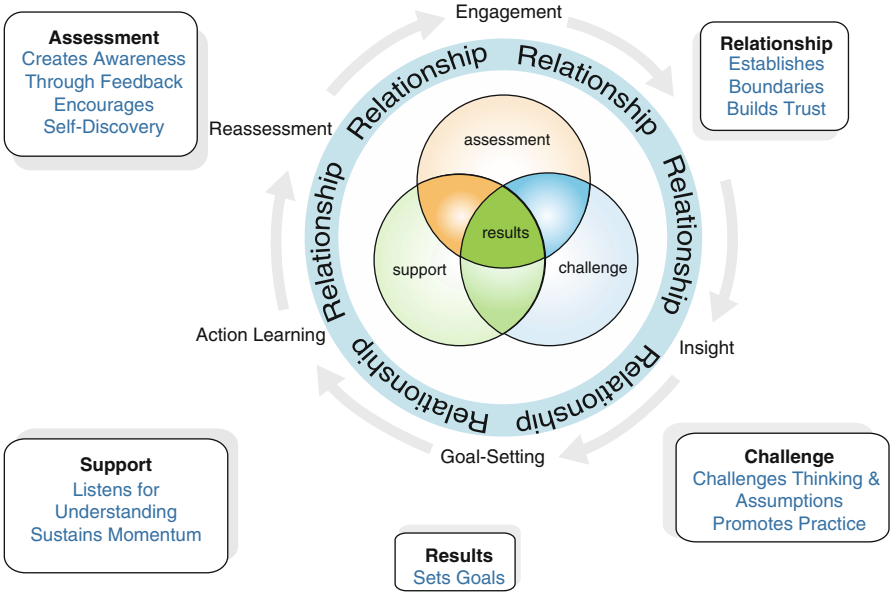
them connect with and accomplish their goals. Are you creating a safe and trusting environment for your mentees to feel inspired to share ideas? Find ways to continue to develop their self-efficacy. For instance, an opportunity to brainstorm may lead to innovation, give you a better understanding of your mentee's thinking, and build confidence. If you ask good questions and listen well, your insight about what is important to your mentees will expand. To the extent you connect your advice or counsel to what is meaningful to your mentee, it is more likely to be embraced.

Coaching in the Context of Mentoring

As you can see from the mentoring functions, using an inquiry-based approach is an important ingredient for an effective mentoring relationship. You are likely familiar with the old adage: give a man a fish and he'll eat for a day; teach him to fish and he'll eat for a lifetime. While it is easier and faster to tell people what to do, we know that asking questions to challenge their assumptions, perceived constraints and mental models makes *them* do the hard work and is more likely to result in longer term and sustained development.

The Center for Creative Leadership's coaching model contains five major elements: **R**elationship, **A**ssessment, **C**hallenge, **S**upport and **R**esults (RACSR) [6]. The RACSR coaching model draws on decades of research and experience focused on leadership development.

CCL Coaching Model



For development to occur, it is important to have a balance of Assessment, Challenge, and Support. For instance, inadequate assessment might lead to a focus on irrelevant goals. Too much challenge without enough support could overwhelm someone and derail a developmental process. Conversely, too much support without enough challenge can result in little being accomplished towards a goal. Relationship is critical as it is the container in which the developmental process can occur. A trusting relationship sets the stage for open dialogue, an essential element in coaching. Further, a focus on Results or goals is important as it provides a vector for change. Below is a description of each element of the RACSR model with sample coaching questions.

Relationship

To build relationships with people you are coaching, it's important to get to know them better and to ask questions such as:

- What are some of the challenges you are facing?
- How can we best work together (on these issues)?
- How will we know that our (coaching) relationship has been successful?

Assessment

The key components of assessment are creating awareness through feedback and encouraging self-discovery as you seek to reach a place of mutual understanding about a particular challenge or issue:

- What do you think about the feedback you recently received?
- What was surprising and what was confirmed for you?
- What did you learn?
- What do you want to do with what you learned?
- How can I help you in your development?

Giving and receiving feedback is critical for an effective mentoring and coaching relationship, and creating awareness through feedback is an important component of assessment in coaching. A practical tool is "Situation—Behavior—Impact or S-B-I," which, when used well, is a bridge to important developmental conversations. The key to using the S-B-I feedback tool effectively is to focus on the behavior and its impact on *you*, rather than by making a judgmental statement about the *other* person. When you are crafting the "impact on you," focus on your thoughts and feelings. For instance, "I felt ____"(frustrated, unheard, disappointed, delighted, concerned, proud, confused, etc. Notice that these are all feelings that you own, not

judgments about the other person's behavior, motivations or competence. Delivering feedback in this way enables the receiver to stay engaged in the conversation without getting defensive. Keep the S-B-I short. It is the bridge to deeper conversation (for more information, see Chap. 3).

Challenge

The goal of challenge in coaching is to establish a clear picture of what is possible by questioning current constraints and helping explore new possibilities. The primary actions are to challenge thinking and assumptions, and promote practice. Following are some questions you might consider:

- What are you currently doing, or not doing, that is getting in your way?
- What alternatives might you imagine?
- How could you look at the situation in a different way?
- What is the cost of not making a change?
- You say you can't do that, but what would it look like if you could?
- What is the next step for you?

Support

The goal of support is to show that you are committed to, and invested in, the success of the person you are coaching. You will help identify the type of resources and support needed to achieve goals. The key components of support are listening for understanding and sustaining momentum. Some questions you might consider asking include:

- How can I best support you?
- Who else do we need to get involved?
- What resources do you need and how will you get them?
- What might get in the way of your being successful?

Results

The objective of results is to establish specific goals and to develop accountability systems in order to build and maintain momentum. Establishing goals in a coaching relationship is a collaborative process. Consider using the S.M.A.R.T goal-setting method: Specific, Measureable, Achievable, Relevant, and Time-bound. Explore current priorities and main tasks, and how developmental goals will support these

priorities and tasks. Agree on goals, performance indicators, and a timeline, and document them. Following are some results questions to explore:

- What will you begin to do differently? Why?
- What will that look like?
- How will you know you've been successful?
- What specifically will be different?
- When should we begin to see a difference?
- How will we measure progress?
- Who are your accountability partners?
- What would I see or hear that would convince me the goal has been met?
- What impact would this change have on you? On others? On the organization?

Conclusion: Leadership Lessons

Physician-leaders of the next generation of are in a prime position to build competencies that are essential in the complex environment of academic medical centers. These vital leadership abilities go well beyond the skills called for by their medical specialty. There is an increasing need for skills such as collaboration, influence without authority, boundary spanning, and community engagement. Through intentional application of mentoring and coaching you are helping to create a robust pipeline of physician leaders who will be prepared to lead in the context of volatility, uncertainty, complexity and ambiguity.

Pearls and Pitfalls

In each interaction, be clear about where you need to be on the continuum from advocacy to inquiry to best serve the needs of your mentees or others you are coaching. Guidelines:

- Discuss roles and working relationship: Mutually agree on goals for the relationship
- Develop rapport through exchange of background information, career and personal interests and reasons for participating in the mentoring or coaching relationship
- Establish clear expectations for the following:
  - meeting dates/times
  - time commitments and constraints,
  - duration of the relationship
  - method of communication
- End each meeting by identifying and agreeing on action items and timing for the next meeting

Some Do's and Don'ts of Mentoring

Do

- Allow your mentee to take the lead in the relationship
- Respect your mentee's time as much as your own, making the meetings a priority and commit to meet regularly
- Listen attentively
- Keep your relationship on a professional basis including demonstrating and encouraging professional behavior
- Pass along information and suggest resources that could be helpful to your mentee
- Introduce your mentee to others who may be helpful in the mentee's development
- If appropriate, include your mentee in key meetings and, subsequently, recap the meeting to unpack key learnings
- When feasible, allow your mentee to shadow you during an important meeting or presentation
- Share your experiences and tips for success, as appropriate
- Provide continuous feedback to your mentee on his/her performance and ideas, being honest, but professional, in your delivery

Don't

- Expect all your advice will be taken verbatim or your suggestions implemented; the mentee must use his/her best judgment about how and when to do so
- Avoid difficult or touchy topics
- Prolong the mentoring relationship indefinitely
- Attempt to clone yourself
- Assume that you are always the teacher, you can learn from your mentee too.
- Hide your mistakes from your mentee; take advantage of those learning opportunities.
- Breach your mentee's confidence

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Chapter 16
Leading Up

Rob Kramer and Matthew Mauro

Introduction

Common trends in current leadership literature focus on leading others, inspiring teams, self-improvement, strategic decision making, and guiding organizations. However, a primary component of a person's everyday success is her ability to work within a hierarchy and effectively report to someone else. As an academic physician moves from the responsibilities of scholarship, teaching, and clinical service into formal leadership opportunities, the dynamic of "faculty member-chief/chair" becomes more of a reality, and the need to effectively work with senior leaders becomes a higher priority. In this chapter we will explore strategies to effectively manage relationships with people higher up in the organizational chart, including those in parallel organizations (medical staff vs. hospital administration). We distinguish "leading up" from other forms of working with those in higher ranks, as leading one's boss involves a unique relationship dynamic and higher output of positive results.

Complexity in Leading Up

In an academic setting, managing relationships with supervisors is multifaceted. To begin with, both parties may have similar credentials (MD's, senior faculty, etc.), training, and experience. Your peer one day may be your supervisor the next. For example, a division may have five faculty led by a division chief. The five faculty

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_16

have similar levels of responsibilities and they all report to the division chief. One day the division chief announces he is departing for another position. The chair appoints one of the division members as the new division chief. Her relation to her prior peers immediately changes.

Additionally, the context for medical faculty is unique as the setting is both academic and clinical. On top of the typical demands of teaching, research, and service, the academician may also have clinical responsibilities which bring additional workloads, time pressures, multiple work locations, and RVU (relative value units) or similar performance benchmarks. The potential for two contrasting cultures exist: the academic culture which assesses the medical faculty member's performance for promotion and tenure, and the more corporate culture which is driven by the hospital's desire to be sustaining, financially solvent, and market-driven for growth and success.

Given the context of working in a medical faculty setting, how does one effectively lead the boss? Perhaps the most common belief in a reporting chain is to "make your boss look good." Though this may be an effective ideology, it is also limiting. If a person becomes over invested in accomplishing this, what other parts of the work suffer? A person can be labeled as one who works well with his boss (or worse, labeled as "kissing up"), but does a lousy job of managing a staff. That is, one chooses the relationship with the boss to be more important than with his or her team. In order to be effective, however, one has to balance the skill of leading others no matter where they are in the organizational chart. Ultimately, there may be tension between accomplishing an assigned task while being attentive to the needs and desires of the work force.

A department chair, for example, is responsible for his executive team (associate chair, administrative heads, faculty, etc.) and relationships he has across departments (with other department chairs, service units, hospital administrators, etc.), as well as the person(s) to whom he reports. This person may be a senior hospital administrator, an academic dean, and/or the head of the faculty practice. The chair may also sit on various committees across the hospital, each with its own committee head. Furthermore, the chair may serve in professional membership organizations, adding further reporting and workload responsibilities to his plate. Competing demands on his time and attention may hamper his ability to effectively lead up.

Lastly, consider a residency program director who reports to the vice-chair of education or even to the chair. That position requires a balance between serving the needs of the department and chair versus the desires of the trainees (residents). The program director is required to be the primary faculty advocate for the residents but is also expected have the residents perform their duties at a high level.

In any example, a dilemma emerges when the boss being reported to is a hindrance (ineffective, unresponsive, or even a barrier). Some bosses are better at supporting their direct reports than are others. Thus, the techniques to gain buy-in, to influence, and to enroll senior leaders varies depending on multiple factors: the boss's temperament and management style, the quality of the relationship with the boss, clarity of expectations and mutual accountability, as well as timing, resources, desired outcomes, and other contextual factors effecting a given situation.

How then does someone successfully work with, manage, and lead his or her boss? (See "Pearls and Pitfalls" at the end of the chapter for a breakdown of ideas to try and to avoid.)

Assess Before Leading Up

If circumstances warrant influencing one's boss, there are a few foundational components to consider.

1. Perception
   Is she seen as a high performer by the leader(s) she wants to influence?

   This consideration is fundamental to leading up success. How does the boss view her performance? If she is seen as a moderate (or worse) performer, why would the boss want to be influenced by her? (Consider putting yourself in the same position: if you had a direct report who you perceived to be a lower performer, how open would you be to that person's ideas? How easily would you allow yourself to be influenced by him or her?) Credibility and competence are two components to consider. Being viewed as credible (trustworthy, dependable, knowledgeable, sincere, and believable) can lead to enormous influence potential. Additionally, competence can open doors to influencing power by being seen as capable, skilled, proficient, or experienced. Depending on the situation, the percentages of credibility versus competence can fluctuate in the eyes of the boss. One may be more or less important for each unique situation. Competence does not necessarily mandate credibility, nor does credibility ensure competence.

   If, indeed, it appears that the boss sees her as a lower than desired performer, she can ask herself, "am I willing to do what it takes to be seen as a high performer in the eyes of this person?" The changes to be made may be minor or grand. It is critical to understand what it would take to be a high performer. To do so will often require a frank and open conversation with the supervisor. The requirements may seem rational or they may not match her values. In the end, however, she can decide if she is willing to make the changes needed to be viewed as a high performer by the boss. If not, a boss could demote her or severely marginalize her influence.
2. Internal decisions
   There are a few internal and personal decisions to be made as someone prepares to take on the challenge of influencing his boss. Adjusting his mindset to change how he views his boss and their relationship can open doors to new possibilities. He can challenge himself to see possibility in his boss whenever possible, and use negative thoughts as a signal to move back into seeing opportunities. Two possibility adjustments to make are:

   - Accepting that the boss has limitations as a manager, leader, and human being. Placing blame is a frequent first reaction to an unfavorable situation. Finding peace of mind may come with recognizing that bosses are not perfect, that

they cannot solve all problems, they make mistakes, and they have foibles. People often hold their bosses to higher (or even unrealistic) standards, thus placing blame upon them as soon as things do not work out perfectly. By recognizing that bosses are just people, it can help ease impractical expectations to more realistic levels.

- Taking responsibility for building a relationship and clarifying expectations with the boss.

  It is easy to place the responsibility for both quality of the relationship and clarity of work on the boss. However, by taking a proactive stance towards these powerful components, one can more easily find success in leading up. Make time to increase trust and clarify expectations with the boss. This task can be accomplished directly, such as through the quality of work provided for the boss and engaging in meetings or other settings. It can also be accomplished indirectly by being a trustworthy, high integrity employee who represents the department with the highest of personal and professional standards. Both methods start by being proactive in influencing relationships and expectations. For a busy academic physician, his own workload is enough to keep from investing much time understanding what his boss does or building much rapport. However, when he does need the support of his boss, having an already established solid working relationship in place makes those conversations much easier.

3. External decisions

   Having a keen awareness of the external environment is critical in assessing leading up strategies. Two external areas of focus are:

   Understanding and consciously observing the surroundings.

   Maintain a heightened sense of awareness to the situation, context, and setting. Leading up often involves gaining the support of the boss, yet it cannot happen in a vacuum. Timing and place also positively or negatively affect how the boss may respond. For example, it is helpful to understand the current budget and its limitations. Are there constraints affecting the boss's autonomy to make decisions? Is your idea in alignment with the boss's or the medical center's vision or ideology? Are resources available to support new ideas or needs? What other conditions can be considered that would cause the boss to be influenced?

   Clarify whether to "manage up" or "lead up."

   Understanding the boss (leadership style, values, beliefs, goals, etc.) as well as the context in which you are both working (as outlined in the previous bullet), can help inform what strategy to take when attempting to influence up the chain: manage up or lead up. "Managing up" is speaking to the boss with a management perspective, for example, by referring to existing policies, procedures, rules or regulations. Managing up first focuses the conversation on the organization's standpoint rather than the boss's. This strategy can relieve the strain of "my beliefs versus yours." Leading up involves the use of power, rapport, inquiry, and other interpersonal tools to influence the boss to follow a person's direction, idea, or belief. Assess which strategy to try first when attempting to gain followership from higher-ups. (Additional information on leading versus managing is available in the chapter, "The Leadership Stance.")

Communication, Power, and Influence

Leading up correlates to the quality of communication, which involves understanding and navigating when, how, and what to say to gain support. Two key elements that help shape the communication message are power and influence.

The art of framing a message includes answering the following questions: what, why, how, and when. Addressing "what" is to discuss the task or action to be taken. "Why" involves two possible areas: the immediate and the long term impact for the need and how it benefits the entity. "How" is the process being proposed to accomplish the task, and "when" is, of course, the timing or implementation schedule. Here is an example of how these questions could be used in a leading up effort:

> Kenneth is an associate professor, physician-scientist in cardiology at a mid-sized teaching hospital. He has been on the faculty for eight years, after completing his residency and fellowship at the same hospital. His division chief is a former peer, Jan, who has since become a full professor and assumed her new role as division chief nine months ago. Kenneth is frustrated by his new clinical schedule over the past six months. It interferes with the time required for his funded research, which is suffering as a result. Kenneth wants to change his clinical hours but has not approached Jan about it, as she has been very vocal about being overwhelmed in her new role. Kenneth does not want to add to her stress, yet needs a change or he risks damaging his grant funded study. He finally asks Jan for a short meeting. Kenneth addresses the issue by stating:
>
> "I recognize your role as division chief has created challenges and a lot more stress for you (*relationship building*). I do have an issue of concern I need to raise, however. My R01 has been suffering tremendously since the new clinical schedule was set (*what*). I know how important NIH funded research is to you and our institution. It is quickly reaching a crisis point where I risk losing funding if I can't reach certain key benchmarks in the next couple months (*why*). I would like to propose adjusting my schedule from Tuesday and Thursday mornings to the afternoons starting next month (*when*). I have spoken with Peter, and he has already agreed to trade shifts with me on those days. I am also willing pick up an extra on-call shift per month for the next six months (*how*). How does this sound to you, Jan?"

By addressing the four questions of what, why, how, and when, Kenneth clearly articulates his situation, need, and has a specific plan of action. Additionally, by starting out with relationship building, empathizing with her work load, he can open Jan to being more receptive to his request. This strategy appears at first glance as well thought out. However, let's see how much more effective it is if Kenneth considered power and influence strategies, as well.

Kenneth may not seem to have power in this scenario. He is an associate professor, whereas Jan is a full professor and division chief, and he reports to her. However, Kenneth does have relational power, by getting Peter to agree to switch shifts. Peter is a distinguished full professor who has been in the division longer than the two of them combined, and is a well-respected clinician and scholar. Peter also has worked the same clinical shifts for years. Thus, for Kenneth to have already gotten Peter's approval to change shifts with him for this temporary time period speaks volumes on Kenneth's relational power with others. Additionally, Kenneth is influential. Notice that at no point does he ask Jan to solve the problem for him. He comes with reciprocal solutions, and simply is requesting her approval. He knows that Jan is stressed in her role as division chief, having also mentioned how she feels like she

always has to solve everyone's problems. Kenneth is strategically easing her burden. He has a solution, adjusting what appeared to be an immovable block (Peter's agreement to switch schedules), and he has offered to take on additional duties (extra on-call shifts) which makes his peers happier and creates no scheduling short falls to manage. The totality of this strategy makes it easy for Jan to say yes.

Conclusion

The complexity of influencing senior leaders can seem untenable. However, with well thought out actions, plans, and communication skills, the odds of success can improve dramatically. Understand the context: who you are trying to influence, and what pressures he or she is under. Recognize that this person is human and has flaws, and take responsibility for building trust, credibility, and competence with the senior leader in question. Look for opportunities to use management language as an influence tool, and hone the leadership tools of influence and power. Building rapport, clarifying expectations, and coming with solutions are foundational strategies to successfully lead up the line.

Pearls	Pitfalls
Understand what is required to be a "high performer"	Assume your activities will lead to success
Be viewed as a high performer: it increases leading up success	Ignore how your performance is perceived by superiors
Manage up and lead up	Complain to the boss to fix your problems
Build a relationship of trust with superiors	Be demanding, difficult, and resistant
Leverage your power and influence	Do not think through strategies/options
Focus on what you can change (mindset/attitude)	Try to change your boss
Clarify situations; consider options; choose strategies	Shoot from the hip and hope for the best
Have a "critical issues" list ready when the boss is near	Don't take advantage of access to the boss
Listen for understanding and intent	Talk more than listen
Understand the boss's world	Care only about your own needs
Learn how the boss thinks	Complain openly about the boss's style
Come with solutions, not more problems	Be the loudest complainer in the room
Leverage help from others when appropriate	Form a mob-like mentality with others
Remember others are watching	Focus only on competing with this boss
Communicate early; no surprise bad news	Keep things quiet and the boss won't know
Have patience	Have unrealistic expectations

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Chapter 17
Political Savvy

Tom Stevens

Divide and rule, a sound motto. Unite and lead, a better one.

—Johann Wolfgang von Goethe

Introduction: What Does Political Savvy Have to Do With Leadership?

As particularly outlined in Chap. 14 and repeated throughout this handbook, leadership is in essence about gaining willing *followers* toward a *vision* in a particular *context. Political savvy* focuses on the context corner of the *followers-vision-context* triad, especially on choices leaders make within the context to gain willing followers for the organizational vision (Fig. 17.1).

Political savvy is the acumen of taking into account differences in power, status, and interests of stakeholders within and without an organization. For any vibrant organization, political savvy is an important skill in one's leadership toolbox.

Special Challenges in the Current Organizational Landscape of Academic Medical Settings While just about any industry or profession can point to the enormity of change in the twenty-first century, medicine and medical education could be poster children. In addition to the generic politics that simply are a part of human organizations, anyone associated with healthcare delivery or medical education must also deal with a host of issues specific to the industry.

Inherent in healthcare professional education are creative tensions between academics, research, practice, and of course, funding and finances. Ongoing changes involve not only the avalanche of new knowledge, research, and technology for treating patients, but also shifts in power, controlling interests, and how decisions get made regarding the systems in which healthcare is practiced. For example:

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_17

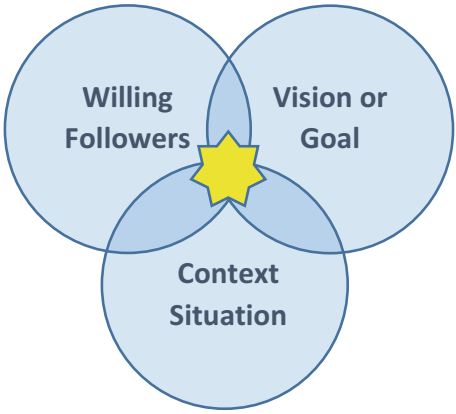

Fig. 17.1 The three intersecting circles of leadership

- A continuing trend moving away from a time when physicians worked with relative autonomy, toward (as one doctor I spoke with recently described) more and more parties "looking over your shoulder" at everything a practitioner does. This can include members of an interdisciplinary practice team, various insurers or payers, regulatory entities, researchers, or administrative functions;
- Shifts in the landscape of healthcare professions and what they do—e.g., the emergence of nurse practitioners and physician assistants providing certain levels of medical care, and the expectation of working in multi-disciplinary teams;
- A shift toward more complex practice organizations—especially at large research universities and hospitals where units or divisions are becoming organized into separate specialized departments. Where once a medical director might oversee the entire span of practice specialties, more specialties now have their own department and directors. Practice norms at large institutions and universities can vary significantly from community based practices;
- The establishment of electronic medical records that can be shared throughout and between large healthcare systems imposes structures and systems on practitioners that increasingly drive how healthcare is delivered;
- "Hot-button" public policy issues that impact both society at large as well as medical practice and research, such as the Affordable Care Act, birth control access, treating illegal drug use, end-of-life care, abortion services and stem cell research, to name a few;

How stakeholders in an institution grapple with these longstanding, yet very current and fast moving issues in their organizational landscape is what an aspiring medical faculty leader must discern, navigate, and influence just to get routine work done, much less mold into a vision that attracts followers.

It is easy to understand an initial reaction to the term "political savvy" as being something to avoid, perhaps even the antithesis of good leadership. The phrase conjures associations with the kind of scheming, ruthless behavior depicted on the

popular shows *Game of Thrones* or *House of Cards*, not to mention the real-life examples of self-serving manipulation in both historical and contemporary halls of power. Scheming "political" behavior seems particularly at odds with academic medical and health professionals who dedicate years of long hours toward a career to preserve and improve people's lives.

Certainly, effective (and ethical) leadership avoids over-politicization and self-serving manipulation in an organization. But in its general definition, "politics" in human interaction cannot be totally avoided even when desirable. By politics, I refer to behavior related to power, status, and differing interests. Power is the authority and ability to command certain actions by others, often by formal position or expertise. Status is about relative social or professional standing, often informal or culturally based. Differing interests affect how people go about making decisions, using resources (in particular money and information), and forming relationships.

Political behavior is as human as emotions. A good leader doesn't dismiss emotions because they have the potential to be a barrier, but rather embraces and learns about them; in short, cultivates emotional intelligence. In a similar way, an effective leader doesn't dismiss organizational politics, but rather cultivates a healthy use of political understanding and skill—i.e., *savvy*—for gaining followers for a shared vision in the service of the organization.

Political Behavior in the Organizational Landscape

The dynamics of power, status, and differing interests (not to mention differing personalities) contribute to a complex social system which includes "political" behavior. Any such system will be referred to as the *organizational landscape.* Indeed, organizational landscape is another way of understanding the *context* in which leaders seek to gain followers for the organization's vision.

As discussed above, the organizational landscape contains elements that are both ***formal*** and ***informal***. Formal elements include the structural components of the organization, hierarchical or otherwise. Informal elements include intangibles such as friendships or animosities, differing status of individuals or subunits (e.g. oncology compared to emergency department, accounting compared to housekeeping) or how information really flows versus what the formal structure would indicate (e.g., a shared interest in tennis can go a long way in getting the Dean's ear).

The organizational landscape contains both internal and external components. ***Internal*** are those existing within the formal boundaries of the organization, such as employees, students, patients; and ***external*** are stakeholders and influences outside of the formal organization, such as professional associations, foundations and funders, suppliers and vendors, regulators and governments, advocacy groups, and other similar organizations in the same industry.

Core Strategy for Political Savvy: Discern, Navigate, Influence

At the heart of developing political savvy is a continuum of overlapping skills:

- *discerning* the organizational landscape,
- *navigating* the organizational landscape, and
- *influencing* the organizational landscape.

Discern

To *discern* the organizational landscape means to be aware of diverse human and organizational dynamics with a degree of understanding how alternative actions might lead to different outcomes.

The key to discernment is the too-little-celebrated skill of simply observing. Ask trusted colleagues what they observe about the organization. Keep an open mind, especially in regard to the attribution of intent or motivation.

Following are some questions that may help organize thoughts and observations about discerning the organizational landscape:

- What are the formal organizational structures and lines of authority?
- Who are different stakeholders and how are they grouped?
- Who (or what units) have higher levels of status? What are informal lines of authority? Whose opinions seem to carry more weight? Under what circumstances?
- What are the processes by which policy and major organizational decisions are made? How are policy changes or new organizational ideas initiated?
- How are key drivers of decisions balanced? (e.g., Finance? Risk? Practice? Research? Customer service? Quality? Recognition?)
- How does the money work? Who controls and access to what resources?
- What happens when people make mistakes?
- How are conflicts among individuals handled? How are conflicts among units handled?
- What are people proud of? Worried about? Complaining about?

The purpose of discernment is to inform choices for meaningful action.

Navigate

To *navigate* the organizational landscape is to use one's discernment of the organizational landscape, along with professional and interpersonal skills, to effectively get things done on a day-by-day basis. Particularly useful interpersonal skills include networking (reaching out to build relationships across boundaries within and without the organization) and negotiation (being able to come to workable agreements with others).

Influence

Influence denotes changing the organizational landscape itself beyond simply navigating it—whether in a formal or informal way. Influence must be long-term as well as short-term. Influence is where true leadership becomes evident, particularly in transcending "politics" and changing the organizational landscape so it is increasingly conducive to gaining followers and advancing the vision.

Discerning, navigating, and influencing the organizational landscape are perhaps best summarized by singer Kenny Rogers' line, "You gotta know when to hold 'em, and know when to fold 'em."

Two Common Errors Would-be Leaders Make

As a leadership coach (and as a town mayor) I routinely see two errors that people make. The first is simply ignoring human factors in the organizational landscape and believing the "solution" is either self-evident, or that the discussion is finished once someone has been told the solution. This error appears to be an occupational hazard for professionals requiring high levels of technical knowledge in their field (think engineering, legal, science, or medicine) who are used to adding value and influencing through their expertise. At its core this error is an assumption that an idea stands on its own logic. Unfortunately, this stance ignores human interests, buy-in, empathy, and as Upton Sinclair declared, the difficulty of getting "a man to understand something, when his salary depends on his not understanding it." Logic is essential for persuasion, but relying entirely on logic (usually the logic from a single perspective) will not necessarily gain willing followers, and is unlikely to keep them.

The opposite error is acting as if only (or predominantly) politics matter—i.e., decisions are made predominantly on who you know, how you dress and look, saying the right things, what you offer for payback—in short, how well you play the game. It is a cynical view. While there is always an element of these factors contributing to either explicit or implicit biases, it can be too easy to think that is all one needs to do. It's difficult to navigate an organizational landscape for long simply on political maneuvering, and likewise, accomplished leaders work to influence the organizational landscape so politics don't become the predominant driver.

Avoiding these two errors requires a "Goldilockian" approach, as in the fairy tale of Goldilocks and the Three Bears. Political savvy must be taken into account: not too little and not too much, but just right.

Savvy Leadership Skill Set: Lead Without Telling People What To Do

Comments I hear from professionals often reveal that their default concept of leadership is about being in charge, that is, obtaining a position of power, having the most information, and giving orders: the classic "command-and-control" boss.

From this viewpoint, effective leadership requires having all the answers so you can tell people the right thing to do. This view posits that leaders make decisions and give marching orders with political savvy to make it work.

There is indeed a place for command-and-control leadership skills. However the more likely challenge for medical faculty is bringing together specialized talent, with interdependent needs, who have differing interests, and with them form a team of *willing* followers.

One can find oneself in situations, whether as the chair of a committee or advisory board or simply on inpatient rounds, where one has limited formal power to compel others on the team to do anything. So what's an aspiring leader to do? Table 17.1 describes seven leadership actions other than telling someone what to do.

If your motto is "Unite and lead" and you want to gain willing followers, diligently develop and practice these strategies.

Exemplify

One of the most powerful acts of leadership is setting an example. Gandhi said it best, "Be the change you want to see in the world." Model decision making, sharing information, and open respectful communication as an example of how you want to see it done in your organization. Be someone worth imitating.

Acknowledge

If serving as an example is powerful, so is acknowledging others who serve as examples. In a world where we can't possibly have time to attend to everything, showing interest, asking questions, giving someone or something attention all elevate that person or item in importance. It adds status. The act of offering recognition, public and private, formal and informal, to those who are already performing well can deeply and positively affect future behavior of those recognized and those who witness it. Savvy leaders give others lots of credit for success, both those with celebrity status, as protocol requires, and also unsung heroes who perform quietly in the background.

Table 17.1 Actions to unite and lead rather than command-and-control

• Exemplify
• Acknowledge
• Articulate
• Frame
• Follow
• Facilitate
• Presence (be present)

Articulate

There is tremendous force in effectively speaking on behalf of a group, to give meaningful voice to collective values and vision. To inform others; to be able to summarize the what, why, and how of a circumstance; to describe the current path; and to invite people to a vision of the future-all are potent leadership actions of consequence. To this end, developing speaking and presentation skills is a valuable investment. One doesn't have to necessarily be a polished superstar speaker. My experience is that the standard for business and professional presentations is so low that polishing just one or two speaking skills can help one stand out above the crowd. As Mark Twain said, "Whatever you say, say it with conviction."

Frame

Framing is an extension of articulating an idea. All language involves not only the specific definitions of words used, but also a host of associations and ideas that channel our thinking in specific directions. Framing uses language to establish parameters about what someone is likely to automatically think (or not think) about an issue, the way that a picture frame puts boundaries around an image. To use a customer service example, there is a huge difference between saying to a patient, "I'm sorry, I can't give you an appointment until Friday" and "You're in luck, I can give you an appointment on Friday."

Framing is one of the most powerful skills a leader can master, spanning the continuum of most obnoxious political manipulation (as in the way, unfortunately, many controversial legislative bills carry titles that state the opposite of their intention) to the most sensitive handling of a crisis when nerves are clearly raw. The case example about UVA President Teresa Sullivan in Chap. 14 includes a statement by Virginia Governor McDonnell, "I am also concerned that the first female rector seemed to become the sole target of recent criticism." Among other things, this statement is an example of "re-framing" a situation; in this case, she shifted from a frame that the situation is primarily a dispute between two leaders (Sullivan and Dragas) to a frame holding multiple parties accountable.

Another example of framing, for better or worse depending on your point of view, is the use of the word "provider" by insurance and managed care interests rather than specifying "physician" or other profession. "Provider" vs. "physician" frames differing expectations about what work is being done, who does it, and how and how much that work is compensated.

Framing is relevant not just to significant events and major policy issues, but also to the everyday work of navigating the organizational landscape. A friend who is a physician of significant stature in his field once said to me his magic phrase is "I need your help." Offered with the right tone, the phrase immediately offers a frame that suggests collaboration and status equity. Savvy leaders pay close attention

to how they "frame" everyday interactions. Some common framing alternatives that leaders can be more intentional about include:

- either/or (e.g. do you support the new policy?) vs. a range or continuum (e.g., on a scale of 1–10, what do you think of the policy?)
- us/them vs. we;
- a problem (something that needs fixing) vs. a possibility (an outcome to which we aspire);
- a problem (which implies there's a solution) vs. a conundrum (something that can be navigated, but to some degree must be endured);
- a position (I'm opposed to the policy) vs. an interest (I want to see better customer service, and I think this policy gets in the way);
- what is wanted vs. what is NOT wanted;

Follow

The working definition of leadership in this handbook is gaining willing followers toward a vision. Often the most significant leadership action one can do, paradoxically, is to follow someone else's lead, especially if others will then follow you.

Following goes beyond acknowledging someone else's idea, or being able to articulate it to someone else. Following, here, means publicly getting behind the idea, agreeing, or lending the idea your support. An often observed dynamic of group behavior—think teams, committees, boards, etc.—is when one person says "let's do this" but the group doesn't move until someone else (the first follower) affirms the proposal.

Facilitate

Facilitation as a leadership skill can be thought of in two different ways: facilitation of dialogue in meetings, and facilitation of action across organizational boundaries.

Dialogue is the process by which diverse talent and differing view-points can be synthesized into something of value. Skill in meeting facilitation is the ability to listen to and articulate alternative perspectives, steer conversations so everyone can contribute, and guide people through processes for joint problem-solving and decision making. One of my chief duties as mayor is to facilitate meetings of the town council, and as a facilitator I will invite commissioners who have been quiet to speak, invite commissioners who have been outspoken to step back briefly so others will have a turn, and bring the council discussion back to the agenda when discussion has drifted off topic.

Facilitation also means fostering communication and action across organizational boundaries, indeed helping convene stakeholders so a dialogue can take

place—something that can often require a healthy dose of political savvy. In my role as mayor one of the more significant ways I can create value is being able to facilitate various community stakeholders to focus on a particular issue, or make introductions across jurisdictions to address conflicts or move projects forward.

Presence

Woody Allen once remarked that 80 % of success is showing up. Absolutely, one has to show up to practice leadership. Beyond just showing up, though, be fully present, ready to engage and lead. One is more influential if one takes leadership action when fully present, ready to make a contribution, intentionally applying the range of talents one has to offer.

While unconventional, I purposefully use *presence* here as an active verb rather than a passive one. To *presence* rather than to *have presence*. "To presence" is to actively intend and will oneself to be in the moment, physically, cognitively and emotionally. "To presence" is to willfully see outcomes as accomplished, and use this vision to inform one's actions that make it so. In a world that is growing exceedingly complex, "presencing" provides an experience of clarity. While perhaps esoteric in concept, presence is the glue that holds all other techniques and strategies of leadership together in a coherent whole.

Pearls

- **Connect 360°**
  Network and nurture relationships up, down, and across the organization—not just with your boss or just with your peers. Regularly offer value to your connections. When you are hungry is pretty late to plant a garden, likewise when you need to have a serious talk is pretty late to be introducing yourself to someone.
- **Cultivate trust**
  Trust is not neutral—it either accelerates or decelerates what you can accomplish. If you engender high levels of trust as a leader, you get the benefit of the doubt. On the other hand, if trust is low or absent, people will question everything.
- **Make connections personal**
  Nothing builds trust like one to one interaction. Trust is contagious. One person's level of trust, positive or negative, often becomes a cue for how other people will also respond.
- **Stand for something**
  Consistency, congruence, and coherence build trust and create influence. Consistency, what you do over and over again, shows reliability. Congruence, matching actions to your words, demonstrates authenticity. Coherence, your

identity and your story over time, imparts meaning that helps people understand what you are about.

- **State intentions and interests**
  Simply interjecting criticisms or 'constructive' observations, no matter how valid, one after the other, can come across as negative. Positive intentions are invisible if not articulated. As an executive coach, I encourage leaders to craft statements of intention (i.e., outcomes they want to see happen) and talk about those intentions often. Then when you offer criticisms, they're in the context of the positive outcomes desired for the organization.
- **Market transparency**
  A problem with many organizations is that transparency may exist, but nobody knows about it. Don't simply be transparent, but 'market' how people can see what is going on in an organization. Summarize key information and be proactive in distributing it.
- **Seed accountability and weed blame**
  People can respect being held accountable. They are, of course, likely to avoid being blamed or punished. An atmosphere of accountability and responsibility encourages corrective action; blame encourages ducking and laying low so you won't be punished.
- **Speak of others as though they were present**
  There are few better habits for building trust and trustworthiness. When you speak of others as if they were present, then people trust you are not speaking of them critically without their knowledge.
- **Learn to apologize**
  Leaders make mistakes; it comes with the territory of taking risks and growing. When we have fallen down on our commitments, it's appropriate and necessary that we apologize. Explanations and excuses aren't helpful. And of course, follow up apologies with appropriate restitution or corrective action, when appropriate.
- **Avoid 'all or nothing' thinking**
  A common trap of discerning the organizational landscape is getting caught up in "either/or" "all or nothing" thinking. Rather than ask yourself if something is true or not true, ask 'how much' something might be true. The proper understanding of problems—and therefore the key to solutions—is found in the grey areas, not black and white.

Conclusion

Political behavior is human and is an inevitable part of the landscape of an organization. Political savvy takes into account differences in power, status, and interests as a leader discerns, navigates, and influences the organizational landscape. Effective leaders seek to transcend gamesmanship and engage stakeholders in efforts to advance organizational vision.

Additional Resource

Think Leadership Ideas website: http://www.thinkleadershipideas.com/

Tom Stevens Following a two-decade career as a therapist, educator, and chief executive of a family services agency, Tom Stevens founded *Think Leadership Ideas*, a boutique consulting practice whose clients include global corporations, small business owners, universities, hospitals, associations, public agencies, and enterprising non-profits. In 2005 Tom was elected Mayor of Hillsborough, NC, and is currently serving his sixth term in that office

Chapter 18
Moral Courage

Kim Strom-Gottfried

Leading with Courage

The practice of medicine is replete with difficult decisions—sorting differential diagnoses, deciphering equivocal test results, initiating end-of-life conversations. The role of leader also requires difficult decisions—managing budget reductions, addressing grievances, identifying promising staff for promotion. The requirement that physician leaders act with courage, however, goes beyond routine activities. Courage, by definition, involves personal risk. In some jobs, such as that of fire fighter, the risk incurred may be physical harm, or even death. For other positions, the risks of action are also significant, if not life threatening. Budget managers may fear retaliation for identifying inappropriate expenses on an administrator's travel account. Residents may worry that speaking out about another physician's cognitive impairment will result in ostracism by attending physicians and peers. A nurse who observes negligent patient care may find that if she speaks up about it, she has committed career suicide, irrespective of the merits of her complaint.

Definitions of Courage Courage is resistance to fear, mastery of fear- not the absence of fear.—Mark Twain

You must never be fearful about what you are doing when it is right.—Rosa Parks

Courage is not the absence of fear but rather the judgment that something is more important than fear.—Ambrose Redmoon

[Moral courage is] The capacity to overcome the fear of shame and humiliation in order to admit one's mistakes, to confess a wrong, to reject evil conformity, to renounce injustice, and also to defy immoral or imprudent orders.—William Ian Miller

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_18

It takes a great deal of bravery to stand up to your enemies, but just as much to stand up to your friends.—J. K. Rowling, *Harry Potter*

Courage is what it takes to stand up and speak; courage is also what it takes to sit down and listen.—Winston Churchill

The opportunities for exercising courage are limitless. Sometimes individuals must speak up to right a wrong. At other times they must act in defense of a principle, such as honesty or respect. Who on the research team will resist including spurious findings in a manuscript? How should food service staff react when the treatment team discusses a patient in the cafeteria line? What should the department chair do when post-docs report sexual harassment by the chair's old friend, a visiting professor? When a prospective donor makes a racially offensive joke at an initial meeting, should the development staff member say something? If so, what might they say or do?

These scenarios vary in intensity and importance, yet their resolution relies on the will of one individual to raise an objection, share an observation, or ask for clarification.

For the physician leader, the test of courage is embodied in two questions:

- *How will I, as a leader, create an organizational culture that fosters integrity?*
- *How will I exercise moral courage when circumstances demand it?*

Organizational Culture

Studies in health care settings have identified issues of moral courage as the keys to avoiding medical errors, enhancing retention and worker morale, improving patient outcomes, increasing productivity, strengthening adherence to workplace rules, and developing respect and support among colleagues [1, 2]. How can the physician leader create a culture where "doing the right thing" is valued and honored? Four steps can make a difference in any organizational environment. Effective leaders: (1) demonstrate daily that they value integrity, (2) encourage critical thinking to avoid groupthink, (3) eliminate distortions in the chain of command, and (4) foster and model courageous followership.

Value Integrity

Effective, ethical leadership begins with leaders who themselves demonstrate and value integrity. Physicians who engage in or condone unethical or illegal behaviors cannot create a climate where staff or colleagues are willing to stand up for what is right. Actions and communications must be congruent with values. A leader cannot espouse a belief in the "highest standards of conduct" in the department mission statement while wiring an allegedly open job search so that a friend or crony is

selected. The alignment of messages and actions requires transparency, to the extent that confidential processes allow, so that those working in the unit believe in the leader's honesty and trustworthiness. Staff and colleagues will observe the leader's response to critical incidents and organizational crises, and the ways personnel are chosen and treated, as the criteria by which rewards and status are allocated. These and other "culture embedding mechanisms" outweigh rhetoric: actions speak louder than words ([3], p. 5).

Leaders must also mindfully reinforce the behaviors they want to cultivate and hold others accountable when they fail to live up to expected standards. The sense of futility can be a powerful deterrent to ethical action. Staff observe what behaviors get rewarded and punished and decide accordingly whether they are willing to put their reputations and relationships on the line in instances of improper conduct. A clerk in accounting who discovers self-dealing by the procurement manager must be lauded for her actions, and the individual responsible for the fraud be disciplined appropriately. Shunning the accountant or letting the manager off with a warning will effectively erode the moral health of the organization [4].

Studies suggest that the greater the difference in power between the person who commits an inappropriate or harmful act and the person who observes it, the less likely it is that any action will be taken to report or correct the mistake [5]. Known as "the authority gradient", this phenomenon is particularly common in health care, higher education, and other settings where educational attainment, socioeconomic status, and influence are unevenly distributed among co-workers. Staff members of all strata must be empowered to act if problematic behavior is observed. Efforts to reduce errors in hospitals often include culture change initiatives that encourage all staff to accept responsibility for patient well-being and to "say something if you see something." Correspondingly, these changes in culture require fellow staff and administrators, regardless of rank or position, to respect and respond to earnest efforts to correct errors, regardless of who committed the error and who reported it.

Groupthink is a powerful phenomenon where the desire for unanimity or conformity prohibits honest expressions of dissent or disagreement [6]. Most professionals have had the experience of being in a meeting and harboring concerns about a decision, but have withheld comment because all others attending seemed to accept the proposal, only to find out later that others had reservations, too. The effective leader can mitigate groupthink by moderating his or her own opinions and supporting disagreement as a constructive norm to in order to avoid prematurely narrowing options or forcing decisions. Leaders should encourage wide ranging generation and evaluation of options and support "devil's advocates" in the group who may help uncover flawed logic or insufficient support for the decision.

Another structural element in organizational integrity involves the processes for communication. Leaders must rely on input from a variety of sources to make sound decisions. However, various factors can distort the accuracy of the information they receive [7]. Communications are distorted when they pass through too many layers of bureaucracy and when they are manipulated by the interests of those in the chain of communication. Sycophants, untrustworthy sources, and subordinates who fear the leader will "shoot the messenger" can all create a climate in which the leader is

prevented from receiving honest information and candid feedback, thus eroding a culture of integrity. Leaders can combat these tendencies by the careful selection of administrative staff and the leadership team, by personal candor, and by willingness to listen to others. Forthright conversations about mutual expectations for trust, honesty, and integrity will set the tone for a constructive working relationship in which communications throughout the unit advance the mission and identify problems promptly and accurately [8].

Efforts to align messages and actions, support integrity, improve communication, and eradicate groupthink are all elements in the creation of courageous followership. Proximity and courage are the critical variables in preventing abuses of power; thus, leaders must engage and support courageous followers, and be courageous followers themselves [7]. The effective leader must create not only a culture that fosters integrity, but also develop personal capacities for courage.

Exercising Individual Courage

Creating an ethical organization culture is one step in courageous leadership. The second involves the leader assuring that he or she is capable of exercising courage. Leaders can foster this personal development by confronting the barriers to courage, acquiring support for courageous action, and developing the skills to act on courageous intentions.

Understanding Barriers

A number of common impediments prevent well-intended people from acting when principles such as honesty, trust, respect, and fairness are being violated. As noted earlier, the fear of reprisals—of alienation from friends and colleagues, of being labeled a troublemaker, of being passed over for promotions or other opportunities—can silence individuals from speaking up or intervening in troubling situations. Some people are simply uncomfortable with conflict, with making waves or being disliked. Others have internalized strong societal or cultural messages not to be a snitch, call attention to oneself or question authority. Other individuals are dissuaded by a feeling of futility—that whatever effort they put on the line in service of principle, it will come to no good end because the situation is rigged and they lack the power to change it. Ironically, the greater the number of people who are aware of troubling events the less likely it is that any individual will act to address them. This phenomenon, known as the bystander effect, creates an aura of collective irresponsibility, wherein everyone wonders why someone else does not act, or they assume others will act, and thus fail to do so themselves.

The barriers to courage are familiar, understandable, and based in reality. Whistleblowers do lose their jobs. People who question others' behavior may indeed be seen as a nuisance or crusader. Some scandals are so deeply entrenched and long-standing that it is impossible for one person to be an agent of change. While it can be difficult to argue against these risks, it is also important to consider the risks of NOT exercising courage.

Most scandals get revealed eventually, and when they do, it is often a single person who served as the tipping point for change, aided, no doubt, by the voices and actions of courageous individuals who tried and failed before [9]. While people who are deterred by futility stand aside, numerous whistleblowers have testified that although they were unable to change the course of events, they were happier having tried and failed than not trying at all [10]. And, while there may be costs of action, there are also compelling costs of inaction. Inaction allows disturbing activities to continue and spread. Inaction also exacts a personal toll. As Senator John McCain states in his book on courage, "Remorse is an awful companion. Whatever the unwelcome consequences of courage, they are unlikely to be worse than the discovery that you are not the man you pretend to be." ([11], pp. 70–71).

Role Models

Acting with courage can be a lonely and perplexing road. Leaders can strengthen their resolve and capacities when they have role models and support. Role models may be personal or iconic. Some leaders draw strength from a parent who "did the right thing" or who made them take responsibility, by returning pilfered candy to a store and acknowledging the theft to the manager. Sometimes it was a mentor, coach, or teacher who demonstrated principled action and paid a price for it, yet maintained their dignity and self-worth regardless of the outcome. Others are inspired by iconic role models, whose decisions and actions are captured in news stories of bravery, through Profiles in Courage awards, or biographical accounts. Such inspirations are important, as too often whistleblowers are portrayed as tragic figures or fools. In depictions of scandals the news accounts often focus at length on the scoundrels involved, but give short shrift to the individuals who may have tried to right the wrongs, or who brought the situation to light.

Beyond inspiration and modeling, leaders need people for support and advice during challenging times. Consistent and trusted confidants can act as sounding boards, helping the leader to process challenging situations, consider strategies, reflect on missed opportunities, and examine weaknesses. All too often, though, shame and hubris conspire to keep leaders from seeking help until crises arise. Cultivating consultative resources from the beginning is a normative, prudent, and helpful antidote to the isolation leaders often experience.

Skilled Conversations

By the time they have arrived in positions of authority, physicians and other academic leaders have often developed effective communication skills. However, when courage is called for, leaders must be able to broach delicate topics, listen thoroughly, and articulate sensitive positions. The first challenge involves initiating the conversation. A leader concerned about a colleague or more senior leader's actions might preface the comment with a defusing statement such as, "You know how I respect your work and value our relationship, and I'm sure you'd want me to be honest with you…" [7]. Inappropriate jokes or actions might be met with a simple "I statement", as in "I'm not comfortable when staff discuss patients in that way." Or "I prefer we not use terms like that in this unit." An ill-considered decision or pressure for groupthink may be countered with questions: "How will X view this decision?", "What questions might we face by those who are affected by this decision?", "Have we considered all the downsides?", "How does this fit with our mission and standards?", and "I'd like to share an observation about our process in this group." Statements such as "I'm not sure I heard you correctly. Did you mean to say….?" or "I'm uncomfortable with what I just heard/saw" can set the stage for conversations about an array of problematic behaviors from bullying to bigotry to proposals for fraudulent or illegal activity.

Leaders must avoid the temptation to meet bad news or negative feedback with defensiveness and denial. A helpful standard response to buy time and restore composure may be, "That is useful information…please tell me more" or "What can I do to help?" As in all communications, tone of voice matters. Impatience, sarcasm, paternalism will undermine the positive effects of the constructive conversation. Curiosity, sensitivity, and the determination to create a positive outcome influence the leader's tone and demeanor.

Numerous resources are available to help leaders and followers improve communications about sensitive matters, nurture organizational integrity, and enrich personal courage [12–17]. The cultivation of courage is a journey not a destination, and it may seem an unfair burden amid the fast pace and grave challenges that healthcare leaders already encounter. Nevertheless, the organization, the people who work there, and those who are served by them will be better for the climate and example set by the courageous leader.

Conclusion

In its Code of Ethics, the American College of Healthcare Executives identifies among the leader's obligations the responsibility to be a moral advocate, to personally behave in an exemplary manner, to act on errors and on the inappropriate behavior of others, and to demonstrate loyalty to patients, employees, the organization, community and society [4]. The commitment to moral courage is an imperative for

leaders in healthcare. Organizational integrity can be fostered through personal integrity, candor, staff empowerment and effective communications. Individual courage is developed by understanding and challenging the barriers to courage, cultivating role models and relationships that foster courageous action and utilizing the communication skills that put courage into action.

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Chapter 19
Leading Change

Elizabeth B. Upchurch

Introduction

The health care industry is radically changing in response to the political and economic environment. An important goal is to achieve high-quality patient care, positive employee satisfaction and sustainable health care systems. Leaders are under pressure to make changes happen and to do so in a way that ensures progress with as little chaos as possible. Leading change requires the ability to orchestrate complex systems in a dance of transformation. Change management tools and techniques are not enough. Leading change requires four core character traits—self-awareness, perspective, compassion, and willingness to work hard. These traits interplay with the most complex of systems—the human one. Practice is essential to developing the traits and becoming skillful in their use. The case study later in this chapter will illustrate the potential results of learning and practicing these traits.

Character Traits Are Key

Character traits optimize the use of management skills like the operating system of a computer allows the use of applications. I often ask participants in workshops if they have ever been taught a feedback model. Most raise their hand. Then I ask if they regularly give feedback when needed. Almost everyone lowers their hand. Why? When asked they will say, "I might make things worse." "I don't want to hurt feelings." "It is too uncomfortable." They have the understanding but not the qualities of character that will enable them to move past the discomfort to practice and use the skill.

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_19

Essential Character Traits of Effective Change Leaders

Of the four character traits core to leading change, self-awareness is so foundational that it has its own chapter in this book (Chap. 1). The other three -perspective, compassion, and willingness -create a strong leadership platform for change (Table 19.1).

Organizational change is not as often disrupted by large scale resistance as it is by persistent resistance from people who either don't understand or don't like what you are trying to accomplish. It is critical that you have the *perspective* to know how change affects the people involved and what will help them get past their resistance to engage in helping make change happen. You must have *compassion* for the challenges they face, and the *willingness* to face uncertainty, conflict, and resistance with grace as well as power.

Table 19.1 Key traits for leading change and the skills they enhance

Trait	Problems that indicate a developmental need	Trait enhances these skills
Perspective	• People seem confused or unsure of next steps	• Influencing others
	• Resistance that is non-specific	• Negotiation
	• Frequent communication breakdowns	• Presentations
	• Lack of initiative or engagement with change	• Strategic planning
	• Processes that don't work well	• Reorganization
	• Structures that do not fully support the work or the people doing the work	• Process management
	• Problems that keep recurring even after solutions are in place	• Empowering others
		• Effective feedback
Compassion	• Specific, strong resistance	• Innovation
	• Solutions cause anger or frustration	• problem solving
	• People not engaged	• Engagement
	• Resistance to any new idea	• Coaching
	• Difficulty convincing others of your ideas	• Influence
	• Direct reports who are not developing and growing	• Negotiation
	• Lack of direct feedback	• Communication
		• Effective feedback
		• Conflict resolution
Willingness	• Bad behavior among some employees	• Execution
	• Quality issues that don't get better	• Enforcing quality of care expectations
	• Others see you as moody	• Consistency in behavior
	• Safety violations	• Enforcing safety
	• Lack of trust	• Winning the trust of others
	• Lack of constructive conflict	• Conflict resolution

Perspective

Perspective is the ability to see something from a unique or particular point of view. The perspective trait includes understanding a bigger picture and how the things within it are connected. That understanding is most useful when a leader is able to help others see the big view and their place in it. Leaders with perspective head off resistance and discontent to a larger degree than those without it. Table 19.2 lists some tips for developing perspective.

One of the barriers to perspective is not clearly understanding which things are connected. This lack of understanding leads to dismissing certain aspects of a situation that may be key to helping others to understand or embrace change. One of the most frequent aspects missed is that people are often confused about how to go about meeting new expectations. Behaviors that may indicate confusion include resistance, mistakes, relapses into old behaviors, and sometimes, just plain bad behavior. Engagement starts with the leader being able to convey needed changes in such a way that people understand a bigger picture and how to take their place in it.

Application: A Day at the Ranch

In a small southwestern health system, the Chief Operating Officer (COO) was a former rodeo champion. His children were beginning to compete, and he had a large number of horses that he was training, riding and entering in competitions. One day we were discussing how to get department heads on board with a major shift in how they were to manage. He was having a hard time with their resistance to allowing more autonomy to make decisions at a lower level. As we talked, he suddenly jumped up and exclaimed, "I get it! It's a lot like training horses." His experience with horses allowed him to see what he needed to do to help employees understand the direction he wanted them to go and then let them run with it. We brought the managers out to his ranch and let them experience some things he knew about horses that would help them understand what he was hoping for and why. The managers learned to settle

Table 19.2 Tips for developing perspective

• When faced with several urgent problems at once, take some time to see how they are related. Then see which chronic problems they may be related to. This approach often creates new ideas for more permanent solutions.
• Take up a new hobby. Learn a new skill in an arena that you are unfamiliar with.
• Read in depth on topics that interest you instead of getting the digest versions through magazines, vendors, broadcast news outlets, and sound bites.
• Read fiction, biographies and documentaries from long ago. Think about the author's point of view and what has driven changes since that time.
• In meetings or coaching sessions, take time to check people's understanding of why they are doing things. Instead of explaining how to get things done, make sure they understand *why* to get things done.

themselves as they saw how their nervous energy negatively affected the horse. They learned that the time taken to connect with their horse saved double or triple that time in teaching new skills. They learned to get the horse to go in the right direction by gently making it hard to go the wrong way and very easy to go the right way. The day was the beginning of a hugely successful change process as the managers understood what was needed and why. They began to far exceed expectations and opened the organization to a whole new level of success. Being able to see a bigger view and transfer that to his managers allowed this leader to take his department heads from feeling like victims to becoming vital and strong proponents of the changes the organization had to make.

A crucial part of the perspective trait is to be able to increase the understanding and knowledge of others. It wasn't enough for the COO to "get it;" he had to be able to find a way to convey what he understood to others. Sometimes that is best done experientially, as with our day at the ranch. Other times it is an explanation that is elegant in its simplicity. Good questions often allow people to find their own answers and experiences that shed light. Reflection is a powerful tool for gaining perspective for oneself and for helping others do the same. However it is done, the leader with a large and varied perspective that he or she can effectively convey will be in position to have a strong influence on the change process.

Compassion

You may have read the story of Aravind, the eye care system that has clearly laid out the business case for compassion, or have seen the results of Planetree, the organization that helps hospitals become compassionate, patient-centered places of healing. In these cases, the evidence reveals how compassion in organizations helps lead them to be innovative and successful.

Having the trait of compassion is to recognize the suffering of others and to take action to transcend it. Of course, organizations don't have feelings and don't take actions—their leaders do. Compassionate leaders create compassionate systems and compassionate change processes that work. Developing compassion (Table 19.3) can transform your relationships, your employees and your organization.

People resist change for reasons ranging from losing their position (fear) to the miserable feeling of uncertainty about what might be at the end of the change process (powerlessness). Resistance to what is happening is one of the major causes of suffering. All of us have experienced resistance to a situation or person that did not suit us, and suffered from it. Compassion is understanding and responding to behaviors that arise by trying to alleviate the suffering instead of judging and labeling the person in any negative way. This idea is not to suggest that you resign yourself to bad or inept behavior, but instead, help people transcend it.

If we stop thinking of change as something we don't like—and therefore something to resist—and start thinking of it as a process of learning, it becomes easier to drop the resistance. The more we learn, the easier it is to quit resisting. The actions

Table 19.3 Tips for developing compassion

• Remember that compassion is a choice and like a muscle one has to exercise the compassionate choice many times to be able to do it easily.
• Before confronting a problem, take a few minutes to imagine that you were the person or member of the group you need to confront. Imagine how you would feel in the same situation. Don't do this superficially—really spend the time to put yourself in their shoes and play out the situation in your mind from their point of view. Then confront them.
• Practice during the inevitable home conflicts. Try to really see what is behind behavior you don't like. Ask yourself, "What must they believe or feel to behave in that way? What do they need?" Then identify a time when you believed or felt the same way.
• Practice picturing people who irritate you and then silently wishing them happiness and the absence of suffering. Do this in a quiet space at a time you are not irritated by them. Work at really meaning it.

of compassionate leaders can help people keep from getting bogged down in unproductive behaviors, processes and emotions.

Tom Leahy of Leahy and Associates has put forth a model which clarifies what is happening in the various stages of learning and what actions are required.[1] It offers a compassionate view of behavior and helps leaders meet the needs of those who have to learn a new way to work. As people solve the problems associated with change, they can feel stuck or bogged down. It becomes difficult to work cohesively; they slog through activities where they see little progress. At that point they are on, what Leahy calls, the Learning Edge. There are three places teams might go from that point. Bailout is where people begin to just go through the motions, not keep agreements on group decisions, or just withdraw. Breakdown is a situation where conflict, frustration, and anger take over and there is no constructive activity at all. Breakthrough, the desirable outcome, is where things begin to come together and there are new perspectives. People feel energized and momentum grows. Leaders affect these stages by providing what the team needs to Breakthrough and avoid or recover from Bailout or Breakdown as seen in Fig. 19.1.

What teams need while on the Learning Edge is tools. Tools may include technology or equipment, but often teams need the tools of people systems and processes—things like meeting management skills, conflict and negotiation skills, clear processes for obtaining permission or resources, or facilitation skills. What the leader should be cautious of is pushing too hard given the level of available knowledge, tools, and resources.

Application: Having Compassion for Resistance

A charge nurse in a large hospital was trying to help her nurses make the leap from a physician centered care system to a patient centered one. Most of the physicians were on board but there were a few hold outs who were sometimes grumpy and arrogant about the changes and were taking it out on the nurses. The situation was

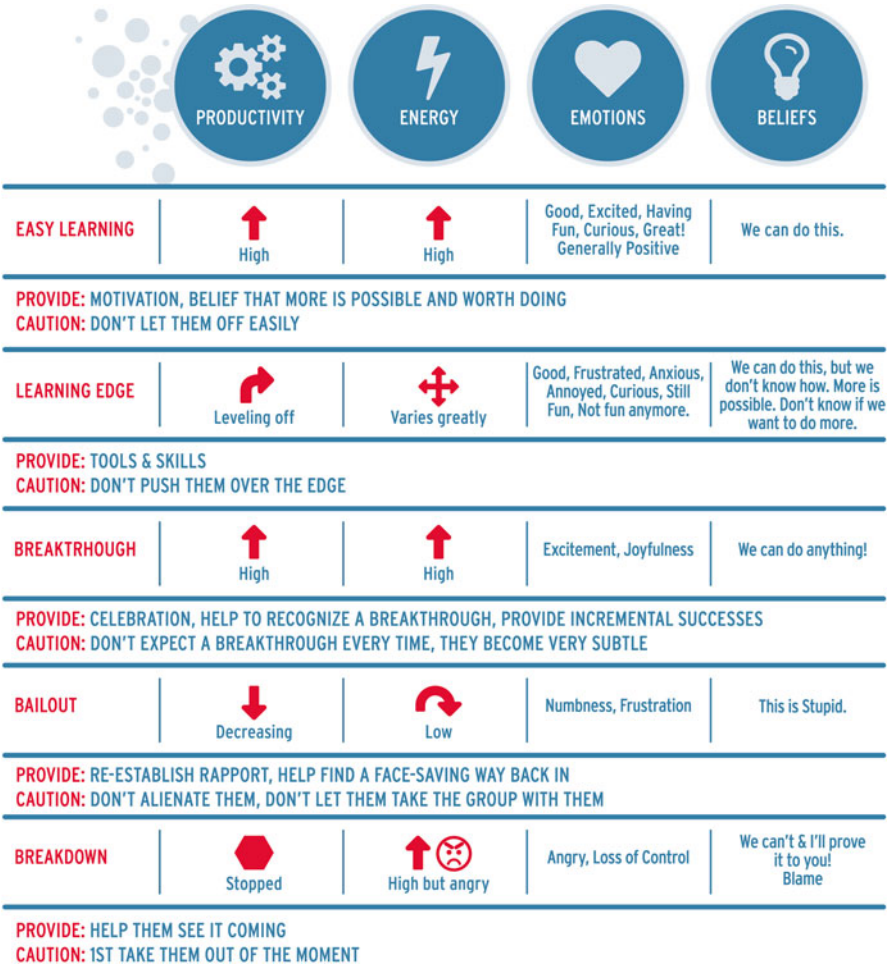

Fig. 19.1 Breakthrough© model by Thomas Leahy

frustrating and time consuming. The charge nurse realized that her team was on the Learning Edge of changing their approach to physicians. They needed tools to use, and compassion as they learned to use them. Pushing them harder to deal differently with those physicians was useless. It wasn't an issue of desire but a lack of skills. The charge nurse incorporated training in how to deal with difficult people. After several learning sessions and some phone coaching for specific situations, they began to effectively work through issues with these doctors, arriving at positive outcomes. By providing tools instead of pressure, the charge nurse was able to help them move through a sticky part of the change process. By having compassion for their situation, she was able to reframe it as a learning stage instead of blaming the physicians, her nurses or the administration.

Willingness

Willingness is the ability to take the right action despite feeling fear, anxiety, boredom, resistance or discomfort. It is NOT an absence of these feelings but the willingness to do the right thing to the best of your ability. Decide what kind of leader (or manager, spouse, parent, or citizen) you want to be and develop the willingness to do what needs to be done. Remember the example of learning feedback models and not using them? Willingness is the character trait that would enable people to use a feedback model they have been taught. This doesn't mean they don't have any willingness, but rather the trait could use more development. Without the willingness, using feedback is sporadic or non-existent. Willingness is also a matter of where you put your focus. If you don't pay attention, then you float through situations thinking that things are happening *to* you instead of taking the actions needed to create the outcome you *want*. This is not to say that you can control everything, but that we are often unwilling to pay attention to that which we don't want to deal with. Not paying attention is a way of being unwilling without taking responsibility. To develop willingness (Table 19.4), the first step is to be able to pay attention to the part you play or are choosing not to play in your leadership and then doing the right thing no matter how uncomfortable.

In organizations, lack of willingness is what makes people not address conflict, generally to the detriment of everyone involved. Chronic lateness to meetings, not replying to requests for feedback, not mentioning looming problems before they get out of hand, missing deadlines, and failure to communicate are all symptoms of a lack of will to do what needs to be done. Failure of the will to take the right actions is typically caused by fear, stress, laziness, or lack of focus. Lack of willingness leads one to take the safe or easy alternative and leads to low self-esteem, avoidance or the appearance of being disorganized.

Table 19.4 Tips for developing willingness

• Make a list of all the things you have been putting off and then schedule them into your calendar and systematically do them, or make the decision that you are not ever going to do them and cross them off the list.
• Take five minutes each day to pay special attention to what you are doing. It isn't important what it is and the purpose isn't to change it. The point is to learn to pay attention. Set your phone or watch alarm for a random time and just pay attention for five minutes. This is far harder than it sounds.
• Learn to get present to your own fear, anxiety or boredom. Meditation, yoga, martial arts, distance running, lap swimming or any activity that allows you to spend uninterrupted time with your own thoughts and awareness will eventually let you see your anxiety, fear, boredom, or resistance.
• Take up an activity that invokes fear or resistance in you for the purpose of exercising your will to do it anyway. Dancing, Toastmasters, volunteering at a soup kitchen, being a Big Brother or Big Sister, coaching a kids' team. Anything that evokes anxiety, discomfort, or boredom is a good practice ground.

Application: Facing the Challenges

Early in my career I faced a lack of will when confronted with having to tell people what they didn't want to hear or to having to do tasks that were not my strength. I put off having to follow through on routine or distasteful obligations. I was stuck in a situation where my team liked me but didn't like working *with* me. More importantly, I didn't like the self-doubt about my own capabilities. I felt weak giving in to the path of least resistance in the short run and then having to deal with the fall out. Once I understood that willingness was the key to becoming the manager I wanted to be I began an intense period of exercising my will for my own good and the good of others. The result wasn't instant, but over time my reputation for being disorganized and ineffective turned around, and people began to enjoy working with me. I began to like my job more and felt proud of how I faced day to day management challenges. Best of all, I became a manager with integrity, consistency, good team behaviors, and solid results.

Change the Leaders, Change the Company: A Case Study in Developing the Character Traits of Change Leaders

A hospital facility with two sites was experiencing high turnover, leading to many mistakes and missteps in almost every arena. Almost no preventive maintenance was being done which caused more breakdowns. Clinical staff had to work around facilities that were out of order and rooms that could not be used due to basic problems with toilets or showers. Turnover was at 65 % per year resulting in great difficulty staffing shifts, too many new people on each shift, the inability to develop good teamwork, hiring unqualified staff, to say nothing of the expense. The organization's reputation in the community was not good. Morale, from directors to charge nurses to direct care staff, was very low and frustration high.

A culture survey and interview process revealed that trust was so low within the organization that it could not be measured. The survey model showed a lack of organizational stability in structure and processes, extreme lack of engagement and people development, and low patient focus. Interviews revealed a great deal of uncertainty about what might happen or not happen on a day to day basis. Staff felt as though they could be fired at any moment depending on the mood of their manager and that processes changed with no warning or reasoning. Managers believed that the administration didn't understand them, and the perception existed that a couple of truly toxic executives and directors were "protected." Directors couldn't understand why their people took no initiative and seemed to make "stupid mistakes over and over."

In coaching the administrators it became clear that they did not have a clear set of leadership/management behaviors that were expected and enforced. They did not have a strategy beyond survival, and they had not articulated their purpose to

most employees. The executive administrators were very motivated to make things better but really didn't know how.

Developing the traits of *self-awareness*, *perspective*, *compassion*, and *willingness* in these leaders was the first order of business, because while culture drives success, leaders drive culture. By developing a clear and well-articulated strategy for culture change and clear messaging about the expected results, they began to paint a picture of what success would look like and how systems and processes would be aligned. Next, we looked at their values, because values drive behavior. When asked what their core values were I first heard about 30 s of deafening silence, and then the basic goodness of these men and women came out as they described what they wished for their organization and all those who came in contact with it. Over a period of time they boiled that down into the values by which they wanted to govern. These values reflected a compassionate way to run their hospital, and they began to explore and learn how to make the values apparent in their own behavior and manage according to the core values.

The CEO was particularly open to understanding how he had created the former culture and what he could do to change it. He didn't like hearing that his unwillingness to demand professional behavior was demoralizing and holding bad behavior in place. He didn't like facing news that his desire to be liked was making him hold back telling people the whole truth. But he listened with compassion to his employees and had the courage to change. He worked at getting consistent feedback about his clarity, staying the course in the face of opposition, and telling people not just most of the feedback and expectations he had for them, but all of it, even if it meant he and they were uncomfortable.

His team members each did their own soul searching as well. One of the directors left because he was clear that he didn't want to change. Another director worked hard to develop compassion for himself and his teams instead of judging and finding fault most of the time. Once they began to develop new ways of operating, they began to help their managers to do the same. They held leadership workshops, coached their direct reports, helped formulate messaging about what part each person played in the success of the hospital and what values and behaviors were expected.

Within six months, employees began to believe that things were going to be different and better. Those who didn't want to make the changes left and those who were going to make this hospital successful engaged. Within a year, turnover was down, and at the two year mark it had dropped to 24 %. Facilities Services was doing more preventive maintenance than urgent repairs, morale was high, and the hospital began attracting new employees from nearby towns. Some former employees who had left began to return, and they were recruiting top notch staff because their reputation had been repaired. Employee-led task forces had streamlined several major processes including hiring, onboarding, pay, and performance evaluation systems. After 4 years they added another facility with little of the usual acquisition headaches.

There were many job related, technical, skills related, and organization tasks that had to be done to turn this hospital around, but without the traits development of their leaders, they would not have been able to be successful. Leaders without these traits have a very difficult time gaining willing followers.

Table 19.5 Final tips for leading change

• Do not start in high stakes situations unless unavoidable. When first starting, you will find you are sometimes brilliant and other times quite clumsy. Practice with people who love you, are already on your side, and those who know you are trying new things and will extend grace for the clumsy attempts.
• Do make sure you practice where it counts—soon. Make the rubber hit the road quickly so that you gain the benefit of real world learning.
• Have an ally who you see often to get feedback on character traits and corresponding behaviors you are working on. It will go much faster with honest feedback.
• Do not think you can practice here and there and make much progress. You really have to pay attention to practicing some aspect of these traits in short bursts each and every day.
• Do not judge yourself when you are less than brilliant. It will not make you better in any way and may create behaviors in yourself that are detrimental to your goals.
• Do not expect to "get this and move to the next one." Making character traits part of your internal operating system is a lifelong process. We all regress from time to time but those regressions get less frequent and more subtle.

Conclusion

Developing the key character traits of self-awareness, perspective, compassion, and willingness creates a foundation which is necessary to be successful as a leader. It is a practice, not a one time learning event. Practicing anything to learn or improve takes persistence. Review the final tips below (Table 19.5). Practice using these traits and you will see the benefit. Some will come quickly and others over time. Celebrate your successes and practice further when you stumble. That is also what you ask of others because it works to create continuous improvement. Do it for yourself and enjoy the fruits of your practice.

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Chapter 20
Thinking Strategically

Christopher J. Evans

Introduction

The choices faced by healthcare providers and health system leaders continue to be driven by changes in, among many things, consumer behavior, demographics, reimbursement models, organizational initiatives, market consolidation, and competition and regulatory guidelines. In response, physician leaders in academic health systems need to marshal the very best of their raw processing power and discernment (intelligence), recognize the immediate and future effects of their actions, and manage polarity thinking in cases where complex issues are not problems that can be solved, but contain important, yet opposing elements that must be balanced toward a strategic end. Physician leaders are, therefore, being called upon to become *health system thought leaders*. One of the most critical skill sets be effective in this environment is thinking strategically.

Thinking strategically (or strategic thinking) is a skill business leaders use to effectively and proactively respond to the increased rate of environmental change. By its nature, and given its interaction with so many market forces, academic medicine falls squarely in the middle of widespread change. The term VUCA, coined by management consultant Daniel Wolf, describes the healthcare industry well [1]. VUCA is an acronym used to reflect on situations and circumstances. VUCA stands for:

- Volatility—Nature and dynamics of change and the nature and speed of change forces and catalysts
- Uncertainty—Lack of predictability; the prospects for surprise and the sense of awareness and understanding of issues and events

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_20

- Complexity—Multiplex of forces; the confounding of issues and the chaos and confusion that surround an organization
- Ambiguity—Cause-and-effect confusion; haziness of reality, the potential for misreads, and the mixed meanings of conditions

Building further on VUCA's premise, John Kotter, professor emeritus at Harvard Business School, conducted a landmark 20-year study of 115 members of the Harvard Business School's Class of 1974 [2]. Kotter described how the globalization of markets and competition is altering career paths, wage levels, the structure and functioning of organizations, and the very nature of work itself. Kotter identified:

- **The New Reality of Change.** The need not to rely on convention. In academic medicine this means carefully honoring the past, exploring how to respond to new demands from patients, payers, and regulators, and managing the long-term survival of the health system.
- **New Responses.** The need to involve leadership, not just management, and the emergent need to focus on small, entrepreneurial approaches rather than large and bureaucratic ones.
- **Underpinnings**. The need to be responsive requires both a competitive drive and the dedication to lifelong learning. These include the need to continually re-create systems through learning and adaptations of management, leadership, and organizational processes.

Thus, there is high demand for effective organizational methods to cope with change and foster innovation. This reality requires a framework to understand change and to create an organizational culture that can respond effectively and strategically. As a result, physician leaders are increasingly called upon to establish data driven links between departmental, environmental, cultural, and health system strategic plans.

All of this rapid change points to the need for strong decision making skills, aimed at creating sustainable organizational outcomes. In short, the ability to think strategically is paramount to leading within a vibrant academic medical center. Leaders cannot afford to make strategic decisions in a vacuum.

The First Step: Evaluating Our Thinking

All thinking is a response to a question. Our minds think 'blue' only in response to asking 'what is that color?' While accomplished professionals often equate educational and professional success, in part, due to their thinking abilities, much of our day to day thinking is significantly flawed. Critical thinking leaders Richard Paul and Linda Elder of The Foundation for Critical Thinking say, "…it is biased, distorted, partial, uninformed or downright prejudiced. Yet the quality of our life and that of what we produce, make or build depends precisely on the quality of our thought." [3] Every person makes errors in judgment. To create sustainable organizational performance, leaders need to regularly evaluate and develop the quality of

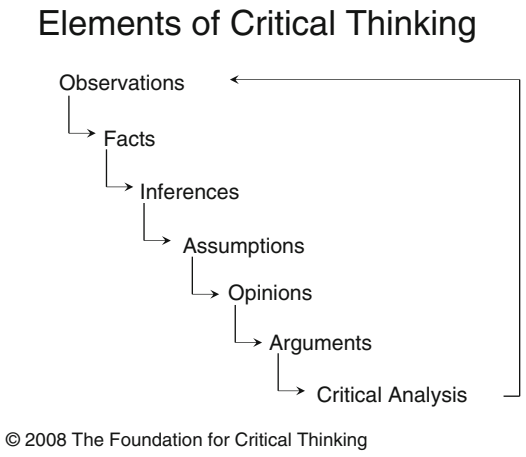

Fig. 20.1 Elements of critical thinking

their thinking with an aim toward improving it. Before we can become outstanding strategic thinkers, we need to build a critical thinking foundation.

Paul and Elder define *critical thinking* as the art of analyzing and evaluating thinking with a view to improving it [3]. When done well, it is self-directed, self-disciplined, self-monitored, and self-correcting (Fig. 20.1). It also requires adherence to standards of excellence and the need to overcome our own preferences, whether driven by our biases, personality-based styles, or other desires. Critical thinking answers the deep questions exploring purpose, information, interpretation, assumption, implication, point of view, relevance, accuracy, precision, consistency, and logic [3].

In summary, critical thinking is

- A set of skills to process information and beliefs
- The habit, based on intellectual commitment, of using those skills to guide behavior
- Never universal—everyone is subject to undisciplined and irrational thought
- A matter of degree, with blind spots and tendencies toward delusion
- A lifelong endeavor

Beyond the rigor of thinking critically, leaders also need an orientation on thinking that is strategically relevant to their work and their organizations.

The Second Step: Thinking Strategically as a Leadership Competency

Thinking strategically is not the same as developing a business strategy, strategy execution, strategic management, or strategic leadership, but examining these related concepts can help us become better strategic thinkers. *Strategy* reflects the pattern of choices an organization makes to position itself for superior performance over time. It involves a process of discerning from a mass of objects and relations

what is most important and decisive, through discrimination and judgment [4]. According to Porter (1996), "The essence of strategy is choosing what not to do." [5] The strategy itself is the result of the process.

Some organizations may interchange strategy with the term strategic initiatives or strategic drivers. *Strategic drivers* are the relatively few (3–5) determinants of sustainable organizational performance that lead to superior performance over time. They can incorporate areas such as technology, marketing, faculty recruitment, physician engagement and organizational resources. Individually or in connection with other organizational resources, competencies and capabilities, strategic drivers strengthen competitive positioning and, perhaps most importantly, they indicate where to invest limited resources. Strategic drivers are aids in determining where organizations should and should NOT dedicate time, energy and investment.

Strategic Drivers Help

- Discern where and how aggressively to invest time, energy and money to strengthen competitive positioning
- Aid understanding risk aversion and risk taking when making decisions related to strategic investment
- Match changing external environment conditions with internal organizational capabilities and organization structures
- Align strategic vision and operational decision making

Questions to Identify Drivers

- Are our current key strategic drivers (initiatives) absolutely vital to move us toward our desired future?
- Could some other investment be more essential to support our mission and/or goals?
- Is it clear how we will invest in them—what actions will we take and do their Ends Statements support our vision?
- If a driver was neglected or missing, could it be established quickly to move the organization toward our desired future?

Sample Strategic Drivers and Their Related Ends Statements (Vision)

- Driver: "Patient—Centric Care"; Ends Statement: We will be the primary health system of choice in our existing markets.
- Driver: "Destination Health Services" Ends Statement: We will become a destination system for healthcare services beyond our immediate referral area.

- Driver: "Provider Engagement"; Ends Statement: Develop a robust system to engage, include and ensure a pipeline of physician leaders.
- Driver: "Primary Care Transformation"; Ends Statement: We will be the preeminent health system in access and customer convenience.
- Driver: "Diversity Inclusion and Engagement"; Ends Statement: We will rigorously engage our staff and community in enhancing the quality of patient care.

Strategy execution is the process used to implement the goals and their supporting tactics for each strategy or strategic driver. Because the individual tactics lead to the success of the overall strategy, these individual outcomes are more important than the manner in which they are connected [6].

Strategic management is the organization-wide process encompassing situational analysis, strategy development, implementation, strategic control and adaptation. Because it is a whole systems approach, it helps create a learning organization (an organization that embraces the learning of its members as a core competency through its cycles of planning, implementation, evaluation, and modification in an ongoing manner.) Management expert Peter Drucker reminds us that strategic management makes the organization capable of anticipating the storm, weathering it, and in fact, being ahead of it [7].

Strategic leadership, as developed by the Center for Creative Leadership (CCL) and described by Hughes, Beatty and Dinwoodie in their text, Becoming a Strategic Leader [4], encompasses how effective management and leadership practices are necessary for creating sustained organization performance over time. Individuals, teams and organizations enact strategic leadership when they think, act and influence in ways that create direction, alignment and commitment throughout the organization. Embedded within CCL's strategic leadership framework are:

Strategic thinking—understanding the complex relationship between the organization and its environment, and utilizing that understanding to make decisions that facilitate the organization's enduring success. It includes the cognitive and social processes required to collect, generate, interpret and evaluate information and ideas that shape an organization's superior performance. These embody both traditional thinking processes (analytical processes, linear connections, verbal framing, explicit approaches, direction, "head-thinking") as well as innovative thinking processes (synthesis of ideas, nonlinear connections and processes, visual representations, implicit framing, "heart-consideration").

Strategic acting—taking decisive and timely action consistent with the strategic direction of the organization, despite the ambiguity, complexity and chaos inherent in organizational life. These include actions and decision making that commit resources to build superior performance, such as: setting direction, establishing priorities, delegating responsibility, assuming accountability, capturing learning, acting despite uncertainty, balancing long- and short-term, and having the courage to act.

Strategic influencing—engendering commitment to the organization's strategic direction by forging relationships (inside and outside the organization), utilizing organizational culture and systems as influence tools, and inviting others into the strategic process. Strategic influencing is done when the outcome has strategic

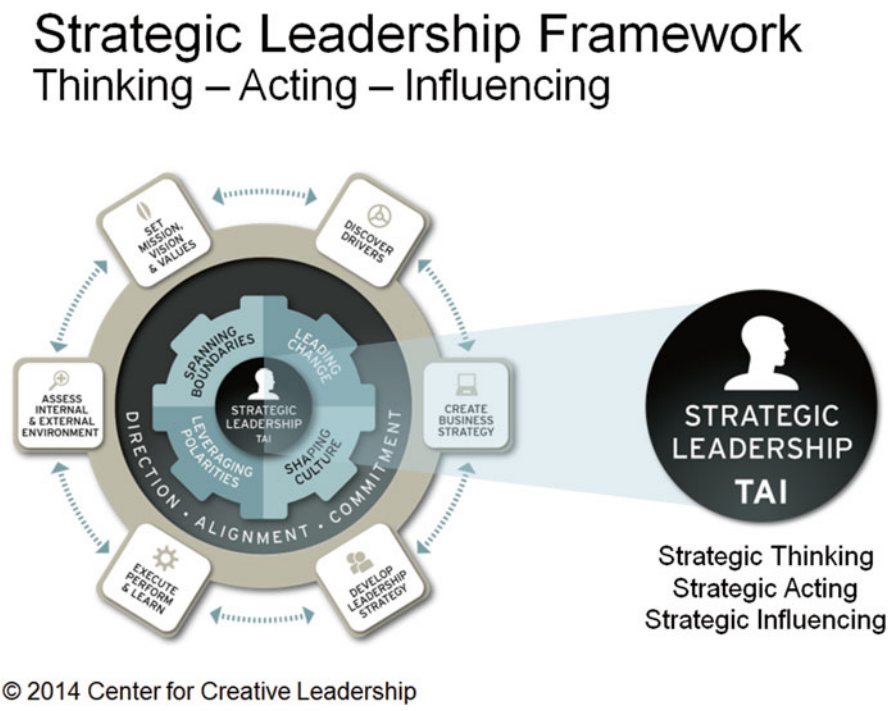

Fig. 20.2 Strategic leadership framework

implications for the organization; commitment toward the goal is critical. Strategic influencing occurs over long periods of time and typically involves people from across the organization. Strategic influencing essentially focuses on having an impact on the web of relationships that shape how and if things will get done.

These domains of individual and collective thinking, acting, and influencing are the keys to enacting strategies in times of rapid change. Leaders tend to be strong on one or two of these domains, but competence in all three are necessary (Fig. 20.2).

Selecting Your Strategies/Tactics. Strategic leaders design, enact and orchestrate their influence efforts to build trust, credibility and relationships on a targeted network of stakeholders. They create win-win scenarios that consider the needs of others from a systems perspective. Some approaches to clarify your thinking include:

- Draw attention to the need/opportunity
- Provide information
- Involve others in the ownership of the idea
- Leverage past support
- Ask questions
- Work on a small scale and build momentum
- Adjust your goals to avoid resistance

- Compromise with those who are opposed
- Start with your most likely allies
- Connect to other initiatives
- Time it right

Strategic thinking, as a leadership competency therefore, encourages you to ask:

- How do I manage the paradox between sticking to a plan and challenging that same plan, as warranted, in response to changing conditions?
- Am I as leader constantly learning?
- Have I tried to intentionally broaden my view and see multiple perspectives?
- Am I aware of blinders and filters that are part of my individual and/or our organizational prism?

The Third Step: Strategic Thinking as a Competency

Academic physician leaders who think strategically have a future focus that guides their behaviors and decisions today. For example, a strategic thinker may see value in balancing the needs of basic science researchers with translational efforts to get their laboratory breakthroughs into the clinical space.

Core strategic thinking skills that leaders can develop include:

- Setting a 1–3 year organizational strategy in alignment with the future view of the larger department, division, center, or organization with a shared understanding of the organization's strategy
- Making effective decisions by considering diverse sources of information, including open-mindedness, critical thinking, and data-driven thinking
- Having a systems perspective about multiple, interrelated variables
- Being intent focused—persistent and not easily distractible
- Thinking and acting in time—simultaneously holding past, present and future in mind
- Being hypothesis driven—using both creativity and critical thinking to develop ways to test critical hypotheses
- Being responsive to good opportunities
- Scanning the environment for forces that may positively or negatively affect one's organization
- Discerning the truly key facts or trends amid large amounts of available data
- Visioning well—developing a picture of the future
- Re-framing issues to see different possibilities
- Prioritizing key issues and discerning those which are strategically relevant

At the entry levels of an organization, or perhaps when a faculty physician takes on his or her first significant organizational responsibility, challenges are often straightforward and clear. They may be operational or procedural in nature, have short-term timelines or require working through solutions that are presented (given). For example, Dr. Grahame may be asked to serve as the faculty coordinator for

continuing education for the department, or to chair the quality committee on which she's been a member for the last three years, or to liaise with the operating room administrative department head around scheduling.

As the leader's career grows, so does the complexity of his or her job. The challenges become more complex, more ambiguous, more conceptual, requiring attention to both long and short-term timelines and novel solutions. For example, Dr. Speaks may become the committee chair exploring strategies by regional competitors who have been siphoning off patients to walk-in clinics, or she may lead the readmissions team that includes community service and other non-faculty representatives.

Growing Your Ability to Think Strategically

Physician leaders need heightened self-awareness of their own strengths and weaknesses in order to effectively lead teams and execute organization level initiatives. As complexity and new demands increase for faculty physicians, they may be lacking in these critical skill sets to maintain pace and be effective (Fig. 20.3).

To gain further insights, explore the following questions [8]. Rate yourself on how well you manage these topics *now*, and which issues might be important for you to grow as a strategic leader. Take notes to guide your thinking, and use the following scale where applicable:

N/A = Not Important Now	1 = Needs Work	2 = Skilled	3 = Expert

Fig. 20.3 Experiences that build strategic thinking ability

- I can objectively balance my consideration of the near-term tactical details and planning for the future
- How comfortable am I with challenging the status quo?
- Can I integrate diverse perspectives into a coherent strategic view?
- What probability of success must exist before I am willing to take a risk?
- Am I comfortable speculating on the unknown?
- Do I have enough, or the right data, to form an opinion?
- Do I keep pace with trends and consumer market information?
- Can I create small milestones along the way to a bigger goal?
- What is my preferred way to make decisions? Is it intuitive? Is it participatory? Is it data driven?
- Am I using the best decision making method for this particular decision?
- Am I able to adjust my decision making method based on the situation?
- How confident am I in my analytical skills and processes?
- What feedback have I been given in the past about the effectiveness of my decisions?
- Do I have experience working cross functionally?
- Do I access other perspectives sufficiently before coming to a decision?

To strengthen strategic thinking capacities (Fig. 20.3), consider the following "On-the-Job Assignments" [8]

- Volunteer to work on the strategic plan for your team, department, or division
- Explore new opportunities or territories for your academic unit
- Study and report on the effects of emerging technologies on your organization
- Identify and examine the constraints to your organization's greater success
- Develop processes for tracking progress toward long-term goals
- Present your vision and strategic plan to senior management and others
- Look for opportunities to work on ill-defined or recurring problems
- Get involved in decisions that require broad input from across the organization
- Provide mentoring or coaching to others struggling with a significant organizational or individual issue. Seek a mentor or coach for your own development.

Conclusion

Physicians who aspire to lead in academic medical settings will be asked to participate in system design and improvement unrelated to their own academic and work experience. They will be asked to rapidly understand and assimilate new views of leading large, often multi-site, organizations and be expected to think, act and influence both in ways that are expected of highly trained and intelligent physicians, but also of seasoned healthcare administrators. They will be increasingly thrust into roles demanding they think in new ways and work with colleagues who do so readily. Physician leaders will also need to balance their existing roles of clinician, department or committee chair, researcher and mentor as they work through novel, collaborative challenges and develop their senior leadership skills.

Physician leaders can develop their strategic thinking skills through both individual learning and developmental assignments. As they to continue to pay attention to their own awareness and competence under new leadership demands, they will improve their effectiveness with their own projects and agendas, in leading teams of others, and in designing and executing organization-level initiatives.

Tips and Pitfalls

It is valuable to be clear about what strategic thinking is not. It is not:

- Tackling a problem without searching deep and wide to understand root causes
- Basing your plans on past experience only, without attending to changes in the context
- Using only existing measures to guide decision making without asking if they are the *right* measures
- Looking for only confirmatory evidence/data
- Letting your biases and preferences play too strong a role in your thinking
- Reacting to everything that comes across your plate and not prioritizing each in the context of your strategy

As a mindset, strategic thinking is:

- Both an individual and a collective process because no one leader possesses all of the knowledge, skills, experience, and understanding to tackle all challenges. Strategic thinkers deal with organizational impacts by engaging diverse perspectives, experiences and viewpoints.
- About the present, not just the future. Organizations are routinely clear about strategic goals, but strategic drivers are not so well defined—those capabilities that are distinctively critical to drive organizational strategy. Prioritizing these strategic drivers and aligning tactics to match these drivers is an outcome of excellent strategic thinking.
- Having an artful side as well as a rigorous analytical side. We need to ask: What cognitive processes are necessary to collect, generate, interpret, and evaluate information for good decision making?

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Part IV
Advancing Your Career

Chapter 21
Growing in Your Current Role: Reaching the Next Rung on the Ladder

Mary Jane Rapport

Introduction

If the goal you have set is to reach a certain academic level, position of leadership, or recognition of expertise, then how do you know when you've achieved it? As you go through your daily work and responsibilities, you are challenged with maintaining productivity while at the same time always looking further towards growth and development in your current role. What is the tipping point at which you see more, or want to reach for the next rung on the ladder, and how will you get there?

As you walk into the patient's room in a clinic or healthcare facility, start a new position, or are presented with new challenging responsibilities, you are exposed to a wide landscape of opportunity. You must take the time to understand the possibilities, all the while tackling the challenges before you. This requires some ability to explore options and self-reflect, but it also requires the ability to seek resources, ask questions, and request assistance. As you grow in your current role, you must have foresight into future opportunities, being aware of both lateral opportunities and those that are considered more advanced or provide ways to move up the career ladder (Fig. 21.1).

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_21

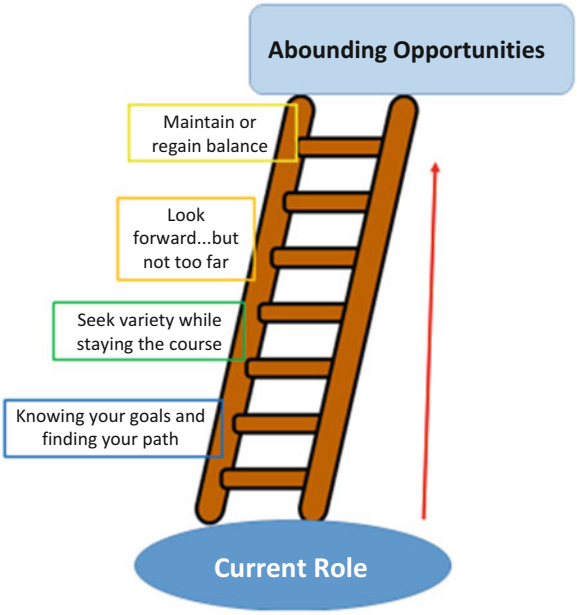

Fig. 21.1 Moving up the career ladder

Knowing Where You Are and Where You Are Headed

Personal Goals and Planning

For the most part, faculty in academic medicine have generally focused their career goals and aspirations on some combination of patient care, teaching, or research. These career goals were preceded by earlier life achievements of getting accepted to a professional education program, obtaining a terminal clinical or research degree, and then assuming a clinical or research position. It is rare that someone comes to academic medicine with the goal of becoming a program director, department chair, or even a dean. These goals may come later, or are never even considered at all. In an effort to best prepare for professional growth and to pursue the many opportunities that abound in academic medicine, faculty would be best served to carefully consider and discuss personal and professional goals, and make use of the many resources, including people, available at their own institution or in their professional organization [1].

> Jenny was an Associate Professor who had been on faculty and was a respected Residency Director in her department. She had made some positive changes in the residency program over the past five years and was feeling ready for a new challenge in her academic medicine career. Over the past twelve months she had applied for several different positions—each of which seemed interesting and provided a new focus. In the end, the positions were always offered to other faculty, and Jenny was now preparing her cover letter for yet another opportunity that seemed intriguing. She paused to think about whether she may be missing some

key points in her letter and wondered if she should explore this latest opportunity with Alice, a colleague from whom she occasionally sought advice and mentoring. Alice had been curious when Jenny might seek out her opinion. She was well aware of Jenny's interest in moving up the administration ladder while observing that other more junior faculty had been offered the very positions Jenny had applied for during the past year.

As a colleague and mentor, Alice felt a sense of responsibility to be open and honest with Jenny, but she wasn't certain that she wanted to be the one to deliver the difficult message about why Jenny was not being selected, or even considered, for these positions. Alice also wasn't sure that Jenny truly wanted to hear the reasons why other faculty were being selected time and again instead of her. What could she say to Jenny that would be heard and understood?

Alice knew there were two primary issues affecting Jenny's ability to grow and advance professionally. One was the result of Jenny's behavior early in her academic medicine career. Her actions had been perceived as "using" other people to achieve her own goals after she let her procrastination get in the way of an important project and had to rely on other faculty and administrative staff to pick up the slack. In the end, when she had the opportunity to share or give credit to others, she took full credit for the project herself. The resulting resentment from others has continued to plague her, even some years later.

Despite the reputation that persisted her by allowing other faculty and staff to do her work and then taking the credit, Jenny's larger issue was the pursuit of multiple positions over the past year or more. Hunting for new challenges and new ways to grow professionally was being perceived by others as indecisiveness about what career path or goals she really wanted. In her university's culture, position hopping was not accepted or encouraged. In fact, the more positions Jenny sought, the more her applications were not considered. Senior faculty began to wonder what Jenny was seeking and in what direction she saw her career heading. Alice attempted to share these perspectives with Jenny when they finally sat down to talk.

Jenny did not accept Alice's feedback well, and seemed unable to understand how actions from years ago could be so misconstrued and continue to be so damaging to her career. She also had difficulty understanding why seeking a leadership role in multiple areas was cause for concern. As she stated to Alice, "I just want to grow and advance in my career and see many different positions in which I could apply my skills and get things done."

There is certainly something to be said for establishing goals, setting a course, and staying on a steady path [1]. There will also be times when it will be not only necessary, but also beneficial, to deviate from the established plan. In these situations, the benefits and challenges of staying the course, compared with the perception of others around assuming a new path, should be carefully considered by looking at both short and longer term possible outcomes [2, 3]. It may be the case that a short-term challenge leads to longer term benefit, and consideration should be given to each opportunity and whether the benefits are sufficient to make a change from one position to another or even entertain moving to a new institution. Akin to the concepts of adaptive work or adaptive leadership, deviation may be necessary for forward movement over time [4]. Jenny would have done well to carefully consider Alice's feedback, analyze her strategy, make adjustments in her behavior to address past and current mistakes, and then determine a new or altered course of action for her career trajectory.

Figure 21.2 is a form that can be used to assist in developing a plan for short and long range goal setting, including action steps and resources that will be necessary to achieve each goal. By addressing different time periods, you are directed to consider at what point you perceive career advances will likely present as viable opportunities.

Time Period	Identified Goals	Action Steps	Resources Needed
	List 1-3 professional (scholarship, clinical service) and/or leadership goals you hope to achieve in measurable, specific terms	*List the steps necessary to meet each of the identified goals –what actions or activities will it take to achieve the goal*	*List resources or supports, including people and items, you will need to achieve the action steps and the goal*
Next 6-12 months			
Next 2-4 years			
Next 5-10 years			

Plan completed by: _____ Date: _____

Fig. 21.2 Career and leadership plan worksheet

The longer the time period is from the present, the more difficult it can be to detail the action steps or feel any sense of accuracy around goals. However, it is this type of projection that opens the door to thinking about the opportunities that may lie ahead and how to be better prepared to approach each one. It is not only beneficial to create the plan, but to refer back to the plan periodically, as a reflective exercise and mechanism for career plan and goal modification.

Forests or Trees

Promotion within academic medicine (see Chap. 22) is most often based on selecting a "track" and pursuing excellence by demonstrating accomplishments consistent with criteria in the given track [5]. For example, there may be opportunities to pursue research, teaching, or clinical pathways towards promotion. While career development is not based solely on promotion, the two are intricately intertwined in the academic faculty setting. The activities and pursuits required for promotion are generally the same as what would be expected for growth in a current faculty role; and these are essentially the same to be considered for an advanced title or a position with additional authority up the career ladder. For example, as a clinical physician or a bench researcher attempts to establish a career path, consideration must be given to the extent to which each of them will take a broader perspective or seek

expertise in a more narrowly focused direction. There is challenge in achieving recognition for expertise in a refined clinical area or research specialization while attempting to maintain a broad enough view to be considered for advanced positions within the institution. Are you known for your ability to perform the science or procedure, or are you known for your administrative talents and leadership? This dichotomy can lead to limiting perceptions, such as having a lack of focus, willingness to engage in too many projects or activities outside of an identified scope, having too narrow a focus to assume more responsibilities, or being unable to do well outside of a limited area. Is it a matter of seeing the trees through the forest or the forest through the trees?

Finding Opportunities

Do You Find Them or Do They Find You?

We all have room to grow and develop in our knowledge, skills and abilities, but finding the right opportunities to assist with one's growth is not always easy. In fact, the more developed you are in a specific area or skill set, the more challenging it may be to identify and pursue true learning opportunities that would be of benefit. Depending on the size and scope of the academic institution, many faculty may be able to access a variety of internal courses, programs or workshops to build skills [6].

Larry is a junior faculty member who exemplifies a level of productivity beyond most of his contemporaries, and he has many good ideas. He is energetic, punctual, and has a skill set that supports opportunities for future large scale projects and leadership positions. He is currently at a satellite hospital with limited access to the daily interactions on campus and at the main hospital. Larry often assumes a bulk of the work when he serves on task forces or committees, and his organization and attention to detail are always appreciated and praised by others. As Larry reaches the point in his career where additional opportunities for advancement seem possible and appropriate, he has started to apply or request that his name be entered into the pool. What Larry doesn't realize is that his interpersonal skills and communication style often come off as abrasive and as a "know-it-all." He has been identified as someone who makes others feel inferior during meetings, and a few clinicians at the hospital have even been heard to mumble under their breath, "What does he think I am, stupid?"

Larry is not well known across the institution, and therefore, he hasn't received much feedback from those colleagues who have found his personality to be challenging. Perhaps, the issue that has plagued Larry most is that he finds himself learning about opportunities for institutional advancement after they have been filled. On more than one occasion, he has seen a position posted, contacted the senior faculty or administrator who is overseeing the search, only to find out that the position was being filled by someone who had advance notice or was already serving

in the role before the posted announcement. Larry feels that his chances of advancement are limited by his clinical assignment at the satellite hospital. He also doesn't fully realize the extent to which his interpersonal skills are a blind spot that may be limiting his career path. Unless Larry seeks input from colleagues or mentors to help him recognize his deficits and identify potential pathways for change, he is unlikely to be considered for future opportunities and will likely become increasingly frustrated and dissatisfied.

In many cases, positions of leadership and management appear to spontaneously present themselves, regardless of any planned preparation or skill building that has occurred [7]. Assuming leadership opportunities may be a matter of "being in the right place at the right time," or may be the result of natural growth and evolution in assuming greater responsibility as the result of longevity or seniority. Rarely do we find faculty in academic medicine who aspire to these positions; and with competing requirements for clinical time, teaching, research and service, the opportunities to advance into leadership may be difficult to plan for and to anticipate [8]. Thus, the need to jump at an opportunity of interest when it is presented may be necessary. Waiting for just the right opportunity can be frustrating, particularly when months and years pass by and the leader is in no hurry to retire, step down, or leave the institution. The frustration can become damaging when there is no room for sharing new ideas, fostering confidence, and building skills in leadership and management as a result of the current leader's own style or preference for leadership and control.

Confident, But Not Cocky

Invariably, many faculty seem to take on an endless number of responsibilities in the attempt to build networks and collaborations, learn or demonstrate new skills, and position themselves for the next opportunity. Without spreading oneself "too thin" by taking on too many, or having a diverse portfolio of responsibilities, accepting a variety of roles and challenges can provide a rich network of connections and additional opportunities over time. Perhaps, you will meet the very person who can help you reach new potential or introduce you to other opportunities internal or external to the institution.

As your inner circle of contacts and connections expands, so do your opportunities to gain allies and identify mentors. The ability to establish quality relationships with mentors has been covered in another chapter and will not be described in detail here. However, suffice it to say mentors and job coaches who act in supportive roles can be exceptionally well positioned to help you grow in your current position and prepare you for the next position or step in your career [9]. A strong career mentor or coach will understand what you need to do and will be able to work with you on how to achieve success as you grow your strengths. A mentor should be able to carefully boost your self-confidence while simultaneously sharing opportunities where

you need development, without letting others know you have identified limitations. Of course, we all have some areas that need further work, but keeping those quiet leads to a safer situation for maintaining focus on your strengths and accomplishments as you continue to grow.

Growing with Balance

There has been a growing concern regarding work life balance, particularly as our busy lives have become consumed with the need for instant electronic communication and gratification. Many physicians are torn by the desire to be responsive to patient needs while attempting to maintain a semblance of personal time, space and privacy. This tension creates a difficult challenge that is often accentuated even further when there are students, residents, or other advanced clinical or leadership responsibilities in the mix. While you can find a variety of possible solutions to maintain privacy, time, or inherent balance across competing professional demands, there is not a single strategy that works for everybody. Indeed, balance in all facets of life requires some trade-offs between priorities that must be integrated over time [10]. Thus, it becomes a personal responsibility to find one or more possible options that work for you. Dr. Steven Lowenstein, M.D., M.P.H., has offered several "real life" solutions including a commitment to reserve blocks of time to write, and suggestions for regaining control over email. Lowenstein writes: "…it is not enough to simply "manage the clock." You also need a personal mission statement that contains a clear statement about your priorities. What do you envision for your academic career? What do you value? What do you hope to accomplish (and when)?" ([11], p. 165)

Along those lines, the need for balance between patience and persistence becomes essential. There seems to be a need to pursue goals through constant perseverance, but you must not let this overshadow the need for patience. In this case, patience is not referring to passivity, but rather the need for careful planning, execution and implementation, and then quietly celebrating accomplishments in your current role as you venture along the path to professional leadership and success.

Lessons for Leadership

- Learn by watching others
- Seek opportunities when the time is right and the position suits you
- Use your network and create multiple bridges to more opportunities
- Patiently and persistently achieve success
- In the end, it's more about what you have accomplished than the titles you have held

Pearls and Pitfalls

- Look for committees that interest you, may have openings, and don't seem to be too time consuming
- Whenever possible, maximize benefit from each opportunity
  - Who else can you meet?
  - What else can you learn?
  - What other scholarship opportunities can you gain?
- Recognize when to say 'yes' and when you really should say 'no'
- Consider how a new opportunity will help you in your current role and help build your portfolio
- Keep sight of the forest through the trees

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Additional Resources

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https://www.aamc.org/members/leadership/catalog/322618/careerdevelopment.html
http://www.med.upenn.edu/mentee/documents/mentor_guide.pdf

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Chapter 22
Faculty Development and Promotion in Academic Medicine

Warren P. Newton

Introduction: Prospective Faculty Member

In theory, prospective medical school faculty members have a large national market to search for faculty positions. This market is dependent on specialty, area of work, and economic conditions, but medical faculty are among the most mobile professionals in our society. Of course, in practice, for many individuals, there are substantial constraints, such as careers of partners, family responsibilities, locations of faculty openings and overall economic conditions. Still, prospective faculty should always consider the larger market.

In this market, the variation of institutions that are possible career homes is stunning. The prospective faculty member should consider the fit between his/her career and that of the culture and opportunities at the institutions being considered for the first and most formative phase of his/her career. Traditionally, the US has had a pluralistic system of higher education, with institutions with more public funding (public medicals schools), and those usually with less public funding (private schools), with some of the most successful systems coming directly from practices/health systems (e.g., Mayo, Cleveland Clinic) or from governmental systems (e.g., Veterans Affairs) or private systems (e.g., Geisinger). Key to this process is the process of reading the mission (Fig. 22.1) and culture of the prospective institution: does it fit you? Reputations of the institution and the potential home department are also critical, though difficult to assess. Discussions with mentors, assessing on-line information, and discussions with others in your field are all important.

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_22

The University of North Carolina at Chapel Hill, the nation's first public university, serves North Carolina, the United States, and the world through teaching, research, and public service. We embrace an unwavering commitment to excellence as one of the world's great research universities.

Our mission is to serve as a center for research, scholarship, and creativity and to teach a diverse community of undergraduate, graduate, and professional students to become the next generation of leaders. Through the efforts of our exceptional faculty and staff, and with generous support from North Carolina's citizens, we invest our knowledge and resources to enhance access to learning and to foster the success and prosperity of each rising generation. We also extend knowledge-based services and other resources of the University to the citizens of North Carolina and their institutions to enhance the quality of life for all people in the State.

With lux, libertas — light and liberty — as its founding principles, the University has charted a bold course of leading change to improve society and to help solve the world's greatest problems.

Our mission is to improve the health of North Carolinians and others whom we serve. We will accomplish this by achieving excellence and providing leadership in the interrelated areas of *patient care, education*, and *research.*

- Patient Care

  As a key component of the UNC Health Care System, the School of Medicine will provide superb care to North Carolinians and others whom we serve. We will maintain our strong tradition of reaching underserved populations. Excellence in education and research will enhance our delivery of the very best medical care, which will be presented in an environment that is exceptionally welcoming, collegial, and supportive both for those receiving and those providing the care.

- Education

  We will achieve excellence in educating tomorrow's health care professionals and biomedical researchers by providing exceptional support for outstanding teaching and research faculty. We will offer an innovative and integrated curriculum in state-of-the-art facilities. The School will attract the very best students and trainees from highly diverse backgrounds.

- Research

  We will achieve excellence in research and in its translation to patient care by developing and supporting a rich array of outstanding research programs, centers, and resources. Proximity to the clinical programs of UNC Hospitals, to UNC-Chapel Hill's other premier health affairs Schools (Dentistry, Nursing, Pharmacy, and Public Health) and the other departments, schools, and programs on the UNC-Chapel Hill campus affords an exceptional opportunity for innovative, world-class research collaborations.

In all of these missions, we will strive to meet the needs of our local, state, national, and global communities.

Questions to ask of all institutions:

1. Does the stated mission fit with what you know about the school?
2. What are the priorities of the institution? Do they fit with yours?
3. Do the faculty and leaders you have met fit the mission?
4. What are the relative emphasis on research, teaching and clinical care?
5. Does the institution address on the region, the state or nationally?
6. Is there an emphasis on service? On leadership?

Fig. 22.1 (**a**) Mapping the mission—UNC Chapel Hill. (**b**) Mission—UNC School of Medicine

Faculty Tracks

A key decision for the prospective faculty member is what "track" to pursue. Over the last two decades, different medical schools have developed a variety of "tracks" for faculty. While the details vary from institution to institution, the general pattern is consistent. Traditionally, medical schools have used the tenure track approach common to their associated universities, with entrance as an instructor/assistant professor, a limited initial term (typically 6–7 years), and an "up or out" decision that conferred lifelong employment (as well as other benefits) on the faculty member who is promoted. With the dramatic growth of medical faculty salaries, the large majority of US medical schools have moved to limit the number of tenure track faculty and/or limit the financial risk of permanent employment. At many research intensive institutions, recognizing the challenges of obtaining research funding in the current environment, the initial term before the up or out decision has been lengthened. Moreover, as tenure track opportunities have become less frequent, however, many institutions have opened up large numbers of non-tenure track (also called clinical and/or research faculty) faculty positions, especially for clinicians or clinician-teachers. These positions typically do not have "tenure" but may have extended contracts—up to 5 years at our institution—and may have the possibility of promotion. Finally, most institutions also offer "adjunct" faculty appointments, typically for those who operate at a distance from the medical school and/or fill specially defined roles such as a major clinical presence or participation in specific teaching, research or administrative roles. Typically, there is some recognition of seniority—e.g., an adjunct associate professorship—but a more minor role in the core academic roles of teaching and research in the department.

Choosing among faculty tracks is one of the most fundamental decisions prospective faculty make. It requires consideration of the balance of patient care, teaching and research, the culture and rules of the institutions, and individual aspirations of career trajectory. Important to attend to in any decision is the relative status of the various tracks at the particular institution. The status of different tracks may vary greatly, depending on school and specialty. At some institutions, the research mission is dominant, and tenure track roles have highest prestige; at other institutions, in which the teaching mission is more highly valued, either tenure can be conferred for teaching excellence, or non-tenure track faculty have a more comparable status. It is important to explore the ways in which status is mediated in your proposed institution—are non-tenure track faculty given the same or similar opportunities for development or leadership? Adjunct faculty in most institutions can play key roles, but are typically not involved in the core governance of the school. Importantly, transition among tracks may be limited; it is important for the prospective faculty member to understand the rules. The initial choice of tracks has great long term consequences for your career

Promotion: Understanding the Fundamentals

Promotion—its process and value—is a key issue for career development and success, and faculty considering a school should try to understand the rules, both formal and informal, which govern promotion before starting. A starting point is the timeline—when does one go up for promotion? Another question is: who decides on promotion? It is important to understand the relative influence of department, school, and university, and the likelihood of success (e.g., almost all promoted vs. almost none promoted), along with what happens if one doesn't get promoted. Beyond the formal process, the broader question is the meaningfulness of promotion. Does this department or institution see promotion as a reward for time in rank—a longevity reward—or does it represent recognition of excellence? Are there financial or administrative rewards for promotion?

What is your responsibility for career development and promotion? Prospective faculty members should enter the process accepting a direct personal role in their own professional development. Concretely, this means keeping a portfolio listing your clinical, teaching and scholarly performance, regularly updating your curriculum vitae, and participating with the ongoing work of the organization, e.g., department and school committees and common functions. Institutions often specific guidelines about what information should be kept—research these before you start. More broadly, you are responsible for your own development: this means regular self-assessment of one's performance and needs for future development. It is this commitment to ongoing professional development, combined with excellent performance and personal organization, which are fundamental to success as a faculty member.

What is the tradeoff between career and personal responsibilities? The dramatic increase in female faculty over the last generation is transforming rules and expectations for school faculty—and not just for women. Institutions vary significantly in their procedures, but it is important to know the formal rules going in. Generous parental leave, flexibility about promotion timelines and other options are increasingly common; as US demographics change, these will be increasingly important not just for children but for the care of elderly relatives. Just as important as the formal rules, however, are the informal rules and culture of the department. Are family responsibilities supported? Does the department work with their faculty? Discerning this component of the culture is a key part of the assessment of a prospective institution.

The First Academic Appointment

In most institutions today the first appointment is at the assistant professor level; in some settings, there is an instructor or lecturer phase that may last for a few years, typically during fellowship, and which allows prospective faculty members to develop research and clinical areas of expertise. Regardless of the label, the core task of assistant professors is like the journeyman role in the guild system from which universities grew. Assistant professors learn the core tasks of faculty across

all missions, and are socialized to how the organization works. Within those parameters, different faculty members will have different job descriptions: clinical faculty provide a great deal of clinical care and the core teaching of students, residents and other learners, while research focused faculty must establish a track record of publication and funding. Regardless of the specific job description, however, assistant professors have become ever more important to the health care system. Increasing clinical needs will require more time spent on clinical care; often the preponderance of that care is the responsibility of younger faculty in the institution.

An exact job description is a key element of the negotiation for the position. To improve performance, health care systems and medical schools have developed extensive incentive plans which reward clinical and sometimes academic productivity. Often a substantial component of total compensation is based on these performance incentives, and it is critical that the prospective faculty member understand the rules of the institution he/she is joining. An emphasis on output, however, is only part of the picture for individual faculty members; just as important is input, i.e., what time the faculty member will have to commit to different activities. Important issues include the expected number of weeks worked in a year, the expected number of hours worked in a week, attribution of hours to the core missions and transparency across faculty [1].

How will your performance be managed? Most academic departments/institutions have a system for getting feedback regularly, often monthly or quarterly for clinical work, and a formal process for annual review, in which there is review of performance data, direct communication with a supervisor, and a formal summary. Indeed, this is a requirement of the accreditation of all medical schools. New faculty members need to know the process in their department/institution and explore how well it works for a variety of faculty. Who does the review depends on the department/size; what is key is that it be a consistent person annually. The annual review is an opportunity for the faculty member to record what he/or she has done; the specifics often fade in memory, and it is important to keep good records. The analogy is financial records for tax purposes—keep detailed records at least until promotion.

In addition to annual review, there is also an important role for what might be called a career development review, which addresses longer term professional development. Whereas annual reviews tend to focus on immediate issues—clinical RVUs, teaching evaluation, publications, grants—it is valuable to take some time to consider the longer term picture: where are you going in the mid to long term?. Are you progressing appropriately for promotion, what are your interests in the long term, what new skills and experience do you want to develop, do you need additional mentorship? How this is done will vary greatly with the departmental context. In small units, this can be done by the chair or division chief often at the time of the annual review, or, in larger units, it can be accomplished by more senior faculty. However it is done, a formal process of career review is useful—and important to the vitality of the academic unit.

All faculty roles require scholarship, but the definitions and degree of expectations depends very much on the institution. What is scholarship? In the early 1990s, Boyer presented a taxonomy that has proved very useful. He distinguishes between the scholarship of discovery, of integration, of dissemination and of teaching [2].

Different institutions will emphasize different kinds of scholarship. At research intensive institutions, the major focus is on the scholarship of discovery, denominated in original research papers and grants, with attention paid to both to volume and impact. In some settings, there is more recognition of the other types of scholarship.

What form should scholarship take? In medicine, at traditional research intensive institutions, the emphasis is on peer reviewed papers, but in other disciplines, the emphasis may be on books or other media, particularly as on line resources proliferate. Table 22.1 provides an example of a broader definition of scholarship. The key elements are peer review and an enduring record.

Table 22.1 Scholarship in the UNC Department of Family Medicine

Scholarship is essential to the discipline of Family Medicine and the future of Family Practice. As a national leader in Family Medicine, the Department of Family Medicine at the University of North Carolina has a special responsibility to develop and encourage scholarship among its faculty and across the state of North Carolina. Our vision is to promote the discovery and dissemination of knowledge important to clinical practice, teaching, and the organization of health care. We aspire for our research and scholarship to answer questions that matter in the care of individuals and populations
Every discipline must develop its own definition of scholarship. Family Medicine, as a generalist discipline active in a wide variety of settings, must have a broad understanding of scholarship. Like other clinical disciplines, Family Medicine embraces the *scholarship of discovery*, the exploration of fundamental processes and relationships in clinical care, health services research, and policy. Recent examples of the *scholarship of discovery* from our department include work addressing factors influencing retention of physicians in NHSC, the effectiveness of Alzheimer's special care units, the impact of the Mediterranean diet on blood lipids, and the long-term outcomes of the faculty development fellowship
Scholarship in Family Medicine also includes the *scholarship of integration*, which interprets, draws together or brings new insight to bear on original work. Recent department examples of the *scholarship of integration* include an information synthesis of the effectiveness of interventions for domestic violence, a section on prenatal care in the Essentials of Family Medicine, a POEM about the effectiveness of routine caesarian section for breeches, and an invited presentation at a national conference on the management of knee injuries
Finally, scholarship in Family Medicine includes the *scholarship of application*, which emphasizes engagement with practical problems and the development of new approaches to dealing with these issues. Recent examples of the *scholarship of application* include the Buncombe County project, a survey about the introduction of electronic medical records in residency sites, an intervention to reduce barriers to care among Hispanics, and a COPC-based intervention to reduce the racial disparity in adverse outcomes in diabetics
It is important to distinguish between teaching and scholarship. Teaching is one of our most important commitments, but teaching, per se, does not represent scholarship unless it has direct impact outside of one's own setting and peer group. Likewise, service and advocacy are fundamental parts of the ethos of Family Medicine. To be scholarship, however, service activities must be tied directly to one's special field of knowledge, flow directly out of one's special field of expertise, and have reference to and impact outside of the immediate context of the service
The Department of Family Medicine understands that there are many valuable forms of scholarship. Certain aspects are constant: intellectual curiosity, a constant willingness to learn and to question old assumptions, honesty, a commitment to quality, and a commitment to share knowledge. In general, we will give higher value to scholarship that has an enduring form, demonstrates a sustained focus over time, receives recognition by peer review, and achieves impact outside of the local setting

What are the criteria for promotion? Of course, as with many of the subjects in this chapter, this varies greatly with institution, and it is important to know the rules at your institution. Traditionally, promotion to Associate Professor is a recognition both of current performance and future promise; in the monastic culture from which universities grew, this first major promotion represented the transition from an initiate to a full member of the community. In medical settings, this typically means clinical care which has been seasoned by practice outside of formal training, teaching for which the craft has been learned, and scholarship which is promising. Institutions set different criteria for excellence; Table 22.2 provides one institutional example, which explicitly grades the strength of specific kinds of evidence for the core missions of clinical care, education and research. Keep in mind that, ultimately, what matters is not just quantity, but quality and impact. In some institutions, faculty be promoted on the basis of excellence in other areas, such as administration or community professional service. Here again, the emphasis should not be on time in service but demonstrated excellence with recognition outside of the university, and ideally with scholarship.

Finally, reaching back to the monastic origins of the university—citizenship is also important. Young faculty must learn how to get along with their department and university, balancing service with their own agenda, and participating appropriately in the governance of the department. Different departments and different specialties have different cultures, and learning the pitch can be difficult to master. Nevertheless, increasingly, a component of citizenship is a formal and required component of promotion.

Assistant professorship is a key time for departures, both out of academics, and between institutions. In the early years, there is turnover because of poor performance—some faculty do not make the transition from training to independent work—and because of spousal career moves and family responsibilities. At the end of the assistant professorship phase, as the faculty member acquires an increasingly independent role and a good track record, there are opportunities for moving to other institutions, especially for research focused faculty, those with clinical specialties in high demand, and, increasingly, for physicians with clinical management expertise. As the clinical mission of medical schools has grown, and the relative importance of scholarship has diminished, the leverage of clinical faculty has grown. A major challenge of the home department/division/institution is thus how to retain the core faculty over their career. Assistant professors represent a huge investment, both in recruitment and in maintenance over the years.

Associate Professorship

In the traditional tenure track system, the associate professor rank can be the end stage of a career—institutional recognition that an individual faculty member has achieved permanent membership; as the saying goes, the rank of associate professor can be a terminal rank. In institutions with robust non-tenure track promotion

Table 22.2 Representative Criteria for Excellence Across the Core Missions—Assistant to Associate Professor, Department of Family Medicine, 2015

	Clinical care	Teaching	Research and scholarship
Strong evidence	• Peer review of clinical skills. Documentation and supporting letters	• Achievement of students. High scores, awards, projects, publications, and presentations (evidence of mentoring by promotion applicant)	• Role of Principal Investigator on funded research projects in last 3 years
	• Innovations that improve patient care	• Direction of an educational program or course outside of medical school	• Articles presenting own work in refereed or non-refereed journals (approximately 4 a year should be a goal). Greater weight should be given to first author articles and those published in major highly selective national journals such as *JAMA, New England Journal of Medicine, Annals of Internal Medicine, BMJ,* and *Lancet*
	• Published case reports or clinical articles	• Development of innovative syllabi and course, which include handouts, well-defined objectives, and bibliographies. These must be provided as documentation	• Evidence of methodological innovation
	• Obtainment of funds to conduct clinical service/programs	• Superior teaching evaluations by students and peers	• Membership on study section or external grant review board
	• Mentorship of a learner who publishes or develops academic materials	• Publication of a description/evaluation of an educational innovation	• Supporting letters from national references
	• Direction of a clinical fellowship		• Membership of Funding Study Section or refereed journals/editorial boards
	• Documentation of excellent outcomes of patient care		• Direction of Research Fellowship Program

Medium evidence	• Invited consultation outside own clinical center	• Documentation of specific teaching commitments and activities (at least 3 years of documented experience)	• Editorials and abstracts
	• Clinical presentation at main departmental or CME conferences (minimum of four per year)	• Visiting professorship at another institution	• Presentations at local, regional, or national meetings (at least one)
	• Production of materials for clinical care (i.e., protocols, procedure guides, etc.)	• National presentation on an educational topic	
	• Organization/moderation of CME programs (leadership)	• Consultation on education to local, regional, and national groups or organizations	
	• Description of special clinical skills development and expertise. 23		
	• Presentation at institutional or other clinical workshops		
	• Development of clinical educational materials for patients/public		
	• Mentorship of learner skills/projects		
	• Participation in state or national clinical committees		
Weak evidence	• Participation in clinical trials		• Supervision of student/fellow and resident research projects
	• Participation and leadership in departmental or hospital committees		• Supporting letters from local colleague reference on research ability
	• Teaching in a clinical fellowship		

systems, there is a parallel status for fixed term faculty. For both tracks, for outstanding faculty, the border between the end of the assistant professor phase and the associate professor can be blurry. In any case, it is typically Associate Professors who begin to take on major leadership roles in Departments and schools—directing major research programs which include other faculty, running residencies or other training program, or launching new clinical care initiatives.

Developmentally, the key task of the Associate Professor is to continue his/her development across all missions, though often with more focus on one area. In most settings and in most departments, Associate Professors retain a substantial clinical role and participate in a real fashion with teaching and scholarship. What distinguishes high performing Associate Professors is their ability to continue to develop professionally.

Criteria for promotion to Full Professor also vary by institution. In most cases, the full professor level requires continuing productivity in the areas of excellence identified at the associate professor level. For researchers, it is often easier to demonstrate excellence as careers progress—papers and grants represent de facto peer recognition and an enduring record—and highly specialized clinical care is often marketed regionally or nationally, reflecting a widening reputation. Unfortunately, however, it is unusual for teaching skills or clinical work in generalist disciplines to get regional or national reputation. Citizenship continues to play an important role; the associate professor must continue to demonstrate engagement in the work of the department and, increasingly the work of the institution. Finally, in addition to citizenship, there is typically increasing emphasis on reputation beyond the institution—depending on the culture of the institution, to the statewide or regional levels.

Full Professorship

Full professorship is the highest level of the academic hierarchy. Traditionally, in research intensive institutions, it represents excellence sustained over many years; it practical terms, it ideally represents a substantial track record of academic achievements, ongoing and stable research funding, and a palpable impact on the field at a national level. In fixed term faculty tracks, there is much more variability in the significance of the "full professorship." Faced with compelling clinical and marketplace demands, some institutions have promoted clinicians on the basis of clinical skills or potential clinical contributions independent of traditional academic contributions or excellence. Other departments and institutions, by contrast, have emphasized academic achievements at the full professor level for non-tenure track faculty such as the development of new curricula, significant scholarship and/or a vital research program. Often, national reputation is important; participation at the national level in specialty societies is important, but needs to represent active roles, not just membership or attending meetings. Serving as committee chairs, national office or program committees represents excellent evidence of national role. A major administrative role in the department or the institution, if successful, can also add to the case. In some contrast to the associate professor level, a common thread at the full professor level is formal

participation in the nurturing of young faculty. In many institutions, the full professors are empaneled to review junior faculty performance or promotion. At least ideally, there is group responsibility for the development of the initiates.

Many institutions have begun to institute formal post tenure review or requiring review after promotion to full professor for non-tenure track—for example, every 5 years. The impetus for these requirements is fundamentally financial: given the expense of medical faculty, it is important to make sure that the institution is getting "value" out of the faculty member. At the basic level, this can translate to documenting the value of the academic contributions of the faculty member in terms of teaching, scholarship and citizenship, implicitly or explicitly tabulating the dollars being brought in both clinically and in terms of grants and contracts compared to overall costs. These reviews can be threatening for the faculty member, but can be very valuable in maintaining vitality. The senior faculty member should maintain ongoing faculty development.

Looking Toward Retirement

There are no fixed guidelines about retirement. Legally, prohibitions against age discrimination inhibit universities from setting the general expectation that everyone has to retire at a certain age. Personal issues—health, partners, financial health of pension plans—play an important and appropriate role, and different institutions have different options for continuing employment. For individual faculty, depending on the specialty, when to stop taking call is an important first question; in some departments, this is a financial issue, as call brings financial incentives. Beyond after hours work, the next issue is when clinical work should stop. There are no hard and fast rules, nor good ways of determining the fading of competency, but there is likely to be more attention to this in the future. Teaching roles are mostly but not completely dependent on continued clinical involvement. Funded research and administrative can continue later, but still remain dependent on funding—or the pleasure of the Chair or Dean.

There is no question that vital senior faculty can contribute substantially to a department, leading mature research programs, mentoring junior faculty and supporting other departmental activities. But it is a two way street: the faculty member has to be committed to contributing and staying engaged—and the department/school has to have mechanisms that allow meaningful participation.

Conclusion

Medical school faculty are among the most mobile of professionals in our society; prospective faculty have extraordinary opportunities. Faculty careers follow a lifecycle—from prospective faculty member to early to mid to late career. These phases correspond roughly to the traditional ranks—assistant, associate and full professors

and each phase is influenced by the institution and specialty, with a critical time being the promotion from assistant to associate professor. Choice of institutions and faculty track determine career trajectory and opportunities. Once the faculty position is started, individual faculty goals, commitment to professional development, institutional environment and faculty performance set the career horizon.

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Chapter 23
Executive Physician Development

Christopher J. Evans

Introduction: Setting the Stage

Dear Incoming Physician Executive,

I'd like to welcome you to the senior leadership team in our health system and congratulate you on being chosen for this role. In addition to our discussions during your job interview, I wanted to share a few bullet points of my top priorities for physician executives in our health system: [1]

- Think in systems, not just about individual patients
- Continue thinking of the patient first *but not only* the patient
- Learn to identify waste in the process
- Understand the business levers for our specific health system
- Enhance relationship-building and partnerships using influence more than direct control

Looking forward to you joining our team,

Your Health System CEO

Throughout this book, the authors have set a consistent stage for both the changes in health care delivery due to market forces and systems evolution, and the need for a proactive, transformational response to ensure physicians and other clinical professionals are equipped to lead through the inevitable changes. The response to invest in physician leadership development is but one of the key steps in accountably leading the academic health care organization.

Top executive talent recruiter, Carson Dye, describes his orientation to involving physician leaders in health systems operations:

> "I prefer to use the phrase *physician-centric* because for some, quite frankly, the phrase 'led' turns many people off. Does that mean ultimately every leadership and management position in a healthcare organization will be filled by a physician? My answer is always

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_23

absolutely not. There is a role for a variety of individuals with varied backgrounds and training. It doesn't necessarily mean that every organization should have a physician CEO, for instance. Physician-centric to me simply means going back to the contrast between involvement and input—that you involve physicians on a routine and ongoing basis and you get them into some management and leadership positions in the organization. The degree of physician-centric or physician-led is tied to the type of the organization. Some organizations are very actively involving themselves in the development of clinical integration and the implementation of population health approaches. These kinds of activities clearly require expert physician leadership. Smaller hospitals may not even be to that point, and so there may not be as great of a need toward having physician leaders." [2]

Dye is correct, and echoes the most influential voices and organizations leading and influencing health system operations in the U.S. Consider the following recent comments and task force report findings:

"Strong environmental forces are pushing the separate clinical and operational management models of today's hospitals to find new ways to collaborate and create a clinical management structure that addresses the efficient use of scarce resources while maintaining strong clinical quality and patient focus. As integration continues, physicians are being called upon to bring their expertise to bear on the management of the clinical enterprise in collaboration with other hospital leaders." [3]

"Meeting the challenges facing healthcare organizations today requires not just great leaders, but great physician leaders. The most successful organizations are fundamentally re-thinking and redesigning care delivery at the front lines of medicine." [4]

"As physicians continue to assume leadership roles in hospitals and health systems and serve as drivers of the future health care organizations, they will need to move beyond their clinical expertise and think long term, understand and be able to see the larger issues, and work collaboratively as team players [3].

"As health care financing moves from volume-based to value-based payments, clinicians will be required to work in inter-professional teams, coordinate care across settings, utilize evidence-based practices to improve quality and patient safety, and promote greater efficiency in care delivery. The health care system will need to adapt to support these changes, and hospitals and health systems will need to acquire new competencies." [5]

The problem with meeting these challenges, however, is that physicians rarely are trained or socialized to be workplace partners and decision makers, or as Stoller (2004) phrases it, physicians are disinclined to followership and collaboration. These dynamics play out even more strongly when physicians of various management and leadership skills ascend to the senior operational ranks in health care organizations.

The American Hospital Association's 2011 policy group discussed the skills they felt physicians needed to practice and lead in the reformed healthcare environment, concluding that, "While interpersonal and communication skills are among the current competencies, members felt that more emphasis on teamwork, empathy, conflict management, and customer service were needed. Members also suggested the need to screen for emotional intelligence as part of this competency." [5] This same group was asked to rank key competencies and their relative importance, and concluded the areas of the greatest (leadership) gaps were: [5]

1. Systems-based practice: *Provide cost-conscious, effective medical care*
2. Communication skills: *Effective information exchange*

3. Systems-based practice: *Coordinate care with other providers*
4. Communication skills: *Work effectively with the healthcare team*

Their findings are remarkably aligned with the best thought leaders: to enhance, develop, and engage the very best our physician and lay leaders can offer our health systems in this era of rapid change. While physician involvement and leadership is essential to transform our health systems, physician leaders need to develop into effective *health system* leaders. This transformation goes beyond exposing physicians to management and finance concepts; it includes focused and applied training doing real system leadership work while learning.

A dilemma is that physicians generally cannot devote the same amount of time that successful non-physician health system administrative leaders have spent learning how to lead a system effectively. Add the additional pressures in an academic medical setting of education and research responsibilities, and the time commitment gets even smaller. Physicians who assume organizational leadership roles, especially senior roles, are generally thrust without preparation into situations that demand skills and competencies they may not have learned or practiced. Additionally, physicians are often chosen based on their clinical skills or academic accomplishments rather than on behaviors that enable effective execution of the organization's vision [6, 7].

These factors make the physician leadership and partnership journey an imperative that health systems cannot ignore. Thus, we will next explore not just how leadership competencies play out at the executive level, but also the systems-thinking views necessary to lead effectively in a world of paradox.

Physician Executive Development

Senior physician executives take on responsibilities within a world of systems. Internationally renowned systems guru, Barry Oshry, describes organization life as a system within a system within a system [8]. Interactions between parties, patients, providers, families, support staff, administration, governing boards, and third party payers are all affected by connections and their struggles to cope within their own "worlds" within the greater system. Long gone are the days when physicians influenced by edict, request, or by the prominence of their status as doctor. Physicians are ascending to the place of broad oversight over the entire clinical enterprise, and while that summit offers wide-ranging views, it also creates distance between themselves and where the organization's mission is carried out: one patient/staff/student/human interaction at a time. Business executives across industries understand this reality and spend considerable effort in maintaining connections deep within their organizations. As Indiana Health System executive, Doug Puckett reminds us, continue thinking about the patient but not only the patient [1]. The broad view is crucial to leading at the system level.

Several years ago I was traveling to an industry conference with the new Cone Health (Greensboro, NC) system CEO, Tim Rice, a longtime friend and business colleague who had recently assumed this new role after many years as its chief operations executive. I asked him what he now paid attention to as CEO. He pointed to the television newscast at the airport departure gate. "That's what I pay attention to. I have such a solid operations staff to run the hospital, I pay attention to the political and market forces in the environment—healthcare and beyond—that can have an impact in how effectively we can serve our community." This response is an example of how health system executives balance their attention from the broad to the narrow, of seeing the associated industry impact while exploring the connections to the entire health system. It requires linking the mission to treat individual patients while also remembering that leadership must be in service of the system.

Another example of such systems thinking and leadership effectiveness was shared by a longtime health system CEO and former regional director at the Veterans Health Administration, Clark Doughty. When I was a new hospital administrator, Clark once told me: "Chris, as I make decisions (for the health system), my people don't question my intention. They know I intend to do the right things for this organization, for veterans and their family members, and for our employees. They don't always agree with me, and I can't always share with everyone why I decide what I do, but I've put the time in with them and they know me well enough to know that I always intend to do the right thing." This statement precisely demonstrates the combination of system sight, patient concern, and walking the talk that is a hallmark of effective executive leadership. It is the type of dynamic balance that physician executives will be expected to enact day in and day out when they assume a leadership role (Fig. 23.1). Finally, it is a poignant reminder of the importance of building trust with the system workforce.

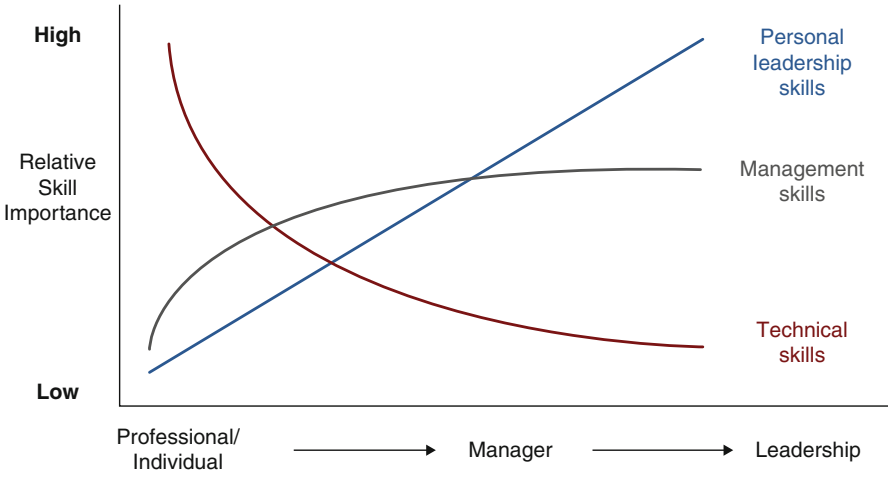

Fig. 23.1 Changing skill requirements for physicians

Being the Top Physician

In academic medicine there is great variety in the physician executive leadership ranks. Some senior roles have a primarily administrative foci and some are almost exclusively in clinical oversight (Fig. 23.2). Most physician executives maintain some clinical practice of medicine to maintain their skills, to stay connected to patient care, and to maintain credibility among their peers. According to the 2013 Physician Executive Compensation Survey by Cejka Executive Search, physician executives as a group devote an average of 68% of their time to administrative responsibilities, 26% to clinical duties and 3% on research. Chief Medical Officers spend 89% of their time on administrative duties [9]. There is also a developing need for full-time, non-clinical physician executives who can dedicate all their efforts to serving in administrative roles.

The 2010 Witt/Kieffer survey on the Transformation of Physician Executives [10] reported health system CEO's rate the following as the four most important *job responsibilities* for senior physician executives:

1. Directing quality, safety and performance improvement initiatives
2. Leading medical staff affairs
3. Being accountable for physician alignment/integration strategies
4. Driving innovation and having a positive effect on financial performance

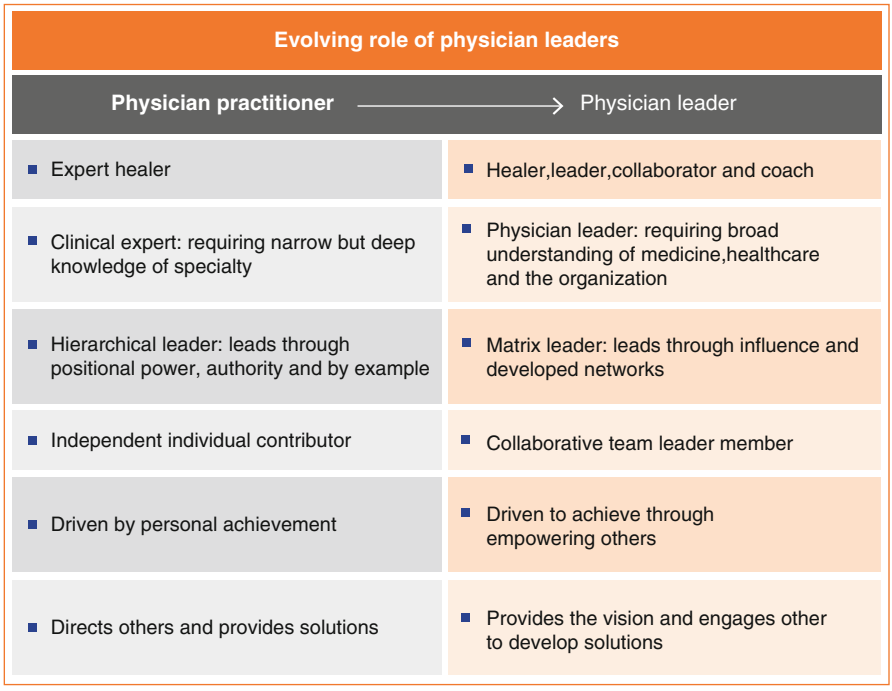

Fig. 23.2 Evolving role of physician leaders

The survey also indicated some disparities between the importance of these responsibilities and how effective they consider their physician leaders to be in these roles. For example, more than half the respondents identified improving financial performance as important or most important, yet only 41% rate physician executive leaders effective in that area.

Another important survey finding was what CEOs considered the most important *work goals* for physician executives. Note here that when the term work goal is used, it often refers to specifically measured outcomes. In the same survey, the following were the most important work goals:

1. Advancing patient interests (98% of respondents)
2. Advancing organization interests (97%)
3. Advance quality/safety benchmarks (95%)
4. Advance hospital/physician alignment (90%)
5. Advance physician interests (85%)

In reviewing the list above, consider the role that influence plays in "advancing" broad organizational initiatives, in many cases, without direct authority. Barry Oshry relates a story about training a group of organization CEOs to think and act systemically:

> "We've been in a room full of CEOs, the top jobs in the organization, yet every one of them knows, at times, they are (at the) bottom (of the organization) in terms of making things happen. Someone else controls the resources, can say yes or no or stall the process. It's an illusion we have, that being at the top, we think they can make the sun shine 24 hours a day. But they can't." [8]

Senior physician leaders know that in most cases they don't have the control to demand compliance around goals and initiatives, but rather must rely on building relationships and coalitions to span organizational boundaries, dismantle siloes, and get buy-in across the organization.

Physician-Executive Job Development Pathways. In the National Center for Healthcare Leadership's Physician Leadership Development White Paper, Binger outlines career stages of physician leaders [11]. In the early stages, physicians are often asked to serve on task forces or provide technical expertise as an individual contributor to a project. They are often chosen because of expertise in a medical or surgical specialty rather than for their skills in leading a group through the development and execution of the project. Their primary inputs tend to be technical in nature. "These physicians head up a single unit or project, typically overseeing one or a few individual contributors representing the same general stakeholder (e.g., fellow clinicians). Consequently, the physician leader need only speak one' language,' and success still depends largely on technical skills and some interpersonal skills." [11]

Mid-stage physician leaders find themselves with demands to lead discovery and, sometimes, implement processes to address health system issues. They are chosen or placed into these roles less because of their medical specialty or because they have knowledge of the clinical system. Rather, the demands are for a balance of technical, interpersonal and conceptual skills. "These physicians head up several units,

committees, and/or projects, and are typically responsible for overseeing managers and individual contributors from multiple stakeholders. Consequently, these physicians need to able to speak in several different languages in order to effectively communicate with varying audiences. Success depends relatively less on technical skills, and more on interpersonal skills and, to a lesser extent, conceptual skills." [11]

At the senior ranks "… physicians lead entire organizations, such as hospitals and/or medical groups, overseeing executives, managers, and individual contributors from all stakeholder groups. These physicians often rise to these roles after making successful and sustained impact in earlier physician leader developmental roles. They have created their physician leadership brand so they are known as systems thinking individuals, concerned not only with the presenting management challenge, but also how that challenge impacts the organization as a whole. To be effective, these leaders must speak many different languages. Success depends less on conceptual skills and knowledge, with interpersonal skills taking on much more prominence. However, the traditional strength of many physicians—the technical skills and knowledge—although unique and important, tend to be a minor driver of success." [11]

The senior ranks of physician leaders include a myriad of titles and responsibilities based largely on the size of the system and scope of responsibility. Leaving off senior department/division jobs, some system-wide roles include:

Chief Quality Officer	Patient Safety Officer
Chief Medical Information Officer	Chief Clinical Officer
Chief Medical Officer	Chief Transformation Officer
Clinical Innovation Officer	Chief of Staff
Vice President Medical Affairs	Professional Affairs
Chief Integration Officer	Chief Strategy Officer
Vice President Medical Affairs	Chief Medical Group
Chief Performance Improvement	

Physicians aspiring to greater leadership involvement often find that serving on and chairing clinical and cross-functional committees, and learning about and practicing their own leadership prepares them well for seeking out part-time formal leadership roles. Do some homework and create a profile of the leadership opportunities in your health system. You may find that committee work, as fruitful or dreadful as it might be, can serve as a real training ground for your influence and discernment skills. In the leadership development world this is called applied leadership learning. Another option is to seek out an executive coach to help you map out your career development journey.

Physician-Executive Leadership Competencies. The term competency is used often in the leadership development and human resources fields to refer to a workplace skill, with a view toward whether a worker has a necessary skill set, and to what extent it is developed.

Much work has been done to identify the competencies of leadership as well as those unique to the realm of physician leadership, and there is much crossover between the two. Stoller (2008) writes, "The competencies needed to be an effective

physician-leader combine general leadership skills and those skills needed to address the challenges of healthcare." [7] He describes six key leadership competency domains for physician leaders:

1. Technical skills and knowledge (regarding operational, financial, and information systems, human resources, and strategic planning)
2. Industry knowledge (e.g., regarding clinical processes, regulation, and healthcare trends)
3. Problem-solving skills
4. Emotional intelligence
5. Communication
6. A commitment to lifelong learning

The National Center for Healthcare Leadership (NCHL), in 2013, charged their Physician Leadership Development Council to deepen its understanding of the competencies needed for physicians to effectively lead healthcare organizations [12]. The NCHL competency model is laudable for its breadth and depth, recognizing that no single leader does everything well.

The Center for Creative Leadership (CCL) identifies what they call the Fundamental Four Leader Competencies as: (1) self-awareness, (2) learning agility, (3) influence, and (4) communication [13]. This skill set is the foundation to which all leaders should aspire, and one that senior leaders must master. CCL has a comprehensive list of competencies they identify as necessary for leaders as they progress into higher levels of executive leadership.

Which ones are important for senior physician leaders? Understand that there are domains of knowledge and skill that will positively enhance your leadership potential. Where should you start? Explore the NCHL competency model side by side with the CCL competencies (see References). Then discuss the expected leadership competencies in your academic healthcare system with Human Resources or other designated representative. Develop a picture for what is expected and what is rewarded in your organization. From there begin to identify the gaps in your leadership skills. Consider having a 360° skills and competencies assessment administered and debriefed with you by a certified executive coach. This process will help identify your strengths and weakness, what competencies you need to develop further, and a roadmap to expand your skills and abilities.

Leveraging Learning to Become a Senior Physician Leader

"Physicians who possess the right mix of leadership competencies will continue to be in high demand for the foreseeable future and are effective partners with hospitals and health systems to move toward a more accountable and efficient health delivery system." [3]

Recall the system CEO's top physician leader priorities at the beginning of the chapter:

- Think in systems, not just about individual patients
- Continue thinking of the patient first *but not only* the patient
- Learn to identify waste in the process
- Understand the business levers for our specific health system
- Enhance relationship-building and networking– using influence more than direct control

Each of these priorities is captured in studies, surveys and competency models put forth by leading industry experts. Thinking in systems, thinking of the patient, reducing clinical variation and waste in the process, and understanding how the business works are all critical. The single element that stands separate from the others, however, is the need for enhanced relationship-building and networking skills.

Formerly called *soft skills*, the ability to interact effectively with others are considered *higher order skills* because they are so difficult to master. The ability to discern the most effective way to think, act and influence, moment by moment, is at the pinnacle of the senior leader's performance. Most non-physician senior executives have honed their higher order skills through years in the trenches of organization life. Physician leaders generally do not have that luxury, as stated earlier. Therefore, in addition to acquiring the technical knowledge of running a complex health organization, physician leaders often need a crash course in effective workplace interaction skills.

Emotional intelligence and self-regulation mediate physician executive effectiveness. It doesn't matter how much you know, you cannot be effective if people don't enjoy being around you. That's the old story of influence versus effectiveness: you can be influential in a process *and* be completely ineffective. You cannot be effective without influencing effectively. The challenge is to bring all the processing horsepower of "physician intelligence" to serve system goals. That means interacting with others who won't see the world the way you see it. Sometimes they actually see it completely opposite to the way you do. And sometimes they may see it more clearly than you do. In the end, can you as effective physician leader be open to changing your own perspective rather than consistently relying solely on your own? How willing are you to be influenced while you are responsible for influening others?

Five clusters that differentiate outstanding from average health care leaders relate to cognitive competencies and to emotional intelligence (EI): [14]

- Cognitive competencies, e.g., systems thinking, pattern recognition
- EI self-awareness competencies, e.g., emotional self-awareness
- EI self-management competencies, e.g., emotional self-control, adaptability, initiative
- EI social awareness competencies, e.g., empathy
- EI relationship management competencies, e.g., developing others, teamwork

While these higher order competencies are important at all levels of leadership, they take on particular significance at the senior executive physician levels. Consider the skills needed to convince a senior administrative team to change direction, to seek alignment from a research colleague who is wasting significant amounts of money,

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In order to facilitate the learning of key information and acquiring of essential skills for your new position, use the following questions to guide your thinking. Then follow the directions in "Accelerated Job Learning Plan."

Questions to Guide Your Learning:

1. What are the most **critical information** and the **critical skills** you need to have to successfully fulfill your new leadership role?

   Information

   Skills

2. Which of this information and what skills are you currently missing?

   Information

   Skills

3. What are the best methods for acquiring this information and gaining these skills?

   Information

   Skills

4. Do you need additional strategies/approaches to accelerate this information/skill learning:

   Yes _____ **No** _____

5. What are the **written and unwritten rules, values, guidelines – the key elements of culture -** that you need to understand in order to be a success in this role and in this organization?

6. What are the best methods to learn these rules, values and guidelines?

7. Do you need additional strategies/approaches to accelerate your learning of these rules, values and guidelines?

   Yes _____ **No** _____

8. Are there other questions that you feel are important to answer in order to quickly learn your new role? List below:

Fig. 23.3 Accelerating your job learning [15]

or to chair several meetings with operating room staff who aren't fully committed to your vision. Remember Barry Oshry's summation of the organization executives—you cannot command and control your way into the hearts and minds of others. Developing awareness and managing yourself becomes the key to your new nature: adapting yourself legitimately (with integrity and authenticity) to be your most effective self for each situation.

It's the rare individual who can self-study their way to becoming an effective leader. Most people require formal and informal study, as well as application (on the job learning). Many benefit from and accelerate their learning and adaptability by working with an executive coach, by mentoring, and by connecting with learning partners. Each of these methods helps leaders improve the quality of their thinking, decision-making and ultimately, their effective influence in the organization. One tool you can use is the Accelerated Job Learning worksheet (Fig. 23.3).

Conclusion

Physicians who possess the right mix of leadership competencies will continue to be in high demand for the foreseeable future. Physician leaders need to develop into health system leaders through focused and applied training doing real system leadership work. Increasing ability to think in systems, not just by domains, is a hallmark of the health system executive. The continual building of relationship management skills through increasing cycles of self- and other-awareness creates the opportunity for self-management necessary to lead across multiple dimensions and among the myriad of stakeholders.

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Chapter 24
Moving Out to Move Up

Janet M. Guthmiller

Introduction

As your academic career progresses, opportunities for substantial leadership roles may be limited if you look only within your current institution. Leaving one academic organization to advance your career in the larger academic community can be challenging, but it provides extraordinary opportunities to observe, learn, develop, participate and lead in different academic cultures. In this chapter I draw upon my personal experiences of over 20 years in academics at four different institutions to discuss the benefits and challenges of "moving out to move up."

When to Look; When Are You Ready?

How do you know when you are ready to tackle new challenges and assume a position to lead, guide, and develop others at another level? Each academic position or role should be viewed as an opportunity to learn, to be a productive member of the organization and to enjoy and develop in that role. Eventually, however there will be signs suggesting that you are ready to move up (Table 24.1).

Perhaps you find yourself taking on new and unchartered opportunities to learn and to challenge yourself or to add a bit more diversity and excitement to your everyday tasks. Maybe you are in a phase of seeking professional growth because you have reached your potential in your current position. You may also feel like you are no longer effective—that you may be stagnating in your position. When stagnation hits, it may be healthy for both the individual and for the organization to

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3_24

Table 24.1 Signs you are ready to move up

• You desire more responsibility and authority
• You find that your interests have changed
• You seek additional challenges/opportunities
• You find yourself becoming complacent in your present position
– You've lost energy or excitement
– You're not feeling challenged
• You are seeking continued professional growth
• You believe you can manage leading/mentoring others at a higher level
• Others (e.g., supervisors, peers, etc.) advise you that you are ready.
• You welcome additional tasks/responsibilities or leadership opportunities
• You are contacted multiple times from the same search firm for one or more positions

introduce "new blood," bringing new energy, different perspectives, different priorities and different goals.

Besides looking within yourself for these signs, keep your ears and mind open to what others say about your leadership and administrative abilities. Such insight may come from people you least expect. It may be obvious—people may say that you "need to be a chair," or you "should be a dean." However, the messaging may be more subtle, such as people giving you increased leadership opportunities or enhanced responsibilities, because they know you can handle them. So, if you find yourself needing a change of scenery as it relates to your responsibilities, your creativity, or your energy, or if you hear or believe others think you are ready for increased responsibility, it might be time!

Networking and Leadership Development

Irrespective of whether you think you want to move up or that you may be ready to move up, always take advantage to learn and grow in your current position. Becoming more skilled and adept in your current role breeds confidence and self-awareness. You will experience failure, and when you do, take the opportunity to learn from it. Seek performance evaluations from others so that you can learn and grow as a leader. As mentioned in the chapter on Developing Yourself, seek out a 360° evaluation and use a feedback coach. Learning about your leadership effectiveness from coworkers is an invaluable experience and usually uncovers areas of opportunity to improve.

Never underestimate the potential of networking. Expanding your academic family provides an infusion of new ideas, resources and comradery within your present position, but can also extend your base for opportunities at other institutions

or within national organizations. Your networking colleagues can be a tremendous resource when you are seeking another position or may even present you with opportunities you were not aware of or might not have considered. In a couple of instances, people with whom I have sought to network have invited me to explore opportunities at their institution, and were willing to create positions that might be a logical fit for both me and the organization.

Continually explore both formal and informal leadership and self-development opportunities. In addition to learning from mentors, peers, and a variety of leadership programs, spend time dedicating and challenging yourself to pursue activities that will help you grow. Learn from observing all kinds of leaders, including leaders outside your organization. Recognize and respect different leadership styles. Observe leaders in multiple settings and listen not only to their words, but carefully observe their actions and interactions with others in the organization.

Looking Outside Your Organization Makes You Appreciate What's Within

Sometimes it takes exploring an alternative position and seriously contemplating a move to open your eyes to what's in your own backyard. Some faculty pursue other positions to improve their current position, title, or compensation at their current institution. Others, myself included, only invest time and energy into exploring positions they would likely take if offered, and if it is a good "fit." Continually seeking out new opportunities but never accepting offers could affect one's reputation at both one's current institution and nationally. Go into a search with eyes wide open and you will likely find yourself drawing many comparisons with your present position. It may, in fact, provide a fresh perspective of your current situation and impress upon you that, for a number of reasons, it may not be the right opportunity or the right time to move.

> A personal example of "not the right time to move" came for me when I interviewed for an external position for which I was confident I was ready. During the on-site interview, it became clear that the position was going to require significantly more time investment which would detract from my principal investigator responsibilities of a large research grant. Upon returning from the interview, I withdrew my candidacy and explained to the institution that while it was a wonderful career opportunity, for me, it was not the right time, and the best fit for me was to remain at my institution in my present role.

Internal Opportunities: Do They Exist?

You might think that you have to leave your institution to advance your career. However, sometimes there are internal opportunities for advancement and leadership. These opportunities may be clear (an open position) or are developed, in that a position and/or title with different or enhanced responsibilities may be created for

retention purposes. Getting involved in campus committees and initiatives can also enhance career growth, build networks, and lead to unexpected opportunities. It is important to share your aspirations of continued career growth not only with your mentors, but to those within the administration. They have the wisdom and the power to explore possibilities within your institution and can offer objective advice about external opportunities.

As part of the negotiations for one of my moves, the institution to which I was looking to relocate offered me a residency directorship whenever I believed I was "ready." I appreciated this futuristic planning by the department and their willingness to extend this leadership position to me, and on my time frame, recognizing that I had other more immediate career goals I wanted to pursue. After being at the institution for a few years, I believed that becoming the program director for the residency was not going to provide the kinds of experiences that I believed would be most helpful to continue my growth as a leader. I graciously turned the position over to a colleague and decided to wait for what I believed would be a more congruent career opportunity combining my research background and leadership aspirations. An ideal opportunity came along shortly thereafter, and I was appointed director of student research for the school.

In another situation, I communicated my aspirations about assuming an administrative academic role to some of my leadership team, but neglected to share this with the individual currently in that role at my home institution. A similar academic position opened at another institution, and I relocated in order to assume this leadership role. Approximately three months after I left, the person in the position at my previous institution decided to retire. I wonder had I chosen to disclose my goals to the administrator in that role, if I could have moved into the vacated position without moving institutions.

When the Headhunter Calls

It is nice to feel wanted. Receiving the first few calls from a search consultant can bring a rush of excitement and sometimes delusional moments visualizing a new, fabulous position in a "perfect place." Remember, it is the search consultant's job to recruit good candidates. Thus, that phone call may merely occur due to your title or your current administrative position. Even if you are not interested, take the call or respond to the email, as you may encounter the same consultant or search firm in the future. Be honest if you are not interested and let the consultant know why, e.g., timing, fit, environment, family reasons. The search consultant will always be appreciative if you can recommend another candidate.

In one instance, I was not a primary candidate for a position, but the search consultant wanted to meet me, so we set up an airport interview. We had a wonderful conversation at an airline club in my regional airport. Walking away from that meeting was most thought provoking. I was told that they were quite far in their process and they had identified who they believed was the candidate of choice; yet they still wanted to take the time to meet with me. In the ensuing weeks, I carefully followed the selection of the chosen candidate and evaluated his credentials. It gave me tremendous insight about the search process, as well as the skills and experience that the institution was seeking for that role. In addition, it also introduced me to a search firm that could be involved in recruiting a future leadership position.

Table 24.2 Preparing for the search

• Make sure your CV is up to date and reflective of your responsibilities in the various administrative/leadership positions you have held
• Prepare your letter of interest and tailor it to the specific position, giving it significant thought and attention
• Talk with others about the institution/opportunity
• Research the search firm and the consultants
• Research the organization—understand its mission, vision and values and the current climate and culture as much as possible
• Research the people on the search committee and at the organization
• Prepare a list of questions that you believe you will be asked and practice your response to these questions
• Prepare a list of questions that you want to ask the organization
• Be prepared

When you are interested in a position, it is important to let the search consultant know that and to be responsive to their firm as the search progresses. The search consultants are expected to assist the institution in identifying and attracting the most qualified candidates. The search firm will often present to the institution the candidates who they believe are the best fit for the position. Therefore, your interactions with the consultant and the firm should be just as professional and meaningful as your interactions with the individuals within the institution. Table 24.2 provides some basic tips in preparing for the search process.

When You Don't Get the Position

You may pursue what you believe is a wonderful next career step. You pour your energy into researching the position, you believe you perform admirably in the search process, and you may even be led to believe that you are a top candidate for the position. Understandably, your mind leaps into the future and you anticipate yourself in the position, moving your home and your family. But, for reasons that may not always be clear, you are not selected for the position. It can be disheartening and frustrating, and you may question yourself, the process, and continue searching for the reasons "why" you were not selected. It may take time, but try to separate yourself from the process and view, as objectively as you can, why you were not selected. Evaluating the credentials of the selected candidate may assist in this process, but also keep in mind that the selection may have been influenced by political or cultural factors or be a result of "the best fit" for the organization.

Ask the search consultant for any feedback and/or perceptions they may have regarding the selection. In my experiences, search consultants vary tremendously in their willingness to provide feedback. In any case, this exploration and self-reflection

provide valuable insight and perspective on where you may need to gain more experience. Importantly, going through a search process generates many lessons, making you more prepared, more comfortable and much more knowledgeable for the next search. Along with identifying ways to grow professionally, the search process can provide renewed enthusiasm for your present position, and the incentive to push yourself, the role, and environment to provide new opportunities.

Juggling Multiple Interviews/Searches

More than once, I have juggled multiple opportunities and have been working with more than one search firm at the same time. In one instance, I was working with three different search firms. It is important to be up front with search consultants about the other positions you are seeking and where you are in the process. Firms will appreciate this honesty, and it may inspire them to move more quickly if they believe you are competitive or a "good fit" for their position. A key to navigating this process is to be extremely organized and to look at each opportunity to its fullest, clarifying if you are fully prepared to accept an offer.

Some may question your interest; however, it is not uncommon to find yourself in multiple searches at one time. In cases where I was asked about being a candidate in simultaneous searches, I provided the reassurance that I was not throwing my hat in the ring for every similar opportunity, but rather was selective to include only those places where I believed there could be a mutual "fit". Lastly, it is important to keep your references updated and to inform them of the consultants you are working with, when they can expect reference checks, and who will be calling.

Should I Stay or Should I Go?

A position may be offered to you such that after weighing the pros and cons, the decision is *not* clear. You might be faced with asking yourself, "Should I stay or should I go?" Even if it is not an upward move, assess whether the new opportunity will offer professional growth and learning or the chance to be in a more supportive environment. A new position may provide new challenges, new experiences, and it could end up being a better professional fit.

> While deliberating one potential move, I was especially conflicted because there really wasn't a resounding "right" answer after comparing my present circumstances with what I anticipated as future ones. I was happy in my current environment and enjoyed working with my colleagues. The pros and cons list I developed did not bring clarity. I finally determined that there wasn't a "right" choice and I resolved that no matter what decision I made, it would be the "right" one. This brought me extreme peace-of-mind and allowed me to make the decision to move and to look forward to new opportunities.

Don't Look Back and Don't Stay Too Long

Once you have made the decision to move, don't second guess the decision. Begin looking forward, not back. It is important to remember that you have made the decision based on a multitude of factors, and no other person—not your partner, best friend, or mentor, is standing in your shoes. No one has carefully weighed the opportunity at hand as critically as you. It is important to be grateful for the opportunities that you have had, the people who have supported you, and the environment in which you have been; these are invaluable elements in your history and can be important in future networking.

Saying "goodbye" can be hard. You have commitments to people, to projects, and to potential. Just remember that the work is never really finished and your inbox will never be empty. While it may be hard to sever ties or to wrap up loose ends, don't be afraid to let go and move on. In other words, don't stay too long once you have made the decision to leave. Your mind will constantly tease if not challenge you to think about your future home, life, and career move. Until the move occurs, juggling two positions, multiple emails and responding to numerous alliances will be demanding. Your current institution is usually ready, or may be outwardly planning for the next stage without you, and staying too long may hurt the organization's momentum [1].

When you do assume your new position, be careful not to transplant every nuance of your previous setting into your new position. Be mindful of referencing your previous institution(s) too frequently. Instead, let your mind be open to the new culture and environment as you begin your new role.

Surprise Opportunities Presenting Shortly After Moving

The excitement, the uncertainty, and the unknown of a new job, a new institution, a new home, and a new community are hard to explain. When you think that the adrenaline rush from all the change and novelties is at maximum capacity, along comes another opportunity.

> Shortly after one of my academic career moves, I was contacted about a corporate opportunity less than a week after arriving at my new home—I was still busily unpacking boxes. For a split second or maybe a couple of days, I questioned my decision, my fate, and my sanity! I was extremely honored to be invited to consider this opportunity and it challenged me to consider a career outside of academia; however, I carefully reconstructed the many reasons that I chose the new academic opportunity and the commitment that I had made to my new institution. In addition, the idea of moving my family so quickly weighed heavily into my decision not to pursue this alternate opportunity. I gracefully declined, providing the rationale to the company, who completely understood and respected my situation and decision.

Honeymoon Period: Reestablishing Credibility

Moving into a new position from another institution makes you the "outside expert;" and you have a honeymoon period where people may give you the benefit of the doubt as the newcomer. However, along with this benefit comes the fact that you are not a known entity, and with each new position, you need to adapt and reestablish your credibility (Table 24.3). You have a steeper learning curve as an outsider in that you don't know all the skeletons in the closet, and you must learn who you can trust and to whom you can responsibly delegate. In addition, with each progressive leadership climb, the more challenging it becomes, and the more time it takes, to achieve a new level of respect [1].

Moving a Family

While this chapter has focused on moving for professional advancement, many of us have families that will be factored into this equation. It can be difficult uprooting kids out of school and partners out of jobs. Thus, be sure to be in close communication with members of your family as you navigate through the process. They will be affected by the move, and you want to make sure it is the right decision for everyone. Sometimes, as alluded to in the beginning of the chapter, the timing of a move may not be right because it is not right for the family. I have heard of several instances where a candidate was a finalist for a position or was offered the position, but turned it down as their partner did not want to relocate. This reason may have been an excuse for the candidate to withdraw from further consideration, but it leaves a bad impression with the institution and the firm, given the time they have invested in the candidate.

Table 24.3 Adapting to your new position

Tips	Pitfalls
• Stay connected with mentors	• Don't force another culture
• Be prepared to embrace and adapt to a new culture	• Don't always speak about the way things were done at your previous institution
• Be careful of making significant changes too quickly	
• Don't be afraid to admit when you don't know—remember if you are new to an organization you cannot be expected to know all the answers	
• Infuse new ideas carefully	• Don't tackle too many issues at once, instead try to prioritize the main issues
• Allow yourself time to learn	• Don't pretend you know everything about the institution
• Be courageous	
• Look for easy wins	

Conclusion

Pursuing leadership opportunities often means moving—moving to a new city, a new institution and into a new position. While it can be challenging to make these life changes, along with this transition comes an opportunity for personal, professional and leadership growth. Development and self-reflection occur as a result of going through a search even if one stays in their present role. I have truly appreciated and valued each of my institutions and their respective environments, and it was always difficult to leave. However, with each move, I experienced exponential growth and I have valued the chance to learn and live in different environments and different institutional cultures. If you believe it's the right time and the right opportunity and there is the right "fit" with another institution, in another position, I encourage you not to be reluctant to move out to move up!

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Afterword: The Changing Healthcare Landscape

Warren P. Newton

A Time of Transformation

The modern university has its origins in the middle ages and retains many characteristics of those origins: a sense of sacred mission, love of hierarchy, shared governance—and often a different set of rules for those living within the academic cloister. In the nineteenth century, modern universities emerged as the increased wealth and specialization of knowledge driven by the industrial revolution spawned new disciplines; for medicine, the organizational revolution led by Flexner firmly established medical schools as a part of the university and emphasized the key role of basic sciences [1]. Since the 1950s, increases in research funding from government and business and major increases in clinical funding through Medicare, Medicaid and commercial insurance have led to dramatic growth in number of faculty and the overall size and complexity of medical schools and their related academic health centers. In parallel, over the last 50 years, American health care expenditures have grown much more rapidly than inflation, with little or no downturn in times of recession; realistically, most doctors have had jobs for life with increases in income much more than inflation. These have been times of fabled growth for medical faculties.

The boom is coming to an end, however. Health care reform is bringing unprecedented change in the organization of care, with widespread consolidation of hospitals, employment of physicians and implementation of electronic health records within offices and across health care systems. The pace has been remarkable. For example, in the last three years, North Carolina's over 130 independent

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A.J. Viera, R. Kramer (eds.), *Management and Leadership Skills for Medical Faculty*, DOI 10.1007/978-3-319-27781-3

hospitals have consolidated to less than 15 independent systems, the large majority of physicians have become employed, and two electronic health records systems now dominate the state. Similar changes are occurring across the country.

What are the implications of these changes for academic health centers and for their faculty? Both symptom and cause of the transformation are the explosion of expense of health care in the US—approaching three times the cost in other countries [2], endangering economic growth itself—and increasing recognition of the poor performance of the health care system in terms of quality of care [3–6] and the overall health of the population [7]. Financially, as pay for value replaces fee for service, the reimbursement academic health centers have been able to command is coming under increased pressure, and the cross subsidization of research, teaching and indigent care through higher pricing for patient care will be constrained. The result will be substantial cost pressures on large health care institutions, and hence their associated medical schools. Adding to this brew are the dramatic changes in information technology and genetics, which increase cost, but hold the promise of better engagement of patients, more efficient organizations and more efficacious treatment of cancer and other diseases. When added to the aging population and its higher prevalence of chronic disease, the pressures for dramatic change in health care systems increase dramatically. Medical school faculties will be at the center of the maelstrom, and will play a leadership role in transforming patient care, teaching and scholarship to meet the new conditions and the needs of society.

Implications for Medical Faculties

The fundamental task of medical faculty is thus changing. Clinical care will play a major and increasing role, given the relative decline of external support for research and teaching. The clinical care of the future will increasingly be directed at the triple aim—improving health, patient engagement and cost-effectiveness—rather than services and procedures for which more volume will yield more revenue [8]. The transition from fee for service to fee for value will likely be stepwise and difficult for both individual faculty members and for their institutions. Moreover, institutional strategies will require investment and growth in some service lines. Faculty in different departments may thus experience dramatically different environments and incentives depending on their specific clinical role, the mission of the school, and the strategic needs of their particular academic health center.

The context of clinical care is also changing dramatically. Especially in the integrated health systems of which most medical schools are a part, there will be new emphasis on organized group practices, established protocols for care, universal use of electronic health records, team based care with involvement of many specialties and professions, quality improvement and population health, with incentives based not only volume but also quality, and, increasingly, patient satisfaction. The modern faculty physician must be comfortable with practicing in that environment—and must learn to teach their students and residents how to practice in that environment.

These dramatic changes in clinical care are occurring just as the traditional academic missions—teaching and research—are also changing significantly. Since pre-Flexnerian times, medical faculty have taught primarily medical students—and later residents—with a combination of lectures and apprenticeship learning, mostly on hospital wards. In the last generation, as care has shifted to the outpatient setting, teaching has also shifted (though more slowly) to the outpatient setting. Most medical schools now also start clinical education in the first year, so the range of learners faculty teach has expanded across the continuum of medical education. In addition, schools have developed training programs for increasing numbers of professionals from a variety of disciplines. Thus, as interprofessional education gains momentum, medical faculty will need increasingly to teach learners from a variety of health professions, including nursing, pharmacy, public health, and social work, as well as increasing numbers of other learners such as medical office assistants and EMTs. Finally, with increasing recognition of the pitfalls of passive learning and experimentation with new information technology platforms to engage learners, our teaching methods are undergoing a revolution. The role of lectures is diminishing rapidly, being replaced by online asynchronous learning, "flipped" classrooms and interactive small groups. Even one-on-one precepting is changing with the development of student portfolios, real time feedback, and team teaching. The medical faculty of the future will thus teach many different learners, over the full continuum of care and over a larger part of their care and in ways very different from a generation ago.

Research and scholarship are also transforming. Boyer, in a classic work from 1994, described a taxonomy of scholarship, distinguishing among the scholarships of discovery, integration, and dissemination [9]. The first, scholarship devoted to inquiry into basic mechanisms of disease, increasingly emphasizes the key role of interdisciplinary teams working on common and major problems. The increasing expense of such research, however, has meant that governmental funding will focus on a narrower set of institutions. Not as many institutions will be able to sustain a robust research mission. The explosion of knowledge increasingly means that scholarship of integration can achieve important insights; the need for new models of care will drive the scholarship of dissemination—i.e. the evaluation of new programs or clinical innovations. The future role of faculty will therefore depend to some extent on their institution's missions. Scholarship of discovery will be much more supported financially at institutions that do a major amount of research, or which aspire to. Scholarship of integration and dissemination can be done many places, once the cultural resistance to these kinds of scholarship diminishes.

It is important to underscore that the economic forces bearing upon health care systems, and their underlying medical schools, will also drive dramatic change for faculty. Over the last generation, the financial margin of hospitals and health systems has been the major driver of increases in faculty numbers, development of clinical programs and clinical research. Threats to that bottom line translate directly to the health of the academic enterprise. Over a decade ago, the financial crisis of the University of Pennsylvania health system raised the spectre of bankruptcy of the entire university; now, as the Affordable Care Act threatens the margin of health systems and capital needs increase with electronic health record implementation

and the major clinical retooling required for pay for value, many institutions have begun to ask the question of how much research they can afford and to develop new ways of addressing their academic missions. At the level of individual faculty members, what this means is constant attention to the balance of costs, both direct (salary, fringe) but also indirect (staff and ancillary support), and revenues earned, both direct (fee for service) and indirect (ancillaries ordered, plus downstream). Gone are the days when a faculty member, like any physician, could set up shop and be assured of essentially permanent job security; instead, as in many other industries, the reality will be constant attention to productivity, incentives and value brought to the organization, filtered through a lens of the need to increase revenue over the short term.

A final component of the current environment is increasing public demand for social accountability for the academic enterprise. At the clinical level, this demand will mean increasing engagement of patients, both clinically and financially. Many health systems already have begun to compete on patient satisfaction; patient engagement powered by personal technology is a promising strategy for managing the chronic diseases that drive both cost and morbidity. On the horizon, however, is more engagement of patients in ongoing operations, which will force clinical teams and clinicians to adapt dramatically [10]. Even more significant, however, are the winds of social accountability, which will become more evident as resources are constrained. Examples abound. In August, 2015, the IOM found that the GME financing had become badly out of synch with the needs of the nation, and called for major structural reform [11]. Most other countries around the world have called for social accountability of medical schools, that is, a commitment to meeting the needs of the population though clinical care, teaching and research. Increasingly, this kind of lens will be applied to the substantial governmental funding that is the foundation of modern academic health centers—Medicare and Medicaid funding, NIH, CDC, AHRQ, PCORI funding, as well as state support. Medical faculties will be at the forefront of mediating these forces—working out the systems for addressing social accountability, while innovating in the organization and content of care, and training the next generation of health professionals.

Conclusion: Implications for Medical Faculty Careers

The prospect of change on the scale and pace that is coming is intimidating to many, but rich opportunities will remain for medical faculty. Of human organizations that have lasted over 500 years, almost all are universities, underscoring the fundamental ability of universities to adapt despite profound changes in economics, science and society. Over the long term, universities are very adaptable, and benefit both from the high value of the mission of educating the young in modern society and of leading the future development of society. So, too, the next generation of medical faculty will see dramatic changes in what they do day to day and over their careers—but there will also be the opportunity to build a better system of health care, develop new ways of teaching and conduct research that improves health dramatically.

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