

# The Leadership Dilemma

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How do we make leadership happen?

To answer this somewhat odd question, we must address both the what and the how. And herein lies the problem, at least the root of it. To be candid, we are not sure what leadership is (i.e., what the work of leadership entails) and we are even less sure how to make it work. It is uncomfortable and awkward for people who think of themselves as leaders to admit that they sometimes feel incompetent exercising leadership.

Most of us come to the table with a fixed and predetermined set of assumptions on how leadership works and how to exercise it (our implicit leadership theory). These assumptions are bolted firmly to our DNA. It is exceedingly difficult to pry us loose from these deeply entrenched beliefs. But we must be willing to let go. Why? Because many of the challenges that confront us today are enormously complex and varied and our ingrained implicit leadership theory doesn't always work in solving them. Different contexts call for different leadership strategies. We need to learn new ways of making leadership happen.

This is our leadership dilemma. Despite agreement that effective leadership is one of the most important (if not the single most important) determinants of organizational performance and success, we are still not sure how to make leadership happen. Many of the approaches that worked in the past are not as relevant today. Yet we continue to flail, using leadership approaches that are out of date, limited under the best of circumstances, destructive under the worst.

Leadership doesn't happen on its own. It's up to us to make it happen. Indeed, we make it happen everyday through the choices we make and actions we take, sometimes for better, sometimes for worse. We want to make the right choices so we make responsible leadership happen but at times we encounter barriers. Sometimes the barriers are evident—a disruptive person(s), vague goals, lack of support from the top, insufficient resources, or incorrect information. But not infre-

quently the obstacles are not clear or we are not aware of them and we are left not knowing how to tackle a leadership challenge.

## OBSTACLES TO CREATING AND EXERCISING EFFECTIVE LEADERSHIP

The purpose of this article is to examine some of the not so obvious obstacles to making leadership happen. We will not be able to remove (or at the very least reduce) these leadership barriers unless and until we understand them and recognize them. There are at least nine and they are cleverly at play everyday in our organizations.

### Lack of a Language Taxonomy

One of the very first obstacles we must confront in understanding leadership is that we don't have a consistent and agreed upon language of leadership. It's difficult to talk and think about "leadership," let alone exercise it effectively, without a baseline, shared meaning. A functional taxonomy should give us a common, coherent and meaningful structure to the way we talk about and make sense of the word leadership. A shared meaning system will help us better understand leadership and think more intently about how we make it happen.

Language is the most formal of human meaning systems [1]. A system of meaning is a set of relationships between one group of variables (like words) and the meanings which are attached to them. Relationships in meaning systems are arbitrary; there is no particular reason why the word "kidney" should refer to a bean-shaped organ in the retroperitoneum that makes urine, for example. However, when we (as a society or profession) agree upon certain relationships between certain words and their meanings, a system of meaning is established.

We have a consistent and agreed upon language meaning system in medicine. When we use words like

ischemia, anuria, jaundice, cirrhosis or abscess there is a widely shared understanding among clinicians as to what they mean. On the other hand, words like leader, leadership, management, change, power and authority—which make up the language of leadership—are used in ways that are often synonymous, occasionally contradictory, and not infrequently confusing. When the basic building blocks are not agreed on, it's difficult to build a language taxonomy.

Consider the two most common ways we use the word “leadership” in everyday conversation. Usually, we use it to describe an individual—we say, for example, that John is providing good leadership in the cancer center. Implicit in this assertion is that John, through his choices, actions and behaviors, is moving the cancer center in the right direction. Other times, we use the word leadership to refer to a group of individuals at the “top” of the organization who make important decisions, allocate resources and set direction. Whether these people are actually exercising effective leadership as described in the first example is often debatable. Ken Lay was regularly referred to as Enron's leader but was he exercising good leadership?

Developing a more robust meaning system for the word leadership is essential. For example, we must be clear that there is a difference between a leader and leadership. One refers to a person, the other to an activity or a capacity. Some leaders exercise good leadership, some exercise bad leadership and others don't lead at all. Some people who have never been viewed by themselves or by others as leaders have exercised extraordinary leadership (e.g., Rosa Parks). Much of the leadership they exercise goes unnoticed. Leadership from individuals who have little formal authority is frequently subtle and unheralded. Thousands of these small acts of leadership happen every day and collectively they help to move the organization forward and shape its destiny.

If we can create a more functional language meaning system, perhaps we will become more competent in tackling the many leadership challenges that confront us.

#### Today's Popular Notions of Leadership Are Inadequate

We tend to think of leadership as being about a person who dominates, wields power, stands apart and stands above. This view distinguishes leadership as a skill or proficiency held by a handful of people we call “leaders” because they are “in charge” or have positional authority. The model constructs leadership as the possession of a person who gives orders and commands power. The leader “acts” on followers to create leadership. We expect leaders to exercise good leadership that has a positive impact on people and the organization. History, however, is riddled with examples of bad leadership.

The word “leader” often brings to mind vivid images:

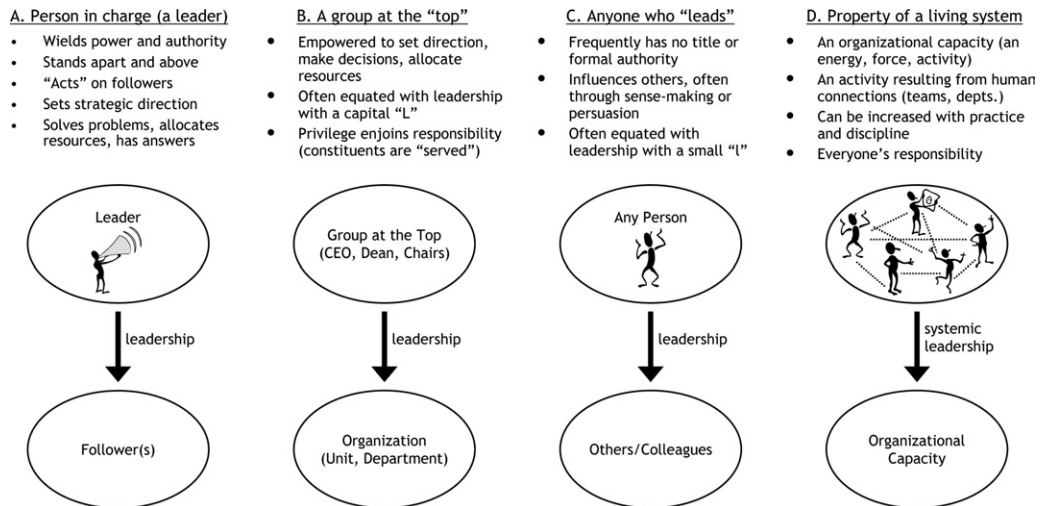
the technically gifted surgeon; the brilliant scientist; the superb clinician and gifted teacher; the faculty member who starts a program from scratch and builds an empire. By and large, our view of leadership tends to center around visible individuals and their talents, their achievements and often their clout.

This implicit leadership theory—leadership equated with a person in charge who sets goals and gets people to follow—is pervasive. It is the way most CXOs, deans, department chairs and faculty think about leadership. We learned to think this way from our superiors and role models. This way of thinking about and exercising leadership happens without much conscious intent and thus is difficult to challenge or even discuss. It has become woven seamlessly into the fabric of academic medicine's culture.

This view of leadership is not wrong, but it is no longer adequate. It is an appropriate model when the leader possesses the required abilities/skills to solve the problem alone or by directing others. But in many circumstances it is limited. Many of the challenges that confront our academic health centers (AHCs) today are so complex and unpredictable that it is practically impossible for one person to accomplish the work of leadership alone.

In addition to the “leadership from a leader” model, there are at least three other ways of understanding leadership (Fig. 1). As mentioned earlier, we sometimes use the word leadership when we refer to those individuals at the top of the organization who set direction, allocate resources, and make decisions. We talk about the “senior leadership” or the “leadership of the medical center” or the “leadership of the nation.” We presume that this group exercises good leadership in the sense that they and the decisions they make add value to the various constituencies the organization was designed to serve. This is often debatable.

A third way of understanding leadership recognizes it as something exercised by people who are not in a leadership position but nonetheless provide leadership. Sometimes these individuals step up to the plate and “take charge,” either proactively or by default. Other times, in a meeting for example, they help the group make collective sense out of a complex problem they are grappling with. They may frame the issue so there is a deeper understanding of the leadership challenge the organization must face. For example, a group of medical students on the surgical service start a program where they call their patients at home the day after discharge to see how they are doing. The hospital CEO hears about it and gets serious about customer service. A post-doc makes sense out of data that has perplexed the research team for months—this paves the way for a major breakthrough. We don't call these individuals leaders *per se* because they do not have formal authority. However, they are clearly exercising



**FIG. 1.** Four ways of understanding leadership. (A) Leadership from a leader. (B) Leadership that refers to a group of people at the top who “run” the organization and allegedly exercise good leadership. (C) Leadership from those without formal authority, often referring to the numerous small acts of leadership that occur every day. (D) Leadership as a property of a living system, a capacity borne out of human connections and teamwork.

leadership and could be called leaders. More than ever, this kind of leadership will need to permeate all levels of the organization to include those people who have, in the past, viewed their jobs as having nothing to do with leadership.

The fourth and most intriguing way of thinking about leadership distinguishes it as an activity created by people working together. The model constructs leadership as an organizational capacity (energy, force, activity) that is created from human relationships. Leadership development occurs through building connections and networked relationships that foster creativity, promote collaboration and enhance resource exchange. Leadership is proportional to connectivity. Building leadership as a property of the system generates the collective capacity that gets people to define reality (the brutal facts) and confront their ingrained values, habits and beliefs so they can take on the leadership challenge(s).

Our views of leadership are shifting (Table 1). Effective leadership in organizations today extends beyond selecting and developing a critical mass of individual

leaders. It also involves the development of leadership as a property of the whole system. Rather than being about a person, leadership is about an organizational capacity that is born out of the relational space between people. Unfortunately, this kind of connected leadership is not natural. More leadership requires more shared work; but as AHCs begin to break down departmental barriers, people have to learn to work with others who are not like them—people who may have a different work ethic, dissimilar styles of solving problems and even contrasting values. Persuading people who don’t share common goals or who have different motivations to line up behind a shared vision and commit to one another can be enormously challenging. The obstacles to this connected leadership are familiar to all of us. They include personal agendas that take precedence over institutional priorities, silos and turf wars, an *us versus them* mentality, lack of a unifying purpose that galvanizes people, and a perceived (or real) scarcity of resources.

The first and most prevalent way of understanding

**TABLE 1**  
**Shifting Views of Leadership**

| Old view  | New view  |
|---|---|
| A person in charge, born with leadership skills, who possesses power, solutions, and resources                          | Something people create together through collaboration, dialogue, and resource exchange   |
| Leadership is the job of a few people at the top of the organization  | Leadership involves everyone taking responsibility for the success and destiny of the enterprise  |
| Leadership is about choosing the right course and getting people to follow that direction to achieve the leader’s goals | A systemic capacity that mobilizes people to confront reality and reprioritize their entrenched beliefs so they can tackle the leadership challenge |
| Leadership is a touchy-feely subject that is mysterious and difficult to study  | Leadership is an activity that involves specific responsibilities that can be studied scientifically  |

leadership—as a person in charge who acts on followers—sees the solution to increasing leadership in the organization as hiring or appointing more leaders. Leader development occurs largely through teaching and training a set of individual skills and abilities. Developing the potential of promising leaders and expanding managerial talent in the organization will grow leadership capacity—but only so much. Understanding leadership as a property of a living system sees increasing leadership capacity as having the right people on the bus and in the right seats but also as the result of connected teams that foster creativity, promote collaboration and enhance resource exchange. Not everyone can be a leader but everyone can exercise leadership.

High quality human connections act as channels for sharing ideas, feedback, and building trust [2]. They may play a key role in constructing our work identity, giving each of us an experience of the contribution we make. They can promote learning and growth through knowledge acquisition and self-discovery. The positive feelings that emerge from such constructive relationships promote trust, staying power, and commitment.

These high quality connections make good leadership happen. There is plenty of room to develop more of them.

#### AHCs Are Loosely Coupled Systems

A third barrier to making coordinated leadership happen across the enterprise is the structure, organization, and governance of AHCs. They have been described as “loosely coupled systems [3].” In loosely coupled systems, the forces working toward integrating the entire enterprise are often weak compared to the forces that encourage separation, even fragmentation. Physicians, for example, favor autonomy and independence, and resist being told how to practice medicine—they are not naturally team players. Within loosely coupled systems, local networks may be highly connected but feedback times are often slow and alignment is difficult.

Loosely coupled systems, though messy, have valid functions within organizations [4]. They allow for localized adaptation without changing the entire system. The opposite, standardization, may be too restrictive. Loosely coupled systems can allow for more variety and diversity in adapting to a changing environment. There is more room for self-determination by actors (e.g., faculty, departments, research teams).

In general, loosely coupled systems are very difficult to systematically change. The loose coupling makes it difficult to make leadership happen, especially from the standpoint of getting everyone playing off the same sheet of music. Connected leadership can be observed locally (e.g., in the operating room, in the research lab, in the multidisciplinary clinic) but it is difficult to exercise systemically.

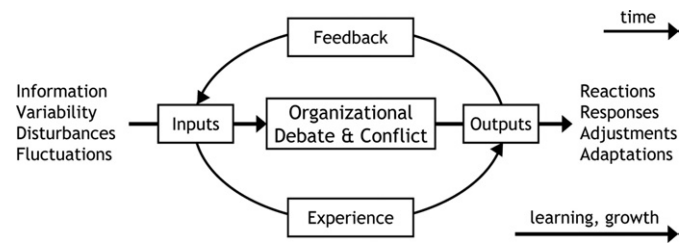


FIG. 2. How organizations learn.

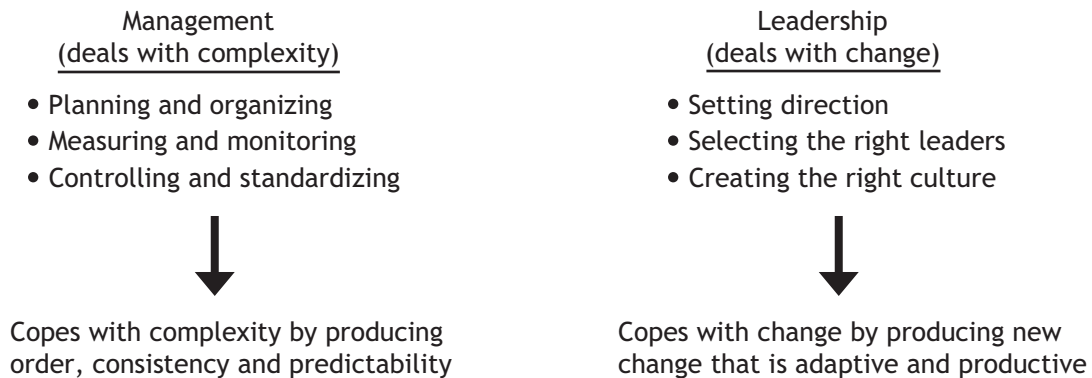
Getting the various microsystems (e.g., divisions, OR teams, research teams) of an AHC to work together beyond their own boundaries is a major leadership challenge. Invariably, resource constraints aggravate the challenge and accentuate the differences in the ways people understand the problems and their solutions. The diversity arising from groups with different goals, norms and perspectives often manifests itself as conflict. In the debate, the leader must keep the heat on and pressure turned up enough that people remain alert and face the challenges, but not so high that the pressure cooker explodes [5]. By holding people accountable, insisting that they deal with tough issues and helping them manage dissent, leaders can help make leadership happen. Organizations and teams that learn to harness conflict and use it constructively come up with more creative ideas and innovative solutions. Healthy conflict and debate are essential precursors for organizational learning and growth (Fig. 2). Sadly, in most organizations this adaptive work is usually avoided, more dirt is swept under the carpet, and the organization suffers.

#### The Management/Leadership Paradox

Another obstacle to making leadership happen is the misunderstanding that exists between leadership and management. Management is often equated with business performance while leadership (as pointed out earlier) is usually associated with a person in charge. This perspective is narrow and misleading.

Management has its roots in the early 1900s when Frederick Taylor developed the scientific management theory, which introduced the careful measurement of tasks, standardization of processes, and the institution of rewards (and punishments). Management deals with the complexity that is inherent in large organizations (like AHCs) and it is designed to create order, consistency and standardization [6]. It is about being on time and on budget. In a very real sense, management is about doing the same things the same way every time to minimize error. Algorithms such as clinical pathways and extubation protocols are intended to standardize patient care in order to improve outcomes and reduce costs.

Kotter [6] points out that leadership and management are different, but complementary activities (Fig.



**FIG. 3.** Leadership and management as different but complementary activities. Modified from Kotter [6].

3) Leadership deals with change (rather than complexity) by creating more change, often by embarking on a new strategic vision or transforming the culture. No change (management) versus change (leadership) describes the paradoxical tension that AHCs have experienced over the past decade. How does an AHC, whose objective it is to endure and preserve itself, change and evolve so as to have a sustainable life?

Many new deans, department chairs and division chiefs find themselves relentlessly surrendering to the tyranny of the urgent, trying to create order (minimize chaos) by constantly putting out fires [7]. Why does this happen? Because they believe that in order to do a good job they have to be on top of everything. Because they want it to appear that they are unflappable. Because they want to say yes to everything and be all things to all people (all well-intentioned), they delegate poorly and end up dealing with one calamity after another. They haven't learned to push responsibility down so they micromanage. There is no time left to ask: Where do we want to be in 3–5 years? What kind of culture do we want to create? The net result is that they get little productive, meaningful work done. In short, enough good leadership does not happen.

#### Failure to Accurately Diagnose the Leadership Challenge

What is the leadership challenge that people must confront? Not infrequently, especially when dealing with complex challenges, the answer to this critical question gets misdiagnosed. Sometimes, the leader is so busy firefighting that he doesn't take the time to thoroughly analyze the issues. Other times, the leader thinks he has all the answers only to be way off the mark. Not infrequently, leaders lack the necessary analytic skills to make the diagnosis.

When Max (a fictitious name) assumed his new duties as Chief of Cardiac Surgery, he was very much aware that the division's 30-day inpatient mortality for both coronary artery and valve surgery was unacceptably high, almost one and half times that of accepted benchmarks. The hospital CEO was concerned for sev-

eral reasons, not the least of which was that outcomes data were now publicly reported. On two occasions the CEO had raised the question with Max as to whether the heart surgeons had the "technical skills to get the kind of results we need to compete in this marketplace."

Max wisely looked at the various risk factors that impact outcomes and paid special attention to case-mix adjusted mortality rates. Then Max met with the surgeons and reviewed their cases for the past three months. It turned out that they were undercoding pre-operative risk factors. When this was taken into consideration, and the 30 day case-mix adjusted mortality rates recalculated, their results were actually better than industry standards.

A correct diagnosis provides an accurate understanding of the context and the issues, the various stakeholders involved, strategies for implementing a solution and the tradeoffs involved. In the hypothetical case above, the solution was a simple one that involved educating people on how to code more accurately. If the diagnosis had been that the surgeons' technical abilities were substandard, a very different solution would have been required.

When the 80 hour work week went into effect several years ago, the initial diagnosis was that it was a manpower problem. Programs responded by hiring physician extenders to help take call and get the work done. This solution helped but only so much. The breakthrough came when people recognized that the real leadership challenge that people had to confront was also a cultural one. The solution required that the faculty and residents modify their behaviors (e.g., make rounds between cases rather than at 7 PM at night) and change their entrenched assumptions about how resident education was accomplished.

Failure to differentiate adaptive challenges from more easily solved technical problems may be the single most important reason for leadership failure today [5]. Adaptive challenges are complex learning problems for which the organization has no pre-existing

resources or solutions. They are complex because they are difficult to get our arms around. Different groups understand both the problem and its solution differently. They are problems because they represent a gap between the present and an aspired future. They require learning if we are going to tackle them successfully. Money alone will not solve them. They can only be solved by people learning new ways of working them out. Learning is a prerequisite for change. Because adaptive challenges force people to make agonizing trade-offs, it is common for them to try to avoid the problem by treating the symptoms rather than the problem itself. However, dealing head on with the issue, while painful, offers a superb opportunity for increasing leadership capacity.

#### The Unwillingness to Confront Reality and Take on the Really Tough Problems

The correct diagnosis of a leadership challenge only gets you so far; the people involved must be willing to follow through with the right treatment. Technical problems are relatively easy to solve because they are usually familiar problems with proven solutions. Adaptive challenges cannot be solved with technical solutions, but not infrequently that is what gets prescribed. Why? Because adaptive work is painfully difficult work. The solution requires that people make changes in themselves, often in their ingrained mental models, values and beliefs. It is easier to throw money at the problem or pretend that it will go away. But we are just fooling ourselves.

In 2005, the Penn State Hershey Medical Center formed the Penn State Heart and Vascular Institute. The institute combines all heart and vascular clinical services as well as research and teaching components into a single entity. All technical and professional revenues and research dollars flow into the institute. The new structure required the chairs of surgery, medicine and radiology to change their underlying long-standing views of how funds flowed in the enterprise. In particular, surgery and medicine “lost” big revenue generating divisions. The upside was that patient care could be delivered with greater continuity, basic research could be translated more readily, and educational programs could integrate residents and fellows from multiple departments.

Dean Williams, a faculty member at Harvard’s Kennedy School of Government, argues convincingly that real leadership gets people to face reality [8]. Real leadership demands that the people make adjustments in their entrenched values, thinking, and beliefs to deal with threats, accommodate new realities, and take advantage of emerging opportunities. The reality in academic medicine is that collaboration, teamwork, interdisciplinary programs, and dissolution of silos are hallmarks of the best organizations. Departmental

lines are becoming more blurred and the ability to work and lead in a matrix structure is a critical leadership skill. This “new order” creates a huge intellectual hernia for many chairs, as their sense of personal worth and security is often tied up in how sizable their departmental reserves are and how much turf they control. They are afraid that if they share resources and build interdisciplinary research programs and clinical service lines they might lose power. They might be less important. These fears often erect barriers that pre-empt the adaptive work that needs to be done.

#### The Wrong People on the Bus

Woody Hayes once said, “You win with people.” I agree with one caveat: You win with the right people. They are your most precious asset. The wrong people are your biggest liability. The wrong people are not bad people—they just don’t belong in your organization, usually for one of two reasons. Either they don’t live the values of the organization or they don’t get results. Jack Welch once reflected, “Numbers and values. We don’t have the answer here—at least I don’t. People who make the numbers and share our values go onward and upward. People who miss the numbers and share our values get a second chance. People with no values and no numbers—easy call. The problem is with those who make the numbers, but don’t share the values. We try to persuade them; we wrestle with them; we agonize over these people [9].”

Every AHC has individuals who are obstacles to making leadership happen. If they are refractory to counseling, they need to move on. These people create the 90/10 rule: you spend 90% of your time dealing with the 10% of the people who are problems. Often, these people are chronically discontented—they may feel passed over or unappreciated. They can sap energy from others with their tendency to lob grenades and speak negatively about the organization. It is essential that key leaders undercut any shenanigans by these disenfranchised individuals who will consistently try to disrupt the ship’s course.

Often the most difficult (and interesting) people to deal with are the “rockstars.” These people add enormous value to the organization either because they lead an internationally known research program with multiple grants or because they have built a huge clinical program that adds both reputational equity and millions of dollars to the bottom line every year. The challenge with these individuals is that they often have a pre-Copernican ego. They believe that the world revolves around them. They have an insatiable appetite for resources, often exhibit behaviors which others experience as arrogant, and act as if they report to no one. For all the good they bring, they can be a real thorn in your hypothalamus.

### Mistrust

Mistrust is one of the most common barriers to making good leadership happen. Everybody knows this and everyone has experienced it. It bears mentioning because even when all the other enablers of leadership are in place, without trust, leadership will not happen, at least not in any meaningful way.

Mistrust is epidemic in the language we use. We tell our residents, “You can’t trust medicine to call you before the patient bleeds six units,” or “You can’t trust anesthesia to keep up with the fluids.” We say to our faculty, “You can’t trust the dean; he’s out to take our money.” I heard these same comments in the 1970s when I was a medical student. No wonder trust is not part of the culture. O’Toole [10] notes, “In essence, the leadership challenge is to provide the glue to cohere independent units in a world characterized by forces of entropy and fragmentation. Only one element has been identified as powerful enough to overcome those centripetal forces, and that is trust.”

When senior leaders of AHCs were asked, “Which core values are most important to the way you think about leadership?”, trust was one of the top three values ranked (out of 38 values) [11]. It was noteworthy that trust was significantly inversely correlated with authority [12]. This negative relationship suggests that the “leadership from a leader” model, which equates leadership with a person in charge in a position of authority, can create suspicion and a tension that may breed mistrust. The ability to manage that tension—when to use authority at the risk of compromising trust as opposed to building trust by exercising connected leadership—is a constant challenge for all leaders.

### Leadership Education/Development Is not an Organizational Priority

How much time, resources and energy do AHCs spend on leadership education and development? Not nearly enough. How often do we see leadership development initiatives being driven from the very top? Not very often. Is the leadership development plan in your organization just as important as the master space plan or the strategic plan? Unlikely.

Why do we underinvest in leadership development? Why are leadership development programs amongst the first to get dumped when there’s a budget shortfall? For one thing, we make the false assumption that competent researchers or physicians will automatically make good leaders; no formal education or development is necessary. Often, they are adequate leaders and we accept that as good enough. Sometimes, they are a disaster and we chalk that up to bad luck or the law of probabilities. Just because a faculty member can surgically repair a thoracoabdominal aneurysm or is a

member of the National Academy of Science doesn’t mean he will be a responsible department chair or an effective leader.

Second, the link between the teaching of leadership and the exercise of leadership has been difficult to establish. We believe in our gut that effective leadership is a critical determinant of organizational performance and success. Intuitively, investing in developing leaders and leadership makes sense. But the payback, if there is one, is long-term and most people can’t see beyond the next fiscal quarter.

Recent research suggests that there is a relationship between good leadership and organizational performance. A study of AHCs demonstrated that tighter alignment between surgical chairs and medical school deans on core values and on leadership climate perceptions correlated with higher school and department NIH standing and higher *U.S. News and World Report* medical school and hospital ranking [11]. Furthermore, major disparities between deans and chairs indicating a misalignment of perceptions and values were associated with poorer institutional effectiveness in the clinical and academic missions. The study did not establish a cause and effect but it did demonstrate that agreement on leadership values and climate perceptions predicted superior performance. The authors suggest that developing effective leaders and leadership in an AHC requires a proper context—i.e., a healthy climate and a set of “real” (not just espoused) core values.

The third reason we don’t teach leadership development is that we are not sure how. We know how to teach and train doctors, radiology technicians and dietitians, but we don’t really know how to prepare people for the practice of leadership. Many AHCs point out that they offer leadership training. Indeed, these programs focus largely on training (as opposed to building systemic leadership capacity) and the education mainly covers managerial topics like budgeting, reimbursement, negotiation, and metrics. It is important to have an understanding of these subjects but they are not at the heart of leadership. They do not teach people how to think systemically and multidimensionally, how to develop a stomach for ambiguity, or how to tackle challenges that threaten their deep-seated values and beliefs.

As the challenges we must face become more and more complex, those organizations that make leadership development an essential priority (as important as research and patient care) will be best positioned to adapt, learn, make progress and add value to those they serve. For more than a century, we have been teaching medical students, residents, nurses, graduate students and post-docs, preparing them for practice in their discipline. Where we have fallen short is in preparing people for the practice of leadership. This must change.

TABLE 2

**The Evolution of Organizational Problem-Solving**

| Past  | Present/future                                   |
|---|--|
| Problems “tame” (simple)                    | Problems “wicked” (complex)                      |
| Language descriptive, comparative           | Language creative, speaks about possibilities    |
| Facts legitimize decisions                  | Sense-making generates consensus                 |
| Find the right answer                       | Develop a shared understanding                   |
| Technical expertise is key skill (IQ)       | Social skills equally important (EQ)             |
| Finding solutions is analytical, fact-based | Problem-solving is a social, cooperative process |

**MAKING EFFECTIVE LEADERSHIP HAPPEN**

What is responsible leadership—the type of leadership that makes a legitimate difference in the world, the kind that adds real value to people’s lives? When I asked this question to the CEO of a major university hospital, he explained that responsible leadership was about developing a competitive strategy that allowed the hospital to provide higher quality patient care and achieve better outcomes. The dean of the medical school at the same institution told me leadership was about improving patient care through innovations in teaching and research. A university president from another institution said that effective leadership was about getting the deans in the various colleges to build top-notch teaching and research programs. The chairman of a surgery department told me that leadership was about measuring performance and holding faculty accountable. Another department chair said that leadership was about making sure the faculty had protected time.

Regardless of how we choose to define “effective” or “responsible” leadership, it should move the organization forward such that it more effectively achieves its goals and serves those constituencies (i.e., adds value to their lives) it was designed to serve. It is vitally important that we appreciate that different contexts call for different leadership strategies if people are going to successfully tackle the leadership challenge at hand and make effective leadership happen. Problems come in all sorts and sizes and we cannot solve them using the same approach (Table 2). We must learn how to diagnose the leadership challenge accurately so we can formulate and implement a solution that fits the problem.

It is no longer sufficient for leaders to focus solely on vision and strategy as the path to leading change. They must also recognize the importance of building a strong working container [13] that holds people together during the disequilibrium and developing others so there is enough capacity in the system to confront the brutal

facts, take on the tough issues, and make effective leadership happen. The concept of a “container” is discussed by Bill Isaac in his book *Dialogue and the Art of Thinking Together*. As used here, the word container refers to the bond—the trust, commitment, fortitude, and connectivity—that holds people together in the face of the tension, heat, and distress that arise in difficult, disequilibrating conversations.

Leadership challenges are everywhere. They are opportunities begging for people to lead. But we fall short for all the reason discussed above. We do not have a good track record of making leadership happen (witness the silos and turf wars at every AHC, not to mention the market share wars, and the literal wars between nations).

Conflict is an inherent part of all barriers to leadership. Some might argue that the problem is not conflict but money. No organization has unlimited resources; conflict is what results when they have to make choices. It is this conflict we don’t want to deal with. It brings to mind memories of stressful arguments, power struggles and bruised egos. Consequently, most people avoid it. We hide from it or squelch it when we see it heading in our direction. Conflict, however, is natural, intrinsic to all living systems—individuals, organizations, communities and nations [14]. It exists because our worldviews differ. Conflict is not negative. It is not a contest. It is not a game of winners and losers. It is an opportunity for learning, growth and leadership.

**Leadership Is Risky Business**

Jim Collins talks about Level 5 leaders, those individuals who build enduring greatness through a paradoxical combination of humility and professional will. Collins notes [15], “Level 5 leadership is not about being soft or nice or purely inclusive or consensus-building. The whole point of Level 5 is to make sure the right decisions happen—no matter how difficult or painful—for the long-term greatness of the institution and the achievement of its mission, independent of consensus or popularity.”

Many of these decisions will not be easy and they certainly won’t please everyone. Responsible leadership asks people to define reality and reprioritize their long-standing assumptions so they can tackle the challenges at hand. Accordingly, people push back. They push back because change represents loss and letting go—letting go of ways of doing things that they are comfortable with, letting go of deep-seated beliefs. Loss is painful and threatening.

People resist change in predictable ways. They usually start by arguing that the data are flawed. This often stalls the initiative while more data are collected. People shift into academic mode, which consumes more time, energy, and other resources. The data may be irrefutable but “the dead horse is flogged yet again.”

Next, people push back against the process. They argue that department X or person Y didn't have enough input. Once again, the necessary adaptive work is put on the back burner. More time passes; people are now getting frustrated or apathetic. Finally, people attack the individuals they perceive to be leading the change. They argue that they are hurting the institution; they may try to damage their credibility. Three years later the same challenge surfaces again. By now you've become cynical and you disengage a bit more. The burn rate of people's time has been huge.

It takes effort to make leadership happen. That's why we call it exercising leadership. It requires generosity. That's why we call it providing leadership. And it takes innovation. That's why we talk about creating leadership. We make leadership happen through our choices and actions. If we choose to erect silos and squander resources, one kind of leadership will happen. If we choose to build a culture that is willing to step up to the plate and build greatness, a different kind of leadership will emerge. It is up to us.

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