



SURGEONS AND SURGICAL LEADERS:

MIXING EXPECTATIONS WITH NEEDS

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I was recently asked by the American College of Surgeons to participate in the panel for its course on leadership and provide my views on “Approaches to Integrating the Needs of Leadership with the Expectations of Surgeons.” It was gratifying after almost eight years in my current position to participate in a panel with old friends and present to an assembled group who, in no small part, represents the leadership of our discipline for the era to come. This article is a reconstruction of my presentation.

Defining needs and expectations

“Approaches to integrating the needs of leadership with the expectations of surgeons” could be addressed from many points of view. First, I could pursue a description of the needs of institutional leaders—individuals in positions similar to mine—and the convergence or conflict of those needs with the expectations of surgeons. In that context, one could characterize such a discussion as a debate between the needs of the collective versus the needs of the individual or, in a political context, a debate between federalism and states’ rights—an interesting topic, but one on which I am only partially qualified to speak, as I am both a states’ rights Southerner and, on occasion, am accused of thinking and acting, in my position, too much like a surgeon. However, I didn’t believe this was the appropriate approach.

I suspect that my presentation title, more likely, relates to a couple of other topics. It could be interpreted as a request to have me list components of a survival guide to provide future surgical leaders with the tools to survive or even thrive in the “foreign territory” inhabited by academic medical center leaders, outside the comfort of the operating room and the like-minded fortress of surgery. Unfortunately, I don’t think such a detailed guide would be of much use and, more to the point, I don’t have one.

Instead, I believe it’s a request for a discussion of how leaders of surgeons should weave expectations from institutional leaders with the needs and expectations of their faculty surgeons. This topic is quite germane to a person’s maturation as a leader of any group, including surgeons.

How perception can affect integration

Before fleshing out my thoughts on how to achieve a balance between needs of surgical leaders and expectations of surgeons, I believe that a few disclaimers and personal observations are in order.

I feel compelled to disclose that my experience is only mine. It is limited to the issues, interactions, and personalities that I have experienced in only the part of the universe to which I have been exposed. Having said that, however, experience is a great teacher and provides valuable lessons for

developing one’s own philosophy or strategy for leadership.

In addition, I realize that I have left surgery and now have lived on the “dark side” long enough to be contaminated and labeled as “one of those administrators.” I can’t argue that point, but I will say that it does give me some perspectives from the other side that otherwise would be ignored in a meeting on development of surgeon leaders.

Lastly, I have a couple of personal biases—observations related to how surgeons as a whole, as well as some surgical leaders, are perceived by others, and how this perception can be used to the advantage of the surgical leader when interacting with institutional leaders and the public—that I cannot prove as true but are worth considering.

I have observed that the public, members of most other medical disciplines, and most institutional heads (as most are nonsurgeons) see surgeons as isolationists—not consensus builders—who are self-confident to the extreme of arrogant, dictatorial, and intolerant of bureaucracies such as those found in medical school administrations.

I don’t know how any of these other groups could come up with such a bizarre opinion about a group of humble, self-effacing, concerned physicians/healers, but nonetheless they have. So, my pearl of wisdom in response is as follows:

People *expect* other chairs in a medical school to be collaborative, consensus-building, institutionally minded, and so on. But when a surgeon exhibits such traits, it’s unexpected and disarming to others, providing her or him a leg up in discussions, debates, or whatever the interaction with others may be, including such interactions with institutional leaders.

As a matter of fact, these same disarming traits are just as important in dealing with the diverse personalities within a group of surgeons. Some surgical faculty members may even see their chair as having some of the same traits of self-centeredness that others ascribe to surgeons, and, when a chair exhibits such traits, that chair becomes disabled in his or her ability to lead a diverse faculty of surgeons and ultimately will fail.

My second observation is that many outsiders, including many institutional leaders, see surgeons and surgical leaders as individuals resistant to change, especially if such change is imposed. I think there are many reasons for such a perception. For

example, many surgeons were reared learning how to do something one way and then they do it that way for their entire careers—as long as it works, many wonder, “Why would I change?” Thankfully, most surgeons exhibit their greatest commitment to the patient and their work as physicians. Their lives are filled with managing patient issues both in and out of the operating room. They desire to have the rest of their environment be constant. How one manages this inborn desire for stability and status quo on behalf of faculty with the reality that “change *will* occur” will be one of the greatest challenges and opportunities for a leader of surgeons.

Achieving the integration

Rather than suggesting how to *balance* the needs of leadership with the expectations of surgeons, the title of this presentation asked how to *integrate* those needs and expectations. I believe that leadership (be it as a leader of surgeons or of an academic medical center) is not about maintaining balance between constituencies; instead, it is about searching for directions, solutions, and positions that are advantageous to both the individual surgeon and the profession as a whole. Although balance in outcomes of decisions is important, I believe that leadership should not think in terms of quid pro quo balance—for example, “Because I did something for one physician, I have to do the same thing for another physician.” Leaders should not put themselves in a position of doing something for one department that will force them to provide a quid pro quo for another. Instead, solutions for managing individuals and departments should be based on premises that apply to the whole, whether the individual department or the entire institution. I believe one should pursue leadership approaches that focus on both the individual and the whole—this presents a subtle difference in approach from quid pro quo balance, and it is an approach that is reflective, I believe, of a higher order of leadership. There will be times when a leader will have to make decisions that do not benefit the individual, but when doing so, that leader should seek solutions that enhance principles that, in turn, benefit the greater population of individuals—or, in other words, the whole.



A hypothetical example

You are a new chair and you have a couple of research faculty members who have been supported with excess clinical revenue for several years (the good old days!). These two faculty members have not received external funding for many years and are pursuing their pet projects with hard-earned dollars from clinical activities of others. What do you do? Do you simply leave this agreement as is? Do you simply fire them to show everyone who is the boss and to let all others know that productivity is required? Or do you consider, for example, setting up internal criteria for funding all intramurally supported research based on merit, and work with those two faculty members to redirect their efforts in directions more beneficial to the department—be it increased clinical or teaching workloads? I suggest this latter course. Then, if they can’t adjust and change, you have a depersonalized, “premiered” basis on which to terminate their employment and do it with the support of all common sense and with productive faculty members on your side. Such a course depersonalizes the consequences to the faculty and sets up a better plan for managing future distributions of resources within your faculty.

Now, apply this story to a larger hypothetical platform. Suppose you are the chair of surgery

and you realize that portions of the institutional dollars—funds likely previously generated by surgeons—are supporting research in another, unproductive department. Are you best served by sitting quietly; by grandstanding and arguing that the school should cut off funding to that department; or by suggesting that an institution-wide algorithm be developed to distribute institutional dollars for research support to all departments, which appropriately benefits the productive departments? From my position, this latter approach is an example of an action taken by a great institutional leader who just happens to be a surgeon and who is deeply appreciated for devising a solution for an unresolved institutional problem.

One could substitute similar hypothetical examples in the clinical arena for the one that I chose in the research arena, as the same premises hold. In the end, the issues are really no different for managing a department than for managing a school. My point is that leaders should look for answers that benefit a greater goal whenever tackling an individual problem and for opportunities for institutional improvements that may also indirectly benefit the department's or individual surgeon's accomplishments.

Culture of change management

Management of change, and its relationship to the joint role of a chair as an advocate for his or her department and as a member of the institution's leadership, should also be addressed.

Change is constant. As much as people would like for it to be different, the only constancy with which we all live is the constancy of external stresses that ultimately are relieved by change. The only issue is whether one discerns those stresses or forces and channels eventual change toward favorable directions, or whether one is left to respond to the new environment created from without. From my vantage point, chairs should be in touch with and embrace the constancy of change. They should approach their duties as leaders through recognition of opportunity to lead change rather than to resist it. By doing so, they become strong advocates not only for their individual faculty but also for their entire institution.

Following is a review of the recommendations

or guideposts for decision making and interactions with the surrounding environment, which can help leaders in implementing change:

- Recognize and embrace the fact that change will be constant in any position or environment. The options are to react to it or to create it. Look for opportunities for preemptive change that benefit faculty members and the environment in which they live as a whole.

- When faced with a specific problem, attempt to place it into a larger context and create a solution that simultaneously advances the larger goal.

- Where possible, look for solutions to problems and needs by searching for those outcomes that will also benefit the largest possible constituency's goals, including your own. In that manner, you end up being a constructionist rather than someone who owes others for successes.

Taken together, these guideposts will not make the role of leadership any simpler. However, they will make the leadership experience more meaningful and rewarding as a career path. □

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