
Some leaders are born. Their natural inclination to take charge of situations is evident at a tender age, and they seem to spend their childhood waiting for their turn to lead. Some leaders are made. Their skills are carefully crafted through hours of diligent preparation.

Leaders take many forms: leaders who have natural charisma and magnetism that draw others to follow them; leaders so deluded by their title that their inadequacies escape the attention only of themselves; leaders who are benevolent and whose strength lies in maintaining peace and good favor; leaders who are dictators and use compulsory compliance to mask their lack of negotiation skills; leaders who are lame ducks and are half-heartedly tolerated until retraining or dismissal relieves the organization of this weight; and leaders who are visionary, successfully impart a shared vision onto the group, and inspire each individual. We are exposed to all of these types of leaders in the field of surgery and remain hopeful that the visionary within each of us will develop.

Insights

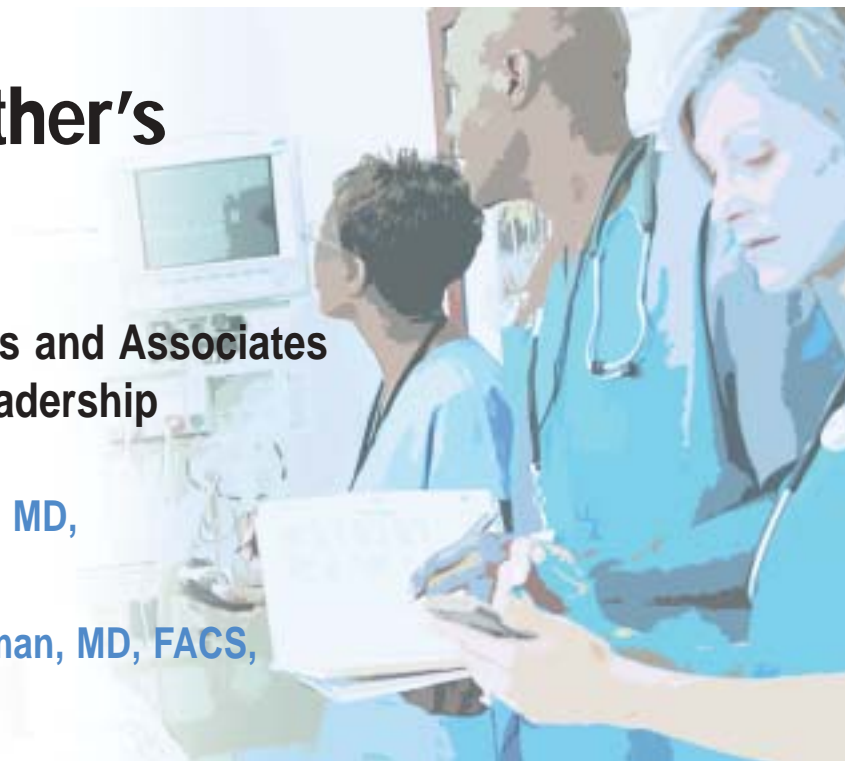
Insight into the current state of leadership training in surgical residency can be gained by examining the origins of our leaders. Claude H. Organ, Jr., MD, FACS, Immediate Past-President of the American College of Surgeons (ACS), pondered this issue. As a result, he presented his related study during his presidential address to the Southwestern Surgical Congress in 1985. To identify the top echelons of American surgery, he and others developed a model based on a point system according to 15 positions of influence in the field of surgery (such as prominence in the College, the American Board of Surgery, and that board's Residency Review Committee; chairs held within the National Institute of Health's surgery study section, surgical societies, or departments of surgery; or editorships of major surgical journals or textbooks) held between 1945 and 1985.¹ Of the 460 surgeon leaders he identified, 8 percent accumulated 30 percent of the assigned points. Based on this point system, 7 percent of the 72 institutions analyzed

Not your father's specialty:

Preparing Residents and Associates for collaborative leadership

by **C. Suzanne Cutter, MD,**
Flushing, NY,

and **Jeffrey S. Upperman, MD, FACS,**
Pittsburgh, PA



contributed 47 percent of the leadership appointments.

Were these leaders somehow compelled to train at these institutions? Were these institutions better skilled at preparing leaders? The author was asked, “Was there an interlocking pattern of friendship, discipline, or institutions in this leadership?” We may not be able to answer these questions definitively, but the track records of the institutions identified in this study are difficult to dispute.

It would be interesting to revisit Dr. Organ’s analysis at this time since both the breadth and nature of surgical leadership have changed. Who are the contemporary leaders in surgery? Politics is a burgeoning pursuit for surgeons as evidenced by: the successes of Senate Majority Leader Bill Frist, MD, FACS (R-TN); the recent election of freshmen members of Congress who are also Fellows of the College, including Reps. Tom Price (R-GA), Joe Schwartz (R-MI), and Charles Boustany (R-LA); and the appointment of Vice-Admiral Richard H. Carmona, MD, FACS, as surgeon general. Nancy Snyderman, MD, FACS, and Sanjay Gupta, MD, FACS, entered the field of broadcast journalism, and are now well-known national medical correspondents. With the emergence of translational research, an increasing number of well-funded surgeons are contributing to our field as accomplished physician-scientists. In what ways can leadership training prepare residents for these vocations?

Leadership characteristics

To design and develop leadership programs, we must first establish a definition of leadership and determine the characteristics of a leader. This is not a trivial task. Most dictionaries attempt to define leadership in terms of an office held or a capacity filled. Wiley W. Souba, MD, ScD, MBA, has devoted considerable effort to analyzing leadership in surgery. He says that focusing on who is in charge is no longer adequate, asserting that “Leadership is created in and emerges from the relational space that connects people—accordingly, leadership development involves building high-quality connections between people.”² Leadership is about building and leveraging professional relationships to accomplish the objectives of an organization, its leaders, or other members of the group.

Representatives of the American Association of Medical Colleges authored a text on academic medi-

“It is better to lead from behind and to put others in front, especially when you celebrate victory when nice things occur. You take the front line when there is danger. Then people will appreciate your leadership.”

—Nelson Mandela,
1993 Nobel Laureate

cine that includes an entire chapter on leadership as collaboration. The authors stated, “Now, however, a more relational model of leadership is emerging—one that conceptualizes leadership as collaborative, as about making sense together of the unknown and making meaning in a community of practice. This model means that not only do leaders require cognitive knowledge (know-what) and advanced skills (know-how); they also need an understanding of systems (know-why) and self-motivated creativity (care-why).”³

Last July, Toby Cosgrove, MD, FACS, a cardiovascular surgeon, was named chief executive officer of the Cleveland Clinic. When interviewed shortly after his appointment, Dr. Cosgrove said that he would “devote all of my abilities to the success of this organization and the patients it serves. But I will need everyone’s help to keep the Clinic moving forward. As we act as a unit, the possibilities are endless.” The threads that link each of these individual insights together are the character traits of the leader. These traits were aptly described during antiquity by Sun-tzu as wisdom, integrity, humanity, courage, and discipline.⁴

While it is difficult to impart character traits on any individual beyond childhood, each of us can be trained to lead. However, the contemporary surgical training environment is far different from that of many of the surgery faculty who may design the curriculum. Patients are exercising their autonomy

as never before and arrive at office visits armed with data and questions. Also, some surgeons find that their role is being marginalized due to the increased use of invasive nonsurgical procedures performed by other specialists. These changes are altering the physician-patient relationship. However, in many cases, the results are positive.

Recent progress

The College and other organizations have taken a proactive posture in encouraging leadership skills in surgeons. The close of the 2003 Clinical Congress signaled the start of the College's "Year of the Resident." During the subsequent 12 months, residents were welcome to participate in College governance by holding seats on standing committees and closely interacting with the Board of Governors. Recently, the ACS hosted a course on leadership for Fellows. Perhaps this program could be expanded to include residents, as does the upcoming ACS Chapter Leadership Conference. These activities provide Resident and Associate Members with instructive exposure to conflict resolution, negotiation skills, consensus building, and compromise. Similarly, the Association of Academic Surgeons (AAS) and the College will cosponsor a seminar entitled *The Tough Work of Leadership* during the 2005 Clinical Congress. Next winter, the AAS will hold an interactive training module entitled *Fundamentals in Leadership* at the Academic Surgical Congress 2006.

Clearly, these programs are timely, insightful, and enriching to all surgeons, but are they sufficient to meet the needs of surgeons in training? Both faculty and residents at certain institutions have pondered this question and determined that residents need more leadership training than they receive.

Recently, Baylor Medical Center developed and administered a survey to determine residents' perspectives on the importance of key leadership skills as well as their individual competence in each of those skills.⁵ More than 50 percent believed they lack competence in leadership skills. According to these residents (greater than 75% of respondents), ethics was the only skill area in which they believed they possessed more than minimal competence. These authors call leadership training a mandate. Leadership action was also described similarly in a recent review of the literature, which assessed the state of pediatric surgery training in the U.S.

and made recommendations on its reformation. In the final analysis, "persistent, bold, proactive leadership" was considered a mandate that will benefit physicians, patients, and their families. Baylor has now developed a "novel educational curriculum" for leadership training.⁶ This curriculum has proven successful in the environment of the 80-hour work week by establishing very specific objectives and criteria for evaluating the curriculum.

Other medical specialties have already adopted leadership training for their residents. At the Cleveland Clinic, internal medicine interns participated in a one-day teambuilding and leadership training retreat. Post-retreat questionnaires indicated "significant increases in attendees' agreement that good leaders challenge the process, make decisions based on shared visions, allow others to act, recognize individual contributions, and serve as good role models."⁷ Psychiatrists and pediatricians have had similar successes.^{8,9} These examples indicate a perceived need for leadership training in surgery and that a formal curriculum may be effective.

Leveraging requisite variety

Even with these strides at the national and local levels, an aspect of leadership development has been neglected. Periodically, we need to glance around our institutions and medical centers to notice our patterns for selecting new colleagues to join our teams. Is the diversity of the organization limited to administrative and ancillary staff? Have we opened ourselves to interactions and collaborations with individuals from other genders and ethnic groups?

The College, surgical programs, and medical institutions have demonstrated their openness to gender diversity but could do more to promote ethnic diversity. Examples of how women are gaining acceptance in the leadership of surgery include the election of Kathryn D. Anderson, MD, FACS, as President-Elect of the College, the inclusion of women on the ACS Board of Governors and Board of Regents, the appointment of women as department chairs and program directors at several institutions, and the acceptance of women into subspecialty fellowships. Nevertheless, the College believes that more can be accomplished, as evidenced by a recent study conducted by Olga Jonasson, MD, FACS, in cooperation with the College to determine whether the number of women in leadership roles in surgery is proportionate to their presence in the

field. Although women comprise 14 percent of surgeons listed in the American Medical Association Physician Master File, they fill only 2 to 4 percent of leadership positions in national surgical societies, represent 4.6 percent of ACS Fellows, and hold less than 7 percent of the director seats of the certifying boards of the American Board of Medical Specialties.¹⁰

The representation of African-Americans, Latinos, and other ethnic groups is less impressive. The historic and recent elections of LaSalle D. Leffall, Jr., MD, FACS, and Claude H. Organ, Jr., MD, FACS, illustrate the College's efforts. Yet, the American Association of Medical Colleges noted that of the 9,366 surgical faculty in 2004, only 3 percent were black, 4 percent were Hispanic (Cuban, Mexican, Puerto Rican, and multiethnic), and 0.14 percent were Native American.¹¹ Although declining enrollment of these underrepresented ethnic groups in U.S. medical schools does contribute to the problem to some degree,¹² many of these individuals would excel in positions of leadership. To do so, however, these individuals will need both mentoring and support. Embracing ethnic diversity as a resource remains an undervalued and underutilized avenue for competitive advantage, growth, and success. The reasons for this apparent lack of insight and the accompanying insufficient action remain unclear.

Dr. Souba speaks of observing the "Law of Requisite Variety," which tells us that survival is dependent on the capacity to move beyond tolerance of diversity and heterogeneity and actually cultivate and embrace them. "The organization should

// It unsettles most people to think that a changeless God imposes a changing pattern of our understanding.... //

Z.V. Kanisseril
and M.A. Kaallumpram¹³

always try to maximize its internal variety (or diversity)" because it "equips the organization to deal with change."² In general, surgery follows these principles. Our institutional boards often comprise individuals from disparate health care and non-health care backgrounds. Likewise, our operating room teams are composed of both physicians and nonphysicians. The potential for growth and success is a by-product of this structured conflict. Heterogeneity does lead to conflict, and many of us view conflict as a negative experience and, unfortunately, the process of resolution as a contest. Dr. Souba points out that, "Organizations and teams that learn to harness conflict and use it constructively come up with better solutions and more creative ideas."²

Perfecting preparation

Our profession faces the challenge of finding a way to adequately prepare surgeons and surgical residents for positions of leadership, whether within the academic institution or beyond its walls. This preparation must simultaneously advance an agenda of competence, compassion, and courage, while embracing the diversity that is very slowly permeating surgery. This diversity is more reflective of the communities from which we draw our patient base.

The topic of leadership and preparation of future leaders in the field of surgery is timely at this juncture. Surgery is under enormous external and internal pressures, including dictates from managed care organizations, a malfunctioning tort system, and reduced reimbursement from Medicare and other payors. Recent additional pressure has come from the heirs apparent of the field: medical




Dr. Cutter is a general surgery resident at New York Hospital Queens, Flushing, NY, and Co-Chair of the RAS-ACS Communications Committee.

students and residents. A much vilified 80-hour work week has made it more challenging to use current systems to deliver health care and declining enrollment in surgical residency programs has made the future uncertain. Collectively, these forces have squeezed much of the luxury out of the surgical lifestyle, instigated decreased job satisfaction, added more stress to the working environment, and, in some instances, have led to an exodus into new endeavors or retirement.

From dialogue to action

We find that inclusion of this topic in the ongoing dialogue with the College membership and constituency is essential. Thus, we leave you with what we believe are provocative thoughts that may lead to measured action to alleviate some of the challenges to budding surgical leaders.

- We need to reflect on and process sociopolitical issues that affect surgeons when determining how best to train young surgical faculty.
- The current medical environment poses new challenges to the profession, and we need a diverse group of surgeons to confront these obstacles.
- The standard criteria for selecting and process for developing surgeon leaders are outmoded. New approaches that embrace diversity are needed to address the unique forces confronting our specialty.
- It is important to maintain access to the knowledge and wisdom of more experienced College members while encouraging and developing the talents of Residents and Associates.

We hesitate to become the voice of the proverbial voiceless. However, we do hope that our observations will stimulate further discussion. There are signs that others are likewise interested in expanding the literature related to surgical leadership. The value of such written contributions will be evidenced by individuals who are thereby compelled to act. Each surgeon would benefit from a sense of purpose for the present combined with a prophetic concern for the future. 

References

1. Organ CH Jr: The interlocking of American surgery. An analysis of surgical leadership in the United States, 1945 through 1985. *Am J Surg*, 150(6):638-649, 1985.

2. Souba WW: New ways of understanding and accomplishing leadership in academic medicine. *J Surg Res*, 117(2):177-186, 2004.
3. Bickel J, Croft K, Marshall R: Developing Leaders in Academic Medicine. In: *Enhancing the Environment for Women in Academic Medicine* (online). Washington, DC: American Association of Medical Colleges, 1996.
4. Sun-tzu: *Sun-tzu: The Art of War: The First English Translation Incorporating the Recently Discovered Yin-ch' ueh-shan Texts/Translated with an Introduction and Commentary by Roger T. Ames*, First ed. New York, NY: Ballantine Books, 1993.
5. Itani KM, Liscum K, Brunnicardi FC: Physician leadership is a new mandate in surgical training. *Am J Surg*, 187(3):328-331, 2004.
6. Awad SS, Hayley B, Fagan SP, et al: The impact of a novel resident leadership training curriculum. *Am J Surg*, 188(5):481-484, 2004.
7. Stoller JK, Rose M, Lee R, et al: Teambuilding and leadership training in an internal medicine residency training program. *J Gen Int Med*, 19(6):692-697, 2004.
8. Steiner JL, Mazure C, Siggins LD, et al: Teaching psychiatric residents about women and leadership. *Acad Psychiatry*, 28(3):243-246, 2004.
9. Lee MT, Tse AM, Naguwa GS: Building leadership skills in paediatric residents. *Med Educ*, 38(5):559-560, 2004.
10. Jonasson O: Leaders in American surgery: Where are the women? *Surgery*, 131(6):672-675, 2002.
11. American Association of Medical Colleges: Table 16: Sex, Race/Hispanic Origin, and Department. In: *U.S. Medical School Faculty, 2004*. Washington, DC: AAMC, 2004.
12. Ford HR: Mentoring, diversity, and academic surgery. *J Surg Res*, 118(1):1-8, 2004.
13. Kanisseril Z, Kaallumpram M: *Glimpses of Mar Thoma Church History*, First ed. New Delhi, India: Kalpana Printing House, 2003.

Dr. Upperman is a pediatric surgeon at Children's Hospital of Pittsburgh, PA, and Immediate Past-Chair of the RAS-ACS.

