Leadership in academic medicine: reflections from administrative exile

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ABSTRACT – Physicians are drawn into diverse leadership roles in academic medicine, but little in our education and training prepares us for these responsibilities. Fortunately, there is growing convergence in the literature on the attributes of successful leaders for knowledge-based organisations. Top-performing leaders seem to be self-effacing team-builders who eschew rapid-cycle strategic planning and management trends, focusing instead on strategic and incremental changes that will gradually transform their organisations. Academic physicians and search committees often concentrate on personal achievement and intellectual or technical mastery in research and clinical care. In contrast, the literature on leadership suggests other-directed skills matter more, eg mentorship, learning and teaching competencies, and so-called emotional intelligence. As a corollary, teaching hospitals, universities, and professional colleges or societies are long-term organisations with a rich history. Leadership in such a context demands stewardship of tradition along with patient pursuit of changes required to ensure that the organisation evolves successfully.

KEY WORDS: academic medicine, collegiality, healthcare management, leadership, organisational behaviour, sociology of professions

The need for leadership

In 2006, it is probably superfluous to articulate the need for excellent leadership in all spheres of human activity. Among those spheres is the broad realm of universities, teaching hospitals and clinics, professional schools, societies and colleges that might together be termed 'academic medicine'.

In academic medicine and healthcare in general, serious challenges are being faced across industrialised nations. We care for an ageing population characterised by a growing burden of chronic diseases, high expectations of modern medicine, and the culture of comfort and entitlement that defines our post-war generations. The promise of post-genomic or individualised medicine has yet to be fully realised, and we are instead still mired in an era of what Lewis Thomas called 'halfway technologies' – interventions that palliate or mitigate a disease process, but do not offer either a definitive cure or a transformative improvement in health status.[1] Thus, as the positive powers of halfway medical technologies have grown, so too has our capacity to do harm and spend inordinate amounts of money for small marginal gains in health status.

Our reliance on public funding has added weight to societal demands for greater transparency and accountability. We are accordingly subject to close and critical scrutiny through the convergent activities of the general and medical media, the courts of law, commissioners and public auditors, and various layers of administration inside and outside our academic and clinical enterprises. Moreover, the rapid sharing of information and misinformation across the world-wide web and the internet has intensified the pressures of practice and administration.

Other challenges include emerging or re-emerging infectious diseases, the pace and stress of wireless communications, the tensions inherent in the complex teamwork that is now the norm in patient care, the non-alignment of incentives for clinical and academic work in the healthcare system, and the reasoned refusal of many younger physicians to embrace the workaholic behaviours of past generations.

All these cross-currents swirl in the rushing stream of priorities that characterises life in every contemporary academic healthcare enterprise, as clinical, teaching, research, and administrative imperatives compete for our time and energy.

How can physicians rise effectively to these systemic challenges rather than merely surviving them as individual professionals? Unfortunately, the curricula of most medical schools offer little in the way of leadership and management education to help them do so. The British National Health Service (NHS) deserves credit for implementing the first large-scale leadership development programme for the healthcare workforce with the creation of its NHS Leadership Centre (NHSLC). That said, the Centre's electronic guides seem to be focused more on clinical quality management within the NHS framework, than on the development of broad leadership skills.[2]

Organisational science?

Physicians and other health professionals with a scientific background may well be sceptical about the literature on management, leadership, and organisational behaviour more generally. In this field, randomised experiments are virtually impossible, prospective quasi-experimental designs seem to be very rare, and the evidence available is largely observational, with varying degrees of rigour in the retrospective manipulation of the data. Nonetheless, convergent observations from management professors and social scientists have delineated some of the characteristics of successful leadership for private and public enterprises.

Two additional caveats are relevant. First, the characteristics of effective leadership seem to be reasonably consistent for complex knowledge-based enterprises in different sectors and settings. However, one need only consider Sir Winston Churchill's comparative popularity and effectiveness as a wartime and peacetime leader of the United Kingdom to recognise that context still matters. There is not one leadership genotype or phenotype that perfectly fits every circumstance.

A related limitation is that any theorising about leadership and management will never fully capture the complexity of social reality. Critics sometimes contrast social science and its competing schools of thought with the consensus-based theories and empirically-grounded progress of the physical and life sciences. This essay is not the place for an exegesis on comparative epistemology; however, one helpful heuristic may be to consider different social theories not as competitors for the status of dominant paradigm, but as complementary perspectives.[3] In that regard, for example, the literature on leadership has a complementary counterpoint in a growing literature on 'followership'.

As a corollary, these brief reflections should be clearly understood as merely one academic physician's thoughts on leadership, grounded in a limited review of a literature of uneven quality, and aimed unapologetically at a general audience comprised primarily of medical colleagues!

Leadership and management

Such disclaimers about incomplete truths are nicely applicable to a dichotomy that is conceptually weak but also helpful so long as we do not lean on it too heavily – the difference between leadership and management. Most effective managers do have leadership roles and characteristics. However, for purposes of this overview, some differences can be highlighted.

Managers are often viewed as implementers, with a more incremental and tactical or operational focus, while leaders are characterised by their wider-angle perspective and strategic focus. This distinction is captured in the old aphorism that 'managers do things right, while leaders do the right thing'. For reference Table 1 sets out in brief some distinctions between management and leadership.[4]

Managers are usually situated within specific hierarchies, with defined authority and reporting relationships. Intriguingly, leadership is often exerted by individuals who do not fit easily into organisational hierarchies and who may have limited formal authority. Most physicians have worked at some point with leaders who were not particularly adept at management, but who had an ability to win loyalty and carry others with them through their clarity of vision, generosity of spirit, and 'people skills'. Ironically, then, leadership may be most obviously exerted when others follow a person who has no direct authority over them, and may be less important in strictly hierarchical organisations where managerial discipline prevails.

Organisation and motivation across different sectors and structures

Much of the literature on leadership and management originates from the business world. Debates about economic markets and the role of for-profit versus non-profit enterprises continue to swirl, but the world has changed profoundly. Whether in the public or private sector, many of us spend our lives in large complex organisations that are based on the generation and use of knowledge. I believe the social theories of Max Weber (1864–1920) remain helpful in understanding such organisations.

Weber highlighted the roles of economic rewards, as well as autonomy or self-efficacy and personal status, as powerful motivators of behaviour. He contrasted bureaucratic or hierarchical organisations, using the military as an extreme manifestation, with collegial organisations such as the academic and consulting professions.[5] A moment's reflection highlights the extent to which our profession, in both its clinical and academic roles, has embraced collegial organising principles. In that respect, Weber and other sociologists[6,7] have not always been kind in characterising our mode of occupational organisation. While professional bodies are usually democratic in their internal governance, Weber suggested that they were generally set up to take over power and insulate the group from other forms of democratic societal authority. Collegial bodies and related forms of professional self-organisation have also been criticised as promoting or perpetuating the mythology of an equally superior and altruistic group that can be trusted to regulate itself in the public interest, while rejecting efforts to hold the members accountable to society at large.[5–7]

Table 1. Leadership versus management.[4]

Managers	Leaders
Working in the system	Working on the system
React	Create opportunities
Control risks	Seize opportunities
Enforce organisational rules	Change organisational rules
Seek and follow direction	Develop shared vision
Guide people well	Align and motivate people
Coordinate efforts	Inspire and energise
Offer instructions	Coach and empower new leaders

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Those criticisms aside, what is intriguing is the extent to which many modern private-sector organisations have moved away from formal and hierarchical forms of management, and begun to function on more of a collegial basis. Indeed, one could argue that in the modern era of service economies, when knowledge-based industries and innovation are the norm, command-and-control organisations in general are in decline. They have been undercut by the pace of technological change, by globalisation with the attendant need for networked organisations, by the primacy of technical expertise and the convergence of disciplines in many enterprises, and by the recognition that creative teamwork and continuous learning are essential for innovation to flourish and move a knowledge-based enterprise forward. Of course, bureaucracies are still prevalent, particularly in the public healthcare enterprises with which academic medicine is necessarily intertwined. However, there is at least a growing sensibility that an ethos of command-and-control is counter-productive even in the public sector.

Implications for leadership

The result of this change in organisational dynamics has been a clear shift in thinking about effective leadership. Celebrity chief executive officers – exemplified by Jack Welch from General Electric, or Lee Iacocca from Chrysler – will always be with us. But experts in organisation theory have increasingly questioned their effectiveness. Henry Mintzberg[8] for one has postulated that:

> *maybe really good management is boring. Maybe the press is the problem, alongside the so-called gurus, since they are the ones who personalize success and deify the leaders (before they defile them).*

Mintzberg has further argued that in managing professionals and other knowledge workers, what is needed is inspiration, not traditional supervision. In 1998, he described this approach as 'covert leadership'[9]:

> *managing with a sense of nuances, constraints, and limitations ….That's because in this world of professionals, a leader is not completely powerless – but neither does he have absolute control over others. As knowledge work grows in importance, the way an orchestra conductor really operates may serve as a good model for managers in a wide range of businesses ….This is the role of the covert leader: to act quietly and unobtrusively in order to exact not obedience but inspired performance.*

In academic healthcare, and particularly the university environment, these comments seem intuitively plausible. Success is achieved by power of reason, not by reasons of power obtained and wielded. Colleagues are influenced and persuaded, not coerced. Last, their motivation may have more to do with earned autonomy and public peer recognition, than with economic rewards or praise from any authority figure.

'Good to great' leadership

These ideas are reinforced by the findings of Jim Collins and his team as summarised in their best-selling book, *Good to great: why some companies make the leap … and others don't.*[10] The book suffers from the over-generalisations and catchphrases that blight much of the management literature. However, it also uses a reasonably rigorous quasi-experimental design with a 30-year performance horizon. The core comparison is between matched pairs of companies: eleven that showed remarkable and sustained earnings growth, and eleven from the same industry that did not. Six other companies were used as exemplars of non-sustained success. Collins' methodology also involved elements of blinding in the coding of companies' attributes such that the usual risk of post-hoc inferences was reduced.

A review of the strategies for success outlined in Collins' analysis is outside the scope of this brief article. Some are not directly applicable to public enterprises with mixed missions such as teaching hospitals and universities, as his companion monograph acknowledges.[11] What is encouraging is the consistency of Collins' levels of leadership formulation with other sources and analyses (Table 2). Collins' Level 4 leader is clearly effective: few would dispute the contribution of a leader who 'catalyzes commitment to and vigorous pursuit of a clear and compelling vision' or who 'stimulates the group to high performance standards'. Among these Level 4 leaders were some charismatic individuals who attained celebrity status. In contrast, the Level 5 leaders were generally low-profile. Collins emphasised that these unassuming

Table 2. Jim Collins' levels of leadership.[10,12]

Level 1
A highly capable individual who makes productive contributions through talent, knowledge, skills and good work habits.
Level 2
A contributing team member who contributes individual capabilities to the achievement of group objectives and works effectively with others in a group setting.
Level 3
The competent manager who organises people and resources toward the effective and efficient pursuit of predetermined objectives.
Level 4
An effective leader who catalyses commitment to and vigorous pursuit of a clear and compelling vision, stimulating higher performance standards.
Level 5
The executive who builds enduring greatness through a paradoxical blend of personal humility and professional will.

individuals took full responsibility for the failures of the enterprises they led, while reflecting credit for successes on all those around them.[12]

Level 5 leaders were usually promoted from within their company. They placed a particular emphasis on recruiting strong leadership teams, focusing only secondarily on vision and strategy. That approach aligns with a managerial mindset of incrementalism and continuity. Perhaps because they had an insider's perspective, these leaders did not favour an overnight redesign of the company based on management trends or a drive-by assessment from some external consultants, nor did they embrace rapid-cycle strategic planning. Instead, they hired other excellent leaders who collectively moved the enterprise forward on a gradual basis, aiming to build steady but inexorable and positive momentum.[10,12]

Another facet of these leaders was their generation of an internal culture of discipline. Collins characterised this as freedom within a framework of responsibility for achieving agreed objectives. Where people are self-disciplined, hierarchy and bureaucracy can be reduced. And where their actions are disciplined, the need for internal controls is reduced, allowing greater creativity and productivity. This organisational strategy, of course, is highly consistent with collegial self-regulation or the management models used by professional services corporations.

In short, while there are definite differences in structures and incentives between the for-profit corporations that Collins studied and the types of enterprises that predominate in academic medicine, the successful leadership attributes described by him seem entirely consistent with those that, intuitively, are best suited to our sphere.

Physicians as leaders

At first glance, physicians should be natural managers and leaders. The process of selecting, educating and training physicians favours industrious individuals with superior intelligence, the ability to solve complex problems, and basic communication skills. Along the way we learn to deal with emotional or stressful situations, and to navigate complex networks of physician colleagues and other professionals. As noted earlier, the nature of our profession means that collegiality trumps ordinary bureaucratic controls, with the result that our occupational genotype is propitiously aligned with modern leadership thinking. Last, academic physicians can also draw on their educational and research skills when they assume leadership roles.

Yet, it is also the case that physicians in general are sometimes stereotyped as poorly suited to managerial or leadership roles. Many colleagues spend the latter part of their careers as resentful cogs in large organisations. Others appear to be reasonably effective at lower- and mid-level management functions, but do not move to top-level executive or leadership roles. Thus, one might reasonably ask: what pitfalls could limit the potential effectiveness of physicians as managers and leaders?

Clinicians must be problem-solvers working one case at a time. In contrast, senior executive positions generally demand a systemic view, looking first for general patterns and only secondarily for the anomalies and variations. Physicians may also be prone to underestimating the value of others' expertise. In recent years many in the profession have tended to dismiss the validity of evidence that does not conform to the latest epidemiological catechism. As well, our self-worth is validated by the manifestly vital importance of our work and the deference that others still sometimes show us. We can fall prey to assumptions about our own infallibility.

On the positive side, we are accustomed to managing uncertainty and solving problems with incomplete information. In so doing, however, we can grow complacent, and conflate our own ignorance with deficiencies in the available evidence. This sloppiness sometimes escapes detection in the clinical context where the individual patient may not challenge the physician. But it is almost always exposed if and when physician-managers try to bluff their way through complex organisations and groups of expert colleagues.

Another challenge for physicians is our focus on high personal achievement and intellectual mastery. The recent literature on leadership suggests that emotional intelligence counts as much or more than cognitive or technical skills. Goleman[13,14] has written extensively on this issue, identifying components of emotional intelligence such as self-awareness, self-regulation, motivation, empathy and social skill. His work is worthy of study by anyone interested in leadership.

As a corollary, Souba[15] has noted that academic medicine has traditionally focused on achievement-oriented abilities when choosing leaders, eg international academic stature, personal track record in research, and core clinical competency. Prospective leaders are expected to appreciate teaching, but the expectations of their personal teaching skills and mentorship commitment are often modest.

In contrast, leadership in today's academic healthcare arguably requires a set of attributes that may be much harder to measure than, say, the cross-product of publication counts and impact factors on an academic curriculum vitae. Important skills include consensus-building and conflict resolution, and the conceptual capacity to respond effectively to rapid changes in the working environment. These competencies in turn must be built on a platform of emotional competence and resilience, and a strong sense of other-directedness, including listening, learning, and teaching skills, and a commitment to mentoring and promoting others. Assessing these attributes requires a different process than most academic or clinical search committees currently follow.

Some concluding reflections

Over the course of the last fifteen years I have had the privilege of working alongside some very gifted leaders in academic healthcare. Recognising that personal observations and reflections are a weak substitute for systematic data collection and rigorous analysis, I hope nonetheless to be forgiven for a few synthetic comments and maxims in the concluding portion of this article.

Excellent leaders have a talent for avoiding 'transactional traps'. In that regard, low-level problem-solving is the crack cocaine of leadership: instantly gratifying, highly addictive, but not very constructive in the long run. Effective leaders seem to distinguish constantly among issues that are tactical, operational, and strategic, and prioritise the latter.

Leadership in academic medicine is often best exercised from behind by creating opportunities for the organisational and intellectual vanguard. The personalities of members of this vanguard can be a challenge. Our most innovative and creative colleagues must sometimes be coached or cushioned so that they are not bruised if and when they bump against the rigid elements in any large organisation.

It is axiomatic that any executive also needs to choose his or her battles wisely. As already noted, leadership in this sphere depends much less on authority or power, and much more on goodwill and respect. Picking the wrong battle can do enormous harm. Conversely, physician-leaders sometimes skirt personnel problems involving other physicians. Suffice to say that organisational rogues and bullies, along with visible under-performers, can do more to sap the morale of an organisation than any budgetary crisis or public scandal.

At risk of promoting one of those glib formulations that appear in low-brow management manuals, I would also suggest that excellent leaders always use 'the three scopes': they apply an organisational microscope to review fine details that matter; they mount a conceptual telescope for the long view – a view that encompasses both the organisation at a distance, and the wide environment that shapes each organisation and the individuals in it; they have a personal periscope so that in those moments when the organisation and its leadership team are deeply submerged in some issue or crisis, they still have a clear view above the waterline in all directions.

Finally, outstanding leaders in our realm all seem to possess a keen sense of stewardship. Nowhere is that sense of stewardship more appropriate than in long-term organisations with a rich history such as the Royal College of Physicians, the world's first-tier universities and their health-related faculties, and the great teaching hospitals that can be found in so many nations. In these contexts, leaders must balance the preservation of valued traditions with the patient promotion of changes essential to the evolution of complex institutions. Put another way, today's leaders of academic medicine have the unique and humbling privilege of building on the work of many previous generations, and the great fulfilment of laying foundations for tomorrow's stewards of our profession and our organisations. There are few roles as challenging, and fewer still that are as rewarding.

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