Types of Leadership and How to Use Them in Surgical Areas

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Clin Colon Rectal Surg 2020;33:228–232.

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Abstract

Surgery is a very complex, changing, and, sometimes, threatening environment. Emotional intelligence is a key skill for surgical leaders. Authoritarian, hierarchical, transactional, transformational, adaptive, situational, and servant–shepherd leadership can all be used in surgical leadership. Patient care must be the priority for surgical leaders.

Keywords

- VUCA
- surgical leader qualities
- types of leadership
- patient care

Even though a newly graduated surgeon may have finished training at a very reputable institution, it is likely the leadership training has not been part of their formal training. As new faculty or as a rising star in a new institution or transitioning from a staff surgeon to a leadership position, one may soon discover that residency training has not empowered one to be a leader. A gifted professional with excellent skills does not automatically become a great leader. Unfortunately, while medical training provides the means to develop skills for treating patients, whether at the bedside or in the procedure room, it does not routinely offer leadership training. Physicians are supposed to learn from their successful leaders. The military provides officers with schools that focus on leadership skills. Executives receive leadership skills training as business school graduates.

Leadership is defined as "the act of leading." The act of leading, in the end, is the ability to achieve the intended results. It is guiding followers to a common goal. Successful leadership requires application of specific skills, depending on the task at hand and several other factors such as setting, urgency of the task, team makeup, and level of communication.

The Changing Environment of Surgical Practice

The historical model of training a surgeon involved learning in an apprenticeship model from one or more surgeons followed immediately by starting a practice. The surgeon was the uncontested leader at the top of a pyramidal structure of power, where feedback was scarce, hospital management was all enabling, and changes were slow to occur. Classic surgical teaching was a reality during the career of some surgeons still in practice. The actual surgical work was hands-on, with less need for documentation, based on personal experience, and decisions typically went uncontested as long as patient outcomes were reasonable. However, this paradigm changed with the arrival of technology, data, and means of immediate communication.

Technology

The introduction of new medical technology relevant to surgery led to changes in the design of clinics and operating rooms, methods of interaction with support staff, and overall workflow. The increased level of complexity required more and more reliance on new personnel specialized in ancillary services. Advances in medical technology changed surgical practice such that procedures once performed by surgeons were transferred to other disciplines. This has led to new professional interactions and intensely technical interprofessional collaboration.

Data

Surgery was considered an art of healing, and not a lot of data were available to measure outcomes. Less than 100 years ago,

Issue Theme Leadership; Guest Editor: James W. Fleshman, MD, FACS, FASCRS

DOI https://doi.org/10.1055/s-0040-1709457.
ISSN 1531-0043.

few surgeons were truly data-driven. Availability of computing and low-cost data storage and processing led to the accumulation of a large amount of information. Analysis and comparison are possible. Metrics have been established, leading to greater surgeon accountability, sometimes without surgeon input. Arbitrary decisions taken by influences outside the surgical profession directly influence surgical practice. Increased accountability due to more regulation and the need for compliance burden the surgeon now more than ever before.

Communication

Radical changes in technology in the last decade have resulted in improved and increased communication between peers, surgical and medical team members, and social and academic groups. It has changed the way marketing and advertising are done. Regulation of new communications is lagging. Access to medical knowledge is getting easier and immediate. Even so, the amount of knowledge gathered is staggering and hard to digest.

Technology, data, and communication pathways are improving at an accelerating pace, creating the basis for change in the concepts of the practice of surgery.

We exist in an environment that is volatile, uncertain, complex, and ambiguous (VUCA). While VUCA was described to reflect the war zone attributes in the 1990s, this combination can be used to describe business and the practice of medicine. Leadership has become more decentralized, with many internal and external factors influencing practice. Leadership has become a collaboration between surgeons, nurses, and hospital management in the setting of certain constraints from legal issues, regulations, costs, technology limits, electronic medical record, hospital system and insurance mergers, and changes in medical insurance. New technologies enter the field at a faster pace, which requires retraining of the surgeon and personnel. As the system becomes more complex, costs are rising.

How do we train and retrain leaders to answer the current challenges? And where do we go from here?

The Multiple Facets of a Surgeon

Before we decide on the ideal surgical leadership profile, we need to first have a complete 360-degrees view of the typical surgeon. The lay public think of a surgeon as someone who spends all or most of their time operating on patients and are unaware of the complexity of the components of surgical practice. The surgeon is a moving pivot between the operating room and various treatment units in the inpatient and outpatient setting. A surgical practice is inevitably connected with other related nonprocedural activities that are integral to a surgeon's performance. Most surgeons work in a group of peers; even someone in a solo practice must interact at various levels with surgical peers, consultants, referring physicians, intermediaries dealing with insurance companies, managed care, and so on. Depending on the scope of practice, there is also mentoring, education (university or postgraduate setting), research, professional society membership, editorial work for journals, outreach in the local community, and marketing. The surgeon interacts with hospital administration and may serve in various hospital committees. Each of these facets of activity requires interactions with specific professionals, who, in turn, must interact with multiple physicians.

Functioning in a variety of contexts requires different interrelational approaches specific to each setting, which is why leadership is not a predetermined single method. We tend to confuse soul with "persona." What is a persona? It is a Latin word referred to a theater mask, and later it was ascribed to a role. We are required to become different "personas" in different situations.

Physicians in a Complex World

The traditional medical world is transitioning, with accelerated change, to new paradigms and ways of practice. A physician can be "trapped," as can business leaders in similar circumstances, in a few patterns:

- The practice environment is changing quickly with new demands, while the physician is slow to react in their practice placing the physician(s) in reactive mode, unable to plan for growth or even for the next upcoming change.
- The uncertainty in the VUCA system creates fear of making decisions that could negatively impact the practice. This eventually brings the practice to a standstill.
- The physician leader tries to manage everything (or micromanage), resulting in an impairment of focus and poor leadership decisions due to lack of foresight.

Any of these scenarios that cause "standstill" in a moving world eventually results in being behind.

Qualities of a Surgical Leader

Any surgeon will be the leader of a team delivering specific care to patients. Therefore, leadership in surgery is pretty much unavoidable. If that is the case, what does a surgeon need to be a leader?

It is widely believed that a great leader should have some of the following traits: charisma, extroversion, a big ego, a high intelligence quotient (IQ), and physical size. Arguably, some of the great leaders have some of these traits; even then, any one of these traits is not sufficient in itself and sometimes can work against the performance of a leader. Some of the most successful leaders do not display any of the aforementioned traits. This is because charisma without substance is not enough, extroversion can be in the way of listening, a big ego might annihilate good insight, and high emotional intelligence (EI) is better than high IQ. Physical presence is more important than physical size, as we know that some of the more authoritative leaders in history were not tall.

Some of the traits necessary to be a successful leader include vision, flexibility, selflessness, motivation, EI, empathy, adaptability, growth, confidence, reliability, accountability, influence, judgment, and management.

Leadership should not be confused with management. Management is an intrinsic part of any leadership activity. However, a leader is typically a good manager, though the opposite is not always true. Management used to be the act of directing people who do not think on their own. In the current age of complexity, this is no longer practical. Fulfilling a certain vision requires, beyond management, advanced interaction with followers, facilitators, and other leaders. A strong insight is essential: knowing one's personal goals as a leader (vision or visions), finding the personal motivation to pursue the goals, and so on. Confidence in one's ability must be countered with honest self-assessment, which leads to adjustments as needed. These skills are essential to avoid straying from your own self and from the followers. Ideally, leaders should know their own true static position and dynamic direction at all times. In real life, leaders get lost even if they are diligent with self-assessment in real time; they must question whether they are on the right track—by themselves and by using the skills of a mentor or a coach who can candidly give them the "lateral view." We all have blind spots in our self-assessment, whether static or dynamic, and mentors can help by pointing them out. A good mentee should never be offended by the opinion of a mentor, and a good mentor should not expect the mentee to adopt all advice. Reliability and accountability are important traits, as followers need a beacon of reference, and a personal example, as we hope that followers will respond by being both reliable and accountable themselves.

Empathy and EI are required for communicating goals and values and receiving feedback. Organizations are becoming more diverse, and medical institutions have been at the forefront of diversity. How the message is passed through both ways varies according to culture, gender, and generation, which is to say that one message and one reaction do not fit all (they never did). The trap here is to wrongly assume that someone who belongs to a certain group will behave or react in a certain way, as the anthropologists found out. Empathy and EI help us overcome the biases we might have and thus avoid disasters in communication.

The Essence of Leadership

The leader should be capable to formulate a vision for the organization to set goals according to the vision and then lead the followers to achieve the set objectives while keeping the team together and making sure that the team can perform optimally while maintaining the well-being of its members. The thoughtful leader will try to best understand the situation at hand by creating a mental model that fits most of the reality and is simple enough to be conveyed and understood (including the chronology and causality of the events), to analyze possible actions and their consequences, and then to act suitably. Different scenarios require the use of different types of leadership.[1]

Types of Leadership

Major leaders have been characterized to have certain styles or types of leadership. This approach is good for examples and retrospective analysis. However, in the current changing and more complex world of medicine and surgery, the leaders must be prepared to use different styles for different situations without any fear of judgment. Leaders should also be able to recognize different styles of leadership to be able to collaborate with, and sometimes counter, other leaders in their organization(s).

Authoritarian leadership is the type of leadership where the leader has full control over setting goals, directing all activities and teams, and enforcing goals, with minimal or no input from the followers. This has been the workflow for individual surgical practices in history and some of the well-known surgical schools. However, this type of leadership is not sustainable in the long run. However, a surgeon has to be ready to assume authoritarian leadership in situations of urgent crisis (whether in the operating room, emergency room, acute care) and in situations where there is no margin of error, such as during risky procedures or risky parts of procedures where the stakes are high. Since this type of leadership is not well received, clarity of communication is of utmost importance, stressing the reason why the surgeon has to switch into the authoritarian mode. This is essential especially if the change of style happens due to an unexpected turn in a patient's condition that requires different focus and skillset.

Mass casualty is another scenario that requires authoritarian leadership until full control is gained, especially in hospitals where mass casualty is a rare event. The team has to be briefed by the surgeon leader, who has to clearly define the layout and the mode of operation of the team and enforce that model. However, the surgeon in charge can opt to deploy a hierarchical leadership style in this situation.

Authoritarian leadership is also necessary if the level of skill of the followers is very low for the tasks at hand, which is when strict guidance and supervision is needed, especially when providing patient care where the team comprises trainees. However, the trap for a leader is to assume that the skillset of the followers will always be low, and the authoritarian approach will be needed for a long term. Authoritarian leadership leads to diminished team member feedback and aspiration for improvement and, eventually, high staff turnover. The incoming staff will be inexperienced, reinforcing the belief of the authoritarian leader that staff will never be up to par as a self-fulfilling prophesy. The proper long-term goal is to improve the skillset of the team to the point where authoritarian leadership can be relinquished in favor of a more enabling leadership style. The operating room is the perfect example of such a team.

Hierarchical leadership is a structure in which the power and the decision-making in the organization belong to specific positions in the structure. In some cultures, hierarchical leadership is the norm in business as well as surgical departments. Hierarchical leadership is prevalent in highly complex and regulated systems (such as university or health care system administration, government agencies, regulatory agencies, insurance agencies), which function according to a strict set of rules that are enforced by specific individuals. The surgeon might be part of hierarchical leadership (chief of department, hospital committees) and subject to hierarchy

rules as a leader and follower. The surgeon will have to interact with such structures, where proper knowledge of these systems, their rules, or their mode of communication must be well understood to achieve good cooperation. The surgeon must be ready to delegate the interaction with some of these entities to other professionals versed in these structures.

Hierarchical leadership can be used at the surgical practice level, where a person is in full charge of a set of tasks with the proper accountability. Also, hierarchical leadership is a very efficient model in a situation of mass casualty However, building a model of hierarchical leadership in preparation for a possible mass casualty event requires training of the entire team, with proper feedback to ensure efficiency.

Transactional leadership is based on results within a structure (such as a hospital or health care system), metrics and performance at the individual and group level, and conditioning rewards upon results. The most prevalent way this is present in the current health care system is conditioning part of the compensation of various professionals on meeting the quality benchmark in patient care. As medicine (and everything else) becomes more data-driven, there will be more and more metrics available to be used as incentives. Transactional leadership is useful in promoting incremental improvement in quality and efficiency in the system.[2] The success of transactional leadership hinges upon good choices of metrics, which best reflect the goals set in system improvement. Metrics are not always popular with the followers. Therefore, to effectively implement metrics, the team needs to fully understand why they are used and what goal they serve, and the leaders should be subject to the same metrics as the followers, where applicable.

Transformational leadership is necessary where a major change from within is needed in the organization. Transformational leadership is the approach where the leader induces the followers and ultimately him/herself to elevate themselves to the next level of patient care).[3] It requires the leader to walk the talk, inspire and motivate, empathize, challenge innovation, and be creative.

Adaptive leadership applies to a culture of readiness and commitment[4] while facing challenges from outside. This happens when the leader and the team have to adapt to changes in the organization, such as mergers of practice and groups of physicians or hospitals, changes in payment and reimbursement, new regulations that impact workflow or patient care, new medical technologies, and new approaches resulting changes in the standard of patient care. The surgeon needs to prepare for such changes, be aware of timelines for change, and have the appropriate teams to deal with modifications in practice. The goal is to survive.

On a more daily basis, the surgeon can be involved in adaptive leadership at the bedside. This happens when a patient needs to make radical changes in lifestyle, habits, or compliance. The surgeon (and the team) has to enable the patient to understand the need for change and to facilitate access to the appropriate tools to ensure that change will happen, enrolling the patient's support system and ultimately the patient him/herself.

Situational leadership is characterized by the leader's use and support in accord with the type of task at hand and the skill level of the followers. Some surgeons are situational leaders in all circumstances, whereas others have to switch to this style in certain situations, especially emergencies. The more common are emergencies as part of being on call, with inherent variability depending on the day of the week, the time, and the patient load, or emergencies superimposed on a routine elective schedule. Less common situations include acute personnel or material/supply shortage, natural disasters, and armed conflict. In addition, any deployment of a medical and surgical team in an area of calamity is managed mainly by situational leadership, even if there is a hierarchical structure in place.

Servant leadership is the cornerstone of compassionate health care. It requires empathy, awareness, persuasion, stewardship, and the sense of community).[5] However, servant leadership is also used for the needs of the organization and the needs of the followers to enable the followers to reach their goals.[6] The goal of the leader is the success of the followers.

Shepherd leadership is the act of leading from behind, by enabling followers in areas where they are the strongest, while focusing on the team and intervening swiftly where the leader's help is needed, without isolating themselves from the followers. The leader must be fully engaged, and the followers need to have the trust that the leader ultimately assumes full responsibility when it is required.

A Combination of Leadership Styles

Once we have defined various leadership styles (and, arguably, not all of them), we realize that in everyday life, leadership does not conform strictly to one style. Certain tasks require the fusion of two or three different styles, as long as they do not contradict or invalidate each other. The surgeon must show the awareness and empathy to fashion how much of one style or another is appropriate in each situation.[7]

As we move toward multidisciplinary teams, surgeons need to collaborate with other professionals and sometimes other surgeons. Complex surgery might require collaboration of multiple surgeons from different specialties (all of which have a slightly different subculture). Inherently, different leaders come in with different levels of experience and different leadership styles. Divergent styles can impact patient care as they can generate confusion and miscommunication. Expectations of one leader might not converge with those of another. Followers might find it difficult to deal with what seems to be divergent tasks. To achieve the best outcome, leaders have to harmonize their approach, preferably by laying out goals, roles, and expectations before the team goes into the execution mode. Good multidisciplinary teams typically have protocols in place, whether written (preferably) or oral. Good communication is essential to avoid missing out on key parts of the patient management or is the opposite, that is, redundant work, which is a time drain.

A Call for Simplicity

In a world that is becoming more complex, some call for simplicity.

Ultimately, a leader, and for that matter anybody else, should know when to do one of three tasks, that is, when to lead, when to follow, and when to facilitate, and sometimes a person needs to switch from one role to another during the execution of a complex task. A good leader must learn how to follow (and that, eventually, will improve his/her leading skills). Give the followers the lead and they will understand better how to follow.

Ultimately, the mission of surgeons is to take care of patients. Students in flight schools are taught that in an emergency while airborne, they should never forget to fly the plane. No matter what the leadership crisis might be, surgeons should continue to treat the patient as the first priority.

Conflict of Interest
None declared.

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