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Leading in Healthcare: A Personal Choice

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"An organization cannot be what its leader is not."

Leadership is one of those things that when done well, we know it, but when done poorly, it is the root of much of what ails us in healthcare. When done well, we see leaders that walk the talk, can articulate their organization's vision, and can be human, vulnerable, authentic, and truly elevate the environment to one that is respectful, safe, productive, and caring. When done poorly, we see results that are mediocre, people afraid to speak up, high staff turnover, complacency, and much worse.

Leadership is frequently used to describe a position of authority, or an activity reserved for certain people or roles in an organization. We hear reference to "leading culture change" and the notion of "leading an improved patient experience" is getting more and more airtime. It is not unusual to hear individuals or groups state that if leadership or the leaders of the organization were doing a better job, really understood the work, or "walked a day in my shoes" that our delivery of care would be safer, more efficient, and more human. There are a plethora of leadership courses, classes, books, retreats, and self-help guides.

It strikes me that the word "leadership" is overused and not very well understood. I would like to propose that part of the problem is a lack of understanding of the word(s) we are using.

What is leadership anyway? Let's start with what it is not. Leadership has nothing to do with seniority or position. I hear too much talk about leadership referring to the senior most executives or clinicians in a hospital. I have seen examples of more authentic leadership from a third-shift oncology nurse, a first-year medical student, and a 30-year housekeeper than I have from some seasoned (long tenure) occupants of the C-suite.

Nor is leadership about managing people. For sure, managing is critical to running a safe hospital; we surely need to support managers to plan, measure, coordinate, hire, and fire, and develop a myriad of other competencies to manage resources. But this has nothing to do with leading people or leadership.

Leading is a verb, not a noun. Put another way, you have to do it.
I subscribe to the notion that leading includes a personal commitment to change the world (however you define the world—yourself, your church, your home, your hospital, your practice) through influence and example that maximizes the efforts of yourself and others around you and that achieves the change as you've articulated it.

According to Steve Farber,[1] author and business leadership expert, "extreme leaders approach the act of leadership as you'd approach an extreme sport: learn to love the fear and exhilaration that naturally comes with the territory." Steve goes on to suggest that to really be a leader, you need to seek opportunities that will stretch you, enable growth, and ultimately cause a certain amount of fear (within you).

This way of thinking resonates for me in the work of leading to improve the patient and caregiver experience in healthcare. As we complete organizational assessments and listen to hospitals and health systems describe their current state, much of what we hear is about the fear of speaking up and having a different

[1] Steve Farber is the author of *The Radical Leap*, *The Radical Edge,* and *Greater Than Yourself, see www.stevefarber.com.*

opinion, the fear associated with disagreeing with the establishment and suggesting changes to how we provide and support patient care, and the fear of having that difficult or clarifying conversation.

A Brief History

There are as many theories on leadership as there are those who have studied and published their theories.

The history of leadership in healthcare mirrors the most widespread theories of leadership since the mid-1800s: Great Man theory, trait theory, behavioral theories, contingency theories, transactional theories, and transformational theories.

In a nutshell, we have evolved from the suggestion in the mid-1800s that great leaders were born not made and that leadership was intrinsic (and as the Great Man theory name suggests, only a man could have the characteristics of a great leader). This gave way to the trait and behavioral theories of the mid-20th century when we began to understand that with the right "conditioning," anyone could have access to the once before "birthright" of naturally gifted leaders. In other words, over the past 150 years, we have woken up to the realization that leaders can in fact be made, developed, and nurtured.

Governing boards, executive leaders, caregivers of all disciplines, middle managers, and frontline staff of healthcare delivery organizations are being increasingly encouraged to think in terms of building high-reliability organizations, leading cultures and environments that are more inclusive of different opinions, and embracing ideas, approaches, and methodologies that continue to inform us as we learn, develop, and grow as leaders.

Leadership: Current State

By current estimates, there are over 55,000 books with the word "leadership" in their titles available on Amazon.com. Last year alone, it is estimated that more than four new books a day were published on the subject, and there is no indication that this is going to let up or change any time soon.

Nowhere has this growth in the interest of leadership been more apparent than in healthcare. Perhaps this is due in large part to the fact that while we have clearly established that leadership can be learned, we have also, perhaps a little too slowly, been awoken to the fact that our current approaches and systems in healthcare are not creating environments and processes for the most effective, safe, patient- and family-centered delivery of care.

While there are pockets of highly reliable, safe, patient- and caregiver-focused systems throughout North America, these remain "pockets" and the prevailing norm is one of mediocrity. There are still too many stories of situations that could have been prevented, stories of people harmed because of failed systems, and examples of disrespectful and threatening behavior directed at patients and caregivers.

There are still too many examples of people not leading with humility and respect, not listening to the opinions of others, and treating a dissenting point of view as a disruption to be ignored, or worse, eliminated.

Lessons

We have established that leadership is a choice, that it can be learned, that it evolves, and that as leaders, we are forever learning, changing, and adapting. I think it is also worth reiterating and remembering that leadership is not reserved for those with title, authority, or position within our hospitals and health systems. This is of critical importance when reflecting on this issue of the needed shift of power, away from the establishment (the doctors, nurses, and others on the care team) to a more informed and balanced model that includes the patient and the family as an equal partner in care.

"Nothing to me without me" should not only be the mantra for how we think about delivering patient care but also how we lead and collaborate with others.

Leader, Know Thyself

Taking the time to understand our own motivations and remembering that we are unique individuals, although all called to similar work, is an important part of developing our leadership skill set and competencies. It is time to abandon

the "Pygmalion Project" of the endless, and frankly fruitless, work of trying to make everyone conform to our way of thinking or doing. So as leaders it is important to self-reflect and then frame (articulate and write it down) what success looks like for us.

In her book *The 85% Solution,* Linda Galindo is explicit about crafting your "definition of success" as a non-negotiable—the idea being that if you don't know where you're going or don't know what you want, then how do you know whether what you're doing is aligned, purposeful, or meaningful.[2] Linda also reminds her readers that our definitions will, and should, change over time. What you aspired to be and wanted as a 25-year-old in your first job and what success looks like as a 55-year-old mid-careerist are likely very different.

There are other important elements to consider in this space of self-awareness—a checklist of sorts:

1. Self-assessment: a wide variety of tools are available such as the Meyers-Briggs Type Indicator, Prevue, DISC, and others.[3]
2. Feedback from others: 360-style tools that invite confidential feedback from a variety of different "levels" around us. This should be carefully supported with coaching to ensure as healthy a process as possible.
3. A mentor: an internal trusted colleague that you can turn to and ask for feedback from.
4. An external coach: a fresh "set of eyes" that will push you with a bias for action and no burden to be politically correct or afraid of "upsetting" you.
5. Go to your mountain: take time as a leader to disconnect and think—time to "look in the mirror" remembering that leadership is a personal choice.

With self-reflection in hand (and forever evolving and changing) we can now work to achieve the necessary clarity required to lead, especially when it comes to the work of making healthcare safer and more patient- and family-focused.

[2] Linda Galindo, *The 85% Solution: How Personal Accountability Guarantees Success—No Nonsense, No Excuses*, Jossey-Bass, 2009.

[3] For methods for evaluating individual board member performance, see Individual Board Member Assessment, Third Edition, Elements of Governance, 2015.

Without clarity about what we want, how to get there, the work we want to do, and why, highly effective leadership will be elusive.

Remember through the self-reflection and getting to clarity this point about everyone being different, with different emotions, backgrounds, triggers, values, beliefs, and norms.

My colleague, mentor, and now business partner, Tim Sullivan,[4] refers to this as "the 94 percent." He crafted this rubric after reading a magazine article where a psychologist stated that 94 percent of the time people view events through how it impacts them personally. Tim's interactive model of behavior helps two individuals through a process where each can be heard and, in turn, listen to the other person's 94 percent on the way to building one inclusive shared reality.

This model is frequently observable in the workplace when individuals are at odds over a goal, process, or "territory" because they are personally invested in their own view or opinion being right, have stopped listening to others, and are no longer open to new or competing ideas. This preconceived and invariably subconscious bias results in leaders making assumptions, jumping to conclusions, and even assuming that because those they work with don't react to or see things their way, they are deemed to be adversarial, unclear, and unproductive. The ramifications of this behavior for healthcare leaders and their teams are serious and potentially dangerous.

Leader, Care for Thyself

If leadership is personal, then we must bring our best selves to this work, especially in the crucible that is healthcare—with its stressors, restraints, counter-intuitive payment models, and our continued appetite as a society to want to discover and cure faster.

As pedantic as it may sound, it is imperative that leaders take care of themselves by:

- Getting enough sleep/rest
- Getting enough exercise
- Getting enough good nutrition
- Getting enough social interaction (put the phone away…)

[4] J. Timothy Sullivan is Founder of Wellesley Partners, Ltd., see http://wellesleypartners.com.

- Getting uncomfortable—challenge your assumptions, learn, and grow
- Getting enough laughs

Through several different industries, from frontline employee to chief operating officer, from Europe to the United States, from those I work with, learn from, and listen to each and every day I have been blessed to bear witness to leadership examples that run the gamut of skill, competence, civility, and effectiveness. In every single case I have been struck by the fact that leading is a deeply personal commitment, regardless of how effective the leader is perceived.

Leading and the work of leadership, when examined closely, is about courage, perseverance, and love. Love of oneself, the work one is called to do, and the space and place that you find yourself doing it. If called or drawn toward leading in healthcare, toward work that is human beings caring for other human beings, there is no deeper personal connection. As Steve Farber would remind us, leadership is indeed a personal decision to change the world, as you've defined it. It starts with truth-telling to, and with, one's self.

The following is the end of a poem attributed to a Hopi Elder in Oraibi, AZ*: "The time for the lone wolf is over. Gather yourselves! Banish the word struggle from your attitude and your vocabulary. All that we do now must be done in a sacred manner and in celebration.* ***We are the ones we've been waiting for."***

The Governance Institute thanks Richard Corder, M.H.A., FACHE, Partner at Wellesley Partners, Ltd., for contributing this article. He can be reached at RCorder@wellesleypartners.com.

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