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Challenges for Physicians in Formal Leadership Roles: Silos in the Mind

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Abstract

Health care systems are among the most complex organisations, facing a wicked intertwining of rapid change in knowledge, cost pressures, increased demand for access, for evidence-based medicine, and for more connection with patients and their families. Within this world, physicians are called to take up formal leadership positions as directors of quality, chief medical officers, section or department chiefs, deans of medical schools, and senior leadership positions in practices, hospitals, and health systems.

Because their training inculcates values of autonomy, learning from experience, and professional distance, physicians see a team (managerial) approach as 'other' and distance themselves from those colleagues who take up formal leadership roles.

The consequences are ambivalence and splits, both among leaders and within individuals who accept such leadership roles. A maladaptive strategy is often silos in the mind, in which the different bodies of knowledge (clinical and business) are kept too separate, with the latter denigrated. Yet, many of the current challenges require closer linking of substantive medical knowledge with sophisticated organisational and managerial knowledge to invent and implement new systems.

Working with case material from US Academic Medicine, which socialises the majority of the USA's future generations of physicians, the article will explore the consequences and some of the challenges of linking these bodies of knowledge in the service of meeting the adaptive challenges facing health care.

Key words: Professional leadership, projection, splitting, ambivalence.

INTRODUCTION

Health care settings are among the most complex of organisations, facing rapid change in knowledge, cost pressures, increased demand for access, innovations in science and services, and pull from patients and families for more psycho-social attunement in the care and cure.

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Historically, physician leaders were loosely coupled (Orton and Weick, 1990) to the administrative and service apparatus. The hospital was regarded as the 'doctor's workshop' and the mere administrative mortals took up their role in support of the priestly work of healing the sick. Their work took on the character of 'parallel play', each in different realms with different distinctive competencies. Physicians, especially in academic medical settings, could remain blissfully ignorant of the cost implications of all their decisions (admissions, level of care, tests, medications, etc.). Administrators stayed clear of the issues of quality and medical decision-making (Gilmore and Krantz, 1990). The result was silos in the organisation and also in the minds of key leaders.

As the issues in research, education, and clinical care become more complex, professional and managerial issues become more intertwined. This creates a double challenge. First, the top team of the organisation needs to integrate across the professionally and administratively trained members due to their increased interdependence. Second, for physician executives there is a particular challenge to integrate within themselves the clinical and administrative aspects of their roles, what Argyris and Schon (1974) have termed their first- and second-order professional skills.

This article will explore the dynamics of the 'managerial other' within physicians as they take up significant organisational leadership. Many physician colleagues, on the occasion of a clinician's or scientist's 'promotion' to a leadership role, express some variant of, 'You are no longer one of us. You are one of them.' Physicians wrestle with this dual identity, some becoming completely caught up in the world of organisation and management; others hold firm to their core professional identity, often at a cost to their effectiveness. If the challenges increasingly require the integration of first-rate medical knowledge with advanced skills in leadership and management, then the working alliance across physicians and administrators needs to be productive (CFAR, 2010). Physicians need to discover ways to value both aspects of their leadership roles, rather than holding the managerial role at a distance. A maladaptive strategy is often silos in the mind, in which the different bodies of knowledge (clinical and business) are kept too separate, with the latter denigrated.

Heifitz (1994) has distinguished between technical work and 'adaptive leadership work'. Adaptive work is value-laden, clarifying and addressing what matters most, surfacing conflicts in values and gaps between values and reality. Unlike technical work on routine problems, adaptive work requires changes in people's values, attitudes, or habits of behaviour. Sometimes those changes are within

themselves, and sometimes they are within their fellow professionals, but increasingly they require changes in the working alliances with non-physicians.

Let us begin by looking at the prolonged socialisation of physicians. A significant period of anticipatory socialisation, as they take pre-med courses and begin striving to be a doctor, is followed by four years of medical school and multiple years of residency, while often being continued by sub-specialisation and fellowships. Until recently, medical students went straight from college to medical school and, therefore, had few experiences of coping in the everyday world of work prior to becoming a physician. From the time of 'becoming a doctor' on, they often experience a splitting of their 'positions' in Oshry's (1999) framework – being a 'top' as they turn towards the patient who idealises them versus a 'bottom' as they turn toward the organisation that they are embedded in. Depleted patients often project magical abilities on to physicians (Main, 1975, p. 61), thereby debiting the patient's competence and heightening the physician's. Complaints and dissatisfactions get displaced on to administrative roles rather than risk injuring, in fantasy, the physicians on whom the patient is so dependent (Jaques, 1955). The nature of the work also makes the physician special. They are authorised to touch, poke, prod, invade, and even inflict pain in the service of cure (Gilmore, 1991). Historically, physicians have had high autonomy in their individual roles and as a profession (Rothman, 1991).

However, as junior members embedded in one of the most complex organisational settings, physicians in training often feel the lowest on the totem pole. In choosing residencies, they apply, and a computerised matching system sorts all graduates into residencies. Salaries and working conditions are given. They take direction from the attendings in a near hazing environment of stress and long hours. They spend years in a context that resembles what Goffman describes as a 'total institution'. He notes that in such settings, 'The self-defining aspects of office [or role] seem to be carried to an extreme. In becoming a member, one becomes thought of as possessing certain essential traits and qualities of character' (1961, p. 111).

Thus, in becoming a physician, one is *not* becoming an administrator, and the differences between these two categories are exaggerated. When Dr Richard Klausner accepted the directorship of the National Cancer Institute, the lead in the *New York Times* was 'I am not an administrator,' as if being in that category would diminish his standing among his peers or as reinforcing a message to himself that his focus would remain on the scientific side – not on 'adminstrivia'. However, the leadership role requires linking both competencies.

When people enter into an intensive focus on specialisation as the mode of advancement in academic medicine, they lack any frameworks for understanding what leadership is and how it makes a difference. Within their medical culture, physicians see administrators as a different category. When they look within their tribe at physicians who have taken formal roles as department chairs, deans, etc., they find that their colleagues, both those who are in those roles and others, often denigrate formal administrative leadership. This splitting prevents the linking of professional skills to the adaptive tasks that the wider organisation faces.

To investigate the linking of the two cultures of medicine and management, I invited physicians who hold leadership roles in many different settings to reflect on what was said to them by close friends upon their first taking up a formal administrative role (CFAR, 1999). Over 80% of the comments were negative or ambivalent – 'Congratulations and condolences', 'This will be the end of your research career', and, 'Are you crazy?'

Below is a list of some of the other responses.

- We've lost an ally. You've become one of them, the enemy.
- You'll have a wider canvas.
- Why are you doing this? For another sentence in your obituary?
- It's the end of your career as a scholar.
- Fantastic, you can fix *all* our problems.
- You went to medical school and spent twenty years learning and mastering your craft . . . now you're an administrator.
- You're no longer one of us . . . you're one of them.
- It's the best job in medicine (chairperson of medicine).
- Economics have taken all the fun from the job.
- I hope they (the faculty) don't cut you off at the knees. You're short enough already.
- What are you going to do next? (Reflecting the implication that after serving as dean, there are few paths back to being a real researcher.)
- You're crazy.

What accounts for the high percentage of denigrating comments? In corporate settings, many people aspire to move up the 'ladder' and their advancement elicits genuine congratulations from real friends. It is not just what people say to physicians, but, as they take on the administrative role, people react to them differently. A psychiatrist who stepped into the position of chair noticed that, while on rounds, the questions he was asked became more administrivial – as if he was less of an expert in treatment of patients. A scientist

taking the head position of a pharmaceutical laboratory had a similar sense that his colleagues began coming to him less for substantive science issues. He noted, 'It was like my IQ had been debited 15 points.' Thus, the complexity of taking on managerial roles triggers an inner resistance that interacts with external reinforcements, leading to holding it as 'other' – inside one but not the real me. Identity changes often have this lag.

The role shapes how people think about aspiring to it or accepting it if offered. Few people will acknowledge having an early aspiration to become a dean or a chairman. It is as if the entire enterprise is led by people who explain their presence in a leadership role as 'accidental', and then tell some story about how they fell into it. I worked with a powerful (at least, as seen by outsiders) vice dean who, after ten years, still regarded himself as 'interim' and that his identification was with being back in the laboratory. One impact of this stance is suppressing one's comfort with power in acting in the service of the organisation's goals, in part to maintain one's colleagueship with one's peers in the professional frame (Zaleznik, 1970). Historically, with a slower pace of change, this 'loose coupling' may have had few costs, but with the complexity of today's healthcare system, the leadership processes may not be requisite to the speed of required change. In probing physicians' stories about how they got into these positions, it was striking how passively they phrased them.

- 'I was trapped into administration.'
- 'The president asked me and in a moment of weakness I said yes.'
- 'The faculty convinced me to put my name in for dean.'
- 'It was either retire or accept the deanship,' and someone responded, 'Aren't they the same thing?'

No one owned up to actively seeking the role. As one physician executive was talking, he prefaced his comments with the phrase, 'When I was chosen or put forward for an administrative post . . .'. What was intriguing was the lack of aggression in comparison to most other organisations where people *seek* positions of executive leadership. It was as if it were illegitimate (at least publicly) to be hungry for a position of power in a professional organisation, even when harnessed to a higher purpose (Mant, 1983); it was as if the paradigm in professional organisations was Cincinnatus being persuaded to put down the plough and, for the good of the country, step into a leadership role.

Isaacson, an executive recruiter who works extensively in academic medicine, identifies three key leadership skills: hunger, speed,

and weight. Speed is intelligence and the ability to quickly learn new bodies of knowledge. Academic physicians have this in excess. Weight is the sense of how one carries one's authority. In the medical culture, weight from their sense of status within the medical hierarchy often does carry over to leadership positions. Hunger, Isaacson defines as follows:

> Hunger is the marriage of imagination to ambition. Hunger is having a rich fantasy about what one wants to accomplish and the will to struggle to realize it in the world. Hunger is the drive to make a mark, to build a monument, to make something out of nothing. It is the capacity of a mature mind to tap the irrational and intuitive depths of personality and to harness those darker powers to moral pursuits. T. E. Lawrence described this quality: 'All men dream . . . but not equally. They who dream by night in the dusty recesses of their minds wake in the day to find that all is vanity, but the dreamers of the day are dangerous men, for they act their dream with open eyes, to make it possible'. (Gilmore, 2003, p. 73)

Might this lack of aggression for taking on the role be related to the difficulty of exercising socialised aggression or power in the role? In a sense, one feels the role itself is depleted by the external attacks and devaluation of it that are amplified by the ambivalence of those who accept these positions. Just as we talk in political science about a 'weak' governor's office, might we have created physician–leader roles that are less potent than they need to be to face today's challenges? Furthermore, we know that the negative projections of others on to the leader are not without their influence on the leader's experience of his agency. This dynamic creates a 'learned helplessness' (Seligman, 1975) where individuals feel unable to make changes amid a system of such complexity. To be sure, objectively academic medical centres are incredibly complex internally and subject to conflicting external pressures from markets, the government, and from patients.

Physicians are understandably ambivalent about taking an administrative role, as they are aware of the losses from giving up some of the satisfactions of clinical care or research. However, when someone has accepted, he or she needs to be connected to the part of him or herself that really wanted the job and the driving reasons, or 'hunger', for accepting – a combination of dreams and the commitment to make those dreams real. Without the moral authority from those dreams, it is hard to make the difficult decisions that today's challenges require. Given that the 'managerial other' within the physician is held in low regard, when others attack them it is easy to collude with the contempt. As the following cases illustrate, leaders

often pre-emptively attack or denigrate 'the administrative function' to join in a colleague frame. This ambivalence becomes what Fairbairn (Trist, personal conversation) termed 'an internal saboteur' relative to the challenges they face.

The dynamics of projection locate various traits of leadership and management in 'the other' in ways that estrange physicians from seeing how many of the skills they already have within themselves. We worked with paediatric interns in their first year, helping them to make sense of the nearly obliterative experience of a tertiary children's hospital (Gilmore, 1987). One significant complaint was the lack of feedback from supervising faculty. We noted that since the interns went on their rounds as small teams with one another and had many interdependent tasks in managing the same patients across shifts, they had considerable relevant information on one another. They could give feedback on their bedside manner, the quality of their collaboration with other physicians and with nursing, their skill at working with parents, or even their different clinical competences. The near-total group resistance to giving one another feedback was overwhelming. One immediately said, 'What are we supposed to do? Go around and say "turkey, turkey, star"?' Here are physicians who, every shift, are working to perfect their differential diagnostic skills in working with patients, completely splitting off this observational skill from its managerial analogue of giving constructive feedback to co-workers. Keeping the professional skills in a silo in the mind protects them from the contamination of feelings surrounding administrative processes of feedback and appraisal.

Several years later, we had the experience of working with the chairs of medicine of forty medical schools. After a week of being together in an intensive executive-development programme, we invited them to give feedback to one another. The resistance was just as intense as from the interns. In the area of organisational design, when invited to create an idealised redesign of departments of medicine, teams created significantly different structures from the present, but felt unable to risk making those changes in their organisations.

To recapitulate the argument, physicians are socialised in a two-culture organisation – professionals and administrators – in which traits associated with leadership, management, and administration are projected predominately into the other group and kept at a distance. One effect of this dynamic on physician administrators is to tend less to the many behaviours, frameworks, and skills within their core training that are similar to their administrative counterparts in the other half of the house.

A second effect is that physician administrators lack rich frameworks for learning or observing leadership in either their physician colleagues or lay leaders. In particular, they have an underdeveloped sense of issues of role, authority, and organisation in a managerial frame. Research on physicians as negotiators suggests, because of their socialisation and the power of 'doctor's orders' when facing patients, they often are weak at working through differences to harvest integrative value (Shell and Klasko, 1996).

A third effect is that when they do actually step into roles with some managerial and leadership component, they do so ambivalently and do not have a significant amount of their identity tied to their success in those aspects of the role. Many continue to be active in patient care or basic science work. They frame the transition as 'ordinary' (Trist, Higgin, Murray and Pollock, 1990) and do not apply their considerable learning-from-experience skills to the phenomena of leadership, followership, strategy, delegation, and influence.

The cycle gets repeated as the leaders model ambivalence about taking the roles and exercising the skills, to the point that the next generation repeats the cycle of entering those roles ambivalently, and tending less to their own relevant skills. Mentoring and teaching is overly concentrated in the realm of first order skills, with little reflection and learning about leading change, creating teams, working through conflicts, and innovating new delivery systems.

TWO VIGNETTES

Two cases illustrate the challenges of leaders to be effective in such settings where these de-authorizing dynamics are so prevalent – both for the leaders themselves and for their followers.

A chair runs the annual meeting of his fellow chairs

The first case was a prominent academic specialist who was serving as the president of his speciality's organisation of chairs. He had overseen a strategic planning process in which they recrafted the mission and developed some new initiatives. He was presenting this work to the full group at their annual meeting. At the event itself, only fifty people showed up when he had estimated 150 and the administrator had said to prepare handouts for eighty-five. Slowly, people arrived, meeting in small informal groups with almost all the people sitting in the back half of the room, enacting their ambivalence at being fully present (Kahn, 1992).

The leader began, pleading ineffectually with people to move forward. He did not frame the meeting effectively, increasing the sense

that people would experience it as fragmented issues with no connective tissue (unlike the systemic perspective he would bring to patient care). A report on an issue concerning training programmes was discussed with no links to the strategic plan, or flagging the challenge to get the residency programmes to act collectively and hold one another accountable for the good of the whole speciality field. He next presented the strategic plan, assuming none had read the brief document, nor using the core group that had been involved in its development. He repeatedly used words like 'spirited, active, positive, thoughtful' to describe the retreat where the plan had been developed, when the here-and-now dynamic felt funereal. He spoke candidly of the sense of the organisation floundering and the need to make a choice to either disband or re-energise itself. However, he was not sufficiently up to the adaptive challenge to note the enactment of this floundering in the current meeting. They voted unanimously (and in flight) to support the new mission. I was struck by the parallels between the depleted sense of the association's annual meeting and the same issues reflected in the individuals (all of them chairs) taking on leadership roles in their home institutions (Table 1).

One might argue that this is a special case because, in the association, people are only colleagues during meetings but much of leadership in academic medical settings is exercised in peer contexts, where one does not have formal authority over the participants. Below, we describe an even more powerful role of a dean with his faculty.

A dean engages his faculty

A medical school had experienced years of turmoil. A new dean was appointed and was a good enough steward during this complicated period, dealing with the university structure, complex relationships with a separate health care system, and trying to rebuild the school.

With the dean's support, a task force designed a faculty development day-long workshop that came shortly after the conclusion of the successful resolution of several key institutional issues. The day was scheduled to begin at 8.30 a.m. with coffee and a talk with the dean, then a series of workshops. Over 100 people signed up. When the dean walked in at the designated start time, there were less than forty people, all seated in the back left of a large, tiered lecture hall. He began his talk with a humorous statement about not giving a test and then said:

Table 1. Parallels between the dynamics of the association meeting and their departments back home.

Feature	*Association*	*Role in home institution*
Leadership	President did not have fun. Acted in a pleading way.	Sense that much of the role is being 'done to' versus doing. Weakened role.
Transitions	Poorly managed: • New members. • My entry as a speaker. • The transition to the new leadership team for the association.	Underattention to people crossing the boundary. Each person takes care of him or herself, self parenting.
Administrator–professional relations	Staff in disengaged and reactive role. Not in a productive harness.	Staff kept in separate status. Less effective collaboration than would really support the enterprise.
Accountability of followers	Assumed people did not read the plan – no holding them accountable. No aggression in working their mood, dynamics and passivity.	Management by guilt. Expecting people to be competent individual contributors. Few direct conversations. Complaints behind people's backs. Low accountability when people underperform.
Reflection/ learning	No thoughtful evaluation or reflection on the meeting, harvesting insights or improvements.	Mortality and morbidity conferences for learning about clinical errors, no comparable after action reviews of organisational changes or actions.

> There are not great medical schools because of deans or administrators, we are up there pushing paper, etc. Great medical schools exist because of you, the faculty. People who are passionate about their teaching, about their research, and about their clinical care.

He then proceeded to interview people skilfully about changes they had experienced over their careers, from being a student to being a resident, and what had attracted them to academic medicine. It was

a lovely discussion that engaged the community as people learning from one another about how long they had been there, and their perceptions of the changes. He was modelling effective leadership engagement and large group skills.

What puzzled me was why he would denigrate himself (and the others in the audience who held leadership roles), especially in the wake of the enormous leadership work he had been doing to create the context for faculty to thrive. What in that culture made it impossible for him to ask for, or accept, acknowledgement for the achievements of his team over the past few years? Why, when many of the participants and one of the tracks for the faculty-development day were looking at issues of management and organisation, would he join with the cultural denigration of all things administrative and managerial? He spoke as if all of leadership is a hygienic factor rather than a motivator (Herzberg, 1966) and only acknowledged when it is absent but not affirmed when it is present.

When I discussed his behaviour with the dean, he responded that he wanted this to be the faculty's day, that he wanted to join with them. Yet, many in his audience, like him, were both faculty and in administrative positions. Furthermore, many of the purely faculty had experienced many past and current effects of his leadership (both positively and negatively), so for him to be self-effacing was likely to trigger feelings of his hypocrisy rather than humility. Furthermore, when I was giving feedback to the dean, I found myself inducted into a culture of indirection, easing in. I said, 'I hope I am not being too harsh', rather than saying, 'I hope you take my feedback seriously.' The pull of the culture is to mute aggression, even when in the service of performance and worthy goals.

It was also not necessary. It would have been honest, appropriate, and developmental for him to express his concern that recent events had so embroiled him that he was at risk of losing touch with the core mission of the medical school. The new world was going to require less splitting or stuffing of all the financial and administrative issues into scapegoated administrators. It would be necessary for all to collaboratively create the context to support great teaching, great research, and deliver high-quality clinical care.

The impact of his self-denigrating comments was to continue to de-authorise the role of the dean and create disinformation about its scope and contributions. If he had made his role more transparent, and his own hungers more visible and confrontable, he could create a more lively academic culture and work with the faculty in productive ways that link both the academic mission and the leadership and management challenges.

TOWARDS A DIFFERENT FUTURE

In closing, I want to look at what it might take to break this vicious cycle of de-authorisation and splitting when the imperative of the challenges academic medicine faces requires the integrating of first-rate science and medicine with first-rate organisation, management, and leadership.

There is a long tradition of scapegoating leaders, even as there is awareness that the issues may be as much, if not more, embedded in the team (Gamson and Scotch, 1964). Kernberg (1980, p. 238) writes,

> It can happen that most of the energy of an institution seems to be spent on 'curing' its leader. It may well be that the astonishing capacity of so many people in so many places to tolerate an unsatisfactory situation over an extended period of time indicates how gratifying it is to attribute the cause of all problems to the administrator, rather than to focus upon the painful and complex interaction of the various systems involved in bringing about his behavior.

The first skill of a leader is to hold a psychologically-informed systems view and to be aware that feelings inside him or herself may belong to others and vice versa. Eisold (unpublished working paper, p. 18) has written, 'having authority in a system often means enjoying the right to displace anxiety onto others, away from oneself'. Leaders have to be attentive to the various attacks, what Kernberg (1980) calls a 'healthy paranoia'. Heifitz and Linsky (2002, p. 48) outline some of the dangers facing leaders who take up adaptive challenges. 'Seduction, marginalisation, diversion and attack all serve a function. They reduce the disequilibrium that would be generated were people to address the issues that are taken off the table (by these tactics)'. They articulate five principles to help prevent this.

1. Identify the adaptive challenge.
2. Regulate distress.
3. Maintain disciplined attention.
4. Give the work back to the people.
5. Protect voices of leadership from below.

This work begins by seeing or framing the task as an adaptive challenge, showing that shifting from a professional role (educator, clinician, or researcher) to a leadership role is not trivial both for oneself and for key others with whom one will work within new authority relationships. It is not ordinary. Trist and co-authors (1990) identified 'the assumption of ordinariness as a denial mechanism'. Working with a case of change in the coal mines, they note the leaders framing a change as ordinary was:

> a means of psychological defense against elements in the situation they were unwilling to confront . . . [the changes] were treated throughout as a production unit under difficulties, rather than perceived for what it was – a training and development project working under the stress of full production. (Trist, Higgin, Murray and Pollock, 1990)

A case that illustrates the importance of leaders who embrace the adaptive challenge is a study of the adoption of a new technology by surgical teams in comparable medical schools (Edmondson, Bohmer and Pisano, 2001). Sixteen teams were studied as they took up a new, minimally invasive way of doing cardiac surgery. Those that embraced the change as both a technical–professional and organisational role learned faster and had better outcomes. Those that saw it as only technical experienced significant difficulties, as they did not tap the important different perspectives from nursing, perfusionists, and others. The successful teams realised that this change was not 'ordinary', and, therefore, selected the team with an eye to the learning agenda. They defined roles flexibly and engaged in significant preparation and dry runs with offline practice under conditions of safety and a climate of encouraging feedback. In the actual surgery itself, the leader actively pulled observations from team members and encouraged thinking and observing beyond the narrow confines of their roles. Afterwards, there was an explicit reflective session to review the data and experience and make appropriate modifications.

In the unsuccessful teams, the group was not specially formed. There was no full-team rehearsal and communication was suppressed. A perfusionist gave the following report:

> We were having trouble with the venous return, and I mentioned it. The surgeon said, 'Jack, is that you?' I said yes. He said, 'Are you pumping [being the first rather than the second, or assisting perfusionist] this case?' I said, 'No, I'm assisting.' 'Well in the future, if you are not pumping the case, I don't want to hear from you.' (Edmondson, Bohmer and Pisano, 2001, p. 704)

Contrast this with a comment from the same role on a successful team in another hospital.

> The surgeon empowered the team. That's why I'm so excited about [the new procedure]. It has been a model, not just for this hospital but for cardiac surgery. It's about what a group of people can do. (*ibid.*, p. 699)

Note that the comment here is not just about the personal leadership of the surgeon, but accurately sees it as contributing institutionally to an emerging model, both for the local institution and the wider

field. What is powerful about this case is the linking of the core professional skills with second-order skills of leadership and management: setting the tone, selection, and management of the creation of the team, thinking ahead in a climate that encourages all perspectives to be active contributors, creating a real-time environment of effective two-way communication, and having reflective learning sessions after the event. These are all concrete examples of skills that arise close to the professional craft, yet are generalisable to many of the other broader management and leadership tasks. They are working at the front line level in ways that model what Hecksher, Rubinstein, Flynn, Erhardt and Boniface (2008) have framed as the 'collaborative model' in contrast to the historic models of autonomous professional and bureaucracy.

There are many other bridges from the silo of one's core professional knowledge to leadership and management skills that link rather than split them. For example, epidemiological thinking has been powerfully used in management worlds to help managers become better problem solvers and pattern detectors based on data. As noted earlier, the differential diagnosis is a framework that can inform coaching and appraisals by exploring differences between when a colleague is particularly effective versus ineffective, or across experiences of a team. Effective communication with anxious patients and families is applicable to dealing with the resistance to significant changes in organisational routines. Managing ambiguity in the face of conflicting signals about key trends in the environment is analogous to managing a treatment course with uncertainty about diagnosis and/or the treatment. Learning from experience itself is a core skill that crosses both the professional and the managerial worlds but requires the mental linking of grand rounds, morbidity, and mortality conferences to their managerial equivalent of the after-action review.

In any hierarchy, if people are mindful (Langer, 1989) and have insightful frameworks, there are relevant analogous experiences. For example, chairs are often surprised to learn that their division heads see them in ways that are similar to those in which they, in turn, see their dean. The negative aspects that they see so easily in the dean's behaviour are less easily owned as part of their role as a leader in a smaller, but still complex, unit of a department. They may be intimidated by the dean, but attend less to how they, in turn, intimidate. They may see the dean as not transparent in resource allocation decisions, but not see their opacity with their division heads.

Cohen and Ettin (1999, pp. 68–69) write about the process of self-differentiation through productive dialogue. Depersonalizing projections, frequent in academic medicine, often cause a withdrawal or

a (real or imagined) retaliation rather than correction via direct talk and dialogue. It can be equally distorting when positive attributions go uncontested, as they often do in academia, regarding the perceived power of leadership roles – which are often seen as far more powerful and well resourced from afar than by the people in the roles. Note the leadership required in the above surgical team cases to set the climate for this two-way communication.

Both successful and unsuccessful occupants of a role leave a shadow on the role itself. Just as effective individuals seem to add new dimensions to the role they occupy and, thereby, create new standards and expectations for those who follow, another leader may actually subtract credibility, confidence, and other qualities from the role itself. In the surgical cases, as leaders step up to the adaptive challenges, they create new expectations for the team leader role, and, over time, can create both superior and follower pressure on any new team leader to meet the new role expectations. Conversely, those who continue to split the professional and the managerial damage the role itself. In the way that we talk about a 'weakened presidency' in political discourse, a leader from any field of endeavour can leave behind a shadow that subsequently impairs the exercise of authority itself. This type of shadow can have a devastating impact on both the new leader and the organisation. All occupants need to see themselves as stewards of the roles that they occupy in academic medicine and work to leave them with the requisite authority for the challenges that they face by more effectively linking the professional and managerial realms.

We are seeing some of the elements of change within academic medicine. Most powerfully, the patient safety movement has brought management tools of Six Sigma into the clinical space, using teams of physicians, nurses, pharmacists, and administrators, working closely with the front line practices of the organisation. We often observe an initial rigid rule-following of the new processes, but, in the best settings, this is transitional towards it becoming an integrated part of how these leaders see the issues, linking clinical phenomena with management processes. One leader of a medical speciality society recently noted that in the professionalism frame of counting on autonomous roles, doing the right thing can only get us 60% of the way towards collective goals, and that systems thinking and organisational changes are needed to approach bold goals such as no preventable deaths or major redesign of clinical care systems.

From the top level, mission-based management (a relative of management by objectives) is a campaign to more explicitly link resources and management to specific aspects of the academic mission.

A hallmark of the process is transparency, so that budgets are seen by peers and dampen the often-rampant fantasies about who got what based on what criteria.

Process clarity and transparency are developmental. If people know who is making a decision and by when, and perhaps what the criteria are, this can substitute for not knowing what the actual decision is and increase leaders and followers holding one another accountable. In a retreat of an academic medical centre, when we called for a fishbowl meeting of the executive–management group, there was considerable confusion about the membership of that group from both outsiders and a few in the group (Gilmore, 1997, pp. 40–41). This situation does not enable followers to hold their leaders accountable or for the leaders to receive acknowledgement from their faculty.

CONCLUSION

The challenge is large. Moore (1990, p. 19) has thoughtfully framed the challenge.

> Medicine and business management are fundamentally different cultures. Employing doctors in managerial roles will yield good results only when we recognize and find means to deal with the radically different values and ideologies of medicine and management.

This paper argues that the first step is to build links between these 'two cultures' and invite physicians to see the opportunities in close proximity to their practice. As always with developmental processes, the progress is uneven with a mixture of new emerging practices in the social ground, with uneven support, and with leadership from above. As people begin to make the links across these silos of professional and managerial, the rate of change will increase. People fill a role differentially. Kahn (1992, p. 322) suggests that being 'fully there' in one's role is rare, and involves four dimensions: attentiveness, connection, integration, and focus. It is sobering to compare the difference between how physician leaders fill their professional roles versus their formal organisational roles. No talented surgeon would enter the operating room without scrubbing, reviewing all the available diagnostic information, and checking the infrastructure and the team's readiness. Yet, that same surgeon, as a chair going into a meeting, will grab a folder from his secretary and skim it en route to the conference room three doors down from his office and begin a meeting with no acknowledgement of absent members, and differentiating between those who, respectful of community life, informed the leader and those who simply did not turn up. The leadership of the meeting often ignores the interdependency of the

various items to one another and to the overall well-being of the institution. What Langer (1989) calls 'mindfulness', when brought to the adaptive challenge facing academic medicine, will go a long way to bringing the inherent intelligence and aggression in physicians core training to the leadership task.

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