

CHAPTER 8

LEADERSHIP DEVELOPMENT IN ACADEMIC MEDICINE

The Leadership Challenge

Bookstores now abound with titles promising improved organizational leadership skills, and a few of these appear in the bibliography that concludes this chapter. To be sure, this expanding literature does not lend itself to summary; moreover, each reader will be looking for and will take away something unique to her or his situation. However, the following points are especially germane to academic medicine and to the challenge of increasing women's leadership.

For much of this century, the four critical factors determining organizational success were size, role clarity, specialization and controls. The new necessities, however, appear to be speed, flexibility, integration and innovation (Ashkenas, et al.). Images of "tidal waves" and "permanent white water" are common in descriptions of this transition. A recent commentary on medical education notes: "The health care system is changing at warp speed. In such an environment, the effective education of young physicians should display . . . a sure sense for the skills that, regardless of organizational setting, will prove essential to effective practice in the 21st century" (Blumenthal and Thier). This need for continuous adaptability has sparked interest in the concept of "learning organizations" where teams "undo their learning disabilities to achieve superior performance" (Senge).

Facing unprecedented restructuring challenges, as never before leaders in academic medicine need to be oriented toward continual learning. Mark Twain admitted: "What I don't know is not as much of a problem as what I am sure I know that just ain't so." Vaill posits that "almost nothing we have learned is immune from challenge" but that our formal educational system and most management seminars interfere with our understanding what continual learning can be because they present

information in terms of "building-blocks" and emphasize "getting it righter and righter" (Vaill). Carse frames learning as the "journey that makes knowledge possible" and concludes that "the very liveliness of a culture is determined not by how frequently thinkers discover new continents of knowledge but by how frequently they depart to seek them" (Carse).

In a time like this, among the most important qualities is the ability to balance order with chaos. A former chancellor of the University of Nebraska Medical Center states the challenge as follows: "Right now, we have too much order in many of our organizations--too much rigidity in structure, in flow of information, in rewards. The order we need amid turbulent change comes from clarity about meaning and direction. Thus the work of leaders today is to clarify organizational purpose, instill and model values, develop people and create meaningful work. . . This kind of values-based leadership represents a dispersion of power that is not welcomed by those most vested in the authoritarian hierarchy" (Aschenbrener).

Most physicians and most current CEOs have much more experience in hierarchical organizations than with de-centralized authority. Many have been accustomed to the view that "if you're in charge, you're right." Now, however, a more relational model of leadership is emerging (Drath)--one that conceptualizes leadership as collaborative, as about making sense together of the unknown (Weick) and making meaning in a community of practice (Drath and Palus). This model means that not only do leaders require cognitive knowledge (know-what) and advanced skills (know-how); they also need an understanding of systems (know-why) and self-motivated creativity (care-why) (Quinn, et al.).

Academic medicine needs deans and

department chairs who conceptualize their work as values-based and collaborative and who will build the consensus and garner the resources necessary for medical schools to become better “learning organizations.” A lengthy bibliography is not the most reliable “gold standard” for this tall order of leadership. The abilities to inspire a commitment to service, to build community support, to turn a group of diverse individuals into a highly functioning team, and to embody the highest professional values need to be given more emphasis in the search for senior administrators. Certainly, the complexities of the challenges facing medicine are such that one person cannot carry the day; and medicine must do better at nurturing the innate leadership skills of individual faculty and students. At the same time, academic medicine must improve its executive search processes. It has been observed that “health care institutions lag well behind corporate America when it comes to leadership search” (Longshore). This is not the place to explore this little-studied area, but certainly part of the problem with current search methods is an overreliance on the traditional grapevine to identify candidates, such that the talents of many women and others who don’t look like the traditional executive remain untapped.

Increasing Women’s Leadership

Women are just as different from each other as men are, so generalizations especially in the area of leadership styles are precarious. There is some evidence that, because of their socialization as relationship-preservers and because they have less investment in the status-quo, women’s styles tend to be more collaborative and consensus-building compared to men who tend to emphasize the roles of politician, boundary-setter and negotiator (Regan and Brooks). Studies also show that women and men do not differ in their effectiveness as leaders but that some situations clearly favor one or the other (Powell). A meta-

analysis of organizational and laboratory studies found that women leaders fared poorly in settings where leadership was defined in highly masculine terms, especially in military settings (Eagly, et al.)

When gender-related stereotypes influence leadership styles, work is less likely to be productive (Senge). An excellent study of law firms compared firms having fewer than 5% women partners with firms having a more sex-integrated leadership (Ely). Women in male-dominated firms could be categorized as “accommodators” (emphasizing a masculine style of aggressiveness offset in some cases by feminine sexuality), “resisters” (criticizing their firms for reinforcing gender stereotypes) or “self-blammers” (internalizing their firms’ devaluation of women). Compared to women in sex-integrated firms, these women were less satisfied with their jobs and had lower expectations of and desire for promotion. Also in sex-integrated firms, women were more easily able to integrate their masculine and feminine characteristics; they regarded feminine attributes as sources of strength and competence and expressed less anger about requirements to enact masculine roles at work. Finally, whereas the more isolated women believed that expressions of their individuality would be a hindrance, women in integrated firms believed their individuality contributed to their success. Ely concludes that “this more fluid construction of gender” allows greater flexibility for both sexes. Since effective leaders are androgynous, that is, robust human beings who draw on their full natures, this flexibility and balance are important to organizational health (Rosen).

Moreover, women’s presence at policy tables in medicine are likely to add value to deliberations and outcomes. Women make the majority of health decisions for their families, frequently personally prefer a woman physician and access the health care network more often than men. Organizations whose executives reflect the diversity of their constituents and the communities they serve are better

positioned to make far-sighted decisions.

Other reasons to increase women's leadership are that women make up 42% of the medical school applicant pool and over 47% of U.S. Ph.D. recipients, and women physicians are more primary care-oriented than men. As they shift from acute care and specialty medicine to primary care and preventive medicine, health care organizations that are attractive to women will be better positioned to recruit the best staff. If they are to adapt to funding losses and to greater accountability, academic medicine must become better at developing all its human resources. The role of department chairs as change agents in this regard cannot be over-emphasized. Chairs' responsibilities for appointments, job descriptions, mentoring, salaries, resource allocation, and faculty evaluation mean that they have great influence on whether more women progress into senior positions. Chairs are also responsible for setting the tone for a high level of professionalism in all their communications and dealings with faculty, trainees, staff and patients. They should address rather than tolerate evidence of bias or disrespect, whether related to gender or any other human attribute.

Unfortunately, maximizing income has become such a pressing priority in many departments that high standards of professionalism along with academic goals may be lost sight of. Trainees and young faculty cannot receive the inspiration and nurturance they deserve under such circumstances. Many chairs need assistance in carrying out their mentoring and human resource responsibilities and should seek education to build these skills (see Chapter 4, "Other Resources"). Large departments might create a vice-chair position that not only assists the chair but also allows younger faculty to develop skills and acquire increasing management responsibilities (Worthington, et al.).

In its recent Project Committee report on increasing women's leadership in academic medicine, AAMC also suggests the following

strategies and considerations for developing more women as leaders and for facilitating change (AAMC):

- Appointing women to search committees and insisting that a woman candidate appear on the "short list" can be a move in the right direction. However, executives need to avoid "tokenism" i.e., thinking that "one woman is enough"; tokens tend to face numerous loyalty tests, lack clout, and are not likely to be effective (Kanter).

- Adding diversity to important committees is crucial but can increase the time required for the group to develop trust and to address conflicts, i.e., move from "polite" to "skillful" discussion (Senge). Nonetheless, the products of diverse teams skilled at examining their methods and addressing disagreements are likely to be of much greater value than the products of teams that do not reflect their constituencies and have not challenged their own assumptions.

- Extra efforts are usually necessary to identify women candidates for top positions. One resource are women specialty organizations (see Chapter 9). Search committees may also need guidance in the equitable evaluation of women and minority candidates (Sandler, et al.).

- In order to improve the functioning of work groups and teams, medical centers should encourage their committees to undertake training in conflict management and to engage in discussions of leadership styles, including examination of gender stereotypes and of how the same words may be viewed differently depending on the sex of the actor.

- In recruiting department heads, medical centers should put more emphasis on the management and nurturance of faculty and residents as well as on team-building skills; centers should provide training in these skills for current administrators. Chairs should be held accountable for the accomplishment of such goals as improvements in the career guidance given to junior faculty and residents and in the proportion of women faculty

promoted.

- Medical centers' strategic planning efforts should emphasize the goals of assuring professionalism and of meeting their social contracts. Just as medical corporations engage in "environmental assessments" to better position themselves in the market, medical centers should conduct *self-assessments* focusing on whether the center is achieving its stated missions and should regularly evaluate staff/students' perceptions of the learning and organizational climate.

Conclusion

Dr. Frances Conley recently observed that "by itself, medicine cannot reform a world where everywhere women work harder to earn less, accept responsibility for family at the price of oppression, where female life is not valued as highly as male life" (Conley). As the preceding chapters have shown, the challenge of ensuring equity for women in academic medicine is indeed complex and is replete with societal and cultural factors far outside medicine's reach. These complexities ought not to be used as excuses, however, because so much work is directly within the purview of medical institutions.

Persistence is essential in improving the environment along the lines suggested in this book and in nurturing more women leaders. In any department with a poor record of retaining women, a year of hard work will only begin the process of change. But this work, guided by principles and eliciting the participation of both men and women, is necessary. Medical centers cannot deliver the best possible quality education, research and patient care unless they engage the leadership capacities of all their members to the fullest possible extent.

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