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Editorial

Rethinking leadership development

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Introduction

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Leadership has long been a core value of Alpha Omega Alpha Honor Medical Society (AΩA). New and effective leaders in medicine, health care, and medical education are vital to our profession to serve patients and society. We asked the question: How can AΩA as an interdisciplinary honor medical society best support and contribute to leadership promotion and development as part of our mission and as one of our core values—to improve care for all by encouraging the development of leaders in medicine, academia, community, and society?

We recognize that leadership in medicine, medical education, and health care is more complex in the twenty-first century than ever before. We also believe that physicians' unique knowledge and expertise in medicine and our understanding of medicine's core professional

values provide us with a solid foundation for leadership. The result is implementation of our new AΩA Fellow in Leadership award and program that provides an important opportunity for rethinking leadership development and what it means to be a leader. AΩA's Fellow in Leadership Award is based on the premise that the principles of leadership from within can be taught, experienced, and learned by those who aspire to become great leaders.

I asked Dr. Wiley Souba, an experienced leader and teacher in medicine, medical education, and health care—and a member of the AΩA board of directors—to write the editorial for this issue of *The Pharos*. His editorial, "Rethinking leadership development" is informative and provocative.

Rethinking Leadership Development

Wiley W. Souba, MD, DSc, MBA

Management consultant and author Peter Drucker once said that "the greatest danger in times of turbulence is not the turbulence; it is to act with yesterday's logic."¹ Yet, the past is what we know and it is what we draw on when making judgments and choices. Most people, however, would argue that using yesterday's logic to solve today's

health care challenges is not an option. We need more effective ways of being, thinking, and collaborating in order to deal successfully with those challenges for which traditional strategies are not enough. But exactly how we broaden our leadership bandwidth is often unclear. We've all experienced how difficult it is to let go of and transcend our deep-rooted, familiar ways of leading.

Recently, the AΩA Board of Directors introduced the AΩA Fellow in Leadership Award as a testament to their continued commitment to developing leaders in medicine. Because health care transformation efforts are often unsuccessful because they overlook the importance of personal transformation, the fellowship emphasizes the inner work of leading oneself. Fellows learn what it is to be a leader and what it means to exercise leadership effectively by making use of a model that distinguishes *being* a leader as the foundation for the leader's actions. Why is the *being* of leadership foundationally primary? An illustration is helpful.

Suppose I were to ask you, "What is an Accountable Care Organization (ACO)?" You answer, "An ACO is a health care organization with a payment and care delivery model that aligns provider reimbursements with quality metrics and cost savings for a given

population of patients.” Your answer provides me with characteristics that describe and identify the entity. Suppose I then ask, “What does it mean to *be* a patient in a (high-performing) ACO?” In response, you say, “To be a patient in an ACO means to be provided with reliable access to care, support for activities and behavior changes to improve health, trustworthy information to help make treatment decisions, and better health outcomes.” The first question, “What is an ACO?” is answered with reference to other entities such as providers, payment models, quality metrics, cost reductions, and populations. The second question is answered with regards to what it means to “be” (exist) in an ACO in various ways, such as being engaged, secure, informed, and healthier. In contrast to the first question, the question of the meaning of anything is always answered in reference to other meanings.

If we now ask which question comes first, it should be clear that what it means to be a patient in an ACO is the basis for the ACO being designed the way it is (or at least it should be). In other words, what it means to be a patient in an ACO is prior to what kind of “thing” an ACO is. If I understand what it means to be a patient in an ACO, I will know what is required to make an ACO. The inquiry into what it means to be a patient in an ACO is not only different from the question about what kind of thing is an ACO, it is also prior to it, for the meaning ultimately explains the entity.²

Suppose I now ask, “What is a leader?” You answer, “A leader is a person who has a title and authority, knows strategy, allocates resources, and gets results.” Your answer to my question provides me with attributes and roles that describe or identify a leader. Suppose I then ask, “What does it mean to *be* a leader?” In response, you say, “To be a leader is to be self-aware, honest, authentic, fair, and committed.” The first question, “What is a leader?” is answered in reference to other entities such as followers, a strategic plan, and a position. The second question is answered

in reference to what it means to exist in various ways as a leader, such as being dedicated or focused. Again, meaning always precedes entity.

Much as understanding what it means to be a patient will tell us what is essential in building a health care system, what it means to be a leader should be the basis for the way in which we educate and train leaders. If I understand what it means to be a leader, I will know what is required to develop leaders. In other words, what it means to be a leader is prior to what kind of entity a leader is.

What we discover with a bit more scrutiny is that we are not preparing leaders in keeping with what it is to *be* a leader. Most leadership development programs focus on knowing (expertise), having (power, resources), and doing (competing), not “being” a leader. Yet, if you’re not being a leader, it is impossible to act like a leader.³ An emerging approach to leadership development starts with four pillars of being a leader—awareness, commitment, integrity, and authenticity—as the ontological foundation for what leaders know and do.⁴ This way of understanding leadership is core to the basic tenets of professionalism.^{4,5}

Our understanding of what it means to *be*—a physician, a medical student, a researcher, a leader—is changing. Accordingly, the institutions that are responsible for preparing these individuals to be effective in an everchanging health care environment must change. Medical schools are revising their curricula to include population health, new payment models, and value-based care in order to prepare physicians to practice in the twenty-first century. And they are starting to take a stronger stand on developing leaders.

Imagine

Each of us has had the unnerving experience of being confronted with a leadership challenge and not knowing how to deal with it. Imagine for a moment what it would be like if, regardless of the problems you were faced with,

you could handle them effectively? In other words, the “you” that showed up was you in your “A” game. Suppose you weren’t limited to those automatic, ineffective ways of being that tend to hijack your amygdala? What would it be like to be at the top of your game, leading from your natural self-expression rather than from some anthology of theories in the latest bestseller on leadership? What if that “inner critic” that was always there judging you wasn’t there? What if you had access to a much wider range of possible ways of being rather than being confined to those default ways of being that have become so entrenched yet are so unproductive?

Our effectiveness as leaders is first and foremost a product of our way of being, which is a function of the way in which the circumstances we are dealing with *occur* for us.^{3,5} From a neuroscience perspective, what we mean by *occur* corresponds to that which is generated by the particular activated neural networks in the brain that produce the experiential perceptions—via our senses—that are projected into the external world. Unless and until we shift the way in which our leadership challenges occur (“show up”) for us—from a problem that is someone else’s to one that we’re all responsible for—our predictable ways of being and acting will prevail and the future will largely be a continuation of the past. Health care costs will continue to escalate, unwarranted variations in care will persist, and tens of millions of our fellow human beings will have little recourse. The response, “If the uninsured would just pull themselves up by their bootstraps like I did,” is both ignorant and arrogant. Yet, this perspective continues to be pervasive. Oddly, the panoply of pompous solutions to our health care predicament—change this, change that, get rid of this, get rid of that—tend to exclude a fundamental imperative: “I need to change too.”

Accessing leadership

The word “access” refers to making something available so as to use it, apply

it, or take advantage of it (e.g., a database, the internet, the medical record). The idea that leadership is something we access may seem counterintuitive as we generally think of leadership as something that people just have (or don't have). However, when we recognize that leadership is about expanding our range of ways of being, thinking and behaving so we can be more effective in dealing with those challenges for which conventional strategies are inadequate, the notion of access makes more sense.³ Without the ability to access new ways of being, reasoning, and working together, we will default to what is comfortable when we are called to take on a major leadership challenge and our results will be mediocre at best.

Access to leadership can occur through first-person, second-person, and third-person inquiries, each of which provides a different, but complementary perspective. Observing leaders and describing their behaviors and attributes is about objectivity (third-person data). This third-person approach to studying leadership, which focuses on what leaders know, have, and do is, by far and away, the most common leadership pedagogy. Leadership education that is based largely on concepts and explanations—where the subject has indirect, inferential access—provides limited access to the being and actions of an effective leadership.⁴ Theories and textbooks provide us with third-person access to leadership, but they alone do not impart what is required to be a leader, much as textbooks do not teach what it is to be a physician.

Rather than teaching leadership from a theoretical (third-person) vantage point, the ontological (first-person) perspective teaches leadership as it is lived and experienced. Such subjective experiences (first-person data) cannot be described entirely by objective reality. When one exercises leadership “as lived,” concurrently informed by theories, one performs at one's best. A science of leadership will eventually generate a framework that systematically integrates

third-person observations about leadership behaviors and their neural processes, second-person experiences and their social correlates, and first-person subjective conscious experiences. In the meantime the only direct access we have to what it is to be a leader is by way of the first person “as lived” experience.

Consider this somewhat ludicrous example. You and I have no direct access to what it means to *be* a gallbladder. We can only measure (third-person) what a gallbladder does and then describe its properties and functions (stores, concentrates, and secretes bile). But these properties give us no direct (first-person) access to what it means to *be* a gallbladder. Moreover, when someone explains to you how to remove a gallbladder, their third-person account gives you no direct access to performing the surgical procedure. You may memorize the atlas on gallbladder surgery and even watch a video on cholecystectomy, but until you experience for yourself what it is to be in the operating room with a laparoscope in your hands, what it's like to dissect the gallbladder off the liver, and what it is to perform an intraoperative cholangiogram, you will never master laparoscopic cholecystectomy.

Similarly, you may keep a list of the characteristics and attributes of leaders in your pocket, but this gives you no direct access to what it means to be a leader. You do, however, have direct access to what it is to be human. It's the only entity to which you have direct access. And through accessing what it is to be human—who you really are—you can access what it is to be a leader. Likewise, when someone describes leadership to you, their explanation gives you no direct access to leadership. You may be able to recite all the leadership books, but until you experience for yourself firsthand what it is to deal with a complex leadership challenge and what it is to confront your fears and inadequacies in dealing with it, you will never be a master leader. You can't lead effectively from the stands as a third-person spectator. You must be on the ice where the

game of leadership is played.

I have been belaboring the point about accessing being a leader and leadership for three reasons. First, direct access is not as simple as it might seem. A rigorous examination of the structure of our conscious leadership experiences entails a careful phenomenological observation. This takes practice because our taken-for-granted beliefs and assumptions invariably get in the way. In order to gain access to more effective ways of leading, we must first expose our engrained beliefs and worldviews about leadership (e.g., I have to have the answers) that are holding us back. This will allow us to relax those limiting (and often hidden) ways of being and acting that have become our automatic go-to winning formulas (e.g., avoiding tough conversations, blaming others) that actually constrain our freedom to lead.³

Second, in accessing leadership it is important to recognize that you and I do not lead from a theoretical standpoint; we live moment-to-moment, situation-to-situation in the way we experience leadership “as lived,” that is, from a first-person point of view. Third, the primary tool we use to gain access to leadership is language. In other words, language (discourse) is the vehicle in and through which we access the world. It functions as a kind of lens that brings our leadership challenges into sharper focus, allowing us to see details and “make sense” more perceptively. Language does not merely reflect reality; as a constitutive element it has the power to shape, even create, how we represent reality. Thus, the transformative power of language resides in its ability to create new futures.

A new language of leadership

We all know people who excel, almost without effort, in their particular disciplines. They take on difficult problems with grace and ease. We often believe that these individuals are born with a special gift or a distinctive temperament that allows them to deal with complex issues more effectively than the rest of us. Actually, what allows such people to

be so effective is that they have mastered the conversational domain necessary to perform exceptionally in their particular field of interest.³ This mastery allows them to interpret and tackle problems in a unique manner.

By conversational domain, we mean—for example, in the case of medicine—the network of discipline-related terms that form the special linguistic domain through which a physician perceives, comprehends, and interacts with her patient’s body, history, illness, and suffering.⁵ This specific conversational domain is required to be a master physician and to practice medicine expertly. Mastery of the conversational domain particular to any discipline—biomedical informatics, astrophysics, population health, etc.—is essential if one is to effectively perform, communicate, and innovate in that domain. To participate successfully in a conversational domain (discourse community), the interlocutors must be familiar with both the implicit and explicit “rules” about how its terms are communicated. A key goal of higher education should be to help students master the spoken and written language of their disciplines.

A bioinformaticist, for example, becomes a master by mastering the conversational domain of bioinformatics. Mastery allows her to observe, interpret, understand, and interact with the world of bioinformatics through a set of specialized terms (for example, *computational biology, genomics, proteomics, deconvolution, relational database*) that are networked together in a specific way to form the linguistic domain of the world of bioinformatics. Similarly, a population health scientist becomes a master by observing, interpreting, and interacting with the world of population health by means of a set of specialized terms (for instance, *outcomes, disparities, determinants, risk factors, health production function*) that are networked together in a certain way to form the discourse community of population health for a master population health scientist. In other words, the source of being

extraordinary in any domain is mastery of the unique conversational domain that gives one access to that domain.⁵

Conversational domains, once mastered, grant considerable power. Experts could not create new knowledge without having mastered their domains’ language because the specialized language is what gives them actionable access. Medical school and residency are “first-person as-lived” experiences that are intended to teach physicians to become masters of the conversational domain of medicine.

Conversational domains can overlap and frequently do. The field of bioinformatics was born when the intersection between computer science and biology was harnessed. Over the past few decades, the conversational domain of bioinformatics has become more sophisticated as researchers have developed a shared language that functions as a kind of lens that grants better actionable access to the world of bioinformatics. This improved access, which enables new linguistic distinctions that further advance the field, is the result of a more refined set of specialized terms that are linked together to create the discourse community. This process of mastering a conversational domain such that it “uses” the master by providing a context (a way of perceiving, interpreting, and relating to the corresponding knowledge domain) is key to performance and innovation whether one is a geneticist, a plumber, or a physician.

Because many of the changes that are taking place in health care are inevitable, mastering context as a leader is critical. Content (the particular situation at hand) is always observed within a linguistic context and, as human beings, we have the freedom to recontextualize our leadership challenges by shifting the context. In so doing, we can *be* a different kind of leader. When we change our thinking and speaking, a different reality becomes available to us. Shifts in our mental maps generate new possibilities for actions and outcomes not previously accessible. Only by means of language can we lead ourselves, each and every

day, to become the wiser, more effective leaders that we must become.⁵

Curiously, our enhanced leadership effectiveness won’t be, first and foremost, because we acquired another technical skill—rather, it will be because the perspective from which we operate has changed.⁶ A different “you” will show up. What is transformed is not *us per se* but the way in which we interact with whatever we are dealing with. Said somewhat differently, the ensuing improvement in effectiveness is less the result of having grasped some new theory and more a function of having altered the context through which we “see” our leadership challenges. This incredible capacity—to go beyond our ordinary selves to unleash our best selves—is unique to human beings and is only possible because we are not determinable by a *what*, like an entity, but by a *who* that is shaped by our choices over time.

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