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Turning Mission-Based Academic-Department Leaders into a Leadership Team: A Case Study in Creating Value

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The current economic and legislative reality creates an imperative for leaders in academic medicine to develop a value equation — one that takes into account clinical outcomes and financial impact—for integrating their three missions: clinical care, education, and research. Even exceptionally skilled individual leaders will not be able to forge this future. Rather, improved performance requires diverse, well-coordinated teams capable of leveraging their differences and engaging in collaborative problem-solving and continuous learning. (http://www.ncbi.nlm.nih.gov/pubmed/22361800)

In most academic medical departments, the three missions are led as silos. And with strong reason: "the cultural barriers to change in health care—doctors' resistance to being measured, their need to be 'perfect,' their reluctance to criticize colleagues, their resistance to teamwork—reflect a deep-seated belief that physician autonomy is critical to quality in health care." (http://www.bumc.bu.edu/facdev-medicine/files/2010/10/HBR-Doctors-into-Leaders-10-26-10.pdf) Sharing stories about transcending these obstacles is critical.

Our story began when the chair of the University of Pennsylvania's Department of Anesthesiology and Critical Care engaged Vector Group Consulting to develop a team-based approach to planning and budgeting. The department's leadership team consisted of the chair, three vice-chairs, and a chief operating officer. The interviews and validated surveys used to assess the team's functioning revealed a group of highly successful leaders who shared information and coordinated departmental activities. They aspired to be more strategic but operated mostly tactically. Although they wanted to work as a coordinated team, they led mostly in silos, communicating mainly through the chair. In line with their job descriptions, the COO and vice-chairs were stewards of their respective missions, confident of their colleagues' proficiency in leading the other missions. They believed that "allowing each other to function autonomously was a sign of respect." The consensus was that "clinical needs are so pressing it's hard to balance the other missions. We don't strive for balance because it is not possible." To explore what change was possible, we designed six sessions organized around three themes:

1. Developing the team's value-based equation. A first step was financial and strategic transparency. We assessed the implications of the larger financial realities, taking a close look at the department's and the larger health system's current finances and long-term financial risks as well as the potential impact of decreased funding on each of the missions. "Value," for this team grew to mean the integration of quality clinical care, research advancement, and educational opportunities within the department's financial means and consistent with the institution's goals and priorities. As a result, each vice-chair transitioned from merely advising the chair to as-

suming greater responsibility for his individual mission within the context of the departmental and institutional missions.

2. Leading the missions as a team. With a shared picture of the environment, the team created a new departmental mission statement. Using the RACI (responsible, accountable, consulted, informed) tool (www.racitraining.com), the team then re-evaluated the role of vice-chair. Instead of leading his mission in a vacuum, each vice-chair focused both on that mission and on the impact of his decisions on the other two missions, as well as its potential to assist them, the department, and the institution as a whole.

To implement this new conceptualization of the role of vice-chair and increase transparency across missions, each vice-chair presented to the team his view of current and future challenges to the department with respect to his mission. To practice integrating the perspectives of the three missions' into departmental strategies and activities, each vice-chair presented his top decisions. The team explored the opportunities each decision provided to the other two missions. Consequently, departmental plans were revised to include innovative provisions for clinical, educational, and research activities.

This integration of missions occurred one decision at a time. Decisions that at first only involved one mission were usually found to impact the other two. The team agreed on the importance of communicating this perspective on balancing their missions to the department's faculty, a future area of focus.

3. Sharpening the team's strategic thinking. With increased transparency came a new approach to departmental planning and budgeting. Each vice-chair prepared a budget for his mission, aligning his request with the departmental mission statement. To spur collaborative interaction, we adapted the format of the reality television show "Shark Tank," in which a group of investors vet requests from aspiring entrepreneurs. Each vice-chair's request consisted of a three-to-five year strategic and financial agenda. The other team members acted as "sharks," providing critiques and encouragement and sometimes new avenues for combining activities. The result was greater transparency, collaborative thinking, and more complete information for the chair and COO in preparing the departmental budget.

Given the constantly changing landscape of health care, building a high-functioning team — one that leverages the diversity of thought and talents of highly qualified leaders with differing goals and objectives but united by a common mission and context — is critical. Key principles for putting this into practice include the following.

Building teams takes time. In health care systems, time is in short supply. To change, one must commit the necessary time. Teams consist of human beings, who need time to develop new approaches to leading together. The time committed by this group was one half-day per quarter, with one team member and the consultant working between meetings.

Building teams demands transparency, especially financial transparency. Everyone involved must be willing to share the realities of his or her situation.

Building teams requires trust. Our team had a track record together and trusted one other. However, trust is not a prerequisite— it's a skill that can be developed. (http://repository.upenn.edu/dissertations/AAI9840250/) At the outset, the chair must trust that he or she has the right people on the bus–individuals who will use information to further the departmental and institutional goals and will not disseminate it inappropriately.

Building teams means understanding context. No team is an island. Every team is nested within a larger system and is a larger entity to others. The institution's goals and strategy and their implications for the department's values, mission, and decisions must be clearly communicated to the team's constituents.

Building teams involves developing skills not commonly learned in academic medicine. Each team session included training in a leadership skill, among them RACI, strategies for staying in role and not taking things entirely personally, negotiation training, and lessons in how to develop functional hierarchies. (http://www.ncbi.nlm.nih.gov/pubmed/8832279, http://www.amazon.com/Systems-Centered-Therapy-Groups-Yvonne-Agazarian/dp/1855753359)

Building teams is aspirational. Did we have to convince, cajole, or set the stage for change? Surprisingly (even to us), no. Perhaps, in part, this was because our team members already aspired to be more strategic and team-orient-

ed. Perhaps, operating in silos, the vice-chairs were not fully aware of one another's ferocious commitment to the academic mission.

And building teams never ends. Did everyone buy in? Yes, members of the team were committed and remain so. A vital next step is bringing this integrative approach to the faculty.

The result of our work was a team that assumed responsibility for supporting and providing input to the chair on all three missions and developing novel integrated approaches to each decision. Concrete examples are the involvement of all team members in

- Defining the role of clinical division chiefs and serving on the search committees for them,
- Developing subspecialty fellowships, and
- Recruiting or developing physician scientists who study educational advances or health care delivery.

Physician leaders in academic medical centers must seek transformative and sometimes integrative solutions — not only in clinical care but also in research and education. This goal is only possible with a team in which every member contributes and is receptive to further development. Like an Olympic team, the dream team is formed through coaching, development, and thoughtful consideration. And like an Olympic team, a strong academic leadership team can bring home the gold.