From command and control to modern approaches to leadership

Prof. Todd Dorman, MD
******@***jhmi.edu

Professor & Vice Chair for Critical
Care, Senior Associate Dean for
Education Coordination Associate,
Dean Continuing Medical
Education - Department of
Anesthesiology & Critical Care
Medicine, The Johns Hopkins
University School of Medicine
Past President - Society of Critical
Care Medicine

Twitter

Historical command and control approaches to leadership fail in building relationships and engendering engagement and thus do not enhance performance like modern approaches to leadership.

Historically, leadership in medicine was taught and practised in an approach akin to the military paradigm of command and control. It was believed that given the need to respond to emergencies in a coordinated fashion a hierarchical approach to management was not only beneficial but required. Such a historical leader was not to be questioned and so the leadership style was both hierarchical and autocratic. Many of these autocratic leaders believed that if they held the most risk, then they should wield the most power and control. Unfortunately that autocratic approach leads to uncoordinated care processes, as each domain only needs to be responsive to its leader. The command and control approach simply does not get the best out of our team members as they are not valued except in how they respond to commands. It also fails to keep the patient and family needs central to decision making.

When something goes wrong, and it will, the historic approach is associated with assigning blame to an individual and thus misses the fact that most events are the fault of the system. In a command and control system these unwanted events should actually be assigned to the leader and not to the staff who happen to be involved in a "not if, but when" situation. In truth, in such a system the leader rarely accepts responsibility. Thus blame becomes the mode of operation and trust is eroded. Blame systems also cause some team members to worry so much about decision-making that they often become paralysed. Unfortunately, indecision, especially in an intensive care unit, can be quite harmful to patients who often require quick decisions.

The staff of such a team may be dedicated to patient care, but they are not fully engaged. Since engagement translates directly into performance, the team cannot achieve the same levels of quality and safety that it might otherwise be able to achieve. Too often, in such a paradigm the leader perceives a high level of respect when in fact they are mistaking fear for respect. Thus the very approach, command and control, actually leads to a lower level of performance and this means that it simply cannot achieve the outcomes that patients and their families deserve. There is a famous saying about raising children, "it takes a village" and the truth be told, the same can be said about high-quality medical care. A leader at the bedside wants and needs the input of every team member, including the family. Autocratic approaches simply diminish creativity and engagement and thus performance.

Consequently, new approaches to leadership need to be sought and taught. The need for this should not surprise us. Healthcare is not static, knowledge constantly increases, and optimal approaches to diagnosis and treatment constantly change. Leadership models change as well.

According to data from the Joint Commission on Accreditation of Healthcare Organizations, communication problems/failures are the leading cause of sentinel events, medication errors, delays in treatment and infection-associated events. For optimal patient outcome, the healthcare

team needs a leader who brings out the best in every member. It can be safely stated that high-performing teams require a leader who does not try to be a hero, but strives to be a multiplier. A leader who creates an open environment that supports and values open respectful communication. Yes, teams need leaders and critical moments require decision-making under the duress of time, but even in those most stressful of times, using everyone's eyes, ears, and experience can and will enhance performance. Leaders who help the team flourish garner respect.

Understanding modern leadership requires that we appreciate the differences between a manager and a leader. The attributes associated with a manager include authoritarian, workfocused, planning and budgeting, control, has subordinates, tends to maintain status quo and aims to do things right. A leader innovates, is charismatic, people-focused, sets direction for planning, develops new ideas, imbues trust and does the right thing. In many circumstances in healthcare, clinicians are asked to do both roles simultaneously, creating confusion for staff and the individual as it may not always be clear which role the person is playing. Thus, when possible, it is best to separate these into distinct roles.

A modern leader strives to make every member of the team feel appreciated and valued. Such a leader avoids using descriptors like "I" and "mine" and instead uses 'we' and 'our'. In meetings they ask for input before offering their opinion so as to avoid stealing a team member's thunder or biasing the discussion. If a team member feels that they are not valued the modern leader helps that individual participate in creating solutions, so that they can be an active part of the solution and not the problem. This type of leader understands the importance of relationships in achieving results.

The modern leader focuses at strengths while admitting there are barriers. This sounds easy, but it is not. Too often, we only see the reasons that things can't be changed or improved. Team members may have a significant amount of pent-up frustration from having tried to facilitate change but having failed or perceiving that the system failed them. Getting everyone to focus on the positive requires practice. It requires a leader to be empathetic. Leaders must appreciate that although things may not have been different in the past, by facilitating and coaching everyone into being co-creators, only then will change, improvement and innovation flourish. These additional inputs are beneficial in such complex systems.

This philosophy affects how they see events and how they structure and conduct meetings. Thus the modern leader spends the majority of time in meetings on identifying what works and what the team does well so that those elements are translated into other domains. The team is encouraged to build from success instead of focusing at the negative. Then, only after working through the strengths, is everyone asked to identify 1-2 barriers. This avoids the barrier discussion from being up front, encourages folks to think about solutions first and not the negative, yet still recognises that barriers exist and need to be addressed. The agenda should be crafted in a manner that mirrors this approach of learning from the positives before getting to the negatives (barriers).

In meetings, a true leader avoids speaking up first as this colours and can dampen subsequent discussions, as some present will be reluctant to speak up in a manner that might contradict the "leader". In addition, by encouraging others to speak up first, a modern leader is allowing the team to work to a solution and thus increasing the team members' sense of self-worth and supporting their work effort, creativity and engagement.

There is an important parallel to mention. Education has been conducted by the "sage on the stage". The sage holds all of the knowledge and their job is to push it to you. Education research has shown that this places the learner in a passive role in which they learn much less effectively. The modern education approach is for the educator to be more a coach, a facilitator and an orchestrator. Similarly, the command and control leader needs to morph into one that does not require their minions to merely passively respond, but to be actively involved and engaged. This easily translates to the bedside where the modern leader engages all members of the team, including family, to facilitate their understanding of the patient and the team's understanding of the complex issues at play in critical illness.

In conclusion, modern leaders are different from the iteration of command and control leaders. They are empathetic and they work hard to multiply the impact of all team members. They are more coach than simply Delphi. Given this coaching role, I will quote a National Basketball Association coach, Steve Kerr, who recently stated in an interview published in Sports Illustrated and written by Chris Ballard, "The people to me who are the most powerful leaders are the ones who have great talent in whatever their field is, great conviction in their ability to teach it and act it, but an awareness and a humility and compassion for others." Clearly there is a new path to leading and maximising performance of our teams all in the name of enhanced patient and family care. Importantly, while this approach helps enhance patient and family care, it also can help empower our team and thus can have impact on the rates of PTSD and burnout in our teams.

Suggested readings

Books

Wiseman L (2010) Multipliers: how the best leaders make everyone smarter. New York: Harper Collins.

Jennings KR, Stahl-Wert J (2016) The serving leader: five powerful actions to transform your business, team, and community. 2nd ed. Oakland, CA: Berrett- Koehler Publishers.

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Website

Robert K. Greenleaf Center for Servant Leadership greenleaf.org

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