

Robert M. Daugherty, Jr., MD, PhD

## Leading among Leaders: The Dean in Today's Medical School

### ABSTRACT

The magnitude and pace of change in the health care environment demand that medical schools change. Leading in a time of great change is difficult, and it is ironic that just when stability in leadership is most needed, the average tenure of deans is dropping. Indeed, the path to leadership in academic medicine is strewn with inherent ironies, paradoxes, and idiosyncrasies. For example, few people who become leaders in academic medicine aspire to, plan for, or seek training for leadership, yet leadership skills are essential to meet today's complex institutional demands. Also, most medical school deans were once medical students, and were selected and trained to be assertive, independent physicians, not to collaborate. For faculty, the medical school environment traditionally values individual autonomy and rewards individual achievement, not behavior that supports a larger community interest. Yet today's deans must be skilled at collaborative behavior, since they must have a vision for their schools

and find ways to offer direction to the faculty and others to realize that vision.

The author offers ideas about leadership and its development, and stresses that good leaders must above all curtail their egos in order to do what is best for their institutions. What a dean does as an individual is not nearly as important as what a dean enables others to do. The author also provides a checklist of deans' characteristics and responsibilities to help deans-to-be understand the job and current deans to think about how to succeed and thrive. He concludes by reiterating that the culture of individual faculty success based on individual entrepreneurship is passé. To operate in the new collaborative culture, today's successful dean must meld persuasion with educational statesmanship, always informed by a vision of how the school can prosper and serve.

*Acad. Med.* 1998;73:649-653.

Oliver Wendell Holmes reportedly once referred to Franklin Delano Roosevelt as "a man with a second-class intellect but a first-class temperament." What Justice Holmes did not question was President Roosevelt's leadership abilities or success as a leader. Throughout history, and from my own experiences, I can think of examples of leaders with first-class intellects and second-class temperaments. Not all were successful leaders. Of what does a first-class temperament consist?

*Dr. Daugherty is dean, University of Nevada School of Medicine, Reno.*

*Correspondence and requests for reprints should be addressed Dr. Daugherty, Office of the Dean, Savitt Medical Building 332, University of Nevada School of Medicine, Reno, NV 89557-0046.*

*The other four Special Articles and the President's column in this issue are also about medical school deans.*

This question is an important one for medical schools. When seeking leaders from among our faculties, it is easy to find people with first-class intellects. However, finding those who also have first-class temperaments is less assured. What are those other characteristics and skills that successful leaders of today's medical schools must have? And, most important, how do we develop and select such leaders?

An important sign of successful leaders is that they understand and act in a manner consistent with the specific situation they are facing. For example, in President Roosevelt's case, the demands of a nation strained by a major economic depression and a world war called for bold, progressive action and a leader confident in taking risks. The same characteristics and actions by a president during a less volatile period in U.S. history might have positioned that presidency to be unsuccessful. A nation at peace and a nation under threat require different types of leaders—as do medical schools.

Medical schools are now a sort of "nation under threat," for reasons we all know well. I am concerned about what the demands of this new, volatile, and sometimes scary external environment means for leaders of medical schools—specifically, medical school deans. The magnitude and pace of environmental change demand that medical schools change, but at each institution, someone has to lead that change. Doing that requires a more active and dynamic form of collaboration and leadership than has traditionally been a part of the medical school culture. For example, success in the new environment is facilitated by collaboration within and between institutions to deliver patient care, or by moving department-based faculty practice plans toward multispecialty group plans. These and other major departures from past practices in medical schools often meet with resistance, making the job of leading change difficult. Accordingly, the job of deaning has become more difficult.

In 1996, I was honored to learn that I had been elected to serve as the chair of the Association of American Medical Colleges (AAMC) Council of Deans (COD) for the 1997–98 academic year. Serving as chair of the COD is a privilege and an opportunity to provide leadership to an extraordinarily impressive group of leaders within American medicine. My position caused me to reflect on leadership in general and specifically on leadership in medical schools. The complexity of leadership in medical schools quickly persuaded me to adopt "leadership" as the focus and theme of my year as chair. Having passed the halfway point into the year, I am writing this article to share some of my ideas and observations with the broad community of leaders who contribute to the vitality and success of academic medicine.

### IRONIES, PARADOXES, AND IDIOSYNCRASIES

One of my primary observations is that leading during a period of significant change creates great hazards for the longevity of leaders, ironically at a time that requires stability in leadership. Indeed, the path to leadership in academic medicine is strewn with inherent ironies, paradoxes, and idiosyncrasies. First, very few people who become leaders in academic medicine seem to aspire to or plan for this type of career or to seek training to help develop leadership skills. Yet leadership skills are essential to meet the demands of leading complex, multi-million-dollar institutions, particularly for physicians who are trained and practice with a focus on the individual rather than on a collective or collaborative view associated with long-term planning. It seems that medical school deans are often selected using criteria that are not consistent with the demands, functions, and skills of the position.

Our academic and medical culture and environment are not conducive to the development of institutional leaders

among our students and faculty. The academic environment traditionally values individual autonomy and rewards individual achievement. Medical schools accept as students people who have excelled in and demonstrated impressive individual achievement, not achievement within a group. Individual achievement in medical school is reinforced in the education process through grades and other markers of success, such as acceptance into the most prestigious residency programs. Indeed, the goal of medical school faculty and administrators is to prepare students to be competitive candidates for selective residency programs, with an ultimate goal to help students develop into effective, independent, self-confident physicians. Our system rewards individual achievement, not group performance, nor behavior supportive of a larger, community interest. Most medical school deans were once medical students. Like current students, we were selected and trained to be assertive, autonomous, independent physicians, not to collaborate.

Historically, we have rewarded autonomy and the individual activities of our faculty rather than their institutional activities. For example, faculty promotion is based on individual achievement. In most instances, securing research funding or achieving clinical recognition is a singular quest and accomplishment. The faculty culture is specialized and decentralized. Most individual faculty members identify more closely with peers in specialty organizations and with their disciplines than they do with the schools where they work. They establish allegiance to the National Institutes of Health or funding agencies that support their research interests. Faculty are encouraged to pursue their own teaching and research interests, often with freedom to decide on what level they will participate in school activities.

The culture and demands of the medical school shape the experiences and priorities of the faculty. The conflict between individual and institutional demands, culture, and the reward system results in the challenge for leaders that has been likened to herding cats. The faculty are members of a collegial body made of individual successes, while the dean "sits" between the faculty and the university administration. Almost by definition, members of a collegium resist being led and have a basic skepticism and distrust of administrators. I find it remarkable how often the faculty at the University of Nevada refer to me and other deans as "part of the administration" or "the dean's office" rather than by name or as "our leader."

The pool of people who are now deans or are positioned to become institutional leaders of medical schools were educated and raised in this professional culture with a focus on an individual, not a collective or collaborative, perspective. In essence, medical schools are led by and are creating groups of people (among them our institutions' future leaders) who are all acculturated to resist being led.

Here I find another paradox. It is not common for leadership to be actively sought or developed in medical schools, yet, in my mind, an effective physician, by definition, functions as a leader. I think of leadership as an activity requiring a person to develop a vision and then make a commitment to turn the vision into a reality. To lead well, someone must be driven by a goal or purpose larger than himself or herself. These characteristics are inherent in the role and function of a physician as a patient advocate and a community resource.

A formal leadership position is an extension of these precepts, and here, too, a sense of purpose is needed. As Tom Gilmore of the Wharton School explained to me, without the moral authority from dreams, institutional leaders encounter difficulty making the tough decisions that today's challenges require. Leaders need to focus on the broad scope and to translate their dreams into applied institutional operations and functions. To accomplish this, a leader must identify the institution's core ideology, lead strategic planning, create a common vision, and offer direction to the collective membership of the organization in order to accomplish the plans and realize the vision.

Let me illustrate by discussing my own situation. In accepting the deanship, and making the transition to an official leadership job, I found it necessary to be more willing to step out front with ideas and initiatives, create institutional goals in consultation with the faculty, and then steer the way. I realized quickly that I could not lead or establish a future direction without input or without being seen. I saw that an important responsibility of a medical school dean is to actively shape and support an environment in which all members of the academic community can succeed in carrying out their own leadership roles, both individual and institutional.

The dean has always played a significant role in shaping the environment in which the faculty teach and pursue scholarly activity. In what now seems like the distant past, I remember most deans' using and describing a "hands-off," facilitative approach or leadership style. They allowed the environment to "develop." Such an approach was consistent with the manner used to select deans. Most deans were chosen by a search committee, based on evaluation of the candidate's scholarly accomplishments and patient care expertise. As a faculty member, a prospective dean had achieved academic success. Is this the most appropriate way to continue to select leaders for the future? Moreover, what message are we in the community sending to potential future leaders by adhering to such selection criteria and processes?

Unlike most institutions, medical schools do not have processes or cultures that support the development and long tenure of the school's most identifiable leader, the dean. As I listen to personal stories and reports by colleagues, it is clear

to me that most people who become deans or institutional leaders in academic medicine do not set out with or admit to having such aspirations. Very few plan for such a career or seek training to help develop leadership skills. My point is illustrated repeatedly in annual sessions organized by the AAMC for newly appointed medical school deans, associate deans, and department chairs. During one portion of these seminars, for example, the presenter asks participants to reflect on how close friends and colleagues responded to the news of accepting a significant and administrative leadership role. The stereotypical comments range from, "Congratulations and condolences," to "It's the end of your career." One new dean told a friend, "I was trapped into administration, and it was either retire or accept the deanship." The friend responded, "Aren't they the same thing?"

### HEIGHTENED THREATS AND CHALLENGES

These cultural characteristics and trends were less problematic previously, when the external pressures on medical schools were less intense. Now, the external environment presents heightened threats to medical schools and heightened challenges for deans. I am not surprised by the finding reported by Levin and colleagues in this issue that the average number of years in a medical school deanship has dropped in recent decades.<sup>1</sup> I personally feel more intense demands on my leadership, management, and administrative skills than when I began serving as dean 17 years ago. I have more accountability, but no more authority. I am not alone in my perceptions.

In 1996, the COD Administrative Board identified and began to address concerns related to the national trend of a decreased average tenure of medical school deans. We hoped to gain insight into why there was a high turnover rate of leadership in medical schools. Board members agreed that a sensible initial approach to address such concerns would involve collecting data and developing a better understanding of the problem. Our second step would be to direct development of programs or interventions designed to reinforce the effectiveness of the dean and the dean's office.

The findings from our first step are presented in the article by Yedidia in this issue.<sup>2</sup> His report is the result of a study involving interviews with 22 former and current medical school deans and vice presidents. The perceptions shared in the 22 interviews reveal what a sample of leaders believed to be among the most essential features and personal characteristics of medical school leadership. The characteristics identified as essential included:

- Patience with process
- Tolerance of ambiguity

- Ability to listen to diverse points of view and devote attention to a variety of complex issues at once
- Ability to be flexible and open to persuasion
- Ability to take pride in the accomplishments of others

In summary, patience, listening, and flexibility are important to enable the leader to capture the different interests that can then give shape to the vision of the institution.

That article identifies some important ingredients in building a foundation for stability in medical school leadership. I believe Yedidia's findings will provide insight and guidance to individuals considering a deanship, as well as those institutions in the process of searching for or selecting a dean. However, his report is *not* a study of leadership. It does not attempt to define leadership. It does not describe how to develop or acquire leadership skills, ability, and knowledge.

Defining leadership and its development is not easy. But let me offer some ideas. First, I believe that a good leader must, above all, curtail his or her own ego in order to make the kinds of decisions that meet the needs of the institution. As dean, the comment that I most appreciate receiving is "You always are trying to obtain or do what's best for your school." Leaders must place the needs of their institutions above their individual needs. The transformation will not be evident to all observers. The public and faculty's perception of the school develops from the words and actions of the dean as he or she presents and represents the students and faculty of the school as the best and the brightest. The successful dean as leader derives satisfaction from the accomplishments and contributions of the faculty and staff and from the learning of the students. What a dean does as an individual is not nearly as important as what a dean does to enable others to do.

#### A CHECKLIST AND RECOMMENDATIONS

I have created a checklist for "the dean" to outline what I consider to be the characteristics and responsibilities required of leaders in academic medicine in today's environment. This list should help deans-to-be understand the job and should assist deans in thinking of how to be successful, survive, and thrive.

##### *Checklist for the Dean*

- Are you aware of conflicts between the educational mission and the clinical enterprise?
- Have you considered the amounts of effort and time needed by you to assure sufficient collaboration among the educational and clinical components?
- How do you resolve conflict? Do you enjoy or avoid conflict and its resolution?
- Do you enjoy and can you deal with the many issues in a day that need consideration and possibly decisions or resolution?
- Do you have a vision?
- Do you enjoy bringing groups together to develop and plan?
- Have you thought of how to bring department chairs together in the new collaborative culture to share decisions and develop a common vision?
- Do you enjoy working long hours?
- Can you enjoy not controlling the schedule of most of your days?
- Have you had experience dealing with personnel issues (e.g., promotion and tenure denial) and/or disciplinary issues (e.g., dismissal of an individual or reprimand of an individual in areas of sexual harassment, patient care, student interaction)?
- Can you be happy with an ambiguous job description, as well as the lack of clarity of a clear mandate from the president or your immediate supervisor?
- Do you enjoy meetings back-to-back throughout the day, some with just one or two people, some with ten or 12 or more?
- Have you had experience working toward collective goals outside your own research, teaching, department, division?
- Can you negotiate in "good faith" with someone who is not a friend or who does not appear to share your professional and personal values?

Strong and enduring leadership is critical to the stability and long-term survival of most institutions, and certainly to medical schools. Stability in leadership contributes to a dynamic strategic planning process, the ability to make decisions, the ability to implement a strategic plan, and the ability to achieve long-term institutional goals. I have witnessed and steered enormous change at the University of Nevada School of Medicine in the 17 years I have served as dean. Yet, my situation is highly atypical. The average contemporary medical school has three or four deans in the period of time I've been in the deanship at Nevada. In 1980, the average length of time in office for a medical school dean was nearly seven years; today the average dean lasts less than four years. Longevity trends for medical school department chairs appear to be moving in a similar downward direction. Such instability causes concern for both the institutions and the individuals involved.

I believe the academic community must devote considerably more effort to developing and supporting leaders. To start, we must devote significant effort to understanding the issues. And, we must develop thoughtful approaches to support the enduring leadership that will promote our institutions' enduring successes. The next step is for the AAMC to

turn to the issue of how to reduce the risk of failure of current aspiring deans, and to help develop a pipeline of people poised to move into the many leadership positions that will carry academic medicine forward successfully. As we design ways to lower the risk of failure, it is imperative that we also establish programs to develop leaders from within our medical schools.

The main question for academic medicine today is: How do you provide leadership in today's culture for tomorrow's academic community? And related questions are: Should the culture change? What are new definitions of academic success? How can deans and other academic leaders manage dynamic institutions and support successful faculties?

I believe the culture is changing and that the new culture requires a more active and dynamic form of collaborative leadership. Today's culture demands more collaboration, with group process leading to the desired outcomes. Collaboration within and among institutions is already commonplace. Multidisciplinary research programs that cut across basic science disciplines and across clinical departments

have become the prototypes for success. Simultaneously, to be successful in the patient care marketplace, medical schools are moving department-based practices into multi-specialty groups. Today's success is predicated on "one for all and all for one." The culture of individual faculty success based on individual entrepreneurship is passé. In this new world, the successful dean is one who is active, is dynamic, and can meld persuasion with educational statesmanship, always informed by a vision of how the school can prosper and serve.

---

#### REFERENCES

---

1. Levin R, Bhak K, Moy E, Valente E, Griner P. Organizational, financial, and environmental factors influencing deans' tenures. *Acad Med.* 1998;73:640-4.
2. Yedidia MJ. Challenges to effective medical school leadership: perspectives of 22 current and former deans. *Acad Med.* 1998;73:631-9.