10-15-2016

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Two Models of Health Sciences Center Leadership During Turbulent Times

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Abstract

Leadership and change in health sciences centers are explored through contrasting two models of leadership: commonly practiced leadership and what has been referred to as "good enough leadership" (GEL). Several common cases or scenarios are presented through the lens of each model, with the conclusion that good enough leadership is more functional, creative, and healing than more widespread conventional models.

Introduction

This paper explores two models of health sciences center leadership in stressful times of enormous cultural and economic change. The two models are (1) what might be called conventional and widespread styles of leadership, and (2) what has been called the Good Enough Leader (GEL) style of leadership (Stein & Allcorn, 2014; Allcorn & Stein, 2015). Conventional leadership styles and organizational scenarios are described first through four vignettes or cases. Psychodynamic analyses of them are offered, as well as an exploration of the consequences of the leadership styles. An alternate, more humane, and functional model of HSC and COM leadership, which is referred to as Good Enough Leadership, is proposed later in the article.

The authors have spent their entire careers, each over 45 years in academic health sciences centers, one as an executive in multiple health sciences centers (Allcorn) throughout the US, and the other as an applied medical anthropologist teaching in schools of medicine (Stein). Both have served as organizational consultants. Likewise, both possess considerable experience with health sciences center downsizing.

Enormous change has characterized the experience of working in health sciences centers since the 1970s. These experiences include waves of organizational expansion and contraction; international financial crises; downsizing, restructuring, reengineering, and deskilling of the workforce; evolution of the computer as the major system of communication between individuals and institutions; communication dominated by the electronic medical record (EMR); an increasingly corporate-and insurance-company regulated practice of medicine and payment for services; the introduction and routinization of managed health care; cuts to state funding of universities; and a widely experienced deprofessionalization and mechanization of health professionals into employees of a business (Allcorn & Diamond, 1997). Countless physicians and nurses have said to one another and to the authors that they no longer feel the relationship to the patient and the treatment of illness are the primary factors that drive the health sciences centers. Rather, classification (coding) of diagnoses and treatment; profit; corporate structure; and competition, cost effectiveness, and productivity have become the foundation of health sciences center life.

It is in such an atmosphere that leaders of health sciences centers manage their organizations and address the reality of constant change. The ravage of change occurs both from the outside and from within. One need only think of leader toxicity, harm, and waste to realize

that, while leaders often invoke *outside* dangers to account for all present problems and the need for drastic solutions, it also is often the case that this finger pointing serves to displace attention from *internal* emotional poisoning of the workplace. It is against this background that two types of leadership are discussed through the medium of four brief and commonly experienced vignettes/cases and a discussion/analysis of each.

Case 1 – Breakfast

It was a clear and cool morning on what would be possibly another hundred degree day in the southwest. A new medical school dean was having his first breakfast with the two key administrative deans of the school, as had been the custom with the former dean. Breakfast was provided usually once a week, giving the three deans an opportunity to explore events of the past week and to discuss actions to be taken in the next few weeks. These breakfasts were enjoyed and had a very nice sense of inclusion and collaboration. There were many challenges to be met and often unanticipated problems and issues to be resolved. It took an excellent team to accomplish this.

The new dean was clearly uncomfortable with this gathering. During this first breakfast he lectured the two administrative deans on his view of performing his job and running the medical school. He began by saying, "I want to be dean for a long time." In order to achieve this, he indicated he had to deal with what, in his view, was a 80/20 split among faculty. Eighty percent as a group could be actively supportive, or at least passively supportive – creating no challenges or problems for his leadership. However, the remaining 20% could be a problem, in that in one form or another they are going to challenge, attack, backstab, and otherwise obstruct and make life miserable for him. Given this eventuality, he was going to focus on them, pursuing a strategy of trying to assuage, buy off, or otherwise neutralize them.

After the breakfast, the two administrative deans began to realize they were being reduced to players in this grand scheme, and the good energy and spirit of breakfast with the former dean was now in the past. It was not long before the 20% rule began to adversely affect operations. Faculty, some in senior leadership roles who were aggressive, sometimes self-serving, and willing to do what was necessary to have their way, began to test the new dean with the predictable response of him yielding to neutralize the threat. Standing against them as the former dean had done was clearly off the table. While he appeared many times to be in charge of

the school, deals were being cut behind the scenes to buy off the troublemakers. He was following the phrase of keeping friends close and enemies closer.

This type of strategy certainly is not new. Yielding and cutting deals to buy off the aggressors seldom appears to work, as evidenced by Neville Chamberlain's "peace in our time" deal with Adolf Hitler. In this case the approach seemed to encourage the behavior by rewarding it. Gradually, a number of areas of the medical school's operations began to be compromised by the deals or constant meddling, manipulation, and threats to some of those leading important administrative aspects of the school. In one instance an especially aggressive faculty member with an administrative role created a situation in which he demanded one of the administrative deans do something, although the dean had no authority to do so. This began a sequence of events that eventually led to the administrative dean accepting a position at another school. The dean would not support his people if it meant challenging some of those in the 20%. Thereafter, more unaddressed operating problems arose, detracting from overall performance.

Discussion and Analysis of Case 1

There are a number of ways to understand this story. For example, the dean did not stand up and set boundaries similar to the former dean, who was willing to handle tough problems that required confronting dysfunctional faculty. Rather, he appeared to have led by buying off his restive subordinates. The new dean communicated his *underlying job description and mission statement* at breakfast: to be the medical school dean for a long time. His *modus operandi* was to capitulate to the wishes and demands of subordinates. Nothing was said about core principles or setting limits, or of long-term plans, as his style was to maintain his position by pleasing people, buying them off, one at a time.

All of these circumstances rest on narcissism; poor self/other boundaries; grave self-doubt (as in, "Whatever you want I want, so that I can keep my job as dean."); the need for approval; and a passive aggressive, indirect response to conflict. Buying off potential resistance was interpersonally dishonest and organizationally disastrous. With this scenario, only short-term planning was possible – "putting out fires," as it is often called. Operating problems were left to fester. The new dean confused his personal wish to keep his position with the needs of the medical school. The medical school was left floundering.

Case 2 — Is there a leadership problem here?

A large academic health sciences center recently experienced significant leadership turnover punctuated by one year tenures of interim campus presidents and School of Medicine deans. In less than five years three externally recruited presidents and two interim presidents each served one year. The School of Medicine had a relatively new dean who departed, followed by an interim dean, and then a newly appointed dean. Sudden, sometimes short-term changes in direction or, in some instances, no direction at all or clearly self-serving actions were the pervasive sense of this leadership context. This chronic turnover of leaders had been the topic of articles in the local newspaper that publicly asked, "Is there a leadership problem?"

Discussion and Analysis of Case 2

Many organizations, higher education included, often experience a "revolving door" of upper management. The "leadership problem" in the previous vignette consisted in part of university presidents, deans, and interim deans who, driven by narcissism, temporarily exploited their positions and hurriedly left – leaving others to pick up the pieces. It in fact almost always was about them and their career and reputation. They had "exploited" the emotional neediness of the university and School of Medicine by promising to rescue them from a declining reputation and a decreasing influx of external funding. No progress, however, occurred.

In this case of shamanic leadership and followership, they emotionally "fit" with one another. The needy university and School of Medicine were ripe for leaders who wished to take advantage of them, in a sense fulfilling their identity of being unworthy. As is often the case with all types of organizations, public and private, recruiting senior executives resembles a mutual seduction process in which the potential leader promises emotional and financial supplies to the emotionally vulnerable and needy organization.

Case 3 — Regime change

A college of medicine dean (Bill), who has near absolute control of all matters financial, dominates every aspect of the several hundred million dollar organization. No facets of the operation are too small to miss his attention.

Organization members are fearful of this executive, who has a 30-year track record of hammering anyone who crosses him. Many have been subjected to continuous bullying and intimidation. Some survivors who did not voluntarily leave feel exhausted, drained, and unsure of themselves.

Ironically, a new Vice Chancellor for Health Affairs and former Medical School Dean (Jennifer) forces him out and also assumes the role of micromanaging and intimidation — described by organization members as "the new Bill." It was clear that there was room for only one of these types of leaders in the organization, and Bill had to go. Organization members continued to feel dominated, oppressed, over controlled, and at risk, other than those who, in the eyes of others, "sucked up" to this new leader.

Discussion and Analysis of Case 3

This story illustrates what has been referred to as "hard" leadership (Stein & Allcorn, 2014). Both Bill and later Jennifer are obsessed with power and control and drill down their will through micromanagement. Bill and Jennifer are abusive, even brutal, toward their subordinates; and the workplace is terrorized and oppressed by them, even when not physically present. Virtually everyone attempts to perform his or her job and to keep a low profile ("stay under the radar"). Everyone lives in constant fear. Employees feel they have a "target" on their backs. Some feel they can save their bodies, souls, and careers only by leaving – but the years of bullying take a toll through a type of PTSD. They carry their terrible experiences with them, are haunted by them, and any similar occurrence in the new workplace triggers a re-experiencing of the earlier trauma.

Leaders such as Bill and Jennifer feel the need to be "the only one" in the School of Medicine and the health sciences center. Malignant narcissism and the need for inordinate power mask vulnerability and a sense of emptiness that can be "treated" and reversed only in a social role in which they are unassailable – and, as is often the case, treat others as they were treated in their families of origin. Further, the reign of terror often is inadvertently invited. Trustees, regents, and boards of directors often feel their medical school or university is in decline and someone is needed who promises to turn it around to restore the past greatness of the college and university. Often it is the case that "turn around leaders" leave the organization in chaos and worse than when they arrived.

Case 4 — Life in the trenches

A geographically decentralized health sciences center has had turnover for a number of years in most of the senior leadership roles. These roles historically have been filled through upward promotion of healthcare professionals who possessed an eagerness to "make things happen," but who had few leadership and managerial skills to do so. This has created a chaotic sense of top management on the part of the employees. Many of those who aspired to lead had left, having failed in their role. A closer inspection of this organization reveals that it kept running not by senior management but by the employees who continually fill in for the many leadership and management gaps created by upper management. Employees accomplish the work and keep the health sciences center running, despite the executives.

Discussion and Analysis of Case 4

The story in Case 4 is all too common. Promotion of employees who have "risen up the ranks" of the organization involves the virtue of having executives who know the workplace well – unlike bringing in a new leader from a totally different work environment, an individual who only knows how to manipulate numbers. On the other hand, a leader who rises within may possess proficiency in only relatively constricted roles and may have few leadership skills to manage an entire organization.

The complicating factor for this organization is its complex structure that distributes authority and responsibility throughout the state, which makes the need for balancing autonomy and integration even greater than if the organization was in only one location. In this health sciences center, the new leaders do not have the interpersonal and organizational skills to be effective leaders. One could say, psychodynamically, that they are high on narcissism and low on mature object relations. Feelings of omniscience and omnipotence are accompanied by poor reality testing. This health sciences center coheres and remains functional due to the hard work and dedication of employees who pick up the pieces of failed leadership and assume these functions – and for the most part are unrecognized. This is also true in Case 2. This dynamic occurs all too often in dysfunctional workplaces, in which informal networks of employees compensate for the incompetence of leaders.

An Alternative Model of HSC Leadership: The Good Enough Leader (GEL)

These four case examples are commonly found in academic medicine. Each is different from the others in the specifics, but they share common dysfunctions often driven by an unacknowledged element from the dark side of human nature, discussed here from a psychodynamic perspective. Regrettably, often there is little one can do when these dysfunctions are created by powerful leaders. Only the "fool" (as in court jester) attempts to do so and at great risk. Leaders such as these, when challenged, often respond punishingly, possibly ending one's employment and career. Very often the messenger is killed and the scapegoat slaughtered.

An alternate method exists to envision leadership and management. The principles of a *good enough leadership* (GEL) offer a new, different, and challenging approach that can in practice avoid outcomes similar to those in the four examples (Stein & Allcorn, 2015). Before discussing GEL, it should be made clear that this is an approach to leadership that requires much from the individual in the role of leadership. In particular, GEL is founded on the ability to become and remain reflective, avoiding psychological regression that arises from excessive anxiety, with its origins in overdetermined deeply personal needs to be loved, admired, and in control.

Based on the authors' experience and close observation of hundreds of leaders in academic medicine and higher education, they have infrequently observed leaders who possess these "personal skill sets." Two things should be acknowledged. First, the leaders who often float to the top of organizations do so because of their individual neurotic tendencies, not despite them. Second, a good enough leader is an individual with a strong, well-integrated sense of self who does not often become personally disorganized under stress, and thereby remains thoughtful, reflective, and not personally threatened by events.

A discussion of good enough leaders follows that links back to the previous four case examples for purposes of comparison and operational definition. The GEL leader works hard to avoid being driven by his or her unconscious dark forces (Stein & Allcorn, 2014; Allcorn & Stein, 2015). The GEL leader's personal needs are subordinated to a larger purpose. Difficult decisions can be made without the leader seizing unilateral control of the work and bullying employees. The GEL leader

listens attentively to others *before* acting. As the GEL leader seeks others' perspectives, he or she does not self-isolate and is not alone at the top. Decisions are made with employees, not *despite* them. For the GEL leader, there are no dark secrets, no "black boxes" to which only a few are privy. Everything is put "on top of the table." The GEL leader encourages storytelling and is a willing listener. He or she desires to know the way in which employees experience their organization and its leadership.

For the GEL leader, making hard decisions and implementing them is an open, inclusive, transparent, collaborative, trusting, and respectful process, rather than a unilateral, top-down, and frequently poorly informed dynamic. The GEL leader does not treat fellow executives, managers, and employees as *objects* through which to impose one's will, but rather as *experiencing subjects* with whom the leader collaborates. The GEL leader is able to stand solidly in the rapid stream of organizational process – often chaotic – and to let the stream flow around him or her without toppling into personal disorganization.

Perhaps above all, the prerequisite of being a GEL leader is what Donald Winnicott called "the capacity to be alone" (1958). This capacity is one based on early experiences of being alone *together* with the mothering or caretaking figure, and internalizing the good enough caretaking relationship. Here the mothering figure is soothing and nurturing, absorbing the baby's anxiety and anger rather than retaliating.

This capacity for integration and self-differentiation creates a quality of self- and other-experience far different than stone-like isolation from others and the experiences of aloneness that have been described previously. Paradoxically, the GEL leader can reach out for support and test ideas with others without feeling diminished. Finally, GEL leaders are not driven by unconscious dark forces, although they can recognize them in themselves and others through the process of self-reflection.

Implications of GEL for Health Sciences Center Leadership: Return to the First Four Vignettes

To illustrate the manner in which GEL leadership is practical in the management of colleges of medicine and health sciences centers, the GEL concept should be applied to the previous four scenarios and imagining how the process and outcome might be different. In the first case ("Breakfast"), the GEL leader would not lead by bribery and virtual blackmail. Although he may have wished to be dean for a long time, this would not be his mission, but rather an outcome of his mission; e.g., to meet the challenges discussed at the initial breakfast and to address unresolved and unanticipated issues. The administrative deans and faculty would not be treated as extensions of the new dean's grandiosity and narcissism, but would be treated as valuable and skillful administrators and faculty with separate personalities, needs, and contributions.

The GEL leader would not passively "buy off" and forestall attacks by aggressive, often senior faculty, but would establish clear boundaries and ask that they contribute to the organization – rather than exploit the institution for private gains. He or she would not rely on the 80% of the faculty to be supportive of the leadership, but would attempt to engage their interests, talents, and commitments to the organizational mission and goals; i.e., their support would not be to and *about him or her*, but about the work of the medical school. The GEL leader would strive to be open, inclusive, transparent, collaborative, trusting, and to respect them, rather than to rely on bribery to accomplish work. He or she would not respond to others' aggression with passive aggressive maneuvers but would be direct in a response.

In the second case ("Is there a leadership problem?"), a new GEL leader would first interview and get to know many employees at all levels of the organization regarding the history of the health sciences center in which leadership turnover occurred. He or she would attempt to uncover meanings, relationships, feelings, and metaphors beneath the manifest problem of leadership turnover. He or she would try to gain a sense of "what it is like to work here." Perhaps a sense of loss and grief, and of shame and guilt, pervaded the institution. Perhaps the legacy of a previous strong leader existed who harshly imposed his or her will on the health sciences center. First and foremost, the (prospective) new leader would not enter the revolving door with the narcissism-driven arrogance that "I can fix this problem because I am better than my predecessors." Humility, curiosity, compassion, and a steady hand are the prerequisites of the GEL leader in these circumstances.

In the third story ("Regime change"), a GEL leader, perhaps a new dean who replaced the ousted dean of the College of Medicine, would strive to create a clear boundary between the College of Medicine and Jennifer, the new Vice Chancellor for Health Affairs, in order to protect those in the medical school. This is a tall order and might not be possible. The dark forces of

Jennifer's voracious appetite for exclusive dominance ("only room for one, and that one is me") to feed her insatiable narcissism might create an atmosphere in which even a GEL leader would fail and be driven out. To complicate matters, even if the new GEL dean could somehow prevail, he or she must deal with the *emotional legacy* of Bill's bullying, hammering, intimidating, and emotionally terrorizing the entire College of Medicine. A period of rest and recovery would be needed from the feared and despised former leader. The memory of the former dean likely would haunt the medical school and its new dean. Specifically, faculty and other employees might treat (via transference) the new dean as if he or she was or will become abusive and intimidating ("See, he/she's just like Bill."). The new dean would, thus, need to help the faculty and employees work through the transference in order that the dean emerge with a distinct identity and relationships not haunted by the past leadership. Ideally, the new GEL dean would help faculty and employees to begin to feel emotionally safe, not abused, free to be open and creative and to feel empowered.

This healthy outcome is not inevitable. Governed by projective identification, the faculty and employees might attempt to "force" the new dean to act the same as the previous dean. The GEL leader would need to be in-the-moment reflective and to recognize the unconscious transaction that was occurring. Also, Jennifer's need to be "the only" one with power, a nonpareil, might result in her insistence on violating the boundaries of the College of Medicine, marginalizing the new dean.

Finally, in the fourth scenario ("Life in the Trenches"), the new GEL leader, whether "rising through the ranks" of the health sciences center or brought in from the outside, would need to resist the temptation to try to "make things happen," as occurred with the predecessor. Rather, the new GEL leader would seek to empower faculty and staff to have their voices and concerns heard, to be part of solutions rather than the victims. The GEL leader would need to relieve faculty and staff of the role reversal for which they had so long compensated for failed leadership. The model of leadership would be inclusive and collaborative rather than imposed. The GEL leader would, through making clear boundaries, reclaim the responsibility of making the ultimate decisions. Simply put, senior GEL management would lead the organization, rather than abandoning faculty and leaving employees to their own devices.

Further, due to the wide geographic distribution of the decentralized health sciences center, the new GEL leader also would need to work toward an open, inclusive, transparent, collaborative, trusting, and respectful relationship with leaders of branch or satellite components of the health sciences center across the state. This would involve face-to-face meetings, followed by possible regular teleconferences to keep everyone informed and able to test reality, rather than feel abandoned to their own imagination.

In Conclusion

This paper has explored leadership and change in medical schools and health sciences centers through the lens of two contrasting models of leadership, conventional and widely practiced styles, and the style being referred to as "good enough leadership" (GEL). Several frequently encountered cases/vignettes/stories/scenarios have been provided and examined as if GEL leadership was practiced. The authors have suggested that medical schools and health sciences centers could emotionally and functionally improve and prosper if principles of GEL leadership are practiced. They also were cognizant of the fact that the dark forces of the unconscious could undermine attempts at GEL leadership in health sciences centers and elsewhere.

GEL leadership is not a permanent cure for toxicity in institutions of higher education. Rather, the GEL leader is perhaps the first individual to acknowledge the *presence* of toxicity that could sabotage the best conscious intentions, strategic plans, and temporary successes. Paradoxically, the ability to recognize and articulate the presence of these toxicities – the unconscious becoming the conscious – offers the best chance that they will not blindside and ruin efforts to foster a humane, creative, healing, and functional educational environment.

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