FOREWORD

I am a coach. I mostly coach physicians, but sometimes other professionals find their way to me. Coaches aren't supposed to give advice, but I'm also a retired physician leader who has held leadership roles in clinical care and medical and health sciences research. Other physician leaders, particularly new ones, keep asking me for advice. This book is an attempt to resolve that conundrum. It's written from a physician viewpoint, but I suspect that any professional who must lead amongst highly qualified and often very independent peers will be able to relate to the examples used.

Writing a book for physician leaders may seem like an exercise for a very narrow market. That depends on how you define leadership. Most popular definitions reflect the idea that leaders influence and guide individuals and groups to achieve things. Those definitions do not include a requirement for a title, authority or formal qualifications. Neither does this book. Whether it is supporting patient and families through medical complexity, doing a small quality improvement project, running a clinic or department, or overseeing a facility or an entire healthcare system, leading is something all physicians are likely to do in some way, and at some time in their career. This purpose of this book is to help physicians be ready in those moments.

There are now many excellent resources to support and train physician leaders who do take on more formal leadership roles. Imagine if we lived in a world where physicians made an early career choice that they wanted to lead. They would then enter a clear career pathway that provided incremental training in proportion to needs of steadily increasing

leadership responsibilities. They'd have time to participate in the available excellent training relevant to their needs before they needed to apply those skills and knowledge, or at least, just in time. For most physician leaders, this career path remains a distant hope rather than a reality. My coaching clients usually come to leadership down one of two pathways. The most common is that a senior or respected colleague taps them on the shoulder to take on the role. That role is often already vacant or about to become so. This happens more often during crisis points for organizations or parts thereof. There's little or no time for preparation for the role. The other path is taken when someone becomes sufficiently passionate about a cause to step up to try to make a difference. They're armed with passion but poorly prepared for the process. In both cases, they are dedicated, passionate people who usually take on the leadership role while continuing to do the same amount of clinical care, teaching, and research, while also juggling a life outside of medicine. With six months' notice, on a good day, assuming no one else in the department or their family has a crisis and there aren't any unexpected budget cuts, they might get to one leadership course per year. If that describes your lot, this book is written for you.

Helping clients explore for resources and ideas that will help them excel falls within the mandate of a coach. There are challenges doing this with physician leaders. Physician leaders often have limited time to dedicate to research about leadership. They also often need these different skills urgently. Although physicians are highly educated and better trained in the use of literature than most people, they live in a narrowly focused academic world. Although this is changing slowly, most of the high quality, evidence-based leadership-practice research literature exists outside the health sphere. This is not a road well travelled by physicians. The final challenge is that physicians are bred and trained to be skeptics. They prefer resources supported by empirical proof.

I'm commonly asked, "*Is there somewhere where introductory physician leader stuff is all in one place?*" If there is, I have yet to find it. Think of this book as the travel guide you might buy before a major trip. It provides some suggested itineraries around common challenges. It covers

some of the background and details that you might find along the way. It points you in the direction of other resources that might be helpful and of interest. This book is not a deep treatise on leadership theory. No disrespect is intended to the deep wisdom that exists in these many frameworks. You'll find many of them listed in the "Further Reading" sections. Everything listed in those sections was, at the time of writing, accessible through online book shops or online academic library services that most physicians other high-level professionals should be able to access.

The order of the topics in the book is deliberate. It reflects the most common sequence of concerns that new leaders have presented to me in coaching and workshop sessions. I have tried to write each chapter so that it can stand alone as a reference in time of need. This means you can choose to read the book cover to cover, or cherry pick chapters that meet your immediate needs. If you do the latter, I would still encourage you to read and reflect upon the first two chapters first; understanding your own vision of leadership and the skills of engaging with others underpin almost everything else.

This book is about leadership tactics rather than theory; it's a manual of things physician leaders can actually do to work with the common conundrums they face. I touch on some of the theory behind these practices, but I do so lightly. My goal is to provide physician leaders with some tools to use right from the start of their leadership. This book will not take you straight to the mastery of leadership, but if it helps you to experience some early satisfaction and success, and that in turn stimulates you to engage deeper, I will be delighted. This book is about "how." "Why" is another journey for you.

I have used and coached with everything in this book in the service of medical leadership. Consider everything field tested. There are some areas that physician leaders find challenging that are not included. Finance and contracts do fall within the sphere of operations of some physician leaders, but working with these often involves very detailed and specific processes that are unique to the organization involved. Rather than sow confusion, I urge you to seek organizational support

for these situations. Negotiation is mentioned briefly in the chapter on Conflict, but if this is to be a major part of your role, I strongly encourage you to both read deeper and complement that reading with training by negotiation specialists. Many of the concepts introduced are supported by specific intensive training programs that you may find useful if those models resonate with you.

This book is not an alternative to coaching. Discussions around application of the practices described here are good starting points for both informal and formal coaching conversations. Awareness of the value of coaching to leadership and subsequently to organizational quality is growing in the physician leadership world. Application of that awareness to structure, policy, and practice still has some way to go before access to this type of support is as widely available to physician leaders as it is in most other high-technology, high-performance environments. I hope you will explore the benefits coaching can offer your leadership.

Good luck and smooth sailing on your leadership journey!

OUR CAST

This book is going to follow the initial journey and challenges of two new, but imaginary medical leaders. You'll meet them as they face issues that are commonly experienced by physicians who take up the leadership mantle. While the characters are fictional, their circumstances and conundrums are almost certainly going to resemble those of "anyone living or dead" to some degree. Great pains have been taken, however, not to draw on any complete, individual real-life situations. Scenarios have been synthesized from elements of many, many physician-leadership and physician-leadership-coaching encounters. If you think you see yourself or someone close to you in the story, it really is coincidence!

Rosalind is a thirty-eight-year-old emergency physician who has just taken on the role of Chief of Staff at a hospital in a small rural city. The hospital has seventy-two beds with specialist support in Anesthesia, General Surgery, Internal Medicine, Obstetrics, Psychiatry, and Pediatrics. Some visiting subspecialists also hold privileges. The nearest tertiary facility is about four hundred kilometres away, so the hospital often confronts challenging clinical situations as the first line of care. Rosalind had served as the head of the Emergency Department for a bit over two years prior to taking this role.

She took that position a year after arriving in the community with her partner, Susan, after a stint in Africa with Medicin Sans Frontiers. She and Susan, who is a freelance web-designer and digital-marketing specialist, love the lifestyle of the region, have bought a small ranch, and are exploring options to start a family. Rosalind is passionate about healthcare equity and finding ways to improve services to marginalized groups

in society. She is well liked by ER staff and many of the younger physicians but has experienced some friction with some of the senior medical staff members, particularly when she has felt they've been dismissive or not adequately responsive to ER situations and requests.

Rosalind took the position after it had been vacant for several months after the previous incumbent developed a serious illness precluding a return to work. She accepted the position with some reservations but at the urging of the regional executive medical director. Although she was the only candidate, she was interviewed by a search committee consisting of both medical staff and administrative representatives, and it's rumoured that she received a majority, but not unanimous, recommendation.

Sanjay is a thirty-nine-year-old Internal Medicine specialist with additional certification in addictions medicine. He has just been appointed department head of medicine at an urban community hospital. The 220-bed community hospital has no formal subspecialty medical departments. He has twenty-three department members consisting of thirteen internal medicine specialists who do general medicine and some ICU call, four cardiologists working a separate call schedule, four physical medicine specialists, a solo endocrinologist, and a solo rheumatologist. The department is hoping to set up a gastroenterology group one day.

Sanjay and his wife, Evelyn, have two school-age children who are very active academically, in sports, and in music. Evelyn works four days per week as a social worker with an agency helping women offenders. He also has extensive extended family connections within the local Tamil community, including his aging immigrant parents who have some chronic health programs. Keeping his family connected to that origin is important to him.

He is passionate about providing high quality, evidence-based care. He likes to work by building consensus, and he's popular with non-medical staff, medical students, and rotating residents. He's had some frustration with perceived administrative barriers to care, and at one point, he was referred to work with a mediator around some harsh words with a site director.

Sanjay was asked to take the role by the Chief of Staff. There was no formal search beyond the Chief of Staff asking if there were any objections at a department meeting, and again inviting opinions from department members in an email. In compliance with the medical staff bylaws, the appointment was recommended by the hospital Medical Advisory Committee without discussion and subsequently confirmed by the Board.

WHY AM I LEADING?

Rosalind comes into an 8:00 a.m. to 4:00 p.m. day shift the day after the announcement of her appointment as Chief of Staff, effective in about two weeks, was sent out to all medical and hospital staff. Throughout the morning, staff in the ER congratulate her on her new appointment and wish her well. While waiting in line at the coffee shop, one of the senior internal medicine specialists stops as he passes her. Raising an eyebrow, he says. "So, you're to be our new Chief, are you?"

"I am," Rosalind replies, "starting in two weeks. I think I'm looking forward to it and dreading it at the same time!"

"Well, I guess we'll see if you can last longer than the last one. It's not really a job for a … millennial," he replies, walking away without waiting for a response.

Rosalind is a bit taken aback, but it's not her first prickly encounter with that physician, so she tries to brush it off.

Later in the day, at the end of her shift, she hands over to a colleague whom she considers a friend.

"Rosalind, I didn't know you had applied for the COS job. Why did you do that? The old-fart brigade here will make your life hell. Why not just keep your head down and leave the politics to someone else—you're too nice for that job."

This is not the vote of confidence for which she had hoped. When Rosalind gets home, Susan takes one look at her and asks, "What's wrong?"

Rosalind frowns. "Am I making a big mistake taking the Chief of Staff job?"

Susan smiles. "I think we need a glass of wine for this conversation"

Choosing to lead

"Why become a physician leader?"

If you ask that question in public, you'll hear lots of excellent justifications for having physicians in leadership positions. Having healthcare led by people with a deep understanding of the nature and challenges of clinical work is a proven asset in improving the quality of care. Having the groups involved in the delivery of care represented in leadership is useful in engaging with these groups (we talk more about this later). Numerous articles list reasons why physicians *should* take up leadership roles, but not so many discuss why they *do*. All well and good for the system, but what's in it for you? Let's rephrase the question:

"*Why do you feel the need to become a physician leader?*"

The distinguished physician leader Dr. Ruth Collins-Nakai once wrote: "Many physicians can truly be considered 'accidental leaders.'" Physician leaders often characterize their leadership start as being asked by someone to "step up." The "tap on the shoulder" as a common entry point to leadership, rather than following a logical career path, is supported by research findings. In a study of nurses and doctors who moved to leadership positions, Dr. Ivan Spehar and colleagues at the University of Oslo found that while most went through a period of increasing awareness that there was more that they could do or be, the actual tipping point to moving into a position was often a conversation with a superior or colleague. Some physicians talk of feeling that they have a duty to contribute. Sometimes, circumstances such as a health condition or family commitments require a shift away from a previous role. These answers are still skirting the issue. The important question, the answer to which will shape your approach to leadership, is this: What made you say yes to the leadership opportunity when you could have said no. If you keep picking away at this, most physician leaders eventually say something like:

"I need to make a difference."

There is a story that, in 1961, John F. Kennedy was visiting NASA headquarters for the first time. He introduced himself to a janitor and asked him what his role was at NASA. The janitor replied, "I'm helping put a man on the moon." The moral of this is that someone created a strong and specific purpose at that time for everybody in NASA. What is your purpose? Can you describe the difference you want to make? Let's try a little exercise. Complete the following statement:

I will make a difference as a leader by _____.

<insert your purpose, the main thing(s) you hope to achieve here>

Now, let's explore why you need to make a difference. Dr. Åsa Lindgren and colleagues at the University of Gothenburg interviewed physicians to explore their interest and motivation in health system development. They found that physicians committed to system development who "wanted to make a difference" expressed a strong theme of feeling useful and making progress, which they characterized as professional fulfillment. This fits well with predictions of a model of human motivation called Self Determination Theory. This field of psychology, based upon work by Drs Edward Deci and Richard Ryan, holds that we have innate needs to grow, develop, and change, just as we have innate needs toward sustenance, safety, and reproduction. We shape our sense of ourselves through three areas: autonomy, competence, and relatedness. Autonomy is our need to feel in control of ourselves and what we seek to achieve. Competence speaks to our need to demonstrate mastery of skills and processes. Relatedness is about our need to belong within groups and to feel connected or attached to others.

You can use these three headings to gain insight into why you are seeking a leadership role and where you might focus your efforts to improve both your leadership and your comfort level within the role. Whether you're in a leadership role or considering one, try this exercise:

Write down answers to the following questions:

1. How does/will this role increase my control in achieving my goals? (Autonomy)

   _____

2. What does/would need to change for me to feel more in control in achieving my goals? (Autonomy)

   _____

3. What skills and talents does/would this role allow me to practise and demonstrate? (Competence)

   _____

4. What skills do I need to improve or acquire to perform this role? (Competence)

   _____

5. What connections does/will this role create or enable for me, and what connections might it jeopardize? (Relatedness)

   _____

6. What connections do I need to establish to be effective in this role and which might I have to change? (Relatedness)

   _____

I often use these questions in coaching conversations with clients who are thinking about taking a new position. The answers to the odd-numbered questions speak to why you are looking at the role. You might want to consider whether your answers can help you assess, over time,

how much the role is a success for you personally. The even-numbered questions are a good place to start planning activities that will help your leadership be more enjoyable and effective by setting some specific goals and timelines.

Leading with Values

There is another layer on top of needs that exerts a powerful influence on choice and style in leadership. That layer is values. Values can show up at different levels. Outrage at a perceived unfairness, concern for avoidable suffering, or an aspiration for excellence may have been the trigger that pushed you into acting on a need for autonomy, competence, and relatedness. The desire to see a kinder, more considerate workplace may be important to you. Being able to show pride in your standard of care may urge you on.

Table 1. Examples of Values

Adventure	Contribution	Happiness	Optimism
Achievement	Compassion	Harmony	Peace
Authenticity	Courage	Honesty	Popularity
Autonomy	Creativity	Humility	Realism
Balance	Curiosity	Humour	Recognition
Boldness	Determination	Integrity	Safety
Compassion	Fairness	Justice	Self Respect
Challenge	Faith	Kindness	Self Love
Family	Friendship	Learning	Service
Citizenship	Fun	Loyalty	Spirituality
Community	Grace	Modesty	Trustworthiness
Competency	Growth	Openness	

This list is based on values identified in conversations with physicians but is not exhaustive.

Once in a leadership role, values shape how you behave and how you would like to be seen. Leaders are often expected to demonstrate the stated values of their organization. Conflict between personal and organizational values has been proposed as a driver of workplace stress and burnout in areas outside of healthcare, although publications report conflicting findings. Irrespective of the alignment with the organization, finding success and satisfaction in leadership rests heavily on knowing and being faithful to personal values while securing achievements that are meaningful to you.

Try this exercise.

1. Write down your most important values (five to ten). You can use Table 1 to help or do the free online assessment at the Barrett Values Centre (https://www.valuescentre.com/tools-assessments/pva/).

   _____

2. Write down the published values of the organization for which you have/are considering a leadership role.

   _____

3. For the values that you share with the organization, list some ways you can demonstrate them in your leadership.

   _____
   _____
   _____

4. For personal values that are not on the organizational list (if any), list some ways you can demonstrate those values without conflicting with the organization's values.

   _____
   _____

5. For organizational values that are not on your personal list (if any), list some ways you can demonstrate those values without conflicting with your personal values

   _____
   _____
   _____

Setting Leadership Goals

Now you have a defined purpose. It's likely that you're working in an organization that also has a mission, vision, and goals. These words, and the activities that generate them, frequently produce eye rolling when raised with physician leaders, or any leaders. Sadly, that's probably a reflection of either how poorly these things are generated, or how organizations fail to live up to them, diminishing their significance and meaning. Eye rolling aside, your leadership journey will be clearer if you have a vision and goals in addition to purpose. Let me a use a metaphor to illustrate these terms:

You have decided to visit India. All your life, you've been intrigued by the varied and spectacular buildings that exist there. Your mission is to experience and learn about the architecture and history of India. Your vision is how you describe what you expect to experience and what it will feel like (i.e., the actual sensory experience). Your goals can be "process goals," such as creating a different way of doing something, like learning how to travel and get around using public transport in India. They can be "outcome goals," in which you achieve a specific measurable result, such as visiting the Taj Mahal in Agra and Meenakshi Amman Temple in Madurai.

If you haven't already, you'll encounter the term "SMART goals" in your leadership journey. This useful tool arose from the writings of George Doran in 1981. While the acronym has become immensely popular, his original model, which was aimed at managers setting goals for subordinates, has changed somewhat over the years. The most popular version,

popularized by Paul Meyer and based on a 2001 essay published by Professor Robert Rubin, is as follows:

> **Specific**—It should be very clear what the goal is.
>
> **Measurable**—You need some objective way or metric that will confirm when the goal is met.
>
> **Achievable**—The goal may be challenging or a stretch, but it should be possible. In the original model, this stood for "assignable," meaning you could identify to whom the goal was given.
>
> **Relevant**—Achieving this goal supports your mission/purpose and brings your vision closer to reality. In the original model, this was "realistic," now supplanted by achievable above.
>
> **Time-bound**—A time frame can be realistically set to achieve the goal.

Try this exercise. Think of either a process or outcome goal(s) for your leadership and set them up under the SMART framework:

Specific (articulate exactly what will be achieved)

Measurable (What measure will you use to know the goal is achieved?)

Achievable (What enables this goal to be achieved [e.g., personnel, resources, regulatory environment, space, etc.]?)

Relevant (How does it contribute to your purpose/mission, and vision?)

Time bound (When will it be done?)

Setting goals should come with a disclaimer, and here it is: If you sit down right now and set goals, you'll be doing so based largely on what you're experiencing in the moment. But say the world suddenly changes tomorrow … because it always does. Is your goal still relevant? In pursuing this goal, are you ignoring something more important? If you use goals, it's important to put aside a few minutes every week or month to reflect on them. By reflection, I mean more than just checking the milestones. I mean re-asking every one of the SMART questions again. A good leader can take their team in a specific direction but also has the flexibility to change direction and let goals go when that's the right thing to do. Good communication with your team around such changes is critical. Your goals should be a useful guide, not an overbearing master. The excellent review by Lisa Ordóñez in the "Further Reading" section at the end of this chapter gives an excellent appraisal of the limitations of goals.

My Personal Leadership Statement

Now let's take all three of these exercises and write a personal leadership statement.

> "I have taken on this leadership role to be better able to <*enter your purpose*>. This role will better enable me to achieve these goals by <*enter ways in which autonomy is enhanced*>. I bring <*enter existing talent/skills to the role*> and will strive to develop <*enter new required or desired talents/skills*>. I will work to develop new relationships with/within

> <*enter new relationships made possible or required by the role*> while taking care to maintain <*enter existing valued relationships*>. While leading, I will demonstrate <*enter personal value*> by <*enter behaviour that exemplifies it; repeat for each value as needed*>."

While framing this and putting it on your wall may be a bit extreme, if that works for you, go for it! At least keep it somewhere accessible and make regular appointments with yourself, perhaps every three months or so, to spend thirty to sixty minutes re-reading it, reflecting on how you are doing, and updating if necessary.

Boundaries

Another important area that needs reflection and definition are your boundaries as a leader. This term has long been used in clinical practices with a narrow and specific meaning around maintaining proper, objective relationships with clients/patients. The revelations of the #MeToo movement have reinforced this type of boundary concept in many other domains. But boundaries have other important applications in leadership. Think of leadership as a complicated object that can be seen in different dimensions. In each dimension, it has an edge where it ends and something else begins. That is the boundary for that dimension.

Researcher, author, and consultant Dr. Brené Brown talks of defining personal boundaries for leaders: "setting boundaries is making clear what's okay, and what's not okay, and why." It's important to find the edges on what behaviours and actions are and are not acceptable in your landscape. Brown advocates that knowing this and sharing it is of great value in developing trust-based relationships and allowing leaders to work with their own vulnerabilities.

Dr. Gervase Bushe, another researcher, author, and consultant, views boundaries from the lens of needing to define the edges of one's personal experience, the final construct in our minds that is generated by sensory

input and cognitive and emotional processing. He advocates that effective leadership is supported by clarity on the leader's own experience and what belongs to other people. If we are clear on what's being generated in our own heads and can differentiate that from the experience of others, while striving to understand and appreciate the alternate experience, we're in a better leadership position. He argues that we should avoid allowing ourselves to be ruled, positively or negatively, by the experience of others, a state he calls "fused," when the boundary around our own experience is too leaky.

Examples of this could include acting to keep someone happy or to keep them away to save us ourselves anxiety over what they're experiencing, rather than acting from what we believe should happen. On the other hand, being rendered completely impervious to the experience of others by a hard, impenetrable boundary around our experience—a state he calls "disconnected"—is also to be avoided. An example would be implementing a change that will adversely affect another person or group, without even being aware of or considering the implications for them. An appropriate differentiated leadership response would be to not let the impact on them stop a necessary change but to sympathize with their plight and explore reasonable mitigation strategies. Dr. Henry Cloud, a psychologist and consultant who has written several best-selling books specifically about boundaries and boundary setting in personal and professional life, makes the comment that as leaders, "you get what you create and what you allow."[1] What will you allow?

Boundary setting develops with time and should retain some flexibility as people and circumstances change. A full discussion of the mechanism of setting boundaries is beyond the scope of this book; my point in this section is to get you thinking about yours. That said, there is no time like the present to start. Can you list a few things you will allow in your leadership and a few that you won't, both within your behaviour and thoughts and the behaviour of those around you? Can you test when you're doing something based on your experience and when you're reacting to

1 Henry Cloud, *Boundaries for Leaders: Results, Relationships and Being Ridiculously in Charge* (New York: HarperCollins, 2013): 14.

someone else's? Can you think of a time when you disregarded someone else's experience that, on reflection, warranted your attention?

Reasons to Not Accept a Leadership Role

Are there poor reasons for taking leadership roles? For most physicians, adopting leadership roles does not enhance material rewards; indeed, it might have the reverse effect, so purely mercenary motives are usually off the table. Seeking authority to make something happen may be a wish. In fact, while the type of power that comes with a title may be useful in transiently enforcing compliance to policy, it tends to be a poor tool for system change. Authority does not change minds and hearts. Changing process without changing minds is a recipe for resistance and sabotage. We will explore this in more detail in a later chapter. This isn't to say that a leadership role doesn't offer opportunities for influence and profound change. Such influence, however, arises from the enhanced relationship opportunities that a good leadership position presents.

Enhancing status and respect may work as a reason in some situations, but the community of physicians doesn't tend to put its leaders on pedestals; indeed, working in leadership for healthcare organizations is often described as "going to the dark side" by the physician community. Assume respect is earned, not conferred.

Taking a leadership role under pressure from someone else to serve their agenda can be a pathway to a very unhappy time if their goals and needs aren't closely aligned with yours. Although it's true that others may see potential in us that we underappreciate ourselves, it's important to distinguish between encouragement to take a position for your sake, the action of a friend, or for their sake—the action of a manipulator.

Taking a role to block someone else from getting it, whether on your own initiative or at the behest of others, is usually a mistake. If there are no suitable candidates for a position, there are more constructive ways of finding interim solutions while the question of why no suitable person

applied is properly considered. Blocking as a strategy usually guarantees at least one very unhappy individual.

Perhaps the worst reason for taking a leadership role, but one that is surprisingly common among physicians, is that it's "your turn." Leadership is not dishwashing, and leadership selection should be more discriminating than passing the hair shirt. Accidental leadership can be a happy accident; truly reluctant leadership rarely is.

Whatever the path that puts a leadership role in front of you, run through the questions listed in this chapter. If you can't find a satisfying answer to them, it's time to question whether this is the role or the time for you. Saying no to such an opportunity is a tough, anxiety-provoking conversation that will call for courage, but the cost of a wrong decision is inevitably higher. I will cover techniques to help with this type of conversation in a later chapter.

Let's check in on Rosalind and Susan …

Susan tops up the chardonnay. "So, we've established that this job will help you introduce some of your quality improvement ideas in other departments. It will also give you a more official standing to build on the conversations you've started with community groups about getting their input about hospital programs. Right?"

Rosalind smiles. "Right, as usual, Ms. Analytical Mind!"

Susan raises her glass in acknowledgement. "So, tell me why this is better than what you can do now."

"Well, I can get a … higher viewpoint. I mean, see things at a level above just the links between the ER and the wards. I'll be more involved in recruitment and perhaps able to both lift our image and make sure we're recruiting people for what the hospital needs rather than just individual practices. I may be able to finally get some community people on our committees. I'm looking forward to applying some of the things I learned in those leadership courses about engaging people and passing on some of the quality improvement training. I'm also looking forward to getting to connect more with the docs who don't spend a lot of time in the ER and meeting more of the staff

without someone being resuscitated between us. And, of course, I'll now be able to officially do some of the community work."

Susan is nodding. "Sounds good. But what's the catch? Or should I say, the catches?"

Rosalind thinks for a moment. "Well, at a personal level, there's no way of pretending this isn't more work. If we as a couple aren't going to pay a price for that, I need to convince the ER group to change shift scheduling, and maybe even recruit, so that I have enough time to do this properly. I know I haven't always made friends by trying to champion the ER. I'll need to work on taking a deep breath and listening, including to some people who make me want to head out the nearest door. I guess I am their Chief of Staff too."

"Fair enough, but how will you do all that?"

"I think the first thing I need to do is set up a meeting with Jim (the regional Executive Medical Director) with a bit of a formal agenda. I think his support will be helpful in dealing with the ER group and persuading them that losing a bit of my billing will be offset by having me better connected to leadership. I'm also going to need someone I can bounce things off at pretty short notice at first. Maybe him, maybe someone else who's been in a similar position for a longer time, or maybe both. I'd like to connect with others doing this type of work as well in other communities, since I'm the only one here. And I'm hoping they'll pay for some more leadership training or coaching."

Susan raises her glass again. "Sounds like a plan!"

Key Learnings

- *Leadership is a choice. Know why you have chosen it.*
- *To enjoy leadership, it must meet your needs as well as those you lead. Pay particular attention to how it will allow you to demonstrate competence, achieve autonomy, and develop new relationships.*
- *Identify an overall purpose for your leadership.*
- *Set SMART goals for your leadership but hold them lightly and be flexible when circumstances change.*
- *Know and share the values that guide your leadership.*
- *Have the courage to decline a leadership role if the choice does not feel right.*

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Boundaries

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Gervase R. Bushe, *Clear Leadership: Sustaining Real Collaboration and Partnership at Work* (Boston: Davies-Black, 2010).

Henry Cloud, *Boundaries for Leaders: Results, Relationships and Being Ridiculously in Charge* (New York: HarperCollins, 2013).

IF I'M LEADING, WHO IS FOLLOWING?

Sanjay decides to start his tenure as a department head with a meet and greet to introduce the ideas he'd like to bring to the department. He picks a Thursday evening at 5:00 p.m. as the time and arranges for pizza, salad, and soft drinks to be delivered to the hospital boardroom. He sends out invitations to all department members two weeks before the event and sends reminders a week before and the day before. He spends hours perfecting a PowerPoint presentation of his ideas and agenda.

The day arrives. To Sanjay's dismay, by 5.30 p.m., only four people out of the twenty-three invited have turned up. Three are the physicians with whom he shares a private office practice and one, rather to his surprise, is Gwen, their sole endocrinologist. Gwen has a well-earned reputation for not being shy in pointedly expressing her opinions. She had openly expressed reservations about his ability at the previous department meeting when his appointment was announced. She was department head for over ten years some time back. Feeling rather sheepish, Sanjay goes ahead with his presentation. His practice partners applaud and make suggestions for how he might polish the presentation. Gwen, who has been uncharacteristically quiet, then speaks up.

"What makes you think this is what anybody else in the department wants? Have you asked them?"

Sanjay is stung. "Pretty hard to ask them when they're not here!"

"And why is that?" Gwen replies.

Sanjay shrugs, feeling a bit humiliated.