Dilemmas of Physicians in Administrative Roles: Dealing with the Managerial Other Within

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Thomas N. Gilmore
Vice President
CFAR (Center for Applied Research, Inc.)
3600 Market Street, Suite 501
Philadelphia, PA 19104
tgilmore@cfar.com

Introduction

Health care settings have been characterized as "church-state" organizations in which physicians and administrators collaborate to produce the organization's services (Gilmore, Hirschhorn and Kelly, 1999). Historically these two groups were loosely coupled (Orton and Weick, 1990). The hospital was regarded as the "doctor's workshop" and the mere administrative mortals took up their role in support of the priestly work of healing the sick. Their work took on the character of "parallel play" with each in different realms, with different distinctive competencies. Physicians, especially in academic medical settings could remain blissfully ignorant of the cost implications of all their decisions (admissions, level of care, tests, medications, etc.). Administrators stayed clear of the issues of quality and medical decision making. (Gilmore and Krantz, 1990)

The organization of health care is changing dramatically with most of the significant issues requiring much greater collaboration between the church and state sides of the house (Starr, 1982). This is especially true in academic medicine. In any of the three missions of education, research and clinical care, the complexity and costs require advanced substantive thinking and sophisticated organizational and managerial knowledge to invent and implement the new systems.

In academic medicine, within the medical school, the leadership roles of dean, chairs, center directors and section heads were always filled with physicians. Now, in academic medical centers many of the significant administrative leadership roles are being taken by physicians. As the issues become more complex and the boundaries between their substantive knowledge (basic science, clinical care or education) and managerial issues becomes more intertwined, they face the challenge of building their competence in the business and organizational aspects of the work. Additionally, many more business leaders are taking up roles within senior leadership, such as chief financial officers, chief information officers, directors of technology transfer, etc. This creates a double challenge. First, the top team of the organization needs to integrate across the professionally and administratively trained members due to their increased interdependence. Second, for physician executives there is a particular challenge to integrate within themselves the clinical and administrative aspects of their roles, what Argyris and Schon (1974) have termed their first- and second-order professional skills.

This paper will explore the dynamics of the "managerial other" within physicians as they take up significant organizational leadership. Many colleagues, on the occasion of a physician's "promotion" to a leadership role, express some variant of, "You are no longer one of us. You are one of them." Physicians wrestle with this dual identity—some becoming completely caught up in the world of organization and management, others holding firm to their core professional identity, often at a cost to their effectiveness. If the challenges increasingly require the integration of first-rate medical knowledge with advanced skills in leadership and management, then the working alliance across physicians and administrators needs to be productive. Physicians need to discover ways to value both aspects of their leadership roles, rather than holding the managerial at a distance.

Heifitz (2001) has distinguished between technical work and “adaptive leadership work”. Adaptive work is value-laden, clarifying and addressing what matters most, surfacing conflicts in values and gaps between values and reality. Unlike technical work on routine problems, adaptive work requires changes in people’s values, attitudes or habits of behavior. Sometimes those changes are within themselves, sometimes they are within their fellow professionals, but increasingly they require changes in the working alliances with non-physicians.

Let us begin by looking at the prolonged socialization of physicians. A significant period of anticipatory socialization as they take pre-med courses and begin the striving to be a doctor is followed by four years of medical school, multiple years of residency and often continued by subspecialization and fellowships. Until recently, medical students went straight from college to medical school and, therefore, had few experiences of coping in the every-day world of work prior to becoming a physician. From the time of becoming a “doctor” on, they often experience a splitting of their “position” in Oshry’s (1999) framework—being a “top” as they turn towards the patient versus a “bottom” as they turn toward the organization that they are embedded in. Depleted patients often project magical abilities onto physicians (Main, 1975. p. 61), thereby debiting the patient’s competence and heightening the physician’s. Complaints and dissatisfactions get displaced onto food or housekeeping rather than risk injuring, in fantasy, the physicians on whom the patient is so dependent (Jacques, 1955). The nature of the work also makes the physician special. They are authorized to touch, poke, prod, invade, even inflict pain in the service of cure. Historically, physicians have had high autonomy in their individual roles and as a profession (Rothman, 1991).

However, as junior members turn to the organizations that they are embedded in, they often feel the lowest on the totem pole. In choosing residencies, they apply and a computerized matching system sorts all graduates into residencies. Salaries and working conditions are given. They take direction from the attendings in a near hazing environment of stress and long hours. They spend years in a context that resembles what Goffman describes as a “total institution”. Goffman (1961, p. 111) notes, “in total establishments the self-defining aspects of office [or role] seem to be carried to an extreme. In becoming a member, one becomes thought of as possessing certain essential traits and qualities of character.”

Thus, in becoming a physician, one is *not* becoming an administrator and the differences between these two categories are exaggerated. When Dr. Richard Klausner accepted the reins of the National Cancer Institute, the lead in the New York Times was “I am not an administrator,” as if being in that category would diminish his standing among his peers.

When interviewing junior faculty about their “leadership experiences” while they were in transition between fellowships and becoming faculty, they could think of few instances where they exercised institutional or group leadership. They offered up predominately administrative tasks such as running the journal club or a seminar series. Nor are they astute observers of “leadership” behavior. When pushed to identify leadership in others, a junior faculty informant acknowledged

that his section had changed significantly since the arrival of a new physician leader, but he was hard pressed to identify what the levers or variables were that the new leader had used to bring about these changes. It is as if the challenge of taking in so much knowledge in science and medical frameworks stunts their ability to think about leadership and management.

A colleague was consulting with a chief resident—a position of considerable responsibility. The chief resident's self-assessment was that she brought no particular skills to her new role. While the colleague was coaching her, a bicycle accident occurred outside their window. The chief resident rushed down, took charge of the situation both medically and by accessing the needed help, then returned to her coaching session—failing to connect her behavior with models of leadership. It is as if the skills exercised in the context of their primary work—medicine—are not generalized to resemble management and leadership skills, even when there are many similarities.

When people enter into an intensive focus on specialization as the mode of advancement in academic medicine, they lack any frameworks for understanding what leadership is and how it makes a difference. Within their medical culture, physicians see administrators as a different category. When they look within their tribe at physicians who have taken formal roles as department chairs, deans, etc., they find that their colleagues, both those who are in those roles and others, often denigrate formal administrative leadership. This splitting prevents the linking of professional skills to the adaptive tasks that the wider organization faces.

To investigate the linking of the two cultures of medicine and management I invited physicians who hold leadership roles in many different settings to reflect on what was said to them by close friends upon their first taking up the role. Over 80 percent of the comments were negative or ambivalent—"congratulations and condolences," "this will be the end of your research career," "are you crazy?"

Below is a list of some of the other responses:

- We've lost an ally. You've become one of them, the enemy.
- You'll have a wider canvas.
- Why are you doing this? For another sentence in your obituary?
- It's the end of your career as a scholar.
- Fantastic, you can fix *all* our problems.
- You went to medical school and spent 20 years learning and mastering your craft …. now you're an administrator.
- You're no longer one of us … you're one of them.
- It's the best job in medicine (chairperson of medicine).
- Economics have taken all the fun from the job.
- I hope they (the faculty) don't cut you off at the knees. You're short enough already.

- What are you going to do next? (Reflecting the implication that after serving as dean, there are few paths back to being a real researcher.)
- You're crazy.

What accounts for the high percentage of denigrating comments? In corporate settings, many people aspire to move up the "ladder" and their advancement elicits genuine congratulations from real friends. It is not just what people say to physicians, but as they take on the administrative role people react to them differently. A psychiatrist who stepped into the position of chair noticed that, while on rounds, the questions he was asked became more administrivial—as if he was less of an expert in treatment of patients. A scientist taking the head position of a pharma lab had a similar sense that his colleagues began coming to him less for substantive science issues. He noted, "it was like my IQ had been debited 15 points."

In part because administrative roles require thinking about the unit or organization as a whole, they go against the tradition of the individual scientist or physician and the high value placed on autonomy. In academic cultures there is a long tradition of the behind-the-scenes leader—"the real leader in surgery"—who often is the target of positive attributions rather than the person who has been chosen for and has accepted the formal leadership of the department.

The role shapes how people think about aspiring to it or accepting it if offered. Few people will acknowledge having an early aspiration to become a dean or a chairman. It is as if the entire enterprise is led by people who explain their presence in a leadership role as "accidental" and then tell some story about how they fell into it. I worked with a powerful (at least as seen by outsiders) vice dean who, after ten years, still regarded himself as "interim" and that his identification was with being back in the lab.

In probing physicians' stories about how they got into these positions, it was striking how they phrased them.

- I was trapped into administration.
- The president asked me and in a moment of weakness I said yes.
- The faculty convinced me to put my name in for dean.
- It was either retire or accept the deanship and someone responded, "Aren't they the same thing?"

No one owned up to actively seeking the role.

Isaacson, an executive recruiter who works extensively in academic medicine, identifies three key leadership skills: hunger, speed and weight. Speed is intelligence and the ability to quickly learn new bodies of knowledge. Academic physicians have this in excess. Weight is the sense of how one carries one's authority. In the medical culture weight from their sense of status within the medical hierarchy often does carry over to leadership positions. Hunger, Isaacson defines as follows:

> Hunger is the marriage of imagination to ambition. Hunger is having a rich fantasy about what one wants to accomplish and the will to struggle to realize it in the world. Hunger is the drive to make a mark, to build a monument, to make something out of nothing. It is the capacity of a mature mind to tap the irrational and intuitive depths of personality and to harness those darker powers to moral pursuits. T. E. Lawrence described this quality as follows: All men dream…but not equally. They who dream by night in the dusty recesses of their minds wake in the day to find that all is vanity' but the dreamers of the day are dangerous men, for they act their dream with open eyes, to make it possible. (Gilmore, 1989)

As one physician executive was talking he prefaced his comments with the phrase, "When I was chosen or put forward for an administrative post …." What was intriguing was the lack of aggression in comparison to most other organizations where people *seek* positions of executive leadership. It was as if it were illegitimate (at least publicly) to be hungry for a position of power in a professional organization, even when harnessed to a higher purpose (Mant, 1983); it was as if the paradigm in professional organizations was Cinncinatus being persuaded to put down the plow and, for the good of the country, step into a leadership role.

Aspiring toward leadership is less legitimate without widespread understanding or belief that leadership can be the basis for fulfilling core values in a more leveraged way. One participant spoke quite eloquently about the power in an administrative-medical role to shape the health status of large populations—e.g., developing clinical protocols; negotiating more, rather than less, effective managed care arrangements; etc. These are ways to influence substantially the health care of many people versus single individuals.

Might this lack of aggression for taking on the role be related to the difficulty of exercising socialized aggression or power in the role? In a sense, one feels the role itself is depleted by the external attacks and devaluation of it. Just as we talk in political science about a "weak" governor's office, might we have created physician-leader roles that are less potent than they need to be to face today's challenges? Furthermore, we know that the negative projections of others onto the leader are not without their influence on the leader's experience of his agency.

Some have suggested that this is merely public rhetoric: both the people stepping into the roles and the friends who make the comments are simply participating in a harmless ritual about formal leadership. On the contrary, these comments confirm the considerable data from many other sources that suggests academic cultures are ambivalent (at best) toward leadership. If academic medicine now faces challenges that require speed, decisiveness and effective implementation, the undermining of leadership roles can only hurt. Many of the difficult issues on today's agenda require the best and the brightest to seek these roles and to use them effectively to shape adaptive responses that preserve core academic values. This leadership is not about administration or bureaucracy, but about research, education and quality clinical service. The mechanism of splitting debits the leader as an administrator and also over claims the mission aspects of being passionate about research, teaching and care for the faculty. This often becomes a self-fulfilling prophecy as physician leaders get more and more overloaded with administrative issues and lose their connection to the purposes.

People are understandably ambivalent about taking an administrative role. However, when someone has accepted, he or she needs to be connected to the part of him or herself that really wanted the job and the driving reasons or "hunger" for accepting—a combination of dreams and the commitment to make those dreams real. Without the moral authority from those dreams it is hard to make the difficult decisions that today's challenges require. Given that the "managerial other" within the physician is held in low regard, when others attack them it is easy to collude with the contempt. Does this ambivalence become what Fairbain (Trist, personal communication) termed "an internal saboteur" relative to the challenges they face?

The dynamics of projection locate various traits of leadership and management in "the other" in ways that estrange physicians from seeing how many of the skills they already have within themselves. We worked with pediatric interns in their first year, helping them to make sense of the nearly obliterative experience of a tertiary children's hospital. (Gilmore, 1987). One significant complaint was the lack of feedback from attendings. We noted that since the interns rounded as small teams with one another and had many interdependent tasks in managing the same patients across shifts, they had considerable relevant information on one another: their bedside manner, the quality of their collaboration with other physicians and with nursing, their skill at working with parents, etc. The near-total group resistance to communicating this information was overwhelming. One immediately said, "What are we supposed to do? Go around and say 'turkey, turkey, star'?" Here are physicians who, every shift, are working to perfect their differential diagnostic skills in working with patients, completely splitting off this observational skill from its managerial analog of giving constructive feedback to coworkers.

Several years later, we had the experience of working with the Chairs of Medicine of forty medical schools. After a week of being together in an intensive executive-development program, looking at common issues and dilemmas in their roles, we invited them to give feedback to one another in areas that the recipient would control by setting the agenda for the conversation. The resistance was just as

intense as from the interns. In this case, in addition to the segmenting off of relevant skills, I believe that another component was the threat to their identity as members of the priestly class from engaging in behaviors so closely associated with the administrative side of the organization.

To recapitulate the argument, physicians are socialized in a two-culture organization—church and state—in which traits associated with leadership, management and administration are projected predominately into the other group and kept at a distance. One effect of this dynamic on physician administrators is to undertend to the many behaviors, frameworks and skills within their core training that are similar to their administrative counterparts in the other half of the house.

A second effect is that physician administrators lack rich frameworks for learning or observing leadership in either their priestly colleagues or lay leaders.

A third effect is that when they do actually step into roles with some managerial and leadership component, they do so ambivalently and do not have a significant amount of their identity tied to their success in those aspects of the role. Many continue to be active in patient care or basic science work.

The cycle gets repeated as the leaders model ambivalence about taking the roles and exercising the skills to the point that the next generation repeats the cycle of entering those roles ambivalently, under tending to their own relevant skills, etc.

Two Vignettes

Two cases illustrate the challenges of leaders to be effective in such settings where these deauthorizing dynamics are so prevalent—both by the leaders themselves and by their followers.

A Chair Runs the Annual Meeting of His Fellow Chairs

The first case was a prominent academic specialist who was serving as the president of his specialty's organization of chairs. This specialty is one of the most significant revenue contributors to health care organizations' bottom lines. He had overseen a strategic-planning process in which they recrafted the mission and developed some new initiatives. He had asked me to talk about the implementation of strategy using the campaign framework that CFAR had been developing (Hirschhorn and May, 1999). My first interaction indicated how his busyness with his other work prevented any thoughtful preparation and linking of the work of the annual meeting with the strategy and transition to the next leader. This is a major problem with people taking up leadership tasks on the fly and devoting little focus or attention to the work involved. Furthermore, despite the presence of a paid staff member in support of the organization there seemed to be no productive pairing of the resources—again, evidence of keeping these issues apart in ways that are dysfunctional.

At the event itself only 50 people showed up. The president had estimated 150 and the administrator had said to prepare handouts for 85. Slowly, people arrived, meeting in small informal groups with almost all the people sitting in the back half of the room.

The leader began, pleading ineffectually with people to move forward. He did not frame the meeting effectively—increasing the sense that people would experience it as fragmented issues with no connective tissue (unlike the systemic perspective he would bring to patient care). A report on an issue concerning training programs was discussed with no links to the strategic plan, nor flagging the challenge to get the programs to act collectively and hold one another accountable for the good of the whole specialty field. He next presented the strategic plan, assuming none had read the brief document, nor using the core group that had been involved in its development. He repeatedly used words like "spirited, active, positive, thoughtful," to describe the retreat where the plan had been developed when the room felt funereal. He spoke candidly to the sense of the organization floundering and the need to make a choice to either disband or reenergize itself. However, he was not sufficiently up to the adaptive challenge to note the enactment of this floundering in the current meeting. They voted unanimously (and in flight) to support the new mission.

The goals were modified slightly from the floor. "Voice of Academic (Specialty)" was thought to be too weak and needed more "muscle" connected to the voice—again, without any ability to confront the here-and-now sense of impotence.

I was struck by the parallels between the depleted sense of the association's annual meeting and the same issues reflected in the individuals (all of them chairs) taking on leadership roles in their home institutions.

Parallels

Feature	Association	Role in Home Institution
Leadership	▪ President did not have fun ▪ Acted in a pleading way	▪ Sense that much of the role is being "done to" versus doing ▪ Weakened role
Transitions	Poorly managed: ▪ New members ▪ My entry as a speaker ▪ The transition to the new leadership team	▪ Underattention to people crossing the boundary ▪ Each person takes care of him or herself
Church-state Relations	▪ Staff in disengaged and reactive role ▪ Ministerial ▪ Not in a productive harness	▪ Staff kept in separate status ▪ Less effective collaboration than would really support the enterprise
Accountability of Followers	▪ Assumed people did not read the plan —no checking, no holding them accountable ▪ No aggression in working their mood, dynamics and passivity	▪ Management by guilt ▪ Expecting people to be competent individual contributors ▪ Few direct conversations ▪ Complaints behind people's backs. ▪ Low accountability when people underperform

One might argue that this is a special case because, in the association, people are only colleagues during meetings. Below we describe an even more powerful role of a dean with his faculty.

A Dean Engages his Faculty

A medical school had experienced years of turmoil. A new dean was appointed and was a good enough steward during this complicated period, dealing with the university structure, complex relationships with a separate health care system and trying to rebuild the school.

A group developed, with the dean's support, a day for faculty development that came shortly after the conclusion of the successful resolution of several key issues. It was billed as the first faculty-development day and a chance to engage the faculty as a community with sessions aimed at speaking to some of their issues such as mentoring, getting published, being effective in teams, etc. The day was scheduled to begin at 8:30 a.m. with coffee and a talk with the dean, then a series of workshops. Over one hundred people signed up. When the dean walked in at the designated start period there were less than forty people, all seated in the back left of a large tiered lecture hall. Despite three different microphones failing, the dean began his talk, walking up the aisle and engaging individuals. He began his talk with a humorous statement about not giving a test and then said:

> There are not great medical schools because of deans or administrators, we are up there pushing paper, etc. Great medical schools exist because of you, the faculty. People who are passionate about their teaching, about their research, about their clinical care, etc.

He then proceeded to interview people skillfully about changes they had experienced over their careers from being a student, to being a resident and what had attracted them to academic medicine. It was a lovely discussion that engaged the community as people learning from one another about how long they had been there, their perceptions of the changes, etc.

What puzzled me was why he would denigrate himself (and the others in the audience who held leadership roles), especially in the wake of the enormous leadership work he had been doing to create the context for faculty to thrive. What in that culture made it impossible for him to ask for or accept acknowledgement for the achievements of his team over the past few years? Why, when many of the participants and one of the tracks for the faculty-development day were looking at issues of management and organization, would he join with the cultural denigration of all things administrative and managerial? It is as if all of leadership is a hygienic factor rather than a motivator (Herzberg, 1966) and only acknowledged when it is absent but not affirmed when it is present.

When I discussed his behavior with the dean he responded that he wanted this to be the faculty's day, that he wanted to join with them. Yet, many in his audience, like him, were both faculty and in administrative positions. Furthermore, many of the purely faculty had experienced many past and current effects of his leadership (both positively and negatively), so for him to be self effacing was likely to trigger feelings of hypocrisy rather than humility.

It was also not necessary. It would have been easy, honest and appropriate for him to express his concern that recent events had so embroiled him that he was at risk of losing touch with the core mission of the medical school. The new world was going to require less splitting or stuffing of all the financial and administrative issues into scapegoated administrators. It would be necessary for all to collaboratively create the context to perform great teaching, great research and deliver high-quality clinical care.

The impact of his self-denigrating comments was to continue to deauthorize the role of the dean and create disinformation about its scope and contributions. If he had made his role more transparent, and his own hungers more visible and confrontable, he could create a more lively academic culture and work with the faculty in productive ways that link both the academic mission and the leadership and management challenges.

Towards a Different Future

In closing I want to look at what it might take to break this vicious cycle of deauthorization and splitting when the imperative of the challenges academic medicine faces requires the integrating of first-rate science and medicine with first-rate organization, management and leadership.

There is a long tradition of scapegoating leaders, even as there is awareness that the issues may be as much, if not more, embedded in the team. (Gamson and Scotch, 1964). Kernberg (1980, p. 238) writes,

> It can happen that most of the energy of an institution seems to be spent on "curing" its leader. It may well be that the astonishing capacity of so many people in so many places to tolerate an unsatisfactory situation over an extended period of time indicates how gratifying it is to attribute the cause of all problems to the administrator, rather than to focus upon the painful and complex interaction of the various systems involved in bringing about his behavior.

The first skill of a leader is to hold a psychologically-informed systems view and to be aware that feelings inside him or herself may belong to others and vice versa. Eisold (no date, p. 18) has written, "having authority in a system often means enjoying the right to displace anxiety onto others, away from oneself." Leaders have to be attentive to the various attacks, what Kernberg (1980) calls a "healthy paranoia." Heifitz (himself a psychiatrist) and Linsky (Heifitz and Linsky, 2002) outline some of the dangers facing leaders who take up adaptive challenges. "Seduction, marginalization, diversion and attack all serve a function. They reduce the disequilibirum that would be generated were people to address the issues that are taken off the table (by these tactics) (p. 48)." They articulate five principles to help prevent this:

1. Identify the adaptive challenge
2. Regulate distress
3. Maintain disciplined attention
4. Give the work back to the people
5. Protect voices of leadership from below

By containing their own reactiveness to the attacks, leaders create the opportunity for working through by the faculty. Bennis (1989) has coined the phrase "the unconscious conspiracy" to describe how followers will so overload a leader as to prevent him or her from making significant changes that would threaten the status quo.

Leadership is not a sole property of the formal leader. Says Eisold, "leadership is a function of collective life, a way of enabling a group to keep in mind a concerted effort toward a common goal." (1998, p. 34) He explores a case where a dean's unconscious choice, "to lead part of the faculty, not the whole," led to splits in the

faculty—between the talented, fun-to-work-with chosen and the denigrated, self-indulgent, unproductive others. In light of our argument, just as the leader needs to attend to that split within him or herself between the mission and management aspects of the role, the leader also needs to link the parts to the whole.

For example, in a retreat with a dean and his faculty leaders, the researchers were heaping contempt on a costly clinic in an urban neighborhood. The dean sharply reminded them that the appropriation from the state legislature critically depended on that clinic, hence their well being was also linked to that aspect of school being well executed. In this instance he educated and linked. Tichy (1997) has written about the leader's need to have a "teachable point of view" that both encompasses the substantive challenges as well as the leadership and management aspects of the enterprise. Too many academic medical leaders collude with their faculty, remaining ignorant of basic facts of the operation of their academic medical center.

The frameworks of group psychotherapy may be a model for the leadership challenges in academic medicine. The authority and power of the therapist is both real and the subject of considerable projections and distortions that get modified over time. Furthermore, the dynamics among members are equally critical. Cohen and Ettin (1999) suggest several movements that might serve as a starting point for thinking about the leadership work of reinvesting the role with the requisite authority both to attract talented people unambivalently and engage followers in accountable ways.

They write that, "this evolving social system … help(s) participants reclaim incompletely developed, denied, split-off or projected aspects of self and behavior, as members elaborate and consolidate their self-structural resources." In their framework, at any one time, people have a multiplicity of "versions of their self." When taking on a leadership role in academic medicine, people too frequently hold onto their core academic identity as their positive identity and keep at arms length (with active support from followers and colleagues) a managerial or leadership identity. Their hunger to make a difference through a collective, rather than individual approach, and considerable skills from their repertoire can, with some mindfulness, cross into the realm of managerial work.

For example, chairs are often surprised to learn that their division heads see them in ways that are similar to those in which they in turn see their dean. The negative aspects that they see so easily in the dean's behavior are less easily owned as part of their role as leader in a smaller, but still complex, unit of a department. Cohen and Ettin (1999, p. 68 – 69) write about the process of self-differentiation through productive dialogue. Depersonalizing projections, frequent in academic medicine, often cause a withdrawal or a (real or imagined) retaliation rather than correction via direct talk and dialogue. It can be equally distorting when positive attributions go uncontested, as they often do in academia, regarding the perceived power of leadership roles—which are often seen as far more powerful and well resourced from afar than by the people in the roles.

In both positive and negative cases, by being more transparent about what aspects feel real and which do not, or by making what Havens (1986) has termed "counter projective" remarks, a community can move towards reclaiming projected, denied or split off parts of selves. (Gilmore and Ronchi, 1995) Counter-projective interventions establish a frame for working away from the dysfunctional shadows cast by past leaders or beliefs about the role. The externalizing function of counter-projective interventions locates the problematic emotions and perceptions *out there* where resolution is often easier to achieve than allowing them to go unchallenged when placed in the one or the other—e.g., the irresponsible faculty members who are only looking out for themselves, or the dean who is a power monger and only cares about finances and not the mission.

Havens (1986, p. 125) describes two features of such statements:

> Speaking about whatever is being projected on the therapist, and doing so with some of the feeling that the patient has towards the projection. Essentially, the therapist positions himself beside the patient and shares the feelings and attitudes toward the projection.

Both successful and unsuccessful occupants of a role leave a shadow on the role itself. Just as charismatic individuals seem to add new dimensions to the role they occupy and thereby create new standards and expectations for those who follow, another leader may actually subtract credibility, confidence and other qualities from the role itself. The effect goes well beyond the real or perceived failure of an individual; the role itself is left damaged. In the way that we talk about a "weakened presidency" in political discourse, a leader from any field of endeavor can leave behind a shadow that subsequently impairs the exercise of authority itself. This type of shadow can have a devastating impact on both the new leader and the organization. All occupants need to see themselves as stewards of the roles that they occupy in academic medicine and work to leave them with the requisite authority for the challenges that they face. Moore (1995) speaks about the "authorizing environment" for any particular strategy. This is made up of formal legal authority and informal support from key stakeholders in giving the role the legitimacy, resources and intelligence it needs to function effectively.

We are seeing some of the elements of change within academic medicine. Mission-based management is a campaign to more explicitly link resources and management to specific aspects of the academic mission. A hallmark of the process is transparency, so that budgets are seen by peers and dampen the often rampant fantasies about who got what based on what criteria.

Process clarity and transparency are developmental. If people know who is making a decision and by when, and perhaps what the criteria are, this can substitute for not knowing what the actual decision is and increase leaders and followers holding one another accountable. In a retreat of an academic medical center, when we called for a fishbowl meeting of the executive-management group, there was considerable confusion about the membership of that group from both outsiders and a few in the group. (Gilmore, 1997). This situation does not

enable followers to hold their leaders accountable or the leaders to receive acknowledgement from their faculty.

Conclusion

The challenge is large, yet the arena is in the daily encounters among leaders and followers and begins with respecting the importance of the management and leadership tasks. People fill a role differentially. Kahn (1992, p. 322) suggests that being "fully there" in one's role is rare and involves four dimensions: attentiveness, connection, integration and focus. It is sobering to compare the difference between how physician leaders fill their churchly roles versus their state roles. No talented surgeon would enter the operating room without scrubbing, reviewing all the available diagnostic information, checking the infrastructure and the team's readiness. Yet, that same surgeon as a chair will grab a folder from his secretary and skim it en route to the conference room three doors down from his office and begin a meeting with no acknowledgement of who may be missing, or differentiating between those who, respectful of community life, informed the leader they would be absent from those who are simply no shows. The leadership of the meeting often ignores the interdependency of the various items to one another and to the overall well being of the institution. What Langer (1989) calls "mindfulness," when brought to the adaptive challenge facing academic medicine, will go a long way to bringing the inherent intelligence and aggression in physicians core training to the leadership task.

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