

# LEADERSHIP DEVELOPMENT



THE AMERICAN ORTHOPAEDIC ASSOCIATION®

*Leading the profession since 1887*

Fellowship Education Coalition

Influencing others to  
achieve a common goal

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Part of the Fellowship Education Transition to Practice Lecture Series, this white paper accompanies the “Leadership Development” module, an educational resource to help fellowship directors answer their fellows’ crucial questions about negotiating an employment contract. The Lecture Series is a production of the American Orthopaedic Association in collaboration with the Fellowship Education Coalition comprised of the following orthopaedic specialty societies: AOA/CORD, AAHKS, AANA, AAOS, ABOS, ACGME, AOFAS, AOSSM, ASES, NASS, OTA and POSNA. Visit [aoassn.org](http://aoassn.org) or one of the subspecialty society websites to access the Lecture Series. Updated January 2020.

# Introduction

Founded in 1887, the American Orthopaedic Association (AOA) is the oldest and most distinguished orthopaedic association in the world. Its mission is to engage the orthopaedic community to develop leaders, strategies, and resources to guide the future of musculoskeletal care. The AOA has had significant involvement in the founding of several major orthopaedic organizations, including Journal of Bone & Joint Surgery (1889), American Academy of Orthopaedic Surgeons (1933), the American Board of Orthopaedic Surgeons (1934), and the Orthopaedic Research & Education Foundation (1953). In 2003, the AOA became the formal home and supporter of department chairs, program directors, fellowship directors, and academic faculty with the incorporation of the Academic Orthopaedic Society and in 2009 the formation of the Council of Orthopaedic Residency Directors. In 2019, the AOA, in collaboration with AAOS, ABOS and subspecialty societies, continued its mission to develop leaders by forming the Fellowship Education Coalition to address the Transition to Practice educational needs of fellows and fellowship directors. This white paper strives to support the leadership development needs of fellows and senior residents as they transition to practice.

Medicine and healthcare are increasingly complex and will continue to be a source of rapid evolution. Physicians, based on their expertise and fundamental core values, are ideally positioned and prepared to serve as leaders. Embracing the critical role of research to advance the field, garnering respect for their values, commitment, and societal contributions, orthopaedic surgeons and especially AOA affiliates are situated at the centerpiece for leading.



*If your actions inspire others to dream more, learn more, do more, and become more, you are a leader.* ~ John Quincy Adams

# What is Leadership?

Leadership is defined as the ability to influence others to achieve a common goal. Leaders must develop a common, adopted vision as well as strategies to achieve this vision. Leaders must also clearly communicate to those whose cooperation is necessary to achieve these goals by creating correlation/teams that understand and accept the shared vision and strategies. By necessity, leaders must motivate members to identify and overcome barriers while also providing the necessary resources to achieve their goals. Fundamentally, every patient encounter in an operative case is a leadership opportunity.

## Levels of Leadership

Leadership can be broadly defined at three levels.

- Tactical (small group/unit) level is the immediate actions to achieve the mission. An example is when leadership is necessary for effective operations of a clinic or operating room.
- Operational (division) level is the integration of other unit's/group's actions into a cohesive plan. Examples include the preoperative, operating rooms, PACU, and discharge units of the perioperative suite.
- Strategic (department) level is long-range planning, resource allocation, and standards & policy necessary for the broader organization's mission and vision. Examples of strategic level of leadership include department chairs and members of the hospital C-suite (e.g. CEO, CMO, CFO, etc.). The scope of this white paper will focus on the tactical level of leadership necessary for the fellow to transition into effective practice.

## Commonly Confused Terms

Owing to the idiomatic nature of the English language, for the purposes of this white paper, it is important to delineate the differences between commonly confused terms when used to describe leadership.

- *Management* refers to the administration of an organization in stewardship or resources. While good leaders have strong management skills, people generally do not like to be "managed."
- *Command* refers to the legal authority to direct actions, which is typically by appointed position or title. While all commanders are in positions of leadership by appointment, not all commanders have strong leadership skills.
- *Director* is a person who oversees an activity organization. Again, while all directors are in positions of leadership, not all directors necessarily have strong leadership skills.

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*Manage* resources  
*Command* organizations  
*Direct* activities  
*Lead* people

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## Transactional vs. Transformational Types of Leadership

There are two main types of leadership: Transactional and Transformational.

**Transactional leadership** is the type of leadership achieved by changing the actions of people.

This is typically exemplified by a positive reinforcement, or rewarding, of mission-supporting behavior while simultaneously discouraging mission-detracting behavior through the system of negative reinforcement or punishment (AKA “Carrots vs. Sticks” style of leadership). Through transactional leadership tactics, change happens quickly but does not persist.

**Transformational leadership** changes the beliefs of people.

Transformational leaders are typically described as charismatic. Historical examples include Abraham Lincoln, Mahatma Gandhi, and Martin Luther King. Under a transformational leadership style, change happens slowly, but the changes persist over time.

# Common Leadership Missteps

Common leadership missteps include communication/miscommunication, failure to address internal and external biases, poor feedback delivery/receipt, and poor conflict resolution.

## Communication

As previously stated, the crucial aspect of leadership is the ability to achieve a common goal for communicating a common, adopted vision as well as strategies to achieve this vision. The product of a well communicated, and adapted vision that is understood by all involved is called a shared mental model.<sup>2</sup> However, creating a shared medical model is notoriously difficult due to the idiomatic nature of the spoken English language with myriad regional variations to colloquialisms. For example, the words “up” and “down” have opposite meanings yet the phrases “The house burned up” and “The house burned down” connote the same meaning. The process of building a shared mental model can then, pose a dilemma similar to the situation portrayed in the fable of the five blind scholars describing an elephant (Figure 1). For this reason, it is vital to use precise, professional language as much as possible.

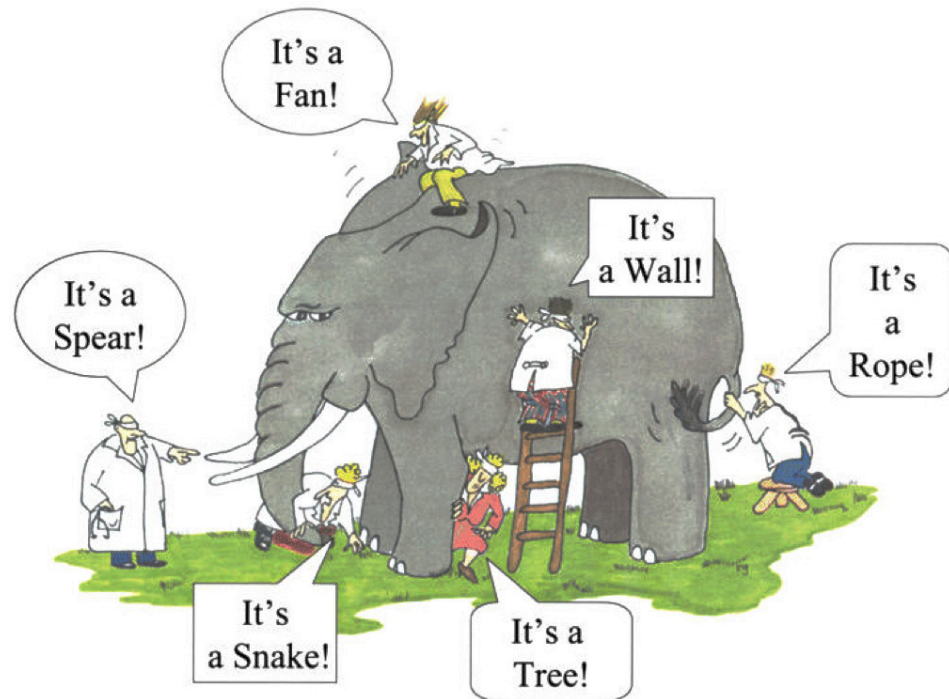


Figure 1. Depiction of the “Blind Men and the Elephant” fable.

## Biases

A bias is a disproportionate likelihood of decision making for or against an idea that is typically prejudicial. Biases can be innate or learned and are typically thought of as *conscious* (explicit) or *unconscious* (implicit). Biases exist as a method of decision making due to information overload and are filtered through perceptions, interpretations, preferences, selective attention, and memory. Biases can also stem from logical fallacies or cognitive framing. For example, telling a patient there is a 30% chance of re-dislocation after a first time traumatic glenohumeral dislocation vs. a 70% chance of successful treatment with appropriate non-operative treatment (especially if change in occupation, activity level, or sport is a viable option) provides the same information but biases the decision making towards surgical intervention. Myriad examples of statistical and systematic bias in research are well described in the literature.

A particularly difficult bias is unconscious or implicit bias. These biases are often incompatible with our conscious values and are not limited to ethnicity, race, or gender. Implicit bias can often be activated by high stress situations such as decision making in time-constrained environments or while multi-tasking. Unfortunately, we are all more likely to recognize biases in others than ourselves. Thus, the failure to recognize our own biases is also a form of cognitive bias. The first step in combatting unconscious/implicit bias is to become cognizant of our own biases. The Implicit Association Test (<https://implicit.harvard.edu/implicit/index.jsp>) measures attitudes and beliefs that people may be unwilling or unable to report. The IAT may identify an implicit attitude that you did not know about.

## Feedback

Feedback is the process of utilizing information about reactions to a product or performance of a task with the intent to improve performance. While evaluations as a systematic determination of performance using criteria governed by a set of standards is a form of feedback, it typically occurs at the end of a performance period and occurs too late to assist the team member in making corrections during the period of performance in question. Thus, a system of regular and frequent feedback is necessary for high functioning teams.

Effective feedback, like most human functions, is optimized when certain criteria are met. First, the giver of the feedback must be in the right mental state to provide the feedback. As a leader, if you are agitated, angry, anxious, fatigued, hungry, or otherwise time-constrained (e.g. after a complication occurs in the OR), it is best to delay delivering the feedback to a time when you are rested and calm. Second, the receiver of the feedback must be in the right mental state to receive the feedback and best received when rested and calm in a neutral environment. Finally, the environment must be appropriate to deliver and receive the feedback. The ideal location should be private and neutral. For example, negative feedback should not be delivered at the OR front desk within earshot of the receiver's peers.



Delivering negative feedback requires the leader to possess high emotional intelligence. Emotional intelligence refers to the capacity to be aware of, control, and express one's emotions, and to handle interpersonal relationships judiciously and empathetically. Development of emotional intelligence is taxing both intellectually and emotionally. The process is more of a journey rather than a destination. The leaders must constantly be aware of and improve their self-awareness/confidence, self-management/control, social awareness and empathy, as well as social skills and influence.

### **Conflict Resolution**

Conflict is inevitable in inter-personal relations, especially during conditions of limited resources (personnel, equipment, money, etc.). It is common for one party in the conflict to feel victimized while viewing the other party as the villain while the other party reciprocates the perceptions. In addition to clear communication and emotional intelligence, the leader must be assertive while displaying empathy for all parties involved. Impartiality is vital to the ability to mediate a resolution, so strong interviewing and active listening skills are required.

# Physician Leaders

For many surgeons, leading occurs naturally during training, operating, or researching. Leadership is manifested through mentoring or coaching, running an operative room or clinic, chairing a committee, or the myriad responsibilities of running a hospital or practice. Regardless, learning to lead is experiential, cultivated through one's career and continually improved upon. While the landscape of medicine is rapidly changing, the core principles of accomplished leaders is constant.

Dr. Wiley Souba described five fundamental leadership principles:<sup>1</sup>

- Recognizing that the work of leadership involves an inward journey of self-discovery and self-development.
- Establishing clarity around a set of core of values that guides the organization as it pursues its goals.
- Communicating a clear sense of purpose and vision that inspires widespread commitment to shared sense of destiny.
- Building a culture of excellence and accountability throughout the entire organization.
- Creating a culture that emphasizes leadership as an organizational capacity.

# Leadership Opportunities for the Young Leader

**Leadership opportunities, both formal and informal, are unlimited and ubiquitous.**

As previously stated, every patient encounter is a leadership opportunity at its core. The local community may offer opportunities for leadership roles through religious organizations or clubs. Your department or hospital may offer opportunities to serve on committees or boards. Your state, regional or national orthopaedic societies (e.g. AOA, AAOS, subspecialty society, ABOS, etc.) continuously are seeking volunteers to serve. Service in orthopaedic societies are limited only by your initiative and interest, including clinical development, networking, leadership development, advocacy/policy development, research and/or innovation, mentorship/trainee development, or GME/CME. Societies may have a geographic focus such as state or regional societies, subspecialty focus, advocacy/business focus, or a focus on clinical practice.

Regardless of the society you choose, the multiple benefits include broadening your professional network, staying up to date on treatment trends and controversies, increased level of expertise/credentialing, access to research studies/resources and traveling fellowships/international opportunities, leadership and professional development opportunities, and volunteer opportunities. Involvement in an orthopaedic society begins with membership.

Next, apply for a committee that meets your interest, volunteer as a course instructor or journal reviewer, or become a mentor to new and emerging leaders such as medical students, residents, and candidate members of your society.

Finally, avoid overextending yourself early. Remember to prioritize your family, patients and clinical practice. Start by focusing involvement in a couple of areas of interest and only expand involvement as time allows and dictates. A fatal flaw is to over promise and under deliver to your family, practice partners, or the committee to which you volunteered. Learn how and when to say "No," or preferably "I cannot commit to this right now."

Remember to seek counsel from your mentors, acknowledging they have all been where you are. Ultimately, join a committee to make a difference in a positive way.

1. Souba W. Building our future: a plea for leadership. World J. Surg. 2004 May;28(5): 445-50.
2. Gardner A.K., Scott D.J., Abdel Fattah K.R. Do great teams think alike? An examination of team mental models and their impact on team performance. Surgery. 2017; 161: 1203-1208.

# Fellowship Education Transition-to-Practice Lecture Series

An educational resource produced by the American Orthopaedic Association's  
Council of Orthopaedic Residency Directors (CORD)  
in collaboration with the Fellowship Education Coalition

[aoassn.org](http://aoassn.org)



THE AMERICAN ORTHOPAEDIC ASSOCIATION®  
*Leading the profession since 1887*

Fellowship Education Coalition

The American Orthopaedic Association engages the orthopaedic community to develop leaders, strategies and resources to guide the future of musculoskeletal care. The Fellowship Education Coalition brings together the orthopaedic community to identify, curate or develop educational tools and resources to better prepare graduating fellows for practice. The Coalition is comprised of the the following orthopaedic specialty societies: AOA/CORD, AAHKS, AANA, AAOS, ABOS, ACGME, AOFAS, AOSSM, ASES, NASS, OTA and POSNA.