Non Solus—A leadership challenge

G. Alexander Patterson, MD

It has been a true privilege to serve as the 90th President of the American Association for Thoracic Surgery (AATS). I view the AATS as an extraordinarily productive organization. I take pride in the fact that I have always belonged to productive outfits, starting with my own family.

I owe a great deal to my father, John, and my mother, Joan. I was raised as the second child of a large family in a beautiful small town in Eastern Ontario. My older brother Andy, sisters Christine and Charlotte, and younger brothers Duncan and Malcolm are all productive people who have supported Susan and me in our professional and family life. I am pleased they are here today.

A short while ago I heaped praise on Susan Mackinnon as an outstanding surgical-scientist. We get along fine in the operating room as long as I do exactly as I am told. She is also a wonderful spouse and mother. She has provided me with a wonderful family. I would not be standing before you today without her love and support. We are blessed with 4 beautiful and productive children.

Lachlan, shown here with our granddaughter, Lydia, is an outstanding chef. His restaurant, Frasca, is ranked one of the top 40 restaurants in the United States. He is a James Beard Award winner, and his restaurant is nominated for another James Beard Award at the annual James Beard Awards Ceremony in New York City this evening.

Our daughter, Megan, an orthopedic hand surgeon, is shown here with her husband, Ganesh, a sports orthopedic surgeon, and our grandson, Kiran. Megan and Ganesh are on the faculty at the University of North Carolina Chapel Hill.

Our son Brendan is to be married to Jenny this weekend. Brendan will graduate later this month from Washington University School of Medicine and begin his orthopedic training at the University of North Carolina Chapel Hill, I am told under the direct supervision of his big sister.

Our daughter Caitlan, shown here with her partner, Tom, just completed a Master's of Health Administration degree at Tulane University and begins an administrative fellowship at Barnes-Jewish Hospital next month. Susan and I will soon be working for Caitlan.

Susan's sister, Jennifer, and her husband, Steven, are also here today. They have been tremendously supportive of our family. We enjoy the wonderful times together at our camp in Northern Ontario.

I have had the distinct honor of working with 5 AATS past presidents (Figure 1). I am proud to be a member of the Pearson School of Thoracic Surgery. Griff Pearson was an outstanding thoracic surgical teacher and the most academically generous person I have ever met. Joel Cooper is one of the most visionary surgeons I have ever known. His determination and energy were infectious to all in our group. I believe I was the beneficiary of his wisdom and talents through many years of productive partnership. Jim Cox was my division chief at Washington University. He recruited an outstanding team of cardiothoracic surgeons and led what I believe was the best program in the country. He remains an active educator and investigator and an emeritus professor in our Division. When Tom Spray left Washington University, I lost a valued friend and colleague. He continues to direct one of the elite congenital heart programs in the world and skillfully led the AATS last year. What can I say about Tom Ferguson? He is past President of both the Society of Thoracic Surgeons and the AATS, Editor of *The Annals of Thoracic Surgery* for many years, and the mainstay of CTSNet for its first decade. He continues to provide valuable insight and advice as an emeritus member of our team at Washington University.

I have had the privilege of working with an outstanding group of thoracic surgeons directed by Bryan Meyers, a leader in the AATS, a section editor of *The Journal of Thoracic and Cardiovascular Surgery,* and a director of the American Board of Thoracic Surgery; cardiac surgeons led by Ralph Damiano, internationally recognized for his contributions to the surgical management of cardiac arrhythmia and minimally invasive cardiac surgery; congenital heart surgeons led by Dr Chuck Huddleston, recognized for his continued contribution in pediatric lung transplantation; and cardiothoracic anesthesia/critical physicians directed by Dr Michael Avidan, who has assembled a terrific group of computed tomography (CT) anesthesiologists who are members of our division and committed to our patients. Together with outstanding research faculty, this cardiothoracic division with busy clinical programs in every discipline is also responsible for grant support, including 7 R01s, 2 K08 awards, 1 training grant, 2 Small Business Innovation Research awards, and 1 award from the American Heart Association. I am lucky indeed to be part of such a productive group of talented cardiothoracic surgeons.

This productivity is made possible by an outstanding clinical research team led by Tracey Guthrie, Jennifer Zoole, and

From the Division of Cardiothoracic Surgery, Washington University School of Medicine, St Louis, Mo.

Presented at the 90th Annual Meeting, American Association for Thoracic Surgery, May 3, 2010, Toronto, Ontario, Canada.

Address for reprints: G. Alexander Patterson, MD, Division of Cardiothoracic Surgery, Washington University School of Medicine, 660 S Euclid Ave, Campus Box 8234, St Louis, Mo 63110 (E-mail: pattersona@wustl.edu).

J Thorac Cardiovasc Surg 2010;140:495-502
0022-5223/$36.00

doi:10.1016/j.jtcvs.2010.06.014

FIGURE 1. Five AATS past presidents: F. Griffith Pearson, Joel D. Cooper, Thomas L. Spray, James L. Cox, and Thomas B. Ferguson.

FIGURE 2. Five tribal stages. Logan D, King J, Fischer-Wright H. *Tribal Leadership: Leveraging Natural Groups to Build a Thriving Organization*. New York: Harper Collins; 2008.

Marci Bailey. I am also indebted to all of the fellows we have had the pleasure of working with over many years. Most of these outstanding surgeons are productive members of the AATS or soon will be.

I have always thought that one of the great benefits of academic surgery is the opportunity to learn of the culture and practice of surgery around the world. I have warm memories of a steady stream of international visitors to our thoracic program while I was a young trainee and faculty member. I established friendships that remain strong to the present day. Among the many international thoracic surgeons I consider good friends, 3 deserve particular mention because they have advised and taught me, and have been generous to my family over many years.

Erino Rendina, immediate past President of the European Association, is an outstanding friend. I have had a close relationship with his team for more than 20 years. Walter Weder is a past President of the European Society of Thoracic Surgeons, and Walter Klepetko is a past president of the European Association for Cardiothoracic Surgery. These 3 outstanding surgeons have each made important contributions to thoracic surgery. I have learned a great deal from each of them.

I also owe a great debt to my assistants, Mary Ann Kelly, who has worked with me for 19 years, and Sheila Hall. Finally, like all AATS past presidents, I have benefited greatly from the hard work, support, and advice of AATS staff members: Elizabeth Dooley, Cindy VerColen, Jane Pimental, Amy Doucette, Matt Eaton, and Yvonne Gruenebaum. Honorary AATS member, Bill Maloney, has been a friend and advisor to me for many years. My AATS presidential year has been greatly facilitated by his support.

The core mission of the AATS is to promote scholarship in thoracic and cardiovascular surgery. The tag line ''We Model Excellence'' encapsulates a commitment to leadership, scholarship, mentoring, and quality patient care. These values are time honored. Our history is replete with examples of legendary figures of thoracic surgery who are icons in our field and examples of our values. As we look back, we see solitary surgeons who moved the field forward with individual vision and accomplishment. Consider the contributions of those for whom AATS scholarships are named: Drs Churchill, Gross, Blalock, Harken, Morrow, Alexander, Oschner, Gibbon, Kirklin, and Shumway. Many of you sitting here today are held in the same light: remarkable individual scholarly and scientific achievement. Our traditional academic medical environment favors individual achievement. Just think of what is necessary to get there: terrific grades, high SAT and MCAT scores, matched to top training programs, and outstanding performance during training. After academic appointment, the reward system, monetary and otherwise, is typically focused on individual accomplishment: articles published and grants awarded. Indeed, the holy grail of academic achievement, promotion and tenure, are awarded on the basis of broad recognition of individual accomplishment.

This concept or model of individual achievement is not new. It extends to ancient mythology: the Savior, the Messiah, the heroic warrior. This classic painting of Joachim Wiewael from 1611, currently hanging in the Louvre, depicts Perseus, with benefit of the shield of Minerva and wings of Mercury having just beheaded Medusa. He encounters Andromeda, the beautiful daughter of King Cepheus and his Queen Cassiopeia. Andromeda has been chained to the rocks as a sacrifice to the fearsome sea monster. Perseus slays the monster as it is about to devour the lovely Andromeda, who becomes his bride. This recurring emphasis on and celebration of the individual continues throughout history, through the Middle Ages to the present day and even into the future. Just consider the story line of the biggest box office movie of all time, *Avatar*.

Indeed, many of our legendary forbearers in cardiothoracic surgery have taken on near mythic status. Our history, training paradigms, and practice patterns have fostered independence, individualism, self-discipline, and responsibility, which can inappropriately foster this mythology I have been discussing. While not taking anything away from the accomplishments of our heroes, the solo academic cardiothoracic surgical leader is the illusion, the myth.

In fact, the entire culture of academic medicine is moving away from individualism. The tertiary care world is shifting from the achievements of individual experts toward cooperation between individuals and groups to address complex problems in clinical care, research, teaching, and administration. The environment in which we must implement our core values has changed.

The year 2010 marks the 130th anniversary of the publishing company Elsevier and the 430th anniversary of the publishing house of Elzevir, from which the current company takes its name. The original Elzevir printer's mark is used as the logo of the current company Elsevier. We see an old man standing beneath an elm tree. The tree is entwined by vines under which is inscribed the Latin term *Non Solus* (not alone). Although the origin of this logo is unclear, most scholars appreciate a moral in this illustration. As Erasmus said, ''like the vine which, though the most distinguished of all trees, yet needs the support of canes or stake or other trees which bear no fruit, the powerful and the learned need the help of lesser men.'' The logo represents the symbiotic relationship between publisher and scholar. Scholars, like the vine, require the strong support of the publisher, the elm tree, to produce the fruit of their labor.

We cardiothoracic surgeons are *non solus*. We need the interdependent relationships and skills of a multitude of disciplines for success. It is interesting to reflect on our perception and those of others about our place in our environment. In former years, thoracic surgeons worked in a system of vertical integration.

In his Presidential Address to the Western Thoracic Surgical Association in Banff 2009, David Fullerton eloquently described the historical preeminent, perhaps solitary role of thoracic surgeons in the care path of our patients.

Diagnosis, operative management, early postoperative care, long-term care, and assessment of outcome were all the responsibility of the thoracic surgeon. However, as we all know, we now exist in a system of horizontal integration with colleagues of multiple disciplines and interest groups affecting patient care at each point in the care path. Add to this the interaction with hospital administration, nursing, and a myriad of university departments. In this era of multidisciplinary integration, who among us does not need a highly integrated coherent team with commitment to a common goal? Without such teams, excellence in patient care, teaching, and research is impossible.

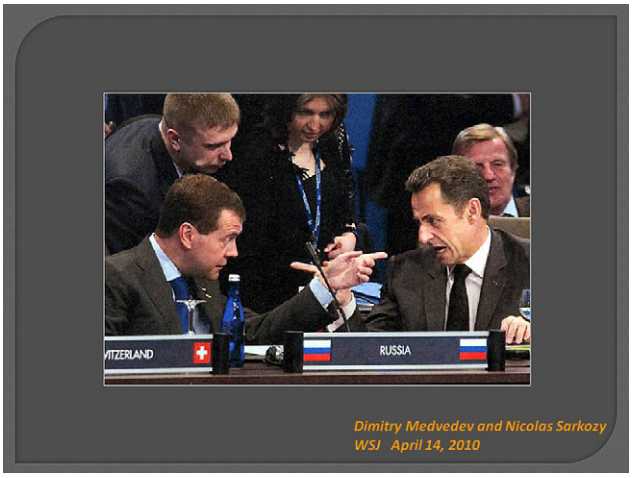

FIGURE 3. Russian President Dmitry Medvedev and French President Nicolas Sarkozy in angry discussion. Reprinted by permission of *Wall Street Journal*, Copyright © 2010 Dow Jones & Company, Inc. All Rights Reserved Worldwide. License number 2478840255509.

In his best selling book *Tribes: We Need You to Lead Us,* Seth Godin[1] points out the primal need for human beings to belong, to belong to a like-minded group committed to a common goal—a tribe. ''You cannot have a tribe without a leader and you can't be a leader without a tribe.'' In my view, the most productive groups, programs, tribes if you will, are those in which everyone contributes and takes from the enterprise knowing all the while that his/her individual contribution to the goal is vitally important. This is a leadership challenge for thoracic surgeons: to create and lead integrated, highly skilled multidisciplinary teams committed to a common goal.

In their insightful book *Tribal Leadership: Leveraging Natural Groups to Build a Thriving Organization,* Dave Logan, John King, and Halee Fischer-Wright[2] describe 5 tribal stages (Figure 2). These stages accurately depict what we have all observed in various organizational systems. Stage one is basically gang warfare: the Bloods versus the Crips, or some similar organizational structure where the basic premise is that ''life sucks'' for everyone—no hope, no aspiration. Stage 2 is an organizational state where the prevailing attitude is ''my life sucks.'' The individual feels ignored and left out, and believes others in the organization must surely have a better situation. This culture is typified perhaps by the Department of Motor Vehicles, the Postal Service, Transportation Security Administration airport screeners, and employees of health insurance companies. This is obviously not the kind of outfit you want to be a part of.

Stage 3 is actually a commonly encountered organizational model in modern academic medicine. In this model, the prevailing leadership attitude is ''I am great'' and ''you are not.'' Stage 3 leaders hoard information: ''I know things you do not.'' The focus is on ''I,'' not ''we,'' and the values

are personal, not tribal. The typical stage 3 leader sees himself/herself as a lone warrior, tough, hardworking, and without competent support staff. The culture of stage 3 brings to mind Machiavelli's famous saying, ''It is better to be feared than loved.''

In stage 4, the attitude is ''we'' not ''I.'' A spirit of collaboration and shared vision of what the goal is give rise to the conviction that everyone in the tribe is deriving benefit in the pursuit of a common organizational purpose. In this situation, of course, there can be an enemy, but it is outside the organization. The prevailing attitude is ''we are great, but they are not.'' This sort of organization, not commonly encountered in academic medicine, having shared core values and accountability, is capable of remarkable achievement, group and individual satisfaction.

Stage 5 is rather like a state of nirvana where the prevailing attitude is ''life is great.'' In this environment there is a perception of innocent wonderment about the infinite possibilities of organizational accomplishment. Although we may all aspire to organizational stage 5, few tribes reach this level.

Now if it is obvious that working together in functional groups is ideal, why is it that CT surgeons often have difficulty achieving and maintaining this goal? It is clear there are many factors that impede success in team building. Many of these are beyond our control: Hospital and university financial models, decrease in reimbursement, inadequate nursing and physician staff, malpractice expense, and the endless requirement for compliance, disclosure, and documentation of presence are all factors over which we as surgeon leaders have little or no control.

However, I am convinced that the biggest obstacle to successful team building is a factor over which we have complete control—our behavior. Like all who have preceded me as AATS President, I have read a number of scholarly works in preparation for this address.

Perhaps the most profound is Robert Sutton's classic, oddly titled, *The No Asshole Rule: Building a Civilized Workplace and Surviving One That Isn't*.[3] On the back face page, the publisher depicts the text as ''the definitive guide to working with—and surviving—bullies, creeps, jerks, tyrants, tormentors, despots, back stabbers, egomaniacs, and all the other assholes who do their best to destroy you at work.'' Sound familiar?

The basic premise of this book is that you need to treat the person right in front of you, right now, in the right way. We have all witnessed bad behavior in the work place. We are all aware of sad examples of disruptive behaviors that have resulted in job loss, career destruction, and family disruption. In our own midwest region, a thoracic surgeon lost his job after making disparaging remarks about the physical deformities of a staff member in the operating room environment. Another thoracic surgeon was terminated and charged by law enforcement after threatening a nurse with gun violence. In our own department of surgery, a recent survey among faculty members discovered that although the majority of faculty had never themselves engaged in bad behavior, a similar large majority of the same faculty had witnessed bad behavior by the same faculty colleagues participating in the survey.

FIGURE 4. Essential qualities of successful group leadership.

Angry outbursts in the workplace were the focus of a recent review in *The Wall Street Journal*.[4] In this article, actress Valerie Harper, playing Tallulah Bankhead in the Broadway show ''Looped,'' demonstrates 6 faces of anger, unfortunately familiar to all of us: agitated, masked anger, irritable, retaliatory, irrational, and explosive. None of these anger modes fit with responsible group leadership. Even the quiet facial expression in early anger display is readily picked up by attentive members of the work group. The completely obvious angry outbursts depicted in later stages are actually dangerous in a group environment, not to mention the health risks to the exploding individual. Imagine the face of a thoracic surgeon, perhaps yourself, in any one of these panels: not a pretty picture.

Diagnostic designations have been assigned to these angry outbursts. You all think of IED as the acronym for an improvised explosive device, recently popularized by the insurgency in Iraq and Afghanistan. However, much more common, admittedly less fatal, but destructive nonetheless, is intermittent explosive disorder: episodes of aggression against people or property out of proportion to any provocation. One in 20 Americans, mostly men, have this condition. Intermittent explosive disorder, recognized as an illness since 1980, can be associated with temper dysregulation disorders. I am not making this up: This condition is listed in the *Diagnostic and Statistic Manual* about to be published in 2010. Such behavior is common among people in leadership positions.

Figure 3 shows the Presidents of Russia and France engaged in a pleasant conversation about nuclear weapons during a recent summit in Washington. Notice the facial

FIGURE 5. Social intelligence qualities valuable for group leadership. Goleman D, Boyatzis R. Social intelligence and the biology of leadership. *Harvard Business Review*. September 2008:1-8.

expressions and the finger pointing. Makes you worry about who has their finger on the trigger.

Errant behavior among busy cardiothoracic surgeons is a particular problem, not only because of its impact on patient safety, staff performance, resident training, and a host of other parameters, but also because it is often tolerated. CT surgeons as a group generally represent a positive revenue stream and high-end promotional opportunity for hospitals and universities. Bad behavior among ''rainmakers'' is frequently tolerated.

There are a host of explanations for such disruptive behavior: stress, lack of transparency, loss of control, and lack of trust. The issue of trust is interesting to contemplate. In his 2007 Presidential Address to the Association of American Medical Colleges, CEO Dr Darrell Kirch describes an ''academic paradox.''[5] Every academic medical center is filled with individual practitioners we would trust with our lives, yet there is a uniformly low level of group trust. We need to move to a place where group trust is as strong a force as individual trust.

A discussion of disruptive behavior among highly educated, skilled cardiothoracic surgeons engaged in the business of life and death must include narcissistic behavior. The details of Greek and Roman mythology differ slightly in their depiction of Narcissus, a beautiful lad who disdains all who love him. In Caravaggio's masterpiece, we see Narcissus, who seeing his image for the first time in a forest pool is so captivated that he cannot leave the pool side and perishes as a result. We have all witnessed narcissistic behavior among our colleagues. In its simplest form, narcissism is manifested as excessive interest in the well-being of self: selfishness. There is nothing wrong with ego strength and self-confidence. Indeed, in the practice of cardiothoracic surgery, these are in a sense mandatory attributes. Yet our cardiothoracic environments are all too often focused on I, me, and mine, instead of we, us, and ours. Even less commonly encountered is ascription of ownership or credit entirely to others with the terms *he, she, his, hers,* or *theirs*. Narcissistic behavior also implies a certain disdain for the opinion or interests of others within the group. Self-concern and absorption are dangerous in a multidisciplinary environment of colleagues, trainees, and students committed to a common goal.

As we progress in our academic careers, we are afforded many opportunities to mentor young colleagues and trainees. We should seize these opportunities for they enhance everyone in the group and the tribe as a whole. We need to be mindful about self-promotion at a senior stage of our career. Young people will not receive good mentorship from senior colleagues for whom self-promotion is important. I was always taught to stay away from people who engaged themselves in a reflective surface. This brings to mind the story of the spoon. Individuals who know whether their image is right side up or upside down in the concave or convex surface of a spoon spend too much time admiring themselves. Try this at lunch.

The impact of disruptive behavior cannot be overemphasized. There are a number of definitions of disruptive behavior. Simply put, disruptive behavior is any interpersonal interaction that might negatively affect patient care and the mission of the organization.[6] The Institute of Medicine has noted that the organizational culture and interaction of nurses with other health care providers, especially physicians, is a potential threat to patient safety.[7]

The negative impact of disruptive behavior on patient safety was noted in a sentinel alert issued by the Joint Commission entitled ''Behaviors That Undermine a Culture of Safety.''[8] Eleven recommendations were made.[9] New leadership standards were developed that require all accredited health care organizations to define disruptive behavior, develop a written code of conduct, and implement processes to deal with disruptive behavior. The common forms of abuse are, of course, condescending language, demeaning in public, disrespect, sexual harassment, and a failure to communicate in a timely manner with professional colleagues.

This behavior results in poor communication and errors. Staff and trainees create alternative care and communication pathways to circumvent the intimidating physician. This puts patient safety at risk by providing an excellent opportunity for miscommunication and error. We have all seen this in our own practice environment. In our own program, a surgeon's intimidating behavior was such that the critical care fellows would avoid contact or communication with the surgeon whenever possible. When communication was absolutely necessary, the responsible senior intensive care unit fellow would practice his/her delivery to the surgeon with intensive care unit attendings or other fellows before speaking with the surgeon directly: ridiculous and dangerous. Such behavior adversely affects staff and trainee retention and

recruitment.[9] No less a medical authority than *The Wall Street Journal* observed that ''there is mounting evidence that poor communication between hospital support staff and surgeons is the leading cause of avoidable surgical error.''[10]

Everyone is entitled to safety of person and psyche in the workplace. Even subtle disdain is unacceptable. A well-known story is told of British Prime Minister Margaret Thatcher having dinner with her esteemed cabinet colleagues. A waiter asks Mrs Thatcher what she would like for dinner. Steak, she says. The waiter pauses for a moment and asks what about the vegetables? Without a moment's hesitation, she says ''They will have steak as well.'' Often made in jest, such disdainful remarks, or much worse, commonly made in our operating rooms, clinics, and laboratories are heard by the members of our team, nurses, students, and trainees. A statement made in jest, no matter how clever or funny, is not appropriate if an individual is the butt of a joke. Negative perceptions of CT surgeons behavior is often cited as one reason why so few students, particularly female, choose a career in our discipline.

By mandate from the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties, we are required to provide our trainees with training and certify competency in 6 core areas:

1. Patient care
2. Medical knowledge
3. Practice-based learning
4. Interpersonal and communication skills
5. Professionalism
6. System-based practice

Four of these 6 core competencies have specifically to do with appropriate physician professional behavior.

How can CT surgeons be leaders in an environment where they do not control many important elements? For effective leadership, we do not need to control the entire environment. Several years ago, our Department of Surgery embarked on a project to develop behavioral and leadership excellence. Our department chair, division chiefs, and section chiefs all participated in a 360-degree Emotional Competence Inventory (ECI) administered by the Hay Group. This multi-question online survey was completed by these 13 highly skilled, accomplished national surgical leaders, and each of us was evaluated also by 9 other individuals in our work environment: peers, direct reports, and managers. It was illuminating enough to complete the survey but much more instructive to receive feedback on our leadership skills from others in the environment. As a group, we scored well in many areas. However, some areas were significantly deficient. On measures of empathy, only 2 of 13 chiefs met expectation. On measures of conflict resolution, none of the 13 chiefs met expectation. This is not surprising because for successful conflict resolution, empathy is an essential quality.

In other words, our leadership group was found sorely lacking in essential qualities of group leadership: empathy, self-awareness, and emotional or social intelligence (Figure 4). These attributes, learned behavior in every case, are mandatory characteristics of group leadership irrespective of the field.

In 1998, Daniel Goleman[11] described the relationship between emotional intelligence and leadership. One might characterize emotional intelligence as an amalgam of personal attributes that enhance social and professional interaction. Central components of emotional intelligence are empathy and self-awareness. It is clear that superior social interaction improves personal and group performance in a wide range of disciplines, including business and medicine. In a recent review, Goleman and Boyatzis[12] describe the state of social intelligence and support their argument with data from recent behavioral biology research. Positive mood in a group elicits better performance. It seems laughter is serious business because top performing leaders elicited laughter from their subordinates more frequently than leaders with less productivity. Goleman and Boyatzis partnered with the Hay Group (who administered the 360-degree ECI mentioned earlier) to describe 7 social intelligence qualities (Figure 5).

Empathy
- Do you understand what motivates other people, even those from different backgrounds?
- Are you sensitive to others' needs?

Attunement
- Do you listen attentively and think about how others feel?
- Are you attuned to others' moods?

Organizational Awareness
- Do you appreciate the culture and values of the group or organization?
- Do you understand social networks and know their unspoken norms?

Influence
- Do you persuade others by engaging them in discussion and appealing to their self-interests?
- Do you get support from key people?

Developing Others
- Do you coach and mentor others with compassion and personally invest time and energy in mentoring?
- Do you provide feedback that people find helpful for their professional development?

Inspiration

- Do you articulate a compelling vision, build group pride, and foster a positive emotional tone?
- Do you lead by bringing out the best in people?

Teamwork

- Do you solicit input from everyone on the team?
- Do you support all team members and encourage cooperation?

These attributes are queried in the 360-degree Emotional Intelligence Inventory survey. Deficiencies can be identified and focused attention can be brought to bear to provide a learning experience and improve leadership qualities at all levels.

Empathy as promulgated by every business leadership course, book, and seminar has unfortunately acquired somewhat of a bad reputation. Empathy is the hallmark of compassionate patient care, yet empathy is often left out in our interactions with others in our work environment. When our department, as a result of our 360-degree ECI experience, was confronted by the prospect of focusing on empathy, one of my colleagues, a very busy, widely respected surgeon said ''Empathy? I am very busy, I don't have time for empathy.'' Empathy does not take time; it takes commitment. Empathy need not be soft, fuzzy, or hand wringing. In fact, the most effective is tough empathy: Balance respect for the individual with the goals, vision, and mission of the enterprise. A look of concern, understanding, and listening go a long way to convey the sense that there is concern and respect for the opinion and situation of others.

In our high-tech, competitive, stressful environment, it seems listening has become a lost art. Too many of our leaders seem fascinated by the sound of their own voice; have endless, frequent repetitive information to impart; and are too often in a state of ''transmit,'' rarely in a state of ''receive.''

The relationship of listening and effective leadership is beautifully described by Roger Nierenberg in his monograph *Maestro: A Surprising Story about Leading by Listening*.[13] Nierenberg is a widely acclaimed conductor. He uses the metaphor of a symphony orchestra to demonstrate the leadership opportunities available by encouraging individuals in a complex organization to contribute to the entire piece by drawing on the full range of their individual talents. By receptively listening to the individual components with the overall goals of the organization in mind, a better product is accomplished.

Dean Rusk, Secretary of State in the Kennedy administration, said ''one of the best ways to persuade others is with your ears—by listening to them.''

I am not a leadership guru, and this discussion is not meant to be another leadership lecture. However, I have a clear idea of what I have observed in academic cardiothoracic surgery over the past several decades. Collegial cooperative groups with clear goals and commitment function best and are most productive. The environment of academic medicine has changed, and cardiothoracic surgery has not been spared. The paradigm of self-centered individualism of the past has been replaced by one of multidisciplinary collaboration, transparency, and mutual accountability—all focused on the best outcomes for our patients. Our clinical, research, training, and administrative environments have all changed. In his address to the Association of American Medical Colleges, Dr Kirsch acknowledged the courage required to confront this obvious fact of our times as academic physicians. We should embrace the leadership and behavioral excellence adapting to this change will require. We can develop endless strategies for future success in all of our institutional, departmental, and divisional initiatives.

However, without developing a culture of group success, we will fail, for ''culture eats strategy for lunch every day.'' As leaders in academic cardiothoracic surgery, we need to embrace the concepts of social intelligence and behavioral excellence. We are all surrounded by talented, highly committed individuals who want to be part of a successful team.

So, in addition to constant attention to our behavior, what can we do right now to maximize group or tribal leadership? Transparency in all interactions is key. Surgery job satisfaction surveys are readily available, and I would be pleased to provide anyone the survey taken by our department. The ECI, a 360-degree tool, is also readily available for immediate access (www.haygroup.com).

Every one of you works in an institution with a code of conduct in place. The Washington University Department of Surgery code of conduct is available at http://www.surgery.wustl.edu/Surgery.aspx?id=1146&menu_id=96. Use your code of conduct; commit to it and its enforcement. If it needs modification to suit the needs of your department, get it done. For individuals who are having behavioral problems, offer them the many counseling and coaching opportunities available, and support them fully in their efforts to change.

As a leader, when confronting bad news, look in the mirror to assign blame and responsibility. When confronting success, look out the window to give credit to others and see new opportunities for growth and development. Listen, delegate, and celebrate the success of others as their success elevates the entire enterprise.

Social intelligence and behavioral excellence are not ethereal concepts or warm and fuzzy notions from the liberal left. They are learned behaviors. As academic cardiothoracic surgeons, we must lead in a new culture of multidisciplinary horizontal integration.

Eric Hoffer, American philosopher and 1983 recipient of the Presidential Medal of Freedom, once said that ''in times of change, learners inherit the earth, while the learned find themselves beautifully equipped to deal with the world that no longer exists.'' Individualism runs counter to the

foundations of what the AATS espouses. ''We model excellence.'' The core values of the AATS—leadership, scholarship, mentoring, and quality patient care—require a constant commitment to behavioral leadership.

References

1. Godin S. *Tribes: We Need You to Lead Us*. New York: Portfolio; 2008.
2. Logan D, King J, Fischer-Wright H. *Tribal Leadership: Leveraging Natural Groups to Build a Thriving Organization*. New York: Harper Collins; 2008.
3. Sutton RI. *The No Asshole Rule: Building a Civilized Workplace and Surviving One That Isn't*. New York: Warner Business Books; 2007.
4. Beck M. When anger is an illness. *Wall Street Journal*. March 9, 2010.
5. Kirch DG. Culture and the courage to change. AAMC President's Address, 2007 Annual Meeting. Washington, DC: Association of American Medical Colleges; 2007.
6. Piper LE. Addressing the problem of disruptive physician behaviors. *Health Care Manag*. 2003;22:335-9.
7. Page A, ed. *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington DC: The National Academic Press; 2004.
8. The Joint Commission. *Behaviors That Undermine a Culture of Safety*. Available at: http://www.jointcommission.org/sentinelevents/sentineleventalert/sea_40.htm. Accessed November 26, 2003.
9. Saxton R, Hines T, Enriquez M. The negative impact of nurse-physician disruptive behavior on patient safety: a review of the literature. *J Patient Saf*. 2009;5:180-3.
10. Landrio L. Bring surgeons down to earth. *Wall Street Journal*. November 16, 2005. DA-4.
11. Goleman D. What makes a leader? *Harvard Business Review*. 1998;76:93-103.
12. Goleman D, Boyatzis R. Social intelligence and the biology of leadership. *Harvard Business Review*. September 2008;1-8.
13. Nierenberg R. Maestro: *A Surprising Story about Leading by Listening*. New York: Portfolio; 2009.