

TEACHING STUDENTS
TO TAKE THE

LEAD

OVER THE PAST YEAR, fourth-year medical students at Geisel had the opportunity to take an elective course on the topic of leadership. The course, which was led by Dean Chip Souba, is part of the medical school's effort to train students to take on the most pressing challenges facing the nation's health-care system. Meredith Bartelstein ('13), who will soon be leaving Geisel to begin her residency in orthopaedic surgery at Mount Sinai Hospital, took the course this spring. Recently, she sat down with Souba to ask him about leadership and about how to help students and physicians become effective leaders.



Jon Gilbert Fox

MB: (MEREDITH BARTELSTEIN) First, could you talk a bit about what it means to be a leader?

CS: (CHIP SOUBA) The standard (and often unchallenged) way of thinking about leadership in academic medicine—as being about a person in charge who wields clout and directs followers—is becoming increasingly ineffectual. This implicit leadership theory is not wrong; in fact, there are times where authoritative decisions are important. But it is limited because the challenges and problems confronting medicine today are so complex that it is impossible for one person to accomplish the work of leadership alone. Unless and until we change the lens through which we understand and exercise leadership, the future will be largely a continuation of the past.

From the 50,000-foot level, we might say that a leader is anybody who moves an organization or even a country forward into a future that better serves the needs of the people it is intended to serve. Several examples come to mind: Abraham Lincoln, Martin Luther King,

Mother Teresa. These larger-than-life examples of leadership are inspiring, but most leadership is leadership with a small “l” that begins with “being” a leader. In the elective our students took, we tried to emphasize that a leadership framework that distinguishes being a leader as the basis for what leaders know and do is central to upholding medicine’s ethical foundation. Four pillars of “being” a leader—awareness, commitment, integrity, and authenticity—are proposed as fundamental elements that anchor this foundation and the basic tenets of professionalism. If you’re not being a leader, it’s impossible to act like a leader.

MB: People often talk about “natural-born leaders.” Is leadership something that can be taught?

CS: The idea that leaders are born is a myth that we need to dismiss. Leadership can be learned, and it has to be learned. I’m certainly counting on our students—and our faculty and staff—to learn to be more effective leaders. The good news is that we all can learn to become more effective as leaders if we put in the effort.

MB: Why is leadership an important skill for physicians?

CS: We talk a lot here at Geisel about creating physician-leaders, but that doesn’t

mean that the goal is for all our students to become CEOs or deans or department chairs. The goal is to equip our students with the skills and competencies that will make them more effective, whether they’re the CEO of a big pharmaceutical company or a physician in rural New Hampshire. We’re not just talking about managerial skills, though they are important. We’ve all known people who have strong managerial abilities but also have trouble leading people. Leadership and management, while complementary, are different activities.

It’s a harsh world out there, and we need people who are deeply committed to constructive change. Anyone striving for significant social change who doesn’t see beyond the possibilities of the present reality is at a disadvantage, because the forces that can work against us can be huge and the obstacles often seem to be insurmountable. Without being committed to a future that’s bigger than you are, the “you” that you need to be won’t be sufficient.

MB: So then how would a physician who spends most of the workday seeing patients apply leadership skills to that work on a day-to-day basis?

CS: You can start by asking, “How do I continuously improve the care of my patients? How do I provide higher quality, safer care at a lower cost?” Cost constraints are here and they’re not going to go away. We also know from studies done here at Dartmouth that there’s an awful lot of waste in the American health-care system. So it’s critical for every physician to constantly be thinking about how to reduce

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unwarranted variations in their own practice. There are useful decision support tools becoming available that can help them reinvent their practice. But more fundamentally, physicians have to be able to reinvent themselves. This is why we focused on leading yourself in the leadership elective.

MB: How did you become interested in the science of leadership?

CS: Historically, leadership has been seen as more of an art than a science. But more recently it has become clear that there is a scientific basis to leadership. Much of that work is related to some recent advances in our understanding of the brain and how we make choices and decisions. So I am very interested in learning more about how the brain works. What is it about the brain that is responsible for what people call willpower? What is it about the way the brain is wired that makes people altruistic? What default ways of being and acting get in our way of leading effectively, and can they be overcome?

MB: How is Geisel incorporating leadership into the medical curriculum?

CS: We're in the middle of significant curricular reform. One of the things I've asked the curriculum redesign team to look at is how we can create a four-year longitudinal leadership experience, where the students get “in the trenches” experiences. Providing students with a solid education in the broad field of leadership is something that, historically, medical schools haven't done. We want to be a leader in that space.

MB: That's great. But along those lines, what will distinguish Geisel's leadership curriculum from other leadership courses out there?

CS: We can no longer only prepare our students for the practice of medicine; we must also prepare them for the practice of leadership. There are other medical schools that have content related to leadership in their curriculum, but that content often has more to do with the economics of health care or health-care policy. I'm also interested in making sure all students leave with a solid understanding of what they stand for, whether it's patient care or global health or research. We want the education our students get to make them more effective as residents and as life-long members of the health-care work force.

MB: I've often heard you discuss a special language of leadership, or a conversational domain of leadership, and I was wondering if you could explain why that is so critical.

CS: There are a number of things that make humans unique as a species, but what is most distinctive is our language. It's not possible to become an expert in any discipline if you haven't mastered the language in that field. So, for example, there's a whole language of molecular biology that was born in 1953 when Watson and Crick published their famous article on the structure of DNA. Their breakthrough discovery transformed the world of science and opened up vast new possibilities for the application of nucleic acid research.

The significance of elucidating the structure of DNA was not in describing something that was always already there, but in making available new knowledge that allowed scientists to relate to and engage with the world more meaningfully. Language allows us to turn events into “talkable” objects, making them accessible in the sense that we can name them, debate them, and “get our hands” on them.

Whether in law, medicine, or molecular biology, if you don't speak the language you cannot function, communicate, or innovate in that domain. It is not unlike going to a foreign country where you don't speak the language. The point is that if you really want to be effective, whatever the discipline or area, you better learn the language.

Meredith, you're a great example of someone who in the past four years has become much more skilled in the language of medicine. When you came here, you basically didn't speak it.

MB: Medical school really has been a huge vocabulary lesson.

CS: The conversational domain of medicine is what gives you access to your patients. The way that a patient occurs for you today, the way that you interact with her, is very different today than it was four years ago when you didn't speak the language. The language gives you a unique kind of access to your patient's body, to her history, to her illness. It gives you access that allows you to make a diagnosis and develop a treatment plan.

The same thing is true of leadership. There is a prevailing conversational domain of leadership that has existed for years. It includes words like vision, strategy, value, culture, and accountability, terms that are familiar to most everyone. This conventional leadership model explains performance (e.g., value) as an effect of some cause (e.g., improving quality, reducing costs) and assigns that cause to some combination of the leader's physical and mental characteristics and attributes as well as the external circumstances of the performance situation. This dominant worldview of leadership is deeply embedded in the mental maps of most individuals and organizations. This view is not wrong or ineffective. But it provides us with nominal access to our human ways of being and acting that limit our leadership effectiveness. It grants us limited actionable access to create for ourselves what it is to be a leader and what it is to exercise leadership effectively as our natural self-expression.

If there was a different language of leadership that gave us greater access to exercising leadership, then it would be worthwhile to master, right? It would be pretty neat for Geisel



to play a central role in creating a conversational domain for leadership that helped tackle these challenges.

MB: Switching gears a little, what can a medical student do outside of the curriculum to become a better leader?

CS: Nobody is going to learn to be an effective leader just by reading books and articles, just like reading all your textbooks is not going to make you a good doctor. The theories and concepts are necessary, but they're not sufficient.

So one of the things that students can do to get experience is to do exactly what you've done—take on some responsibilities where you need to work with people who have different goals and perspectives. At Geisel, we have students on the Strategic Planning Committee, on the Biomedical Research Council, on the Medical Education Committee, and on the Curriculum Reform Task Force. And we have several students on national committees. It's very important that students have opportunities to get their feet wet, if you will, partly because they are rich experiences, but also because they bring a perspective to the table that the faculty don't have. The more different perspectives we can get, the better. The literature is pretty clear that diverse thinking, vigorous debate, and creative conflict are healthy.

MB: I think one big takeaway for me from the course is that leadership is not a title; it's not a position that you hold. It really is a way of being and acting, which is something we've discussed as part of the elective. And by understanding myself and my individual leadership style as well as my limitations, I've been better able to move beyond those.

CS: That's an important point. The implicit leadership theory that sits in people's heads, the image that they have of leaders in academic medicine, is often of a brilliant scientist who wins the Nobel Prize or the amazing diagnostician who everyone goes to when they can't figure out what's wrong with a patient. If that's the model of leadership that you carry around with you, then you might conclude that if you're not one of those people you can't be a leader. That's a myth that we want to debunk. We want everybody in this organization to be clear that they can and must contribute to the systemic leadership

capacity in this organization. I truly believe this—the more leadership we have from the students, the better off we are, no question about it. We want students to say, “I may not have any formal authority. I may not have a title. But I can still lead.”

MB: Contribute to the conversation.

CS: That's right. Help us “language” our challenges in health care so we understand them better and so they are “hittable.” Language, I believe, is the most underutilized resource leaders have at their fingertips. Right now, we lack a clear, shared understanding of exactly what the problems are; the various stakeholders—patients, physicians, payers, government, corporations—see the problems through their different lenses.

It turns out that words are powerful in this realm of possibility we call the future. Our ability to use language to bring forth innovative ideas and possibilities will determine the kind of health-care system we will create and will shape the future of our world. In this light, leadership can be understood as an exercise in language that reframes (recontextualizes) people's challenges such that more productive ways of being and acting result.