Section 1 Leadership and Strategy

Chapter 1

Leadership Principles

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Contents

Evolution of Leadership

What Is Leadership?

As individuals move up within an organization and accept more responsibility, their interest in leadership rises as they have more people reporting to them. Leadership is about leading people, or the *capacity to lead*, and specifically the behavior of an individual when directing the activities of a group towards a shared goal [1]. Akin to a conductor of an orchestra, a leader has a capacity to direct and motivate multiple professionals to perform to their peak ability while minimizing uncoordinated activity.

In our own experience, leadership is about making sure everyone in the organization (1) shares vision and purpose, (2) is engaged in the future outcome of the organization, and therefore (3) favors collaboration over pursuing their own agenda. Among many other responsibilities, leaders are role models for the values of the organization, set the optimal course, and establish priorities. Making people connect and collaborate, as well as finding the appropriate style and amount of communication, are formidable challenges, but central tasks for healthcare leaders.

Just because a person is in a leadership position doesn't make him or her a leader [2].

The goals of this chapter are to review what is known from the published literature about leadership in general and in the context of healthcare organizations to illustrate the operating room (OR) suite as a challenging workplace, where different parties must cooperate or thwart each other, and to identify the challenges inherent to an OR leadership position.

Predispositions for Leaders

Trait theory, which suggests that leadership abilities depend on the personal qualities of the leader, is controversial. However, some traits are related to leadership emergence and effectiveness. Leadership emergence refers to whether and to what degree an individual is viewed as a leader by others within a work group. On the other hand, leadership effectiveness is a phenomenon affecting interactions between groups, and refers to a leader's performance in influencing and guiding the activities of his or her unit toward achievement of its goals.

Five dimensions can be used to describe the most prominent aspects of personality: neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness. This five-factor model of personality was also shown to be a reasonable basis for examining dispositional predictors of leadership [3]. Extraversion and conscientiousness are the most important traits of leaders, and these dimensions are more strongly related to leadership emergence than to leadership effectiveness.

The following traits are associated with successful leaders [4]: humility, courage, integrity, vigilance and passion, inspiration, sense of duty and dedication, compassion, discipline, generosity, dedication to continuous learning, collaborative approach, and competitiveness.

Appendix A has a checklist that may be a way for leaders to self-assess some of their own strengths and weaknesses as leader. In addition, it could be used by people working in a surgical suite to evaluate the OR director.

Leadership Styles

Multiple differing leadership styles have been described. Some aspects of each leadership style definition overlap with one another [5–8] (Box 1.1).

The mix of the healthcare workforce and the complexity of the medical workplace demand a team approach to problem solving. This requires a leader who is comfortable "sharing power" by empowering

Box 1.1. Leadership Styles

Authoritarian (coercive, commanding) leaders employ coercive tactics to enforce rules and to manipulate people and decision making.

- Derived from the Prussian military, the command-and-control model is the primary management strategy.
- Believe in a top-down, line-and-staff organizational chart with clear levels of authority and reporting processes.
- Demand immediate compliance to orders and accomplish tasks by bullying and sometimes demeaning the followers.
- Used in situations where the company or group requires a complete turnaround.
- May be effective during catastrophes or dealing with underperforming employees, as a last resort.

Pacesetting leaders set high performance standards for themselves and their followers and exemplify the behaviors they are seeking from other group members.

- Give little or no feedback on how the followers are doing except to jump in to take over when the followers lag.
- Work best when followers are self-motivated and highly skilled.
- May be effective to get quick results from a highly motivated and competent team.

Transactional leaders balance and integrate the organizational goals and expectations with the needs of the people doing the work.

- Work through creating well-defined structures, clear goals, and distinct rewards for following orders.
- Motivate workers by offering rewards for what the leaders need to be done.
- Offer the appeal of employment and security in return for collaboration and assistance.

Authoritative (visionary) leaders mobilize people toward a compelling vision.

- Most effective when a new vision is needed, or when the path to that vision is not always clear.
- Though the leader is considered an authority, this type of leader allows followers to figure out the best way to accomplish their goals.
- May be effective when changes require a new vision, or when a clear direction is needed.

Coaching leaders are genuinely interested in helping others succeed and hence develop people for the future.

- Help employees identify both their strengths and weaknesses, and provide feedback to their subordinates on their performance.
- By delegating tasks they give employees challenging assignments.
- May be effective to help employees improve their performance or develop long-term strengths.

Democratic (participative) leaders build consensus through participation.

- Give members of the work group a vote or a say in nearly every decision the team makes.
- A collaborative process brings a family atmosphere to the workplace and creates respect for the contributions made by each member.
- When used effectively, the democratic leader builds flexibility and responsibility. This helps identify new ways to do things with fresh ideas.
- The level of involvement required by this approach (e.g., decision making) can be time consuming.
- Appropriate for building buy-in or consensus, or for receiving input from valuable employees.

Affiliative leaders often are more sensitive to the value of people than reaching goals.

- Pride themselves on their ability to keep employees happy, and create a harmonious work environment.
- Attempt to build strong emotional bonds with those being led, with the hope that these relationships will bring about a strong sense of loyalty in their followers.
- May be appropriate to resolve tensions in a team or to motivate people in difficult situations.

Authentic leaders use a deep self-awareness to engage followers, to shape organizational environments, and

eventually allow the organization to achieve persistently high performance.

- Authenticity involves both owning one's personal experiences (values, preferences, thoughts, emotions, and beliefs) and acting in accordance with one's true self.
- The ability of a leader to behave authentically as a person (authenticity of the person) positively affects his or her leadership efficacy (leadership multiplier).

Transformational leaders care about human understanding – they transform and motivate followers through their idealized influence (or *charisma*) and role model, intellectual stimulation, and individual consideration.

- Aim at creating an environment where every person is empowered and motivated to fulfill his or her highest needs.
- Each member becomes a part of a collective identity and productive learning community of the organization.
- See themselves as servants to others and guide them in creating and embracing a vision for the organization. This inspires and brings forth top performance and creates a belief system of integrity. Servant leadership demands that a leader places company goals and values first, the management team and employees second, and the leader's own welfare third. In this paradigm, leaders exist to permit production and to obliterate obstacles, not acquire power, glory, wealth, or fame.

people and is able to make decisions with a balance of idealism and pragmatism – a leadership concept described as "leading from behind" [9]. This type of leader understands how to create an environment or culture in which other people are willing and able to lead. For example, the image of the shepherd behind his herd is based on Nelson Mandela's autobiography *Long Walk to Freedom* and acknowledgment that leadership is a collective activity in which different people act at a different time.

This image of leadership is backed by the idea of Theory Y people, as described in McGregor's *The Human Side of Enterprise* [10, 11]. According to McGregor, people can be divided into the two groups, Theory X and Theory Y. Theory X assumptions are:

- People are inherently lazy and will avoid work if they can.
- Most people have little desire for responsibility and prefer to be directed.
- People must be coerced, controlled, or threatened with punishment to get them to perform.

On the other hand, Theory Y postulates that:

- Work is as natural as play and rest.
- People are ambitious, self-motivated, and will readily accept greater responsibility.
- People will use their creativity, ingenuity, and imagination to solve problems.

In reality, a person's beliefs will fall somewhere between Theory X and Theory Y. Whereas Theory X leaders enforce the rules of behavior and punish those who violate the standards, Theory Y leaders function as "coaches," encouraging their team. They focus on developing and facilitating the team through nurturing, encouragement, support, and positive reinforcement.

Situational Leadership

Goleman suggests that successful leaders employ multiple leadership styles and should be able to move between leadership styles according to a specific situation (situational leadership) [6]. OR leadership requires this adaptive style because of the personalities encountered in a highly trained and demanding workplace. For example, during a cardiac resuscitation, an authoritarian or coercive leadership style may be appropriate to make sure all Code team members receive clear instructions. In contrast, an affiliate style may be appropriate to resolve a conflict between two surgeons disputing over a certain OR time slot.

Goleman's situational leadership model suggests that although leaders may have a preferred style, they must identify and select the appropriate mix of various leadership behaviors in a given situation.

"Emotional intelligence" (EI) may be a better predictor and attribute of leadership effectiveness than intellectual intelligence (IQ) or technical skills [12]. EI is a person's ability to be aware of and being able to manage and use emotions appropriately in dealing with people under various situations (Box 1.2). Experienced leaders with well-developed EI competencies may be more effective and have more satisfied and committed staff members, who better attend to patient care needs.

Box 1.2. Five Main Components of EI

Self-awareness	Understand one's own emotions, strengths, weaknesses, needs, drives, and their effect on others.
Self-regulation	The ability to control and manage feelings and moods so they are appropriate.
Motivation	A passion to work for reasons that goes beyond money and status; persistence and confidence.
Empathy	The ability to understand the emotional makeup of other people; sensitivity to others' needs and emotions.
Social skill	Proficiency in managing relationship and building strong collaborative networks; ability to influence and lead people.

Difference between Management and Leadership

An often heard concept is that managers are people busy with operational tasks (command and control), whereas leaders engage in strategic endeavors (vision and mission, change management). To quote Naylor, most persons have worked "with leaders who were not particularly skilled at management, but who had an ability to win loyalty and carry others with them through their clarity of vision, generosity of spirit, and 'people skills'. Ironically, then, leadership may be most obviously exerted when others follow a person who has no direct authority over them, and may be less important in strictly hierarchical organizations where managerial discipline prevails" [13].

The differences between managers and leaders then may simply be attributed to different leadership styles (e.g., transactional and transformational) or different leader positions (top executive versus middle management).

Significance of Leadership for Healthcare Organizations

Governments around the globe are increasingly searching for cost containment practices to counter mounting healthcare expenditures. This has led to declining reimbursement for physician and hospital services, the replacement of fee-for-service payments with bundled prospective payment systems (PPS) using case-based lump sums based on diagnoses-related groups (DRG), and capitation and other compensation systems that shift financial risk from the payer to the service providers. For example, one of the major goals of the Patient Protection and Affordable Care Act (PPACA), a US federal statute signed into law in 2010, is to reduce healthcare costs. Specifically, structural changes in the healthcare system made by the PPACA aim to shift the healthcare system from paying-for-quantity to paying-for-quality (value-based care [VBC]).

Such profound transformation with reimbursement, technological, policy, and procedural and structural changes intensifies the need for and challenges of healthcare leadership [14].

There are unique leadership challenges inherent to healthcare [15]:

- Healthcare leaders face inconsistent or conflicting dynamic demands from external stakeholders (e.g., patients, regulatory, institutional and market forces, and others).
- As a "human" service rendered directly by providers, healthcare is prone to natural variability.
- Healthcare is a technology-intensive sector with a high frequency of innovation. Such advances exacerbate tensions in balancing cost, quality, and access to healthcare services.
- Healthcare leaders must interact with powerful and dominating professionals (e.g., physicians) who may not be employees of the organization.

Leadership in the Healthcare Literature

In 2002, a review of 6,628 articles revealed that most of the healthcare and business literature on leadership consisted of anecdotal or theoretical discussion [16]. Only a few articles include correlations of qualities or styles of leadership with measurable outcomes such as positive changes in organizations. It is still unclear what leadership attributes are important in improving either patient care outcomes or team and organizational outcomes.

There are, however, some specific studies of leadership in healthcare that are noteworthy [15]. Transformational leadership style is more likely to be used by leaders in not-for-profit organizations than by leaders in for-profit organizations. In the hospital setting, transformational leadership style has been

shown to be positively and significantly associated with staff satisfaction, extra effort from staff, perceived unit performance, and staff retention. Some weak evidence indicates that leadership matters more for nonprofessionals (e.g., nursing assistants, clerks, secretaries) than professionals.

Managers with higher ranks demonstrate more transformational behavior than those lower in the hierarchy. Of note, healthcare leaders may perceive the use of rewards as transformational leader behavior. In contrast, surveys of leaders in industries outside healthcare indicate the use of such reward systems as linked to a transactional leadership style. Physician executives with management degrees were more likely to provide transformational leadership than those without training [17]. Despite evidence that supports transformational leadership theory for the healthcare setting, leadership style is but one important factor in successful organizational change. Organizational structure and culture matter just as much. Participative and person-focused leadership styles are positively associated with nursing staff's job satisfaction, retention, and organizational commitment.

In the healthcare and hospital setting, leaders must take into account their followers' expectations and understand how and why professionals respond (or not) to different leadership styles.

The Healthcare Leadership Alliance (HLA) has developed the HLA Competency Directory as an instrument for healthcare executives to use in assessing their expertise in critical areas of healthcare management [18]. Within the HLA Competency Directory, the competencies are categorized into five critical domains and, within each domain, 3–4 clusters of competencies (Table 1.1).

Managers with advanced education may be more effective in leadership roles. Junior nurse managers value clinical and communications skills compared to senior managers who value negotiation skills and business knowledge more [15].

A systematic review of articles related to physician leadership and EI showed that many authors from a broad range of medical specialties recommend cultivating physician leadership, including EI training, at an executive level in all medical institutions. Although evidence supports the association of EI with business outcomes outside of healthcare, there is a paucity of scientific research examining the benefits of EI in healthcare. A gap has been described between advocacy for EI as an essential training competency in healthcare and the critical need for further rigorous study of the issue [19].

Table 1.1 HLA Competency Directory

Competency domain	Competency cluster
Communication and relationship management	• Relationship management • Communication skills • Facilitation and negotiation
Leadership	• Leadership skills and behavior • Organizational climate and culture • Communicating vision • Managing change
Professionalism	• Personal and professional accountability • Professional development and lifelong learning • Contributions to the community and profession
Knowledge of the healthcare environment	• Healthcare systems and organizations • Healthcare personnel • The patient's perspective • The community and the environment
Business skills and knowledge	• General management • Financial management • Human resource management • Organizational dynamics and governance • Strategic planning and marketing • Information management • Risk management • Quality improvement

Physician Leadership

Hospitals with the greatest clinician participation in management scored about 50 percent higher on important drivers of performance than compared to hospitals with low levels of clinical leadership [20]. Doctors in physician-led organizations seem to be leading in the areas of quality, service, and cost [21]. Physicians have to have enough power and authority to affect change – to determine how quality is defined, what protocols will be developed, and how to hold each other accountable for meeting objectives [22]. In the perioperative setting, strong physician leadership is required for compliance with surgical checklists

and site marking to prevent wrong-site surgery. On matters of clinical medicine and practice, physicians listen to respected peers. A well-trained and accepted physician leader may better inspire, convince, and influence their colleagues. It is critical for this person to serve as a change agent to manage and influence clinical practice patterns and adherence to guidelines.

However, a common myth is that a physician successful in clinical practice can easily transfer to leading an organization [23]. In fact, being a medical expert does not guarantee being a good leader. It is challenging to hire physician leaders who will end up being successful as it is difficult to assess candidates for leadership positions. Deegan et al. point out that "as a consequence of the way … physicians have been selected, educated, and socialized during their training many are highly competitive, relatively independent practitioners. They often eschew teamwork and collaboration and other affiliative behaviors" [24]. When assessing physician leader candidates, the use of a structured decision-making process for assessment and selection should be considered. Physicians aspiring to be leaders actively reflect and internalize the results of feedback and link this information directly to a formal plan of study to gain the competencies needed for their future leadership roles. Physicians in the midst of the transition between clinical and managerial/leadership positions start to realize the substantial differences between clinical and managerial/leadership positions, and that the behaviors that serve them well in their clinical workspace (such as the OR) may be the exact opposite of what they need as executive leaders in hospitals (Table 1.2).

Various barriers exist for physicians to take leadership roles [25]:

- Identity linked to leadership roles may threaten the physicians' view of themselves as clinical professionals.
- Deep-rooted skepticism about the value of spending time on leadership.
- Lack of career development or financial incentives.
- Lack of leadership and management training.
- Risk of losing credibility with clinical colleagues and others.
- The greater risk of unemployment as a leader/manager than as a clinician.
- A loss of popularity due to making tough decisions.
- The need to learn to being accountable to their organization as opposed to their colleagues.

Table 1.2 Differences between Clinicians and Manager/Leader

Clinician	Manager/leader
Clinical competence	Interpersonal competence
1:1 interaction	1:N interaction
Doers	Planners
Value autonomy	Value collaboration
Reactive	Proactive
Identification with profession	Identification with company
Patient advocate	Organization advocate
Lay IT/IS skills	IT/IS power user
Informal communication	Formal communication
Leadership skills optional	Leadership skills essential
Member of "brotherhood/sisterhood"	Member of the "dark side"
Micromanaging a must	Overmanaging a sure way to fail
Independent	Adaptation to a boss
Pursuit of self-interest	Trustworthiness

- A need to overcome an us-versus-them mentality between physicians and health administrators.

For newly appointed physician leaders, a robust onboarding and specific leadership program is critical. Onboarding may include coaching, which can be driven by another leader from within the organization who has more leadership experience, or by an external coach. In the past, healthcare has been slow to adopt systematic organizationally based leadership development programs. Instead, responsibility for leadership development has often been left to individuals and the profession.

Leadership Is Critical in the Management of Perioperative Services

The OR suite is a complex working environment, with different groups of individuals involved in a coordinated effort to perform highly skilled interventions. This is analogous to high-reliability organizations, such as aviation, the military, and nuclear industries, where the importance of a wide variety of factors for development of a favorable outcome has been long stressed [26]. These include ergonomic factors such as the quality of interface design, team coordination and leadership, organizational culture, and quality of decision making.

The role of a leader and manager is central to forming high-performance interprofessional teams.

Underlying key principles for successful team building are a shared vision and mission. To align the goals of employees and physicians, the leader must convey the vision and strategies [27].

The following factors contribute to the growing need for a dedicated professional as a perioperative leader:

- Growing surgical caseload, exceeding regular workday shift-hours.
- Medical consumables included in case-based lump-sum payment, which cannot be charged separately to the payer.
- Multiple lines of authority causing a lack of continuity and ownership for decisions.
- Large variety of professionals working in the OR suite.
- Difficulties in recruiting and retaining healthcare professionals.
- Increasing number of ORs and creation of different OR suites within the same facility.
- Increasing number of nonsurgical interventions outside the surgical suite with growing need for hospital-wide provider scheduling.
- Lack of physician involvement in OR leadership.

Challenges in OR Leadership

Organizational Structures of OR Leadership

Hospitals have always been in search of the optimal OR leadership structure. The need for leadership training was recognized more than 60 years ago. For example, in the English literature of the 1950s, a textbook contained descriptions of the ideal OR governance structure and recommended that "the administration of the surgical department shall be under the direction of a competent registered nurse who has executive ability and who is specially trained in operating-room management" [28]. In 1983, an article about OR management delineated eight managerial measures to improve OR management efficiency and effectiveness. One of these measures was the identification of a clear line of authority and appointment of an individual with far-reaching responsibilities, including policy making, running the daily schedule, and managing staff stepping out of line [29]. The article pointed out that this person would not only have to be a senior physician with institutional authority but also be formally recognized as being in charge.

There is no perfect organizational structure. The organizational structure of an OR suite must be individually tailored to its internal and external needs.

Small organizations often feature a flat hierarchy and do not require many formal organizational structures. These organizations benefit from close relationships between people. This allows for quick and informal problem solving. An OR charge nurse or nursing director as the sole formal leader may be sufficient in small OR suites since ad hoc problem-solving groups form spontaneously and dissolve naturally.

Large organizations, on the other hand, with several surgical subspecialties require a more complex organizational and leadership structure because cooperation and coordination of tasks among departments is challenging. OR suites of large medical centers often feature several complementary leadership structures (Box 1.3).

Outside of the United States, OR management is a relatively young science, and knowing the leadership literature is also a recent phenomenon. In Germany, OR management first appeared in the scientific literature in 1999. The reason this topic produced interest much later than it did in the United States may be the introduction of the German DRG reimbursement, a PPS for inpatient hospital services in 2003. In the United States, PPS was introduced in the 1980s. With the introduction of government-mandated healthcare cost containment measures such as PPS, hospital revenues declined and hospital and physician executives aimed to find innovative ways to increase OR efficiency (see Franklin Dexter's chapter).

Lonely at the Top

Leaders are often alone with their thoughts because they need to keep an emotional distance and avoid conflict of interests in their professional environment [33]. Leaders are able to develop relationships with people based on respect, not on friendship [34]. In addition, leaders are often surrounded by people with opposite opinions on certain topics for valid reasons. Making decisions that are unpopular with some stakeholders and being attacked for those decisions may increase isolation for the leader. Decision making in uncertainty is a task that exacerbates the leader's loneliness.

One of the interesting observations by leaders is how streams of information suddenly dry up when that person becomes the head of an organization or a group. People hesitate to speak freely with a leader and so adopt a more formal tone while

Box 1.3. Leadership Positions and Structures for the Surgical Suite

Physician OR leadership position (e.g., OR medical director): May be a facilitator, mediator, and negotiator position to balance the priorities of each group in the OR (surgeons, anesthesiologists, nurses, hospital administrators, etc.).

Alternatively, the **OR medical director** may be positioned to be a distinct authority: A position frequently recommended by the German OR management literature ("OR manager") [30, 31]. This may be explained by the fact that in Germany, as in many other European countries, most physicians are employed by the hospital. Where there are many independent, powerful physicians (especially surgeons), a tall or centralized organization with a top decision-making leader may be an ineffective leadership structure.

A **standing OR committee** with strategic and oversight responsibilities (e.g., "OR oversight committee," "OR board"): This committee may consist of the chairs of surgical services and/or departments, the chief of the anesthesia department and nurse managers of the perioperative area, and representatives of the hospital administration. The role of this committee is to provide fair and balanced OR governance [32].

Additional **smaller OR management teams** may be formed with operational responsibilities (e.g., OR executive committee): A typical formation includes a senior surgeon and anesthesiologist (who may be medical co-directors of the OR suite), the director of surgical services, and a senior hospital executive.

Administrative executive physician: This position may be labeled Chief Medical Officer or Vice President of Medical Affairs, and refers to a position often used as a third-party mediator to facilitate finding solutions between two conflicting parties (e.g., between different surgical departments or between the hospital administration and anesthesia department).

communicating. The challenge for a leader then is to find and develop other methods for figuring out what is really going on. A leader in the surgical suite needs to work hard to get people to share their views, and must proactively develop positive relationships so that colleagues feel comfortable and provide their honest opinions.

Culture and Informal Organization

Understanding the organizational culture of the OR suite is key to successful and effective leadership. For example, change management and implementing patient safety initiatives are hard to accomplish without understanding the values, assumptions, preferences, unwritten rules, and behaviors of a certain workplace. If leaders are not conscious of the culture in which they are embedded, those cultures will manage them [35]. The leader needs to perceive the functional and dysfunctional elements of the existing culture and to manage cultural evolution and change in such a way that the group can thrive.

Organizational culture is the essence of the informal organization [36].

In 1976, Hall developed the iceberg analogy of culture [37]. If the culture of a society was an iceberg, some aspects of culture would be easy to see and understand, above the surface. On the other hand, below the water, there is a larger portion of culture hidden beneath the surface that is related to the beliefs, existing relationships, and values of a society. This underwater part of the iceberg culture is difficult for the new leader to understand and includes elements such as the definition of sin, concept of justice, work ethic, definition of insanity, approaches to problem solving, fiscal expression, and approaches to interpersonal relationships. Hall suggests that the only way to learn the invisible bulk of the culture below the surface is by actively participating in the culture. Similarly, organizational culture comprises the visible values and behaviors within an organization, shaped by employee perks and benefits, policies and procedures, and the company brand [38]. It often turns out that the majority of what drives the behaviors within the organization is unseen and inaccessible to leaders unless they actively seek that information, far below the surface. This culture includes the history of the institution, the existing relationships among people and departments, the incentive system and the unintended consequences of the incentive system, and relationships with various stakeholders. "The way things get done around here" is a one working definition within the hidden part of organizational culture. If leaders are unaware of these aspects of corporate culture, they may feel frustrated at not being able to get things accomplished.

In addition to the formal relationships depicted on organizational charts, in every OR suite, there are also

information relationships. There may be an informal network, coalitions of people, and even hierarchy. For example, a powerful surgeon may be able to exert his or her influence on the scheduling process and circumvent official scheduling rules. These informal affiliations shape the organization's culture, and they can either facilitate or impede change. An important aspect of perioperative leadership is understanding and accepting these relationships, managing the informal chain of command, and even leveraging these affiliations.

People Alignment and Change

Tensions between the different professional groups working in the OR probably existed ever since the first surgeries were performed. A nursing report from Australia from the early twentieth century noted that the "disaccord between nurses and physicians often led to troubles in the OR because the physicians would never announce the beginning of surgeries in a timely fashion, but would then suddenly appear in the OR where they would have to wait for the nurses to be finished with their preparatory work" [39].

A core issue for leaders of the OR suite is that the goals of the various professions are not well aligned with those of the hospital and the OR suite. This dilemma is known in economics as "principal–agent problem," where difficulties arise under conditions of incomplete and asymmetric information when a principal hires and motivates an agent to act on behalf of the principal [40]. Getting people to move in the same direction is a crucial leadership activity. People alignment involves communicating the organization's direction to those whose cooperation may be needed to create coalitions that help people understand the overall vision and stay committed to its achievement [41]. One of various managerial mechanisms that may be used to align the interests of the agent in solidarity with those of the principal is performance measurement. In the OR environment, well-designed reporting systems must define relevant performance measures (key performance indicators). This feedback is provided to those owning the critical processes and should be gauged in relation to the OR suite's goals and its most important stakeholders. The OR environment with conflicting goals requires a strong leadership to enforce hospital and OR suite strategies. In US hospitals, the shift toward employment of physicians continues to grow, becoming an important focus of alignment.

Another core leadership activity involves establishing the organization's direction, i.e., producing change and transformation. Reasons for organizations to initiate change include barriers to collaboration due to silos, insufficient innovation, and unpreparedness to excel in the future. Change rarely happens in a linear fashion. Instead, it more often is a cyclical process. Kotter's cyclical accelerator model involves eight key components [42]:

1. Create and sustain a sense of urgency: Top leaders describe an opportunity that will appeal to individuals.
2. Build and maintain a guiding coalition of effective, volunteer employees who role-models the change.
3. Formulate a strategic vision and develop initiatives designed and executed fast and well enough to make the vision reality.
4. Enlist a volunteer group of employees who buy in to the envisioned goals and share a commitment toward making the change.
5. Enable action and empowerment across employees by removing barriers such as inefficient processes or hierarchies.
6. Generate and communicate short-term wins to provide proof that the change created actual results.
7. Sustain acceleration: Adapt quickly to shifting business environments in order to maintain speed and enhance competitiveness.
8. Institute change: Individuals must understand the importance of agility and speed for the organization's success.

Various change initiatives in the perioperative setting have been described following Kotter's model [43–45].

How can a leader assess his or her individual impact? Covey encouraged leaders to work within their smaller *circle of influence*, wherein they will be able to make a difference, as opposed to spending time in their *circle of concern*, whereby they have very little to contribute [46]. For example, our circle of concern may include the broader issues of politics and the reforming and uncertain future of healthcare, such as PPACA. Covey recommended that the energy of leaders be focused on their circle of influence, i.e., on the issues they have influence over, such as the adoption of lean management system into day-to-day hospital operations.

Effective leaders recognize two primary types of change: from the *outside-in* (structural) and from the *inside-out* (cultural/behavioral). A focus on cultural change is a core to sustaining structural change. It is cultural change – the change of the collective behavior of individuals within the organization – that will make possible a structural change at the organization and administrative levels. And it is changing people from within which makes organizational change so difficult. For example, in a complex clinical environment like a quaternary care hospital's OR, the culture may need to be fundamentally addressed before structural changes, such as checklists and other patient safety measures, can be successfully implemented [47].

However, it is hard for leaders to simultaneously tackle all "soft" issues (such as culture and motivation) that are necessary for transforming organizations. Sirkin et al. have found that focusing on these issues alone may not bring about change because organizations also need to consider the hard factors such as the time they take to complete a change initiative, the number of people required to execute it, etc. [48]. There is a consistent correlation between the outcomes of change programs (success versus failure) and the following four variables:

D The **duration** of time until the change program is completed; for change program, this refers to the amount of time between reviews of milestones.

I The project team's performance **integrity**; that is, the capabilities of project teams.

C The **commitment** of senior executives and staff to change.

E The **effort** over and above the usual work that the change initiative demands of employees.

The DICE framework comprises a set of simple questions that help executives score their projects on each of the four factors. Organizations can use DICE assessments to force conversations about projects, to gauge whether projects are on track or in trouble, and to manage project portfolios.

Social Capital

Waisel described social capital as an overall indicator of the quality of the relationships within a community and applied it to the OR suite [49]. Increasing social capital improves communication and trust that, in turn, improves most cooperative undertakings. In the OR suite, the social capital benefits of expectations of trust, robust norms, and better communication help to achieve community goals.

The norm should be that medical professionals seek flawless behavior, particularly in regard to interacting with others and respecting operational guidelines. Other than in the case of small teams, large groups of people are less likely to have developed personal histories of successful interactions. In the absence of a personal history of trust, the expectation of trust from social capital permits individuals who enter into negotiations to assume that they will be treated in a fair, appropriate, and civil manner. Functional operational guidelines help to develop trust in the organization. Improved behavior and successful interactions increase trust and communication, which, in turn, improves the OR working environment and increases the success of cooperative ventures, such as having more efficient ORs.

Importance of Building Trust on Survival of Coalitions

Dialogue promotes understanding between parties in conflict, and the resulting relationship promotes trust between diverse entities [50]. This trust is based on the fact that there is respect for one another's opinion and that team members are willing to listen and share viewpoints openly. If and when leaders promote an environment in which they are comfortable taking on the challenging dialogues (i.e., productive conflict), they can effectively lead change and build respect in the perioperative setting. This leads to a stronger team and better adherence to patient safety measures. A common example is OR nurses speaking up prior to a wrong-site surgery.

The Impact of Leadership on Patient Safety and Quality Initiatives

Many have stated that the magic ingredient to success in patient safety is leadership [2]. Communication and leadership failure are two of the most frequent causes of adverse events [51]. Previous studies have identified that teamwork, communication, and situation awareness are most important to work safely and effectively in a surgical environment and for minimizing technical errors [52, 53].

How is a leader able to move the team to the next level of safety culture? Before a change can be successfully implemented, the leader must first assess