Section 1 Leadership and Strategy

Chapter 1

Leadership Principles

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Contents

Evolution of Leadership

What Is Leadership?

Leadership is about leading people, or the capacity to lead, or, more precisely, the behavior of an individual when directing the activities of a group toward a shared goal [1]. Akin to an orchestra conductor, a leader aims to direct and motivate 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 a common vision and purpose, (2) engages in the future outcome of the organization, and therefore (3) favors collaboration over pursuing individual agendas. Among other responsibilities, leaders are role models for the organization's values, set the optimal course, and establish priorities. Establishing collaboration, finding the appropriate style and amount of communication are formidable challenges but central tasks for healthcare leaders.

Commonly, promotions into leadership roles occur based on prior position success or lack of previous failure. However, those skills and achievements may not always transfer to the demands of new leadership roles.

The goals of this chapter are to review what is known from the published literature about leadership in the context of healthcare organizations. This chapter details the complex operating room (OR) suite environment and identifies the challenges inherent to an OR leadership position.

Predispositions for Leaders

Trait theory, which suggests that leadership abilities depend on the leader's personal qualities, 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 of interactions between groups. It refers to a leader's performance in influencing and guiding the activities of his or her unit toward achieving its goals.

Five dimensions can 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 [2]. Extraversion and conscientiousness are the most important traits of leaders, and these dimensions are more strongly related to leadership emergence than leadership effectiveness. Additional personality trait considerations include an individual's ability to earn trust from team members and his or her ability to put trust in others.

Traits associated with successful leaders include [3, 4] humility, courage, integrity, vigilance and passion, inspiration, sense of duty and dedication, compassion, discipline, generosity, dedication to continuous learning, collaborative, competitive, good communicator, active listener, receptive to feedback, reliable, flexible, open-mindedness, and skilled negotiator.

Appendix A at the end of this chapter has a checklist that may be a way for leaders to self-assess some of their strengths and weaknesses. 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 overlap with one another [5–8] (Box 1.1).

One proposed leadership style consists of a *highly structured* leader. This individual adheres closely to policy and is minimally open to change unless within the confines of the current rule. The leader views himself or herself as a function of the organization, and his or her role is to carry out predefined goals. Ingenuity and "taking chances" are avoided.

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 people and can 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 a 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*. It acknowledges that leadership is a collective activity in which people act at different times.

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 place 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.

This image of leadership is backed by the idea of Theory Y people, as described in McGregor's *The Human Side of Enterprise* [10]. According to McGregor, people can be divided into 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 (little self-initiative).
- People are self-focused and 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. They are eager for promotion.
- 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. Theory X leaders micromanage, reinforce the rules of behavior, and punish those who violate the standards. Conversely, Theory Y leaders function as "coaches," encouraging their team, and facilitate through nurturing, encouraging, supportive, and positive reinforcement.

People are also internally motivated by high and low factors. Lower-motivating factors include financial accomplishments like buying a new car or affording vacation. Once these lower hanging fruits have been achieved, Theory X leadership styles are no longer effective. Higher-motivating factors include ambitions such as career success or notoriety –Theory Y leadership is more successful with high-motivating factors.

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]. Leadership requires this adaptive style because of the personalities encountered in a highly trained and demanding workplace. For example, an authoritarian leadership style may be appropriate during a cardiac resuscitation to ensure all code team members receive clear instructions. In contrast, an affiliative style may be appropriate to resolve a conflict between two surgeons over a specific OR time slot.

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

Emotional intelligence (EI), also considered as interpersonal skills, may be a better predictor and attribute of leadership effectiveness than intelligence quotient (IQ) or technical skills [11]. EI is a person's ability to manage and use emotions appropriately in dealing with people in 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 can better attend to patient care needs.

The Fogg Behavior Model [12] supports the importance of EI. Fogg identified three categories that can promote individual change: motivation, ability, and triggers. Motivation and ability are personal, necessitating understanding an individual's internal motivations and capabilities or limitations. Triggers are signals or "ah ha" moments that initiate behavior change. Leaders with high EI can recognize these three behavioral influences in their employees and, thus, can influence change and achieve targets.

"T-Shaped" Leaders

Situational leaders are strategic thinkers, utilizing EI and flexible applications to achieve goals. However, situational leadership alone cannot

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. Continuation of personal development.
Empathy	The ability to understand the emotional makeup of other people; sensitivity to others' needs and emotions.
Social skill	Proficiency in managing relationships and building strong collaborative networks while maintaining professional distance. Considered to be one of the most important EI features as it relates to understanding team dynamics and personalities.

invoke organizational success. This is where "T-shaped" or "generalizing specialist" leaders are crucial. The "T" represents the horizontal and vertical intersection of leader talents. Horizontal leadership skills include understanding the entire organization across divisions. The vertical line demonstrates area-specific expertise and involvement with each organizational subsystem [13]. Qualities of a "T" leader are further categorized by a "Big T" or "Little T" [13]. A "Big T" leader more appropriately fits with the horizontal line of the T, using external views to understand global organization impact and vision. A "Little T" leader succeeds with vertical roles, spearheading well-defined objectives and executing particular tasks within timelines. The evolution of "T-shaped" leaders has grown to include "pi-shaped" (π) leaders, whose double vertical lines indicate multiple areas of expertise.

Organizational Leadership

Individual leadership styles overlap with the essential components identified for organizational leadership. Like a democratic leadership style, collaborative organizational leadership builds a supportive network of employees and is dependent on equitable teamwork. Ethical organizational leadership follows authentic principles, treating others respectfully and honestly, even when decisions are suboptimal. Conflict organizational management, similar to situational leadership, is a hybrid of all leadership styles, necessitating flexible negotiation skills and resolution tactics.

Difference between Management and Leadership

An often-repeated concept is that managers are 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 could win loyalty and carry others with them through their clarity of vision, generosity of spirit, and 'people skills.' Ironically, leadership may be 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" [14].

The differences between managers and leaders may be attributed to leadership styles (e.g., transactional and transformational) or leadership positions (top executive versus middle management). Correlating with professional rank, managers often have the opportunity for direct interaction with team members, whereas senior leaders may be more removed, facilitating communication through different indirect channels.

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), capitation and other compensation systems that shift financial risk from the payer to the service providers. This includes transitioning to paying-for-quality (Value-Based Care [VBC]) programs.

Such transformation with reimbursement, technological, policy, procedural, and structural changes intensifies the need for and challenges of healthcare leadership [15].

There are unique leadership challenges inherent to healthcare [16]:

- Healthcare leaders face inconsistent or conflicting dynamic demands from stakeholders and diverse customers (e.g., executives, patients, internal committees, regulatory boards, institutional and market forces, insurance companies, and others).
- As a "human" service rendered directly by providers, healthcare is prone to natural variability and unpredictability.
- Healthcare is technology-intensive 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.
- Healthcare is an ever-demanding field. Chronic staffing shortages contribute to burnout, challenging team dynamics, and unpredictable per diem staff or onboarding costs.

Leadership in Healthcare Literature

Although it is unclear what leadership attributes are essential in improving patient care outcomes or organizational outcomes, there are some noteworthy studies of leadership in healthcare [16]. Leaders in not-for-profit organizations are more likely to use transformational leadership than leaders in for-profit organizations. In the hospital setting, transformational leadership style is positively and significantly associated with staff satisfaction, extra effort from staff, perceived unit performance, and staff retention.

Managers with higher ranks demonstrate more transformational behavior than those lower in the hierarchy. Physician executives with management degrees were likelier to provide transformational leadership than those without training [17]. Of note, healthcare leaders may perceive rewards as transformational leader behavior. In contrast, surveys of leaders in industries outside healthcare indicate that using such reward systems is linked to a transactional leadership style. Despite evidence supporting transformational leadership theory for healthcare, leadership style is critical in successful organizational change: organizational structure and culture. Participative and person-focused leadership styles positively affect employee job satisfaction, performance, retention, and organizational commitment.

In healthcare and hospitals, leaders must consider their followers' expectations and understand how and why professionals respond (or not) to different leadership styles. One component of this consideration is past employee experiences with managers or leaders. If a prior leader was intensely strict or lackadaisical, the employee may approach a new leader with a similar disposition, pending the formation of the new relationship structure.

The Job Characteristics Model helps guide a leader's interaction with employees [18]. The model functions because the employee is not motivated when a job is tedious or non-stimulating. It is a challenging and exciting task that benefits staff engagement and inspires productivity. There are five core characteristics a leader must identify for optimal interactions, organizational engagement, and outcomes [18]:

- Task identity (can the selected individual complete the presented task if given proper instruction with resources and see the impactful outcome)
- What is the task's significance to this person?
- Does the task require skill variety?
- Does the task provide employee autonomy?
- Leader gives feedback about the task

The Healthcare Leadership Alliance (HLA) has developed the HLA Competency Directory as an instrument for healthcare executives to use in assessing their expertise in healthcare management [19]. Within the HLA Competency Directory, competencies are categorized into five critical domains and, within each domain, three to four clusters of competencies (Table 1.1).

A systematic review of articles on physician leadership and EI showed that authors from various medical specialties recommend cultivating physician leadership, including EI training, at an executive level in all medical institutions. Duke University School of Medicine identified core competencies for healthcare leadership from a multispecialty concept mapping study. The analysis revealed EI as an essential leadership skill [20]. Although evidence supports the association of EI with business outcomes outside of healthcare, there needs to be more scientific research examining the benefits of EI in healthcare.

Physician Leadership

Hospitals with the most outstanding clinician participation in management scored about 50 percent higher on essential drivers of performance than hospitals with low levels of clinical leadership [21]. Doctors in physician-led organizations are leading in quality, service, and cost [22]. Physicians have to have enough 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 [23]. In the perioperative setting, strong physician leadership is required for compliance with best practice checklists and protocols. On such matters, physicians listen to respected peers. A well-trained and accepted physician leader may inspire, convince, and influence their colleagues. This person must be a change agent to manage and influence clinical practice patterns and adherence to guidelines.

However, a common myth is that a physician who is successful in clinical practice can quickly transfer to leading an organization [24]. Being a medical expert does not guarantee being a good leader. Hiring physician leaders who will succeed is challenging as it is difficult to assess candidates

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 • Supply chain and inventory allocations • Human resource management • Organizational dynamics and governance • Strategic planning and marketing • Information management • Risk management • Quality improvement

for leadership positions. Deegan points 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, collaboration, and other affiliative behaviors" [25]. A structured decision-making process for assessment and selection should be considered when assessing physician leader candidates. Physicians aspiring to be leaders should actively reflect and internalize feedback, linking information to formulate a plan of study and gain the competencies needed for their future leadership roles. Physicians amid the transition between clinical and managerial/leadership positions often start to realize the substantial differences between clinical and managerial/leadership positions. Additionally, 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 executives in hospitals (Table 1.2).

Various barriers exist for physicians to take leadership roles [26]:

- 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.
- Risk of unemployment as a leader/manager compared to a clinician.
- A loss of popularity from making tough, unpopular decisions.
- Need to learn organization accountability instead of colleague allegiance.
- Need to overcome an us-versus-them mentality between physicians and health administrators.

Several interview questions (Table 1.3) may help highlight leadership barriers, skills, traits, or abilities when conducting internal or external leadership searches.

A robust onboarding and specific leadership program is critical for newly appointed physician leader. Onboarding may include coaching, which can be driven by another leader from within the organization with more leadership experience or by an external coach. Healthcare has slowly

Table 1.2 Differences between clinician and manager/leader

Clinician	Manager/leader
Clinical competence	Interpersonal competence
1:1 interaction	1:N interaction
Doer	Planner
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

IS, Information Services; IT, Information Technology.

Table 1.3 Structured interview question examples on leadership

General	▪ Tell me about a time when you organized, managed and motivated others on a complex task from beginning to end. ▪ Describe an experience that has shaped or challenged your ideas of what effective leadership is. ▪ How does your leadership style align with this institution's mission and vision? ▪ How do you support continuous collaboration and improvement? ▪ How do you prepare for a successor?
Technical	▪ What does an integrated organizational system look like? ▪ What technique can be applied to ensure staff retention and organizational loyalty?
Behavioral	▪ Why do you want to be a leader? ▪ What will people that work with you say about your strengths and weaknesses of a leader? ▪ In a past role as a leader, what is an example of how you approach a team member who did not meet expectations? ▪ What challenges have you faced managing teams and how did you overcome them? ▪ How do you as a leader create a sense of community across a team? ▪ Describe an experience that has shaped or challenged your ideas of what effective leadership is. ▪ What are you most proud of as a leader?

adopted systematic organizationally based leadership development programs. Previously, the responsibility for leadership development has often been left to individuals.

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 various factors for developing a favorable outcome has been long stressed [27]. These include ergonomic factors such as interface design quality, team coordination and leadership, organizational culture, and decision making. The role of a leader and manager is central to forming high-performance interprofessional teams. A shared vision and mission are the underlying critical principles for successful team building. To align the goals of employees and physicians, the leader must convey the vision and strategies [28].

The following factors demonstrate the need of a dedicated physician professional as a perioperative leader:

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

Physicians who work in surgical environments have valuable perspectives and experiences beneficial for OR leadership positions. For example, the daily job functions of anesthesiologists demonstrate excellent leadership qualities and skills. Anesthesiologist leadership talents include:

Communication: Anesthesiologists have frequent interactions with multiple service lines (surgical specialties, cardiologists, pulmonologists, internists, pediatricians, ethic committees, perioperative nurses, pharmacy, and laboratory, to name a few). These varieties of interactions necessitate communication veracity and adaptivity.

Systemic understanding: Since anesthesiologists work with many departments and specialists in varying capacities, they have a global and intimate understanding of hospital workflow, resources, politics, and subsystems.

Teaming ability: Each day, anesthesiologists form new teams with surgical colleagues to care for patients. While the anesthesiologist may be meeting a surgeon, nurse, or technician for the first time, they can immediately develop relationships and trust with colleagues to provide safe patient care.

Critical thought: Given the complex nature of anesthesiology, providers are constantly making risk–benefit assessments with every thought or action.

Adaptability: The OR can be an unpredictable environment, and anesthesiologists can assist with schedule changes, remain calm during unexpected events, and adjust practices based on available resources.

Situational Awareness: Anesthesiologists perform constant environmental assessments, surveying the clinical strengths of those around them. For example, the anesthesiologist can quickly identify who is best suited for compressions, defibrillation, and procedures in a code or emergency.

Challenges in OR Leadership

Organizational Structures of OR Leadership

Hospitals have always been in search of the optimal OR leadership structure. In 1983, an article about OR management delineated eight managerial measures to improve OR management efficiency and effectiveness. One of these measures was identifying a clear line of authority and appointing an individual with far-reaching responsibilities, including policy making, running the daily schedule, and managing unruly staff [29]. The article pointed out that this person must be a senior physician with institutional authority and be formally recognized as in charge.

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 only require a few formal organizational constructions. 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. On the other hand, large organizations 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 assemblies. (Box 1.3).

Lonely at the Top

Leaders may intentionally or unintentionally isolate themselves from colleagues in attempts to maintain professional boundaries and develop formal work relationships rather than friendships. In addition, leaders are often surrounded by people with opposing opinions. Making unpopular decisions with some stakeholders may increase the leader's isolation. Decision making in times of uncertainty is a task that exacerbates the leader's loneliness.

One of the peculiar 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 adopt a more formal tone while communicating. The challenge for a leader is to find and develop other informational streams. A leader in the surgical suite must work diligently to get people to share their views, proactively developing positive relationships so that colleagues feel comfortable and provide honest opinions.

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 OR management literature ("OR manager") [30, 31]. 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).

Culture and Informal Organizations

Understanding the organizational culture of the OR suite is critical to successful and effective leadership. For example, implementing patient safety initiatives are only possible to accomplish with understanding a specific workplace's values, assumptions, preferences, unwritten rules, and behaviors. If leaders are not conscious of the culture in which they are embedded, those cultures will manage them [33]. The leader needs to perceive the existing culture's functional and dysfunctional elements and manage cultural evolution so that the group can thrive. Organizational culture is the essence of the informal organization [34].

In 1976, Hall developed the iceberg analogy of culture [35]. If society's culture were an iceberg, some aspects of culture would be easy to see and understand above the surface. On the other hand, below the water, a more significant portion of culture is hidden beneath the surface 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 may include concepts of justice, work ethic, approaches to problem-solving, fiscal expression, and 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 shaped by employee perks and benefits, policies and procedures, and the company brand [36]. Most of what drives organizational behaviors 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 one working definition within the hidden part of organizational culture. If leaders are aware of these aspects of corporate culture, they may feel more satisfied with accomplishing goals.

In addition to the formal relationships depicted on organizational charts, there are also information relationships in every OR suite. There may be an informal network with a social hierarchy. For example, an influential 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 can facilitate or impede change. An essential aspect of perioperative leadership is understanding and accepting these relationships, managing the informal chain of command, and leveraging these affiliations in organizational goal