“Lead from the front”: Participative leadership

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The opinion piece by David Joyce in this issue of the *Journal*,¹ which talks about the first year of practice for a new or transitioning cardiothoracic surgeon, must resonate with all thoracic surgeons, because we have all been in that position at some time in our career. There are some basic points that must be stated up front. The practice of cardiothoracic surgery is indeed a “team sport,” as Joyce suggests, but the outcomes from this undertaking are almost solely the responsibility of the leader (the cardiothoracic surgeon). Perhaps one of the things that makes the practice of cardiothoracic surgery so unique is the near-absolute assignment of responsibility for outcomes to a single individual, the cardiothoracic surgeon. This fact more or less dictates the leadership style that is required of cardiothoracic surgeons. Leadership styles range from laissez-faire to autocratic, but the leadership style most characteristic of cardiothoracic surgeons is called “participative leadership” (also known as “democratic leadership”). This leadership style values the input of team members and peers, but the responsibility for making the final decision (and for outcomes) rests with the participative leader. Participative leadership boosts morale, because subordinates and peers make contributions to the decision-making process. It causes them to feel that their opinions matter. Participative leadership is one of the most effective leadership styles for team building. Everyone is given a role within the department or unit. A participative leadership style promotes creativity as well as productivity within a team environment.

No part of the training of a cardiothoracic surgeon involves teaching leadership skills, yet these skills may be the most important determinant of overall success or failure when transitioning into practice from fellowship training. By way of full disclosure, I had leadership training, although it was not called that, from some of the best leaders that I have ever known. These leaders were soldiers who taught me how to lead men in combat in the jungles of Vietnam. They were professional leaders. That was their main skill. They were not genius mathematicians, outstanding scientists, or clever stock brokers. They were leaders. Military leadership qualities are formed in a progressive

William Mayo as a colonel during WWI.

Central Message

Team training is an important leadership skill.

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and sequential series of carefully planned training, educational, and experiential events—far more time-consuming and expensive than similar training in industry, government, or medicine. If those leaders in Vietnam told me to “walk through a wall,” I would have done it, because I knew that the leader would be the first one through the wall. This leadership style, called “leading from in front,” is associated with the likes of Audie Murphy and Nelson Mandela (Figure 1). You cannot help but understand the point. Joyce correctly identified the value and importance of teams in the conduct and delivery of cardiothoracic surgical care. One thing that I have noticed during the last 35 to 40 years of practice is that the best teams have the best leaders. It is well and good to acknowledge the importance of teams, but the importance of team leaders cannot be minimized. Suboptimal leadership goes a long way toward obtaining suboptimal outcomes.

I noticed that Joyce mentioned a quote from William Mayo that recognized the importance of interacting with teams. I would just point out that the really significant contribution from William Mayo was his leadership in putting together a well-oiled machine, with multiple team members all functioning in a synchronous manner with autonomy but under the direction of a leader. Arguably, William Mayo’s real contribution was to create a team that was empowered to function independently but with multiple interactions with all team members.

Both William Mayo and his brother Charles served in World War I. William J. Mayo served in the US Army during World War I as a colonel. He was chief adviser for US Army surgical services in the office of the US Army Surgeon General. President Woodrow Wilson organized the

FIGURE 1. Leading from the front (Audie Murphy and Nelson Mandela).

Committee of American Physicians for Medical Preparedness in 1916. William Mayo was named its chair, and his brother, Charles Mayo, was one of its members. That committee subsequently became the General Medical Board of the Council for National Defense. William was made a member of the board's executive committee, and Charles was his alternate. After hostilities ended in November 1918, both William and Charles Mayo were promoted to the rank of brigadier general in the US Army Reserve. In addition, they both received the US Distinguished Service Medal for their wartime service to the country. I suspect that there is something about the military that fosters leadership, empowerment, and team management. The Mayo brothers have a long and distinguished history of leadership, undoubtedly tempered by their military experience. If the Mayo brothers were alive today, I wonder how they would respond to Joyce's editorial. I suspect that they would say that the editorial is so obvious and self-evident that they are surprised that it needs to be voiced in a public document. It makes me wonder whether things have changed so much that we have to remind ourselves about

the importance of teams in the performance of cardiothoracic operations.

Something that struck me as I read through Joyce's editorial was the list of proactive measures that he recommends for a new cardiothoracic surgeon beginning his or her practice. Some of the recommendations included the following:

- One of the best investments you can make as a new surgeon is to sit down with the operating room nurse leader before your start date and go over the list of personnel who may be assigned to your room on any given day.
- Consider e-mailing a detailed plan of attack for each operation the night before to each member of the team.
- Identify who will be staffing your cases in advance.
- Use multidisciplinary conferences to review difficult cases with the cardiology team or tumor board before the operation as an ideal mechanism for establishing buy-in from the rest of your team.
- During rounds, try to make a routine practice of asking the nurse what concerns or insights they may have on the patient's progress.

I suggest that many of these recommendations could be considered leadership tools, taking action to create a functioning team. Well-oiled teams thrive on mutual self-respect, empowerment, advance planning, and so on. All these things that Joyce recommends for new graduates could be considered active team building that any effective leader should embrace. I do not think that Joyce missed this point. I think he just underemphasized the necessary leadership components that go into creating an effective team.

One thing I did not see in the editorial was mention of the progression to eventual leadership positions. I would like to see some mention of the maturing of new surgeons that ultimately leads to leadership positions in their hospitals, their professional organizations, their peer groups, or even at a national level. My personal view is that cardiothoracic surgeons are ideal candidates for these leadership positions at every level. I look at cardiothoracic surgeons' behavior as a new faculty member as simply a beginning of the progression to leadership in our profession.

There is almost no formal leadership training given to cardiothoracic surgical residents. So how can they be expected to perform as leaders? I believe that the answer to this key question lies in the training itself. All thoracic surgeons realize that they are responsible for outcomes. The most important component of these outcomes is the

technical performance of complex operative procedures. Surgeons learn early in their training that outcomes depend on more than technical skills. Preoperative assessment, postoperative care, and the smooth functioning of multiple team members are essential components that lead to optimal outcomes. A sense of autonomy that directs key parts of the perioperative care is really what you learn in a thoracic surgical residency. That is another way of describing participative leadership—something that all thoracic surgeons do without calling it that. There is no doubt that mentorship plays a role in all phases of the education and subsequent careers of cardiothoracic surgeons. But mentorship cannot substitute for independent actions in leading a team of professionals. That first day of independent practice after a rigorous training environment is scary, but it is really exactly what the cardiothoracic surgeon has been trained for. It is probably time to make it more obvious that leadership training is an important part of the education of a thoracic surgeon. This may not involve major changes in the thoracic curriculum, but rather a way of formalizing important concepts.

Reference

1. Joyce DL. Leading a team as new faculty. *J Thorac Cardiovasc Surg*. 2015;150:1410-2.