

# Organizational Culture and Effective Leadership in Academic Medical Institutions

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**Abstract:** In the US, a heterogeneity in archetypes of leadership augments the success of an Academic Medical Institution (AMI) in fulfilling its key missions of clinical service, teaching, training, mentoring, research and scholarship, community engagement, inclusion, and diversity. Effective leadership is profoundly influenced by organizational culture with its dominant foundations in shared attitudes, beliefs, mores, behaviors—scripted and unscripted, as well as explicit and tacit rules and policies that become entrenched in the operational repertoire over time. Modulating organizational culture are an AMI’s mission, vision, core and affirmed values, formal governance and its complexity, informal influencers, historical precedent, the rapidly evolving landscape of healthcare, regional and institutional socioeconomics, and faculty prototypes. It is paramount that AMIs endeavor to recruit and position leaders whose values align with those of the institution (“cultural fit”). This treatise highlights the crucial influences that affect organizational culture and its interface with AMI leadership and ensure the success of the organization and its leaders.

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Simply defined, organizational culture is “the manner in which things are done” in an organization.<sup>1,2</sup> Drivers include the organization’s philosophy, vision, espoused values, customs, schemes, ciphers, language, assumptions, tenets, and practices that are ingrained in employee self-image and identity, inner workings, and interfaces with the outside world, and that serve as predictors of future expectations and actions. Organizational culture has its foundation in shared mindsets, opinions, principles, comportment, written and unwritten as well as spoken and unspoken rules that become entrenched over time, maintain credence, and are considered valid by myriad stakeholders.<sup>1–3</sup> Gradually, values and norms establish various prototypes that function at the conscious as well as subconscious level in providing a framework for decision-making that is congruent with the organizational culture.

As observed by Herodotus in his *History of the Persian Wars*, “custom is king.” That is, custom, or culture, establishes the milieu in which leadership fails or flourishes.<sup>3</sup> With over 150 accredited Academic Medical Institutions (AMIs) in the US, there is great heterogeneity in governance structure, including their culture.<sup>3–5</sup> As emphasized by the *National Center for Healthcare leadership* (NCHL Competency Model), however, the essential components for an effectual leadership framework of an AMI are *People* (emotional repertoire, professionalism, relationship-building, talent management, teamwork), *Execution* (change leadership, communication skills, operational design, performance, project, and process management), and *Transformation* (analytical and innovative thinking, financial competencies, strategy, disciplined milestone-driven goal achievement, and community orientation).<sup>6</sup> From a pragmatic standpoint, highly variable and complex organizational governance and reporting structures play a significant role in heralding and propagating “siloed” driven culture and subcultures within the organization at the departmental and divisional levels.<sup>7</sup> To successfully meet the AMI’s overall mission and goals, it is critical that leaders of an AMI (President, Provost, Dean, Chief Executive Officer, Chief Physician Executive, Departmental Chair, Divisional Director, Executive Board) understand the organizational culture and its accompanying complexities (Figure 1).



**Figure 1** Factors that influence organizational culture on AMI leadership.

## Core and Affirmed Values Critical to Organizational Culture

Certain organizational “affirmed” or “aspirational” values, that are not necessarily characterized as “core” values (e.g., Integrity, Efficiency, Innovation, Teamwork, Compassion, Empathy, etc.) are inviolable. Examples of such affirmed values include, a) a commitment to excellence that safeguards beneficial oversight and fortification of assets for state-supported AMIs and charitable sources for private organizations; b) an obligation to accomplish the missions of the AMI, e.g. providing healthcare to the local population, ameliorating healthcare disparities, or fulfilling its social mission(s); c) emphasis on quality of care, e.g. patient satisfaction, outcomes (mortality, readmission rates, length-of-stay); d) striving to enhance rankings against various patient care-, research-, or education-related benchmarks (Vizient, *US News and World Report*, National Institutes of Health, Leapfrog, etc.); e) professionalism underscoring concerted teamwork that eclipses other core tenets; f) emphasis on processes for continuous improvement with focus on contribution from key constituents in fulfilling multi-dimensional needs rather than having a spotlight on end-results alone (“means justify the end”). As highlighted by the *NCHL Competency Model*,<sup>6</sup> such attributes include sharing a compelling vision, inspiring a shared purpose, team engagement, accountability, nurturing proficiency, promulgating the spirit of “collectivism and group thinking,” augmenting collaborative teamwork among various groups, programs, and departments; hierarchical governance, reporting and communication systems in a complex matrix-organization as well as compensation plans already in-situ.<sup>3,7</sup>

## Impact of Informal Leadership and Socioeconomics

Governing systems can be complex and highly heterogeneous across various AMIs, which portends formation of “siloes” in terms of reporting structure, accountability, hierarchical communication lines, funds flow, etc.<sup>7</sup> These formal

governance systems are distinctly different from the informal organization that consists of an amalgam of values, traditions, behaviors, and phenotypes with its own set of informal leaders (akin to “village or tribal elders” in some communities in Africa and India) who hold firmly to principles such as altruism, reciprocity, fairness, accord, harmony, deference, relationships, and transparency in decision-making.<sup>3,8</sup> Typically, such informal “de facto” leaders in AMIs are highly respected senior faculty members (including those who are retired with a conferred Emeritus status) who have a constituency and possess considerable loyal cohorts amongst the ranks.<sup>3</sup> It is critical for AMI leaders to have the sponsorship of such informal leadership, as a definitive means of securing authority as opposed to that conferred by titles and accompanying “position power” that is generally transitory unless approved and buoyed by the informal organization. Regional socioeconomics, healthcare disparities, and financial health of the AMI also have profound influences on its culture by impacting resource allocation for select programmatic growth and development.

## **Influence of Historical Precedent and Prototypes**

Historically, practices in academic medicine become entrenched within its tradition of fulfilling the tripartite mission of clinical care, teaching and training, and research and scholarship.<sup>4,5</sup> Conventionally, tenure has been the defining model of unrestricted academic freedom that includes assured employment, salary support, and space allocation. It signifies the status of continuing appointment as a member of the faculty and the AMI’s community in general and implies professional integrity as well as educational and intellectual merit that make the individual a desirable permanent member of the faculty. Tenure is conferred based on substantial scholarship as well as on the individual’s record of providing value and service to the organization and the AMI community. Over the past few decades, however, many academic institutions have done away with tenure owing to several negative sequelae (ie, the “dead wood” phenomenon with decreased productivity due to assured security, untoward financial burden resulting from loss of extramural funding and downstream consequences to AMIs, archaic and elitist segmentation of faculty, weak post-tenure evaluative processes, inability to dismiss and terminate tenured faculty appointments unless there is unethical, unprofessional, or egregious behavior, etc.). Yet other AMIs ardently maintain the paradigm. For these reasons, appointments at AMIs have evolved into tenure-track (leading to time-sensitive award of tenure) and multiple non-tenure tracks characterized by the dominant prototype (e.g., clinician, educator, and researcher). This system has created a divide with “different citizenships” in many AMIs with palpable resentment among the faculty groups in the two tracks. There is a sense of entitlement among some older or long-term faculty who were appointed and trained in the tenure-track model. Increasingly, therefore, AMIs are recruiting and employing community physicians and constructing coalitions with private practitioner groups to augment their clinical footprint with many establishing a “hybrid model” that includes academic and non-academic patient care services. This is in keeping with the changing landscape of academic medicine with clinical service providing the most important and robust revenue stream, with compensation schemes increasingly being tailored towards clinical productivity and shifting away from, and at the expense of, other missions (e.g., education and research).<sup>4,5</sup> Consequently, there are clear and prevailing implications in peer-review committee-adjudicated appointment, promotion, and tenure policies and processes, in that faculty who are heavily invested in clinical duties receive little academic recognition while those invested in education and research enjoy less compensation. It is critical for institutional leadership to comprehend the culture of tenure and tenure-track in its historical context and the ramifications of this tectonic shift in healthcare for successful messaging to all constituents.<sup>9</sup>

In other service industries, prospective studies have demonstrated that organizational cultures have a correlation with leadership styles. For example, there is a positive correlation between hierarchical culture and charismatic leadership, ideological culture and transformational leadership, and collaborative culture with team leadership.<sup>10</sup> The extrapolation of such correlations to AMIs has not been studied and remains unclear. Not surprisingly, there is some evidence for a relationship between culture and performance in acute in-hospital settings.<sup>11</sup>

## **Recruitment, Search Committee Constructs, and Organizational “Fit”**

If AMIs are to be successful, recruiting the right leader(s) is critical. The pool of candidates is usually from a subset of highly accomplished academics (Departmental Chairs, Program and Institute Directors, Researchers, etc.) who have typically excelled in more than one domain of academic medicine and have a national or international reputation in their

field of expertise. Descriptors such as “triple threat” (excellent clinician, educator, and researcher) and “quadruple threat” (being an excellent administrator as well) have been used to describe some of the successful professional attributes for such leadership positions. Frequently, an AMI’s situational needs may dictate vetting of viable candidates (“Situational Leadership”). While academic prowess and achievement are greatly important for leader(s) in AMIs, such academic skills do not guarantee leadership aptitude.<sup>3</sup> For leaders to be successful in an AMI, there must be congruence on two key domains: 1) possessing proficiencies required for the position and job prerequisites, and 2) upholding the shared set of core and affirmed values. Both are critical and equally important.<sup>3</sup> Traditional attributes of academic success involve intellectual prowess, a focused and defined area of expertise, high self-motivation, and emphasis on individual results and success. However, in recent years, there has been a shift toward broader knowledge and a more holistic view of academic medicine, institutional focus, and mentoring and nurturing the success of others as effective leadership attributes for AMIs.<sup>3,12,13</sup> In addition to the necessary professional qualifications, characteristics such as high emotional intelligence, courage, empathy, aspiration, resilience, good listening skills, and gratitude stand a leader in great stead towards institutional success. It has been stated that “people management” skills are far more important than having individual prowess in any of the domains of academic medicine. There are many challenges in identifying such viable prototypic candidates. Recruitment of such leader(s) are frequently flawed with ill-conceived search committee constructs and searches that do not adequately reflect an organizational culture in congruence with its mission, vision, and values. A screening and vetting process by a professional recruitment firm is an effective practice. Appointment with a balanced representation from each of the important constituencies on the search committee (8–12 members) is critically important, and each member should be given a definitive charge with a disciplined, transparent, and confidential process with clear metrics and milestones.<sup>14</sup> Even after recruitment of the leader, formal and enduring mentoring or coaching can greatly enhance the success of the leader and in propagating a culture of continuous improvement for the AMI, earning it the right to be characterized as a “learning organization”.<sup>12–14</sup> A “distributive model” of leadership with shared responsibility and accountability nourishes the growth and development of future leaders within the organization.<sup>15</sup>

## Cultural Change and Engendering Trust

Bringing about cultural change is one of the most formidable challenges for the leader of an AMI, because the organization’s culture is deeply entrenched in a fortified system comprised of its core and affirmed values, assumptions, attitudes, processes, and procedures. Progress made by introducing unidimensional tools such as Kanban, Lean management, Waterfall, Scrum, Agile, etc. is usually short-lived because the embedded multifaceted elements that dictate organizational culture inevitably take over.<sup>15,16</sup> Furthermore, stakeholders resist change because it entails stepping out of their comfort zone. A deliberate multifaceted iterative approach is critical for achieving success, rather than through a rapid set of tectonic changes. A combination of *leadership tools* (ie, articulating a vision, active listening, storytelling, leading by example, persuasion, and conversation), *management tools* through effective and timely dissemination of information (ie, strategic planning, decision-making, role definitions, measurement, control systems, operating procedures), and *power tools* (ie, incentives and rewards, promotions, punishments, etc.) may be necessary to bring about the desired cultural change.<sup>16,17</sup>

Cultivating and nurturing a culture of “trust” by AMI leadership with myriad constituents is the cornerstone for alignment, leading to cohesive and consistent teamwork.<sup>18,19</sup> Unfortunately, misalignment between leadership and “frontline” stakeholders (physicians, physician extenders, nursing staff, administrative staff, etc.) is highly pervasive in AMIs,<sup>19,20</sup> owing to a dearth of financial limpidity, and consequent decision-making that does not take into account the perspectives of different stakeholders. It is vital that a paradigm of collective accountability (“dyad” constructs of healthcare providers and administrators) and responsibility (inter-reliant as opposed to autonomous) be undertaken toward augmenting trust that heralds methodical milestone-driven goalsetting (Figure 2).<sup>20</sup> Leaders and the AMI leadership must endeavor to operate as a meritocracy with transparency, fairness, and objectivity toward thoughtful programmatic development and growth, in accomplishing staffing needs, recruitment and retention of personnel cooperatively, planning operating and capital budgets, scrutinizing outcomes and operational performance, cost-containment, compensation and incentive plans.<sup>19,20</sup> Active, unremitting, and opportune communication with all stakeholders is foundational in engendering trust.<sup>18</sup>



**Figure 2** Importance of trust for effective AMI leadership.

## Conclusions and Future Directions

Congruence between organizational culture, its core and affirmed values, and those of leadership (“cultural fit”) are major determinants of a successful AMI. A multitude of internal and external factors influence and modulate the culture of an AMI. It is critical that leadership of the AMI understands and embraces cultural shifts resulting from tectonic changes in the US healthcare terrain and the accompanying economic realities in fulfilling the missions of academic medicine.<sup>4,5</sup> Such an evolving topography of healthcare will continue to have a profound effect on AMIs in the foreseeable future. To ensure success and desired cultural change, AMI leadership must adapt by being agile and nimble, by investing in a thoughtful iterative process to build trust and a loyal constituency, by aligning desired behaviors, strategy and processes with expectations and accountability, and by demonstrating positive results through a blend of *Situational*, *Ethical*, *Authentic*, *Servant* and *Transformational* leadership.<sup>21–23</sup>

## Disclosure

The author reports no conflicts of interest in this work.

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