# In the Grip of Expertise

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Effective, collaborative leadership is one of the most credible and important predictors of team performance. This is relevant to us as surgeons because teamwork is now a common part of the vernacular in health care, we do not operate in a vacuum without a team, and we are well positioned to assume a leadership role on our teams. However, our standing as experts, our training and the way we were mentored, an insufficient concept of leadership as a process as opposed to a position, and inadequate nontechnical skills may disadvantage us as surgeons as collaborative members of teams. Liberation from the grip of expertise can be an inflection point for development. *(J Hand Surg Am. 2016;41(11):1094–1097. Copyright © 2016 by the American Society for Surgery of the Hand. All rights reserved.)*

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Trained as a reconstructive microsurgeon and an upper extremity surgical specialist, I have always regarded the definitive litmus test of my work to be a binary analysis of the outcome of my task: either excellent or not good enough. How well it had been done had little to do with anything else other than the surgical outcome. In pursuit of achieving a great clinical outcome for my patients, I would abhor any variance in the process by which I obtained that result. Instruments had to be just so, and my team had to be ever so supportive of my task. Process improvement meant improving efficiency, making sure everyone did his or her job, and eliminating unnecessary delays, but I paid little attention to the social context in which the work was done (the "team climate")—nor did I appreciate its impact on optimal team performance. There was nothing ever to negotiate because I was the expert. I was captain of the ship. This perspective on expertise is the context for the beginning of the story.

On a day in June 2009, I had 4 total shoulder replacements on the schedule at a community hospital where I performed surgery one day, every other week. This was infrequent compared with my outpatient schedule that was 2 full days every week, at the same surgery center, and always with the same team. Although the anesthesiologist, scrub technician, and nurses at the hospital might vary from week to week, the one invariable component of these days was my preoccupation with the task at hand. I regarded the team assembled on any of those hospital operating room days as my support staff, but otherwise did not really contemplate what "team" really meant. I had no long-standing history with anyone, no time-honored relationships or friendships—and that seemed okay with me so long as everyone shared the common goal of delivering safe care and a quality outcome, and carried out his or her tasks. On this particular day, I remember feeling frustrated 90 minutes into my first case when I was getting ready to close subcutaneous tissue because the process of counting bloody sponges had not yet been completed. My customary preoccupation with efficiency caused me to express dissatisfaction with the delay because it was holding me up. When the initial count found that a sponge was missing, I ordered an x-ray, and was told it would take 20 minutes. So while I waited, and after unsuccessfully finding any sponge in the depths of an open shoulder wound, I closed. When the radiology technician finally arrived and took an x-ray, it revealed a sponge, hidden in the corner of the distal extent of the wound. I removed a couple staples and withdrew the sponge. Simple, I thought—task completed.

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But the story is not so simple and does not end there. More than technical proficiency is now expected of surgeons. Quality measures have emerged as part of the expectation of excellence. Compliance with checklists and process mandates, such as *sign your site* and *time out procedures*, are required to ensure that quality and safety outcomes are not jeopardized by the potential for human error. At times performance variance reports are generated if a team member has a concern, but too often the loop is not closed whereby performance gaffs are rectified in the future via meaningful feedback to participants, and robust dialogue amongst the team. In addition to technical expertise and focus, surgeons also are expected to be outstanding leaders, which necessitates being proficient at conflict resolution, communication, and relationship-building, among other nontechnical skills.

Why is leadership so important? Simply put, effective leadership is one of the most credible and important predictors of positive organizational performance—in any field. This is relevant to us as surgeons because teamwork is now a common part of the vernacular in health care. We do not operate in a vacuum without a team, and teams require leadership. Our environments and performance expectations demand that we build high performing practice teams, operating room teams, and organizational teams. These teams make up a complex and fluid organizational system in which we have visibility and responsibility as a leader.

As I reflect back, I had a limited if any real appreciation for, or understanding of, this visibility and responsibility during the first two-thirds of my career. I did not appreciate my critical leadership role in inspiring the members of my team to share a common purpose and to revel, collectively, in the privilege of performing meaningful work together. This was due partly to my preoccupation with technical expertise and tasks, and partly to the time period of my training in which autocratic leadership styles were common and physicians were viewed as captain of the ship. In this world, teams were assembled to support the physician and conflict was viewed almost as an indication that a team member should be replaced by a more supportive colleague. As a matter of fact, my directive leadership style seemed to serve me well at the surgery center, where I built up relationships over time and my intentions were infrequently misjudged. What I had failed to appreciate for years, however, was that I had room for improvement when it came to being perceived as a collaborative team member, especially in situations where trust was assumed based on expertise, but never built through relationship-building. I just did not realize it until I was in the midst of a crucible.

Seven years ago when the scrub technician told me that I should not close the wound completely, I did not ask why. I felt I was the captain of the ship, and did not need her or the team's okay. I had miscalculated the impact of inadequate social capital, and underestimated the consequences of being misperceived. A year later when I was called to task for the infraction, I had no idea that I had not only violated a rule, but that closing the wound over a retained sponge was a state-reportable incident. My behavior had angered the nurse and scrub technician, and I was not perceived by them in a favorable manner. Having to account for breaking a rule and being perceived as a poor team player was a pivotal point for me. I began to reflect on my accountability for how the team functioned, as well as my underdeveloped skills as a collaborative team leader.

That pivotal moment broke open my journey into the meaning and practice of leadership. I found that leadership is a very complex concept. It is actively debated with many underlying theories that are constantly evolving. In an attempt to synthesize contemporary 21st century theories of leadership, one prominent guru in leadership, Northouse, defines it: "leadership is a process whereby an individual influences a group of individuals to achieve a common goal." This definition is relevant because it describes leadership, at its core, as a process, not a role or an assembly of traits. This process involves influence and common goals, and it occurs in groups. In other words, leadership is a relational process.

I began to see that captain of the ship was not even close to a relational process, and that my identity as captain had not served me or my team well. With the help of a coach, I thought about my part in my operating room team relationships. I examined everything I felt including fear of failure, frustration with inefficiency, and intolerance for things such as a perceived lack of commitment or competence. I saw that what I was feeling likely influenced my behavior and how I was experienced, that I had inadequate self-awareness, and that I may have been as guilty of making assumptions about other members of the team, as they may have been regarding my motivations and intentions. I learned that being aware of my feelings and managing my emotions is the substance of what is called emotional intelligence. This developmental work resulted in an appreciation of the critical importance of emotional versus technical intelligence.

My identity as a leader and my motivation to lead a team was changing, and this activated an immersion