Lean back, listen, and own up

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What a crazy and chaotic world we live in: a pediatric patient receives a 38 times overdose—39.5 tablets (large ones)—in a highly regarded academic medical center with best-of-class electronic health technology and dispensing technology and the medical, pharmacy, and nursing staffs all "doing their job," every day. How can this happen?[1]

As we look to the future, artificial intelligence, robotics, and supercomputers like IBM's Watson promise to shatter our current reality, within our lifetimes, with the capability to read a million books a second and provide better diagnostics than any human. The IBM collaboration with Epic Systems and the Mayo Clinic is intended to promote patient health by applying Watson's cognitive computing capabilities to electronic health records in the development of patient treatment protocols, personalized patient management, and provision of relevant medical knowledge to clinicians for improved evidence-based clinical decisions.[2] Three-dimensional printers are producing prosthetics, including artificial hands that function and have sensation. Microchips hold the promise of restoring vision and creating telepathic communication between two people across the Internet. Using stem cells and 3-D printers, it will be possible to "bioprint" human organs.[3]

Looking ahead to the year 2035, there is the promise of free electricity worldwide based on the use of superefficient nuclear reactors and the potential for nuclear fusion. Doubtful? Remember the prices we paid for cell phone service contracts and long-distance landlines in the not-so-distant past?[3]

The world is changing, so hang on for the ride. It is often challenging to keep up, understand, and rationalize our reactions, let alone our responses. Incessant change coming at us too fast, with no time to think through the implications or the next best step in the right direction, is an all-too-common conundrum we face. And the magnitude and impact of the change will continue to escalate, surprise and terrify us, and rock our world.

We are also in the midst of radical reform of the healthcare payment system to focus on value. Obamacare changed the rules of who pays for what but that hasn't done much to change the prices and resulting costs.[4] With costs expected to exceed $3.2 trillion in 2015[5] and projected to be close to $5 trillion by 2020,[6] nearly everyone agrees that that cost trajectory can't be sustained. Drug prices are out of control, and drug companies are buying up products only to double or triple prices, virtually overnight, for maintenance medication that patients depend on and then can no longer afford.

Safety and quality are still enormous challenges despite all the effort, investment, and hard work to optimize systems and processes. We have experienced a glorious blossoming of technological capability in both information systems and automation, yet we seem to be faced with a resulting paradoxical and paralytic complexity. The enablers of our safety net have become complicit in the problem set, particularly at the techno-social interface: where humans interact with technology.

Healthcare in the United States has been described as a wicked mess and a tangle of problems, with no easy answers to right-course our future and the safety of our patients. Walter Cronkite, asked to comment

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Early in her career, Ms. Enright also held several positions with ASHP, including Director of the Division of Planning, Management, and Reimbursement, Director of Membership Services, and Executive Resident.

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on our healthcare system, once declared, "[It] is neither healthy, caring, nor a system."[7] More recently, when asked a similar question, medical humanitarian Paul Farmer, who has spent most of his career bringing effective healthcare to third-world developing nations, responded, "Well,'it would be a good idea,' to quote Gandhi."[8]

We need to change, and I don't sense that there is a lot of disagreement about that need. We need to transform our systems and processes and the outcomes they achieve. With transformation as the ubiquitous goal of most healthcare organizations (and, for that matter, businesses across virtually every industry, not just in the United States but globally), the questions of how and what to do to overcome the obstacles, deal with the confusing paradoxes and disincentives, reengage our teams and valued talent, and provide high-reliability safety and quality are too often a conundrum, with no easy answers, no obvious solutions, and often choices that are only marginally acceptable. These noble goals are as elusive as ever.

We human beings are also facing unprecedented change, large and small, not just in healthcare but in daily life. Increasingly, rapid, discontinuous, and ambiguous change events creep up to jump us while we are looking in a different direction or congratulating ourselves on our progress. And the change trends and signals are constantly evolving, morphing, and redirecting—a constant distractor or stressor in everyday life looming always in our peripheral vision.

And we continue to operate this highly complex system on a model that is a throwback to a pre–Industrial Revolution craft model: train and license professionals, provide them resources, and turn them loose to do their work as high-level individual contributors.

As a result, we—collectively as a society and individually—are paying a huge price literally and metaphorically for an isolationist model of medical, pharmacy, nursing, and other provider practice.[9] This is true from both an economic perspective of management of resources and from the view of patient care quality, safety, and outcomes. Our top-down, all-knowing, control-based leadership model is antithetical to our evolving social workplace expectations of a multigenerational work force and is too slow to respond in the dynamic world of today's healthcare delivery organizations. The team and its leaders need to be less a finely tuned and tightly rehearsed and directed symphony orchestra and more a creative, loosely connected, improvisational jazz ensemble with key players moving nimbly in and out of the performance whenever and wherever the opportunity and need arise.

The current reality is painful. After decades of effort, resource investment, and learning, healthcare still costs too much and the expenditure trends are unsustainable. Patients still need to be concerned about navigating the healthcare system, which is a high-risk experience and is often dangerous despite the best efforts of the patients and their families to communicate with providers and caregivers. Value delivery is an elusive promise, and increasingly our best and brightest are often stressed, frustrated, and sometimes overwhelmed.

These collective challenges are a basis for unprecedented opportunity to learn and to change the way we ourselves, individually and collectively, face the kind of thinking, decisions, and results that will increasingly characterize our 21st-century life. Metaphorically speaking, we are

not in Kansas anymore, and we never will be again.

In fact, we live in a world that is transforming, and our challenge is how to deal with it more effectively under a totally new set of rules that we may not yet fully understand.

The science of discontinuous change

In 1962, Kuhn's[10] *The Structure of Scientific Revolutions* introduced the notion of the paradigm shift: a change in thinking, structure, and process so radical as to make things before and after the shift appear to have little or no relationship.

Morrison's[11] *The Second Curve: Managing the Velocity of Change*, published in 1996, built on the concept of sudden paradigm transformation, offering a model that compared 20th-century healthcare—"the first curve"—with a radically different new paradigm that is coming into focus and redefining our world. Morrison described this change as being in its infancy (it is perhaps now in its adolescence), allowing mere glimpses of what's to come. The transition from the first curve to the second will not be a constant continuum, nor will the transition point always be clear in the moment. But at the juncture of these curves is a maelstrom—something of a vortex, with a strong pull and downward draft. At the edge of this vortex are the most exciting and profitable opportunities for those leaders who have the vision and courage to ride the edge of the new curve, sensing the changes as they are emerging and beginning to stick. Shaping the future state is an advantage in staying ahead of the change curve.

Recognizing the need and having a desire to change simply aren't enough. There seems to be a silent conspiracy to keep doing things the way we have always done them. Even as we want to change the results our organizations achieve, the culture from the first curve continues to en-

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Harvey A. K. Whitney (1894–1957) received his Ph.C. degree from the University of Michigan College of Pharmacy in 1923. He was appointed to the pharmacy staff of University Hospital in Ann Arbor in 1925 and was named Chief Pharmacist there in 1927. He served in that position for almost 20 years. He is credited with establishing the first hospital pharmacy internship program—now known as a residency program—at the University of Michigan in 1927.

Harvey A. K. Whitney was an editor, author, educator, practitioner, and hospital pharmacy leader. He was instrumental in developing a small group of hospital pharmacists into a subsection of the American Pharmaceutical Association and finally, in 1942, into the American Society of Hospital Pharmacists. He was the first ASHP President and cofounder, in 1943, of the *Bulletin of the ASHP*, which in 1958 became the *American Journal of Hospital Pharmacy* (now the *American Journal of Health-System Pharmacy*).

The Harvey A. K. Whitney Lecture Award was established in 1950 by the Michigan Society of Hospital Pharmacists (now the Southeastern Michigan Society of Health-System Pharmacists). Responsibility for administration of the award was accepted by ASHP in 1963; since that time, the award has been presented annually to honor outstanding contributions to the practice of hospital (now health-system) pharmacy. The Harvey A. K. Whitney Lecture Award is known as "health-system pharmacy's highest honor."

trap us with the assumptions, traits, behaviors, and beliefs that make transformational change so much harder.[9] We have to cultivate awareness and mindfulness of the "weak change signals" of what is to come in order to use them to advantage.[12,13]

In 1883, sailors and natives took no meaning from such weak signals prior to the enormous eruption of Krakatoa that spawned a 135-foot tsunami. These warnings included changes in wave action, puffs of smoke, strange noises and cloud formations, and slight tremors.[14] More recent examples include warnings of severe system issues in the banking and mortgage industries, shifts in market forces in the automobile and airline industries, and hundreds of other examples of weak change signals that were ignored in the face of impending crisis. We humans are prone to ignoring these weak signals that highlight the gap between our assumptions—what we believe based on our hindsight and experience—and the reality of what exists in the here and now and what might be predictive.[15]

If we can tune into these weak signals, we increase our chances of anticipating the future. Weak signals in our own industry include hospitals having to survive with Medicare as their best payer, pharmacy's inability to speak with a collective voice, Elizabeth Holmes's founding of Theranos to revolutionize laboratory testing, and Walgreen's aggressive marketing of transitions-of-care services to hospital C-suites. More recently, CVS has approached C-suites to allow CVS access to all inpatient medication information with the intent of managing discharge prescriptions, discharge medication reconciliation, and medication counseling.

There are also breaks in continuity where one paradigm ends abruptly with a triggering event that starts a new and discontinuous journey—think of Apple moving into music and movies or the emergence and growth of concepts like Facebook and Amazon.com. Closer to home, the Affordable Care Act and the subsequent restructuring of healthcare through a series of new incentives rocked our world.

The long-fought Windows–Apple race is over, and both have lost because soon laptops will be an artifact of the past. Today there are 3 billion people online, with 2 billion owning smartphones, and those levels will double in five years, when 80% of adults on the planet will have smartphones. The newest iPhone has 625 times more transistors than a Pentium computer did two years ago; that smart power creates a stickiness and mobile leverage that will shatter our expectations about data and knowledge. Patients and employees will be using smartphones for learning, work processing, and relationship building. In fact, it is projected that within three years professionals will conduct 70% of their work on smartphones. Think of that as one of our glimpses into the vortex—and the implications for communication, work structuring and staffing, and big data, as well as the impact on patients (Wiley PB, Wiley Mindlab, personal communication, 2015 Feb 26).

Change isn't easy

The transformation of our health system will not be comfortable or certain or easy, but we have little choice but to do it. Hindsight and prior experience will not serve us well, and (to paraphrase loosely from Einstein[16]) we are not likely to create solutions for today's problems if we remain embedded in the thinking that created them; neither can we tinker marginally at the edges with tired ideas that worked in the past. In fact, we need to wade willingly into the murky swamp of our most challenging problems and issues and courageously take on the mess.

And it will be messy. Those murky swamps are full of messes with no easy answers, involving a broad spectrum of others we may know only distantly. How do we address issues that we can barely evaluate, that are seldom even discussed in any detail because we are so busy "getting things done" to meet the challenges of the day, working with people we may not know very well or at all?

When messes come bubbling up for all to see, it is really uncomfortable, leaving leaders feeling like they have to be poised for the unexpected somersault, handstand, or backflip. This so often engenders apprehension, fear, and withdrawal from the challenge.

We talk a lot about change, with our focus on creative ideas and structural change. We invest time and resources. We work the plan, announce it with excitement and enthusiasm, and wait for the results we expect to change the future. Yet most (fully 70%) of transformational change efforts fail.[17] With all the emphasis on commitment to transformational change to meet the Affordable Care Act incentives, recently two major medical home studies[18,19] and two readmission prevention studies[20,21] had negative to underwhelming results. Why? We know that the goal is not impossible. Organizations like Intermountain Healthcare, Geisinger, Group Health, and Health Partners have been delivering high-quality care at lower cost through mechanisms like medical homes and accountable care, starting long before those terms were part of the common lexicon.[22]

Organizations like those, the United Kingdom's National Health Service, and Kaiser Permanente have realized that differences in culture and how the people in an organization interact and work together are key. After more than 25 years of teaching and coaching process improvement in healthcare, leaders at The Dartmouth Institute realized that process skills alone were not enough. Without attention to the in-

teractions of people and the relationships that launch and sustain change, and how they impact the culture of the organization, results fell short or were short-lived (Godfrey M, The Dartmouth Institute, personal communication, 2014 Oct). Where there was successful change, the structure and processes were necessary but not what made the difference. The characteristics that led to success were a consistent and shared vision for an often uncertain future and a "learning culture." Also critical are healthy relationships within the practice that are based on solid, open communication and dialog about what is most important. Finally, foundational trust that allows for positive conflict; commitment and accountability; regular time for reflection; and shared, dispersed leadership are key enablers of successful change.[23] While it is not possible to dictate a culture change by fiat, these are the behavioral elements of a culture that allow leaders to influence the cultural change components—the behaviors, traits, beliefs, expectations, and relationships—needed for transformation.[9] Shifting the culture is not about the 10 things a leader needs to do but rather the 10,000 things that need to occur consistently, every day, to reestablish the culture for a new world order.

Culture change is intentional and starts with leadership at every level, builds with perspective and "outside-in" thinking, and grows with new skills and behaviors. Fundamental changes in thinking are essential. Health, facilitated by healing clinician–patient relationships, is a core development goal; strong internal relationships among team members and professional colleagues, as well as with the community and patients, and ongoing conversation and dialog are core tools for getting there. Again, this is an *intentional process*, as compared with the organic and unstructured evolution typical of most organizational cultures.

Because we are dealing increasingly with situations, issues, and ideas that are unique and different from anything we have faced previously, there is no handbook, map, or guide. Yet, we will need to act confidently, still admitting that we have no easy solutions. Leaders will need to learn to "live in the question," exploring with colleagues to find the next best step in the right direction. That will take all of our collective input, vision, thinking, and energy if we are to find our way as we go. This will be a difficult transition for leaders who are used to "having all the answers."

After years of study and experience, the U.K.'s National Health Service offered some advice: "Build leadership systems that are managerially loose, but culturally tight,"[24] giving broader authority to dispersed leaders facing the immediate issues. These tight–loose controls replace the old define-and-direct culture. No level of detail will allow a protocol or guideline to meet every situation, particularly in an environment of radical and rapid change. We need to increasingly rebuild our culture to establish and support value-based behaviors.

Setting tight directional controls to define relationships will demand that leaders pay attention to a range of activities and techniques that I would guess are not common practices in many a pharmacy enterprise. The array of opportunities is focused on clarifying priorities, fostering learning conversations, and engaging in whole-system conversations.

Transformation will not get off the ground without clarifying priorities. This must begin with foundational principles and values, an agreement of what we mutually agree to commit to as shared goals. For example, will we prioritize service commitments in terms of the patient or the provider? Can we provide services in a totally new way? Importantly, connecting these foundational principles into job roles and standardizing procedures throughout the organization are essential to help workers connect the dots to their own role, level, and leadership span and enable them to more effectively take independent leadership action within their span of control. To those ends:

- Creating a sense of urgency moves attention from the status quo to the opportunity and instills a belief that not only is the desired future state better but it is achievable in a foreseeable time frame.
- Distributed leadership and control through the frontlines of care and support must be clear. Be certain that all "small-l" leaders are armed with the skills and development resources to enable them to act on this distributed opportunity for influence, advocacy, and action.
- Build vision into the budget and the schedule. Without this critical support, you risk building engagement (and frustration) in the absence of the essential resources that will create an organizational framework for action. The two parts are essential: commitment and ownership, with the organizational support systems to enable consistent follow-through.

Establish a development perspective by building a change platform, not a change program,[25] and shifting the emphasis from "top down" to "activist out." The longer you have to force the discussion to achieve employee engagement, the more risky your results. You need to have those small-l leaders own the change and run with it. Rather than trying to "sell" the idea to obtain an indifferent or passive "buy-in," invite commitment from those who will be most affected, asking them to engage in defining (or refining) the "how-to" aspect of the transformation. You may be astounded by the uptake, creativity, and enthusiasm for the innovation engendered by merely shifting your emphasis from manag-

ing the change to encouraging a viral or organic spread of new practices.

Unlike Kurt Lewin's unfreeze-change-freeze model of change,[26] this new approach calls for constant experimentation and improvement, creating permanent slush. Change comes naturally when people have a platform that facilitates identifying shared interests and sharing potential solutions. Some ideas to consider[24]:

- Adopt challenges that might be well beyond pay grade or sphere of influence.
- Foster open, honest, and truthful discussion of root causes, including those that wander into the murky swamp of problem issues.
- Nurture more "solution potentials" to decrease the risk of settling in on the most obvious (and least likely to be successful) approach.
- Encourage ownership for change, providing resources—particularly time—to nurture thinking, imagination, and energy to find solutions.

Leaders must also work to break down the cultural barriers that might inhibit enthusiastic jumping onto the change path[23]:

- Encourage diversity by seeking out individuals who might not ordinarily be part of the process, skeptics, and those outside the normal selection pool for work on a particular issue.
- Explore contradictions and paradoxes. Any time you wonder "Why is that happening?" or think "That is strange—I don't quite understand what happened," there's a fertile field for conversation and study.
- Hunt for trouble, discontent, grumbling, and persistent problem areas, and dig in to explore.
- Look for ripples (those subtle indicators that something might be happening beneath the surface) and you will likely find a weak change indicator.

Conversation and dialog are at the heart of learning organizations and the art of learning together[25]:

- Foster learning conversations related to projects using the PDSA (Plan-Do-Study-Act) model and related models as a standardized approach to examining issues and problems systematically, and consider broad-based training for project management.
- Capability-building conversations thrive on dialog[27] and employ techniques like appreciative inquiry,[28,29] mindfulness,[13] crucial conversations,[30] coping and stress management, difficult conversations, setting expectations,[31] conflict management,[32] reflective-thinking and solitude-based skills,[33] communications, negotiation and strategic persuasion,[34,35] advocacy, and influence.[36] Each technique has a unique role and contribution; all have been employed successfully in healthcare situations to facilitate change and transformation and have a long and rich history in organizational development and transformational change.
- It is unusual for teams and organizations to foster and engage in regular whole-system conversations, yet these are precisely the conversations that establish and reinforce direction; redefine boundaries as they change, morph, and erode; and dig into the hard work of imagining a new future while we're still mired in the present and influenced by the past. Innovative and engaging processes and techniques that can open the door to these complex and rich conversations, include the "knowledge café,"[37] Future Search,[38] Open Space,[39] and "positive deviance."[40]

All of these techniques are way out of the box in comparison to our basic and tired communication and meeting strategies. To quote Schein,[9] "It is a tragedy that in our organizational society we joke about meetings being mostly a waste of time and groups being useless because they diffuse accountability." Each of these techniques and approaches is easily applied or can be initially facilitated by external resources to build comfort and confidence in the processes to transform the engagement of your best and brightest.

Leaders at every level and team members need to understand complex adaptive systems, viewing variation demands as an improvisational jazz group might rather than as a symphony orchestra would. Basic principles, long inherent in the Institute of Medicine's simple rules for addressing the healthcare quality chasm,[41] include the following[23]:

- Cause and effect are rarely simple, direct, or linear.
- Any action or decision has multiple consequences that change the environment and influence the decisions and actions of others.
- Many consequences are delayed in time and not immediately predictable.
- Surprise, unintended consequences, and novelty must be expected.
- Purposeful change and development must focus on improvement—not perfection—and a commitment to reciprocal feedback and learning.
- Improvement emerges from competing demands and opportunities.
- Variety, diversity, and conflict should be expected and valued as sources of new learning.

Leaders will need to first change their thinking and invite their team to engage in the dialog. They will need to be vulnerable and admit openly that they cannot have all the answers. They will need to shift their mental perspective to see the mess as a good sign—as evidence that something essential is happening in the transformation that is positive. Eventually there is no way to avoid the messes, and if you—the leader—interfere you are likely to crash the process, evaporating the creative energy that drives your team, and the essential trust that is needed for transformation will be lost.[42] Leaders will increasingly need to *lean back, listen, and own up* to their role in the needed change and help their teams to do the same.

Lean back

Most of us are so involved in our day-to-day responsibilities that we rarely take the time to lean back for a bigger perspective, with an eye on change drivers and the long-term trajectory. Not to disparage Sandberg's[43] *Lean In* message, but it is based on the old hierarchy and thinking.[44,45] Doing more, longer hours, pressing forward in the same ways that have not served us well recently . . . . This is not the answer.

We are in a world of amazing complexity that requires too much from just a few people at the top. According to Gary Hamel,[46] no matter how smart, informed, and dedicated it is, a small senior leadership team can't have the diversity, bandwidth, or time to evaluate and decide effectively about all of the critical decisions that must be made about current operations while guiding their organization into an uncertain future. In organizations where that top-down approach is still in place, "change is belated, infrequent, and convulsive. By the time the small team at the top realizes the need for change, by the time the problem is big enough or an opportunity is clear enough to prompt action to break through all the levels to command their attention, it is too late." Hamel's recommendation: Syndicate the work of leadership more broadly.

White's[47] Whitney Lecture message highlighting the need for small-l leaders was a fundamental one foretelling how we would need to change our perspective and our behaviors to deal with a changing environment. We need to create the opportunity and skills to prepare our small l's to be leaders: lateral leadership, communication, negotiation, influence and advocacy, the ability to engage and set expectations . . . . These are needs that we focus on directly in the ASHP Research and Education Foundation's Pharmacy Leadership Academy and Leaders Innovation Master Series, as well as in the ASHP Foundation's Leadership Resource Center.[48]

Healthcare is a complex set of interrelated systems. In complex systems, order arises from interconnections between people, and how well that works is a reflection of relationships that create the self-organizing set of patterns we call the culture. The quality of the relationships is more important than the quality of the players in defining culture.

And our work environment is changing in other ways, from the bottom up, and with it the expectations of and for each of us.

Many employers have used economic, reimbursement, and policy changes to resize, redirect, and reevaluate the essential work force. This is true across industries and increasingly true in healthcare. Efficiency, effectiveness, and productivity are essential in our workplaces if our organizations are to thrive; this will mean more technology, robotics, outsourcing, and realignment of services. That is not going to change. But it is also clear that doing more of the same isn't the answer and is unlikely to help to move us into what Morrison[11] described as the second curve.

In this new work environment, critical thinking, creative ideas, and the ability to translate them to innovative new approaches are essential. The ability to adapt, curiosity, and courage to develop and test new ideas in order to validate them (or fail faster) and bring value to the organization every day are essential.

For individuals, that means continual awareness that no career is a sure thing.[49] For those entering pharmacy, a professional degree, residency, and an advanced degree (or aspiration to gain one) are increasingly the baseline, entry-level expectations. For those in practice, your past experience and achievements are less important than how they reflect your ability and willingness to learn, to be engaged to take ownership to bring value, to be accountable for a shared change vision, and to be resilient in adapting in an increasingly ambiguous professional and personal environment.

And both groups need to remember that we have two jobs: the first, the job we are hired to do; and the second, to assess, evaluate, and improve everything we touch in the course of our work.[50]

Listen

The social contract of employment is changing. Talent is increasingly the imperative. Who you are (skills, talents, hidden traits, commitment, and resilience)—not a resumé—is what is increasingly important. Pair this with a candidate pool telling employers that the job is less about a career and more about the experience, and the dynamic of roles, attitudes, and relationships is radically changed.

In five years, millennials will represent more than half of the global work force, and they have very different career needs and expectations. Many of us—the baby boomers—will no longer be actively in the work force. We need to understand what this will mean for our organizations, our leadership, and our legacy of professional values.

This new work force is highly networked and tech savvy, and they expect to be involved in leadership decisions, particularly those that impact them directly. They want a broader role in the business and don't see themselves as mere clinicians or simply filling an administrative role. They expect to be part of the healthcare team and system. This commitment will differentiate organizations that can recruit and retain this young talent from those employers with constant staffing churn.[3] Members of the new work force value results over tenure and are impatient to learn, to be involved, and to make an impact. They are more open to collaboration, and

that will serve our profession and our patients well.

With this backdrop, this second curve changes the demands of leadership and followership for everyone working in or with organizations. Mastering new skills to envision new possibilities, sharing and managing the explicit and tacit collective knowledge of a diverse work force, and creating new knowledge will all be the building blocks of success. The implications of this new reality are enormous for leaders, professionals, and anyone working in an organization.[9]

And while we may recognize the need for better collaboration, cooperation, and shared learning, the reality of their achievement leaves a gap of cosmic proportions. Top-down, command-and-control leadership and decision-making is one significant factor, but the need to reshape how work is actually done is equally critical. The "how" is increasingly going to depend on working and learning together.

Teaming is the active process of working together for a fluid network, and while we humans tend to accept the notion of teams and group effectiveness, we tend to act on this belief only when forced to do so as a pragmatic necessity in order to win or get a job done.[51] It is not a normal tendency of human behavior and is typically not rewarded: Incentive and promotion systems are largely based on individual achievement.

Teaming may well be the untapped potential for organizational results and success. It is the base for organizational learning and is enabled by dispersed leadership and allowing organizations to expand knowledge sharing, individual capabilities, and organizational capacity to capture and expand value. Teaming is a vehicle that supports employee engagement and a mindset of organizing to execute, two areas of common vulnerability for organizations seeking sustained results. Organizing to learn is a leadership mindset that encourages speaking up, asking questions, and sharing ideas to actively promote and support collective learning as the basis for effective, reliable, and consistent execution and sustained results (Lencioni P, The Table Group, personal communication, 2015 Feb 27).

Just as teams don't come together naturally and effectively, the skills that individuals need to be successful in teams are not natural talents for most people (who are fragile under stressful situations), and the behaviors that contribute to effective teams require hard work to develop and maintain. Trust, mastery of conflict, achieving commitment to own the goal and shared priorities of the team, holding each team member accountable with open and honest feedback, and the collective focus on results establish the core competencies that are essential to a team being successful and cohesive. And they are in short supply.

We have assumed for too long that—like announcing a change goal and expecting it to fall into place—teams will come together naturally to produce results. In fact, this is one of the messy, swampy problem areas for most organizations. The fact that teaming now is more dynamic, virtual, and episodic than in the past only compounds the issues.

We need skill building for collaborating on the fly, for coordinating without the benefit of stable team structures, and for learning to be nimble and agile in making adjustments to weave knowledge and skills and insights into products, services, and high reliability. And when execution and learning become intertwined, the rules of the game change from fighting over each piece of the pie to increasing the overall size and quality of the pie.

Own up

As value becomes the prevailing measure of significance in the marketplace and the work force, our world is changing. We talk and think about change—its demands and promise, its elusiveness, desirability, and inevitability. But most often we think about change as external: something that happens *to* us.

In reality, the outcome of change is mutually dependent on the change itself and our human reaction to it. As changes come faster, discontinuously, and with increasing ambiguity, our hindsight does not serve us well. We will need to call up skills of outsight (our perceptions and view of the external world), insight (our instinctive gut feeling, awareness, and mindfulness of all the factors evolving around us), and foresight (our ability to pluck from that vortex between the change curves those ideas that will move us forward, allowing us to bend the curve but not be broken by it).

In an essay that is a seminal reading of the Pharmacy Leadership Academy, entitled "Solitude and Leadership," Deresiewicz[33] challenges thinking about successful leadership traits and behaviors. He postulates that the intensity and competitiveness of the world have driven too many of us to be world-class hoop jumpers, or "excellent sheep," with the capacity to make big names and reputations for ourselves and climb the slippery pole to success (however we choose to define it).

In many organizations, getting along by going along—being what other people want you to be or do and not taking risks or asking hard questions about why or why not—is the path to success and promotion. Deresiewicz paints something of a bleak image of bureaucratic leadership as both a promise and a decision point: You will meet these people, but you can choose to be a different kind of leader.

Our crisis of leadership may not be just about demographics and desire; at the heart of our leadership challenge may well be complacency. Deresiewicz postulates that we have been "training leaders who know well how to keep the routine going,

who can answer questions but can't ask them. Who think about how to get things done but not whether they are worth doing" at all. In an age of increasingly narrow specialization, we have people who are incredibly well trained for one thing but have no interest or knowledge of anything outside their interest or expertise domain and, as a result, lack vision. He postulates that what we don't have is leaders. To be a leader, you have to think for yourself, envision what could be different, and act to change for improvement.

With teaming being an essential component of the collaboration that enables organizational learning, leaders are shockingly incompetent in building teams, let alone the killer teams we need to face an increasingly challenging and uncertain future and to innovate and transform our practice.

Yet, we do—and will increasingly—depend on the work our teams do. As the pace of change continues to increase and become more complex, we need high-functioning teams to make decisions and get things done, and this is nowhere more evident than in healthcare.

And we need leaders who think and can inspire those teams more than ever, who have the concentration to develop thoughts and questions that stimulate dialog and ideas and creativity for innovation in their teams. For that, you need solitude—a time for reflection. Leadership means introspection and talking to yourself, finding a new direction, not just following the masses (because, remember, the "m" is often silent). And it means long uninterrupted conversations with trusted colleagues to shape the articulation of your ideas—and thinking out loud for honing and challenging your ideas. Unless you take the time to do that, you will not have galvanized your vision, beliefs, and values with the certainty you will need in times of testing and challenge.[33]

Conclusion

At the end of the day, each of us has to change: ourselves, how we interact with others, and how we fit in the culture and plan to influence it. Each of us needs to own our part in changing ourselves and our practice. Collectively, we need to be accountable—as individuals and in peer-to-peer accountability for results—for making the needed changes to our practice, our culture, and our outcomes.

Regardless of your role, your leadership requires both solitude for reflection and collaboration for change, and we each need to master that paradox.

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