WE LIKE TO THINK THE United States has a monopoly on managerial icons and what we do here influences the world. However, Colvin (2011) reports the next management icon we will be hearing about is from China. Zhang Ruimin started with a refrigerator plant that produced terrible refrigerators. He pulled 76 refrigerators off the assembly line and asked the employees to destroy each of them with sledgehammers. His message was that poor quality could no longer be tolerated. His message was not profitability. Instead he focused on quality and growth and financial success followed. From refrigerators, he expanded into air conditioners, washing machines, and stoves and successfully built a huge enterprise. So what did he do to make his enterprise so successful?

Ruimin reorganized his business so it could meet the demands of the retail customer faster than any other company (Colvin, 2011). He organized his company into self-managed units with each devoted to customers. Employees at all levels were assigned to the units with the expectation they would work directly with customers and make necessary decisions. Managers were responsible for ensuring units were provided with key resources, but they were not in charge because they were not in direct contact with customers. If the employees didn’t like the way the manager was performing, they could vote that person out. Employees were informed of productivity and quality numbers daily, allowing for quick corrections if needed. Ruimin’s leadership style created the culture where new ideas and expectations can flourish because employees were driven by the quest for quality for their customers. When that is accomplished, everything else, including profitability, falls into place.

Mitchell (2011) describes an inner-city hospital with a history of dysfunction and mismanagement that Wright L. Lassiter III took on in 2005 as the CEO. One of his first initiatives with his COO, Bill Manns, was to immediately begin a grassroots money hunt. After gathering the top managers, he told them he and Manns were so new they couldn’t find the restrooms, so it was up to managers and staff to solve the problems of the hospital. The rest of the story is a remarkable turnaround made possible by exciting the staff about what could be done, then listening to their expertise and following through with their suggestions. This is another example of what can happen when leaders realize staff have the expertise to find solutions and are given the structure in which their ideas are gathered, facilitated, and implemented.

**Direct Decision Making vs. Oblique Decision Making: Which Is Right?**

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**Direct or Obliquity Leadership**

There are two ways leaders get work done: Managing directly by determining the solution initially and then directing staff to carry out the plan, or managing by setting objectives and developing approaches that are iterative and adaptive along the way. Kay (2011) learned the term “obliquity” from Sir James Black, a Nobel-winning pharmacologist who determined that goals were best achieved by not intending them. Kay (2011) provides examples of profitable companies that do not emphasize profit but incidentally are the most profitable because of their focus on the product and not the profit. Warren Buffet, Sam Walton, Bill Gates, and Jack Welch are described as people who used the principle of obliquity and constantly learned, improvised, and adapted in the process of creating outstanding companies.

In Kay’s view, the complexity of the environments in which we work makes it impossible to determine the answer before we begin the process. But by using the principles of obliquity rather than direct
leadership, we have the opportunity to learn and adapt as the project unfolds. Leaders who use a more oblique approach that focuses on areas such as long-term economic value, creating significant benefits for the wider community, and building robust social capital within the company are successful (Poote, Eisenstat, &Fredberg, 2011).

**Applying Obliquity Leadership**

In health care, we developed structures to take advantage of the expertise of our employees but the implementation of this strategy is variable across many organizations. For example, shared governance was established in nursing organizations many years ago to purposely empower people on the front lines to own their practice, to critically examine what works and what doesn’t, and to make adjustments. We know some leaders are excellent in creating viable shared governance structures and others are not. Tina Fey (2011) writes about the transition she made from writer/comedian to producer and notes she is a “bossypants” person. She had to learn to tell people what she needed as a leader and then to leave the room, close the door, and let people create on their own rather than her micromanaging the project. We know there are bossypants leaders in nursing and health care who cannot step back and therefore are unsuccessful at developing effective shared governance systems.

Leaders like Tina Fey, in multinational corporations, nursing, and health care, need to make the transition to empowering people to solve problems independent of the leader. Morieux (2011) offers rules for leaders to consider in achieving this skill. They range from developing a better understanding of what coworkers do, to increasing the need for people to depend on each other in the organization by eliminating internal monopolies, and by not letting decisions be escalated to the management level.

Business has become very complex over the past few years. Health care certainly leads that trend. Kay (2011) notes no single person can have the expertise to lead effectively in complex organizations and units. Leaders in nursing should learn from the lead of Fey and others and move from the bossypants, command and control, direct model of leadership to the model of managing indirectly and obliquely (Kay, 2011). Leaders need to be the spark that ignites problem solving in their people rather than assuming they can problem solve alone.

**Shared Governance and Obliquity Leadership**

An interesting exercise is to determine what is being discussed in shared governance meetings and determine if this content is useful for the organization. Is the leader teaching the group to be problem solvers? Does the group seek meaningful work to do, or are they focusing on details that will be inconsequential in 2 years? Kaplan (2011) encourages leaders to look in the mirror and focus on their image through the eyes of others. It is easy to blame employees when functions such as shared governance aren’t effective. Kaplan (2011) reminds us leaders don’t have all the answers and should be reflective, lead by example, and empathize.

Direct command does not have a place in shared governance, either on the part of the leader or on the part of the shared governance leaders. Health care, whether it involves a small inpatient unit, a clinic, or a multi-site system, is entirely too complex for the leader to direct everything. High-performing organizations have mastered the art and science of managing the high-level objectives and the implementation of these goals into realistic actions. This can only be accomplished by evaluating progress and making appropriate changes concurrently in the trajectory of the project.

**Summary: Obliquity Leadership**

Cookie-cutter solutions are not viable in the complex world of health care. How one unit organizes its shared governance activities won’t necessarily work for another unit. Directing the work of the units totally misses the richness and brilliance of the staff who work there and results in second and third-rate solutions. Obliquity is the process of adaptation and discovery and is not a linear-timed process (Kay, 2011). In health care, changes are constant and frequent. Obliquity leadership is very appropriate for health care because of its constantly changing environment. Obliquity leadership and shared governance are great partners in reaching higher levels of involvement and high performance. $