Otroversion and physician leadership: clinical reflections on independence, authority, and ethical action in medicine

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Physician leadership is commonly understood through models emphasizing collaboration, visibility, and group engagement. Although these qualities are often essential, they do not encompass the full range of leadership orientations observed in clinical practice. In this article, I introduce otroversion as a clinically observed personality orientation characterized by resistance to group rituals, norms, and the pressure to conform, with low intrinsic need for group belonging and reliance on internal reference points. Drawing on my experience as a physician in various leadership roles, alongside emerging organizational discourse, I explore how otroversion may represent an underrecognized but valuable leadership orientation within medicine. I argue that otroverted physicians may be particularly well suited to roles requiring independent judgement, resistance to groupthink, and ethical steadiness, and I suggest implications for leadership development, evaluation, and physician well-being.

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Leadership expectations in contemporary medicine

Leadership in medicine is increasingly emphasized as a professional competency. Physicians are encouraged to assume leadership roles, not only in clinical teams but also in institutions, policy environments, and professional

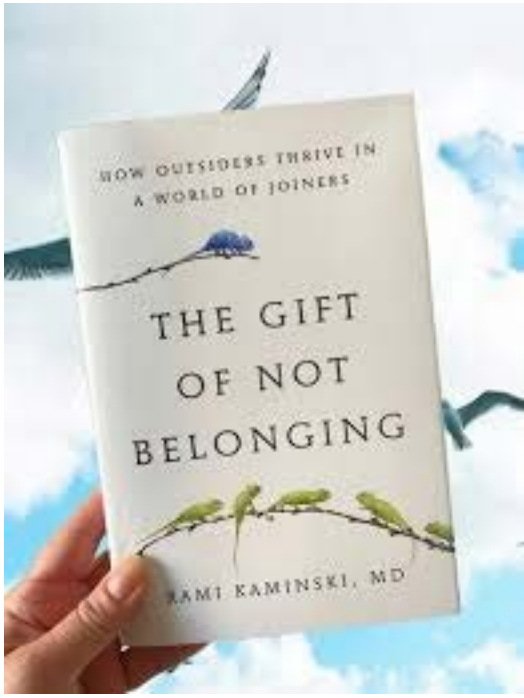
organizations. Dominant leadership models tend to privilege collaboration, consensus-building, emotional attunement, and visibility. These qualities are frequently framed as inherently virtuous and universally desirable.

Yet in my clinical work as a psychiatrist and in my leadership positions, I have repeatedly encountered a subset of physicians who do not comfortably conform to these expectations, but who nevertheless lead effectively, ethically, and with considerable influence. These physicians do not derive motivation from group belonging, social affirmation, or institutional identity. Nor do they retreat from responsibility or avoid engagement. Instead, they operate from a position of principled independence and clarity of role.

Over time, I have come to conceptualize this orientation as otroversion.[1] In this article, I reflect on otroversion in relation to physician leadership. These thoughts are offered, not as a definitive psychological classification, but as a clinically grounded framework that may help expand our understanding of how leadership actually manifests in medical settings.

Defining otroversion: a clinical perspective

Since the release of my recent book, *The Gift of Not Belonging*,[1] in which I describe the concept of otroversion, the term has emerged in discussions of organizations and culture. Otroverts are described as capable, engaged professionals who nonetheless lack a strong communal impulse and do not organize their identity around group belonging.[2,3]



From a clinical perspective, the physicians I describe as otroverted share several recurring features:

- Low intrinsic need for social belonging or group identification
- Comfort with decision-making under pressure
- Preference for clearly defined roles and responsibilities
- Propensity for sustained one-to-one engagement
- Reliance on internal ethical standards

Many otroverted physicians are articulate, socially skilled, and capable of public leadership. Their otroversion traits should not be mistaken for detachment, oppositionality, or social anxiety. Their defining feature is independence from the psychological rewards and pressures of belonging.

Otroversion as distinct from existing personality frameworks

Traditional personality frameworks have been invaluable in helping clinicians and leaders understand differences in temperament and motivation. However, most models assume that social belonging is either energizing (as in extroversion) or draining (as in introversion). In my experience, this assumption does not hold universally.

Otroverted physicians are often neither energized nor depleted by group interaction. Instead, they experience group dynamics as largely incidental to their sense of purpose. Their motivation is closely tied to their sense of duty as physicians and leaders, rather than to relational, political, or social reinforcement.

This distinction matters in medicine, where leadership is frequently assessed through visible participation, committee engagement, and relational presence. Physicians who do not seek these forms of engagement may be perceived as disengaged or insufficiently collaborative, even when their leadership impact is substantial.

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Groupthink, medicine, and the value of psychological distance

Medicine is uniquely susceptible to groupthink. Hierarchical structures, time pressure, fear of error, and institutional loyalty can all discourage dissent. Numerous analyses of medical error have demonstrated how excessive cohesion and deference to authority can impair judgement and compromise patient safety. Many studies have explored the impact of psychological distance in medical decision-making, suggesting that clinicians who maintain a degree of independence from group pressures may mitigate the risks of groupthink and foster more robust ethical standards in health care settings.[4]

Physicians who are less psychologically invested in group belonging may serve as critical counterweights to these dynamics. In my experience, otroverted physicians are often more willing to question assumptions, resist premature consensus, and tolerate the interpersonal discomfort that accompanies dissent.

This does not mean that otroverted physicians are inherently contrarian. Rather, their independence from group identity allows them to evaluate

situations with less concern for social consequences. In leadership contexts, this quality can be particularly valuable during crises, ethical dilemmas, or institutional failures.

Otroverted leadership in clinical practice

Leadership in medicine often occurs quietly and informally. It may take the form of mentoring or moral leadership rather than positional authority. Otroverted physicians frequently excel in these roles.

Examples I have observed include:

- Physicians who intervene decisively when clinical standards are compromised, despite institutional resistance
- Leaders who provide clarity and stability during crises without seeking recognition
- Mentors who profoundly influence trainees through focused, one-to-one engagement
- Medical directors who prioritize role coherence over popularity

These physicians may not conform to dominant leadership narratives, yet they are often those to whom colleagues turn when clarity and judgement are required.

Cultural and organizational discourse supporting the concept

Although the concept of otroversion has emerged primarily from my clinical observations, it has begun to resonate in broader organizational and cultural discourse. Articles exploring otroverts in the workplace describe individuals whose contributions are often overlooked in socially driven organizational cultures, despite their reliability and effectiveness.[2,3]

Cultural essays have likewise explored the experience of individuals for whom belonging is not central to identity or fulfillment, challenging the assumption that social integration is a universal psychological need.[5] Mainstream media publications, including my article in *The Guardian*'s "The Big Idea" column, have further reflected growing public interest in alternative models of identity and participation.[6]

These sources do not constitute empirical validation, but they do suggest that the construct resonates beyond a single clinical lens. They provide a

conceptual backdrop against which the original clinical observations may be better understood.

Implications for physician leadership development

If leadership development in medicine continues to privilege social visibility, consensus-building, and performative collaboration, we risk marginalizing physicians whose leadership is guided by different mechanisms.

Recognizing otroversion has several practical implications:

Leadership identification: Leadership potential should not be assessed solely through committee participation, extroverted communication styles, or group engagement. Independent physicians — mavericks — may possess leadership capacities that are less visible but equally important.

Leadership training: Training programs might benefit from acknowledging multiple leadership orientations and offering pathways that do not require constant social performance.

Physician well-being: For some physicians, leadership expectations that emphasize continuous relational engagement may contribute to burnout. Validating alternative leadership styles may reduce unnecessary psychological strain.

By operating from internal rather than social reference points, otroverted leaders **may help preserve professional integrity within increasingly complex health care systems**.

Ethical leadership and moral courage

Perhaps the most significant contribution of otroverted physicians lies in ethical leadership. Moral courage often requires standing apart from the group, tolerating disapproval, and acting without assurance of support. Physicians who are less dependent on belonging may be better positioned to meet these demands.

In this sense, otroversion may represent a form of ethical resilience. By operating from internal rather than social reference points, otroverted leaders may help preserve professional integrity within increasingly complex health care systems.

Limitations and the need for further inquiry

This article does not propose otroversion as a diagnostic category, nor does it claim empirical validation. The concept remains descriptive and

exploratory. Future research might include qualitative studies among physicians, examination of leadership outcomes, and exploration of correlations with burnout, ethical decision-making, and institutional resilience.

The otrovert's reticence to participate in organized activities, such as conferences and administrative and policy meetings, and their tendency to eschew social events can limit their effectiveness in certain important aspects of physician leadership. An otrovert physician seeking a senior role would be ill advised to pursue roles that require a heavy load of meetings and executive decision-making (e.g., chair of a medical department). Otroverts are more suited to running clinics or other clinical settings where clinical engagement and hands-on teaching are often the most important requirements.

My intention is to articulate a pattern that many physicians recognize intuitively and to invite thoughtful inquiry rather than definitive classification.

Conclusion

Leadership in medicine is not monolithic. By recognizing otroversion as a legitimate and potentially valuable orientation, we may broaden our understanding of how physicians lead — and how they can be supported to do so authentically. In a profession that demands independent judgement, ethical clarity, and resistance to undue influence, otroverted leadership may not only be valid, but also essential.

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Author

Rami Kaminski, MD, is a pioneering psychiatrist with over four decades of clinical experience, treating patients ranging from world leaders to individuals with severe and persistent psychiatric conditions. Based in New York City, Dr. Kaminski continues to advance optimized treatment protocols, including groundbreaking work in addiction medicine. In 2023, he founded the Otherness Institute, introducing the Otherness Scale to identify and measure traits of otherness and otroversion. He previously served as medical director at the New York State Office of Mental Health and held senior roles at Mount Sinai Medical Center, where his research on histamine in degenerative brain disorders led to 11 international patents.

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