John H. Gibbon, Jr., Lecture:

Leadership in medicine

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John Gibbon, Jr., MD, FACS, was perhaps the most important person in the development of cardiac surgery in the past 50 years. The heart-lung machine, which allowed surgeons to operate on the quiet, open heart while the patient was sustained in all other vital functions, was the pivotal development that made modern heart surgery possible. Gibbon pursued this dream for more than 20 years—from animal experiments to final successful use in an 18-year-old woman.[1]

Fittingly, the subject of this article is leadership in medicine, as Dr. Gibbon exemplified leadership to the fullest extent. He established direction with a vision for the future. He aligned the people needed to fulfill his dream, motivated them to overcome its many obstacles, and persevered until the task was successfully completed.[2]

Leadership in medicine has never been more important than it is today. The corporate model in medicine has become ever more common, and physician groups, health maintenance organizations (HMOs), and other health plans truly rival many Fortune 500 corporations in size and financial capacity.

When medicine was practiced by solo practitioners or small groups and fee-for-service was the prevailing method of payment, the need for leadership was not paramount. Only large group practices, such as the Mayo and Cleveland Clinics, or large professional organizations, such as the American College of Surgeons or the American Medical Association, required leadership. This picture changed dramatically after World War II, with the widespread introduction of health insurance, especially Medicare and Medicaid, in which the U.S. government began to play an ever-increasing role.[3] The introduction of managed care brought still more advances in the development of what Arnold Relman calls the "new medical industrial complex,"[4] with seismic changes that we still experience today and will experience for some time.

Yet, almost daily we hear of the disastrous breakdowns of many of these health care systems, and even a cursory analysis shows that poor leadership, in addition to poor management, is the cause. Only three years ago, a major academic institution merged with a private clinic. On paper this marriage looked solid and would have been of great financial and educational benefit to the medical school. Yet, today the divorce is final and will cost millions of dollars. Why? Because of poor leadership. If those in charge had a vision, they clearly were unable to impart it to others. The initial enthusiasm of department chairs and others was quickly dispelled when they discovered that they were to be excluded from the planning and development phases of the combined health system and from the decision making process as well. Instead of motivating and encouraging these department heads, those at the top merely sent down orders from on high from their isolated and distant corporate headquarters. While physician's salaries were reduced and personnel were laid off because of mounting deficits, the chief executive officer (CEO) accepted a significant personal salary increase. Similar events have occurred in many other places—all for lack of leadership.

But what is leadership? As Warren Bennis said: "To an extent, leadership is like beauty. It is hard to define, but you know it when you see it." Much has been written on this subject, and much is probably not true. Wiley Souba, MD, FACS, recently offered a good summary of what a number of indi-

viduals from different walks of life have said.[5] I like this description: Leadership defines what the future should look like, aligns people with that vision, and inspires them to make it happen despite obstacles.[6]

Leadership is not a mystical characteristic bestowed upon a few at birth, although it is evident that some have a greater natural aptitude for the role of leader, just as some have a greater aptitude for playing the piano. But only with development of these propensities, their continued use, and fine honing will a true leader or Vladimir Ashkenazy emerge. In that sense, both are an art that must be learned and continually practiced.

Leadership is not charisma, nor is it the same as management, though both may contribute to leadership. Management and leadership have two distinct roles and both are essential to the success of any enterprise. Management means coping with complex organizations and ensuring that things run well, that everyday problems are dealt with, and that there is a steady and continuous performance of the whole. Leadership, on the other hand, requires dealing with change, often unanticipated, whether it comes from external forces, such as HMOs and government, or from internal forces, such as the development of new technology or systems requiring new knowledge and expertise.

Harvard Business School's John Kotter defines leadership by what leaders do: they cope with change, they set direction, they align people to participate in that new direction, and they motivate people.[6,7] Jack Welch, the CEO of General Electric and one of the most successful leaders in industry, says he has three jobs: selecting the right people, locating the capital resources, and spreading ideas quickly.[8] Thus, a leader empowers managers (departmental chairs or chiefs) to become leaders in their own units consistent with the overall goals of the institution.

It has been estimated that only 10 percent or less of the brain power of the employees in any given enterprise is used.[8] What a waste! We cannot afford such underutilization, nor is it fair to those who have committed themselves to the goals of our institutions or groups. In today's world there is no place for the concept that strong leadership is evidenced by an autocratic leader making decisions and telling his subordinates what to do. Louis the XIV's statement: "L'etat c'est moi" ("I am the state") is now a prescription for failure.

Warren Bennis believes leaders should be catalysts.[8] He concludes that in all organizations—whether corporate, military, or political—constituents seek four ideals: meaning or direction, trust in and from their leaders, a sense of hope and optimism, and results. How true when we think of some of America's greatest presidents—Washington, Lincoln, and Theodore and Franklin Roosevelt. As the ancient Chinese philosopher said: "The wicked leader is he who the people despise. The good leader is he who the people revere. The great leader is when the people say 'we did it ourselves.'"

If we intend to survive as a true profession today, we must recognize the need for change or, even better, initiate it. This requires leadership. A leader must have a vision, must communicate this vision to his or her colleagues, and must motivate and inspire them as a team that will succeed in accomplishing these changes.[2]

Change in medicine, as in all other fields, is inevitable, and if we as physicians close our eyes to that inevitability, we will be tossed by the wayside. No longer is the title "Doctor" one that inspires automatic deference and acceptance.

Kotter speaks of eight errors common to efforts toward organizational change and their consequences. His formulations are from and for the business world, yet they also hold true for our own world.[6] They are:

- Allowing too much complacency.
- Failing to create a sufficiently powerful guiding coalition.
- Underestimating the power of vision.
- Under-communicating the vision by a factor of 10 (or 100 or even 1,000).
- Permitting obstacles to block the new vision.
- Failing to create short-term wins.
- Declaring victory too soon.
- Neglecting to anchor changes firmly in the corporate culture.

But why must we as physicians lead? Why not leave it to administrators who are educated and trained in this corporate world? Why not let us do what we were educated and trained to do? Allow us to practice medicine, and let them administer. I believe this is a prescription for disaster and ultimately will work to the great disadvantage of patients. Medicine is not a business, and the differ-

ences between it and a commercial enterprise are profound, although perhaps less well-defined in the current entrepreneurial climate when compared to earlier times.[2,4,10] Who knows better what medicine is all about? Who knows better the core values of medicine and the need for medical education and research than we? These values are part of us; they have been instilled into our being from the day we entered medical school and have been reinforced over the next decade or longer, and this has not changed! Would one give command of an army to an individual well-educated in the realm of logistics, supplies, and strategy but who had never served as soldier or officer?

There is no question in my mind that the best CEOs for medical enterprises are physicians. Physicians not only know medicine, they understand the core mission upon which all else is based. Some have given as justification for physician control over the delivery of health care their supposed moral superiority.[11] This is self-serving and misses the point. It is not that we are necessarily morally superior to any one, but that we understand medicine and that we have been part of the core values of medicine: the welfare of patients, the education of students and residents, and the need for research. This is our professional life. These are the commitments underlying our profession. These values earn the physician leader the kind of respect from his fellow physicians that is reserved only for those of the same professional background.

This is not to say that we can take any well-respected physician, no matter how good a practitioner, and turn him or her into a CEO. He or she must develop skills in management and leadership comparable to those with MBAs. And, this is precisely the problem; some institutions have appointed nonphysician CEOs who do not understand the essence of medicine and who will make decisions that, in the long run, are inconsistent with the mission of the unit. They have managed it as a pure business, and although the pressures to do so are great, it is essential to remember that our primary reason for being is not profit but patient care.

Meanwhile, MD-CEOs have been appointed who don't know how to lead, who haven't the background to deal with the challenges of change, let alone manage the enterprise, and who have neither a vision nor the ability to convey a vision, and if they have these qualities, no capacity for enlisting the support of those needed to turn that vision into a reality. Hence, this is not to say that non-MDs should have no role in the control of health care delivery. Indeed, in many areas lay managers will be superior to us, and should be: in finance, management of support services, and construction, among others. But leadership and direction, the setting of priorities, must come from physicians.

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How, then, is the future "MD-CEO" to be identified and educated? Medical education is already inordinately long, and to take successful physicians away from their practice and income is difficult. We might look briefly at what other organizations and professions have done. The army has had an outstanding record in this regard, as exemplified by American generals in World War II. These officers did not just appear mysteriously, but had been carefully nurtured to take on the huge tasks of landing troops thousands of miles from home, leading them into combat, and keeping them supplied.

It is of interest that the modern concept of educating officers for high command arose only after

a disastrous military experience. In 1806, Napoleon totally defeated the Prussian Army, thought to be the best in Europe. Warfare had changed dramatically with the French Revolution and the subsequent appearance of huge armies of 100,000 men or more. Traditionally, as in Prussia, the leadership of an army had been in the hands of a prince or another noble often of inconsistent or even questionable leadership abilities. A group of young officers and reformers came to believe that Prussia could no longer afford this gamble, but had to educate some of its officers specifically for high command. With the reorganization of the War Academy in Berlin under Karl von Clausewitz, one of the greatest military thinkers and the author of *On War*,[12] and with the development of a general staff of officers highly trained in all aspects of warfare surrounding the commanding general, a new era was brought about with astounding military results. Parenthetically, it might be noted that the second recommendation of the Prussian reformers, to establish a constitutional monarchy with a parliament, was not accomplished and had disastrous consequences for that country as well as for the world.

Virtually all countries followed the Prussian example. The United States was actually quite slow in doing so, but in the 1890s established the Army War College in Carlisle, PA. Almost all future commanding officers would at some point pass through the "Carlisle Barracks" for a period of time.[13]

Today, officers displaying promise for command are initially assigned to army units, then spend several months or more in Carlisle or other command schools. Some even go on to earn PhDs at universities, all in the quest for future leaders.

Industry has learned similar lessons. After the initial explosion of industrial expansion in the second half of the 19th century, led by such entrepreneurs as Rockefeller, Carnegie, and Ford, companies found themselves in need of continuing high levels of management and leadership. Many did not find such and, therefore, did not survive. About 100 years ago, business schools such as the Wharton School of the University of Pennsylvania and the Harvard Business School evolved. Most major universities followed suit, and today an ever-increasing number of the leaders of industry are graduates of these schools.

What can medicine do? A number of physicians have gone to business school and obtained MBAs, which is a two- to three-year process and adds significantly to their educational period. Furthermore, although these programs ground the individual in the fundamentals of management and leadership, some of the specifics related to health care are only partially covered. Noren and Kindig give an excellent up-to-date summary of the status of physician executive development and education.[14] They point out the need for preparation by practical experience for the physician-executive. In addition to a formal educational program, such hands-on preparation is essential because of the diversity and complexity of organizations, people, and professions to which physician executives must effectively relate. Indeed, in the past this was the only method available to future executives and obviously produced some outstanding leaders. Noren and Kindig further point out that two key elements cannot generally be obtained without substantial direct experience: clinical insight and professional leadership competence. Without clinical insight the physician executive does not differ significantly from the nonphysician executive.

In recent years the Thoracic Surgery Research and Education Foundation has initiated a program for cardiothoracic surgeons within the Kennedy School for Public Policy at Harvard University. Surgeons spend from two weeks to as much as two years in this study. The foundation provides a stipend. Although two weeks are obviously inadequate for a future CEO, the experience is of great help to those with administrative positions at the middle level, such as division chiefs and medical directors, especially if such courses are repeated at intervals and at higher levels of sophistication.

It is my firm belief that this sort of program will become even more essential in medicine as the transformation to the corporate model becomes ever more prevalent. Let me stress: the mere placement of MDs in CEO positions will not be sufficient. It has already been questioned on the grounds that we lack the necessary background for these positions. Furthermore, our supposed "moral superiority" is not apparent in the light of current evidence that some physician-led HMOs have supposedly "defrauded" the government, and many physician-owned enterprises have primarily ben-

efitted the physicians. They say until pressured by government or the insurance industry, physicians have not been self-disciplined and judicious in the use of medical technology and treatment.[9,15] It is not our moral superiority but our commitment to the core missions of our profession, based on the priority of patient care, that make us more suited for leadership in medicine.

The future leaders in medicine, in my view, will be fully medically educated and trained physicians with five to 10 years of clinical experience who, either by self-selection or other processes, direct their careers toward leadership positions. They will enter formal programs at universities, designed specifically to add to the leadership capabilities of the future CEO or medical administrator for a minimum of six months to a year, possibly interspersed with a return to administrative and clinical duties for one or two years.

The American College of Surgeons should be commended for initiating a postgraduate course on these matters, but more extensive courses are needed. Such programs should not and generally cannot be underwritten by individual trainees. Support must come from the ultimate beneficiary of these new leaders—medicine. To that end the Thoracic Surgery Research and Education Foundation has set an example. I believe it would be of great benefit to all medicine were the American College of Surgeons, the American College of Physicians, the American Medical Association, and others to undertake a similar program. It fits with the College's mission of education and ultimately will benefit our patients—the final essence of who and what we are and what we stand for.

Such programs should also be supported by matching funds to be given by the parent medical institution of the candidate. It must be recognized that we are not talking about small numbers of individuals needed for leadership positions. If we as a profession fail to provide leadership, someone else will fill this void. As Harold Shapiro, president of Princeton University, has so aptly put it: "A willingness to accept the risk of failure is one of the costs of leadership and, therefore, the price of all success." Ω

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