Crisis in Medicine: Part 3. The Physician as the Captain—A Personal Touch

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"Report to the Administrator's Office for a discussion 7:00 AM sharp," reads the email on your phone. The phone log sheet from your administrator is handed to you as you are running to the operating room and reads, "Call back Mr. Smith's health insurance company because your patient stayed overnight unexpectedly in the hospital, and if the return phone call is not received by 8:40 AM the complete hospital stay will be disallowed." The text message reads, "The head nurse from the emergency department wants to have a discussion with you tomorrow about what transpired in room 23 last night at 1:33 AM." Your physician assistant calls you because a recent history and physical examination from the out-of-state internist has not been cosigned by you, and, therefore, the patient is still in the admitting office; the admitting officer is waiting to go home and won't accept the physician assistant's signature.

This simple illustration of a surgeon's typical morning is hardly hyperbole. Demands and finger-pointing are routine aspects of care, with a concurrent need to attribute blame and create a hostile work environment whether in the office, operating room, or floor of the hospital by anyone who can proudly say to the physician, "Gotcha!" The environment that produces this ethos is toxic and needs to be changed. While all members of a patient care team must be accountable, no member should be antagonistic toward another, and each member must feel a part of a working whole that is led by a competent, caring, and identifiable physician. Yes, the doctor must be the team captain; he or she must take back the reins of care immediately in order to provide the patient with the best possible outcome.

The loss of leadership can be traced back to the rise of regulatory controls put in place by government entities or local hospital administration to contain costs and limit liability. While the target goals of such measures are laudable, the negative impact on the doctor–patient relationship has been palpable and problematic and requires reassessment. The profession itself will be preserved by refocusing on the doctor–patient relationship and returning the physician to the role of team leader. Our patients deserve to feel as though their health care resides in the hands of the physician as the leader of a team that is pursuing a common goal: patient care with minimal distractions.

What, though, makes a great captain or leader? Sociologists have said that in a stable environment a "participatory model" of leadership is appropriate, while in a high-growth or changing environment, like the one in which we presently live, an "authoritative model" can be used to right the ship.[1,2] Many types of leaders exist within both models. Leaders who are "innovators" will design and bring new ideas and original thought but may generate too many ideas that can't be implemented practically in the hospital setting. Leaders who are "developers" will build and move forward to achieve challenging goals but may be impatient when ideas do not work and may be perceived in many interdisciplinary meetings as unruly. "Bureaucratic" leaders, presently seen in many leadership positions, can be classified as stabilizers and, while they may maintain equilibrium and keep things running smoothly, they often insist on a policy for every situation, resulting in stasis and sometimes even paralysis of the surgical center or hospital system.

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I believe that health management and patient care require the simultaneous use of the authoritative and participatory models to encourage innovation, set attainable short- and long-term goals, and maintain the physician as the team leader. To

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lead effectively under this hybrid model, the physician must be accessible and fair, a teacher and a student, and a risk-taker, but, ultimately, at the end of every day, the physician must be accountable.

The time has come for physician leaders to assemble the troops: administrators, clinical providers, and nonclinical support staff. To paraphrase John Quincy Adams, in your actions inspire others to dream more and become more; then, and only then, are you an excellent leader. A secret to effective leadership is in finding one's voice and acknowledging strengths and weaknesses. The leader must recruit other leaders who are very different from himself or herself and must listen to them deeply and trust them completely. One of our former first ladies said wisely, "A leader takes people where they want to go. A great leader takes people where they don't necessarily want to go, but ought to be." To truly find this leadership model, we as busy surgeons must spend some concentrated time away from our patients and exciting research to sit in the room with our nurses, administrators, and all other members of the health care community and listen to their thoughts and understand their concerns. We must understand policy to assess if it is reasonable and, if it is not, to reject it and propose more effective and appropriate rules for good care. We must remove from leadership positions those that do not have the interest of the patient as their primary concern. We must challenge any policy that does not have the patient's interest and health as its raison d'etre. We must be proactive and not reactive. We must be ready to stand tall and politely question when dictated to unless evidence-based medical reasons can be presented.

You may ask, therefore, where should we lead? The answer is obvious! We need to be involved in every aspect of this great profession. We need to be the leaders of hospital systems, we need to be in charge of research institutions, and, as always, we need to be the chief of the operating room and the chief within each room as the team leader for the nurse, anesthesiologist, and nonclinical staff in order to safely guide our patients through the stress of a medical crisis or routine intervention. We need to find those of us with other degrees, whether MPH, MBA, MHA, or JD, and place those physicians in positions of business and political leadership as well as in leadership positions in hospitals and private practitioner offices. We need to encourage our medical students, residents, and fellows to continue their rigorous training to include an understanding of health care policy and economics so as to help manage and resolve the crisis at hand.

We must now navigate the sea of change to allow for continuity of care and not throw up our arms in despair. The role of physician as private practitioner or as full-time faculty member has its origins deeply imbedded in the roots of our profession, and this traditional role as caretaker and scientist must continue. But in this century, we need to be leaders in the political and business communities as well. This vision requires a new and fresh momentum. We cannot sit idly by as patient care becomes increasingly managed by nonphysicians. The time has come to use our unique position as doctors to frame the debate, participate in the discussion, and lead our profession and the management of health care toward calmer waters with compassion, science, and responsibility. To do this, we must demand transparency, proceed with respect, and require excellence from everyone around us and make sure it is demanded from all of us. ■

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