Rovenstine Lecture

Who Will Lead Us?

Francis M. James III, M.D.*

THERE is a story reputed to have been told by Nasreddin Hodja, a 13th-century character who is deeply ingrained even in modern day Turkish folklore. Hodja was an imam or religious leader for his village, a dervish for two famous Islamic mystics: a judge and a university professor. Stories about him and his wisdom have abounded for more than seven centuries.

In this particular story, Hodja went to the pulpit, but before he started his sermon he asked the congregation, “Do you know what I will be talking about today?” “No,” answered the congregation. “If you don’t know, then what can I tell you?” he replied and walked away. Next week, he went to the pulpit and asked the same question. This time the congregation answered, “Yes, we do.” “If you do, then there is nothing I can tell you,” Hodja said and walked away again. Members of the congregation decided that if Hodja asked the same question again, half of them would say “yes” and the other half would say “no.” The following week, Hodja went to the pulpit and asked the same question again. As they had decided, half of them said, “Yes, we do,” and the other half said, “No, we don’t.” “In that case, those who know tell the ones who don’t know,” said Hodja and walked away again.

From the title of my talk, “Who Will Lead Us?” many of you might anticipate what I am going to say. However, you will not escape as easily as Hodja’s congregation because I plan to talk for several more minutes.

I am honored and grateful to have been asked to present the Emery A. Rovenstine Memorial Lecture. Dr. Rovenstine was one of the foremost leaders of our specialty. In 1949 his department at New York University was one of only two independent departments of anesthesiology in the United States, but even before that, in 1945, he organized the first Post Graduate Assembly in Anesthesiology in New York. This meeting was designed to offer a high-level refresher opportunity for returning veterans and represented an early effort to provide continuing medical education in our field. Manny Papper has said, “The clinical experience with Rovenstine was wonderful in its excellence. At the time of my residency, he was a great teacher and a marvelous clinician who was highly respected by all of the surgeons in the three university divisions at Bellevue. He made a major impact on anesthesiological practice in New York City by bringing the Water’s message of excellent science supporting and modifying clinical practice for the benefit of patients.” Obviously Dr. Rovenstine served as a leader by his teaching and clinical care, by earning the respect of others, by serving as a role model, and by seeking the best for his patients.

Leadership has been defined as the ability, duties, or art of leading, the art of directing and guiding others; the ship that leads the way. I prefer the definition of Robert Hogan, McFarlin Professor of Psychology at the University of Tulsa, who defines leadership as “the ability to persuade a group to set aside individual preoccupations in order to pursue a common goal.” Our common goal must be the welfare of the patient and should clearly guide all else that we do.

We require leadership in our specialty, but we should also think past the boundaries of anesthesiology. We have a proud tradition and must never allow others to impose feelings or beliefs of inferiority on us. Our specialty stands tall within the medical profession as anesthesia clearly represents one of the greatest advances
ever made in medicine. Before anesthesia most surgery was impossible, and that which was done carried with it agony, incredible stress, and horror. Before anesthesia, the annual reports of Massachusetts General Hospital for 1821–1846 recorded only 333 surgeries, less than one per month. As a student of medicine in Edinburgh in 1828, Charles Darwin observed two operations, one of which involved a child. He fled before either operation was completed and subsequently stated, "The two cases fairly haunted me for many long years." Myrtle Simpson reported on the reaction of Sir James Young Simpson (1811–1870), the great Scottish obstetrician, to his witnessing a patient’s pain during surgery:

Simpson at that time was quoted as saying: “Can nothing be done to make operations less painful?” He had asked himself this question many times again. His contemporaries suppressed their feelings at their patient’s agony. As Simpson said, “The surgeon could bear the patient’s pain no doubt somewhat easier than the patient.” Speed was all they could offer the patient faced with an operation. America’s leading obstetrician, Charles Meigs, declared that actually pain did a woman a lot of good. “Notwithstanding I have seen so many a woman in the throes of labour, I have always regarded a labour pain as a most desirable salutary and conservative manifestation of life force.” He had no danger, of course, of experiencing this himself.

In an article in the September 1996 ASA Newsletter, John T. Sullivan, a CA-2 resident wrote,

Before surgery, patients felt like condemned criminals awaiting execution, and if they survived the experience, the memory haunted them for the rest of their lives. In a letter written to Simpson, a fellow physician who underwent amputation of the limb said, ‘I at once agreed to submit to the operation but asked a week to prepare for it, not with the slightest expectation that the disease would take a favorable turn in the interval, or that the anticipated horrors of the operation would become less appalling by reflection on them, but simply because it was so probable that the operation would be followed by a fatal issue. . .’ Of the procedure, he recollected, ‘suffering so great as I underwent cannot be expressed in words. . . The particular pangs are now forgotten, but the blank whirlwind of emotion, the horror of great darkness and the sense of desertion by God and man . . . I can never forget, however, gladly I would do so . . . Those are not pleasant remembrances . . . and even now they are easily resuscitated and . . . they can occasion a suffering of their own.’

The oldest operating room in Britain was in use at St. Thomas’ Hospital from 1822 to 1861. The wooden operating table may have sparked fears and thoughts in the patient worse than those invoked by the electric chair today. The horrors of the room became more alive as people filled it, as depicted in a rendition of an amputation at St. Thomas in 1775–1776 (fig. 1). Although today we have the technical ability to eliminate safely many of the terrifying elements of surgery, most patients are still fearful. Each of us can serve as role models to the rest of the operating team and as comforters to our patients through caring, calming, and appropriate touch. We can hold a frightened patient’s hand or give a reassuring pat on the shoulder. The British call operating rooms operating theatres. Anesthesiologists need to remember that people are watching our performance in the ‘theatre.”
and our leadership in caring, as well as in other responsibilities, must be exemplary.

Most likely, the operating room will always represent the primary focal point for anesthesiologists, but our leadership is required in many additional areas. We serve an important function during labor and delivery, pain management, critical care medicine, the postanesthesia care unit, and the preoperative assessment clinic.

For the most part, intraoperative pain has been conquered. We have the ability currently to combat postoperative pain and, through continuing research, will be even better equipped to do so in the future. It will take our leadership to provide better care in regard to postoperative pain, for much as the forerunners of our surgical colleagues misunderstood and feared anesthesia in the mid-19th century, surgeons today often follow the same pattern regarding the management of postoperative pain.

The rampant use of “conscious sedation” in inappropriate locations by people with inadequate knowledge and training presents us with a special challenge. Only through effective leadership and tireless effort will we be able to improve the safety of patients receiving conscious sedation.

As the pattern of patient care has evolved to improve efficiency and to reduce cost, anesthesiologists have the opportunity and responsibility of directing the flow of patients through the system to a greater extent than ever before.

We must be patient advocates. We must foster the best physical, psychological, and spiritual care for the patient. The creation of the Anesthesia Patient Safety Foundation in 1985 exemplifies our leadership in this area and has recently served as the model on which the American Medical Association has based its National Patient Safety Foundation.

Anesthesiologists are well equipped to provide leadership within the institutions in which they work. Strategic planning, quality improvement, management, and economic and policy issues all demand our participation. Our diplomatic skills and involvement in many activities and locations within and outside the hospital provide us with a valuable perspective. We can often approach problems with less bias and less vested interest than physicians from other disciplines, which makes our participation and leadership even more important.

We have made tremendous progress in the science of anesthesiology since the days of mandragora, henbane, poppy, and alcohol, but important questions remain to be answered, and better and safer drugs, techniques, and equipment need to be developed. In our specialty we must continue to embrace research as important to the improved care of patients in the future. We must support our research endeavors. Individual investigators must be willing to play influential roles at the NIH, FDA, and other organizations of critical importance. Anesthesiology, Anesthesia & Analgesia, and other journals that publish our research require leaders as well. Their editors and editorial boards have great influence within our specialty.

The work of Michael Good, M.D., of the University of Florida, and David Gaba, M.D., at Stanford, in the development of simulators represents innovation and leadership in teaching. We have made progress in interactive computer-based learning and the use of videotaping clinical performance followed by feedback sessions. We need people to lead us toward more new approaches to teaching and improving the environment for trainees.

This environment needs to be improved as educators have commented that residents and medical students often exhibit the behavior of abused children. What does this imply in regard to the kinds of physicians they will ultimately become? We do not need downtrodden, bitter, angry, and cynical physicians. Trainees must learn, but we, their teachers, must also have high regard for the whole person and his or her life outside medicine. The writer Carolyn Coats says, “Children have more need of models than critics.”12 and Albert Schweitzer stated, “Example is not the main thing in influencing others. It is the only thing.”13 Clearly our residents and students will benefit more through observing excellent role models rather than via intimidation and abuse.

Substance abuse represents a major concern for the specialty of anesthesiology, the medical profession, and society as a whole. Unfortunately, our specialty has more experience with this problem than we would prefer. We must allow this experience to provide us with the knowledge, expertise, and motivation to help confront this issue in our hospitals, specialty, community, schools, and state and national governments. The video Wearing Masks,14 which Thomas F. Hornbein, M.D., played a major role in producing, powerfully illustrates the tragedy substance abuse can bring about. Our involvement at a leadership level can help prevent some of these tragic stories.

Our scientific knowledge and technical ability have outstripped the philosophic and theological beliefs and principles we have applied to decision making in the past. We must lead in the area of medical ethics. The
March 1998 ASA Newsletter focus on end-of-life issues and medical ethics was timely and an example of Mark J. Lema’s effective leadership in reminding us of our broader responsibilities as physicians. Assisted suicide, euthanasia, resuscitation, capital punishment, organ transplantation, and the rationing of medical care are but some of the difficult issues that require our thought, input, and leadership. We must practice medicine guided by high ethical standards. We must expect and demand the same of our colleagues and be responsible for counseling and confronting those who abuse the privilege of practicing medicine.

Our leadership must also be present within the medical staff of our hospitals; the community; local, state, and federal politics and governments; our county, state, and national medical societies; our state component anesthesiology societies; and the American Society of Anesthesiologists. The Anesthesia Patient Safety Foundation, The Wood Library-Museum of Anesthesiology, The Foundation for Anesthesia Education and Research, The Association of Anesthesiology Program Directors, The Society of Academic Anesthesiology Chairs, The ASA Resident Governing Council, and the AMA Resident Physician Section represent some of the organizations within our own discipline that need our leadership.

Perhaps the most important reason to become involved in leadership is the rapidity of change today in what we have perceived in the past as a relatively stable medical environment. Life and the world do not stand still. We must involve ourselves with change. Kouzes and Posner in their book The Leadership Challenge write, “People have a tendency to resort to self-pity when they are hurt by corporate downsizing, a shift in national policy or stormy winds of nature. But those who rise through adversity don’t allow themselves to be resentful, bitter, or alienated. Instead they become engaged, involved, and committed.”16 Kouzes and Posner note, “Leaders’ expectations have their strongest and most powerful influence in times of uncertainty and turbulence. When accepted ways of doing things aren’t working well enough, leaders’ strong expectations about the destination, the processes to follow, and the capabilities of the team serve to make dreams come true.”17 Through effective and dedicated leadership each of you can help to turn adversity into opportunity. Optimism and hope can help you to deal effectively with change. Complacency, pessimism, defeatism, cynicism, and negativity do not produce solutions and are contagious and destructive. They will not get the job done!

In Lewis Carroll’s Alice’s Adventures in Wonderland, the Cheshire Cat responded to Alice’s request for directions by telling her that it did not matter much which way she went because since she didn’t know where she wanted to go. We cannot cope with change if we do not define our mission and our goals and abide by the measure of what best serves the needs of our patients, the public, and society as a whole.

The qualities important in leaders (table 1) are too numerous to expound on individually, but I shall take time to enlarge on a few. Creativity and clearly articulated vision are musts. With time and thought, each of you can have vision. Last spring I met with Richard Burr, US Congressman from the Fifth District of North Carolina, to discuss the Health Care Financing Administration’s proposed changes in Medicare regulations. Although in sympathy with his thoughts, he stated that unless we wanted government to incrementally legislate how we practice medicine, physicians and their organizations must carefully outline their goals for health care, determine how to deliver it effectively, and devise realistic plans to pay for it. As individuals and as medical societies, we need to respond to his challenge. Too often we expect our organizations and societies like the American Society of Anesthesiologists, the American Medical Association, The American Board of Anesthesiology, and so forth, to protect us and to solve problems for us without any participation on our part. Each of us must help find solutions to medicine’s current problems.

Communication holds a special place in leadership. How do others know our thoughts and vision unless we effectively express them? Listening also plays an important part in communication. As Kouzes and Posner state, “Listening to what other people have to say and appreciating their particular viewpoints, demonstrates respect for others and for their ideas. Sensitivity to people’s needs and interests is an important ingredient in building trust.”18 We must listen to the needs, ideas, and concerns of our patients, nurses, surgeons, hospital administrators, and society as a whole. Our patients’ good health, efficient and cost-effective delivery of health

Table 1. Qualities of Leaders

<table>
<thead>
<tr>
<th>Vision</th>
<th>Optimism</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creativity</td>
<td>Fairness</td>
<td>Honesty</td>
</tr>
<tr>
<td>Communication</td>
<td>Consideration</td>
<td>Competence</td>
</tr>
<tr>
<td>Persistence</td>
<td>Intelligence</td>
<td>Enthusiasm</td>
</tr>
<tr>
<td>Integrity</td>
<td>Practicality</td>
<td>Energy</td>
</tr>
<tr>
<td>Ethical concern</td>
<td>Loyalty</td>
<td>Courage</td>
</tr>
<tr>
<td>Credibility</td>
<td>Commitment</td>
<td>Compassion</td>
</tr>
<tr>
<td></td>
<td>Understanding of change</td>
<td></td>
</tr>
</tbody>
</table>

Anesthesiology, V 90, No 6, Jun 1999
care, teamwork, the financial stability of the hospital in which we practice, and an excellent community in which to live represent values and goals shared by all of society. We can be leaders by helping others reach mutual goals, not necessarily our more self-centered ones.

Carolyn Coats aptly states, “Leaders are ordinary people with extraordinary determination.”19 Throughout my own career I have found that if one’s goal is the right one and if one is patient and persistent, the goal will often be achieved. Small advances can progress into much greater successes, but we also learn from failures as well as from successes. How many times did Thomas Edison fail before inventing the light bulb? How many times did Abraham Lincoln lose elections before becoming President? Failures will occur; leaders are human, not perfect. Few politicians or military strategists living in the middle of the fourth century B.C. would have predicted that Rome would conquer the world. Rome did not have the powerful navies of city-states like Alexandria, Athens, Syracuse, or Carthage; but they had an army and determination. They persisted in fighting and winning border wars, and these incremental successes ultimately led to world conquest.20

Lastly, a leader must have integrity. For me a Buddhist verse best expresses this: “When leading, be generous with the community, honorable in action, sincere in your words. As for the rest, do not be concerned.”21 Be aware that “leadership is also a performing art—a collection of practices and behavior—not a position.”22 One cannot lead without followers. I came across an e-mail one day that said, “If you’re ridin’ ahead of the herd, take a look back every now and then and to make sure it’s still there.” We must clearly articulate our values and principles if we are to keep our followers behind us.

At the same time, good leaders must also be good followers. Those who follow have the responsibility to advise, educate, be supportive of, and communicate with their leaders. Followers must be part of the solution, not part of the problem. They have the responsibility to elect or appoint effective leaders and to change leaders if that becomes necessary.

So far I have not mentioned who will serve as our leaders. To me the answer to that question is obvious! You, each of you must in your own way serve as a leader. Leadership is not limited to or reserved for academic, male Q-tips, like myself, but rather is required of all of us. Women currently comprise 20% of the ASA membership and 26% of our resident physicians. This number will continue to increase as more women are pursuing careers in medicine. Our history contains numerous effective female leaders, including Margery Van Deming, Virginia Apgar, Gertie Marx, and Betty Stevenson, who has served as our own president. Our specialty must not ignore this source of leadership nor can women fail to fulfill the responsibility of leadership. We need to be more supportive of flexibility in the workplace to improve family life and to be more inclusive of women. By working to reduce the stress of modern society and more fully use the abilities and skills of women, we can increase the enjoyment of medical practice, reduce burnout, and ultimately offer better medical care.

Fifty percent of our membership is aged 44 years or younger. Resident physicians represent nearly 11% of the ASA membership. Henry V of England led an army into battle against the Welsh at age 15 and at 16 was placed in charge of putting down Owen Glendower’s rebellion.23 The Macedonian king and conqueror, Alexander the Great (356-325 B.C.), reputed to be the finest battlefield commander of the ancient world, held his first battlefield command at 16, at 18 led the Macedonian cavalry in a battle that won control over all of Greece for his father, King Philip, and began his own reign at age 20. We need fresh ideas and innovation. We need the energy and enthusiasm of our younger members. We must embrace the participation of women and our younger members, and they in return must step forward to participate. Those in private practice must serve in the future as you have in the past. Without your input and participation, neither the ASA nor its component societies would be representative, worthwhile, or effective organizations. Those in academic medicine must not allow yourselves to believe that your ivory towers provide security. The past few years are full of examples of the vulnerability of the university medical centers. If we are to maintain the important missions of education and research we will need effective and uniting leadership. If we fail in this quest, the infrastructure so important to the excellence of the medical profession in the United States will crumble. Each of us, young or old, male or female, private practitioner or academician must take part in leading us forward. Again, from Kouzes and Posner, “It is not necessary to be a famous, charismatic person to inspire a shared vision. It is necessary to believe, however, and to develop the skills to transmit that belief.”24 Focus on what is to be gained rather than what is to be lost. Reject the ineffective strategy of “hunkering down” in the operating room. Be visible. Demonstrate your own value and that of our specialty through participation in perioperative care; hospital

Anesthesiology. V 90, No 6, Jun 1999
management; hospital and medical school committees; local, state, and national medical organizations; and the communities in which you live.

Think ahead to the future. What will surgery and anesthesiology look like in 10 to 15 years? What will these changes mean to the number and types of people in the workforce? Less invasive surgery, total intravenous anesthesia, increasing numbers of anesthesia sites outside the operating room, growth in outpatient surgery, and an increasing presence of office-based anesthesia represent but a few of the changes already on us and bound to become more common in the future. We must work proactively to improve the health care system as opposed to reacting to changes imposed on us by government and business.

We can call to task peers who practice medicine unethically. We can provide anesthesia coverage for obstetrics, an area many practices ignore because of night and weekend obligations. We can schedule to ensure physician coverage around the clock. Some anesthesiologists practice good medicine from 7 a.m. to 5 p.m. on weekdays but delegate the responsibility for total patient care to nurse anesthetists during less attractive hours.

Flawed interpersonal skills are an important cause of failure in business, medicine, and personal life. Academic departments must develop their residents' interpersonal skills. Remember, examples are followed more often than advice.

We must use medical resources appropriately. The amount of money spent during the final year of life for the older members of society dwarfs that directed toward maternal, infant, and child care. Perhaps we should rethink our priorities and invest more time, effort, and money in areas of medicine that potentially offer benefits measured in years rather than in days or months.

Should we develop combined residency programs? They might offer positive opportunities. For example, a physician who has completed a combined anesthesiology–family medicine or anesthesiology–emergency medicine program might choose a rural community in which to practice, which would use their skills and knowledge in both fields and offer adequate financial support. Combined programs could form a small step toward increasing the number of anesthesiologists practicing in rural hospitals.

We must recognize the multidisciplinary aspects of pain management. The problem of pain holds special meaning and interest for anesthesiologists. The prevention of and relief from pain represent the core of our practice. We cannot ignore the importance of the psychological and rehabilitation components of pain and must not view pain management as a turf issue, but instead work to encourage and include the valuable contributions that other disciplines have to offer to the patient.

Office-based surgery and therefore office-based anesthesia are a rapidly increasing reality. We cannot ignore this phenomenon but must strive to ensure that appropriate standards and safety precautions are followed. The New Jersey Society of Anesthesiologists has shown effective and exemplary leadership in this area. We must also educate and influence our surgical colleagues regarding both the appropriateness and the inappropriateness of office-based procedures for specific operations and patients.

Should we make a home in the American Society of Anesthesiologists for those certified registered nurse anesthetists (CRNAs) who support the care team approach and understand the importance of medical direction by anesthesiologists? Should the ASA play a role in the education of CRNAs? Should certification by physician-governed organizations be offered to nurse anesthetists? Many CRNAs oppose the attitudes and positions of the more militant members of the American Association of Nurse Anesthetists. Would offering the opportunity of membership and participation in the ASA to those nurse anesthetists who share our philosophy improve our specialty and patient care?

Telemedicine presents opportunities to anesthesiology specialty as it does to other branches of medicine. When health care professionals learn to use telecommunications technology to communicate with each other and with patients, they will improve the delivery of health care. Computers, video conference equipment, and telecommunications networks help extend diagnostic and educational services. Two possible applications of telemedicine for anesthesiologists are the preanesthetic evaluation of patients living far from the facility where surgery will be performed and support for anesthesia personnel working in rural hospitals. Telemedicine could maximize patient convenience through reducing travel, support community physicians for consultative and referral services, extend traditional geographic service areas, offer more cost-effective services, and provide medical education to remote locations.

Conscious sedation performed by undertrained people with inadequate knowledge and skills presents a major dilemma for anesthesiologists. How can we effectively set and enforce the appropriate standards for patient safety in our own institutions? Perhaps we should offer conscious sedation services by developing and staffing specific clinics in appropriate locations and providing

Anesthesiology, V 90, No 6, Jun 1999
scheduled times for inpatient and outpatient procedures requiring this kind of sedation.

We must improve our teaching methods. People retain approximately 9% of the information provided during traditional didactic lectures. Perhaps problem-based learning would improve retention. Interactive computer-based learning and simulators are already available, but ripe for greater use.

The number of students selecting anesthesiology for a career, 388 in 1998, has begun to recover from the nadir of 169 American medical students who did so in 1996, but the number of positions available as advertised in Anesthesiology and the numerous practice opportunities being offered to senior residents and junior faculty would indicate we could be headed toward a shortage of anesthesiologists despite the workforce predictions of a few years ago. Those in university settings need to inspire a sufficient number of the best students to enter this field. This means showing the students that we care about them and their education, participating in teaching the basic sciences, establishing anesthesiology interest clubs, allowing students to work with simulators, ensuring clinical rotations and research opportunities in anesthesiology, and serving as excellent role models.

All of the above problems and ideas call for effective leadership. Every one of us has the opportunity and responsibility of leadership. Every one of us will reap the rewards that accompany it. Henri Nouwen, a well-known religious leader, offers some advice for effective leadership: "Remain flexible without being relativistic, convinced without being rigid, willing to confront without being offensive, gentle and forgiving without being soft, and true witnesses without being manipulative." These same thoughts would serve leaders in many aspects of life, including the anesthesiology specialty. When invited by William J. Mayo to join the Mayo Clinic in 1924, John S. Lundy, M.D., resolved to "make one contribution to anesthesia for each of the 35 years which lay ahead." His words provide a challenge to each of us.

We cannot afford to answer the question, "Who will lead us?" with the response, "Who cares?" Each of us must care, and each of us must serve.

References

5. Hogan R. What we know about leadership. Acad Leader 1997; 13(1)
7. Simpson M; Simpson the Obstetrician. London, Victor Gollancz Ltd., 1972, p. 121
8. Ibid.
11. Whitman N: Creative Medical Teaching. Salt Lake City, Utah, Department of Family and Preventive Medicine, University of Utah School of Medicine, 1990, p 160
15. End-of-life issues and medical ethics. ASA Newsletter. 1998, 62:
17. Ibid., p 274
18. Ibid., p 168
20. Reid TR: Roman Empire. Nai Geogr 1997; 192:2-41
24. Kouzes and Posner. Leadership Challenge, 125
25. Kouzes and Posner. Leadership Challenge, 125