

EDUCATION

The professional responsibility model of physician leadership

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Physician leaders are confronted by numerous challenges on a daily basis. These range from making decisions about improving patient safety¹⁻³ to managing disruptive physician behavior,⁴ the allocation of organizational resources,⁵ securing cooperation from reluctant colleagues for the use of evidence-based guidelines,³ and obtaining vital resources from organizational leaders who promise prompt action and then obfuscate and delay.⁶ These challenges require effective management, which includes attention to the ethical issues at the core of many of these leadership challenges. The purpose of this article is to provide physician leaders with guidance for identifying and managing common leadership challenges on the basis of the professional responsibility model of physician leadership that is based on the professional responsibility model of obstetric ethics.⁷

The professional responsibility model of physician leadership emphasizes leadership as a way of life. In short, leadership is a philosophy. To articulate leadership as a philosophy and explicate the professional responsibility model, we draw on the work of historical figures

The challenges physician leaders confront today call to mind Odysseus' challenge to steer his fragile ship successfully between Scylla and Charybdis. The modern Scylla takes the form of ever-increasing pressures to provide more resources for professional liability, compliance, patient satisfaction, central administration, and a host of other demands. The modern Charybdis takes the form of ever-increasing pressures to procure resources when fewer are available and competition is continuously increasing the need for resources, including managed care, hospital administration, payers, employers, patients who are uninsured or underinsured, research funding, and philanthropy. This publication provides physician leaders with guidance for identifying and managing common leadership challenges on the basis of the professional responsibility model of physician leadership. This model is based on Plato's concept of leadership as a life of service and the professional medical ethics of Drs John Gregory and Thomas Percival. Four professional virtues should guide physician leaders: self-effacement, self-sacrifice, compassion, and integrity. These professional virtues direct physician leaders to treat colleagues as ends in themselves, to provide justice-based resource management, to use power constrained by medical professionalism, and to prevent and respond effectively to organizational dysfunction. The professional responsibility model guides physician leaders by providing an explicit "tool kit" to complement managerial skills.

Key words: ethics, leadership, professionalism

that is relevant to the ethics of physician leadership (the Table, in which figures are listed in the order in which their ideas are utilized). We then deploy the professional responsibility model of physician leadership to provide guidance for physician leaders at the individual and organizational levels.

Leadership as a philosophy

Leadership as a philosophy includes the ability to articulate a vision and implement strategies requisite for accomplishing the mission, managerial competence, and, especially, appropriate ethical values. Management knowledge and skills are essential components of leadership. It cannot be overstated that health care organizations are no exception to the general managerial dictum that revenues must exceed expenses. In the absence of excess revenues, no physician leader can capitalize an organization's future and the organization's viability will decline and possibly cease to exist. In addition, physician leaders must develop, implement, and enforce policies and practices that ensure both the quality and service in a cost-efficient manner. Physician

leaders must not lose sight of the fact that medicine is not primarily a business but they also must be committed to the competent management of the business aspects of medicine.⁸

The core component of leadership as a philosophy is appropriate ethical values. Ethical values should shape mission and requisite strategy and guide management decisions. Plato (424–348 BCE) articulated perhaps the most influential philosophy of leadership in the Western tradition in his classic work, *Republic*⁹ (Table). For Plato, the best leader is the philosopher king, someone who has been rigorously trained for years in the life of service to those subordinate to his power. This is a demanding way of life, in which the philosopher king understands his own interests entirely in terms of the interests of the citizens of the republic, who are subordinate to his power. In the technical language of ethics, the philosopher king has the fiduciary and fundamental responsibility to protect and promote the interests of subordinates and keep self-interest systematically secondary.¹⁰ This commitment provides direc-

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TABLE
Historical figures relevant to modern medical leadership

Philosophical figure	Dates	Relevance
Plato	424-348 BCE	Commit to the life of service
John Gregory, MD	1724-1773	Maintain professionalism in the clinical setting
Thomas Percival, MD	1740-1804	Maintain professionalism in the organizational setting
Immanuel Kant	1724-1804	Respect persons, especially those subordinate to one's power
Aristotle	384-322 BCE	Pursue justice in the allocation of resources
Thomas Hobbes	1588-1679	Prevent the calamity of irresponsibly managed power
Niccolo Machiavelli	1469-1527	Analyze and address dysfunctional organizational cultures

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tion and purpose to the leadership role. Without this commitment to the life of service and the direction it provides, Plato rightly feared that leaders will become predatory and subordinates unacceptably harmed.^{9,10}

A modern expression of platonic leadership philosophy can be found in the work of one of the most highly regarded scholars of management science, Peter Drucker (1909-2005). Drucker succinctly summarized leadership as a philosophy in a way that Plato would instantly recognize: "Leadership without direction is useless . . . As the pace of change in our world continues to accelerate, strong basic values become increasingly necessary to guide leadership behavior."¹¹

The professional responsibility model of physician leadership

Two physician-philosophers articulated the ethical concept of medicine as a profession and the professional virtues that should guide physician leaders. John Gregory (1724-1773) addressed medical professionalism in the practice of medicine (Table). Thomas Percival (1740-1804) addressed medical professionalism at the organizational level (Table). They did so to correct the entrepreneurial, self-interested, and guild-interested practice of British medicine in the mid and late eighteenth century and forge medicine into a profession worthy of the name.¹²

Gregory trained at the medical schools in Edinburgh and Leiden. Both medical

schools were deeply influenced by the scientific and clinical teaching of Hermann Boerhaave (1668-1738). Boerhaave's conception of medicine and teaching were steeped in Francis Bacon's (1561-1626) philosophy of medicine. Bacon called for physicians to improve medicine on the basis of "experience," the accumulation of data from carefully observed processes and outcomes of patient care. Gregory repeatedly cited Bacon as a major influence.^{12,13}

Gregory became Professor of Medicine in Edinburgh in the last 7 years of his short life, where he gave extended lectures on medical ethics before taking students to the Royal Infirmary of Edinburgh for their clinical instruction. Gregory turned these lectures into the first text in English on professional medical ethics, in which he introduced the ethical concept of medicine as a profession.^{12,13} One of his motivations was to replace the marketplace model of relentless self-interest, which resulted in rampant distrust, with the life of service to patients, which will earn patients' trust. For example, "man-midwives," physicians trained in obstetrics and exclusive users of the then-advanced technology of forceps, competed intensely with female midwives for the small market of well-to-do women who could afford to purchase their services. Gregory's concern was that pregnant women were ill served by this competition unregulated by professionalism, which is not acceptable.

Competition guided by professionalism is acceptable.¹³

His concept of medicine as a profession has 2 components. The professional physician commits to intellectual excellence by becoming and remaining scientifically and clinically competent and then practicing medicine to exacting scientific standards. Using the language of Bacon, Gregory called for physicians to submit clinical judgment and practice to the discipline of experience-based reasoning. In doing so, Gregory anticipated by 2 centuries what is now known as the deliberative, evidence-based practice of medicine. The professional physician also commits to moral excellence. The physician does so by committing to the protection and promotion of the patient's health-related interests as the physician's primary concern and motivation and to keeping self-interest consistently secondary. The physician also commits to moral excellence by keeping the group interests of physicians, expressed for example in attempts by man-midwives to ban female midwives from obstetrical practice, systematically secondary. Percival captures this component when he called for physicians to treat medicine, not as a merchant guild, but as a "public trust."¹⁴

Percival complements Gregory's focus on clinical practice by addressing organizational ethics. Percival was an accomplished scientist, public health advocate, moralist, and community leader. His *Medical Ethics* was the first book thus entitled in the global history of medical ethics.¹⁵ Percival's *Medical Ethics* became the inspiration for the first modern national code of medical ethics, the 1847 Code of Medical Ethics of the American Medical Association.¹⁶

Percival was concerned about the fierce competition among the physicians, surgeons, and apothecaries at the Royal Infirmary of Manchester, England, which, at times, resulted in profound organizational dysfunction. He called for the creation of an organizational culture of professionalism, based on the mutual, evidence-based accountability of physicians and surgeons, who were still separate guilds (known as the Royal Colleges), to improve the quality

of the processes and outcomes of patient care. He also called for organizational resources to be based primarily on the ethical principle of beneficence and not primarily on economics.

One distinctive feature of Gregory's and Percival's medical ethics is that they identified the clinical implications of the concept of medicine as a profession by appealing to 4 professional virtues.⁸ The leadership counterparts of these professional virtues constitute the professional responsibility model of physician leadership. Together the professional virtues give ethical substance and direction to the physician leader's role, complementing managerial skills.

The first is *self-effacement*, which obligates physician leaders to be unbiased. They should not show favoritism to their own specialties or friends in a health care organization or on the basis of gender or shared academic pedigree.¹⁰ Nor should they show favoritism in decisions about resources in a merged institution, in which they were formerly in a leadership position in one of the components. The second is *self-sacrifice*, the willingness to risk individual and organizational self-interest, especially in the economic domain. Physician leaders must pay attention to the bottom-line (no margin, no mission) but they should not focus exclusively on the bottom-line. They should, instead, value economics as a tool rather than an overriding value. The organization's mission should be the guiding value. Self-sacrifice obligates physician leaders to take risks for the organization's legitimate fiscal self-interest when necessary to accomplish mission, eg, in securing funding for essential clinical services that do not make a profit.¹⁰ The third is *compassion*, which obligates physician leaders to be aware of and respond with appropriate support to the distress of colleagues and staff. To fulfill this obligation, physician leaders should routinely ask, "What can I do to help?" The fourth, and bedrock, virtue is *integrity*, which obligates physician leaders to make management decisions on the basis of intellectual and moral excellence. Intellectual excellence requires clinical care, research, and education to have a strong evidence base. Moral excellence

requires putting the interests of patients first and keeping individual and organizational self-interest systematically secondary. Adherence to self-effacement, self-sacrifice, and compassion is the key to achieving moral excellence. Indicators of integrity in physician leaders, by which they should be judged, include open and honest communication, accessibility, and accountability.

The ethical concept of medicine as a profession emphasizes a reality of which Percival was especially aware: physicians will be able to achieve sustainable professionalism only in the context of a supportive organizational culture. Physician leaders bear the responsibility for creating sustainable cultures of organizational professionalism, permeated by the effects of routinely fulfilling the obligations of the 4 professional virtues of physician leaders.^{8,10}

Deploying the professional responsibility model of physician leadership

Professional treatment of colleagues

Professional treatment of colleagues requires that they be treated with respect. The moral philosophy of Immanuel Kant (1724-1804) is essential for understanding what "respect" means. Kant's enduring contribution to the global history of moral philosophy is his categorical imperative.¹⁷ This perhaps forbidding phrase means that we should treat each other as ends and not simply as means to achieving one's own or an organization's interests. When leaders treat colleagues as ends and not mere means, leaders show respect for each colleague as a person. In health care organizations, the end that all should seek for themselves is professionalism, which has received great emphasis in the medical literature.¹⁸ Physician leaders can implement the professional responsibility model and the categorical imperative by supporting and rewarding professional colleagues and staff in routinely fulfilling their commitments to patient care, research, and education and keep the leader's and organization's self-interest systematically secondary.¹⁹ Respect for colleagues and staff as persons includes fulfilling leadership commitments and

accepting enforcement of such commitments. The familiar management tool of securing "buy in" becomes ethically significant only when the organization's leaders make respect for persons a reality rather than a slogan.

Professional resource management

It is commonplace in the medical ethics literature to claim that resource management should be based on the ethical principle of justice. Aristotle (384–322 BCE) provided the canonical formulation of justice: seeing to it that each individual receives what is due to him or her by treating like cases alike.²⁰ Physician leaders struggle with the demands of justice in making resource management decisions. In the history of philosophy, competing accounts have emerged of what makes like cases alike, with different implications for resource management.

One major view, utilitarianism, holds that cases should be judged alike based on their consequences. Utilitarian justice in a health care organization endorses policies and practices that advance the organization's mission.²¹ This commitment, however, can result in inequality of burdens, such as "taxes" and salary and time for teaching, patient care, and research.¹⁰ These outcomes are acceptable in the logic of utilitarian justice. The challenge for physician leaders is that such inequalities can be experienced as unfair or inequities, when viewed from the perspective of a competing view of justice. Libertarian justice defines unfairness or inequity in terms of the processes of decision making and therefore emphasizes fairness of process.²¹ Fair processes of organizational decision making identify and address the obligations and interests of all stakeholders. Fair processes are consistent with wide differences in resource allocation for salaries and space. Libertarian justice also supports privileges and power based on the generation of revenue streams. The problem with libertarian justice is that it disadvantages individuals and clinical services that do not generate large revenues or margins but are essential to the organization's mission. Egalitarian justice explains why such outcomes are unfair, because it makes obligatory the protection of economi-

cally weak and vulnerable organizational units that are essential to the organization's mission.²¹

The professional responsibility model invokes the corrective force of egalitarian justice to prevent the inequities of utilitarian and libertarian justice. The professional responsibility model guides the physician leader in the just management of organizational resources by justifying constraints on the fiscal claims or demands of utilitarians and libertarians to create an organizational culture of professionalism that is sustainable because it is fair as well as fiscally viable and accountable. Such a culture will prevent the distorting effects of claims to special privilege and power by fiscal "rainmakers."

Professional use of power

Physician leaders, by virtue of their position, exercise power, the ability to make and implement decisions, directly or through others. Thomas Hobbes (1588-1679) was the political philosopher par excellence of power.²² Hobbes lived through the English civil war, in which power was exercised without constraint. Hobbes' called for power to be constrained by a social contract, because the alternative was life that would be "solitary, poor, nasty, brutish, and short."²² The professional leadership model calls for constraints on organizational and individual power based on medical professionalism.^{23,24}

Physician leaders can confront 2 kinds of organizational power.²⁵ Monopoly power is wielded by sellers with a dominant position in a market, such as a medical school with a closed staff. Leaders can also confront monopsony power, the dominance of a single seller, such as an independent hospital that is a primary affiliate of a medical school. Monopoly and monopsony power both can affect the mission of creating a sustainable culture of professionalism by exploitation. Exploitation occurs when power is used to advance self-interest by unfairly shifting financial burdens onto others whose interests are harmed, eg, leadership issuing unfunded mandates to physicians or clinical services for quality improvement or patient satisfaction. The professional

responsibility model calls on physician leaders exercising monopoly or monopsony power to provide transparent justification that constrains the exercise of such power by showing that the constraint is consistent with an organizational culture of professionalism and is not exploitative. Physician leaders subject to such power are justified in insisting on such transparent justification.

The alternative to ethically justified constraint on power is the exercise of raw power, power that cannot demonstrate a connection to professional responsibility, such as penalizing clinical services for failing to meet completely unrealistic revenue expectations. Hobbes helps us to understand the result: the "war of all against all"²² that tears a health care organization apart. The war of all against all invited by exercising raw power is not benign; it is toxic to cultures of medical professionalism. The professional responsibility model of physician leadership prohibits without exception the exercise of raw power and justifies determined resistance to it.

Professional response to organizational dysfunction

A key component of physician leaders' responsibility for creating sustainable organizational cultures of professionalism is the prevention and effective management of organizational dysfunction. The political philosopher Niccolo Machiavelli (1469-1527) has contributed a well-known adjective to the English language, "Machiavellian," which connotes actions based on cunning or, worse, bad faith.²⁶ Dysfunctional organizational cultures can exhibit Machiavellian tendencies when the appearance of professionalism masks the neglect or absence of professionalism. Physician leaders, by fulfilling their obligation to create sustained organizational cultures of professionalism, can obviate the need to cultivate the cunning skills of the Machiavellian physician.

Organizational dysfunction is a progressive disorder,⁶ first presenting as a cynical organizational culture. A cynical organizational culture⁶ exhibits a deteriorating connection between organizational rhetoric and reality and a defensive posture of leadership in response to criticism. For example, a dean may extol

the virtues of teaching but leave unchanged a long-standing promotion system that ignores teaching in favor of research and publication. In such a culture, physicians committed to professionalism find each other and form moral enclaves that provide strength and support for efforts to confront and reform the deterioration of professionalism.

The next stage of deterioration is a wonderland culture⁶ in which organizational rhetoric becomes self-deceptive when used by leaders, who expect subordinates to embrace self-deception. For example, the mission statement emphasizes honest business practice, when it is common knowledge that the organization has systematic shortcomings in this area. Response to criticism takes the form of denial and accusations of disloyalty. In such a culture, physicians committed to professionalism strengthen their moral enclaves and vigorously seek to resist and expose self-deception as antithetical to professionalism.

The next stage of deterioration is a Kafkaesque culture,⁶ in which organizational rhetoric and reality become dissociative. For example, a department chairman strongly publicizes the appointment of a new associate chairman for patient safety and quality and then provides a budget that is entirely inadequate to improve patient safety. The response of leaders to criticism is threats, for example, in the form of, "You might be happier elsewhere." In such a culture, physicians committed to professionalism strengthen their moral enclaves against organizational assault on professional integrity, recognizing the futility and grave personal danger of attempts to change the culture.

Things can get worse; an organization can devolve into a postmodern culture.⁶ The connection between organizational rhetoric and reality, as well as the response of leaders to criticism, becomes incoherent and unpredictable in its variation. Truth is no longer valued. For example, a physician leader is able with aplomb to make incompatible promises to different constituencies and then expresses surprise and dismay about the inability of the different constituencies to work together for the good of the organization. In such a culture

physicians committed to professionalism form moral fortresses until there is a change of leadership that recognizes and seeks to treat a very sick culture; otherwise such physicians quit.

There are 2 common signs of progressive organizational dysfunction: strategic procrastination and strategic ambiguity.²⁷ Strategic procrastination of organizational leaders is evidenced by delays in making and implementing decisions about funding and other vital aspects of the organization's mission, as well as responding slowly to inquiries about such matters. Strategic ambiguity of organizational leaders can take several forms. Leaders can make financial or other promises without a detailed documentation of the promise and commitment to a plan of implementation. Leaders can order a subordinate to terminate someone's employment and then express perplexity about why the termination occurred. Leaders can also use the rhetoric of organizational excellence without offering policies and budgets that make the rhetoric actionable. Strategic procrastination and ambiguity are used by leaders to preserve their power for its own sake and to avoid resolution of organizational challenges and problems—behaviors toxic to an organizational culture based on professional responsibility.

Conclusion

The challenges physician leaders confront today call to mind Odysseus' challenge to steer his fragile ship successfully on a very narrow path between the 2 disastrous options of Scylla and Charybdis, sea monsters that threatened to destroy him and his crew. The modern Scylla takes the form of ever-increasing pressures to provide more resources for professional liability, compliance, patient satisfaction, central administration, and a host of other demands. The modern Charybdis takes the form of ever-increasing pressures to procure resources when fewer are available and competition for them is unrelenting, including managed care, hospital administration, payers, employers, patients who are uninsured or underinsured, research funding, and philanthropy. The professional responsibility model guides physician leaders by proving an explicitly ethical set of responses. The

failure to implement the kind of responses that we have identified means that physician leaders will tolerate what professionalism prohibits: undermining professional responsibility by allowing the emergence of organizational cultures that are antithetical to the life of service to patients first articulated by Plato and translated into medical ethics by Drs Gregory and Percival. Such organizational cultures would be devoid of moral worth occupied by "physician leaders" who, in the words of T. S. Eliot, would be "hollow men and stuffed men" working in the "dead land."²⁸ ■

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