

# **EDUCATION FOR LEADERSHIP**

## **IN ANESTHESIOLOGY**

### **THE SIXTEENTH HUSFELDT LECTURE**

**COPENHAGEN, 11 MAY, 1984**

It is a great honor and privilege for me to have been invited to give the 16th Husfeldt Lecture before the Danish Society of Anesthesiologists.

My predecessors, in this series, have been individuals of major accomplishments in the Scandinavian countries, the United Kingdom, and the United States of America. It is with singular humility and an awareness of the difficulty in keeping up the standard, which was begun in 1969 with the first lecture by Professor Husfeldt himself, that I undertake this task in all humility.

Previous lecturers have talked to you in one of the Scandinavian languages, or in either the British or the American versions of the English language. They have talked to you about matters of importance in Clinical Anesthesiology, Clinical Surgery, and the Sciences of Physiology, Pharmacology, and similar subjects. There has been also some discussion in more general terms about patterns of clinical practice or the development of Anesthesiology.

With some temerity, in that this 16th Lecture will be a departure from the

others, I am going to deal with a subject that I view as one of crucial importance to our own field, but perhaps also to societal issues in general, and that is the need for a renewal and modernization of entrepreneurial leadership.

No better reason for this subject could be found in honoring Erik Husfeldt, who personifies so much the subject matter of this address.

Often the person who delivers a lecture in honor of a distinguished individual does not always have the privilege of knowledge at first hand of the person who is honored. I am more fortunate in that respect in that some 30 years ago when I was one of the relatively young instructors of the W.H.O. course in Anesthesiology in Copenhagen, I met Professor Husfeldt and was profoundly influenced by him over many years as the result of this brief encounter.

His story should be well known to all of you, but immortality, which he richly deserves, is often even in the best of circumstances, relative, and of brief duration.

There are very few people who have graced this earth who have had the achievements of Professor Husfeldt. This is the great man who had so important a role during World War II in striking out forcefully for the dignity and the integrity

of the human spirit as part of the Danish Resistance. That would be enough to make him an immortal and has done so for others. However, his accomplishments in the science supporting his chosen field of thoracic and cardiovascular surgery are also eternally important. His activity as a distinguished clinical surgeon was widely respected as a pioneer in surgery of the chest. Since he became a Professor of Surgery at Copenhagen in 1943 - a Chair he held for some 27 years before his retirement - he accomplished much.

It is not rare that the most prominent surgeons who have an interest in surgery of the chest contribute in a major way to the development and the firm establishment of those apparently collateral fields, like Anesthesiology. The firm establishment of Continental European Anesthesiology is among the more important achievements of this unusually gifted man. No thoracic surgeon can be successful without the support of other specialists in both scientific and clinical medicine. Erik Husfeldt realized this situation fully and he felt keenly the need to have, among other support systems for his own work, the presence of competent and effective Anesthesiology.

His strong conviction in this regard led to the establishment in 1950 of one

of the most unique and important activities in the development of a specialty in the Western World. This was the creation of the Anesthesiology Center in Copenhagen under the combined offices of the medical and government establishments in Denmark and the World Health Organization.

This Anesthesiology Center created by Professor Husfeldt exemplifies the essentials of leadership. Shortly we shall attempt to define them more specifically.

In my opinion, although the United States of America can claim with justification to be the country that discovered general anesthesia, and the United Kingdom can claim with equal justification, the extension of Anesthesiology widely as a major part of the practice of medicine; there is no question that the safe and effective care of surgical patients and those who were critically injured or critically ill received major impetus from the program that Professor Husfeldt was so instrumental in starting in Copenhagen.

At the time the course started in 1950 we were witnessing, at least in the Western World, a phenomenon of great interest and of great importance. It was a period of giants in so many fields of clinical and scientific medicine. These great men and some women had the unique characteristics of being able to perform

what looked like miracles, since relatively few other physicians or surgeons at the time could perform technical or intellectual feats as well. This was the period in the United States which witnessed the towering genius of Ralph Waters of Wisconsin who actually organized and began the course in Copenhagen - another sign of the great wisdom of Professor Husfeldt in getting a program of quality off to a magnificent start. Stuart Cullen, a younger individual in the age of giants, carried through to practical establishment the precepts of the American view that Ralph Waters was so important in leading. Jack Moyers was also a devoted teacher over many years.

In the United States also at that time there were other individuals who belong to this same group of people. Especially one should mention Dr. John S. Lundy, who was in charge of Anesthesiology at the famous American Mayo Clinic and Ralph Waters' most distinguished disciple, E. A. Rovenstine at New York University. Of course, there were other important Americans.

To match this kind of strength for the course in Copenhagen were the giants in the United Kingdom of Great Britain, i.e., Professor Sir Robert Macintosh, Professor Sir Geoffrey Organe, Professor William W. Mushin, and Professor T. Cecil Gray and

many others.

An amazing matter to me in contemplating this situation in Anesthesiology since the end of World War II, was the unique and entrepreneurial qualities of these individuals not unlike those of Professor Husfeldt himself. It was a time, not only of giants but of men at that time, with the extraordinary vision as to what this fledgling field could contribute to human welfare and what it could do in its daily work in the care of patients. These were the evidences of leadership.

In the age of anesthesiological giants there was not a large number of individuals who worked in the daily administration of anesthesia to patients. As their number slowly and gradually increased, they were far removed in numbers let alone in quality from being able to cope with the requirements of the fast developing surgical skills, and the societal requirements of daily anesthetic care. The resolution of the problems of educating doctors and nurses for that kind of daily activity was solved in different parts of the world in different ways also by differing but strong kinds of leadership. There were countries in which attempts were made to persuade young doctors that this was a field worthy of their attention especially in Great Britain and in the United States.

Serious attempts in these two countries to recruit young physicians, into Anesthesiology took place and were, at best, until the last four years, moderately but not greatly successful. Only three per cent or so of graduates of medical schools in the United States of America entered this field until approximately 1978 or 1979. As a matter of fact the situation in Anesthesiology was not radically different from other fields in clinical medicine. For the 30 years or so following World War II, the people of the United States, received an advantage due to the greatly increased standards of living prevailing at that time in our country, to attract physicians from many other parts of the world to America. At one time, as a matter of fact, the number of new people entering into the practice of all forms of medicine in the United States who were not graduates of schools in the United States of America was approximately 1/3 of the total input into the medical profession. Anesthesiology was even more reinforced by non-American physicians. Therefore, supplementation of professional medical care had to occur. In Anesthesiology it took the form of a substantial increase in the education of nurses and some technicians who administered anesthesia sometimes under the direction of and often in competition with doctors of medicine.

In much of Western Society and in Japan, which in many ways is similar to the West from these standpoints and in many ways is culturally dissimilar from the West, there was almost nothing to be found that resembled modern clinical anesthesia until after World War II.

In many parts of Continental Europe, local infiltration anesthesia was common place. An inadequate quality of either regional or general anesthesia was also practiced. The course in Copenhagen changed all of that and developed a sensitivity and an awareness of the value of Anesthesiology as a public health profession as well as a practical clinical one. The graduates of the course in Copenhagen began to make their presence felt in Continental Europe, and the rapid development of anesthesia of high quality in most of the non-Communist world took place as a result of it.

In parts of the Communist world and in parts of the undeveloped world, events other than anesthetic care understandably took precedence over all of these relatively sophisticated forms of providing health care. Good housing, safe food, safe water supplies, and the control of infectious diseases were correctly viewed by those societies as having much higher priority than Surgery and Anesthesiology



and they acted accordingly. As developing nations mature, so do their health priorities. Anesthesiology and Surgery are attracting attention increasingly in these societies.

I plan to have my remarks about education for leadership in Anesthesiology more directed to the societies of North America, the United Kingdom, and Western Continental Europe as a practical reflection of my own knowledge and experiences.

The future development of Anesthesiology seems to me to be at risk because the vision of the age of the giants seems now to have become buried in complacency and, in the bureaucracy of committees. Necessary though they are, they are fundamentally hostile to the development of the kind of leadership which is needed. Many more physicians and nurses can do more useful things today than was ever possible in the past, and they were made possible because of the vision, the energy, and the training programs that the giants stimulated through their remarkable early vision.

I feel rather definitely that as more people have become competent at "routine" anesthesiology, there is also associated with it for reasons that are not

altogether clear to me, a diminution of the sparkle, the excitement, the vision, and the leadership in this specialty and perhaps others including surgery. Is it better to have more people who know many of the things that can be done than it is to have visionary leadership? There really need be no conflict because we must have both.

One of the present leaders in American Anesthesiology firmly believes that most of the major questions concerning the safe care of patients have been solved. The viewpoint is widely accepted that anyone in a proper residency program who is of reasonable intelligence can deliver the kind of anesthetic care for which all of us have striven over these many years. Therefore that particular societal need is more or less solved and need not be given serious attention. I am compelled to reject this notion because I do not believe that knowledge and the truth will ever be totally attained and that constant striving toward excellence and toward the improvement of the lot of the human condition must go on. I believe even if it were possible to attain the status where no patient was badly served by anesthetic care, or even that remarkable condition where there would be neither death nor injury due to anesthesia except for the alleged irreducible minimum, that we should be grateful for that state of affairs but not satisfied with it. Intellectually

and philosophically I have to reject this attitude that no further practical progress is needed. The struggle to do right and not to be right, necessarily is eternal in the best environment of a democratic world.

I would like to propose to you a reconsideration of the need for leadership and the education for it. I think massive strides forward will be more possible than they have been even in the magnificent recent past with that kind of constructive leadership.

Because so little seems to be written about these qualities of leadership in the medical literature and much more concern is evidenced about it in the world of service, broadly defined, especially in the world of business, economics, information transfer and in heavy industry, I have sought for some answers in that direction. Looking for answers at the present time in government circles is fairly hopeless because of their pervasive fear of change and the rigidity of bureaucracy which is, ipso facto, an enemy of change.

The single largest specialty in clinical practice in the United Kingdom I am told is that of Anesthesia. The number of graduates of medical schools in the United States of America who enter the field of Anesthesiology, at present for

reasons that are not altogether relevant to this discussion nor clear to me, has quadrupled in the last four years. In the estimate of some people who study these questions it is predicted that the influx of individuals into Anesthesiology could comprise a substantial number of the new graduates of American Medical Schools. To me this is an extraordinary opportunity, since not only have the numbers vastly increased, but the quality of the candidates has increased phenomenally. I assume that this situation pertains to varying degrees in Continental Europe, although I have seen no data that either support or reject this assumption..

Having established this background let us look together at the kinds of characteristics of leadership that need to be developed.

Education for leadership should begin by identifying individuals as early in their careers as possible. I am speaking of people even in their twenties who seem to have a gift, possibly inborn or genetically determined, and possibly amenable to education in which such potential leaders have the ability that the giants of the past did of attracting others to their magnificent goals and to their vision of the future. There is no one too young to be a leader or developed into one.

We must look to early life and education for characteristics of leaders in a democratic society - the fine line that blends an elitist idea and function with service to others that democracy requires. Leaders, in the past had broad vision which they acquired either in formal schooling or more often because of an insatiable curiosity that led to self learning. Whichever path was followed, leaders learned to communicate ideas with clarity - and very important - they always continued to learn as skillful generalists rather than delegating leadership roles to specialists.

These kinds of leaders will understand at once that one of their major roles is to manage the purposes of their visions. The leader takes great satisfaction in eliminating the wasting of other people's constructive time for work toward achieving the agreed upon goals. He encourages the strengthening of self esteem and outstanding work in his colleagues. He cherishes their success as equivalent to his own. One of the criteria of successful leadership is the healthy thriving of his organization. Recognition is always given to his junior colleagues and his peers.

This kind of leader is always clear in his own mind as to what the outcome

of the goals of the organization should be e.g., what the process of education for clinical care or research should be. He may be wrong sometimes but he is always correct as to what the goals from the long range point of view should be. The kind of leader I am talking about should be thoroughly competent in interpreting what the effective meaning of goals is to a group and certainly his own intentions must be clear by simple and frequent verbal and written communication. He should have the ability to make an idea come alive vividly and inspire the kind of activity where the entire organization and the group want to participate in the achievement of his vision in the development of science or patient care or both.

The leader should have the complete ability to manage trust and confidence for want of better words. He should have the kind of integrity and persistence that all his colleagues not only can admire but where they can be sure of what he believes in and what he stands for. Reliability and predictability are important qualities of leadership.

Such a leader should be able to manage himself with effective self-discipline. He should have a realistic but positive self-regard. He should know all of his strengths very well, and he should develop these strengths to their

maximum. He should also be able to discern and identify the strengths of his colleagues and organization and their particular needs. He should be able to bring out these positive strengths in others and to develop each individual to his own maximum capacity. The standard for excellence is, in my mind, no longer how do we compare with other organizations but are all of us as good as we possibly can be. This is an internal standard of judging excellence of vast importance. It is surprising how large the distance often is between performance and potential. A real leader must aid in closing that gap.

Almost paradoxically until one gives it further thought, this kind of leader rarely tries to focus on weaknesses in his colleagues and certainly does not exercise negative reinforcement of those weaknesses. He will try to enhance the strengths of his colleagues and let the weaknesses be removed gradually by positive support. Some people will unfortunately be eliminated by a stern but fair evolutionary process if the weaknesses override the strengths seriously. Occasionally, appropriate reassignment to areas of competence suffices to overcome situational weaknesses. An excellent scientist may be a poor clinician.

Leadership also implies another trait. The leader should be as logical and as

fair and as informed about the data concerning any question that concerns the organization or the work. However, when there is doubt, this kind of leader, as the giants of the past, will trust their own intuition should there be conflict in the overall data available for making decisions. In general, they are reflected in "doing right" rather than in being right.

The next quality is a strange one to describe and Dr. Bennis of the University of Southern California calls it the "Walenda Factor." Mr. Walenda was the world renowned tightrope walker, who according to his writings and that of his family, never thought of the risks of walking a tightrope. It was always natural to do so. He never worried about falling, and until the fatal accident that killed him he never worried that he would fall. The time that he did worry about falling toward the end of his life, he took a walk on a tightrope that resulted in his death. It was almost a self-fulfilling prophecy. The corollary to leadership qualities of the "Walenda Factor" are that leaders never worry about failure. They view failure as another experience which, to some extent, may be useful. One can learn from failure and correct it the next time. Obviously leadership in Anesthesiology does not carry the death threat of walking a tightrope - at least not usually!



The leader in dealing with his students and his colleagues gets the feeling clearly across to all of them that they really make an important difference in what happens whatever their activities. These associates because of this kind of inspirational leadership always keep learning as long as they are physically and mentally able to do so. They get and sustain a feeling of excitement out of the shared pursuit of the same important goals. In short, they are a "family" and in the pursuit of all of these activities they often have a great sense of fun, joy and fulfillment. They do not worry about time or "lifestyle."

It seems to be that now is the time that one should consciously look for young men and women who have these characteristics and can assume positions of leadership that will make such a difference in the next phases of the development of Anesthesiology. These changes will always result in welcomed instability in which the present accomplishments are enjoyed and are used as spring boards for the development of new knowledge, of new skills, and of new benefits to anesthetic and societal forces. If we can identify and provide educational opportunities for vibrant leadership, we can look to a future that will be exciting. It will never be complacent. Everybody will always feel that something can be

done better than it has been in the past. If that point of view should be developed in our leaders, and, in my opinion it is not there sufficiently at present, there is no end in sight as to what can be accomplished in Anesthesiology - or any other human activity.

They would be able to deal with any possible foreseen or unforeseen contingency. These processes are going on in the information industry of computer technology in the United States, in Japan, and in Europe. It seems to me that we have much to learn from them and can use these precepts in our field.

Leadership is all about people. In a democratic society, the leader leads, but he also serves the members of his organization. How well his service to them succeeds, ultimately determines the vigor of their contributions which is the hallmark of productivity and the pleasure of good and hard work.

There is a fusion of work and play, as Robert Frost put it "love and need are one." Leaders enjoy what they do. They don't worry about reward (which always comes anyway) nor whether they will succeed. They simply achieve the impossible so regularly that one wonders whether anything is impossible. However, there is a caution. The best of the past is part of the future. As the

American Revolutionary Thomas Paine once said, "When planning for posterity, we ought to remember that virtue is not hereditary."

