EDITORIAL

Lost in Translation

Steven P. Davison, M.D., D.D.S.
Washington, D.C.

I define leadership as leaders inducing followers to act for certain goals that represent the values and motivations, the wants and needs, the aspirations and expectations – of both leaders and followers [sic].

—James MacGregor Burns

Everyone wants to be valued. This fact is one of the things that separates us from the animals. When on the hunt, a hyena does not worry about how he or she is valued, just whether he or she gets part of the kill. People tend to want both reward and recognition, and not necessarily in that order.

Over the past few decades, leadership has changed. It has changed in politics, military, academics, and business. Medicine, however, does not seem to have kept up with the times. In a business model, managers discuss and implement new leadership paradigms in employee motivation. In contrast, the traditional medicine training model relies on the "carrot-and-stick" approach. However, "the good old days" have gone. The role the physician once had as the benevolent yet paternalistic authoritarian are over, and with good reason—this system was archaic at best, and quashed any benefit of a team approach. Today's hospital landscape is quite different. The daily hospital operations are controlled by business administrators. Now nurses are the managers that run the operating rooms. The great demand for this role versus a finite supply has ensured a new power structure. The 80-hour work week for residents has created new loops of responsibility. The traditional model of hierarchy for a teaching institution was a level of responsibility and communication from attending to resident to intern. Presently, an attending physician or professor is as likely to get a report from a physician's assistant or nurse practitioners as a chief resident. Yet despite this, we still have a culture of transactional leadership.

What is transactional leadership? Traditional leadership strategy recognized that leaders have a definitive goal while followers also have motivating goals. Unfortunately, the two are often exclusive. The leader sustains their authority by possessing and controlling what the follower desires in return for a service.[1] Herein lies the transaction, a sort of "tit for tat."

The alternative is "transformational leadership." In 1978, James MacGregor Burns coined this term to describe the ideal interaction between leaders and followers.[2] Its modest goal is to get everyone functioning at his or her peak potential. Leaders should appeal to their followers, not merely wield power over them. This is contingent on adequately addressing and appealing to shared values. This places an onus on the leader to realize the aspirations and expectations of the followers. Consequently, both leaders and followers take part in an ultimate shared goal and are raised to higher levels of motivation and morality. In short, they are transformed by it.

When was the last time you were asked for your input in a leadership decision? If you were, did you feel it was simply to pacify you or to serve as window dressing?

An example is my institution's recently implemented "On Time Start Program." As a teaching hospital struggling to start operating rooms on time, a survey was instituted to assess the problem. Administrators ran the study, and it should come as no surprise that the surgeons were found at fault. Of all the confounding factors, from patient readiness, operating room staff, and anesthesia setup, the only person with arrested interest to start on time was fingered. It seemed the only constant impartial observer would be the patient. My suggestion to have the patient perform the time keeping, a sort of stopwatch in hand approach, was unanimously rejected. What followed came the transactional leadership approach. If one's room started late three or more times in 1 month, for whatever reason, the surgeon would lose his or her first case start time. This is irrelevant

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of cause or the total number of cases that surgeon was performing in 1 month. As a surgeon who starts 20 days per month, I have failed before the month begins. Our average institution on-start time is 60 percent, so eight mornings per month I will be late. Three mornings per month requires an 85 percent on-start time for me to meet the criteria. For this policy, who asked for input from the surgeons? How much transforming went on? None, I would argue.

This scenario is replicated up and down the system. Glaring national examples are Health Insurance Portability and Accountability Act regulations or the 80-hour work week. In recent reports, the latter has shown no benefit to surgical patient care.[3,4] Local examples are seen daily at any hospital in the areas of compliance, credentialing, and record keeping, to name a few. Where are the professionals leading inspired subordinates?

It could be said that we surgeons as a group are at fault for our ambivalence or lack of involvement. However, among physicians, I hear many valuable opinions voiced daily from my colleagues, as is echoed in any meeting of doctors around the nation. It is about time we took a greater voice in fixing some of the problems and processes of health care today.

A little transformation of our leadership is long overdue.

Steven P. Davison, M.D., D.D.S.
Department of Plastic Surgery
Georgetown University Medical Center
3800 Reservoir Road NW
Washington, D.C. 20007
spd2@georgetown.edu

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Plastic and Reconstructive Surgery
Rod J. Rohrich, M.D., Editor-in-Chief
St. Paul's Hospital
5909 Harry Hines Boulevard
Room HD01.544
Dallas, Texas 75235-8820
Tel: 214-645-7790
Fax: 214-645-7791
E-mail: PRS@plasticsurgery.org