

The Present State of Military Physician Leadership A Lacking Paradigm?

James A. Pfaff, MD

It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat.

—Theodore Roosevelt

The military health system (MHS) has two unique missions: (1) It supports active-duty Servicemembers with health care and preventive measures and (2) it provides skilled medical personnel who deploy with our warfighters to provide life-sustaining care during conflict and other contingencies. Simultaneously, the MHS provides care to all military beneficiaries in a manner that meets, or exceeds, the civilian community standard. The delivery of health care is a complex endeavor, as displayed by myriad controversies surrounding initiatives to improve our domestic health care system (e.g., the Affordable Care Act).

In community hospitals and medical centers, the Army Medical Department (AMEDD) leadership is composed of a variety of officers with diverse backgrounds such as physicians, nurses, dentists, health care administrators, and other medical disciplines. This often differs from the civilian model in which physicians lead academic institutions and/or act as chief medical officers, while hospital administrators provide the bulk of community hospital administration. Although this article will specifically address the AMEDD, the pertinent points are similar in the other service branches. Army Medical Corps (MC) Officers should be competent in three roles: physician, Soldier, and leader.

Physician

As in any branch specialty in the Army, professional excellence for an MC officer is paramount. The amount of effort

required to become a board-certified physician is substantial, with continuing requirements to maintain professional credentials on a yearly basis thereafter. There is also a requirement for these officers to meet the same professional military education requirements required of officers in all branches.

Physicians are an integral part of the medical team and must be strong academically and clinically.¹ This need, however, must be balanced by a set of knowledge, skills, and behaviors that will enable them to engage and lead in highly complex, rapidly changing environments.¹ In the civilian community, ongoing clinical practice is needed to maintain credibility with other practicing physicians, though this is highly variable in military medicine.²

An old adage exists that “to be a good medical corps (MC) officer, one must be a good physician.” Yet there is no requirement for MC leaders to establish a reputation for clinical or specialty excellence by any standard measure including the number of patients seen, outcome measures, patient satisfaction, peer-reviewed publications, or other measures expected of MC subordinates. While many line officers in leadership positions articulate that excellence in their craft is a core of their leadership and an important part of their soldierly skills, no comparative standard exists for MC leadership to establish a reputation for clinical excellence.

Soldier

Readiness is essential for one to function, assimilate, and provide medical support for the finest military in the world. It demands competence as both a Soldier and a physician. In the late 1990s, a historical shift required operational surgeons (MC officers assigned as battalion and brigade surgeons) to be trained and credentialed in a primary care specialty, requiring them to be board eligible or board certified.

One of the requirements of military readiness is the seemingly unending litany of administrative and training requirements, despite little evidence of their efficacy. Given the sheer volume, these requirements may negatively impact both development of leaders and the efficiency of the health care system.^{3,4} Physicians do military required training to advance in rank, meet the requirements of a professional military officer, and avoid being a battlefield liability during times of conflict.

Correspondence to jampfaff@aol.com

Army Medical Corps Colonel (Ret) James A. Pfaff is an emergency medicine physician affiliated with Brook Army Medical Center, Joint Base San Antonio-Fort Sam Houston, San Antonio, TX.

Our Army requires its Soldiers to be current and competent in their specialty skills. Corollary examples include the need for an airborne infantryman to conduct individual and collective training standards for airborne operations or for pilots to regularly fly in daytime and nighttime, operating in both instrument-flight and night vision-enhanced conditions to maintain competency and currency of flight status.

Acceptance of specialty bonuses requires the MC officer to be competent and current in their specialty, but there are no specified, required benchmarks beyond board certification. Recently published by the Army Medical Command, the new Individual Clinical Task List (ICTL) attempts to define specific skills and procedures required for competence based on medical specialty. While a work in progress, it is unclear if it will require MC officers in administrative, operational, or leadership positions to meet these standards. Often the sole requirement for remaining a credentialed provider in Army medical treatment facilities is to practice a mere 40 hours per year.

There are issues with ownership of the readiness component and challenges to improving combat casualty survival.⁵ While readiness and ensuring operational billets are filled are the core elements of military medicine, there is little emphasis and no apparent requirement for these physicians to meet clinical competency requirements.

Leader

With few exceptions, MC officers were the leaders in the AMEDD until 1997 with the advent of branch immaterial command. This opened the competition for commands and flag rank to all of the AMEDD corps. Given that some corps do not practice clinical medicine or stop practicing it early in their career lifecycles, MC officers may have felt the need to compete in a similar fashion.

Many who aspire to be general officers place emphasis on being operationally, technically, and tactically proficient. In civilian medicine, clinical and academic excellence are similarly cited as the ultimate goals. However, competition for commands and flag rank in the Army MC compromises the importance of clinical and academic competence and currency. The reasons physicians avoid competing for these leadership assignments are complex and varied, but the present promotion structure and professional military education requirements create substantial barriers for physicians to continue the active clinical practice of medicine. MC officers who seek leadership assignments often do so out of a sense of duty and obligation, not necessarily for individual ambition. This does not however, justify the absence of a requirement for clinical excellence.

There is a growing body of evidence that suggests health care works best when physicians are in leadership roles.⁶ In the civilian community, physician leaders were traditionally selected on the basis of their national prominence and excellence as master clinicians, eminent clinical investigators, and revered educators.⁷

Many believe effective clinical leadership is essential for consumers of health care to achieve optimal health outcomes and experience optimal medical care.⁸ While currently no standard definition of clinical leadership exists, common themes mentioned in the literature include clinical excellence and expertise,

direct involvement in patient care, high-level interpersonal and motivational skills, commitment to high-quality practice, and empowerment of others.⁹

Physicians should have the expertise and credibility with their subordinates that command – not demand – respect. Phrases like “lead from the front,” “lead by example,” and “servant leadership” are commonly used to describe military leadership, yet they have little applicability among their fellow physicians when MC officer-leaders do not engage, maintain credentials, or practice their specialties.

During the Iraq Conflict, some general officers such as General Stanley McChrystal and General James Mattis accompanied troops in squad level units as observers. They were prepared to function as infantrymen should the requirement arise.^{10,11} It is unclear if senior military medical leaders could function as practicing physicians at this basic level.

While individuals may be concerned about leadership and the responsibility which comes with it, commanders are rarely relieved because of performance, barring ethical, legal, or publicized medical issues. MC leaders who do not practice medicine are not exposed to the same risks as the clinically active MC officers they lead, such as the federal tort claims act, quality improvement, and patient surveys. Physicians are held accountable for poor decisions made by officers/administrators who are not affected by those decisions including logistics, automation, and contracting. Medical leaders are also burdened by the unending phenomenon of building and increasing administrative staff. Often, this is at the expense of clinical positions, further decreasing the number of practicing physicians and nurses in a system that the Government Accounting Office (GAO) deems very inefficient.¹²

It is the rare senior military medical leader who maintains clinical practice as they progress in rank. Working a shift in their respective clinics, operating room, or emergency department and utilizing the numerous electronic health care records, labs, radiology systems, and administrative and consulting systems that are stand-alone and not interactive, would give them first-hand experience with issues that are not necessarily appreciated at the command-suite level. This is not to suggest that the leaders are not engaged, but there is a substantial difference between an email presence, night rounding, mass town hall meetings, and a physical presence on the ground in which the multiple inefficient administrative systems meet the patient in the clinical environment.

The Way Forward

1. Make clinical practice matter. Ensure that all medical providers including physicians, nurses, physician assistants, medics, etc. continue to practice in their chosen fields. Make it relevant and make it the standard.
2. Emphasize the need for ICTL training for everyone. If unavailable at the local military training facilities (MTFs), seek out military relevant training in the civilian community. Consider aligning these requirements with specialty bonuses.
3. Perform an evidence-based evaluation of nonmedical training requirements and eliminate those that have little value.
4. Build clinical practice into staffing models for all leadership, administrative, and operational positions.

A military physician leader is expected to be a Soldier, role model, and servant. Most importantly, one must be excellent at one's specific specialty, maintaining this excellence through regular practice. In 1962, President John F. Kennedy gave an address at Rice University on the nation's space effort. He said, "We choose to go the Moon in this decade and do other things, not because they are easy, but because they are hard . . ." Arguably, taking care of patients with all that it entails and establishing a reputation as an excellent physician are hard, but it should be at the core of any military physician leader as they progress throughout their career. By setting this example, our leaders will truly be, "in the arena."

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References

1. Warren OJ, Carnell R. Medical leadership: why it's important, what is required and how we develop it. *Postgrad Med J*. 2011;87:27–32.
2. Collins-Nakao R. Leadership in medicine. *MJM*. 2006;9:68–73.
3. Burke CJ. No time literally, for all requirements. *Army Journal*. 4 April 2016. <https://www.ausa.org/articles/no-time-literally-all-requirements>. Accessed 14 July 2022.
4. Delorenzo R. Checking the box of training tasks. *Mil Med*. 2010;8:544–547.
5. Mabry RL, Delorenzo R. Challenges to improving combat casualty survival on the battlefield. *Mil Med*. 2014;5:477–482.
6. Angood P. Cultivating physician leadership is necessary for lasting and meaningful change. *Acad Med*. 2015;90:1290.
7. Lerman C, Jameson JL. Leadership development in medicine. *N Engl J Med*. 2018;378(20):1862–1863.
8. Daly J, Jackson D, Mannix J, et al. The importance of clinical leadership in the hospital setting. *J Healthcare Leadership*. 2014;6:75–83.
9. Stanley D. Clinical leadership and innovation. *J Nurs Educ Pract*. 2012;2(2):119–126.
10. Naylor S. *Relentless strike: the secret history of Joint Special Operations Command*. New York, NY: St Martin Press; 2015.
11. Ricks TE. *The Generals: American Military Command From World War II to Today*. New York, NY: Penguin Press; 2012.
12. Government Accountability Office. Defense health care reform: DOD needs further analysis of the size, readiness, and efficiency of the medical force. 21 September 2016. <https://www.gao.gov/products/gao-16-820>. Accessed 14 July 2022.

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