A Time for Renewed Leadership in Medicine

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It was 25 years ago when I came to Ochsner to provide new academic leadership. With eager anticipation, I brought to our institutions our ongoing experimental and clinical investigative programs in hypertension and initiated a number of innovations with our educational and research programs. But, for those of you who are not familiar with my prior academic background, I came to Ochsner from the University of Oklahoma where I held an endowed chair in its Departments of Medicine, Physiology, and Pharmacology. My prior academic activities were with the Departments of Medicine at Georgetown and Northwestern University Schools of Medicine and with the Division of Research of the Cleveland Clinic where I enjoyed clinic medicine and the research leadership. At each institution, I was fortunate to work with colleagues who remained my role models for my entire professional life. It is the need for collegial role models, as well as friends, that is vital to one's professional growth in life and is the substance of my talk this evening.

It was in Cleveland that I learned the very best of the promises of clinic medicine and about some of the challenges that beset a world-class research effort dedicated to more completely understanding disease mechanisms and to cutting edge innovations in treatment. It was there that I also came to appreciate the critical and clear-cut differences between academic medicine practiced in a multispecialty clinic compared with that practiced in schools of medicine. This was the subject of my first house staff graduation talk in 1976. I pointed out then that the primary mission of a large multispecialty clinic was, and should be, total dedication to quality patient care. Its secondary goals were related to graduate medical education, subspecialty training, continuing medical education, and a strong ongoing commitment to *selected* fundamental and clinical research programs of excellence that are also related and integrated into the needs and finances of that multispecialty clinic. In contrast, I pointed out the differences in these commitments with most schools of medicine. These institutions are (and should be) committed primarily to undergraduate, graduate, postgraduate, and continuing medical education with an equally important emphasis on all aspects of medical research in order to support and integrate the efforts of their overall educational missions. Patient care in medical schools at the time was usually secondary, but an essential

component of the long-envisioned three-legged academic stool that provides the broad education, research, and patient care to their institution's mission. I looked forward to my new pursuits at Ochsner with great excitement and anticipation.

During the ensuing years, academic medicine in our nation encountered major changes in its overall commitments. The schools of medicine experienced a major upheaval. They found that their patients provided a readily available source of support for the income that heretofore was enhanced by federally generated capitation funds for education and by the overhead funding from various types of federal research grants. As you may already know, these capitation funds provided to the medical schools were rapidly and progressively withdrawn and, as a consequence, the commitment by the faculties were simultaneously redirected to patient-generated revenues. A crisis in medical education and research became apparent, which was enhanced further by cutbacks in federal support of research as the inflationary years of the late 1970s and early 1980s impacted upon each of our national medical academic health centers.

In 1985, my second presentation to our graduating house staff suggested that a new source of much-needed academic revenues might be generated from a surtax imposed by the federal government from the for-profit insurance sector of our economy. As you know, no profit-making sector of our overall economy fails to contribute to its own research and development needs as well as to the educational support upon which their work is dependent. It was my suggestion, then, that these funds from the for-profit insurance sectors be directed to supplement and support medical education and research of our nation's academic medical institutions. This concept, which I shared with several of our professional societies, was subsequently advanced by certain congressional legislative leaders — but to no avail. The tight economic years were upon all of our academic health centers.

Many health care administrators at that time, aware of the new sector of managed health care, spoke alarmingly about the impending "dark economic clouds" soon to beset the health care mission of our nation's academic health centers. They alerted the graduates entering into medical practice to be cautious of these ominous signs. I believed that my third house staff graduation talk, in 1996, should positively focus the graduating physicians' thoughts about the exciting new advances in our understanding of disease and on new positive means of providing health care, previously unavailable for the many untreatable and incompletely understood maladies that beset our fellow man. To be sure, the new economic changes had become realities and they presented very real opportunities. Indeed, so have the exciting scientific advances that were — and still are — entering into our professional lives and in daily medical practices. We are all mind-boggled by these promising and seemingly endless, exciting breakthroughs, which have dramatically changed disease outcomes. Thus, just as the economic forces have entered into our daily practice of medicine, so have the tremendous scientific advances made previously unimagined impacts on the conduct of our profession. Would you have believed in 1990 that as you sit here today the entire human genome would be spelled out and that single genes are being inserted selectively into patients' genetic material? I truly believe the only limitation that restricts the conduct of our everyday medical practice is our imagination.

But, today, we face still another new crisis: a drastic need to replenish medicine with new and revitalized leaders — academic medicine's leaders in thought as well as leaders in clinical practice. Our nation has just gone through a long and hard-fought political campaign that has provided a new political leadership for our country. We also face the need for a continuing new leadership in medicine. Many of our outstanding academically oriented clinicians are so beset by the current demand to satisfy the fiscal goals of the schools of medicine and the needs for their delivery of health care, that scarcely enough time is available for them to satisfy their familial, intellectual, and other necessities. In one of my recent editorials in *Hypertension*, I pointed to a renewed call for mentoring by those physicians of our teaching hospitals who have recently retired. I called for the return to medical education by some of these role models to provide vital intellectual support for our continued corps of students and house staff trainees. I feel certain that this urgent need will be satisfied; it must be satisfied. Indeed, several schools of medicine have already begun this effort. There is also a very real need for established clinicians, clinical scientists, and role models to provide everyday clinical leadership. Hopefully, many of you who are graduating from our programs today will see to it that you can and will help satisfy this need in your daily practice, be it in academic health centers, your community hospitals, or in your future individual practices.

However, this is only one aspect of the varied needs in our dwindling medical leadership. As you know, the practicing physician was once the first and foremost professional who enjoyed the trust

and respect by the general public. Indeed, this was the hallmark of this institution's founders. But today, we are repeatedly told by the lay media that this once respected practitioner no longer is standing on a public pedestal as a prime example of the revered humane professional. Would you believe that this person has been replaced by the "Master in Business Administration" and the manager of practice-oriented health care and of our "clinical encounters"?

Let us now make a quick but important distinction between the manager and the leader. The manager is a very necessary individual who is totally committed to the careful expenditure of monies and the use of "things." In contrast, the leader is an individual who has an overpowering and deep-seated commitment to people and to their forward-thinking ideas. Both types of people are extremely vital for a growing and vibrant society and its myriad of activities including medicine. I do not suggest, in the very least, that there is no need for managers; but, unfortunately, there are far too few leaders. For the purpose of this discussion, I refer to clinical leaders.

Leadership can be generated by those who are interested in making a real difference. I have been truly impressed over my years at Ochsner by seeing many of our colleagues come forward as leaders– of hospital committees, as presidents of our medical staff, as officers in their specialty and subspecialty societies, and in many other aspects of our daily life. As you know, some physicians have come forth to provide elective leadership for our local and national political systems. I do not suggest that many of you will or should assume such leadership positions of political notoriety, although several from our former staff and house staff have made that effort. However, I do strongly urge that you keep active in your practice and in your community, that you maintain a current and cutting-edge knowledge of the scientific base of your practice through continuing medical education, and that you anticipate this necessary facet for your professional life. If at all possible, you should help to train and serve as a role model for those who will be coming forward to learn from you. This has been an integral component of the Hippocratic Oath which has been recited by new practitioners over the millennia. I sincerely hope that you will provide the necessary health-oriented leadership for your patients, in your local and national medical societies and organizations, and for your own communities.

Medicine is a truly noble profession. Medicine is and has been worthy of continued respect by the general public. Let us keep in mind that in the future we must, we can, and we will provide whatever leadership that we are able for the benefit of our patients, practices, hospitals and other institutions, and, especially, for our patients, colleagues, and friends. This is the way that you can help to restore and maintain the much needed respect and credibility to what has been termed as "God's most noble profession."

In closing, I wish you, your family, and fellow colleagues my heartiest congratulations and deepest respect on achieving this stage of your professional graduation. May you achieve and value your new careers as much as I do and have mine. You are entering a profession of true wonder. The infusion of your efforts and dreams is vital. Use them generously!