Commentary

Family Medicine's Failures: Reflections on Keystone III

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Like many family physicians, I eagerly anticipated the Keystone III conference that was convened recently to ponder the past, present, and future of our discipline. I was not chosen to participate in the forum, but I eagerly read the position papers. I copied them and shared them with our department's faculty to initiate dialogue about the analysis and the positions expressed and to use this discourse as a means of helping us consider our own future.

As I read through the papers, I felt increasingly sad. Several statements jumped out with startling reality. In their paper, "What Does Family Practice Need to Do Next? A Cross-generational View,"[1] Geyman and Bliss lament that the hopes of family medicine's founders have fallen far short of their expectations. Specifically, they state that family practice did not "reform medical education, medical practice, or the health care system," "family practice remains only one of several options for primary care," during the past 30 years, the "generalist-specialist ratio has shifted farther to specialists and shows no signs of shifting back toward generalists," and "the three primary care disciplines remain distinct tribes on parallel but separate courses."

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Over the past 17 years of my professional career, I have worked within the context of university academic health center environments. Within that context, the observations of Geyman and Bliss ring true. We have not reached our potential. Why?

It is easy to externalize blame—other departments, medical school administrators, political pressure from other specialties, a hostile climate, and a culture that did not espouse our values.

However, the next position paper by Magill and Kane, "What Opportunities Have We Missed, and What Bad Deals Have We Made?"[2] supports my long-held hypothesis that family medicine needs to share some of the blame. Magill and Kane indicate that, in retrospect, family medicine made some bad decisions, including establishing "family practice as a distinct specialty" and espousing a "go-it-alone philosophy" that has "resulted in a self-defeating isolationism." They also suggest that we are still afflicted by a "permanent counterculture" mentality that tries to emphasize "differences from the rest of medicine" while simultaneously struggling to be part of mainstream medicine.

I propose that at least two other factors also account for our failure to realize our potential, especially in the academic setting. First, we never really loved the university-based academic health center as an institution, and, second, in many cases we adopted the wrong leadership model.

Attitudes Toward the University-based Academic Health Center

Throughout my tenure as a faculty member in several academic departments of family medicine, I have frequently heard the academic health center maligned and criticized—almost demonized. Many in family medicine exhibited the sentiment that the entire institution was corrupt and needed to be destroyed so that it could be recreated in the image that they envisioned. They easily embraced the community hospital environment over the university. In fact, some even suggested that the medical school should exit the university and return to community hospital or health system sponsorship.

This attitude contrasts sharply with the spirit I observed a year ago when I had the privilege to represent my university as a fellow in the Academic Leadership Program sponsored by the Committee on Institutional Cooperation (CIC), an academic consortium that links 12 major research universities in the United States. Through programs of communication and voluntary cooperation, the CIC has catalyzed change, innovation, and resource extension and enhancement on the campuses of its member universities. The collegiality and corporate citizenship that existed among fellows and faculty from diverse academic disciplines and universities profoundly impressed me. Their identity as faculty colleagues in the university took precedence over

their individual discipline identity, and they spoke almost reverently about "The Academy"—that society of learned persons organized to advance art, science, and literature—to which they all belonged. Further, the Academy was universal in scope, extending well beyond institutional or even state and national boundaries. These faculty were truly in love with the university—with its history, its traditions, its culture, and perhaps most of all, its values. Because of that devotion, they had committed themselves to serve the institution, working individually and collectively for its survival, helping it to manage change and thrive. They understood that the welfare of their own academic and professional disciplines was intimately connected with the survival of their institutions. They understood the meaning of interdependence.

I firmly believe that if we in family medicine expect to influence our academic health centers in regenerative ways, we must learn to love them for their strengths, to appreciate their positive values, and to care about their futures. Family medicine needs to be appreciated as a valued contributor to the academic culture, not as a demonstrative critic that is unwilling to work for the common good of the institution. When others perceive that we care and that we value them, we will more likely be trusted and given opportunities to influence change through collaboration and by getting our hands dirty in the same trenches where others toil.

Leadership Models

The second factor—adopting the wrong leadership model—also influences our relationships with others in our institutions. Many early leaders in family medicine did not originate from the ranks of academic faculty. They did not hold academic values or understand the nature of the academic environment. For many, their leadership experience was limited to hospital medical staffs or local, state, and national professional societies. The style of leadership they frequently employed focused on successfully manipulating political influence and establishing control by exercising their positional power. The leadership model resembled military leadership more often than academic leadership. The department head behaved like the general whose goal was to establish a beachhead in hostile territory and then, through repeated conflict and confrontation, gradually gain territory until the final battle was won, and he had conquered. Whereas this leadership style may have established departments of family medicine in many medical schools, it did little to win the confidence of other departments, to gain their trust, to break down barriers between them and family medicine, to establish strong coalitions with disciplines who shared similar values with family medicine, or to create opportunities for institutional leadership.

What leadership model may have been more successful? I suggest that a model that applied the philosophy of service to the practice of leadership would have helped family medicine to achieve greater gains. This is the model that Robert Greenleaf so eloquently expounded as a modern-day leadership prophet. Many contemporary theorists and authors in the field of leadership—Max DePree, Peter Senge, M. Scott Peck, Peter Block, Ken Blanchard, Stephen Covey, Warren Bennis, Jim Kouzes, and James Autry, to name a few—acknowledge that Greenleaf's ideas have profoundly influenced their work

In his first essay on leadership, "The Servant as Leader," Greenleaf began to describe the characteristics associated with this style of leadership. He wrote, "It begins with the natural feeling that one wants to serve, to serve *first.* Then conscious choice brings one to aspire to lead. . . . The difference manifests itself in the care taken by the servant — first to make sure that other people's highest priority needs are being served. The best test . . . is: Do those served grow as persons? Do they, *while being served*, become healthier, wiser, freer, more autonomous, more likely themselves to become servants?"[3]

After many years of studying Greenleaf's writings, Spears suggests that 10 central characteristics form the core behaviors that are necessary for practicing servant-leadership.[4]

1. *Listening.* By listening intently and receptively to others, servant-leaders attempt to identify and clarify the will of the group. They also listen to themselves and seek to comprehend what their own body, spirit, and mind are communicating.

2. *Empathy.* Servant-leaders accept and recognize the uniqueness of others. Even when they cannot accept the behavior or performance of others, servant-leaders do not reject them as people.

3. *Healing.* A great strength of servant-leaders is their ability to help heal relationships. This is a powerful, transforming force.

4. *Awareness.* Awareness is that state of being sharply awake to what is happening, both internally and externally to the group, and within the leaders themselves. This characteristic helps servant-leaders comprehend issues of ethics and values, and it leads them to a more integrated, systemic understanding.

5. *Persuasion.* Servant-leaders convince others to adopt a certain position or to embark on a course of action through discussion, negotiation, intercession, and earnest reasoning, rather than by coercing compliance with their will exercised through positional power and authority. Servant-leaders build consensus.

6. *Conceptualization.* Servant-leaders think beyond the realities of the present moment. They nurture their ability to dream great dreams,

constantly envisioning fulfilled potential and new realities.

7. *Foresight.* Servant-leaders have the unique ability to anticipate the likely outcome of a situation. Foresight requires that leaders develop their intuitive sense so that they can reliably predict the consequences of a decision or course of action. To do so, they must integrate a clear understanding of past lessons with present realities.

8. *Stewardship.* Servant-leaders hold their organizations "in trust" for the greater good of others and, ultimately, of the larger society. The organization does not exist to serve the leader. Further, the organization does not belong to the leader. Stewardship means that, above all else, the leader's role is to preserve and enhance the organization's ability to serve the needs of others.

9. *Commitment to the growth of people.* Servant-leaders believe that people possess intrinsic value beyond their contributions to the organization. This belief results in a deep commitment to do everything within their power to nurture the personal, professional, and spiritual growth of those they lead.

10. *Building community.* Servant-leaders seek to build true community within their organizations, where people constantly interact with each other, learn from each other, share common fellowship, and actively care for each other's welfare.

Greenleaf also suggested that servant-leadership was required for institutions as well as individual leaders. His thesis was: "If a better society is to be built, one that is more just and more loving, one that provides greater creative opportunity for its people, then the most open course is to *raise both the capacity to serve and the performance as servant* of existing major institutions by new regenerative forces operating within them."[5]

What Would Have Happened . . .

I can't help but wonder, what would have happened if 30 years ago, all our founding family medicine department chairs had practiced leadership as servants within their own departments and if all our departments of family medicine had committed themselves to the servant model for regenerating their academic health centers. What would have happened if, as departments, we had (1) seriously listened and tried to understand the concerns of other departments, (2) empathized and walked together with other departments, even when we disagreed with them, (3) worked hard to heal fractured relationships, (4) tried to be aware of what was happening within other departments as well as our own, (5) used persuasion more than coercion to establish our position within the institution, (6) helped our institution to think beyond the present and set a successful course for the future, (7) held in trust what was given to us by the university and used that to serve the needs of other departments and the academic health center to which we belong, (8) committed ourselves, not only to grow our own departments, but to help nurture and develop others, and (9) truly dedicated ourselves to building an authentic sense of community within our academic institutions.

From what I observe as the "guard changes" in academic family medicine, I believe that transformation is starting to occur in the relationships we share with our academic health centers and in the leadership models of our current chairs. I still can't help but wonder, however, if we had really loved our academic institutions 30 years ago, if we had sincerely embraced their values, and if we had genuinely wanted to lead them as servants, would we still ask ourselves today why we failed to regenerate them?

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References

1. Geyman JP, Bliss E. What does family practice need to do next? A cross-generational view. Fam Med 2001;33(4):259-67.
2. Magill MK, Kane WJ. What opportunities have we missed, and what bad deals have we made? Fam Med 2001;33(4):268-72.
3. Greenleaf RK. The leader as servant. In: Greenleaf RK. Servant leadership: a journey into the nature of legitimate power and greatness. New York: Paulist Press, 1977:7-48.
4. Spears L. Introduction to servant leadership. In: Greenleaf RK. The power of servant leadership. San Francisco: Berrett-Koehler Publishers, 1998:1-15.
5. Greenleaf RK. The institution as servant. In: Greeenleaf RK. Servant leadership: a journey into the nature of legitimate power and greatness. New York: Paulist Press, 1977: 49-90.