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Military Leadership Lessons for Training Doctors

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Elite medical training programs proudly proclaim that they are preparing future healthcare leaders. But with their focus on clinical disease management and research, training programs actually offer little in the way of true leadership training – authentic experience that helps young doctors develop the leadership skills they will need.

To address this gap, the Vanderbilt Department of Otolaryngology developed a 4-year program that consists of selected Naval ROTC leadership topics, public speaking training, a micro-MBA course, and a capstone leadership project on community disease prevention that puts students into leadership roles.

When I describe this program I get a lot of questions about the military portion. Why reach out to the ROTC? Medicine and the military seem to reside in opposite worlds, the former devoted to saving lives and the latter, when called upon, to ending them. Yet, both are made up of large, complex organizations with clear leadership needs at many levels. The military is highly disciplined in its leadership training, understanding that leadership skills aren't automatically endowed upon joining the organization. Medicine, contrastingly, assumes that its intelligent, industrious providers will somehow evolve into leaders as circumstances require, but without formal leadership training. So, we contacted the ROTC to see what we could learn from them.

Over the course of a year, we learned a lot about how the Navy trains leaders, and have incorporated many military training strategies into the leadership education for our young otolaryngology trainees. Several lessons have emerged from this experiment that are applicable in medical training and, indeed, throughout health care.

Lesson 1: *Medicine must increase its focus on fundamental communication skills.*

Young recruits entering the Navy are often unskilled in (or unaware of) the basic interpersonal social graces that enhance relationships. Sailors are taught to stand when someone enters the room, to shake hands and make eye contact, to use polite greetings like "sir" and "ma'am," and to listen attentively. Young doctors typically receive little such training. Any patient can tell you that health care providers are uneven at best in their greeting and communication skills. Health care leaders, and indeed any provider, must communicate well both verbally and non-verbally. But these days harried providers often make more eye contact with a computer screen than with the patient and family. Providers also increasingly must communicate with groups ranging from internal stakeholders to large audiences at external meetings. Yet doctors rarely receive training in public speaking – and it shows.

What we do now: To build skills in one-on-one communication, we train our residents using paid actors as simulated patients. To enhance presentation ability, we have added an eight-hour course in public speaking to our curriculum.

Lesson 2: *Medicine needs to expand selection criteria for promotion and train individuals to take on the next responsibility*.

When Navy personnel — having been evaluated frequently according to a standardized method — receive a promotion, they are considered unprepared to assume the new command. As one ROTC trainer explained, "When you are promoted on a Friday afternoon, nothing magical happens over the weekend to make you smarter, richer, better looking – or a better leader — by Monday morning". For each promotion, the Navy sends the individual for additional training, customized for the new position, before he or she assumes the new role. Medicine's promotion tracks are currently structured for success in research, educational and/or clinical skills; promotion is not based on pre-eminence in managerial or leadership skills. Even a full professor typically remains ignorant of vital skills related to organizational behavior, operations management, finance and strategy. And no tailored management or leadership training is regularly offered for physicians who become departmental service chiefs, chairs or deans, or who assume hospital executive roles.

What we do now: We have added an 18-hour micro-MBA course for our resident trainees that exposes them to senior administrators from national healthcare organizations such as Kaiser Permanente, Partners HealthCare, and Vanderbilt University Medical Center. The coursecovers topics including healthcare policy, finance, and organizational culture as well as decision making (led by an Air Force colonel) and conflict resolution (led by a minister). Importantly, in each of the past 4 years one faculty or staff member has matriculated for a master's degree in healthcare management.

Lesson 3**:** *Medicine must embrace checklists and debriefings to improve safety.*

In an earlier time, a persistent level of naval aviation accidental injury and death seemed inevitable. Unwilling to accept its accident rate, the Navy introduced pre-flight checklists and post-flight debriefings for every flight – and accident rates have fallen. Although conscious efforts to improve quality and safety in medicine are under way, checklists in medicine are still novel; debriefings, regrettably, mainly occur only in response to poor outcomes.

What we do now: To teach us about their method**,** our ROTC team entered the room in flight suits and reenacted the lengthy processes of checklist and debriefing as it would happen on an aircraft carrier. Knowing that surgeons only erratically conduct organized postoperative debriefings, we are creating a formal debriefing program and our faculty and trainees have already have begun impromptu post-operative performance conversations after most surgical procedures.

Lesson 4: *Medicine needs to reflect on perpetuation.*

Our ROTC collaborators advanced the surprising opinion that the sole role of the Navy was not the defense of the nation. Instead, they posited that the Navy's equally important role is perpetuation of the organization so that the future national defense never will be in peril. Perpetuation requires training to be continually upgraded to

anticipate future needs. Medicine largely trains using classroom educational models developed a century ago – a tired didactic methodology based mainly on the lecture format (plus our still-successful experiential methodology based on active participation in the clinics and operating rooms).

***What we do now*:** Our Otolaryngology training program has revitalized the traditional didactic training program and uses educational methods pioneered in business schools to de-emphasize lectures and promote active team learning, using Bloom's Taxonomy of learning objectives as an intellectual platform.

Our program is a work in progress, but we have early indications of success. For example, this year our residents have undertaken a capstone project that tests their leadership skills. Residents divide into teams and work with Vanderbilt undergraduates, primary care physicians, and others on population-health projects focused on preventing head and neck cancers. They must define their goal, determine performance measures, find and engage allies, create budgets, and publicly report their results, using the tools they've acquired through the program. Our annual resident rankings on a standardized national survey reveal a 100% satisfaction with our training approach, compared to the national average of 74%. In an anonymous vote last year, the residents unanimously supported an acceleration and expansion of the changes we've begun – despite the increased workload they represent.

We are fortunate that our resident-level training efforts are aligned within our larger medical school culture since the wrong culture can eat the best strategy. Any group working to implement leadership training within a healthcare organization must be mindful of the broader organizational culture and be prepared to overcome inertia (and sometimes active resistance) in order to effect behavior change. That, after all, is what the best leaders do.

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