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Doctoring as Leadership

the power to heal

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ABSTRACT   Physician power has been attacked, and tabooed, in legitimate efforts to strengthen patients' rights. Yet the structural and symbolic power wielded by doctors is what makes good and right healing actions possible. Avoiding the power issue contributes to a confusing state, where patient trust is faltering and physicians are uncertain about how to fulfill the doctor's role with the intellectual tools of mere science and technology. I argue that constitutive characteristics of health, illness, and the clinical encounter necessitate a prescriptive and responsible healing agent who is more than a technocrat, an information broker, or a seller. The article proposes clinical leadership as a concept offering practical and ethical direction to clinicians, education, research, and health policy. Leadership presupposes reflective awareness of physicians' structural and symbolic power, and is displayed as discerning, empowering improvisations in critical situations, based on empathy and willingness to learn from patients. The notion of clinical leadership highlights patient vulnerability, medicine's ethical core, and the importance of character development in medical education.

W HY IS IT SO DIFFICULT TO TEACH STUDENTS how to be good doctors, while it is relatively easy to teach them the most complicated biotechnology (Cassell 2004)? Why are many patients dissatisfied, when medicine is more successful than ever in combating disease? It has been argued that inadequate communication skills may express a lack of practical knowledge among modern-day

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physicians in general, and teaching faculty in particular, concerning the relational aspects of health, healing, and doctoring (Cassell 2004; Kirkengen 2001; Malterud 2001; Stewart et al. 1995; Tauber 1999). Historically, this may be seen as an inadvertent effect of the scientific shift in medical education and clinical practice during the 20th century (Cassell 2004). Medical education is now dominated by physicians who are also career scientists, and the objectifying epistemological ideals of natural science strongly influence the teaching and practice of clinical medicine (Good 1994; Sharpe and Carson 2001; Tauber 1999).

Another macro-scale change pulling in the same direction—away from the patient—can, paradoxically, be attributed to the development of bioethics since the 1970s. Starting as a justified reaction against paternalist power abuse, medical ethics has raised patient autonomy to a sacrosanct position. This may have harmed the patient-doctor relationship by causing physicians to shun care-taking or counseling behavior that can be interpreted as paternalism (O'Neill 2002; Stirrat and Gill 2005; Wulff 1995).

In this paper I argue that universal characteristics of the cultural institutions of medicine, of health, illness, and the clinical encounter as a healing covenant, necessitate a prescriptive and responsible healing agent, a physician who is more than a technocrat, a broker of information, or a seller of commodities. To maximize the power to heal while minimizing the risk of abusing it, we need a model of the clinical relationship that makes clear how medical power is created and maintained, how the roles and responsibilities of physician and patient interact, where the major ethical risks lie, and what competencies physicians should strive for. The model should be sufficiently complex to deal with the multilayered interactions of scientific, social, and symbolic aspects of clinical encounters, yet simple enough to be of real help to medical students and doctors in understanding and developing their own professional identities. I do not aim to fully develop such a model in this article; rather my goal is to present a contributing idea—that of clinical leadership—and explore some of its implications. My suggestions are based on literature studies and my own experience from general practice, hospital clinical work, and medical teaching.

Leadership is both a straightforward concept from everyday life, easily understandable for the student, and a theoretical concept that opens up a wide field of scholarship and practical experience from many fields. The term is often misconceived in terms of hierarchical models, where leadership expresses the exceptional qualities or techniques of the person "at the top." The notion of clinical leadership presented here takes leadership to be a fundamentally cooperative, culturally situated function, expressed in the ability to perceive and create structure in complex social processes, especially in crises, when meaning and order threaten to break down (Barker 1997, 2001; Heifetz 1994; Sørhaug 1996). Clinical leadership is a relational competence, where empathic perceptiveness and creativity render doctors capable of using their personal qualities, together with the scientific and technologic tools of medicine, to provide individualized help,

attuned to the particular circumstances of the patient. Whether one uses the term *clinical leadership* or similar terms, such as *coaching*, *mentoring*, *counseling*, and so on, is trivial. The important point is to highlight that physicians have power in other people's lives and must develop adequate theoretical insights, skills, and character traits to wield that power for the benefit of their patients. This article provides arguments for this view and discusses how clinical leadership relates to paternalism, patient autonomy, and the Aristotelian intellectual virtue of *phronesis*, or "practical wisdom"—the ability to judge what will be good for another person in a given situation and to act accordingly.

The Physician-Patient Relationship

The principal determinants of patient dissatisfaction consistently concern interpersonal aspects of care, most importantly communication and empathy (Sitzia and Wood 1997). Studies also show that feelings of professional uncertainty are prominent among students and young doctors, especially when confronted with intimate, emotionally laden situations (Christakis and Feudtner 1997; Sinclair 1997). Doubts about how to fulfill the role of doctor may persist well into professional life, in experiences of insufficiency and embarrassment in clinical situations (Lundh, Segesten, and Bjorkelund 2004; Mathers, Jones, and Hannay 1995).

Clinical interactions that are emotionally and professionally challenging are of course not limited to patients who present with "unexplained" symptoms, though these constitute some 25–30% of consultations in primary health care and 20% of outpatients in secondary care services (Kirmayer et al. 2004; Reid et al. 2001; Snijders et al. 2004). The demanding relational tasks that constitute large parts of any clinician's workload include such responsibilities as breaking bad news; supporting the dying and their families; following up with patients with mental disorders or chronic disease such as diabetes, AIDS, or obstructive lung disease; motivating patients to follow treatment regimens and deal with overweight, smoking, or alcoholism; and supporting relatives of Alzheimer patients or accident victims. Both the quality of care as experienced by patients and—presumably—the quality of the physician's professional life hinge on the doctors' ability to address the emotional and existential aspects of illness and provide a personalized "holding environment" for his or her patients (Duff 1987).

It is possible, however, to construct the physician-patient relationship in ways that appear to avoid this responsibility for the patient as a person. In one such model, physicians are seen as mere brokers of scientific knowledge, neutral experts who can navigate the medical system, understand disease processes, know the therapeutic options, and are able to present these facts to rational patients. On this view, respect for patients' autonomy prevents doctors, on ethical grounds, from assuming a leadership role: clinical decisions are made by the patients, based on valid information (Emanuel and Emanuel 1992). Traditional

medical education adopts this rationalist view: "communication" is seen as a way of collecting data from and providing factual information to the patient in an efficient and rational way, without considering how illness affects mental faculties or how tacit aspects of dialogues with caretakers influence patients (Cassell, Leon, and Kaufman 2001). As argued by Emanuel and Emanuel (1992), the "information broker" model of the physician–patient relationship is inadequate, because its concept of patient autonomy is untenable: freedom of the will and autonomy inhere not in the exercise of unchallenged values, but in the ability to learn, to change preferences, and to modify identity through self-reflection and deliberation.

A different tack to avoiding personal involvement with patients is the commercial view of medical services, in which physician–merchant and patient–customer have interests too different for them to constitute a goal-directed dyad. The "commodification" of health services has been heavily criticized, however, on ethical grounds (Kaveny 1999). Like the informational model, a strictly commercial medicine presupposes that the patient is rational, well-informed, and knows what is best for him, assumptions that do not hold, especially not when people become seriously ill, worried, or existentially threatened—that is, when their need for medical help is most acute (Cassell, Leon, and Kaufman 2001). Adequate medicine generally cannot be exercised within a purely commercial relationship.

Power and Trust

Anthropologists have defined *power* as "a capacity of persons and institutions to make people do things they would otherwise not have done," such as lose weight, use prescription drugs, undergo a risky operation, or feel hope in adverse circumstances (Sørhaug 1996). Power can be seen as a meta-concept or a "floating expression," a potential that in itself is empty and indefinable until materialized in a concrete situation. Relational power is founded on trust. Both power and trust have energy-like qualities; they are potentially present in all social situations, are not restricted to specific forms or expressions, and constitute preconditions for action and cooperation (Sørhaug 1996).

Until the 1960s, physicians were generally trusted, and their power was openly displayed. For example, it was customary for a student nurse, such as my mother, to attentively carry the professor's stool one step behind him from bed to bed during rounds, allowing him to sit down at any moment without even having to look around. Sociologist Talcott Parsons (1951) saw the social power wielded by medicine not as oppressive, but as a general capacity and medium to secure binding obligations in a social system, and thus a precondition for medical efficiency. From the mid-1960s, however, paternalism and power abuse in clinical medicine and research was publicly exposed and heavily criticized (Beecher 1966; Freidson 1970). Through its power to define important aspects of reality, medicine came to be seen as an institution of social control more dominating than

religion or the legal system (Zola 1972). Modern bioethics arose in this intellectual climate, and with it a strong notion of patient autonomy (Beauchamp and Childress 2001).

The negative picture of medical power has, however, itself come under serious criticism, as shown by Måseide (1991) in his aptly entitled article "Possibly Abusive, Often Benign, and Always Necessary: On Power and Domination in Medical Practice." Måseide argues that the benefits of medicine would not exist, were it not for power. Power can be seen as constitutive of institutionalized medical knowledge, medical practice, and lay conceptions of health-related phenomena. The social recognition of medical competence establishes a common "cognitive institution" that facilitates doctor-patient interaction and creates "a legitimate hierarchy of domination and subordination, recognised by all participants" (Måseide 1991). Power in this model does not constitute relationships of domination-deprivation. Studies support this by showing that most patients want their doctors' active participation in medical decisions, and more so when the severity of illness increases. When physicians become patients, they also follow this pattern, suggesting that medical knowledge and sociocultural factors are only minor determinants of patients' attitude to medical decision-making (Ende, Kazis, and Moskowitz 1990).

Power in clinical medicine is constitutive, necessary, and potentially destructive. Patients are particularly vulnerable in the very act of relying on the clinician's competence and judgment, on at least two levels. The first concerns the possibility of damaging or life-threatening judgmental or technical errors; the second is the threat of shame and loss of dignity inherent in the exposure of intimate secrets and body parts, the danger of losing self-respect and even hope, by being met with disbelief, ridicule. or indifference on presenting one's problems (Kirkengen 2001; Rendtorff and Kemp 2000).

The social sciences focus mainly on the structural and institutional aspects of medical power, without considering how the "objective" power of medicine translates into subjective, lived life, influencing a particular person's body and thoughts, feelings, language and actions—indeed, his or her health. This, however, is the level where medical leadership has its main impact. The competent physician actualizes medicine's power to heal not only by adequate use of biotechnical tools, but also by providing hope, empowerment, or even cure, through transformations of meaning.

Symbolic Power

Human existence is a continuous process of interpretation, or hermeneutics, whereby we construct meaning from other people's (and our own) words, actions, facial expressions, uniforms, titles, etc. (Gadamer 2004). The understanding gained is decisively informed by personal experience of the norms, conventions, stories, language, and technology that constitute "culture." Social anthro-

pologist Clifford Geertz (1973) describes culture as an "historically transmitted pattern of meanings embodied in symbols . . . by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life." Symbol, in Geertz's usage, can be "any object, act, event, quality or relation which serves as a vehicle for a conception—the conception is the symbol's 'meaning'" (pp. 89–90). Everything has a symbolic aspect or function, in addition to whatever other qualities it might have (Stivers 1999). Suffering inheres in the perceived meaning of an event: a pain hitherto bearable may suddenly become intolerable when its cause is revealed to be cancer. The rational systems of medicine—the technology and routines, as well as the stereotyped role figures of "doctor," "nurse," and so on—have cultural connotations of hope, trust, agency, and authority. The placebo phenomenon reveals that meaning influences physiology: technically inert substances and methods, when presented to patients as elements of normal medical procedures, can substantially influence organ function (Moerman 2002). Meaning is power.

The strong healing potential of the doctor-patient dyad has been highlighted by outcome research in psychotherapy, the main effects of which do not stem from the specific therapeutic method applied (Wampold 2001). The outcome depends largely on the client's perception of the therapeutic context and the relationship to the therapist, "independently of the therapist's formal competence, training or theory-directed behavior in the therapy" (Ekeland 1999). Given a set of positive cultural expectations, a therapeutic alliance emerges when patients perceive their therapist as a warm, helping, and supportive person, a powerful other who is engaged and shares responsibilities in a common struggle to alleviate the patient's suffering.

A therapeutic alliance emerges through reciprocal interpretation and projection. As doctors "read" the patient, the story, and the body, so patients always engage in a reverse hermeneutics: patients "read" and interpret the physician, judging his or her interest and care for the patient as a unique person. As one patient expressed it in a research interview: "I feel so calm and safe when I know that the doctor simply *sees* me" (Steine, Finset, and Lærum 2000). The healing effect of the physician-patient relationship is what Balint (1964) called "the drug doctor."

Important lessons may be gleaned from these considerations. To the extent that patients, with or without serious disease, also suffer—that is, experience mental imbalance, self-contempt, isolation, grief, fear, and other feelings commonly associated with illness, pain, and existential loss—the literature suggests that becoming part of a therapeutic alliance is in itself conducive to healing and adaptation. This may be especially true—and valuable—when medical technology has little to offer in the way of further diagnostic or therapeutic procedures, as in chronic disease and dysfunction. The outcome of the alliance does not depend on the doctor's technical competence in psychotherapy or counseling, as long as the physician is able to establish and maintain the alliance. The doc-

tor's power in such cases is not technical, but relational and symbolic: the physician's engagement helps the patient perceive reality, both manifest and potential, in ways that strengthen hope, self-esteem, and the ability to learn and adapt.

Authority versus Leadership

Following Heifetz (1994), I contrast leadership with authority, where *authority* designates the power inherent in formal, institutionalized aspects of medicine.[1] When things proceed in predictable and ordered ways, as when a patient presents a problem that can easily be solved by applying standard procedures (a broken wrist, for example), medical authority suffices, and routinized decisions can to some extent replace leadership. This reduces complexity and uncertainty, and increases efficiency. Precisely for this reason, it is also a trap, a temptation to redefine problems so that they fit ready-made solutions. If a young mother is going to die of cancer, it is a denial of reality to define the primary problem as "cancer," yet this may seem tempting both to doctors, patient, and relatives, because it avoids the painful emotions involved in adaptive change. As Heifetz notes: "Even the toughest individual tends to avoid realities that require adaptive work, searching instead for an authority, a physician, to provide the way out. And doctors, wanting deeply to fulfill the yearning for remedy, too often respond willingly to the pressures we place on them to focus narrowly on technical answers" (p. 76). Leadership is more demanding than authority, less predictable, and more prone to failure. Leadership is founded in crisis and aims at adaptation through learning, writes Barker (2001). In complex situations the leader's role cannot be precisely defined in advance: there is no real control and no valid theory of prediction. Leadership can only emerge as an improvised adaptation to the transforming processes of the situation.

Such a conception of leadership is clearly relevant for clinicians. First, medical encounters are primarily concerned with crises, perceived breakdowns in the order of a person's lived life. Crises motivate people to seek help and declare themselves in need of support and guidance. Hence a mandate to lead, originating in vulnerability and helplessness, typically emerges in the very act of establishing the physician–patient relationship: "authority is something which doctors have almost pressed upon them" (Gadamer 1996, p. 119). The notion of leadership does not entail that doctors should set the goals; rather, it suggests a facilitating role in the patient's attempts to understand and act wisely in times of crisis.

Second, every encounter between patient and caretaker is conducted as a dialogue, and all dialogues, even structured ones such as the medical history-taking ritual, consist largely of rule-defying improvisations. Both process and outcome of dialogues are, in principle, unpredictable, and the premises often change as one

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[1]*Authority* should not be confused with *authoritarian*. The latter denotes abuse of power in a totalitarian manner, whereas the former is an indispensable characteristic of all social organization.

goes along and new meaning emerges. That is not a problem in social conversation, which normally is not a power relationship and not instrumental. In medicine, however, the dialogue is the power tool by which leadership becomes a healing force. Dialogue is the foundation of all decisions and technical actions, one-sidedly directed towards the physician's attainment of cooperation, information, and consent from the patient; at the same time, dialogue is the means for establishing rapport, showing respect, concern, and compassion, and for sharing information and advice.

How to achieve all this in any given consultation cannot be predetermined. No communicative "techniques" will spare doctors the task of continuously making improvised decisions about what to say and do, how, and when. Gestures, facial expressions, intonation, pauses, eye movements, and so on, typically convey more information than mere words. Meaning is transmitted on several levels simultaneously: compassion and understanding may be expressed through the look in the doctor's eyes, or the timbre of the voice, or the speed of talking, while factual business is carried out in the explicit, verbal lane. Both participants in a dialogue monitor themselves, and the other, and the other's apparent interpretations of one's own utterances, in a complex recursive interplay. The dialogue thus continually produces new meanings, based on what has already happened in the conversation and the relationship, and on several strata of context, among them the cultural connotations of medicine and doctors as symbolic institutions (Nessa and Malterud 1998). Being in charge of the clinical encounter, even in apparently straightforward consultations, fits Barker's (2001) description of leadership as a competence that "has much more to do with action based upon perceptions of emerging structure in systems where order is periodically breaking down and reforming than it does with the imposition of structure and control relative to an a priori configuration." Thus clinical leadership should never be reduced to the application of procedures or communicative techniques—skillful improvisation based on empathic understanding of the other's perceived reality is always the core of doctoring. Hence mistakes are unavoidable, and the doctor's approach must be correspondingly humble.

Healing as Ethical Leadership

The wielding of power in relationships is always an ethical endeavor, and more so in medicine: the patient is not a diseased object, but a fellow human being, rational and intelligent, often charged with emotions, anxious and perturbed. Ethical challenges reside in micro-decisions that appear simple and straightforward, such as taking the history and doing the clinical examination. How does one gain the trust of a person one has never met before, and get access to her most private experiences, of fears or anxieties, sexual history, family violence or drug use? How does one explore a person's body across all demarcations of taboo without causing shame and humiliation? How does one help without suppress-

ing the patient's capacity for self-help? As Komesaroff (1995) notes: "The ethical question, 'What should I do?,' is perpetually and critically at issue" (p. 68).

When a diagnosis has been made and trust is established, the ethical challenge remains, in endlessly varied forms, always demanding judgment and improvisation. A family doctor who has to divulge a fatal diagnosis to a young mother is faced with a problem that has no technical solution, yet is clearly medical. The immediate pain, grief, and anxiety of the patient, her husband, and children overshadow the questions of cancer therapy. Given the vulnerability and dependence of people in acute existential crises, small nuances in the doctor's behavior may be decisive for the life course of the patient and the "moral community" surrounding her (Duff 1987). The moral stakes are salient, yet abstract ethical principles of respect for autonomy, justice, beneficence, dignity, integrity, and so on, offer little guidance to the doctor, because the ethically relevant decisions concern particular micro-level acts of caring for *this* patient, and how this patient will interpret the well-intended acts when performed by *this* doctor. Patient autonomy is threatened, not primarily by medical power, but by illness. What is needed is a healing relationship in which "the doctor as healer helps provide a route by which the sick patient may regain the autonomy lost to sickness" (Cassell 2004, p. 219).

The physician has practical and technical expertise, knows that adjustments are called for, and realizes, as an experienced clinician, that he or she does *not* know what adaptations the patient and family ought to make. Ethical behavior is displayed in the doctor's attempt to continuously learn with and from the patient and her family as they go along, using the relationship like a containing vessel for the family's adaptive process, regulating stress to keep it within a tolerable yet productive range.

Constructive assistance to people whose lives are falling apart sometimes entails challenging unfruitful adaptations and defenses. This is only helpful if the doctor is perceived by the patient and family as genuinely caring and nonjudgmental, thereby providing a holding relation which allows expression of vulnerability, dependency, and lack of emotional control. By providing an arena in which defenses can be relaxed and "primitive" emotions of anger and despair expressed and acknowledged, the physician-patient relationship can catalyze the growth of independence and autonomy in the patient and her family (Barnard 1987).

Leadership, Dignity, and Empathy

If doctors choose to avoid the complexity of leadership by falling back on technical authority or manipulative control, they usually also shortcut their own power supply, achieve less than desired, and experience frustration, possibly blaming it on the "difficult" patient. The power vanishes because patients continuously monitor and interpret the events, the doctor, and the relationship. If the patient feels disrespected or met with indifference or emotional incompe-

tence, she immediately loses trust, whereby the therapeutic alliance evaporates. This is, I think, what the discourse on patient autonomy is really about: patients' right to be met as fellow humans, with respect, by doctors who are trained to recognize their own vulnerability in that of their patients, are able to take responsibility by being taught by them, take risks by challenging and guiding them, and thereby integrate the fruits of learning-from-the-patient with the general knowledge of medical science. Leadership is often a matter of dignity.

Helping fellow humans presupposes some understanding not only of their lifeworld and who they are, but indeed of how it feels to be them. The ability to act in a responsible way rests on the perception of another's situation as morally relevant, which itself hinges on one's emotional capacity for recognizing the other's suffering *as* suffering (Vetlesen 1994). Apparently insurmountable obstacles to understanding can be overcome if doctors use the experience all persons have of being mortal and vulnerable, exposed to the frailty of body and relations, always susceptible to humiliation in encounters with others.

Against Paternalism

Paternalism, the notion that the physician has better insight into the best interests of the patient than does the patient, and is entitled to ignore or override the patient's choice, is an untenable principle, most often untrue, and in stark opposition to the caring ethos of medicine (Pellegrino and Thomasma 1988). But adherence to naïve models of total patient autonomy is also untenable, since illness, the sick role, and the mere presence of health care personnel continuously affect the patient and produce power asymmetries. Denying or tabooing the power of the physician-patient relationship on the ground that it represents "paternalism" will most likely increase the risks of unintentional harm, especially the harm caused by disengagement and unwarranted non-intervention for fear of infringing on patient autonomy (Stirrat and Gill 2005).

The notion of "clinical leadership" bridges the apparent gap between patient autonomy and physician power by providing a professional function and a set of competencies whereby physicians and other caretakers may manage and integrate trust, power, care, and vulnerability. Medical students must learn to understand themselves and their own role in context, and to respond to suffering as co-subjects, aware of the cognitive, emotional, and ethical challenges present in every moment of every encounter with patients. A basic task of training, therefore, is to help students and doctors strive to develop their personality and become "the right kind of person," by acquiring and acting according to moral and intellectual virtues (Pellegrino and Thomasma 1993).

Avoiding paternalism and its alternative, structural indifference, cannot be based solely on individual responsibility and competence, however. The individual practitioner is operating within powerful cultural and institutional structures (professional associations, legal authorities, mass media, the pharmaceutical

industry, and so on) that limit and direct the professional's self-understanding, attention, and range of actions. The quality of medical care will always reflect the informal mores of the healing professions and the internalization of these in the consciences of practitioners, through reflection, critical debate, and practice (Wynia et al. 1999).

Competence Beyond Theory

"Tell us how to do it!" is a common request from medical students who naturally feel insecure in the doctor's role. It is a request that cannot be fully complied with. Practical competence does not consist merely in the ability to apply theory or memorized action patterns. Practical situations never repeat themselves: they always have new aspects and implications, and require on-the-spot learning and interpretation. Principles cannot prescribe adequate action; thus competence manifests itself in the ability to devise a way to do it. This competence is the intellectual virtue that Aristotle in the *Nichomachean Ethics* called *phronesis*, or "practical wisdom." Phronesis is demonstrated by the practitioner who creatively combines knowledge of universals with experience-based rules of thumb to help "the right person, to the right extent, at the right time, with the right aim, and in the right way." The hallmarks of phronesis are perceptiveness, flexibility, and responsiveness, relational qualities that develop through practice and dialogue in supportive learning environments (Dunne 2001). Their product are mature understanding and judgment, which are precisely what makes it possible to improvise good adaptations to complex challenges (Strand et al. 2004–5).

If theory cannot instruct us how to lead in concrete situations, how then can it enlighten us on good leadership? Theoretical insight allows articulation and teaching of practical wisdom, and helps the wise practitioner resist intimidation by the sophistication, apparent power, and high prestige of "technicist approaches" (Dunne 2001, p. 368). Theory can inform us that the tasks of leadership must be solved in a non-dogmatic, exploratory way, and always involve learning and acceptance of fallibility. According to Cassell (2004); "Diagnostic and therapeutic power in clinicians is directly proportionate to their ability to tolerate uncertainty. . . . To seek certainty itself is ultimately to abandon the patient" (p. 220).

Conclusion

Doctoring entails and generates power. Scientific, technological, societal, and relational forces give doctors the mandate to effect constructive changes in their patients' lives, including its somatic aspect. Ignoring or denying the responsibility to lead may cause harm to patients.

The concept of clinical leadership opens up rich arenas for empirical research

and theoretical reflection on healing encounters. Clinical leadership demands internalized competencies beyond strict epistemic knowledge of facts, rules, and procedures, and necessitates personal involvement beyond the formal minimum. Aristotle's notion of phronesis designates a complex "intellectual virtue" representing the ability to construct adequate understanding of unprecedented particulars in human affairs, and to devise ways of dealing with them that are beneficial to all parties involved. Education for clinical leadership needs to focus on methods and experiences that enhance self-reflection, relational skills, and empathic understanding.

Though medical power may be, and indeed has been, used to abuse and exploit patients, it is not in itself "unethical," but indispensable for help and healing to occur. The notion of leadership highlights the ethical core of medicine, by acknowledging power asymmetry and patient vulnerability. The physician-as-leader must act in ways that respect the expectations inherent in the medical "social contract," while at the same time integrating scientific medical knowledge with knowledge of the particular patient's person, illness, and situation. Crucially, clinical leadership needs to be carried out in ways that convey self-awareness and intellectual humility, thereby "humanizing" the physician, strengthening the patient's dignity as a co-subject, and turning the relationship into a real encounter of mortals.

References

Balint, M. 1964. *The doctor, his patient, and the illness*. New York: International Universities Press.

Barker, R. A. 1997. How can we train leaders if we do not know what leadership is? *Hum Relations* 50(4):343–63.

Barker, R. A. 2001. The nature of leadership. *Hum Relations* 54(4):469–94.

Barnard, D. 1987. "Ship? What ship? I thought I was going to the doctor!" Patient-centered perspectives on the health care team. In *The physician as captain of the ship: A critical appraisal*, ed. N. M. P. King, L. R. Churchill, and A. W. Cross, 89–111. Dordrecht: D. Reidel.

Beauchamp, T. L., and J. F. Childress. 2001. *Principles of biomedical ethics*, 5th ed. Oxford: Oxford Univ. Press.

Beecher, H. K. 1966. Ethics and clinical research. *N Engl J Med* 274:1354–60.

Cassell, E. J. 2004. *The nature of suffering and the goals of medicine*. 2nd ed. New York: Oxford Univ. Press.

Cassell, E. J., A. C. Leon, and S. G. Kaufman. 2001. Preliminary evidence of impaired thinking in sick patients. *Ann Intern Med* 134(12):1120–23.

Christakis, D. N., and C. Feudtner. 1997. Temporary matters: The ethical consequences of transient social relationships in medical training. *JAMA* 278:739–43.

Duff, R. S. 1987. Unshared and shared decisionmaking: Reflections on helplessness and healing. In *The physician as captain of the ship: A critical appraisal*, ed. N. M. P. King, L. R. Churchill, and A. W. Cross, 191–221. Dordrecht: D. Reidel.

Dunne, J. 2001. *Back to the rough ground: Practical judgment and the lure of technique*. Notre Dame: Univ. of Notre Dame Press.

Ekeland, T.-J. 1999. Meining som medisin: Ein analyse av placebofenomenet og implikasjonar for terapi og terapeutiske teoriar. [Meaning as medicine. An analysis of the placebo phenomenon and its implications for therapy and therapeutic theories.] Bergen: Univ. of Bergen.

Emanuel, E. J., and L. L. Emanuel. 1992. Four models of the physician–patient relationship. *JAMA* 267(16):2221–26.

Ende, J., L. Kazis, and M. A. Moskowitz. 1990. Preferences for autonomy when patients are physicians. *J Gen Intern Med* 5(6):506–9.

Freidson, E. 1970. *Professional dominance: The social structure of medical care*. New York: Atherton Press.

Gadamer, H.-G. 1996. *The enigma of health*. Stanford: Stanford Univ. Press.

Gadamer, H.-G. 2004. *Truth and method*, 2nd ed. New York: Continuum.

Geertz, C. 1973. *The interpretation of cultures*. Repr. New York: Basic Books, 2000.

Good, B. J. 1994. *Medicine, rationality, and experience: An anthropological perspective*. Cambridge: Cambridge Univ. Press.

Heifetz, R. A. 1994. *Leadership without easy answers*. Cambridge: Harvard Univ. Press.

Kaveny, M. C. 1999. Commodifying the polyvalent good of health care. *J Med Philos* 24(3):207–23.

Kirkengen, A. L. 2001. *Inscribed bodies: Health impact of childhood sexual abuse*. Dordrecht: Kluwer.

Kirmayer, L. J., et al. 2004. Explaining medically unexplained symptoms. *Can J Psychiatry* 49(10):663–72.

Komesaroff, P. A. 1995. From bioethics to microethics: Ethical debate and clinical medicine. In *Troubled bodies: Critical perspectives on postmodernism, medical ethics, and the body*, ed. P. A. Komesaroff, 62–86. Durham: Duke Univ. Press.

Lundh, C., K. Segesten, and C. Bjorkelund. 2004. To be a helpless helpoholic: GPs' experiences of women patients with non-specific muscular pain. *Scand J Prim Health Care* 22(4):244–47.

Malterud, K. 2001. The art and science of clinical knowledge: Evidence beyond measures and numbers. *Lancet* 358(9279):397–400.

Måseide, P. 1991. Possibly abusive, often benign, and always necessary: On power and domination in medical practice. *Sociol Health Illn* 13(4):545–61.

Mathers, N., N. Jones, and D. Hannay. 1995. Heartsink patients: A study of their general practitioners. *Br J Gen Pract* 45(395):293–96.

Moerman, D. E. 2002. *Meaning, medicine, and the "placebo effect."* Cambridge: Cambridge Univ. Press.

Nessa, J., and K. Malterud. 1998. "Feeling your large intestines a bit bound": Clinical interaction—talk and gaze. *Scand J Prim Health Care* 16(4):211–15.

O'Neill, O. 2002. *Autonomy and trust in bioethics*. Cambridge: Cambridge Univ. Press.

Parsons, T. 1951. *The social system*. Glencoe, IL: Free Press.

Pellegrino, E. D., and D. C. Thomasma. 1988. *For the patient's good. Restoration of benficence in health care*. New York: Oxford Univ. Press.

Pellegrino, E. D., and D. C. Thomasma. 1993. *The virtues in medical practice*. New York: Oxford Univ. Press.

Reid, S., et al. 2001. Medically unexplained symptoms in frequent attenders of secondary health care: Retrospective cohort study. *BMJ* 322(7289):767–69.

Rendtorff, J. D., and P. Kemp. 2000. *Basic ethical principles in European bioethics and law. Vol. 1, Autonomy, dignity, integrity and vulnerability*. Copenhagen, Barcelona: Centre for Ethics and Law, Institut Borja de Bioetica.

Sharpe, M., and A. Carson. 2001. "Unexplained" somatic symptoms, functional syndromes, and somatization: Do we need a paradigm shift? *Ann Intern Med* 134(9, Part 2):926–30.

Sinclair, S. 1997. *Making doctors: An institutional apprenticeship*. Oxford: Berg.

Sitzia, J., and N. Wood. 1997. Patient satisfaction: A review of issues and concepts. *Soc Sci Med* 45(12):1829–43.

Snijders, T. J., et al. 2004. Prevalence and predictors of unexplained neurological symptoms in an academic neurology outpatient clinic: An observational study. *J Neurol* 251(1):66–71.

Sørhaug, T. 1996. *Om ledelse: Makt og tillit i moderne organisering*. [*On leadership: Power and trust in modern organizing*.] Oslo: Universitetsforlaget.

Steine, S., A. Finset, and E. Lærum. 2000. Hva er viktig for pasienten i møtet med allmennpraktikeren? [What is important for the patient in encounters with general practitioners?] *J Norw Med Assoc* 120:349–53.

Stewart, M., et al. 1995. *Patient-centered medicine: Transforming the clinical method*. London: Sage.

Stirrat, G. M., and R. Gill. 2005. Autonomy in medical ethics after O'Neill. *J Med Ethics* 31(3):127–30.

Stivers, R. 1999. *Technology as magic: The triumph of the irrational*. New York: Continuum.

Strand, R., et al. 2004–5. Complex systems and human complexity in medicine. *Complexus* 2:2–6.

Tauber, A. 1999. *Confessions of a medicine man: An essay in popular philosophy*. Cambridge: MIT Press.

Vetlesen, A. J. 1994. *Perception, empathy and judgment: An inquiry into the preconditions of moral performance*. University Park: Pennsylvania State Univ. Press.

Wampold, B. E. 2001. Contextualizing psychotherapy as a healing practice: Culture, history, and methods. *Appl Prev Psychol* 10(2):69–86.

Wulff, H. R. 1995. The inherent paternalism in clinical practice. *J Med Philos* 20(3):299–311.

Wynia, M. K., et al. 1999. Medical professionalism in society. *N Engl J Med* 341(21):1612–16.

Zola, I. K. 1972. Medicine as an institution of social control. *Sociol Rev* 20:487–503.