The transformation in transformative leadership

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In this issue of *The Pharos,* we celebrate the winning essay from this year's Robert H. Moser Essay contest,[1] as well as a second essay that received an honorable mention.[2] The Moser Award is presented to the author of an outstanding essay that celebrates the life of a physician who enriched the world through their career in medicine. Dr. Moser organized one of the first MASH units during the Korean War, and served in numerous posts, including Chief of Medicine at the Walter Reed National Military Medical Center, Editor of *JAMA,* Executive Vice President of the American College of Physicians, and member of *The Pharos* Editorial Board.

The Moser essays featured in this issue discuss important aspects of the life work of two physicians separated by more than a century in time but displaying remarkably similar characteristics in terms of their leadership. Dr. Smith's work in the New York State mental health system in the late 1800s and Dr. Wibe's work with the surgeons of Norway in the early twenty-first century are, in my opinion, case studies in relational leadership. We talk in modern times about things such as community-based participatory research and strategies to facilitate change and, at the end of the day, the process is wholly dependent not so much on strategy as it is upon mutual trust and understanding. Dr. Smith earned the trust of both the neurologist and the alienist (the precursor to modern psychiatrist) communities, who in many ways were at odds with each other, in his efforts to improve the conditions in New York State psychiatric institutions. Dr. Wibe and his collaborators earned the trust of the hospitals, rectal surgeons, and the public across the entire country of Norway in their efforts to get surgeons to adopt a new and difficult, but superior, approach to rectal cancer surgery. In an editorial in the Winter 2026 issue of *The Pharos,*[3] I mentioned that I believe relationships to be fundamental to the practice of medicine, and now here are two examples of the power of relationships in the practice of public health.

While relationships were critical for both Drs. Smith and Wibe in fostering their respective communities' adoption of new ideas, organizational structures, and personal behaviors, I think that there is a subtle and even more foundational event occurring in both stories, and that event has to do with both physicians' personal transformations. Dr. Smith was a surgeon experienced in public health and sanitation, who was being asked to take on the mental health infrastructure of an entire state. While he certainly brought who he was in terms of public health thinking to the task of reforming state psychiatric institutions, he also had to understand two very different mindsets with respect to mental health, and to incorporate and merge them with his own mindset, thereby emerging with a new understanding with respect to the care of the population of New York State psychiatric institutions. Dr. Wibe, as a budding general and colorectal surgeon, had to learn and adopt a technique that most in his field felt was either unnecessary, too dangerous, or both. In short, both physicians had to transform their thinking and, some might say their identities, as they set about doing the work in front of them. If one is inclined to quote overused cliches, both physicians embodied "being the change" before any widespread change could happen.

In the early years of my career, I was part of a group that was interested in exploring how we could better teach humanism at the bedside. The idea was relatively new at the time, and our leaders, William T. Branch Jr., MD (AΩA, Marnix E. Heersink School of Medicine at the University of Alabama at Birmingham, 1966), Thomas S. Inui, ScM, MD (AΩA, The Johns Hopkins University School of Medicine, 1988), and Gary A. Mitchell, MD, had assembled a collection of faculty at various stages of their careers for monthly conference calls to brainstorm, share stories, and challenge each other to think deeply not only about what humanism is, but also to generate new ideas about how to explicitly teach it in clinical settings.

One particular month, our call occurred on the day before I was assigned to do one of my monthly stints as ward attending. Our discussion that day focused on the idea that attending physicians are presented with myriad opportunities to role model or teach humanism but might miss them in the cognitive overload that exists on the teaching wards. I resolved to try to see such opportunities. Even if I did nothing different, my goal was to at least recognize the scenarios in which something humanistic could occur.

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The next day, I joined the new team on the ward. We were picking up a service that had been on call, and there was a whole group of patients who had been admitted overnight. As we entered the room of the first patient, I noticed an elderly man reclined in bed with a full tray of untouched breakfast in front of him. The intern started presenting the case: "Mr. B. is an 83-year-old man with a past medical history of dementia, who was admitted with urosepsis…" As the intern continued, it occurred to me that Mr. B. was unable to feed himself, and there was no one available to assist him in eating his breakfast. So, I sat down on the side of the bed, motioned to the intern to continue, scooped up a forkful of eggs, and offered it to him.

Mr. B. was hungry! As our team discussed the case, he enthusiastically gobbled up everything I offered. With the intern's presentation and our subsequent discussion winding down, his plate still had food to be eaten, and he was still enthusiastically taking everything I offered. I turned to one of the third-year medical students and asked, "Would you be willing to stay back and help Mr. B. finish his breakfast? You are going to be following him, and the nurses are overworked, and there is no one around to help to feed him. If you agree to do this, please page us when you are done, and we will let you know where we are, and my promise to you is that if we see any medical things that are really cool, we will double back, so that you can see them, too." The medical student said, "No problem!" and off we went.

I didn't give this little scenario another thought. While I tried to be mindful to make points about humanism during the month, I can't say I did or experienced anything particularly unusual for the internal medicine wards. At the end of the month, the senior resident, who aspired to a career in academic medicine, asked me if I would come early one day to watch her make work rounds with the team before our usual attending rounds, and give feedback and tips on teaching the interns and students. I agreed with the proviso that I would hang back at some distance down the hall and watch from that space to avoid any sort of Hawthorne effect my presence might have on her dynamic with the learners. I stationed myself down the hall as the team came to the first patient…

Whoosh!

The team swooped in on the patient and started fluffing the pillows, with one student running to fill the patient's water pitcher as the intern started presenting, and the other intern fixing the sheets that had slipped out from under the bed. The team completed its rounds and moved on to the next patient. I was perplexed. They arrived at the second patient's room…

Whoosh!

Same thing again. I had totally forgotten about our first day on the wards, and was thinking: "WHAT are these folks DOING?" They finished with the second patient and moved on to the room of the third…

Whoosh!

I couldn't stand it anymore. I came running into the room, exclaiming: "What are you folks DOING? What's up with the fixing, the water, all this *nursing stuff*?" They all looked at me with that kind of look my

sons sometimes give when I ask them an overly obvious question. "We got this, Dr. Haidet. We saw you feed that patient. We know the nurses are overworked. We know we can help, so we did." The matter-of-fact tone with which the answer came from multiple team members was unsettling.

In that moment, I had an epiphany. While I ascribed to and said that phrase "be the change you wish to see in the world" countless times before that day, my understanding of what it meant fundamentally changed in that moment. Until then, I understood it to be about being a role model and demonstrating to the world the "right" way to go. In that moment though, I began to realize that what we really need to do is attend to our own transformation. If the transformation is good, and the people with us are watching, the world might just change around us.

The chilling aspect of this story for me is that I had been a ward attending for nearly ten years before that month, and had seen countless patients just like Mr. B. However, I never acted to be helpful, to truly serve any of them, because I was tripping over my own role construction. *It just wasn't a doctor's job to feed a patient,* and, while I had sometimes spotted the need, my solution was always to go and tell a nurse that the patient needed feeding, rather than to pick up the mantle and feed them myself. To feed Mr. B., I had to transform my understanding not only of what I *could* do, but also what I *should* do. And, it just so happened that on that magical month, I was surrounded by some very special people who, it turns out, had seen what had happened, and came up with a plan about what *they* could do for the patients and nurses who were lucky enough to be served by their team. Being the change, it turns out, involves becoming the change, and that becoming is a matter of shifting one's paradigms.

We are hit with many aphorisms of leadership these days. Good leaders are data-driven. Good leaders hire the right people and get out of the way. Good leaders communicate caring for the communities they lead. The problem with these statements is that they sometimes run counter to images of leadership in the media, images of "strong" leadership in our heads, and they sometimes fundamentally challenge the personal attributes and attitudes that we think need to be cultivated in great leaders. It turns out that relationality, humility, and integrity are equally or more important than vision, strength, and power. And herein lies the transformation—there are many fellowships, degrees, and programs on leadership for physicians. The content taught in them is generally excellent. My impression, though, is that the content is only the beginning. If one wants to teach humanism, one needs to *become* humanism, and that becoming might just challenge one's perceptions about who they are and what their job is anyway. I would have liked to meet Dr. Smith, and hope that one day I might meet Dr. Wibe. I will ask him about the things as a young surgeon he absolutely knew were true, and that he had to let go of in order to do the important transformative work with the surgeons in Norway.

References

1. Harris JM Jr. The nineteenth-century surgeon who changed mental illness care: The most interesting figure in American medicine and American public service. *Pharos Alpha Omega Alpha Honor Med Soc.* Spring 2026; 89(2): 21–7.
2. MacGregor J. Avoiding our mistakes: Arne Wibe, the holy plane, and the retraining of a nation. *Pharos Alpha Omega Alpha Honor Med Soc.* Spring 2026; 89(2); 29–35.
3. Haidet P. A beacon for challenging times. *Pharos Alpha Omega Alpha Honor Med Soc.* Winter 2026; 89(1): 1–12.

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