EP51 | The Invisible Hands on the Scalpel Transcript

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Healthcare Conflict and the SPARC Framework

If [music] you work in healthcare, you already know this. Conflict is everywhere. In the O, [music] in labor and delivery, in committee meetings, between physicians, nurses, administrators, and teams that are all trying to do the right thing. But here's [music] the problem. Most of us were never trained to handle conflict well. We learned procedures. We learned diagnostics. [music] But we didn't learn how to navigate the moments when few professionals strongly disagree.

That's why I developed the [music] SPARC framework. Spark stands for stop, pause, ask, don't assume, reflect, and respond, and create a path forward. It's a practical system designed specifically [music] for high stakes healthc care environments through keynote [music] talks, residency workshops, and spark master classes.

Podcast Introduction and Episode Theme

I teach physicians, nurses, [music] and healthcare teams how to turn destructive conflict into productive [music] conversations that strengthen teams and improve care. If your hospital, residency program, or medical conference is looking for a speaker on conflict, communication, [music] and leadership in healthcare, I'd love to work with you. You can [music] learn more in the show notes because in medicine, conflict is inevitable, but handled well, it can [music] make teams stronger.

In every operating [music] room, in every ward, in every clinic and every team meeting, a silent battle bruise, conflict, [music] negotiation, identity. Welcome to the Scalpel and Sword podcast where I, Dr. Lee Chararma, physician and conflict analyst. [music] Explore the hidden negotiations beyond modern medicine. Let's trade burnout for boundaries [music] and learn the art of healing with precision and power.

Hello my peaceful warriors and welcome to the scalpel and sword podcast. I am your host Dr. Lee Chararma, physician and conflict analyst.

How Non-Clinicians Shape Modern Healthcare

I'm really glad to welcome you back to the scalpel and sword today where we explore the tension between healing and harm, between purpose and pressure, and between the oath we take and the systems we inherit.

Today's episode is not going to be comfortable and it's not meant to be because we're going to talk about power. Not the power that comes from knowledge or from years of training or from sitting at the bedside making impossible decisions at 2 a.m. We're going to talk about the other kind of power. The kind that operates outside the exam room, outside the O, and increasingly outside the reach of physicians and the patients it affects. We're talking about the non-clinians who have learned how to control and profit from health care without ever going to medical school.

There was a long time, not that long ago, when medicine primarily governed by those who practiced it. Imperfectly, yes, but decisions about patient care were largely made by people who had taken care of patients. That is no longer the case. Today, health care is shaped, sometimes dictated, by a triad of influence, malpractice attorneys, administrative systems, and third party insurers, none of whom are required to understand the lived reality of clinical care. And yet each of them has found a way to sit at the table and increasingly to control it. Let's start with medical malpractice.

Now to be clear, accountability matters. Patients deserve recourse when they are harmed. But what we've built is not purely a system of accountability.

It's an industry. An industry where financial incentives are tied not to justice but to volume, to settlement, to fear.

Communication failures, something we know is deeply human, deeply fixable, are often reframed as negligence.

And what happens? Physicians begin to practice defensively. Tests are ordered not because they're needed, but because they're protective. Conversations become guarded. Documentation becomes a legal shield rather than a clinical tool.

Malpractice, Administration, and Insurance Pressures

And the relationship between physician and patient, the very core of medicine becomes subtly adversarial. Not because either party wants that, but because the system rewards it. Now, let's talk about administration. Hospitals and health systems have grown more complex. That part is real. But something else has happened, too.

The administrative layer has not just expanded. It has repositioned itself as the operational center of healthcare. metrics, KPIs, throughput, length of stay, RV use.

These are not inherently bad concepts. But when they become the primary language of health care, something gets lost. Patients are not metrics. Physicians are not production units. And yet increasingly decisions about care delivery are made by those whose expertise lies not in medicine but in management, finance or operations.

And again, there's value in those perspectives. But when they dominate without clinical grounding, we see the consequences. shortened visit times, increased documentation burden, reduced autonomy, rising burnout, and perhaps more importantly, a growing sense among physicians that they are no longer in control of the care they provide. And then there are the insurers.

If malpractice creates fear and administration creates structure, insurers create limitation. Prior authorizations, coverage denials, step therapy. These are not just bureaucratic hurdles.

They are decision-making mechanisms. They determine what treatments are allowed, what medications are approved, what care is covered. And those decisions are often made far from the bedside. Sometimes by algorithms, sometimes by reviewers who have never met the patient, sometimes by policies designed more around cost containment than clinical nuance. And again the attempt may be to manage resources but the effect delay friction and a quiet erosion of trust between physician and system and between patient and care.

What do these three forces have in common? They operate at a distance. They influence care without directly participating in it.

Reclaiming Physician Influence and Leadership

They carry authority without bearing the same level of immediate accountability to the patient in front of them. And perhaps most critically, they are all financially incentivized in ways that are not always aligned with patient centered care. That doesn't make them villains, but it does make the system vulnerable. Because when those closest to the patient lose influence and those furthest from the bedside gain it, something fundamental shifts. We often talk about the financial cost of healthcare. But we don't talk enough about the human cost of this power shift. The physician who hesitates before making a decision, not because they don't know what to do, but because they're anticipating push back. The patient who feels like a case number in a system of approvals and denials.

The erosion of trust, the quiet moral distress that builds when clinicians feel they are no longer practicing the medicine they were trained to provide.

This is not captured in RVUs. It's not reflected in quarterly reports, but it is real and it is growing. So what now? This is the part where we could stop, where we could say this is the system, that's what it is, and move on. But that's not what scalpel and sword is about. Because recognizing power is only the first step. The next step is reclaiming influence. And that doesn't mean eliminating these systems. It means rebalancing them. It means physicians stepping into leadership roles, not just clinical, organizational, investing in communication, not as a defensive tool, but as a proactive one, engaging with policy and advocacy even when it feels outside our comfort

zone.

And perhaps most importantly, naming what is happening clearly and without apology because systems persist in silence and they evolve through pressure. Here's the uncomfortable truth. The system didn't take control. It was given control incrementally over time, often with good intentions to manage risk, to improve efficiency, to control cost. But somewhere along the way, the balance shifted and now the question is not whether these forces should exist, it's whether they should lead. Medicine is not just a science. It's a relationship and relationships require proximity, trust, and shared understanding. When decisions about care are made too far from the bedside, we lose all three. So the challenge for all of us is this. How do we bring the center of gravity back to where it belongs? Not by dismantling the system, but by reasserting the voice of those who live, work, and heal within it. The ones holding the scalpel, the ones carrying the weight of the sword.

Closing Remarks and Podcast Disclaimer

Thank you for joining this episode of Scalpel and Sword. If this resonated with you, share it with a colleague, start a conversation, push the dialogue forward because the future of medicine won't be decided in silence.

It will be shaped by those willing to speak. And so, my peaceful warriors, until next time, be at peace. Every [music] episode is an invitation to speak, to negotiate, to choose. I'm Dr. [music] Lee Chararma. Join the dialogue by subscribing to Scalpel and Sword. [music] Until next time, peaceful warriors. May your choices be sharp and your voice be even sharper. [music] This podcast is a reflection of lived experience and [music] research in conflict resolution. The scalpel and sword is not intended as medical [music] or legal guidance. For personal matters, please consult a qualified professional.