Don Berwick: the importance and challenge of clinical leadership

Richard Bohmer: Why is it that we want doctors in particular and clinicians broadly...doctors and nurses to take a much larger leadership role?

Don Berwick: Well, I think clinicians need to take a leadership role for a number of reasons. But probably, the primary one has to do with what they call a modern view of excellence itself and enterprise. I think a modern organisation...whether it’s a for-profit company or a not-for-profit endeavour, even a governmental one, I think, seeks excellence through the eyes of the person it serves. That’s the modern view, the consumerist view which says “I’m as good as the people I serve think I am and no better”. It’s a distinct alternative to the kind of technocratic view of excellence in which the profession gets to determine the nature of excellence. But that still requires deep, deep knowledge of the needs and the condition of the person you're serving.

Who has that? The people serving you. That’s where the interface is. If we cut professionals out of the redesign process, we lose all the knowledge, a tremendous amount of knowledge, about what the nature of a proper helping interaction looks like. Pursuing change without the leadership of clinicians is extremely hazardous. The other thing is science. I mean, it’s important to do things properly according to facts, according to the nature, the way nature works. And yeah, I suppose non-clinicians can study that and learn it. But that’s what we’re trained to do; we’re trained to understand what the fact base is, and we'll make very naive decisions as a health service unless it’s guided by distinct mastery of science.

RB: How do you mobilise large groups of coalface level doctors and nurses and therapists to take a much greater role?

DB: I think in general, my rules for better engagement of clinical leaders would be trust them...trust their hearts. You know, I think that on the whole, they want to do well...they want to serve patients, that’s why they came into this part of their lives. They want to relieve suffering. So identify at that purpose level, first, they need safety. They need a space in which they can learn and experiment. I think we need data, information. I mean, it’s very hard to work in the dark. And so, properly provide it with great respect, information on how we are doing this collectively and individually, I think, would be helpful, motivating to potential physician leaders.

And they’ll need training; it’s certainly not in our DNA, we don’t learn it in childhood. We don’t learn systems thinking and measurement. And improvement is not an important capability like walking and it has to be taught. But I think if we trust the clinician workforce and give them the tools, and the information and the psychological safety to pursue improvement, we’ll see it.

RB: So you are arguing that, you know, it’s the leader’s job to allow people to remain connected to why it was they wanted to be doctors and nurses in the first place, or encourage them to get reconnected to that primary kind of motivation?

DB: One of the jobs of leaders is to set a context at work that allows people to find meaning in their own work. Paul O’Neill, the former secretary of treasury and Alcoa chief executive has said that...a preconditioned excellence; he calls it a precondition...is that the people who do work have to be able always to say three things about their
work. One is that “I am treated with dignity and respect by everyone I encounter”. A second is “I’m given the tools and the support to do work that adds meaning to my life”, and the third is that somebody notices. And I can’t think of three better rules. Flip it over and say if you are a leader that treats always with dignity and respect and expects that of the people around you that are constantly surveill, for whether you are giving the workforce tools to add meaning to their lives, to do the work that adds meaning to their lives, and that you notice you are en route to success. And that option is always available to the leaders.

**RB:** One of the things that was so galling, I think, to a lot of professionals was the kind of the frank loss of compassion represented in the Mid-Staffs environment. If we are nothing, we must be compassionate in all our dealings with the people whom we serve. How do we think about preserving compassion as healthcare becomes progressively more technologic and technically enabled and driven?

**DB:** At Mid-Staffs, there were behaviours and experiences the patients had that look, for all the world, like loss of compassion as the caregiver no longer cared. But we need to go upstream from that. Why, what happened? I cannot believe that the average nurse or doctor or therapist at Mid-Staffs truly didn’t care, truly lost caring. They simply disconnected from parts of their souls, parts of their spirit. Something made them do that, something about the context made it impossible for them to remain whole. The culprits would have been probably leadership issues, support systems that became impossible. If you want to drive a person insane, keep giving him a task that they cannot possibly carry out in the context. They must, in their own defence, disconnect from carrying about the task. What else would they do? So I see the issue of compassion as a consequence, not a cause. Does technology push us that way? Absolutely not, absolutely not. I mean, the technologies provide us with new ways to help people and new challenges to what compassion will mean. But, of course, we can be compassionate in the most technically minded intensive care unit just as we can in a psychiatrist’s office.

**RB:** How do you think about scale in a world where we truly feel that it’s local leadership and that they will have the board of governors of this institution, at the level of the executive of this institution; how do we think about creating the conditions for scale in a world of distributive leadership?

**DB:** I think the very important problem of scaling the change now is maybe one of the hallmark problems of this next decade in trying to get healthcare change. Concepts, concept frames are somewhat central. For example, the idea that patients are better cared for when they are powerful, when they actually have voice and are involved; I think that’s a general principle that I would strongly endorse, almost is proven. The idea we should use science in practice, general principle. So call these concepts, change concepts for better care. Those can be assembled and made available and articulated and, I guess, in some terms centralised; I don’t mean that’s not a power issue, that’s just a knowledge issue. And there is a duty of leaders to do that.

Second is will-building like, you know, it’s more comfortable usually to stay put than to change. So someone’s got to provide the drive; so you know what, standing still is not really going to work, let me explain how. And there are day-to-day tasks of support that
can’t be centralised: helping with budgets, helping with training, helping with information technologies. But you know, the actual details of changing care, “what does it mean to involve patients here in this ward, this time?” “How will I make sure care is reliable in this operating theatre at this time?” That’s highly local. And if you get top-down management of details, you are about to make a mistake. So this combination of local implementation, adaptation, of problem solving, figuring things out, and will and ideas and support to execution from the centre, that’s the cocktail that I think works best.

RB: You know, there’s this tension in the UK between kind of uniformity and equity and local excellence. You know, in a distributed model of performance improvement and innovation, you’re always going to end up with some geographic variations. Which may equalise over time, but in the short run. And so you run the risk of the kind of the postcard lottery argument that says we’re not comfortable or tolerating this level of variance. Do you have a sense of that problem? In the UK, it’s a deeply held value that there be equity around the countryside...

DB: I mean, idea of committing to excellence as a uniform promise in a system like the NHS is not just acceptable; it seems immoral to me. So I understand a theory that says we’re going to create some form of equity. But you can’t write the details down from the centre, it isn’t going to work. There’s too much variation in local context, local needs. Mrs. Jones is elderly and lonely and she needs time to achieve comfort. And Mr. Smith is a busy lawyer and he needs just 10 minutes to get this done and please get him in and out fast; well, that’s variation, but it’s variation that’s adaptive to the local needs and demands and that’s smart. There’s no substitute for wisdom, and you got to have be wise enough to allow, to encourage this adaptation to local context, local histories, local priorities. And a smart leader will do that.