

Leadership & Managing People

10 Leadership Lessons from Covid Field Hospitals

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November 16, 2020



ExCel Centre in London Converted Into Temporary NHS Nightingale Coronavirus Field Hospital

Summary. The pandemic has forced leaders of hospitals around the world to adopt new practices as they have struggled to contend with the crisis. In this article, the senior leaders of two emergency field hospitals in the United kingdom

and the United States — the... [more](#)

The 2020 Covid-19 pandemic starkly revealed fundamental deficiencies in health care delivery around the world, including endemic racial disparities, the fragility of supply chains, the vulnerability of staff, and the depth of uncertainty about both a novel disease and our own systems. It also sparked innovations in the delivery of care and a transient change in how our organizations are managed. Many credited their successful Covid-19 response to flatter hierarchies, easier access to senior leaders, a sharper focus on what really matters, quicker decision-making, rapid experimentation and tolerance of experimental failure, and less-experienced staff spontaneously stepping up to lead. As one academic observed, “In a small crisis power moves to the center,” but in a big one, “it moves to the periphery.”

However, once the first wave of crisis abated, staff returned to their usual routines and traditional management and governance models were reintroduced. Productivity targets replaced the compelling and unambiguous goals of saving lives and protecting staff. The status quo ante reasserted itself. New plans once again had to make their way through the byzantine bureaucracy of multi-layered approval processes. Yet, although the pandemic has evolved into a more chronic phase, both the uncertainty and the need for innovation persist. At the same time, we are now confronted with new problems, such as caring for patients with persisting post-Covid-19 symptoms (so-called “long Covid”) and addressing the backlog of untreated patients while maintaining a Covid-free environment.

Instead of returning to the old leadership and management style, we should continue to encourage the kind of innovation leadership that characterized the acute response. How can we preserve the recent

energy and enthusiasm of distributed, team-based, rapid problem-solving — when many staff felt they were their best selves — and put it to work on the new problems that health systems are now facing? Most importantly, how can senior leaders free up staff creativity and support rapid learning while at the same ensuring the quality and safety we expect?

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We served as senior leaders at two emergency field hospitals, both of which were established in convention centers at the beginning of the first surge: the NHS Nightingale London, which exclusively treated patients on a

ventilator, and Boston Hope Hospital, a facility that treated post-acute patients not ready for discharge but no longer needing the services of a major hospital. During that period, we observed the following 10 senior leader behaviors that served to empower, encourage, and support leaders across professions as they stepped up to address the uncertainties they were facing. We believe these have ongoing applicability across care settings and should not be abandoned for historical and more conventional approaches.

1. Publicly acknowledge the uncertainty. In both field hospital settings, senior leaders openly acknowledged both the general uncertainty and their own. As Boston Hope was being set up, when nurses asked the hospital's co-medical director such fundamental questions as which supplies to stock or how to induct new staff, she simply admitted that she didn't know since she had never done this before.

Paradoxically, a leader does not diminish his or her status by asking for help; rather, subordinates respect her all the more. Such transparency takes the pressure off staff who might believe that they should know what to do, legitimizes investing valuable time and resources — often in short supply in a crisis — in the search for answers, and enables others to fill the ignorance space confidently.

2. Focus the search. Of course, simply admitting uncertainty without committing to learning serves no purpose. When resources are finite, problem-solving needs to be efficient and senior leaders need to focus the search on the most pressing uncertainties. By indicating priorities, senior leaders define what is critical and what can wait, assign a lower status to minor distractions, and tailor energy and resources to the urgent problems.

At the NHS Nightingale, the large multidisciplinary management meeting that took place late each day began by discussing the questions “What did we learn today?” and “What do we still not know?” and then went on to set the learning objectives for the next 24 hours. In contrast, smaller issues at many hospitals in the past have distracted attention and resources from a few major ones as clinicians’, educators’, researchers’, managers’, and regulators’ imperatives jockeyed for position so much so that the ultimate goal of better patient care sometimes became obfuscated.

3. Delegate authority. In both field hospitals, the crisis revealed the capability of junior staff who relished the opportunity and license to tackle difficult problems that the urgency created. Senior leaders deferred to expertise, not seniority, and authority for specific problem areas was delegated to whichever staff member had the best expertise, irrespective of his or her organizational status. Frontline staff were responsible for establishing new patient care routines.

There is more capability deep in their organizations than senior leaders often know or acknowledge. However, in delegating, it is important to simultaneously give a clear sense of accountability by clarifying expectations through setting goals and defining acceptable process. Newly empowered junior staff in the field hospitals were not given *carte blanche*. There were both clear boundaries limiting their discretion and a schedule for reporting progress: trust but verify.

4. Don't delay making the difficult (and unpopular) decisions.

Empowered independent teams that tackle important issues with energy and excitement is a popular management trope. But the reality is that occasional autocracy is necessary. Leaders certainly have to create an inclusive and empowered work environment where dissent, challenge, wild ideas, and lively debate are encouraged. But they must also shut down unproductive lines of inquiry quickly so as to preserve resources for more promising ones.

5. Shorten the feedback cycle. In many hospitals, multilayered decision processes and ambiguity about who has ultimate decision authority are common. Even when the answer is “no,” it can take an excruciatingly long time for it to be rendered. All too often the outcome of a meeting is another meeting and the outcome of an audit is another round of counting.

In contrast, both field hospitals emphasized frequent progress assessment through both data review and multi-disciplinary team meetings. A regular rhythm of staff huddles, service chief report-outs, and decision-making meetings examined the barriers to and efficacy of proposed solutions. These were complemented by a daily news cycle that focused on key data and meaningful issues and kept everyone alert to the priorities. Both field hospitals also insisted on

data parsimony (measuring only what matters) and clear decision-making processes, and explicitly identified which authorities needed to ratify which decisions.

6. Legitimize reversal. A necessary complement of making decisions quickly is making it easy to change them. During the crisis, staff often expressed a legitimate concern that important decisions were being made very quickly. (Clinicians have a natural caution when considering new therapies, and consequently a preference for more data, more debate, and more consideration. This also tends to be applied to new organizational arrangements for delivering those therapies.) To address this caution, leaders at both Boston Hope and NHS Nightingale emphasized that a decision was only for now: It will be reviewed tomorrow, possibly even later today. The daily review at the NHS Nightingale of what worked and what did not, coupled with an occasional reversal, reinforced the idea that well-designed experiments that fail are a key source of learning.

7. Set expectations. Liberty to problem-solve by “trying it and seeing what happens” comes at a price. Freedom to experiment is constrained in a framework created by goal clarity, scientific process, and expectations of individual performance. As Gary Pisano notes in this HBR article, tolerance for failure is not the same as tolerance for incompetence or bad science. In fact, tolerating failure presumes individual competence and rigorous methodology. Senior leaders must therefore set expectations by distinguishing productive failures that lead to learning from unproductive ones in which no learning can be abstracted because of poor scientific practice. Those who are not up to the task must be either coached early and often or removed from that task (but not from the organization).

8. Include patients and their families. In the heat of a crisis response, it is easy to be singularly focused on solving the many technical problems. In health care, however, our *raison d'être* is to solve problems with and for patients, and in most health care delivery systems, patients and their families are critical contributors to uncertainty reduction and problem-solving. Their perspectives and insights lead to solutions that would otherwise be missed.

In the best hospitals, engagement with patients and their families is much more than fashion or correctness: They are members of the team. Even at the NHS Nightingale, where patients were unconscious on arrival and for much of their stay (in contrast to Boston Hope), the Compassionate Care team worked with relatives to change patterns of care substantially. This team, made up of clinicians and chaplains, was charged with ensuring that ventilated patients were treated with dignity at all times and that care was responsive to families' needs and preferences. It found ways to bring relatives, in full personal protective equipment (PPE), onto the ward toward the end of life, and when this wasn't possible, a video-call via a tablet provided connection to a loved one.

9. Look after your people. Frontline staff have borne the brunt of the pandemic; they have been taking greater personal risk to care for their patients than in more normal times and have been suffering the consequences. For too long we have taken staff professionalism and commitment for granted, and even before the acute crisis evidence pointed to increasing burnout. Reducing the burden of work at the bedside and protecting the physical, mental, and spiritual safety of staff has become a pressing senior leader priority. All staff at NHS Nightingale were debriefed as they came out of the hot zone at the end of their shift and offered immediate counseling and access to subsequent psychological support. The Compassionate Care team, representing multiple faiths, also offered spiritual support to staff.

10. Be there. Finally, all the leadership behaviors we observed and associate with managing a coherent response to the uncertainty of the pandemic are predicated on one key leader behavior: being there. Senior leader visibility and availability is an essential precursor to all of the above.

The layout of the Nightingale and the Hope in the relatively contained physical spaces of convention centers made it easy for leaders to be visible and present. In other surroundings, this requires deliberate effort: It is not enough to say, “My door is always open.” Senior leaders must work to maximize their visibility and accessibility in work areas and be available to coach the staff to whom they have given authority. The Nightingale’s senior leaders abandoned their offices and worked in the main team room where they were easily interrupted: Neither personal assistant nor physical distance limited access.

The Covid-19 pandemic is far from over and the longstanding weaknesses in health systems that it has exposed remain. It is already clear that there will be no returning to business as usual. The world has moved on and new structures and approaches are unlikely to be dismantled, even in a future with Covid under control. More importantly, uncertainty, instability, and system fragility persist, and new and unexpected problems continue to arise. The leadership approach we describe above, honed during the most difficult and uncertain days in two field hospitals, remains applicable.

Although leaders are under constant pressure to manage health care as a routine production process in a stable environment, uncertainty and a need to learn are ever present. Arguably, the conventional leadership and management approaches the field hospital leaders

replaced were never really up to the tasks of reliably adopting and implementing best practice innovations and learning and adjusting dynamically.

Leadership under uncertainty as practiced at both Boston Hope and NHS Nightingale London was not so much having a plan and giving orders as focusing on the target and clearing the way for others by creating conditions that enabled them to push back the frontier of our ignorance. Rather than allow ourselves to slip back into more traditional leadership styles, these behaviors should become a permanent part of each senior leader's armamentarium across settings in more usual times.

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