Reflections on leadership in the time of COVID-19

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The COVID-19 pandemic, even as we are in its early phase, invites reflection on best leadership practices. As hospitals and providers pivot to respond, the pandemic spotlights leadership in healthcare. What is working as we all collectively combat this global viral scourge? The impetus to analyse leadership practices especially now comes from the adage that ‘a crisis is a terrible thing to waste’.1 The danger of COVID-19 is self-evident and is already too apparent around the world. At this writing today (1 April 2020), 873 008 individuals have been infected worldwide and 43 275 have died.2 In addition to the scientific opportunities to better understand the virus, its epidemiology, and strategies to prevent and cure COVID-19 disease, there is a clear opportunity to reflect on how to lead in healthcare through a crisis, to catalogue best practices, and to cascade these leadership practices broadly.

Even as we are in approaching the surge of the pandemic—in my community, on day 10 of a modelled course that predicts a surge approximately 40 days from now, there are already many lessons on leadership—extraordinary actions from ‘big L’ leaders—those with titled organisational responsibility as well as from ‘little l’ leaders—individuals without formal leadership titles whose leadership emerges organically. Indeed, a crisis such as this tests available models and hypotheses about leadership.

In cataloguing some best practices that I have witnessed at my institution—the Cleveland Clinic, I will try to articulate these practices and frame them through the lens of extant leadership models. The model by Kouzes and Posner3 of five leadership commitments—challenging the process, inspiring a shared vision, enabling others to act, modelling the way and encouraging the heart—provides an especially opportune taxonomy. What follows, then, is a catalogue of leadership practices, an annotation of each with specific examples, and a reflection of how these specific behaviours invoke or challenge existing leadership concepts.

As a favourable example of proactivity before the crisis, the New York Times on 20 March 2020 discusses modelling for a viral pandemic that was undertaken in 2019 by the US Department of Health and Human Services. The model forebode that within 48 days, a viral pandemic would sicken 110 million Americans, hospitalise 7.7 million and kill 586,000. Such anticipatory behaviour, ideally coupled with commensurate action, is key to understanding the people, roles and resources that are needed when a crisis actually befalls us. As discussed below, the coupling with quick action is key, as modelling without action is a hollow exercise.

Proactivity during the crisis regards real-time, dynamic modelling. Based on the expected events, what is the challenge that will materialise tomorrow, next week and next month? From the earliest signal of disease, laboratory medicine colleagues at my institution were developing testing capability for COVID-19. The result is that as of 20 March 2020, roughly two-thirds of all the positive tests in the US state of Ohio were performed at my institution, where local testing capability was developed early. As another example, medical students, respiratory therapists, intensivists and biomedical engineering colleagues at the Cleveland Clinic are currently advancing designs for a rapid production ventilator in anticipation of a need for ventilators that will exceed supply should a surge occur. Also, in the spirit of ‘little l’ leadership that can be so impactful, medical students in the Cleveland Clinic Lerner College of Medicine have launched an online repository to identify volunteer activities to help busy interns, residents and fellows. Proactivity abounds. Leadership is occurring diffusely, both by those with leadership titles and those without.

Proactivity is captured in the Kouzes and Posner leadership commitment of ‘challenging the process’. The centrality of seeing the current state—a projected shortage of equipment and personal protective equipment, developing models with contingencies and, most importantly, using these predictions to drive action has been underscored by the coronavirus pandemic.

BE PROACTIVE

Proactivity—anticipating events with contingency plans—has been a critical leadership competency in the coronavirus pandemic. Two kinds of proactivity seem evident—proactivity before the crisis hits and proactivity once the crisis is under way. Indeed, the critical relevance of proactivity has been evident both in its presence and in it absence. The urgent need to catch up on testing capability in the USA and the potential insufficiency of the supply of personal protective equipment provide examples of the consequences of inaction.

CLARIFY GOVERNANCE FOR THE CRISIS

Crisis test the adequacy of existing governance structures and also require deployment of new ad hoc roles. For example, in the coronavirus crisis, the primacy of supply chain and sourcing personal protective equipment from novel sources, like the paint and construction industries, has become evident as we plan for and ready ourselves for the surge of affected patients. Development of an ‘incident command’ centre which convenes key leaders regularly, makes real-time decisions based on harvesting the group’s wisdom, and cascades
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According to Kouzes and Posner’s “encouraging the heart”.6 Leadership in a crisis requires both framing the challenge while coupled with optimism—exemplified by sharing specific stories—that our talent, commitment and organisational culture will assure ultimate success. Even when, as now, we are just approaching the eye of the storm, optimism and acknowledgment of colleagues’ contributions to date galvanises people’s commitment and provides stamina for the long haul.

That leaders demonstrate optimism in their demeanour and behaviours is also key. Embodying the principle of ‘modelling the way’, colleagues look to leaders’ affect to guide their responses. As they see clinician leaders on the front line of clinical care, their resolve to pitch in increases. This opportunity underscores a major advantage of a physician leadership model in which leaders engage in active clinical practice, perhaps especially in times of pressing need as now.8

Overall, a crisis heightens the need for great leadership and underscores needed leadership competencies, both through success in their presence and through failure in their absence. Along with specific leadership practices that may hold value to others as they navigate the current coronavirus pandemic or the next challenge, this reflection invokes the five leadership competencies articulated by Kouzes and Posner7 as well as the primacy of creating psychological safety.7

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