Interview with Professor Peter Spurgeon: Part 1

The following is a minimally edited transcript of an interview between Professor Peter Spurgeon and Tom Turmezei performed on Tuesday 13th December, 2011.

Summary

Peter starts by talking about his beginnings in applied psychology, working with air traffic control in the late Eighties and later on with the much slower black box of tanker shipping off Norway. He gives a retrospective rationale on his career so far and moves on to discuss the nature of training, the ethics of decision-making, patient safety and reconciling differing perspectives in leadership and management.

Tom Turmezei: I wanted to ask about your early professional years because I think that it would be interesting to know how you came to be in such as position related to leadership...

Peter Spurgeon: It is a bit chequered, but in an appraisal meeting with my head of department at my first university, he said to me "A key thing you need to do is decide on a specialism and stick to it". I said, "That's problematic for me, because I'm interested in lots of different things and I tend to get bored very easily, so sticking with one is a problem."

Now, I suppose where I come from is applied psychology, which has always struggled to attain a level of academic credibility, as more pure psychologists would argue. I think it's crucial and part of my career rationale, although it tends to be a retrospective rationale, to see the application of theory and research and models to practice; that's what I'm about.

I started a journal called Health Services Management Research (http://hsmr.rsmjournals.com/), of which I have been editor for 27 years now. The first editorial that I wrote was about how work settings and academia should relate to each other in a much more positive way, rather than being reasonably hostile to each other. Academia is seen as being irrelevant and the work setting is seen as filthy lucre just after profit. They have an antagonistic approach and I think they could both benefit from working together.

So my approach has been to try and make application of different research and understanding of problems. As a researcher, I am fundamentally an applied problem solver and that will become relevant, I think if the argument is coherent, as to why I end up looking at issues of leadership for doctors and other clinicians who transfer into a managerial or leadership roles and then are faced with a number of issues for which they really have no particular training other than their knowledge of service delivery and their particular specialty.

But the problems of management and leadership tend to be broader than that, so you are going outside your expertise base to solve problems. Then you say "On what basis are you solving a problem?" This starts to define the nature of management or leadership and the transition that people need to make in order to tackle problems that are outside a narrowly defined expertise.

What I have is a very broadly defined expertise: it's the application of research methods, enquiry methods and consultancy type methodologies to a range of problems. I look at the nature of problems that people have in different industries, hence my travel across a range of such industries. I've worked largely in universities in different departments. I've worked in applied psychology departments, management schools, and I've worked in medical schools. It's the range, which is slightly unusual in an academic career, of taking a wider perspective on the nature of issues that those different settings encounter, rather than specific expertise in the basis in each of those separate disciplines.

That is, I think, what I am trying to bring. So when I say I've worked in air traffic control, it was in particular on a computer-aiding project. What we were trying to do was understand how a computer-aiding system could help controllers under heavy work pressures. The psychology of air traffic control is very much about the construction of graphical mental models. They have a picture of the movements of aircraft across sectors, which are often quite complex, very fast moving and involve very interactive pathways and flights. We built the computer-aiding system with a view to total computerisation of air traffic control on the basis that it would be safer; you'd have multiple systems backing up should one go down.

TT: Can I ask when this was, because one would imagine the transition into a computer-supported system would have been very necessary given the technological capability [of the time]?

PS: This was in the late Eighties. We were stopped, not in our tracks, but controllers themselves started to say, "I understand what you are trying to do, but if anything goes wrong we need about 10 minutes to reconstruct this model and we are not going to get that. What we want is a computer that is going to reduce a lot of our repetitive stuff but not stop us from controlling the dynamic of the flows, so that should we decide to intervene, we have a manual override that allows us to come back into that system, take over and change it."

I'm no longer a specialist in air traffic control at all, but it's the application of both how to create that mental picture and how it applies to what the computer designers are trying to do. And it's also me as an interface between the workforce (my main interest), the context in which they work, and the particular issue that they are tackling at the moment, which might be computer-aiding.

I came to computer-aiding in air traffic control having worked previously for a company in Norway called Norske Veritas (http://www.dnv.co.uk/), which is a bit like Lloyd's in that they insure shipping. I was a research fellow looking at shipping accidents and why they occur. We developed a type of 'black box' similar to those that exist on aircraft, but for shipping. Of course, the dilemma for shipping is that it is much slower. You could be on one of these enormous tankers for a month to 6 weeks, so that black box is incredibly boring. But again, it is about the model of what causes accidents. How would you know what is happening that lead to this accident: whether it was a minor grounding of shipping? I was doing work up and down the Norwegian coast, which could have been on a minor sea-going vessel, on a passenger or fishing vessel all the way to the big tankers, looking at why they could go off track. It could take days to turn round; they take hours to actually shift their course.

So, what are the processes that these people are using? One of the themes emerging again is that I like to work through the concept of mental models, and that for me is the diversity of my thinking. I'm less involved with diversity as it's currently understood (which is about people and origins) rather diversity as different mental models. I think that is the key to a lot of conflicts, a lot of misunderstandings and a lot of work problems. People are thinking about things in a different way, and because they are doing this they don't necessarily have the language to describe their processes to somebody else who thinks about them differently. They are at odds; without having interpersonal conflict, they don't see things in the same way.

TT: Do you think that is an innate characteristic or do you think it's something that is cultural or learnt or that can be instilled in training, because that will very much come on to how people develop as leaders?

PS: Exactly. I think that there has to be some degree of personal style or quality that makes peoples brain systems work slightly differently. They have a preference for seeing things in certain ways. And that's very much a part of their own personal upbringing. And that will be the cross-over between their genetic endowment, their experiences and all that sort of stuff. I'm not saying

that you can get rid of that, but there is a tremendous interaction with that and subsequent training.

Training tends to be expert-based on the basis of knowledge acquisition. It's changing a little bit with some of the professional bodies talking about societal medicine. In the 21st century it will be more about people, especially the elderly, who have a range of conditions that need to be managed rather than cured. I think that there will be a broadening, but traditionally it has come from a particularly 'knowledge' base.

Now, that is different from the managerial perspective, which tends to be a more collective-base, more like "I am making *that* decision on behalf of *this* organisation for most people", as opposed to the individualistic knowledge-base approach of medicine which says "I'm seeing this patient in *this* consultation, with *this* problem and I'm making *that* decision, and *that* is the best decision that I can make" with only limited exposure to the implicative decisions that go on around that patient. So it's been slightly narrowed and I think it is beginning to take on that wider perspective.

TT: That's certainly what I have picked up in the book so far. In fact, one of the very interesting chapters–which I really enjoyed reading–was the one on the differences between managers and doctors, which is a very classical theme to do with the title of the book itself: *From the Dark Side to Centre Stage*. I personally felt that out of that, which I scripted as a battle between the two, managers seemed to have taken a hard time from it and seemed to be doing their very best to bring this broader perspective to the medical staff, who were being slightly narrow-minded and maybe a bit blinkered about it...

PS: Well, both that and sometimes the degrees of self-interest or “not wishing to go there.” We have to recognise that it would be constraining. We tried to raise this: the issue for many doctors is around clinical freedom and clinical autonomy. It is a true dilemma, because as a patient you want your doctor to exercise unbridled clinical freedom. If you think that the best treatment for this particular patient is one thing, it is difficult to articulate how as a patient you want that doctor to be saying "Hmmm, yes, but if I choose this I might be infringing my capacity to make other decisions for other patients later on. So I won't go down that absolutely ideal route, I'll go to my next best."

Now that is a real ethical dilemma, because if it is not the best [route] and it is constrained for whatever reason–the obvious one would be finances, but it could be that there are different ways of treating that could be done differently–you are balancing off something that has been absolutely implicit and, to a degree, explicit in medicine: that you do your best for the patient. It's a trade-off: you are not quite doing your best. For many doctors, that is just a no-no!

Managers are, of course, coming from the other end of the dimenson of "Yes, we'd like to do the best for our patients, but for all patients. So for me that might require a trade-off." The difficulty is that most managers are not in the position of making the decisions to allocate the resource where the trade-off implications occur. So they have to influence the clinical judgement, which again produces another tension when the doctor says "Well, you haven't been trained in this, so why would you be a reasonable person to be influencing the decision I am making about this patient?"

And, of course, they're *all* right. That's why we are trying to argue, certainly near the end [of the book], that the notion of duality is what we are trying to move towards. Not the dominance of one group over another, but the recognition of those perspective differences and how they can be reconciled into a better system. What we don't want is to train doctors as managers. We don't see that as appropriate. There are many competent managers; some are less competent, but there are many competent ones. Why would you waste 5 to 8 years training as a doctor to

say that "Now you need to train as a manager"? What we really want to do is bring the perspective of the doctor to the managerial context that is healthcare.

It is the marrying of those perspectives, or at least the recognition in a respectful way, that we are both trying to do something here. If we are in conflict, we have to try and reconcile. Disparaging managers because they are not giving patients care is not fair because that is not their job. Similarly, managers saying "Oh, it's the doctors again. They're using non-generic drugs. They're doing *this* and *that*!" is also not fair because they are following their perspective.

We've gone back now to where I've come from with these multiple perspectives, these different ways of thinking, different ways of understanding a problem. And if you differ, you are not going to agree with how somebody else sees the problem. So that's is where I come from!

TT: Just picking up on that background again, is it a question that you've found from your own personal career that you've been able to take those experiences and those different ways of thinking to develop your appreciation of how these [ideas] work in an academic sense, in particular how this has culminated in being related to healthcare and management?

PS: I've always worked in the healthcare sector, which I think is a slight advantage in the current climate; useful too to understand the perspective of other sectors. Without arrogantly saying I understand the perspective of all these people I've encountered, what I've actually come with to those different people and sectors is a degree of humble ignorance. I'm actually saying that I don't understand your expertise, so I don't know why you make that decision.

What I then bring is a range of more formal analytic techniques, which might include things like process mapping or assessing levels of risk in care pathway, to a more informal, more intuitive judgement where I am using (I suspect) a range of experiences to pick up "So that's how you see it... Talk to one of your colleagues, because in my mind, I know that they don't see it like this." I might have been brought into some medical teams that have been warring for years. They won't work together, they use different protocols, the nursing staff are tearing their hair out: it's been Mr Watson's day but it's Mr Johnson so we have to do it this way...”

TT: They're not real characters, I take it?

PS: They are not real characters, but one can imagine they might exist!

TT: They sound like they are surgeons as well...

PS: Well, some of them are. But it is this process of "Okay, you are doing it differently. I'm being brought in to try and get you to work more collaboratively." You can ask "How will I do that?" but I think that is not an appeal to knowledge, because they have the knowledge and I don't. There's got to be a meta-process appeal that you are working across a system with other colleagues who are unclear about the delivery, which could raise some patient safety issues. It could even raise–and has done in some circumstances–some GMC-type issues because unsafe care could be prompted by poor team-working as much as it can from not making the right decision.

Once the GMC starts to recognise collaborative working as a requirement, then I have another lever. So I will bring these people together, often in very tense rooms, where I'm going to expose the underlying philosophy differences and I'm going to ask for reconciliation in a pure sense. But I may not do that quite as upfront because it sounds a little like going to a religious meeting. What I'm really doing is saying that "I've picked up some differences in the way you work here" and I'll be challenging them to understand each others difference and looking at why these still exist.

For example, I might use some leverage from a senior nurse who says that "This is a real problem and one of my junior nurses just didn't know what to do." I see if I can create the momentum of the argument of why you should change. I don't have to change because I'm not there: they do!

TT: Is it naïve of me almost to think of this as a framework for a counselling session?

PS: It can get close to counselling. Some of those individuals will want to talk about themselves and their colleagues and will want to tell me why it's inappropriate for me to get them to switch over.

TT: That could be a very close personal and emotional attachment to the service that they provide.

PS: Absolutely, and therefore it is not a *right* or *wrong*. I can't come along and say "Oh, yeah. I think that you need to change." I've got to ask them to think about that attachment and where it is really coming from. If somebody else is equally attached to something different, are we saying that this is a complete range of care that is available to everybody? Can everybody just make it up? So why does a colleague bother with guidelines? Pointless really, isn't it, because you're over *here* and your over *there* and neither of you are paying any attention to the guidelines!

In a sense, the patient safety movement has created something of an opportunity around this. I tend to challenge the medical profession with this. Patient safety really became big-time in the Nineties. You could argue from a public perspective that weren't we making the assumption that patient safety was always a priority? Sort of "yes", but then why did we have a patient safety movement that was required to promote guidelines? Where did that come from if it really was implicit? Of course, we're now getting into that territory again of clinical freedom in a way to practice that you think is best. Is that clinical freedom or is that potentially unsafe practice. And who knows what the difference is?

TT: It sounds like regulation and revalidation maybe had something to do with this?

PS: Well it pops up!

End of part 1