Dr. Brook Talks About Why Healthcare Needs Accountability and Why Mentoring is Satisfying and Joyful Work

The National Center for Healthcare Leadership is proud to present the 2010 Gail L. Warden Leadership Excellence Award to Dr. Robert H. Brook of RAND Corporation and UCLA for his distinguished research career as the inventor of quality measurement and evidence-based medicine, forever changing the way healthcare policy makers address these issues and their implications for the health of the U.S. population. Furthermore, Dr. Brook is recognized for his personal dedication to an entire generation of clinical scientists, many of whom today hold leadership positions in government and health policy research. For his visionary leadership to advance the nation's healthcare and for inspiring healthcare leadership across the country, NCHL salutes Dr. Brook.

ROBERT H. BROOK, MD, ScD

Vice President, RAND Corporation
Director, RAND Health
Professor of Medicine and Health Services, University of California, Los Angeles
Director, UCLA/Robert Wood Johnson Clinical Scholars Program

EDUCATION

University of Arizona, BS Chemistry, Phi Beta Kappa, 1964
Johns Hopkins University School of Medicine, MD 1968
Johns Hopkins School of Hygiene and Public Health, ScD 1972

CAREER

U.S. Public Health Service, 1972–1974
RAND Corporation, 1975–present
UCLA, 1975–present
Robert Wood Johnson Clinical Scholars Program, 1976–present

PRINCIPAL HONORS AND AWARDS

Gustav O. Lienhard Award, IOM
Dave E. Rogers Award, Association of Medical Colleges
TRUST Award, Health Research & Educational Trust
National Committee for Quality Assurance Health Quality Award
Research America's 2000 Advocacy Award
Robert J. Glaser Award of the Society of General Internal Medicine
Richard and Hinda Rosenthal Foundation Award of the American College of Physicians
Distinguished Health Services Research Award of the Association of Health Services Research

LEADERSHIP POSITIONS, SOCIETY AND BOARDS

Institute of Medicine
American Society for Clinical Investigation
American College of Physicians
Chair, Clinical Advisory Panel, California Coronary Artery Bypass Graft Outcomes Reporting Program
Board of Visitors Advisory Group, Columbia University School of Nursing

Robert Brook may have developed his penchant for breaking down barriers, challenging the status quo and exploring the great unknown from his youth growing up in the wild, wild west of Tucson Arizona during the 50s and 60s, where everybody rode a horse, lived in the same kind of slab house, and everyone was the same. When he moved to Baltimore for medical school at Johns Hopkins, he was stunned by the city's segregation—by race, religion, and status—where he saw firsthand how communities crumble when different cultures are blind to each other's needs. That set the stage for his desire to practice medicine to benefit whole groups of people, rather than individual patients. But his biggest frustration was the lack of follow through in healthcare. He wanted to treat patients and know how they fared, a concept that received scant attention at that time. Dr. Brook decided to change that. Over the past four decades he has dedicated his research to showing that the quality of physician and nursing care can predict outcomes and that quality can be measured. His work has transformed the American healthcare landscape by changing the conversation from one of controlling costs to one of ensuring value and for mentoring and training more than 350 researchers and physicians who have become important leaders in the field.

Q: What is the single biggest challenge facing healthcare leaders?

A: Leaders in different places need to address different leadership challenges. At the healthcare policy level, leaders must move the public towards thinking about healthcare in terms of the value proposition and away from thinking about coverage and cost. It will require a vision and a team approach to understand and to communicate the value proposition, to organize the right messages, and to use social media, such as Facebook and YouTube, to reach a larger public audience. At the institutional level, I would love to see hospitals work with community leaders to develop responsibility for a geographic area as part of their business, with

a goal of improving the health of that community. In medical schools, leadership should move towards a vision in which our students and residents work more closely with the community.

Q: What skills and competencies are required of today's healthcare leaders?

A: To become a leader in healthcare, you need to learn how to make decisions and you need to understand the role of the hospital and its relationship to the health of the community. We currently have three models for health: the public health model, the social health model, and the classic medical model. We need a vision that balances these three so that we can move away from a mostly academic model of improving quality towards a model of improving value. Leadership needs the right tone and vision and it must be accountable to the community.

Q: What prevents healthcare from improving?

A: Healthcare has no feedback loops and often lacks accountability. Without accountability, it's hard to change the world. Doctors and healthcare organizations won't make change happen, and until we empower communities to understand this, change won't occur. Society is not prepared for the change that is needed in the way medicine should be practiced. Healthcare practices are influenced by financial incentives, so as long as organizations are profitable, they have little incentive to change.

Q: Why does a lack of accountability persist in healthcare?

A: It's the way we have practiced medicine forever. Why is it, after all these years that I, as a physician, don't know which patients are filling their prescriptions? With all the automation we have, why can't I know this? Why isn't this a priority? If you don't have the information and systems needed to know what you are doing, it is difficult to make positive change. These are simple basic principles, but 40 years ago we were talking about using teams to provide coordinated care for multiple health conditions, and we are still talking about it.

Q: As a healthcare leader, does that frustrate you?

A: It's the same problem I have seen throughout my career. Very early on I resented the fact that we worked countless hours in medicine without knowing what we were doing or accomplishing. I would ask, "Shouldn't we know what we are doing—shouldn't we find out what happened to the people we treated?" I was stunned by the lack of rudimentary coordination of care and was frustrated to be working so hard in the absence of information.

Q: What challenges do leaders face?

A: Sadly, it is hard for policy leaders to be accepted today if they are controversial or out in front with new ideas. I was fortunate—I have always been out in front and I said what I felt and felt what I said and I was very open. But to attain a high level of leadership position today, the only way to do it is not to say very much.

Q: What is the role of teamwork in healthcare?

A: Medicine doesn't have a lot of ways to motivate teams. Years ago I was in the emergency room at Hopkins. Back then it was staffed by young white male interns, the head of the ER was a young white RN, newly minted from Hopkins, and she was supervising many older LPNs in their 50s who had little career trajectory, as well as nursing assistants who were mainly minority women supporting their families. These different groups hid things from each other. The only time that changed was when there was a true emergency, and they would come together to cooperate. How can you motivate teams to work together when everyone has different expectations? To work together as a team, first everyone needs to respect the other team members. Why does the doctor get to order the nurse around? Why can't the nurse challenge the doctor? Why is the doctor allowed to write a prescription illegibly? All these years later, we still have these problems in healthcare. It's not that we have a nursing shortage, but that nurses find the work environment so offensive that they opt not to work. Certainly we have more diversity in the healthcare workforce and in that way we have moved forward, but in other ways we haven't moved at all.

Q: What inspired you to focus on quality measurement?

A: My parents were community leaders so I have always had an interest in communities. I was also attracted to the kind of work that involved groups of people—a team approach—rather than treating a single patient. When I began my career in 1968, people didn't believe you could measure quality or even that it was necessary to do so. There was very little science in this area: we treated patients, but didn't know outcomes. So my accomplishments early on were to show that quality could be measured to better reflect what happened to patients. With good information and systems, we can measure results and use that information to add value to the practice of medicine. There are still a lot of people who don't believe in measuring quality—they believe that medicine is an art and that the value of the art is in the eye of the beholder.

Q: What obstacles did you overcome to pursue your career?

A: I had an interest in both medicine and public health. Fortunately, I was able to persuade leaders at the medical school—such as Dr. David Rogers—to find a way to marry my interest in both areas. Then I was fortunate to have great mentors like Dr. Sherman Mellinkoff—an academic dean who also had a major social vision. Don Rice at RAND was also a person who thought a lot about domestic policy and its relationship to economics and clinical policies.

Q: You are widely respected for the large number of individuals you have mentored. How did you come to value mentoring?

A: Mentoring is simply a joy to do. A mentor has to take professionals who have grown up in a regimented education system and make them believe in themselves. These individuals are coming out of medical schools where everybody is competing over a point on a test and everyone is worried about who is smarter. But leaders need self confidence and a belief in what they want to do. Doctors in particular face an enormous number of constraints; but real leaders need to break out of the paradigm. And the job of the mentor is to support them and to encourage them to be risk takers.

Q: How do you size up healthcare reform?

A: Health reform extends coverage and gets more people into the system. Hopefully, this will make change more likely. But to really change our system, health reform will need to be revisited, and we will need more reform in a few years.

Q: What do you see as your most important contribution to healthcare?

A: I believe I helped to legitimize the idea that physicians can be trained in both health policy and clinical medicine and can play an active role in both. I have pushed hard to produce leaders who can function in these two camps at the same time. That connection produces a sense of reality that is very different from making healthcare policy without seeing patients. I also helped legitimize the area of evidence-based medicine and quality assurance as its own field and academic discipline.

Q: What is the ultimate goal in healthcare that you would like to achieve and how can it be achieved?

A: I want to see increasing value for every health dollar we spend. We want to spend money on things besides going to the doctor. The goal of the doctor, meanwhile, should be to keep patients out of the physician's office and the hospital.

Q: It seems like a reasonable goal; what prevents it?

A: We don't want to produce a system that deals with health. We are concentrating on what is happening in front of us at any given moment. Even though we live in a much more complex world, medicine still thinks the same way: it is focused on the person in front of the doctor at any given moment and that's it.