

# “Be the change you want to see: a personal challenge to clinical leaders”

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## Key message

In all the turbulence of healthcare reform and workforce crisis, can you define a centre of stillness? By your personal example, can you lead people away from defensive posturing and inspire a way of *being of service* rather than *providing a service*? Can we grow beyond job roles and hierarchies to find in ourselves the essence of the healing art? Through personal reflection and the sharing of inspirational stories we can strengthen our sense of identity, of our meaning and purpose, and therefore find the place where we can stand strong and be of service and inspiration to others.

“*Be the change you want to see*”. (Gandhi).

## Be the change you want to see: a personal challenge to clinical leaders

I want to begin with an image that for me powerfully symbolises a philosophy of healthcare practice that if adopted widely could solve many of our health workforce problems.

This story was told me by a lady in New Zealand called Jenny who does volunteer therapy with spinally injured people. I am having trouble knowing what word to use to describe these people; they are not "patients". "Consumers" is even worse and they are certainly not her "subjects". We don't seem to have a word that encompasses a two-way healing relationship where both parties have equal power and significance.

No matter. The therapeutic relationship with Jenny is based on humility, respect, patience and trust. She performs a therapy which is physically manifested as a series of movements and gentle touch but in her hands (and heart) is more profound. All three of her companions have complete spinal cord lesions, with no prospect of any recovery according to conventional science. The first little miracle is that her companions report that they can feel her touch even in areas with no sensation. That doesn't happen with any other therapist. The second little miracle is the beginning of recovery of movement in paralysed limbs.

Jenny is one of the world's gentle and sensitive people. She recoils from the controlling manner of some of the other therapists and instead she works with her companions on their own terms. This story gives a clue to the quality of her being.

When Jenny was eleven, her parents acquired a pony that previously had been maltreated. This animal was very shy and fearful of humans. Jenny, in her quiet and thoughtful way, observed the process of catching the pony, which involved trapping it in a corner of the paddock. She sensed the fear and distress of the pony and determined she would follow another strategy. This is the image I want you to hold in your mind because it's central to the theme I will be developing.

Jenny walked very quietly to the very centre of the paddock and lay down. She made no sound or movement. With the greatest of patience, she waited as the pony gradually became used to her presence and circled ever closer. Eventually the pony came close enough for a sharing of breath. A deep and trustful bond began to form.

I stand in awe of the love and wisdom of that small child. I am not surprised that she performs miracles as an adult but I have also come to know that this innate capacity for shared healing occurs in all of us if we would take the time to be still.

So, as I begin to explore some of the complex challenges in health workforce, I want you to reflect on the image of that small girl lying patiently in the middle of the paddock as a symbol for a different way of being and as a role model for a gentle and wise form of leadership.

I have been studying Te Reo Maori, the language and culture of the Maori, the indigenous people of New Zealand. They have some important lessons for us. The most inspiring health practitioner I know is a Maori nurse practitioner who brings a deep spiritual dimension to her work and who has integrated advanced Western knowledge with a set of cultural traditions and practises to achieve the most astonishing results in chronic disease management. I think Janet would recognise a soul mate in Jenny. One of the concepts that Janet uses to describe her integrated model is "*Kaua e korero*", which is simplistically translated as "don't speak". By this she means a process of sitting with another person in deeply respectful silence and attentiveness.

From the perspective of Maori culture, the Western customs of individual rights, self determination, and private interests seem foreign. Their's is a much more collective society of shared ownership and mutual obligations. Also of supreme importance is a sense of personal identity and connection related to the natural world, the ancestors and familial connections. I have learned to perform the formal Maori speeches of welcome and acknowledgement which include a deep account of one's own connections: one's tribal affiliations, the identity of ancestors and living relatives and the connections to the land. Personal introduction includes naming your mountain, river and forest, your birth place, the ancestral burial ground, where you grew up, where you live and also the identity of your Marae, the cultural centre

of each Maori community. Performing this ritual speech engenders the most powerful feeling of personal identity and connection. It defines a place where you stand with strength and dignity, called “*turangawaewae*” in the Maori language.

When Jenny lay silently on the grass in the middle of the paddock, I think she too had a complete sense of self and her relation to the Universe.

As health practitioners I think we also have our place of strength, of a shared identity built on generations of accumulated knowledge, and connected with deep meaning and purpose in our wish to serve individuals and the broader community. However I think we have lost the art of the rituals that allow us to express this spiritual side of our professional identity.

OK, now back to the challenges of the present. The commonest word I hear spoken in relation to the health workforce is “crisis”. It feels like a crisis. In my hospital we have staggered through the winter with 30-40% of our house officer posts vacant. In one of the other hospitals in town, the nursing workforce is turning over at a rate exceeding 40% a year in some departments. The consequences are dire. We have an aging workforce and the numbers predicted to retire in the next ten to fifteen years will create critical shortages in many specialties. Forward projections are alarming. It’s estimated the US may be short of 200,000 doctors by the year 2020. In response, we scramble to create new and innovative health practitioner roles to fill the gaps, physician assistants and the like. Traditional professional boundaries are under threat and we are at risk of developing a siege mentality. At all turns, demand for services threatens to overwhelm supply.

In the invitation to speak at this conference, I was asked to address some of these issues. What could be practical strategies for clinical leaders to facilitate these difficult transitions? How can we persuade beleaguered health professionals to drop their defences and build new models of inter-professional learning and practice?

It seems like a very real problem, “out there”. But maybe we are looking in the wrong place for the problem and the solution? In Western culture we have a strong tendency to objectify issues, to see them as external to us, a problem that needs to be worked on. We “figure out” a solution, or “sort out” the problem or “help out” those in need.

Our habitual way of thinking is rooted in our object-orientated language. Our basic sentence structure is subject, verb, and object. And yet other ancient languages are alive with the subtleties of interpersonal relationships much more than external objects. The Maori language has many words for “we”, “you” and “they” depending on the relationship to the speaker and to the one spoken to.

Since the age of Descartes in the seventeenth century we have separated mind and body. We place a high value on objectivity, emotional detachment and rational argument but these concepts don’t even exist in some other contemporary cultures. You can’t translate the English word “emotion” into Tibetan. In the Tibetan Buddhist world, there is simply no concept of a mental state of emotion as separate from cognition. Now that we have functional MRI scanners to examine the brain function in real time, we may have to agree with the Buddhist view and discard Western concepts of pure cognition and rational objectivity.

So this is quite disconcerting, to discover that our very basic assumptions and truths about the world may only be an elaborate mental construction that is culturally determined. It seems that the vivid experience of the world as an external reality – including perplexing workforce problems – may be an internal invention rather than something that really exists out there. Other writers are having similar thoughts. I came across one paper on medical manpower problems with this wonderful title, “*A shortage of physicians or a surplus of assumptions?*”

This reframing of the health workforce problem is counter-intuitive. The problems out there are very vivid, urgent and real so I have some work to do to persuade you of a different view. My own beliefs on these issues have changed profoundly. In my own practice, the most vexing and troublesome issues of professional and patient demand have simply melted away to be replaced with the greatest joy and satisfaction. Each one of you has this power to transform your experience of the world but it requires you to find your own “*turangawaewae*”, the place where you stand with strength and clear purpose.

I'm going to share with you three stories to illustrate how much of the world you see as objective reality is actually a result of creative imagination, over which you have considerable power. This might seem like a sleight of hand or a trivial matter of definition but I hope my stories will inspire you to realise how profound a change this can be.

The first story is an amusing account of the frailties of human perception, which we call "truth". In my training as an anaesthetist, I needed to acquire the skills to operate a fibre-optic scope to examine and safely intubate the windpipe of patients with life-threatening airway lesions. I persuaded a physician friend to invite me to a regular diagnostic bronchoscopy session, where I could practise the first part of the procedure and he would take over to do the diagnostic work. One of our patients presented with a seven month history of persistent cough, repeated segmental pneumonia and some episodes of blood stained sputum. This constellation of symptoms was highly suspicious of lung cancer. We examined the long series of chest x-rays and then I performed the bronchoscopy. I made an astonishing discovery. Lodged in a major airway was half a chicken wishbone – the bigger half that you get when you snap the bone and get to make a wish. In short order, the bone was removed and the patient was cured. Armed with this new knowledge, we went to re-examine the chest x-rays and discovered that the outline of a chicken wishbone was clearly visible on every single film. Every x-ray had been systematically examined by consultant physicians and radiologists and each written report concluded with the phrase, "*no bony abnormality seen*", which made us chuckle!

The point of this story is that our perception is powerfully influenced by our prior assumptions. We see what we expect to see and we don't see what we know can't be there - even if the evidence is right before our eyes. Now, had this case come to court, I could imagine six very persuasive expert medical witnesses swearing under oath that there was no abnormal bone to be seen in the chest x-rays. This would be very conclusive evidence, taken as truth. Conversely, once the chick bone is "seen", nobody can "un-see" it.

The next two stories are about my finding a profoundly different truth with respect to workforce issues and a reframing of the problem from "out there" to being "in here", a place where I had the ultimate power to define my world experience.

The first is a story about the sometimes fractured relationship between midwives and hospital specialists. Here are two groups with profoundly different philosophies and experiences. The midwives come with a strong belief in childbirth as a natural process for which there should be minimal medical intervention. The hospital specialists see only the clinical crises and have to respond swiftly to life threatening emergencies. There is a natural tension between the values and beliefs of these two groups of professionals. It's a microcosm of wider workforce issues.

As I write these words, I am sitting in my hospital on a Tuesday afternoon, on duty for calls to the maternity unit. I am the on-call anaesthetist doing epidurals for pain-relief in labour and providing anaesthesia for emergency Caesarean sections or other medical procedures.

I work a 24-hour shift. Childbirth is not an office-hours business. Sometimes I'm called out several times in the night, becoming fatigued and sleep-deprived. In those circumstances, it's only natural to feel somewhat grumpy and sorry for yourself. I used to carry my grumpiness into work with me and be intolerant of frustrations, delays or missing equipment. I didn't always experience the friendliest of receptions when I entered the labour room. Sometimes it felt like I was the enemy, the 'wicked' doctor come to intervene in childbirth when the plan was for a natural process with no drugs and no technology. It was an uphill struggle to find the necessary equipment, to ask the midwife to get the mother positioned for the epidural, and to communicate instructions. Sometimes the epidural didn't work well and I'd be called out of bed again. I was overwhelmed with negative thoughts, tired and grumpy.

One day I decided to choose a different attitude.

I choose to put different thoughts in my head. Now, when I'm called out in the middle of the night I think about the extraordinary privilege of being invited to take part in an intimate and life-changing event. I take great care with the spirit and presence I bring into the room. I enter the room with gentleness and quietness and compassion. I notice the effect this has on the mother in reducing fear and distress. I greet and acknowledge the other people in the room. I ask after the midwife, enquire whether she has been busy or had any sleep or rest. I do the epidural with the minimum of fuss and then witness the miracle of pain relief. It is a joyous experience. I don't care how tired I am. I go home with love and joy in my heart.

How amazingly the world changed when I chose to have a different attitude! I used sometimes to think that the midwives resented my coming to do an epidural. They were sometime surly and uncommunicative, they would neglect to introduce me to the mother or other family members in the room, I would have to ask for assistance, the equipment wouldn't be ready. Now I feel like an honoured visitor. I am greeted warmly. I have the sense that my praises have been sung to the mother even before I step into the labour room. An extra special effort will be made to anticipate what I need to make preparation for the procedure. I find that my pain relief is much more effective and the rate of complications is greatly reduced.

For most of my career, I considered the problem of the relationship with midwives as a problem, "out there". My more recent experience leads me to believe that the problem and certainly the solution existed in my own head. The only person who changed was me but the consequence of that was a remarkable change in my whole world experience.

Sometimes you have to change "me" to change the world.

As my practice deepened I began to reflect on my role, how I might best serve my patients and where I might find the sources of the deepest satisfaction and joy. I came to realise that for much of my career, my identity and self esteem were wrapped up in being a highly trained technical expert. I was always friendly and helpful but I was certainly the person in charge of the agenda. If my patients brought up other concerns or questions, beyond the scope of my technical expertise, I was skilled at diverting them back onto safer ground. Over time, I have gradually reconceptualised my role as that of a caring human being first, and an expert second. That enabled me to be much more humble and respectful, to listen patiently, to form more trusting relationship with my patients and to bring much greater compassion and humanity to the relationship. I began to take great pleasure in helping patients in whatever way I could, regardless of whether it related to my specific technical role as an anaesthetic specialist.

One day, I decided that I would no longer have 'difficult' patients. I decided that difficult patients didn't exist "out there" but were a consequence of my attitudes or judgement, an internal problem. I decided that if a patient continued to make demands, or to break rules, or otherwise be disruptive, it was a matter of my failing to understand or meet some need. I owned the problem as my own, rather than projecting it out onto the patient. This had an interesting effect.

Most of the 'difficult' patients had a long and chequered history of interaction with healthcare services. They had often been treated with a lack of compassion or respect and had even on occasion been punished by health professionals for what was interpreted as manipulative behaviour. A classic example is the patient with chronic pain admitted to an acute care setting. Often their behaviour is interpreted as "drug seeking".

When I changed my attitude, I noticed an immediate effect. Often the patients were surprised or taken aback, they were quite unused to doctors treating them with respect. I found it was easy to negotiate solutions for particular problems with a bit of give and take on both sides. I often have to be an advocate for the patient but it is usually a small matter of negotiating agreement with the rest of the staff, for instance to allow the patient to leave the ward to go for a smoke. Quite suddenly I found I didn't have difficult patients any more. This was definitely an improvement in the quality of my working day! But paradoxically, the only person who changed was me.

I was so encouraged with the positive results of this experiment that I decided to extend it to all my patients. I decided to take the attitude that no patient of mine made unreasonable demands (unless they had organic brain pathology) and I would simply do my best to respond to every matter brought to my attention. I would be very attentive, I would try not to judge, I would be careful in the use of power, I would let the patient set the agenda and I would continually seek permission and approval for the process we were following together. My role came to resemble that of a coach or mentor, rather than expert.

My colleagues thought I was completely mad. It was obvious to them that I would soon be overwhelmed, exhausted and burnt out. In their experience, patients continually made demands that couldn't be met and they had to employ a variety of means to defend themselves against this unreasonable onslaught.

My experience was of completely the opposite effect. The demands of my patients grew less, not more. In this paradox lies a clue to solving the workforce problems that seem to besiege us.

The key insight is that there is a difference between fixing, helping and serving. Fixing is often the appropriate course of action for an acute condition or injury, or where chronic disability can be reversed through technology such as hip joint replacement. Fixing puts the expert in charge but that's fine for the right kind of problem. The patient has a short term contract: I put myself in your hands for the sake of achieving this specific improvement. It's a transactional relationship.

Of course, many of the chronic problems we see don't have a technical solution, they can't be fixed. While, on the surface 'helping' seems a laudable approach, we should be mindful of the resulting power relationship. The helper is always in a position of power over the person being helped. It's a dependent relationship that takes power away from patients. They take less responsibility for their own health and wellbeing because it's the doctor's job to fix the problem. I'm unhappy, so give me a pill. I'm overweight so treat my hypertension and diabetes. I've ruined my coronary arteries through unhealthy lifestyles so give me a heart bypass operation – now!

As long as the doctor is stuck in the "helper" mode, demand will be unrelenting. In the end, chronic helping and rescuing diminishes patients, it makes them less capable of dealing with their own life problems. Maybe our workforce crisis is a consequence of a professional climate change, not global warming but global helping?

So why is my experience different? I choose to serve my patients on their own terms. You can tell when someone is truly being served because you witness personal growth. The person being served takes greater responsibility for their own health and wellbeing. Their capacity for dealing with life's challenges is enhanced by your coaching and support. The relationship is one of deep mutual respect, honesty and openness. In this circumstance, no patient makes unreasonable demands. The workload for the doctor decreases not increases. However the joy and satisfaction in work is greatly enhanced. It becomes a privilege to be invited to participate in intimate life events and to witness the extraordinary courage and generosity of ordinary people as they struggle with this thing called "life". I certainly take delight in seeing their growing capacity for effective and wise responses to life's challenges.

There is a world of difference between *providing* a service and being *of* service. If you take away no other idea, I would like you to reflect on that.

Robert Greenleaf wrote of the concept of the "servant leader", one who truly serves his or her people and community. It's worth listing the key roles of servant leaders as identified by Greenleaf.

- Listening
- Empathy
- Healing
- Awareness
- Persuasion rather than the use of power or coercion
- Conceptualisation – creating a vision for the desired future
- Foresight
- Stewardship – holding something in trust for another
- Commitment to the growth of people
- Building community

This seems to me an admirable list of ideal attributes for the health professional who wishes to truly serve his or her 'co-healers' and the wider community. I use that term because I wanted to remind myself to explain something about compassion that I think we understand poorly in the Western world.

We have an assumption that compassion is a one-way street and that giving our empathy and compassion to every patient would drain our resources and lead to burnout. You will have a sense from my stories that my experience has been different, that another paradox is being witnessed. In the Buddhist culture, each act of compassion is perceived equally to be an act of compassion for the giver as much as the receiver. My experience has been that the more compassion and loving kindness I give, the

greater is the store of love in my heart. When we “practise” compassion we strengthen and grow the parts of the brain concerned with positive emotions.

So I end where I began, to stand once again in awe of the love and wisdom of that small child lying patiently in the middle of the paddock. When I look into the heart of each one of you I see that child. It gives me great hope for the future. Step aside from the noise of the world and let that child grow. Know who you are, find your place to stand and be the change you want to see.

It's been a privilege to speak with you.

## Further reading.

I have not given formal references because an “abstract” is just that – abstracted from meaning, context and purpose. I suggest the following selection of books and resources for those who wish to explore a different view of the world and find wisdom in your leadership.

**Destructive Emotions** by Daniel Goleman with the Dalai Lama. An account of a fascinating cross-cultural dialogue about the nature of emotions, of compassion, of the functioning of the human brain and practical ethics for building a better world.

**Kitchen Table Wisdom** by Rachel Naomi Remen. Rachel founded the Finding Meaning in Medicine Group in the USA. She writes with extraordinary grace and insight about the healing journey for health professionals who find their humanity again after the brutalisation of medical training. You can also visit <http://www.meaninginmedicine.org/>

**Love, Medicine and Miracles: Lessons Learned about Self-Healing from a Surgeon's Experience with Exceptional Patients** by Bernie Siegel. A wonderfully heart-warming tale of a surgeon who also lost and found his humanity and went on to inspire generations with his compassionate and holistic approach to patients.

**The Field: The Quest for the Secret Force of the Universe** by Lynne McTaggart. A very readable tour of weird science, of the theories of quantum physics, complexity, chaos, human consciousness, mind over matter and more. This book sums the leading edge science by prominent scientists in prestigious institutions – not the customary Western view of the world but none-the-less, reproducible science. It will shake your concepts of human consciousness and reality.

**Leadership and the New Science** by Margaret Wheatley. If the new science described by McTaggart and others is a more realistic view of the world than our traditional, mechanistic models, what are the implications for leadership? Margaret is a renowned thinker and writer on leadership and solving tough problems in communities, taking these different world views as a starting point. She makes much material available free on her website at <http://www.margaretwheatley.com/writing.html>

**The Fifth Discipline: The Art and Practice of the Learning Organisation** by Peter Senge. This is a classic book, available in any good book store, that examines aspects of internal mental models, complexity, system thinking, organisational learning, personal mastery and leadership. It's very readable and full of insightful stories and observations.

**The Lost Art of Compassion** by Lorne Ladner. Lorne is a Western psychologist who has studied Buddhism for many years and has created this easily understood interpretation of Buddhist psychology from a Western perspective. A great introduction to Buddhism, which appears to have a much more realistic understanding of the nature of the mind and humanity than Western traditions. Much of Buddhist wisdom is now being verified by neuroscientists in the Western world, a nice irony.

**The Tao of Leadership: Leadership Strategies for a New Age** by John Heider. This slim volume is very simply written but not easy for Western readers to comprehend. We are so bound up in Western ideas about leadership connected with authority that the Eastern concepts can elude us, ideas such as non-judgement and non-resistance. There is an enormous amount of wisdom in this book but each small chapter needs a lot of reflection. The book is about the essence of leadership by personal example and the quality of *being* rather than *doing*.

**Growing the Distance: Timeless Principles for Personal, Career and Family Success** by Jim Clemmer. Jim is one of the American leadership authors I enjoy because he had a gentler idea of leadership aligned with ancient wisdom. He has published a number of excellent books and has a large amount of resource available for free on his web site. I recommend signing up for his “Improvement Points” electronic newsletter <http://www.clemmer.net/articles/>

**Servant Leadership: A Journey into the Nature of Legitimate Power and Greatness** by Robert Greenleaf. Greenleaf coined the term “servant leadership” and his inspiring vision is supported by a number of international centres. See <http://www.greenleaf.org/>