Mission command: applying principles of military leadership to the SARS-CoV-2 (COVID-19) crisis

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Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), (COVID-19) presents a challenge to UK society and its health system unprecedented in peace time.[1 2] Naturally, many have reached for wartime metaphors to capture the pandemic's impact and the demand for resilience, community and adaptability it engenders.[3] Healthcare leaders at every level must make decisions, provide leadership and control their organisations while unsure of how the situation will develop and employing staff who may fear for their safety. The parallel to the challenge of military command is obvious.[4] However, popular misconceptions of how military command operates emphasise coercion (orders/punishment) and centralised command. These tools are neither available in the NHS nor desirable in this crisis. The best lesson to learn from the Armed Forces is one of decentralisation and empowerment of subordinates: the doctrine of *mission command*.

MISSION COMMAND

The principle of 'mission command' is founded on the clear expression of *intent* by commanders and the freedom of subordinates to act to achieve that intent.[4] The concept is hierarchical but decentralised: people are briefed on the intentions of their commanders two levels higher in the hierarchy. Subordinates are told what to achieve, not what to do. Such a mode of working is not alien to the NHS. Clinical teams are naturally hierarchical, but great responsibility is delegated to even very junior medical staff. Good leaders will act to 'flatten the hierarchy', preventing it from being a barrier to initiative or open communication.[5] When in doubt, military and medical staff can fall back on the more-or-less implicit intent of their superiors. However, this approach is much less familiar in non-clinical aspects of NHS leadership. It is common for authority to be tightly held, for decisions to require ratification at high level and for budgets to be centralised. This approach may be appropriate when the pace of institutional change is slow, the appetite for risk is small and the control of money is paramount. We no longer live in that environment. Is it time to emphasise a mission command approach to NHS leadership?

APPLICATION OF MISSION COMMAND IN THE NHS

The key components of mission command are unity of effort, freedom of action, trust, mutual understanding and rapid decision making. All of these aspects of command are directly relevant to civilian practice in the NHS, especially during a crisis such as the one we face today.

Unity of effort

Achieving unity of effort depends on leaders making clear their intention or purpose: their *intent*. Crucial to this is the specification of the 'main effort': the current priority to which other tasks are subsidiary and on which resources will be concentrated. Clear statement of a main effort allows the contextualisation of individual actions and has relevance for all teams and individuals beneath it. The main effort of a component of the health system should contribute to that of higher components and will change rapidly. For example, a surgical department may move quickly from its normal emergency and elective services to providing a greatly constrained service that cedes resources to the hospital's main effort of treating patients with COVID-19. By making this main effort clear, consequent clinical priorities become apparent.

Freedom of action

In the military domain, subordinate commanders, teams and individuals are enabled to enjoy freedom of action to achieve the commanders' intent. This freedom of action relies on personnel being suitably empowered to act, while themselves having the required knowledge, drive and ability to do so. The freedom given to a subordinate organisation, team or individual must be made clear, sufficient for the task they are assigned and tailored to their abilities. Such freedom of action has clear advantages in a large organisation such as the NHS, where individual hospitals, departments and teams may in turn work towards their leaders' intent without being stifled by arduous or cumbersome bureaucracy.

Trust

Mission command requires that leaders trust their subordinates to interpret and support their intent and to work effectively to achieve it. It also requires that the subordinate trust the process and people that have fashioned the intent they are to support. Crucially, they must also have confidence that they will be supported for their work, even if they sometimes meet with failure despite their best efforts. Trust is essential for teamwork and fosters a mutual and collegiate relationship between leaders and followers. Establishing this trust may be the greatest challenge in implementing mission command in the current coronavirus crisis, but the pace of events will provide ample opportunity for all actors to earn it.

Mutual understanding

Mutual understanding is a basis of trust, an aid to interpreting a leader's explicit intent and the means to infer the implicit intent when the facts make the stated goal inappropriate or outdated. Established relationships, shared values and common experience provide the NHS with a strong foundation in this domain.

Rapid decision making

The dynamic nature of the COVID-19 challenge demands that judgements and decisions are made quickly. A rapid decision in the context of some missing information is likely to be more effective than one made slowly with the complete picture. Former US National Security Advisor General Colin Powell concisely summarised this in two parts:[6] part I: '*Use the formula p=40 to 70, in which P stands for the probability of success and the numbers indicate the percentage of information acquired*', and part II: '*Once the information is in the 40 to 70 range, go with your gut*'. Caseload, resources and medical knowledge will all develop and evolve too quickly for perfect plans to be specified. The solution is to push information and responsibility down to the level where they can best be employed.

The practical applications of mission command are derived from these

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principles, which all appear to be relevant to NHS practice in these uncertain times. A robust response to the COVID-19 outbreak requires that NHS leaders at all levels ensure that those working under them understand their *intent*, which will be dynamic and adapting. Leaders should enable their teams to work as they see fit to achieve that intent and should be careful not to micromanage in an environment of mutual trust and understanding. This expands the leader's capacity to think beyond the immediate task, to plan and to consider the team's welfare. Subordinates must articulate their requirements for resources or additional freedom of action. An ancillary benefit derives from the empowerment of more junior staff: with a sense of agency comes improved morale and greater resilience.[7] Parts of the NHS's response to COVID-19 will require strict obedience to central instructions (eg, there is little scope for initiative in the matter of doffing and donning drills). However, the rapid transformation of one of the world's largest organisations in the face of a challenge that progresses with each day can only be achieved by fully harnessing the knowledge, initiative and good sense of its greatest resource: the teams and individuals who staff it. Adapting the doctrine of mission command is the best way for leaders to achieve success in a rapidly evolving landscape.

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Contributors All authors contributed to conception, writing, critique and editing of the paper.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

To cite Pearce AP, Naumann DN, O'Reilly D. *BMJ Mil Health* Epub ahead of print: [*please include* Day Month Year]. doi:10.1136/bmjmilitary-2020-001485

Accepted 3 April 2020

BMJ Mil Health 2020;**0**:1–2. doi:10.1136/bmjmilitary-2020-001485

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