Dr. Donald M. Berwick, who has tirelessly pioneered efforts to improve the quality of medical care and the safety of patients, faces new challenges as he assumes the reins of the Centers for Medicare and Medicaid Services (CMS). Democrats and Republicans alike were surprised when President Barack Obama announced his recess appointment of Berwick to the key CMS post, which had not been filled by a confirmed administrator since October 2006. A White House spokesperson said Obama acted because “many Republicans in Congress have made it clear . . . that they were going to stall the nomination as long as they could, solely to score political points.” But the plot is thicker than that and includes the administration’s ongoing struggle to neutralize Republican efforts to derail the health care reform law through verbal assaults, lawsuits, and other means. By sidestepping the normal Senate confirmation process, the administration denied Republicans not only a forum for maintaining their assault on the reform law, but also the opportunity to question Berwick about his admiration of the British National Health Service and his views about reining in the unsustainable costs of the U.S. health care system.

Other considerations were also at play. The White House seemed uncertain whether Berwick could win confirmation, and perhaps as a consequence, its public support of him had been somewhat muted. Berwick is a Harvard-trained pediatrician who founded the Institute for Healthcare Improvement (IHI; Cambridge, MA) and has been its chief executive for 22 years. Undertaking collaborative initiatives with health care providers aimed at improving quality and increasing patient safety, IHI has built a strong reputation for delivering on its mission.

Nevertheless, in the status-conscious Congress, both Democrats and Republicans took exception to the unanticipated recess appointment and its skirting of the normal Senate confirmation process. Senator Max Baucus (D-MT), chair of the Finance Committee, which would normally have considered Berwick’s nomination, characterized the appointment as “troubling.” Baucus said, “Senate confirmation of presidential appointees is an essential process prescribed by the Constitution that serves as a check on executive power and protects . . . all Americans by ensuring that
crucial questions are asked of the nominee — and answered.”

Also upset were senior Republicans, including Senator Charles Grassley of Iowa, the ranking member of the Finance Committee, who said he had no intention of delaying Berwick’s confirmation hearing and urged that it be scheduled before the Congress’s July 4 holiday break. A memo from a Grassley staffer suggested that by using a recess appointment, the administration may have been avoiding questions about whether IHI received undisclosed funding from industry groups.1

The Constitution grants presidents the power to “fill up all vacancies that may happen during the recess of the Senate, by granting commissions which shall expire at the end of their next session.” Thus, Berwick will have all the powers of a permanent appointee but not the full blessing of the politically deadlocked Senate; his tenure as a recess appointee will end in December 2011. At that point, the administration would have to renominate him, and if he were confirmed, he could continue as chief of the CMS. Obama is far from alone in wielding the recess-appointment power, which he has done 15 times; all recent presidents have used this tool — a fact that reflects increased polarization of Congress. As two-term presidents, George W. Bush made 171 recess appointments; Bill Clinton, 139; and Ronald Reagan, 243.

Though Republicans have made their opposition to Berwick clear, many major private interests representing physicians (including the American Medical Association and the American College of Physicians), hospitals, nurses, and pharmaceutical manufacturers expressed support for his nomination when it was announced April 19. Three former administrators of the CMS or its predecessor, the Health Care Financing Administration (HCFA) — Gail Wilensky, Thomas Scully, and Mark McClellan — who were appointed by Republicans also support Berwick’s nomination. McClellan described him as “a person who’s spent his entire career committed not just to talk about ways to make health care better, but actually helping organizations around the country change health care for the better.”

Yet Wilensky predicted that the new administrator would pay a political price for his “terribly unfortunate” recess appointment, which she said would “have at least two very serious ramifications” for Berwick, whom she characterized as a long-time colleague and friend: “First, his tenure is limited, by definition, to December 2011. Second, his appointment is tainted, certainly in the eyes of Republicans — even those who had not spoken out on sensitive issues that Don had raised in previous statements and writings. . . . Don will carry an extra burden because he was not confirmed by the full Senate through the normal confirmation process.”

Berwick comes to the agency at a time of frenzied activity within the Department of Health and Human Services (of which the CMS is a part) — activity related to the early implementation of provisions of the reform law that are seen as having mass appeal. Over half the funding of the law, which will cost an estimated $938 billion over 10 years, comes from reductions in Medicare payments to hospitals and other nonphysician providers. As these reductions take hold, providers will no doubt apply pressure on Congress and the CMS to pare down the cuts.

Previous CMS and HCFA administrators brought varied backgrounds and management styles to the agency. Berwick is only the second administrator who brings a depth of experience as either a practicing physician or an administrator of a health care institution. The late Robert Derzon was the first such administrator, having directed the hospital and clinics of the University of California, San Francisco, before he became HCFA’s first administrator in 1977.

Berwick has a reputation as a physician leader who has worked closely with doctors, nurses, hospitals, and health systems, and he has a long record of building collaborative partnerships with private interests and fostering innovation that builds teams rather than maintaining “provider silos” and emphasizes improving systems of care instead of blaming individual practitioners for medical errors. Berwick’s experience as an agent of change will be valuable, because the law authorizes the testing of new models of care delivery and reimbursement, such as accountable care organizations, patient-centered medical homes, and bundled payment approaches.

Over the years, IHI’s efforts have borne substantial fruit through campaigns to improve quality and patient safety. In June 2006, Berwick announced that 3000 hospitals, taking part in an 18-month effort to prevent 100,000 unnecessary deaths by improving patient care, had exceeded their goal, preventing “an estimated 122,300 unnecessary
deaths” and proving “that it’s possible for the health care community to come together voluntarily to rapidly make significant changes in patient care.” The IHI’s campaign came under criticism from some physician researchers, who questioned the accuracy of the number of lives saved and other details. Berwick and colleagues responded by acknowledging that this critique contributed to the “type of scrutiny that will help place the improvement of health care systems on the soundest possible scientific foundation.”

For the first time in his career, Berwick is entering a highly charged milieu where ideology, along with evidence, research, politics, and campaign financing, plays a role in shaping policy. Certainly not all legislators share Berwick’s support of systems in which government plays the dominant role in allocating health care resources. One who does not is Representative Michael Burgess of Texas, the ranking Republican on the House Energy and Commerce Subcommittee on Health and a licensed obstetrician–gynecologist. Burgess is among the vast majority of Republican legislators who detest the Democrats’ reform law.

Burgess has criticized a core belief embedded in the law—that physicians’ compensation should be based on the quality of the care they deliver rather than its quantity. He recently defended the fee-for-service model, asserting that doctors are “so goal-directed that we need that impetus” to motivate them to deliver the highest-quality care. Burgess noted that because so many physicians are in despair over the direction in which the health care system is moving, a record number of doctors — 46, 40 of whom are Republicans — are currently vying for congressional seats.

If Berwick can persuade Burgess and other skeptics that the IHI is built on collaborations with health care providers, not regulatory regimes formulated by government, and that he will bring those experiences to bear at the CMS, maybe he will have a chance to translate his private successes into public victories. But no matter what the final outcome, Berwick is taking on a challenging assignment at a tumultuous time in the history of U.S. health care, and he should expect a rough ride.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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