From resistance to attraction: a different approach to change - Positively Influencing Physicians

Paul E. Plsek

PHYSICIANS AND OTHER health professionals are bombarded daily by those who would influence their actions. Guidelines, education sessions, academic detailing, and quality improvement projects are but a few of the diverse approaches employed. Many methods of behavior change tend towards the coercive--at least that is how others experience them. Further, most of these efforts have been only marginally successful, with hard-won advances often followed by rapid reversions to old systems and habits. (1)

The study of complex adaptive systems in nature and its application to organizations is providing insight into how change occurs in human systems. (2-6) A key finding is that change is occurring naturally within the existing system. For example, a forest naturally spreads, old growth dies away and new growth springs up in an ever-changing, complex milieu. This is also true of a health care organization or clinical office. What physician practices medicine in the exact same way she or he did ten years ago? Five years ago? A year ago? The next time you face "resistance to change," talk with those you are trying to influence and you may find that they have naturally adopted many new procedures, medications, systems, and technologies.

Teams from the 23 participating health care organizations in the Institute for Healthcare Improvement's (IHI) Idealized Design of Clinical Office Practices (IDCOP) initiative found it refreshing to realize how much change their colleagues had undertaken on their own over the years. The initiative's goal is to fundamentally redesign all aspects of the clinical office--access, care provision, and financial management--to improve performance. Such deep redesign has required more than a focus on resistance to change and barriers to progress. Rather, it has demanded that these organizations create alternative systems that attract participation.

Change is not so much about overcoming resistance, as it is about creating attraction. Viewing the movements of a colony of ants over time reveals a detailed pattern of complex behavior and many cycles of change as the insects build and then move. Paradoxically, the underlying attractors that drive this behavior are quite simple: food and survival. (7) In human psychotherapy, clients are more likely to accept the counselor's advice when it is framed in ways that enhance their core sense of autonomy, integrity, and ideals. (8) These are underlying attractors within the complex and ever-changing system of a person's detailed behavior.

Moving from resistance to attraction

Goldstein asserts that the concept of attractors turns the idea of "resistance to change" completely on its head. (9) What we label as "resistance" is really an "attraction" to factors in the current system that we might not fully appreciate. Resistance is therefore seen as a natural, but potentially changeable, reaction of a system attracted to something else. For example, many technologies, such as ultrasound exams in uncomplicated pregnancies, provide strong attraction to both patients and health care providers, leading to their overuse. (10-12) Classic blinded-study research attempts to remove social influences, but the advocates of change often find that the pull of social system attractors overwhelms the hard science that tells us to behave differently. (13)

Change the attractors, or tap into existing ones better, and the system may do the rest of the work of change on its own. In the IDCOP initiative, physician leader Roger Resar, MD, tells of an office assistant who was resistant to a proposed change that would offer same day appointments to patients and dramatically reduce the booking of future appointments. The assistant was
attracted to the comfort of the existing scheduling system, chaotic though it was, because she understood it so well.

Rather than simply labeling her a "resistor," Resar engaged her in a friendly conversation about the most appealing and unappealing aspects of her job. One prominent dislike was having to call 30 or more patients to reschedule appointments when the doctor needed to be away. When Resar pointed out that the open access system would virtually eliminate the need for this activity, the assistant became actively attracted to the new idea—the same idea that she was seen as resisting just moments before. The proposed change was now associated with the comfort attractor and the resistance vanished. (For more about Resar's efforts, please see “Creating Attractors for Change” on page 43.)

The concept of attraction is intuitively behind the successes of incentive systems, academic detailing, and confidential data feedback. Where these approaches succeed, it is because they have tapped into natural attractors, such as the competitive nature of physicians and their desire to provide the best care. Where they fail, it is likely that we have oversimplified or otherwise misunderstood the various attractors within the system.

Understanding diffusion of innovations

Each of us resists change from time to time, for reasons that seem to us perfectly rational.

Rogers' research on the diffusion of innovation suggests a distribution in the time when individuals adopt a change. (14) A small percentage of people are innovators and early adopters. These are followed by the early majority, those who decide that it is good to change only after others have tried it out. Next, the late majority finally come on board, followed by the laggards who come on very late or perhaps never at all.

This model is misunderstood as ascribing durable personality traits to individuals. We say, for instance: "Terry is a laggard, always against anything new." But the research that led to Rogers' categories was based on observing the time at which an individual adopted a specific innovation. This does not necessarily mean that that individual will fall in the same category for the next change. A person might be an innovator in one area, a laggard in another, and among the early majority in a third area.

Whatever category individuals fall into on a specific change, they will likely have reasons for their actions that are rational, at least to them. An exercise that the ID-COP participants found enlightening was to identify areas of their life in which they are laggards. We all have such areas of behavior where we are set in our ways. When these "change agents" began explaining their rationale to their colleagues around the table, everyone had to laugh at themselves. At some level of consciousness, we realize that our rationale may not make sense to others. Still, we hold on, despite well-intentioned, logical explanations that try to sway us to the contrary. Rather than labeling others when change fails, we would do better to inquire why individuals are reluctant to embrace the change. Their rationale will often reveal the most profound attractors.

Prototypes, pilots, and tests of change can reduce risk and complement attractors.

Ideas spread more rapidly when they can be easily observed or tried out before investing in full adoption. (15) While the technical soundness of the idea can create an attractive pull, the perceived risk of making the change can distort the pulling force. The ability to observe someone else make the change, or the ability to try it out oneself under risk-controlled conditions, reduces the risk and complements the attraction force. (Please see "Creating Attraction" on page 45.)

Attraction and risk reduction are complementary concepts, but not completely overlapping. We must work on both in order to facilitate change.
Themes for positive action

We began by noting past frustration in improvement efforts and asking how we can be more effective at the task of change. Learning to recognize naturally occurring change, identify attractors, explore the rationality of others' points of view, and reduce risk are clear and constructive insights from research and emerging systems science. Here are some additional themes for positive action:

* Understand the issues of those you wish to change. Attraction suggests that our efforts should be directed toward issues important to those we want to change—not only towards issues that we alone deem important. For example, while we may want physicians to change their clinical behaviors, they may be much more concerned on a daily basis about operational issues in their office. We push on clinical change, they worry about efficiency. This hurts our credibility and damages the relationships necessary to fostering cooperation. (16)

* Create changes that are "exothermic." Past promoters of change often failed to produce tested, refined, and clearly advantageous changes that added energy to the system. Changes that sap energy are doomed. For example, few guidelines come packaged in a way that obviously makes a clinician's life easier. If a change requires more energy to maintain than the current state, the change, even if initially achieved, is unlikely to persist. The changes we promote should be exothermic—releasing energy into the system that allows frenetic lives of busy health professionals to be lowered a palpable notch.

* Produce system changes instead of depending on individuals to change within an unaltered system. A primary tenent of systems theory is that all systems are perfectly designed to achieve the results they achieve. (17) Successful leaders of change focus not only on influencing behavior, but on redesigning the systems around the individual. (18) For example, while Resar's practice assistant is now attracted to the new scheduling system, she is unlikely to be successful without cooperative colleagues and additional changes in supporting systems.

Educational efforts, guidelines, and one-on-one detailing are examples of efforts that encourage individuals to change, but do little to improve the underlying systems in which they work. Encouraging individuals to change within an unsupportive system is a recipe for failure. Attraction is much less concerned about nagging individuals to change as it is with producing attractive, new, whole systems in which good people naturally do good work.

* Be reflective, accept responsibility, learn from failed efforts, and develop more positive strategies, instead of placing blame and creating negative energy. Creating sufficient attraction is the change leader's work. When change fails, it is generally because the promoter fell short in this task. When resistance is the focus, leaders of failed efforts tend to point blame in an us-versus-them exercise. Physicians are blamed for being uncooperative, staff for being poorly motivated, and administrators for not providing necessary resources. Attraction suggests that those interested in being effective promoters of change become comfortable looking first in the mirror rather than externally.

* Focus on relationships—attractors are easier to create when working together in cooperative, positive relationships of trust. The culture of blame in past efforts has tended to separate socially, organizationally, and hierarchically the advocates of change from those who must carry out the change. The two groups seem to barely know each other. Taking the time to restore relationships that encourage honest dialogue is essential for uncovering the profound attractors that may exist within complex human systems. This relationship building is not simply a nice thing to do. Rather, it is clearly indicated as essential by good science.

Conclusion

The concept of attraction turns on its head most of what we have come to believe about making change happen. We have a new
language and underlying systems theory to support fresh, positive, and constructive approaches to change. Understanding the concerns and attractors of others, allowing them to observe and test for themselves, tackling dysfunctional systems, cultivating honest relationships, and focusing more on what we can do rather than what “they” should do addresses the major reasons why so many change efforts have failed to produce real change.

Acknowledgements

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References


SUGGESTED READINGS AND RESOURCES


For more information about the IHI ID-COP initiative, visit http://www.ihi.org.

RELATED ARTICLE: BE A CHANGE AGENT

How can physician executives be more effective at the task of change?

1. Learn to recognize naturally occurring change

2. Identify attractors

3. Explore the nationality of others points of view

4. Reduce risk

5. Understand the issues of those you wish to change

6. Create changes that are "exothermic"

7. Produce system changes

8. Accept responsibility and learn from failed efforts

9. Focus on building relationships of trust

Creating Attractors for Improving Access to Clinical Offices
Luther/Midelfort Mayo Health System is part of the Mayo Foundation and is a Wisconsin regional system of three hospitals, 11 outpatient facilities, 160 physicians, and 2,000 staff.

Poor patient access to clinical offices has been a chronic problem. Despite high levels of frustration and a sense that improvement must be possible, most clinicians and office leaders either did not know what to change or were hesitant to make changes. The difficulty in implementing a change was seen as more burdensome than maintaining the status quo.

Senior leaders at Luther/Midelfort joined the IHI ID-COP initiative because they believed that such a redesign would not only benefit patients and the system as a whole, but would also help clinicians and office staff. Most clinicians were hesitant, if not outright resistant.

Early work focused on office access and efficiency

Collective wisdom suggested that better clinical care and financial outcomes would be achieved if we could help physicians and staff improve their efficiency and productivity. We were convinced that such changes would thrill clinicians and staff by addressing the chronic 'out-of-control' feeling and helping them get out of the office on time each day.

Doctor's lounge conversation generated heated discussion. While the changes promised significant benefits in several months, it was clear that it would take real work to get there. Most were not interested. However two physicians were interested in trying some of the changes. Both were from practices with difficult access and scheduling problems and had reached a "burnout" stage. One even stated, "the change cannot be any worse than what I have now."

While the goal was to change the way the whole organization practices ambulatory care we knew that the place to start was by focusing on a few sites. If success and advocacy by clinicians could be gained on a limited basis, and if the improvements were clearly advantageous, the spread of innovation would occur much more easily. Increased of trying to convince "resistant" clinicians, were wanted to create changes that were so attractive that they would volunteer to participate.

The early attractor was offering something different from a situation that seemed hopeless. With a minimum of planning and focusing on a few rules that physicians receptionists, and patients could follow changes in access and effi-imbedded in those practices the advantages have been so powerful that

Imbedded in those practices the advantages have been so powerful that

Sliding back into the old system is not possible. Both offices now keep about 60 percent of their appointment slots unbooked releasing them only on that day. The plan is to increase this percentage even further so that every patient who requests a same-day appointment can get it. Neither would go back to the old system in spite of some difficulties with the new model.

Word has spread about these two successes. The "resistors" are still saying that this will never work for them but the demand from offices wanting to implement the changes now surpasses our ability to provide assistance. The attractors are so strong that the departments who want to try the new process are "wildeating" (just doing it on they own). We need to slow the rate of acceptance of these new concepts so the support staff's ability to handle the change is not outstripped. It is a nice problem to have.

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Creating ATTRACTION THROUGH PROTOTYPING

Gordon Moore

Strong Health is an integrated delivery network in Rochester, New York with a 200-bed community hospital, a 750-bed academic medical center, two nursing homes, a home care agency and an HMO insurance product jointly owned with the local Blue Cross/Blue Shield.

For our participation in the IHI ID-COP initiative, we needed two pilot sites that were likely to have early success. Past experience told us to look for innovators and early adopters rather than selecting on some political basis. We sent announcements to all 1,100 physicians within our health care system asking those with an interest to contact us. We did not give much time between the invitation and interview schedule and asked the interviewees to come to us. The stated purpose of the interview was to go over the description of the initiative and the travel schedule. The subtext was to measure enthusiasm willingness to change.

As an academic medical center, we chose one specialty and one primary care practice as our pilot sites. Both displayed and enthusiastic approach to change and a willingness to do more work in the hope of coming up with a better way to provide clinical care. One runner-up primary care site was so eager to participate that they asked to be fed as much information from the initiative as possible. Because of their enthusiasm they become our first "dissemination site" (a target for the spread of the innovations beyond the pilot sites).

The prototype sites had demonstrated significant success within the first seven months of their efforts (January to July 1999). At Fairport Internal Medicine, 100 percent of patients surveyed reported that they would rather get their care from Fairport than any other practice. In a very tight patient market, each physician has maintained a weekly influx of 12 to 15 new patients. University of Rochester's.

Ophthalmology resident clinic moved to open access (offering same day appointments to patients) and sustained a 25 percent increase in visit volume (please see Table 1). An eye clinic across town called up to say, "Our patient volume has plummeted. Patients say they can get in with you guys the same day they call. You've got to stop this!"

We have a three tiered approached communicating this early success. The message is consistent at every level of the organization. "We have found a way to make life less miserable. We're practicing smarter, not harder our staff are happier our patients are happier, we're providing better clinical care, and our finances have improved." At the system level, we let everyone know via electronic and print newsletters and we meet monthly with our senior management sponsors, showing graphs of data over time. At the mid-level of the organization, we present the results to as many physician/provider groups as possible. The third tier is the grass roots initiative. In hallway conversations, at picnics rounding or riding the shuttle between our hospitals, the pilot teams and change agents discuss how nice it is to finally correct some of the seemingly intractable problems.

The attention to change shows in two arenas. Senior level managers are attracted by the reduced cost per visit, coupled with increased office visits leading to higher market share. Physicians and other providers are attracted by the renewed hope of solving intractable issues and creating a livable work environment that serves patients.

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The fulcrum and the lever

Sean K. Kesterson

Telling a group of bright people that there is one and only one way, and it is my way” leaves them feeling as if their intellect development, and individualism have been sacrificed. Physicians have a reputation for being almost impossible to manage. Metaphors of herding cats apply well to this scenario. Volumes have been written on the subject. There are good reasons for this perception, but I am not convinced that physicians are being difficult just for stubbornness' sake These are bright determined principled and educated people with a strong sense of values.

Physicians are feeling the strain of market-based health care. Different physician groups are trying to position themselves to address the concerns of diminishing reimbursements and pressure for productivity. Some feel vulnerable and withdraw from cooperation to protect their shaky ground. Added pressure to change from within the ranks of the health care organization is clearly not enthusiastically received.

Providing leadership in this turbulent environment is more complex and challenging than ever. Yogi Bera said. "If you don't know where you're going you might not get there. "The leader's job is to decide where the organization is going and why--and then show others why it's good for them too.

DO PHYSICIANS KNOW WHAT YOU WANT?

It is assumed that physicians know what you, the physician executive, wants. This is the fulcrum for the lever--the work that needs to be done inherently rests upon it. Physician executives need to understand how important it is to be clear in stating expectations. It’s easy to under communicate hard to over-communicate. It's best to also explain the basis for the concern.

Consider the doctor-patient interview. Physicians are trained to explore the chief complaint, but is that satisfactory if the chief concern hasn’t also been addressed?

For example:

Chief complaint: I have a sore throat chief concern: I’m worried that this might be strep throat.

One could argue that what the patient really wants addressed is the chief concern.

Physician executives need to ask themselves whether they have addressed the chief concern. Simply telling a physician group that it needs to be more productive is empty. Physicians will want to know why. The challenge is to show them that your goal and direction are valid. Only then can they get on the lever and lean on the fulcrum. They may even provide solutions that hadn’t been considered, including ways to work smarter, but not necessarily harder.

It is also helpful to present the goal as a question rather than a directive for example

Statement: Our patient satisfaction data are disconcerting—we must do better

Question: What is your reaction to the patient satisfaction data?

I try to do this openly and invite critiques and suggestions from the group. Though email has plugged us into communicating efficiently there is no substitute for face-to-face conversation. Try to make yourself clear-carefully thoughtfully tactfully, and
compassionately.

Ann Richards, the former Texas Governor is an expert on knowing exactly what you want and being determined to get there. She calls this focused drive-getting to where you need to go means you have to be able to say it and see it clearly. Long-winded vision statements are fine, but the effective leader makes it short and sweet.

CHANGING LEADERSHIP STYLE

Leading in an engaging, understanding manner is more valuable than ever. Command and control leadership is ineffective in this complex health care environment. A posture of superiority must give way to humility. Talented physicians are part of a competitive labor market, and changing jobs, though it would be difficult is possible for any physician at any time. Another job is waiting somewhere. Peter Drucker said, "Changing jobs is a nuisance and nothing more." (1)

Daniel Goleman points out that effective leadership is not completely dependent on the intelligence quotient in Emotional Intelligence. Emotional intellect and components of emotional intelligence. Being decent and fair apparently makes good business sense.

This is not counter-intuitive to physicians who adhere to the oath 'first do no harm' when treating patients. Maybe we should consider this in providing leadership as well, for much harm can be done by delivering unilateral directives.

Mutual understanding is a necessary co-factor in reaching goals and objectives. It is important to understand the expectations of the physicians in the group collectively and as individuals. The leader should commit to helping physicians accomplish their goals and be prepared to make sacrifices to do so. This includes accommodating personal and professional development, parenting and material responsibilities, important health and family commitments, and community involvement. This is a valuable investment. Accommodating approving and supporting is payment into the physician emotional bank account. Helping them means they will be more likely to help you in your time of need. As the great Ohio State football coach Woody Hayes said, "There is no paying back, there is only paying forward."

And sometimes that may not be enough. Despite best efforts and gut wrenching compromise, a physician or group may still remain wedded to the past. In the end, the physician executive will need to decide whether to act or wait. Hard decisions including whether to part ways, will probably have to be made.

CONCLUSION

At our facility, we talk about what we want-flexibility understanding cooperation, and hope I’ve got a small management team, and hope I’ve got a small management team, and when it comes to solving problems, we use this as our focal point. So far things are going pretty well.

Physician executives need to learn the new principles of effective leadership and how to take change (please see recommended resources) Warren Bennis said. Becoming a better leader is becoming a better human being. Life itself is the career. (3) Even better reasons to develop ourselves and those around us as leaders. The impact on the workplace home and community could be dramatic.

References

(2.) Coleman D. Working with Emotional Intelligence and Emotional Intelligence New York New York Bantam Books 1998 and 1995 respectively


RECOMMENDED RESOURCES

Fast Company is a monthly publication that a one year subscription is available for $19.95 visit their website at www.fastcompany.com It’s definitely worth the trip


These organizations focus on leadership development and offer consulting services and educational programs likely to be useful to today’s physician executives.

American College of Physician Executives provides programs and services for physician executives interested in leadership development call 800/776-1571 or visit their website at www.acpe.org for additional information.

The Hay Group provides emotional intelligence assessment and training Call 800/776-1571 or visit their website at www.haygroup.com for additional information.

The Leadership Group provides leadership effectiveness assessment and training as well as executive coaching. Call 248/737-7292 or visit their website at hanpeter@aol.com for additional information.

Linkage, Inc’s Global institute for leadership Development provides programs and services targeted to long-term leadership development. Call 781/862-3157 or visit their website at www.linkageinc.com for additional information

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