SPOTLIGHT STORY

ENGAGE AND EMPOWER: A FAIR PROCESS MATTERS —VAL ULSTAD, MD, MPA, MPH

Resistance from physicians to safety initiatives is legendary. It is often misinterpreted, unconsciously provoked and even worsened by the reactions of others. What seems like "docs don't care" may actually mean they care a great deal but don't feel included and are unable to see how to participate in shaping and owning the solution. Safe, high quality care is the work of everyone. What might happen if we collectively thought about resistance as a *signal* to try to work differently? How might systems invite greater participation in and leadership by physicians in making our hospitals safer?

The ability to influence and have a voice in shaping our new work is important to us as doctors. Physicians want to do the right thing and really hate having things done "to us." We bristle at mandates that seem to come out of the blue. We get angry when asked to "just accept" a way of doing things that seems destined to fail because realities as we see them were not faced thoroughly. How can organizations talk about safety initiatives in a way that will engage the heart, minds, creativity and powerful collegial influence of doctors? I want to offer four ideas.

First, **name the "why."** Frame the initiative, being honest and firm about what is not negotiable. Talk about what needs to be tackled and be transparent about the reason it must be faced now. Was it an incident, a regulatory mandate, or a new insight about patient safety? If it is, for example, an incident, educate yourself to the details and speak to it when you make the case. Tell the story of what happened, within privacy bounds, and how the incident represents a general vulnerability of the system. Be clear about the consequences to your patients and to your organization for not addressing it. If there is a new regulatory imperative, be very clear about what parameters are fixed by external agencies. Don't present the issue as optional if it is not.

Second, **co-create the approach to the "how."** Fundamentally this all starts with a shared desire to create safe, high quality places to give and receive care. Present the initiative in a way that is compelling, meaningful and clear and linked to that notion. We all want to give the kind of care we would want our loved ones to have. This isn't a time for people to be seeking the "OK" for their favorite workaround. Those leading initiatives should not collude in this type of avoidant behavior (and it is really tempting to do so!) but stay clear in purpose and willing to speak to that purpose often and passionately.

You don't need (and should not try) to *fix* every concern, but you do need to *hear* and consider every concern as the approach is formulated. Stay genuinely curious about what physicians, nurses and other stakeholders think it will take to do the work well under the given circumstances. Be very clear what is open for thoughtful input using the fixed parameters to bound the input. It is very unlikely that consensus will get the job done; don't pretend everyone will get their way. Invite docs to give their thoughts about how the issue can best be addressed, listen to what they have to say and seek to really understand their message. Name the ways to give input (meetings, written feedback) and clearly limit the length of time over which you will accept it.

It is essential for the authorities in our systems (chief executive officer, chief medical officer, chief of staff, or chief quality officer)to back those who are asked to exercise leadership to move an initiative. Although safety initiatives are often led by nursing, they are not the work of nursing alone. Nurses have frequently stepped up to lead safety work in our organizations but often at high personal cost. People who step up have to tolerate being seen as the one who embodies the new issue and therefore face personal attacks (being yelled at, bullied, having emails or meetings ignored, having one's competence called into question) that really represent reactions to the change. It is unfortunately a well-developed human reflex to derail a difficult conversation by making it about the character of the person courageous enough to start the conversation instead of talking honestly about what is being asked of them.

Helping a group take up new work requires helping others see that things can't remain the same but doing so at a rate that is tolerable to them. One of the things that makes the exercise of leadership really hard is that the people being led set the pace of progress (either unconsciously or consciously). The reactions of people—doctors and everyone else—are organizational symptoms to notice. If you are perceived to be going too fast, not really listening or being dictatorial, people *will* let you know—by their behavior. Leadership requires seeing and understanding that behavior and trying another way "in." There is no quick fix to helping people do new capacity-building work together. This requires leadership training, learning from experiences that didn't go well and the opportunity to have others to talk to in real time about what could be tried next.

Third, **present your synthesis of the input, declare how you will begin and explain how you will track the process**. Once the input has been gathered, communicate the approach your system will take clearly, concisely and courageously. Talk about why you decided what you did. Be willing to talk about what influenced the decision. Also be willing to talk about what is not going to happen. By doing this you are letting people know you heard them and that the process used the input from the community. You are informing people of how the work will begin and hopefully demonstrating an awareness

of what it will take in your unique system and culture. Don't open the discussion for revision but let physicians and other stakeholders know how you will assess the efficacy of the work and when you will reassess the approach you are beginning. This is what great clinicians do: they begin, reassess regularly and refine based on response to the intervention. Be clear what you are going to measure and report.

Finally, **hold everyone accountable including the implementation team**. Be consistent and fair. Do what you said you were going to do. Regularly report evidence of impact. This is more than measurement, and may include stories and anecdotes, or noticing people being effective and creative in implementing. Celebrate success and acknowledge hard work. Build collective confidence and pride in what can be done together.

The *process* is crucial and will be more effective if the purpose is compelling, widely shared and if the effort is respectfully implemented and felt to be fair. Physician work changes at a rapid speed. We physicians are trained to be experts and have been rewarded to act like experts. In the emerging world of health care, nobody is expert and everyone is learning in real time. In this new world, together we are confronting the issues that will improve our care of patients and make our hospitals safe places of rescue and healing. This requires all of us to behave differently.

As a physician my plea is this: don't present a new initiative to me fully baked. Include me, listen to me and after input is gathered, tell me why you decided to begin the way we are beginning. Remind me that giving me a chance to give input doesn't mean I get my way. Tell me I am an essential partner in executing important work—not just a difficult person who "just doesn't get it." Then, assure me you will keep an eye on how it is working, refine it as we go on with real evidence in many forms, and I will enthusiastically join with you.

Physician engagement is not going out convincing docs to "do it your way." What often makes people angry is feeling like they are asked to participate in consensus when a decision is already made—they feel manipulated. The process I am describing is not consensus, but it is transparent and fair. It's using physician input to create more robust solutions to serve patients. Our organizational cultures are how we actually behave—not how we *say* we behave. ***A culture of safety is ours to create—together***.

Val Ulstad, MD, MPA, MPH is an educator in independent practice, a process consultant focused on leadership capacity building in health care, a member the advisory board for the Institute for Physician Leadership, and a member of the Board of Directors of the Center for Courage & Renewal. A practicing cardiologist for over 25 years, she has served in a variety of leadership roles in medicine, and recently reframed her "heart practice" to focus on facilitating the development of individuals and organizations.

Reference - W Chan and Mauborgne, Renee (Jan 2003) Fair Process: Managing in the Knowledge Economy. Harvard Business Review.