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ABSTRACT

This booklet presents guidelines for the management of change in medicine in Great Britain, particularly post-basic medical education. Following a forward and introduction, a description of the study from which the guidelines were developed is presented. That study was a major investigation of adapting business and industry change management theory to the medical context. The next section lists the most frequently preferred style of change and optimal process of change. The following section presents a model for change through a table that lists professional characteristics and styles matched with core activities and tactical choices and styles for each. The remainder of the booklet, sections 5, 6 and 7, is dedicated to a thorough explanation of this model of medical change. Section 5 discusses possible ways to use the model and emphasizes that the bulk of the effort should be put into the preparatory phase. Section 6 discusses professional characteristics and styles noting that understanding the context and the opportunities and limitations it offers is an essential starting point for those contemplating change. Section 7 provides the information for putting the model into practice by discussing the core steps and their associated tactics and styles. A final section presents concluding thoughts. Nine references are included. (JB)

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MANAGING CHANGE IN A MEDICAL CONTEXT: GUIDELINES FOR ACTION

Rodney Gale and Janet Grant

THE JOINT CENTRE FOR
EDUCATIONAL RESEARCH AND DEVELOPMENT
IN MEDICINE

1990

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FOREWORD

by Lord Walton of Detchant

In my capacity as President of the Association for the Study of Medical Education and as a former Dean of a Medical School, in which capacity I was much involved over many years in planning and implementing substantial changes in the medical curriculum, I warmly welcome this booklet prepared by Dr Janet Grant and Dr Rodney Gale. Essentially, this summarises the findings of a major investigation which they have carried out jointly over the course of the last year and upon which they have prepared a substantial and much more lengthy report.

May I urge all of those concerned with, and interested in, medical education to read and study this booklet with care as it contains a great deal of information which will be invaluable to those contemplating changes in the undergraduate medical curriculum or changes in the programmes of postgraduate medical education.

Some doctors who have found the introduction of management philosophy into the NHS to have proved less smooth than they might have wished could conceivably be slightly put off by reading the words "change management" in the second line of the introduction to the booklet. There may even be others, convinced of the need to modify educational programmes to meet the changing needs of medicine and society, who would nevertheless share the view of the late Dr Henry Miller who once said that curriculum review was an occupational disease of Deans resulting in the same subjects being taught in a different order.

But in fact this publication contains some extremely sensible, well-presented and well-argued advice, based upon the authors' own experience and upon their wide consultation with

members of the profession involved in medical education at all levels and upon a careful study of the UK scene over the last two years.

A glance at the table of contents will surely convince the reader that the booklet is carefully and logically planned and I venture to suggest that all who read it with care will find it, as I have done, immensely readable, wise and full of sound advice and precepts which can, if adopted, be greatly to the advantage of medicine in the future.

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1 INTRODUCTION

These guidelines have been produced to make the essence of current good practice in change management available to everyone involved in changing medicine, particularly post-basic medical education. For most people, time is very precious and in very short supply, and it needs to be used sparingly, economically and to good effect. Most of us also have a finite quantity of enthusiasm and energy which is all too easily frustrated by fruitless or unsatisfactory attempts at change. Many good and valuable ideas are not coming through because the available human time and energy is not being applied in the most efficient way. These guidelines can help you to use your time more effectively and to achieve more lasting and more satisfying changes with the time and energy you have available.

Medical education at post-basic level has always lacked recognition and has always taken place in borrowed time. It has relied on enthusiasm, professionalism and dedication on the part of teachers and learners in order to survive in its present form. Service pressures are growing and more and more free time is being squeezed out of the system. It is all the more important to use the scarce time and resources to good effect.

Our interest in the management of change in medicine arose because we had seen so many good initiatives allowed to wither on the vine for lack of a decent strategy to see them into place, so many good ideas wasted because of the way they were presented and so many changes made harder through failure to create a climate of cooperation. These guidelines can help all those involved in change, or contemplating change, to be aware of the consequences of particular approaches and to choose the best route to follow

for their own circumstances. They can also help people planning change to perform that little bit more knowledgeably and to use their scarce time and energies to better effect for the development of medicine and medical education.

Our guidelines are firmly rooted in medical practice and apply to issues over a very wide range indeed, much beyond educational matters to organisational and operational issues too. We do not prescribe what to change, we are concerned with how to go about change and we give plenty of hints and tips to make that process more effective. We provide a framework in which to think about the change being contemplated and raise the issues that should be considered.

It was surprisingly difficult to arrive at the designation of "Guidelines" to cover the topics we wished to present. We are not offering a blueprint or 'change in easy stages.' You might prefer to see our work as a road map which gives many starting and ending points and many routes between them. Others may think of our model of change as a checklist from which a change strategy arises by elimination. Whatever way they are described, we trust you will find the guidelines an asset in your work.

2 THE LEVERHULME PROJECT

The basic data for these guidelines were gleaned from a major research project supported by the Leverhulme Trust. The project report, entitled **Guidelines For Change In Postgraduate And Continuing Medical Education**, is obtainable from the British Postgraduate Medical Federation and we strongly recommend you to consult it.

The Leverhulme project was designed to take what was known about the management of change in industry and in education and to adapt that knowledge to the medical context. To give detailed advice about the management of change, it is essential to know and understand the context in which the change will take place. It is very little use to ask a manager of industry for advice about change in medicine, except in the most general of terms. The nature of the enterprise, the distribution of power and influence, the degree of external political control and the outlooks of the professionals involved will all interact to limit the styles and types of changes that are possible. Advice must be firmly anchored in the context of medicine and must take account of its special nature.

We started our research with a hypothetical framework, or model, of the change process in medicine and from it derived a format for semi-structured interviews. The interviews were focussed on particular recent episodes of change in which the participants had been involved. We tried to avoid a discussion of change in the abstract and to avoid a detailed but narrow analysis of a few specific changes. We wanted a broad range of changes and we wanted practical information. The interview format was pilot tested by a representative group.

We carried out interviews with a sample of 55 doctors, loosely arranged in the 5 groups listed opposite:

- **General Practitioners**
- **Hospital Consultants**
- **Clinical Tutors**
- **Deans and Regional Advisers**
- **Government and College representatives**

The interviews were recorded and later analysed, by a process called content analysis, to reveal the underlying factors that participants thought were important in the management of change in a medical context. By this process, we achieved a blend of the knowledge of change in industry and education with the practical experiences of change in a medical context that the participants provided.

We undertook reliability studies to eliminate subjectivity from our analyses and so extracted from the interviews a reliable and widely applicable set of factors that were important in change management. The next task was to arrange these factors into a description or model of the change process in medicine and to sort out those factors which were concerned with the context of medicine, those which related to essential or critical steps and those over which some choice could be exercised.

A prior stage to the development of the model was to examine the most frequently cited important factors in change management which came up in the interviews. These are presented on the next page. An inspection of the table reveals very few surprises. The most frequently cited factors are themselves a useful checklist.

3 THE MOST FREQUENTLY CITED FACTORS IN CHANGE MANAGEMENT

		<i>% of sample</i>
1	Thorough consultation	69
2	Talking to people and explaining the changes	56
3	Teamwork	55
4	Ensuring the need for change is agreed	51
5	Ownership of the change	49
6	The use of demonstration projects	47
6	Constraints of time	47
6	Predicting potential barriers to change	47
9	The avoidance of imposed change	44
9	Awareness of timescales	44
9	Presentation of the change	44
12	Harnessing committees	42
13	Constraints of money	36
14	The personal position of the change leader	35

This list indicates our interviewees' preferred style of change and the optimal process of change. The desires for thorough consultation and for people to have changes explained to them personally mean that agreed change will be a long process. The desire for wide ownership of the change and the preference for demonstration projects also imply that slow and steady progress is preferred to untested radical changes.

4 A MODEL OF MEDICAL CHANGE

We used the rank order of factors to derive a model of medical change with three aspects relating to the professional characteristics and styles, the essential steps or core activities in a change programme and the tactical or style choices that must be made. These three aspects enable us to sort all the factors into a usable model of the change process in a medical context; a model that contains all the prior knowledge of change in industry and education converted to a form relevant to the special nature of medicine and medical practice. This is because the model is derived from doctors' accounts of change. The model is a checklist and not a recipe; your judgement is still needed to determine the weight of each factor in any circumstance.

Having said that the model is not a recipe, it is difficult to describe the model in a linear fashion without sounding somewhat prescriptive. Change is seldom a simple logical process where one task is completed before moving on to the next, so models give a false impression of order. We urge the reader to try to ignore the logic of the presentation which follows and to think of reality where tasks will occur in parallel and be brought up in the "wrong" order, where people will be following their own agendas. Actual change is not a logical, stepwise process.

A Model Of Medical Change

<i>Professional Characteristics and Styles</i>	<i>Core Activities</i>	<i>Tactical Choices and Styles</i>
Consultation	1 ESTABLISH THE NEED	Lobbying, consultation conjunction of circumstances
Demonstration	2 POWER TO ACT	Key people, ownership harnessing committees authority/borrowed power political/external power personal position local environment
Evolution	3 DESIGN THE INNOVATION	Feasible?, resources, timing, timescale, involvement, scale, directive/elective, degree, predicting pathways & barriers, winners and losers
Ownership		
Power to hinder	4 CONSULT	Appropriateness, leadership, teamwork talking and explaining
Commitment	5 PUBLICISE THE CHANGE WIDELY	Presentation, vision, amending proposals, communication

<i>Professional Characteristics and Styles</i>	<i>Core Activities</i>	<i>Tactical Choices and Styles</i>
Energy & Enthusiasm	6 AGREE DETAILED PLANS	Detailed plans
Motives	7 IMPLEMENT	Demonstration projects, scheming/bypassing, implementation strategy opportunism, pathways & barriers to change
	8 PROVIDE SUPPORT	Resistance, overcoming difficulties, objections, maintaining change
	9 MODIFY PLANS	Compensation, modifications
	10 EVALUATE OUTCOMES	Evaluation strategy

5 AN ACTION PLAN

The remainder of this booklet is dedicated to a thorough explanation of the model of medical change. This description should act as a stimulus to those contemplating or involved in change. The description of the model is itself an action plan which can be used, whatever stage your change programme has reached. If you have already embarked on a particular change, it may be wise to take note of the stages that you have already completed, in case there is something that was overlooked or not handled as well as possible. Whether you are contemplating change or involved in it, the descriptions of the core activities and their associated tactical choices and styles provide a substantial menu from which to select the optimal approach for each particular circumstance.

The essence of the model of change is that the bulk of the effort should be put in to the preparation phase; establishing the need, ensuring sufficient power to act, designing the new system with consultation and publicity and modifying the design until it is the best that can be achieved within the constraints of time and effort available. If these aspects are properly handled, there will be far fewer difficulties when the implementation phase is reached because everyone involved will have known all about the project and will have had their views taken into account in the final design. With this careful approach, there should be fewer surprises lurking around the corner than if there is a headlong gallop to 'get something done tomorrow'.

We have already made clear that change is not necessarily a smooth linear process and it is quite normal to find oneself moving backwards and forwards among the various stages or processes. With the best will in the world and with the best planning, it is still possible to meet brick walls or large

obstacles in your chosen path. It is here that a fine judgement is needed to determine the next steps.

The brick wall may be telling you that the project, in its current form, is not viable. In which case you may wish to backtrack and find another route forward, avoiding the wall by modifying your design or seeking new supporters, or you may wish to marshal your forces and try to push the wall aside, or you may have to accept that what you were attempting was too ambitious. We feel that if the processes of consultation, discussion and refining of ideas has been adequately carried out, then there should not be insurmountable obstacles in the chosen path.

It may happen that external circumstances change the rules of operation or the basic need for the chosen change. In these circumstances, it may be best to abandon the current initiative and try again later, with a suitably modified version.

Section 6 discusses professional characteristics and styles, these describe the normal medical way of going about things, or the overall context in which other actions must be set. Understanding the context and the opportunities and limitations it offers is an essential starting point for those contemplating change.

Section 7 provides the information on what you actually have to do to put the model into practice. It does so by discussing the core steps and their associated tactics and styles. It is the responsibility of the person proposing change to choose the balance of emphasis of the various components of the model according to local conditions and circumstances.

6 PROFESSIONAL CHARACTERISTICS AND STYLES

The context of medicine must be recognised and taken into account if change is to be successful and lasting. Characteristics and styles which must be considered are as follows:

6.1 Consultation

Doctors expect to be asked, to be consulted and not to be told what to do. This is as true on a national scale as it is locally when dealing with colleagues or members of your own team. Consultation makes good sense in that it uncovers a rich seam of ideas and thoughts. Consultation is a signalling process, it is the first step in change.

6.2 Demonstration Projects

The scientific basis of medicine leads to a reliance on scientific methods in organisation too. Doctors place greater validity on the outcomes of proper trials, or demonstration projects, than they do on personal opinions. In managing change it is important to be aware of this factor and to present change on a rational basis.

6.3 Evolution

Gradual change is preferred to radical or gross change. The progress of medicine as a whole consists of a series of small advances and improvements and a similar style of organisational or educational development is desirable. An evolutionary approach allows people time to adjust to the changes and to assimilate them.

6.4 Ownership

The autonomy of doctors means that they will not generally be enthusiastic about change unless they feel they are the owners. Ownership is the perception that the changes proposed are your solution to your problems. For a change leader, wide ownership of the change process presents a possible dilution of the concept or ambiguity in the direction and control of the process. Without a spread of ownership, however, there will be little enthusiasm and progress.

6.5 Power to Hinder

The autonomy of doctors gives them a power of veto over many types of change. Doctors are not as interdependent as many professionals in other organisations and face fewer consequences for lack of cooperation. Proposers of change need to recognise and accommodate this factor.

6.6 Commitment, Energy & Enthusiasm and Motives

Without commitment from the group leading a change, little will happen. Without the application of time and energy to the process, little will happen. If there are any suspicions concerning hidden motives or hidden agendas for change on the part of the leader or leading group, there will be little constructive progress and much bickering and resentment. Commitment and energy are communicable and contagious in that they will be transmitted to others and have an influence on the success of the venture. On the other hand, doubts about the motives of change leaders and worries over their potential personal gains have a negative effect on the process and progress of change.

7 THE CORE ACTIVITIES AND ASSOCIATED TACTICAL CHOICES AND STYLES

7.1 Establish The Need *Lobbying, consultation, conjunction of circumstances*

For any proposed change, it is vital to establish the need. This must be shared by all those upon whom the change will have an impact. Perception of need is fundamental. Change is an uphill struggle, even more so without a widely accepted need.

The need may arise from a crisis, poor exam performance, student unrest, low uptake of postgraduate training, cuts in funds, for example. It could also arise in the form of the desire to effect substantial improvements in quality or reduce the effort to achieve a particular goal as a result of better methods becoming available. The need sometimes arises as an opportunity brought about by the conjunction of two or more circumstances. These opportunities may only exist for a short time and may not be repeated for many years. An example might be the retirement of a departmental head at the time when resources are available and a new Dean has arrived, or a known future reorganisation of local postgraduate education arrangements coinciding with available resources and the availability of manpower. The need may also arise in relation to a directive from above.

The hazard faced by most potential change leaders is to establish the need for change without putting forward a particular proposal to meet the need. From the standpoint of spreading ownership and gaining commitment from those

affected by the change, it is essential to separate the need for change from proposed solutions. This is difficult because we often understand the need for change in terms of what we could do to improve matters, rather than in terms of exactly what the opportunities are or what is wrong. Despite the difficulty, it must be done and the change leader must promote needs, not solutions, must explain the opportunity, not his or her pet proposal.

It is also important to ensure the widest possible sharing of the need for change by consulting with peers, colleagues, Heads of Department, Deans or whoever can influence the outcome of a change initiative. The process of discussion then acts to incorporate their views and to trigger their interest and involvement. Even at this early stage, it pays to think ahead and to make sure that all important and influential people who can determine the outcome of the initiative are involved at the beginning. People do not like to think they have been consulted as a last resort and much prefer to be informed or consulted early in the process. The dangers of fuelling the opposition are much less than the penalties of slighting the home team.

Sometimes it will be necessary to have a mandate to proceed with a change initiative and it may be necessary to secure agreement from a local or Regional committee. It may be prudent to lobby the members of that committee to ensure their full understanding of the issues. It may also be prudent to lobby your colleagues if their support is needed, even if there is no need for their formal approval.

In summary, it is important to establish the need for change separate from the potential solutions or developments. Agreement on the need to do something is separate from agreement on what to do.

7.2 Power To Act

Key people, ownership, harnessing committees, authority, borrowed power, political/external power, personal position, local environment

Having established a need or opportunity for change, it is necessary to look at the sources of power to move the change forward and the forces which might hinder it.

A primary consideration should concern the ability of the hospital or practice, say, to withstand the rigours of a change process. There must be a sufficient number of people with the time, skills and abilities needed for the degree of change proposed and the local organisation must be capable of absorbing such a change without terminally destructive consequences.

The organisation may have the ability to change, but the change leader still needs to ensure sufficient power to carry through the changes. Power can come from positional authority or from external and political sources or from charismatic influence over others or from recognised leadership. Other sources of power arise from being a mandated representative of a group, an authority or of a Royal College. Power also resides in enthusiasm and action and it is often surprising how much influence motivated people can have.

Whatever power is to be used to smooth the path of change, it is essential to ensure that there is sufficient power available of the right type for all stages of the change process. The creative parts of the process may need a different sort of

power and influence from those parts which relate to implementation and rapid problem solving. How much power and in what forms are matters for local judgement, but you do not have to use all the power you have available.

Because change has many elements of a political process, power and influence are very important. Who else is on the side of this initiative? Who is against it? The change leader who lacks sufficient personal power has several options to bring power to bear on the situation. Firstly, influencing key people or even getting them to join in is an excellent step. Key people may be in positions of authority or may be natural leaders. Secondly, power can also be gained by spreading ownership of the process to a larger group of colleagues. In this way a critical mass for change can be developed which itself has political power in a local context. At this point, it is worthwhile speculating on the spread of impact of the changes, whatever form they take, and making sure that all affected parties are aware and that none of them has any power of veto.

Another useful strategy to account for lack of personal power is to borrow some power from an important person. This may take the form of agreement to participate in the project in some limited fashion or agreement to clear lines of communication to higher authorities, for example. The borrowed power is used to raise the status and profile of the change initiative.

Committees can be used positively to promote change by conferring their authority on individuals or groups. They can also act negatively if not informed of change initiatives early enough.

In summary, power is needed to bring about change. Power can come from personal sources or from position. Power can be borrowed in the form of authority to take action or by using the good offices of a powerful person.

7.3 Design The Innovation

Feasible? resources, timing, timescale, scale, degree, involvement, directive/elective, predicting pathways and barriers, winners and losers

Consideration of the need for change and a review of available power will have helped to put boundaries around the possible design of a new system. Some other factors are also important.

Is the proposed change feasible? Is its scale or degree over-ambitious or too costly and is it within our abilities to achieve? Have we access to sufficient material and human resources to implement this proposed change? It is important to tackle something that is ambitious and worthwhile and yet remains within the available capacity. It may be wise to tackle a major change as a series of smaller ones.

The timing of change needs to be addressed. There are times when organisations suffer from what is termed initiative overload; they cannot cope with anything else. If there is any flexibility, it would be worth trying to choose a favourable time for the change.

Most people who have undertaken a major change agree that they seriously underestimated the time it would take. Major changes are discussed in years and not months. The most time-consuming item was the constant round of talking to people and slowly influencing them. Given this perspective, the need for change must be an enduring one.

At the design stage, a little time spent looking forward can be

amply repaid. When a possible design is produced, it should be analysed in terms of the groups of people who are likely to be in favour of it and those who will be against it, and their reasons for this. This process, called force field analysis, can be really useful in gauging the strength and quality of possible opposition.

The origins of force field theory lie in the systems theory of organisations proposed by Kurt Lewin. This theory holds that the status quo in any organisation, at any particular time, is an equilibrium brought about by the action of forces pushing in opposite directions. The action of these forces on each other maintains the equilibrium. There are forces promoting change and forces of resistance. The forces are ideas or opinions about the way the organisation should operate or develop, they are the views of individuals or groups, they are sometimes inertial attitudes, they are sometimes general notions arising from society in general.

Force field analysis is very useful in analysing change. A change in an organisation necessitates a shift in the equilibrium. It requires the forces for a particular shift in direction or behaviour to be stronger than those who are resisting the change and trying to preserve the current order of things. It is not a precise analytical tool, rather it is a decision making aid.

To use the technique, divide a piece of paper with a vertical line, list on the left the positive forces: all the benefits and factors that are in favour of the innovation proposed and all the sources of support. On the right, list all the negative forces: weak points in the design, all the likely opponents and all the factors which might make the proposed change difficult or impossible. An example is given below for illustration purposes only.

Force Field Analysis of The Introduction of Audit

<i>Positive Forces</i> → → → → →	← ← ← ← ← <i>Negative Forces</i>
Improvement in quality of service and care	Another burden on time
Basis for structured educational courses	Need for training
Professional collaboration	Better ways to get information
Aid to career planning	Difficult to implement
Money available, etc	Lack of local skill
	Surgeons have their own, etc

The dynamic nature of an organisation equilibrium means that the harder it is pushed in one direction, the harder it pushes back. The astute change leader therefore puts the maximum effort into reviewing the forces of opposition and seeking ways in which to weaken their effect. This may be achieved by encouraging key individuals to defect or by changing the design of the innovation to avoid likely opposition or by incorporating opposition ideas. This review process may show the opposition for a particular design of change to be too powerful to continue. If the change is thought feasible, it is helpful to put the positive and negative forces in order of significance and to tackle the strongest opponents first. Some effort needs to be applied to maintaining the positive forces.

A good design is one that minimises the number of people who lose position, status or influence as a result of the change and maximises the number who stand to gain. Those who will

gain may become supporters but those who stand to lose could become an effective opposition. A good design also takes notice of the favourable local factors, the pathways to change, that can be a bias to success. Good design looks at the possible hurdles or difficulties that must be overcome or avoided, the barriers to change, and tries to minimise their impact. Barriers are sometimes looked upon as absolutes, as immovable constraints; eg doctors do not like change. Our view is that the barriers depend very heavily on what is being proposed and how it is proposed; they depend on the content and style of change.

If sufficient power is available and it is felt that it should be used, then it is possible to adopt a directive or coercive style of change management. The gains are speed and integrity of the original idea. The costs are a possibly compliant audience with deep resentments. Lasting change can only be achieved by involving all those affected and accepting long timescales and some dilution of the original concept.

In summary, when designing change, it pays to look forward and analyse the positive and negative effects of a proposal. Action can then be taken to improve the design or to weaken the case against the proposal.

7.4 Consult

Appropriateness, teamwork, talking and explaining, leadership

When a solution to the problem or a response to the opportunity has been designed, it is essential to consult widely with all those touched in any way by the changes. The process has the benefits of receiving feedback to help improve the proposals and involving those affected by the change more closely in the events. The only limits to consultation are the time it takes and the patience of the audience. It is much better to have incomplete ideas in the public arena than to work secretly to develop the perfect scheme and then to spring it on an unsuspecting world.

The consultation process ensures that the proposed scheme is appropriate to its purpose, it makes sure there are no surprising consequences from the proposed changes and that the desired results are within the capacity of the local resources. The consultation process is a preparation for the implementation stage.

The aspect of consultation concerned with disseminating the idea or proposal is one over which leadership can be exercised. Once change has been put on the agenda, events may well take on a life of their own and move in the wrong direction, unless guided by the leadership of the individual or team managing the change. The leadership role has to find the best balance between keeping things moving along roughly the optimum path and taking time to consult and discuss. Leadership demands courage and fine judgement.

Consultation is a lengthy process. Consultation takes time, but

every effort needs to be put in to make sure that everyone important to the outcome of the change initiative has been contacted. It will be clear that teamwork has an essential role to play. A team of people can do more than the sum of its members because of team spirit, the lesser impact of individual shortages of time or energy and the greater source of ideas. The presence of a team working towards change can have the effect of reducing the suspicion of personal motives and actions and so encourage commitment on the part of those affected by the change. There are consequences of teamwork in terms of loss of individual control and direction of the project, but these costs are outweighed by the benefits.

There is no effective substitute for talking to people directly and explaining to them what is going on, how they are affected and what will happen next. It may be tempting to devise a short-cut, to seek a way to consult with people without talking to them. Attempts to do so by writing to them or putting up notices will cause a later backlash of resentment. In thinking about any change, a sufficient budget of time and energy must be set aside to go round and talk to all the key individuals who can affect the outcome of the change initiative, not once but several times. The larger and more complex the change attempted, the more effort will be needed to shift the climate of opinion towards acceptance and understanding.

Another way to seek to shorten the process of consultation is to use representatives with whom to negotiate and discuss. This policy is also not without problems. The representatives may not have a sufficient mandate from their members to agree to novel arrangements and the advantages of seeing people in person and being able to influence them directly is lost.

7.5 Publicise the Change Widely *Presentation, communication, amending proposals, vision*

The consultation process is carried on with those most centrally affected by the change, but such is the interconnected nature of the NHS and medical education that change in any part of it can affect other parts in many ways, big and small. The alert and concerned change leader will take every opportunity to publicise the current state of plans and progress. Rather like the consultation process, the act of publicising, reaching a wider audience, can uncover unforeseen consequences of planned actions and can thus allow the plans to be modified.

Publicity is used to alter opinions and behaviour and so the way the changes are presented is of great significance. However radical and innovative the design, it is always helpful to present the changes as incremental improvements, as small changes in the previously accepted direction. It is beneficial to present changes as experimental and to leave open the option of a later return to the status quo. In practice, it is hard to remove a system once established, but it can and should be modified according to experience.

Sometimes, publicity has to be produced before too many of the actual details have been worked out. It is here that vision, an idea of how things could be after the change, or an ideal to strive for, plays a role. Such a vision can capture the imaginations of others and provide a very useful anchor, to which to cling, when being tossed about by the turmoil that major changes can unleash. A vision can help to provide a guiding path through the apparent chaos that is generated by

the change process. Change is seldom a smooth process.

A large change project generates a considerable curiosity. A good change manager will be aware of this and ensure that efficient channels of communication are set up with the community of interested parties. The choice of communication is dependent on local factors and resources. Leaflets, posters, newsheets, videos and meetings have all been used to good effect. Whatever process is chosen to make the change programme public property, it is important to open channels for feedback. The more people who can be encouraged to think about the proposals, the richer will be their quality and the easier their passage into existence.

Feedback is valuable, but it is of diminished value unless it is used actually to amend the proposals. By now it should be becoming clear that change is a rather fluid process that involves large numbers of people. Successful change relies on converting the majority to supporters or even owners of the project. Listening carefully to feedback and being seen to respond positively to it help enormously in gaining acceptance. It might be imagined that publicising a less than perfect proposal would lead to a large loss of face and consequent ridicule. In practice, this only occurs when publicising the change with a rigid determination to stick to it. If feedback is encouraged and is used, then early publicity is positive.

The change leader has to balance the urge to get on with things against the need to establish a favourable climate for the proposals. It is important not to try to shorten the processes of consultation and publicity because those missed out may well form a strong opposition.

7.6 Agree Detailed Plans

Detailed plans

The process of design, consultation and publicity and the impact of feedback lead to a set of proposals that are agreed and can be put into the form of a detailed plan of what is to be done, by whom and when. The change process has moved on from its free and creative phase towards its much tighter and task orientated phase where plans and action assume greater importance.

To many, the long slow build up may have seemed full of frustration and tension and they may have become anxious to do something. We strongly believe that it is foolhardy to try to shorten the design and consultation phase. This is because people need time to understand and adjust to new thoughts, to new views about their role and status, to new relationships with colleagues and to new procedures. If the process of acceptance is unduly rushed, resentments, defensive and/or negative feelings may result, and the change manager will be faced with a deeply entrenched opposition rather than an uncertain set of supporters.

The drawing up of detailed plans of what will be done signifies the end of the acceptance phase and heralds the actual implementation stage. The change leader will already have experienced many demands for detail that could not reasonably be satisfied. When a change is announced, everyone, quite understandably, wants to know exactly what it will mean to them and to their work: they want to know in detail. Up to this stage, the detail has been an act of faith or a matter for negotiation and compromise. Now detailed plans have to be made.

The process of going backwards and forwards through the design, consultation and publicity stages will not have attracted everyone's agreement and this is not necessary.

There must, however, be a critical mass of supporters who can carry the rest of the hospital, committee or FPC, say, with them. Many lingering doubts and uncertainties can only be dispelled in practice, once the changes have been implemented. The detailed plans inform all individuals of their roles in the new order and provide a chronicle of events which is of great value in the intensive stages to follow.

We present below some comments on plans and planning taken from our interview survey:

- **People need to think what they are going to do, what and how the parts interdepend.**
- **One of the most important things in educational change is to have the stages laid out in detail with tactics and timescales.**
- **It cannot be just an act of faith, you have to set out the details.**
- **The whole thing was planned in detail like a military operation (*but not in a military manner*).**

7.7 Implement

Demonstration projects, scheming/bypassing, pathways & barriers to change, opportunism, implementation strategy

The careful and patient preparation described so far should lead to a smooth implementation. Many change efforts fail at the implementation stage because of rushed preparation or the desire to implement the parts of a programme that have been agreed without regard for the consequences.

We have already discussed demonstration projects, or pilots, as part of the medical way of doing things, but they can also have a role in a long-term implementation strategy. It may not be possible to reach agreement with everyone concerned, but a small group may be willing to embrace fully the new methods. Such a demonstration is a way of improving proposals and of taking some of the risks away through familiarity.

When larger changes are being implemented it may be tempting to cut short the consultation and debate and to use the decision making machinery to "slip one through the committee." Any advantages gained by such tactics are ultimately illusory and will be reversed in due time. Lasting change cannot be built on slick manipulations, it must rest on acceptance and agreement.

Another danger in implementation is to ignore the logic of making sure the support systems are in place at the right times and in the right order and opt for putting the easy bits in place first. Such an opportunistic approach is a recipe for disaster because people will lose faith with changes that are

made too incoherent and unsupported to operate. Implementation has to be managed in order to make the adoption of the new system as painless as possible.

It is for these reasons that a proper strategy for implementation has to be drawn up and discussed with the key players in the drama. People will have agreed why they are changing, but they also have to know what to do, with whom and when.

Up to this point pathways and barriers to change have been considered in design and their impact has been minimised. At the implementation stage, any residual problems or unforeseen routes to success will become apparent and active. "Pathways and barriers" is a convenient notation for all the good and bad aspects of the stages in change management and all the good and bad aspects of the choices of tactics and styles of leadership that have been adopted. We said earlier that pathways and barriers are not absolutes, rather they are created by the ways change is presented and approached.

To provide a flavour of the sorts of things that were felt to be important by the participants in our study, we list a selection below:

<i>Pathways to Change</i>	<i>Barriers to Change</i>
Shock from adverse reports	Sticking to contract
Panic due to finances	Threat to status
Tradition of innovation	Protection of territory
Professional pride	Service commitments
Change of key staff	Lack of reward or gain
Supportive group	Clinical independence
Avoiding something worse	Lack of will to change
Government pressure	"Not my idea"
Incentives for acceptance	Cover-up of limitations

7.8 Provide Support

Resistance, overcoming difficulties, objections, maintaining change

During the implementation stage all thought of relaxed creativity can be set aside and pragmatism and problem solving skills come to the fore. Implementation is not the end of the process, but it is probably over halfway and certainly a key stage. Implementation is not the time to pack up the tools and set off for the next challenge. The new ways of working are still a fragile flower that needs nurturing and care if it is not to wither. People need help to assume new roles and relationships, they need support and encouragement. Support can mean offering a helping hand to those finding it difficult or struggling with die-hard elements bent on sabotaging the plans.

Even after the most exhaustive consultation there may still be some who resist the changes. Resistance should not be confused with outright opposition, it is much more mild. Resistance amounts to qualified acceptance and serves a useful function in making sure that the new system of operation achieves the highest possible standard within the resource constraints. Resistance is the enemy of complacency and smugness.

Sometimes when people are genuinely trying to implement change, they come across insurmountable difficulties, items in the plan which do not work and cannot fit in. Such difficulties must be addressed speedily and steps must be taken to sort them out lest they should become a focus for opposition and attempts to reverse the course of change. It is almost impossible to predict every situation in advance and probably

unproductive to try to do so, but problems that arise need urgent treatment.

Once the new system is in place, there may be those who have genuine objections to it when they realise what is actually involved for them. Objections are not the same as difficulties and may contain a higher emotional content. In handling objections it is necessary to use judgement. The change leader needs to hear the objections and try to be conciliatory. At the same time it will be necessary to decide whether the views represent widely held opinions or whether they are those of professional objectors making a last attempt to halt progress.

New methods of working are still vulnerable to regression unless the change leaders show interest and offer rewards and encouragement to those operating in the new ways. It is not a good idea to forget about the system once implemented, because habits will drift back to the old, secure ways. New methods, new procedures, new relationships take time to be learned and absorbed and they take time to become the new status quo. Change leaders need tact and patience to help everyone to accept and operate the new system.

One doctor we interviewed was involved in a major campaign to change the behaviour of GPs and the general public in relation to the treatment of a particular disease. This doctor found it necessary to take a new approach about every two years in order to prevent the initial enthusiasm from waning and the old ways of working from returning.

Many initiatives that have been introduced as a result of pressure or coercion tend to wither and die out at this stage. It is difficult to maintain pressure and without support and goodwill from the majority of those involved, the new system cannot last.

7.9 Modify Plans

Compensation, modifications

Sometimes it will be necessary to redesign a system in the light of practical experience, in order to overcome difficulties or remove objections. If these modifications are reasonably minor, it should be possible to achieve them by a process of discussion with those concerned followed by direct implementation. If the changes are more major and would alter the spirit of the original system, then more extensive negotiation, consultation and publicity will be needed, as will a proper set of plans. Extensive modifications take on the character of separate changes and should be treated as such. But, do not despair, it is usually a much quicker process to modify a change in order to make it work properly than it is to start from scratch and have to convince people of the basic need and to negotiate the best course of action.

Here are some comments from our interviewees:

- It soon became clear that having a set day would not work because some consultants were severely disadvantaged, so we changed to a rotating day.
- It soon became clear that our criteria would have to be modified, so we modified them.

It may be that plans are being held up by the attitudes and actions of one or a small number of people. These people will have withstood all the individual and collective efforts at moral persuasion and will not suffer embarrassment from their isolated positions. If these people are significant and

influential, it may be prudent to consider some form of extra compensation, in a form available to the change leader, in order for the change to proceed and the majority to enjoy the benefits. Such compensation could be seen in a similar way to compulsory purchase orders for houses in the way of road improvements or other infrastructure developments of benefit to the wider community. The big danger in contemplating compensation payments, in whatever form, is that their existence is an encouragement for people to adopt extreme viewpoints and obstructive attitudes in order to be bought out and so extract extra benefits. Compensation is best attempted as a private negotiation and is actually best discouraged altogether because the informal networks have a habit of making private deals public knowledge.

We give below some experiences of compensation from our interview sample:

- We did a deal in the end to remove a key opponent.
- Some people are opportunistic, they fly in the slip stream and see an advantage in being difficult so that they have to be bought out.
- Compensation is only really an issue in major changes and its impact can be minimised by careful design.

7.10 Evaluate Outcomes

Evaluation strategy

Throughout this monograph, we have been concerned with change designed to meet a perceived need or to exploit a given opportunity for improvement. Once the changes have had a chance to settle in, it is prudent to evaluate their effectiveness in meeting the stated purpose. This is a relatively limited, but essential, form of evaluation. It is, of course, possible to evaluate the process of change, to help with future changes and the performances of the change team members, to know what to trust them with in the future and how to improve on their performance.

It is important in evaluating the degree to which the actual changes met the perceived needs to take into account the viewpoints and feelings of the recipients of the change as well as those who led the process. Evaluation methods are a matter for local skills, resources and expertise. For major changes, it may be feasible to enlist outside professional help. For smaller changes, self-help is probably sufficient and a relatively informal evaluation should suffice.

The nature of the change process is such that it is difficult to unleash it with sufficient energy to overcome the inertia of the status quo and at the same time exert sufficient control over the events to be able to predict the outcomes with certainty. In the heat of battle, twists and turns are forced on the change leaders by events and the change process takes on a life of its own. It is thus not unknown for the final outcome of the change episode to be quite other than that which was first envisaged or even desired. Wide ownership of the process and extensive involvement also act to blur the clarity of the outcome from the viewpoint of the change leader. It may be,

however, that the changes remain acceptable to the majority and do meet the original needs, albeit not in the planned way.

It will be clear that an evaluation strategy is useful. Such a strategy might be concerned with devising the criteria for success, or defining a range of success from qualified to better than expected, say. Evaluation will be helped by having the aims and objectives of the change clear at the outset.

Despite the underlying scientific ethos of medicine, we encountered very few people who had evaluation high on their personal agendas. This was surprising because it would be unthinkable not to analyse the results of a clinical trial or controlled experiment.

We present below a few comments on evaluation from our interview sample:

- Unless there is some element of assessment, I don't quite see how you know how you are doing anything useful.
- People will often wait for someone else to lead but they won't wait for them to succeed or fail.
- Nobody has objected to it and several have thanked me for reminding them.

Evaluation is an important part of any change programme and needs proper consideration at an early stage.

8 FINAL THOUGHTS

Armed with a reasonable understanding of this model of change in a medical context, there should be less fear of the process. We have made every effort to present information in a clear and user friendly way with the intention of encouraging people to be more bold in attempting change. We have tried, in section 7, to give advice on what one actually has to do to bring about successful change. We have not told you what to change, nor what to put in its place, but we have presented a number of options for the process of change management. A much fuller account with a more detailed description of the tactical choices and styles can be found in Gale and Grant (1990a).

It is worth repeating that our model of change is a sufficient basis for managing change in a medical context, but it is not a blueprint. The person contemplating change will still need to exercise considerable judgement concerning the strengths with which local factors apply and the optimal style and tactical choices to be made. Having said that, we would still advise anyone setting out on a programme of change to make sure that the need for change was widely perceived and accepted. This is a process that should not be truncated.

Our model of change provides a road map for the user to help get from the known starting point to the desired finishing point. There are several roads in between the two points, there are many branches and turnings to be made. As in any journey, there will be unforeseen events along the way; some roads may become blocked and force you to turn back and seek a new route, new by-passes may have opened since you planned the journey and there may be accidents forcing you to stop and repair the damage.

If you prefer to view the model as a list of action steps or checklist, then you will need to work through it and decide which parts of it you will need to emphasise and which parts you can safely ignore. This choice will depend on the type of change you are contemplating, on its complexity and the number of people affected by it. It is difficult to offer any more profound advice since the local people and local circumstances will play a major part in influencing the optimal process. We would, however, stress that time spent in consulting others and talking to them about the need for change and the changes themselves is an investment that should be maximised.

We would very much like to be able to provide a clear set of instructions for managing any change. Unfortunately, it cannot be done, because the best way forward depends on local conditions. It depends on the change leader's skill, enthusiasm and available energy. It depends on the local history and experience of change. It depends on the complexity of what is intended and on many other factors. The best starting point is probably to find a friend or colleague upon whom to try out your ideas, then find another and so on. The discussion process should help you to find answers to most questions and give you courage to proceed or stop.

Having sounded a note of enthusiasm and tried to encourage more people to become involved in the management of change, we must sound a small note of caution. Change is a complex process, particularly where large numbers of people and processes are involved, and it is easy to underestimate the difficulties. When contemplating major changes that touch many people and processes, it may be prudent to seek professional advice to help steer a fruitful path through the complexities.

9 FURTHER READING

We give below an extremely selective list of the readings we find helpful. There are many books and articles on the management of change, written from a range of standpoints, and they all contain some useful ideas.

Dalziel, M.M., Schoonover, S.C. (1988) **Changing Ways**. Amacom New York.

Gale, R and Grant, J.R. (1990a) **GUIDELINES FOR CHANGE IN POSTGRADUATE AND CONTINUING MEDICAL EDUCATION**. The Joint Centre, BPMF. (price £9.00 +p&p)

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Mennin, S.P. and Kaufman, A. (1989) The change process and medical education, **Medical Teacher**, 11,1 9-16

Plant, R. (1987) **Managing Change And Making It Stick**. Fontana/Collins, London/ Glasgow.

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