

Engaging the Head and Heart: Leading Change

Q & A with Jack Silversin

[IN = Interviewer JK = Jack Silversin]

IN: In the wake of today's global economic downturn, more and more companies are making organizational changes, from restructuring to right-sizing, to stay competitive. For more than two decades, the healthcare industry in Canada has been transforming its system and streamlining its operations through care integration and centralized governance. Change management has become the *de rigueur* catch phrase used by executives to describe everything from new taskforces and strategies to new tools and processes. Yet studies show few organizations are succeeding at it. As a healthcare consultant who coaches leaders through change, what do you think that most of these firms fail to do?

JK: You're right that most change efforts don't succeed or, when implemented, are short-lived. The organizations I work with are beginning to understand that the key to successful change is *engaging people at all levels* of the organization. The days of top-down, command and control change management are gone. Imposing change on people leads to resistance, lack of commitment, even sabotage. You lead change; people manage themselves.

Restructuring fails in 60% to 75% of cases, not because of poor strategy, but because executives didn't understand the importance of people. It's people who change organizations. Getting the buy-in of those who need to implement change, whether we're talking about physicians, clinicians or managers, is the critical success factor. People get on board with change when their heads and hearts are engaged.

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IN: So what you're saying is that change happens through people, not to people, and that leaders need to engage everyone in the organization. You have worked with health regions, providers, hospitals and physician groups in Canada, the United States and the United Kingdom. How do the best change leaders engage people?

JK: Leaders need to develop a shared picture of the future and help others to buy into the vision and the reason for change. A good vision taps into shared aspirations, creates a pull toward the future and clarifies what makes the risk, pain and loss worth the change. That's a key step that too often gets rushed over. There has to be some context, some sense that as an organization, or as a network of providers, we are going someplace together. That destination has to be meaningful – it has to have some emotional resonance to it.

I should also add that leaders need time to get their heads and hearts engaged, too. You can't expect staff to cross the bridge if you haven't crossed it first yourself. When organizational changes are deep and broad, leaders must have the opportunity to reflect and move away from old structures and time frames.

The other best practice that I see among good change leaders is the appreciation for, and application of, two types of change. We'll refer to one type as technical – not because it necessarily involves technology – but because it is relatively straightforward. It is a simple change in execution and does not cause a person any internal tension or frustration. If a surgeon, for example, learns a new and improved technique, there will likely be a learning curve, but not a significant emotional component associated with the change from current practice.

In contrast, many changes in healthcare are of the second type – adaptive. Changes that cause stress, disequilibrium or tension between competing values are called adaptive because they challenge deeply held assumptions or values and require a deeper transformation of beliefs or relationships. For example, asking physicians to practice according to protocols challenges many physicians' beliefs that their own experience and judgment is best.

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The distinction between the two types of change – technical and adaptive – was coined by a physician who teaches leadership at Harvard's John F. Kennedy School of Government. Dr. Ronald Heifetz says that a common cause of failed change is that leaders promote technical solutions to what are largely adaptive problems.

Disruptions in the traditional referral patterns physicians have established among themselves is another adaptive change. If a health ministry sets up new networks that cause old referral patterns to be set aside and new ones to emerge, it needs to understand that there are adaptive changes people will need to move through. If it doesn't, the change process might cause alienation and frustration that threaten the outcomes of more efficient, better care.

IN: Can you give an example of an adaptive change for front-line staff?

JK: Any change or process of decentralization that breaks up old teams and creates new teams would be an adaptive change. People change what they identify with when their team changes. They need to embrace the new team and discover the value that others bring to the team.

IN: Do some leaders have difficulty engaging others or want to skip over the shared vision step?

JK: Yes, quite a few leaders feel that setting the agenda for change, making tough calls and motivating change is what is expected of them...and in part it is. But increasingly, people need to be engaged, and it can be hard for leaders or executives to switch gears from the traditional leader role to be more inclusive. Time constraints are often the rationale for top-down decisions, but underneath there is a fear of, or ambiguity about, engaging people. They need to be allowed to say, "I don't have all the answers," and to collectively work with people to determine what needs to be done.

For many executives and leaders, the whole idea of a vision or shared destination feels fuzzy and too amorphous to be helpful. But this misses the human need to connect to something larger. Recently, Barack Obama took the oath of office and gave what I thought was an inspirational address. He concluded by drawing attention to an episode in American history when the outcome of the revolution was far from certain. He compared those hard times to our own today, and urged Americans to keep our eyes "fixed on the horizon." He wants us to hold on to a vision that is cherished. His power in these early days of his administration derives from his ability to both engender hope and make the vision of a better future real. There's an essential leadership lesson in that.

IN: What about leaders who resist pulling in the ideas of others for fear of losing control of the change process? What can you suggest?

JK: That's very common and for good reason. There is some loss of control in asking for ideas. But if we appreciate that head and heart engagement is central to successful change, and that ownership is developed by trying on ideas and "kicking the tires," then finding ways to get input before a change is finalized makes sense.

IN: What ways would you recommend?

JK: Wherever I am invited to talk, I find people connect strongly with the idea of *fair process*. This notion comes out of the literature on procedural justice. As human beings, we care about decisions and how they affect us. In fact, most people will interpret the need for change as a criticism of what they are

Successful Change Leadership Practices

- Address both the technical and adaptive aspects of the change.
- Help others feel the urgency for change.
- Build or regain trust across professional boundaries.
- Work to build a shared picture of the future.
- Engage stakeholders in a transparent decision-making process.
- Clarify reciprocal expectations – make explicit what others can expect of you and what you will expect of them.

currently doing.

But when we have taken part in a transparent, merit-based process, we more readily accept a decision not in our best interest. When a process is fair, we can more easily accept the outcome and move on.

For a leader, this does not mean letting go of the reins entirely. It means that you communicate right at the start of the input process what criteria you will use to evaluate all ideas and suggestions. The criteria are transparent. Once all ideas are offered and the best ones incorporated, you close the loop by explaining to everyone who offered input what was useful and why, and what was not and the reasons it didn't shape the final product or decision. Any steps that a leader can take to ensure a process is fair will help others own the decisions for change.

Change is an evolution, not an event. Employees should believe they are contributing to an evolving solution on how to reach that shared destination. Leaders should be asking the questions that help people discover their contributions to the question "how do we get there?" Remember, there is usually no one answer, or right answer, but the most fit answer within a given context.

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IN: This discussion about fair process implies trust, something we haven't talked about yet. You believe that trust plays a significant role in whether changes are adopted. Can you say more about that?

JK: Trust is a huge topic and one that is getting increased attention these days. If people are suspicious of the motives behind

those promoting a change, suffice it to say that change isn't going to succeed. If there's baggage, such as promises broken or commitments not fulfilled, it's hard to get the needed head and heart engagement.

In healthcare, the world of clinicians is very different from the world of administrators and policy makers, and that difference in world view can lead to mistrust that can slow change. In almost every large-scale change effort that cuts across professional boundaries, there's likely to be some accumulated baggage getting in the way of honest dialogue and forward movement.

I encourage clients who need to build trust to invest in the skills of a facilitator to clear the air. One very useful framework is to ask the two parties to answer the same set of questions: how do we see ourselves (our strengths, weaknesses, contributions), how do we see the other party and how do we think they see us? Getting these perceptions into the open is a healthy start to recalibrating a relationship. From there it takes individuals to acknowledge that some of their behaviour is contributing to less than helpful perceptions and then commit to different actions.

IN: You've said the leader is the one who has to create energy by helping others to see the need for change. Most involvement processes proceed so slowly they are in danger of losing what little momentum they have. Is it necessary for people to feel the urgency before they will change? Does the platform really have to be burning?

JK: Great question and one I've thought a lot about. It seems to me that, for a few people, when the pull toward a desired future is great, they readily and quickly move on to embrace new ideas. For most of us, there has to be some discomfort or unease with the present situation before we're willing to change. When we are content with what is – or at least have found a way to make existing routines or practices work – we need some energy to move us to try something new. I don't think the platform can always be burning. People need recovery time, too. But there should be tension between where we are and where we are going. It's an internal urgency, and that urgency is key for almost all changes. John Kotter's newest book – *A Sense of Urgency* – is devoted to this topic (Kotter 2008).

IN: Are there key lessons on urgency from Kotter's book that you can share with us?

JK: His view is that most of us who desire change are still too complacent. He also says that there is a lot of false urgency, based in fear and anxiety, which is the result of some failure or external pressure being put on a group. People have a true sense of urgency when they feel that action is needed now to reach a shared destination. The leadership challenge is to keep that urgency high, but not overwhelm people with panic or anxiety.

Don't initiate a feeling of crisis if it isn't a crisis, or you will turn people off and they will distrust you. Leaders must sustain the sense that action is needed over a long period by tapping into that internal sense of urgency. In Kotter's view, all change has to start with a sense of urgency and if it fails at that step, he deems most changes to be short-lived or not even implemented.

IN: The majority of staff in healthcare work on the front lines, and their priority has always been the care of patients. What role, if any, would patients play in healthcare reform?

JK: You need to engage the public in an extended conversation. You need to bring them to the table, and talk to them about choices that need to be made. They need to understand what you understand and be given the opportunity to share their perspectives. Through discussion, let them discover what you have learned and come to a shared place of understanding of where you are.

IN: Many people have heard you talk about compacts – what are they and why do you feel they are important to successful change processes?

JK: *Compact* is shorthand for a set of reciprocal expectations. For decades, the implied compact in most businesses was job security in exchange for good work and loyalty. Some have called it a psychological contract. In every health organization, doctors and staff have an explicit understanding of what they need to do as members of that organization and what they are entitled to expect in return.

I have been saying that the old compact for physicians was built on expectations they would have autonomy, some measure of protection from market forces and special privileges due to their status. These were not unreasonable expectations and were reinforced by society at large as well as hospitals and other organizations. Since a compact is a two-way deal, there are expectations of physicians. But I'd say that until recently, all that was expected of physicians was to be compassionate, ethical and provide good care – but that expectation was very personally defined. Now we've moved into an era of benchmarking, performance measurement and best practice protocols.

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IN: So you're saying that many changes are being directed at physicians – and others in the health profession – without renegotiating the compact or implied deal?

JK: Yes, and this clash of legacy expectations and evolving societal needs causes tension and frustration. I think this mismatch between the old compact and society's new needs is at the root of what many call resistance to change. I prefer not to say health providers are resistant to change – any more than we all are – but I see attempts to hang on to the status quo as indicative of a gap between old expectations and new imperatives.

In my work in Canada and elsewhere, I have championed a dialogue process to align expectations between physicians and organizations. Typically this is between a hospital and the medical staff where the hospital needs engaged physicians to partner with them to improve safety and care. This often means physicians accepting protocols or standard work and new relationships with other health professionals. That would be a new "give" for physicians. In return for limits on autonomy, most physicians are interested in having a seat at the table when decisions are made. When a new, explicit compact gets crafted it is clear that everyone changes. Administrators need to bring healthcare providers into decision-making in ways they might not have in the past.

IN: In Alberta we recently established a single provincial health authority to oversee the delivery of health services. It's a large scale, complex transformation – from 12 entities to one – with very different patient/client, professional and stakeholder groups, and staff numbering more than 80,000. You emphasized the role of shared vision in your advice to leaders. What does that mean in practical terms to us as we move through this transition?

JK: Change of the magnitude you have described is never easy. In part because – going back to my earlier remarks – this is an adaptive change. So those leading it need to appreciate what it is they're asking doctors, managers and staff to do. Those leading the change need to communicate widely the vision of what they are trying to achieve in a way that is compelling. I would suggest wide-ranging dialogues with various stakeholders to share the vision and see what part of it will be the greatest challenge for those on the front line and what most excites them about being part of this.

IN: You said there is another aspect to this need to address emotions that is most often overlooked by change leaders. What is that?

JK: Too little attention has been paid to the role of self-discovery as a part of the change process. Leaders tend to get excited by a good idea or innovation that worked in one location or depart-

ment and decide to “roll it out” to the rest of the organization. That strategy leaves more people than not feeling “rolled over.”

Real engagement is the result of individuals coming to some conclusion on their own – either by seeing data that is compelling and drawing their own conclusion that “we could do better,” or collecting data about their own practice, or having any kind of penny-dropping experience that leads them to say “Aha, now I get it.”

The leader’s role is to create the conditions for others to discover the need for change. As we said earlier, self-discovery comes from asking others the right questions and allowing them to contribute to finding the answers. This is empowering.

We tend to rely on logic, rationale, evidence and expectations to drive change. Real life is rarely like that. The evidence, data or rational arguments need to strike an emotional cord. When an internal lever gets flipped and individuals shift from “Why do I need to do this?” to “Now I get it,” you’ve sown the seed for successful change. Change is an open system, a dynamic thing; it involves asking questions and getting feedback.

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IN: What is the one critical piece of advice that you would leave with us?

JK: Actually I have two pieces of advice. The first has to do with the consistency of message for change to succeed. As someone recently put it, “The mouth, feet and wallet all need to be going in the same direction.” This alignment sends clear signals about what the priorities really are. Too often change processes are slowed because those on the front line get mixed messages about what is most important; they hear lofty language about aims and transformation, yet budgets don’t reflect what is being said, or the lack of attention from top leaders undercuts any communication about urgency.

Second, leading change takes courage, for all the reasons we’ve been discussing. People generally find ways to opt out of change processes that they think are burdensome, inefficient and not necessary. Leaders must have the courage to set the course, create opportunities for engagement, develop and sustain urgency, and keep going in the face of opposition.

And third, if I can add one final comment, employees need to take personal responsibility, too. All need to ask themselves how they can influence change and help reach that shared destination. **HQ**

Reference

Kotter, J.P. 2008. *A Sense of Urgency*. Boston, MA: Harvard Business School Press.

About the Author

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