The art and science of clinicians leading change

Clinicians, the experts in care delivery, are well placed to drive health system improvements

You go to the ward; something feels wrong — the care is not as person-centred as you wish, not conducive to patient safety, or not consistent with wellness guidelines for your colleagues. You discover that the problem is commonplace. You are losing your sleep over it. This means you care enough to notice that there is a problem and you want something done about it. Then you talk to someone responsible. They criticise you for overreacting or doing something outside of your job description; you feel demoralised.

Having worked in the health system for a few decades and effected a variety of teleoncology reforms,[1,2] we would have benefited from leadership advice early in our careers. This would have made us more effective at leading change and potentially prevented us suffering moral injury from time to time. In this article, we share our learnings and experiences of pathways to leading change.

Traditional change management approaches assume all systems are hierarchical, and staff will follow line manager directions. Contemporary approaches understand that health systems are different from businesses.[3] Experts and passionate clinicians at the frontline often report to managers who are not clinical experts. By its nature, this structure creates a malalignment of informal and formal power structures and threatens a split between clinical and operational governance. While the structure can work to solve problems and improve systems when managers adopt a collaborative or partnership approach with clinicians, the structure fails when managers adopt a command and control approach. Genuine clinical concerns and risks can be ignored or dismissed by managers, and ultimately patients are put at risk. At the heart of hospital failures that make the press is often a failure of a collaborative management–clinician relationship. More commonly, if decisions are imposed on clinicians without their involvement, they may react unconstructively, which can escalate problems, and if persistently ignored, clinicians disengage.[4]

Clinicians are trained and expected to advocate for patients, colleagues and the broader health system by finding solutions and pushing for system change. So how do clinicians effect positive change or quality improvements when the governance system fails, and no forums are available to raise concerns and develop solutions? We believe a careful plan utilising the skill sets discussed below may empower them, and make them successful at leading change.

These skill sets can be categorised into knowledge of implementation science,[5,6] negotiation skills, articulating purpose,[7] clinician levers[8] and self-care. Implementation science is the scientific study of methods and strategies that facilitate the uptake of evidence-based practice and research into regular use by practitioners and policymakers.[5] Implementation science frameworks help us pick the worthy issue, garner the support of the stakeholders, identify effective solutions, develop an implementation plan, and monitor its success. Negotiation skills are important to reach successful compromises and win–win situations where a shared vision is achieved. Our observation is that in a health hierarchy, imbalance of power between line manager or colleagues and the clinicians is common, and clinicians may need several levers to keep partners engaged, reach agreements and effect change.

Identifying and articulating a worthy cause

The first step is to observe that something is not right and to clearly understand the magnitude of the problem. It is useful to ask these questions: Is this problem an important one for wellbeing of staff and patients? Is it a common and recurrent problem that is supported by data and agreement among colleagues? Is it so important that something needs to be done (pick your battles)? Is this problem area highlighted in peak body guidelines, and/or the strategic priorities of your organisation?

If the answer is yes, fine tuning and articulating "why this needs fixing" is a key activity so that you can convince stakeholders and take everyone positively on the journey to change.[7] Another key activity at this stage is involving (talking to) as many people as possible, including the managers and colleagues who are needed for change; this will enable co-design of solutions and smoother implementation of change.

Selection of stakeholders and building a coalition

Stakeholder engagement and involvement from the outset is crucial for success. The nature of projects will determine the type and number of stakeholders required for success. Many frameworks exist for selection of stakeholders. For example, the World Bank recommends the following questions:[9]

- Who is affected (positively or negatively), and who represents those most likely to be affected?
- Who is voiceless and in need of representation?
- Who is responsible?
- Who is most likely to mobilise for or against?
- Who can make it more effective by participating, or less effective by not participating?
- Who can contribute financial or technical resources?
- Whose behaviour must change in order for the project to succeed?

Developing feasible solutions and implementation plans in partnership

Solutions can often be found in the literature, or from best practice implemented elsewhere in other

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doi: 10.5694/mja2.51404

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health services and systems. If not, creative and new solutions are needed. It is important to ensure that the proposed innovation is sensible, feasible and implementable. The Promoting Action on Research Implementation in Health Services checklist guides us to ask the right questions.[5] These questions include:

- Is the innovation supported by research and published guidelines?
- Are there clinical experiences and perceptions?
- Are there patient experiences, needs and preferences?
- Is there local practice information?
- Is the innovation implementable?

Consideration is given to relative advantage, observability, compatibility, trialability, design quality, and packaging and costs.

A co-design approach where key stakeholders conceptualise the ideas, arrive at feasible and implementable solutions, and develop implementation or project plans with timelines and accountabilities by considering multiple perspectives can be rewarding, powerful and makes the process of change less rocky.

Negotiation skills and clinician levers

Every encounter with stakeholders is best framed as a negotiation. Getting agreement that there is a problem, agreement to collaborate, and agreement to identify solutions all require negotiations. Fortunately, in health care, many stakeholders share common views regarding safety and quality and are prepared to improve systems. However, this is not always smooth, with unexpected and apparently inexplicable roadblocks being constructed. Since most people are passionate about their roles, it is critical to listen carefully and understand their perspective as to why change is not necessary or difficult before escalating things further. Following these comprehensive conversations, if there is a consensus view that senior management or clinical colleagues are erecting roadblocks that are not in the best interest of patients, colleagues or organisations, clinician levers can be useful to overcome these obstacles.[8]

Clinician levers are strategies to use when others are not following agreed plans or are refusing to accept solutions that are well designed and supported by colleagues.[8] The more complex a problem and its solution, the more diversity and number of clinician levers may be required (Box). It is useful for clinician levers to be identified and potentially brought into play from the outset, appealing to the intrinsic idealism of other clinicians and managers. These levers can be packaged under the following categories:

- Patient advocacy, including connections with local and external advocacy groups.
- Workforce advocacy, including connections with local and external peak clinical bodies.

Relationship between complexity of problems and hierarchy of levers

	Types of clinician levers and examples			
Problem	**Patient advocacy**	**Workforce advocacy**	**Standards compliance**	**Escalation**
Colleagues within a department or ward unit may not be compliant with hand hygiene principles	▪ Frame discussions around the impact of poor hand hygiene on risk of infection and patient mortality	▪ Emphasise the impact of poor compliance on risk of infection among colleagues	▪ Emphasise the relevant safety and quality standards on hand hygiene ▪ Display the compliance rates of other units	▪ Involve the team leader or the clinical lead relevant to the craft group of the colleagues
A service division within a health service does not consider fatigue provisions for rosters	▪ Highlight relationship between fatigue among clinicians and poor patient outcomes	▪ Emphasise the impact of fatigue on clinician wellbeing ▪ Highlight the negative impact of stress leave on other clinicians ▪ Engage local staff societies	▪ Refer to enterprise agreements and workplace health and safety legislations calling for fatigue provisions	▪ Escalate to line managers for the relevant service division or CEO ▪ Involve peak clinician bodies and unions
Patients are not receiving care closer to home and new models of care are required across a health service	▪ Explain the negative consequences of long distance travel and relocation to receive care on quality of life, financial status, family and businesses ▪ Engage patient advocacy groups within the health service and the region	▪ Demonstrate the professional benefits of telehealth models for rural health practitioners ▪ Engage state-wide clinical networks and staff societies	▪ Refer to government and health service strategic plans aspiring to provide care closer to home ▪ Emphasise the need for person-centred care models outlined by the relevant safety and quality standards	▪ Involve the health service CEO or the board ▪ Involve politicians representing the area

- Standards compliance, emphasising accreditation standards, guidelines and enterprise agreements.
- Escalation through, and involvement of, formal line management, regulatory bodies, politicians and political bodies, and media.

A problem with escalation is that it may affect relationships and career progression. This requires careful consideration of the impact on patients and colleagues, compared with the importance of the individual's relationship with stakeholders. There is protection in numbers, so using a collective approach to escalation is recommended. It is also important to check with organisational media rules before seeking the help of the media.

Self-care while leading change

Improving health care requires good clinician leadership. Being involved in implementing a useful change can be immensely satisfying. However, the work required is time-consuming and can be frustrating, confronting and stressful. Significant change may take years due to sociopolitical complexities such as leadership turnover, government changes, and emerging complexities such as weather events and pandemics. It is important that clinicians recognise their susceptibility to psychological harm and burnout and put in place personal protective strategies. Understanding the sociopolitical and emerging complexities, and the perspective of and pressures on non-clinician managers, can also bring a level of humanity (respect and kindness) to interactions that is psychologically protective for both parties, and is helpful in moving things forward.

This article has provided an overview of the components of pathways to leading change. Like other skill sets, confidence and expertise in leading change could be further developed through practice and application on a day-to-day basis.

Competing interests: No relevant disclosures.

Provenance: Not commissioned; externally peer reviewed. ■

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