Igniting Innovation

By David A. Shore, Ph.D., Harvard University and University of Monterrey (Mexico), Business School

When it comes to change, people reflexively fear the new. However, the rationales for this fear vary in healthcare delivery organizations.[1] More often than not a leading argument is some manifestation of the NIH ("not invented here") syndrome, which is a recurring affliction and a cause of fatigue in igniting innovation. Another familiar refrain when a change initiative is proposed is to take a "not now" approach. Rather than decide whether or not to invest, leaders and governing boards take on a "wait and see" attitude. I know of no better ways to extinguish ideas for future innovations than these two responses. In today's ever-changing environment, healthcare leaders need to be open to new ideas and create a culture where innovation is cultivated.

The Semmelweis Reflex

An exploration into the challenge of change in healthcare and the consequences of not changing would not be complete without exploring the Semmelweis Reflex case. The Semmelweis Reflex (or Semmelweis Effect) is a metaphor for the reflex-like tendency to reject new evidence or knowledge because it contradicts established norms, beliefs, or paradigms. This was named after Ignaz Semmelweis, a 19th century Hungarian obstetrician whose perfectly reasonable hand-washing recommendations were ridiculed and rejected by his contemporaries. As you read the following story, I invite you to reflect on this question: If physicians found it so difficult to grasp as intuitive and straightforward a prophylactic practice as hand washing, how challenging is it for healthcare professionals today to embrace innovations where the evidence is far less clear, the ROI is far less certain, and the potential adverse consequences far more personal?

Dr. Semmelweis worked at the generally well-respected Vienna General Hospital. However, the mortality rate among women on his ward was one in 10. Its reputation was so bad that many women preferred to give birth on the street and *then* go to the hospital. It is estimated that 2,000 women died each year in Vienna alone from Puerperal fever. Patients at Vienna General Hospital pleaded to be transferred off of Dr. Semmelweis's ward and onto a second section of the maternity ward where the mortality rate was (only) one in 50.

Dr. Semmelweis became consumed by the disparity on the two wards and attempted to control all factors (i.e., birthing positions, ventilation, diet, venue for laundry). He noticed there was one glaring distinction between the two sections. His section was attended by physicians, while the other section was attended by midwives. As a teaching and research hospital, physicians split their day between research on cadavers in the morning and treatment of patients in the afternoon. Midwives were neither required nor allowed to perform autopsies. Dr. Semmelweis concluded that "particles" from cadavers and other diseased patients were being transmitted to healthy patients by the hands of physicians. He experimented with various cleansing agents and eventually instituted a policy requiring all physicians to wash their hands thoroughly in a chlorine and lime solution before examining any patient. The death rate precipitously fell to one in 100.

In 1848, the mortality rate in Dr. Semmelweis's division went from 18.27 percent to 1.27 percent. Yet, the doctor was *not* rewarded for his discovery and changes in protocol. In fact, the following year, he was dropped from his post at the clinic and turned down for a teaching position. In 1861, he published a book; however, his doctrine continued to be roundly rejected by the medical community. A few years later, he suffered a nervous breakdown and was admitted to a mental hospital, where he was routinely beaten by asylum personnel and died at the age of 47. It was 14 years later that his discovery was accepted after Louis Pasteur revealed the presence of Streptococcus in the blood of women with child fever.[2]

Key Board Takeaways

Higher-performing hospitals and health systems all have one thing in common: the ability to ignite innovation. Too often leaders fear what is new and different and end up dismissing or pushing off innovative ideas. Healthcare delivery organizations need people in leadership positions to be agents of change, capable of igniting innovation and realizing benefits from these efforts. Boards should evaluate their own organization's tolerance and capability for change:

- Do we have the capacity and infrastructure to ignite innovation?
- Are leaders effectively managing organizational change?
- Is innovation encouraged at all levels of the organization?
- What can we do to stimulate and sustain a culture of change?

Being Right Isn't Good Enough

The Semmelweis case reminds us of Voltaire's warning, "It is dangerous to be right in matters on which the established authorities are wrong." It further reminds us that the human mind often treats a new idea the same way the body treats a strange protein, it rejects it and often tries to destroy it.

Had Dr. Semmelweis received training in "soft" or non-cognitive skills his efforts to introduce change might have met with a more positive response. Indeed, with regard to the selection of healthcare leaders (both clinical and non-clinical) there is currently a tradition of measuring these non-cognitive factors in an effort to predict

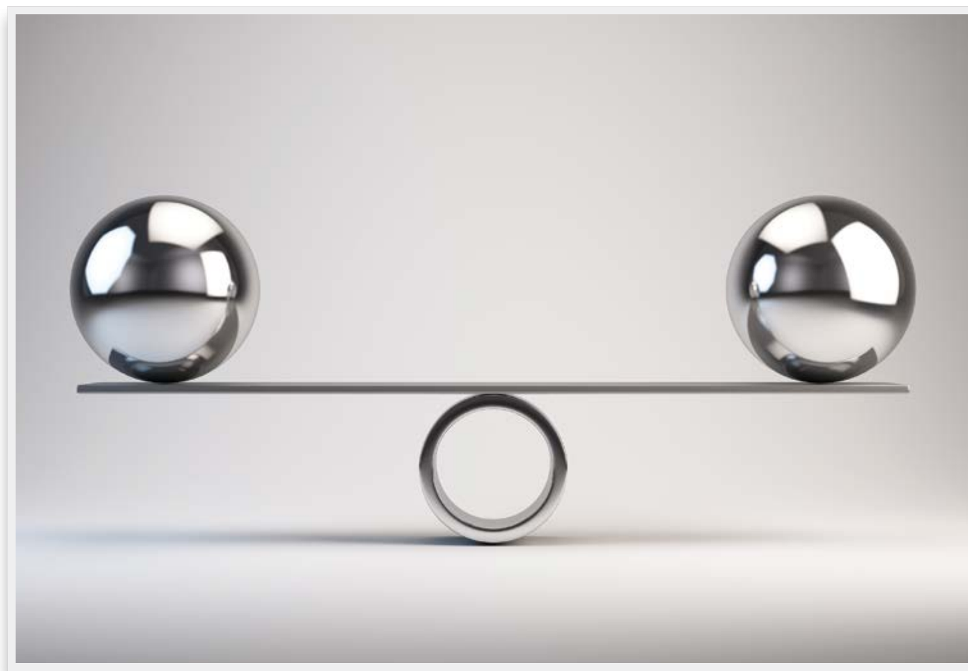
1 David A. Shore, *Launching and Leading Change Initiatives in Health Care Organizations: Managing Successful Projects*, San Francisco: Jossey-Bass, 2014; David A. Shore and Eric D. Kupferberg, "Preparing People and Organizations for the Challenge of Change," *Journal of Health Communication*, Vol. 19, No. 3, 2014, pp. 275–281.

2 The Semmelweis story is drawn from multiple sources including: The Arbinger Institute, *Leadership and Self-Deception: Getting Out of the Box*, San Francisco: Berrett-Koehler, 2002; Ignaz Semmelweis (translated by K. Codell Carter), *The Etiology, Concept, and Prophylaxis of Childbed Fever*, Madison: University of Wisconsin Press, 1983; K. Codell Carter and Barbara R. Carter, *Childbed Fever: A Scientific Biography of Ignaz Semmelweis*, Westport: Greenwood Publishing Group, 1994.

success.[3] Generally, healthcare leaders have responsibilities that can be grouped into three main domains:

1. **Managing up:** relationships with CEO, board, and dean
2. **Managing across:** relationships with other members of the leadership team
3. **Managing down:** relationships with division chiefs and chairs, etc.

Despite the growing importance of personal and social skills, most healthcare organizations have a long way to go in assessing these critical management skills. The task becomes all the more pressing when we add a requisite fourth category: *managing change*.



The Big Five Personality Trait Taxonomy

In contrast to the past, there now exists a reasonable degree of consensus that personal characteristics that impact job performance cluster into five main domains, often referred to as the "big five."[4] The big five personality trait taxonomy includes:

1. Extroversion
2. Agreeableness
3. Conscientiousness
4. Emotional stability
5. Openness to experience

The first four traits might be thought of as the "usual suspects" and therefore perhaps of little surprise to most. It is the fifth trait we so desperately need in our leaders: *openness to experience*. Openness to experience includes the degree of intellectual curiosity, creativity, and a preference for novelty and variety. This trait also refers to the extent to which a leader is "imaginative, independent, adaptable, and *change oriented*."[5] In other words, healthcare delivery organizations need people in leadership positions to be agents of change—serial innovators, capable of igniting innovation and realizing benefits from these efforts.

I am currently working with the leadership team of a service delivery organization in which managing organizational change has been identified as one of a handful of core competencies (i.e., communication, team leadership, business acumen, and functional performance effectiveness). We have established evaluation criteria along three classifications—questionable fit, solid performer, outstanding—each with a narrative that describes and defines the criterion. When we started six months ago, the leadership team gave itself high marks on the other core competencies, but when it came to managing organizational change there was consensus that is was a "questionable fit." Now, halfway through a year-long executive education and consultation period, the group self-assesses themselves as "solid performers" en route to "outstanding." The goal is to create inside entrepreneurs or "intrapreneurs"—acting and behaving like entrepreneurs while working inside the organization. After all, how could you expect anything less of management and boards when 60 percent of CEOs list innovation as their company's primary focus?[6] There is one important caveat, and that is that these internal change agents do so without incurring the risks often associated with entrepreneurs.

In my experience, what distinguishes higher-performing organizations from the rest is the chronic failure of most organizations to ignite innovation. When we ask CEOs, boards, and leadership teams what keeps them up at night, "failure to innovate" is regularly referenced as a challenge that haunts them. Imagine how history may have been different if our protagonist, Dr. Semmelweis, had the training and toolbox to be rated "outstanding" in managing organizational change. It is time to remedy our healthcare culture in which the Semmelweis Reflex is a common affliction. How about adding this as a goal to next year's strategic plan?

The Governance Institute thanks David A. Shore, Ph.D., former Associate Dean of the Harvard University School of Public Health, and current faculty of Harvard University and Adjunct Professor of Organizational Development and Change at the University of Monterrey (Mexico), for contributing this article. Dr. Shore is also on The Governance Institute's faculty. He can be reached at dshore@fas.harvard.edu.

3 F. Lievens and P. Sackett, "The Validity of Interpersonal Skills Assessment via Situational Judgment Tests for Predicting Academic Success and Job Performance," *Journal of Applied Psychology*, Vol. 97, No. 2, 2012, pp. 460–468; Fredrick L. Oswald et al., "Developing a Biodata Measure and Situational Judgment Inventory as Predictors of College Student Performance," *Journal of Applied Psychology*, Vol. 89, No. 2, 2004, pp. 442–452.

4 Murray R. Barrick and Michael K. Mount, "The Big Five Personality Dimensions and Job Performance: A Meta-Analysis," *Personnel Psychology*, Vol. 44, 1991.

5 *Ibid.* (italics added)

6 PricewaterhouseCoopers, Global CEO Pulse Survey, 2013.