14 North of England Study of Standards and Performance in General Practice. *Final report: III—the effects of setting and implementing clinical standards.* Newcastle upon Tyne: Health Care Research Unit, 1990. (Report 42.)
15 Haynes RB, Davis DA, McKibbon A, Tugwell P. A critical appraisal of the efficacy of continuing medical education. *JAMA* 1984;251:61-4.
16 Mugford M, Banfield P, O'Hanlon M. Effects of feedback of information on clinical practice: a review. *BMJ* 1991;303:398-402.
17 Russell IT, Grimshaw JM. The effectiveness of referral guidelines: a review of the methods and findings of published evaluations. Aberdeen: Health Services Research Unit, 1991. (Occasional paper 8.)
18 Speight ANP, Lee DA, Hey EN. Underdiagnosis and undertreatment of asthma in childhood. *BMJ* 1983;286:1253-6.
19 Hughes J, Humphrey C. *Medical audit in general practice: a practical guide to the literature.* London: King's Fund Centre, 1990.
20 Irvine DH, Irvine S, eds. *Making sense of audit.* Oxford: Radcliffe Medical, 1991.
21 Irvine DH. *Managing for quality in general practice.* London: King's Fund Centre, 1990.

(Accepted 2 April 1992)

Managing Change in Primary Care

Strategies for success

Chris Atkinson, Jacky Hayden

This is the third in a series of articles looking at how to manage change in general practice

Health Services Management Unit, University of Manchester, Manchester M13 9PL
Chris Atkinson, *fellow in health service management*

Department of Postgraduate Medical Studies, University of Manchester, Manchester M60 7LP
Jacky Hayden, *regional adviser in general practice*

BMJ 1992;304:1488-90

Change in general practice when handled well can be stimulating and rewarding. Improving the practice to benefit patient care and providing care more economically are good for practice morale, which in turn boosts patient care. If change is handled badly, however, it can create anger and resentment and have a negative effect on patient care.

We all like to think that we are doing a good job and most of us would resist criticism; this is particularly true in general practice, which inevitably has considerable personal involvement and investment. Introducing change in general practice can often be met with considerable resistance.

A problem may become obvious in a practice in various different ways: a crisis may occur, such as a preventable death, which may highlight a deficiency in practice organisation; one or more partners may have experienced a new way of working; or the practice as a whole may decide that external forces, such as the new general practitioner contract and alteration in patient demography, have created a need for change. Alternatively, the practice might undertake systematic audit and identify deficiencies in its systems, holding regular management meetings to identify and implement change.

STEPHEN LILLIE

Vision sharing

Working in a general practice is like working in any other team—if all members of the health care team are involved in determining the character of the practice they are more likely to be committed to those ideals and to implement them.[1] Alternatively, introducing change without consultation may result in members of the team obstructing the proposed change. Consultation must, however, ensure that all members of the practice understand the new process, as shown by the following example.

EXAMPLE 1

A practice decided to introduce dietetic services for the local population. The doctors and practice manager met with the dietitian and planned the introduction of the service; reception staff were consulted and were in agreement. The service was popular with the patients but conflict arose within the practice because one member of the reception staff had failed to understand that the service was for all the local population, not just the patients registered with the practice. She resented local inhabitants other than those registered with the practice using the service, apparently taking care away from the practice population.

STRATEGY MEETINGS

The first stage in managing change is to define the overall aim of the practice. It is important that everyone involved in the practice is able to share in this stage. In a small practice it may be possible for all the practice team to work in a single group, each having an opportunity to express his or her views on their ideal practice. In a large practice this process may need to involve only a limited number of the team—perhaps the doctors, practice nurse, and practice manager—as when a meeting is too large individuals are inhibited from contributing. An important preliminary step, however, is for this group to listen to all the other team members and to share the results of the smaller meeting with everyone concerned.

Such strategic thinking will need time. One way of ensuring that the meeting is uninterrupted is to hold it away from the practice, perhaps for a whole day.

Where is practice now and where does it want to be?

When the broad aims of the practice have been identified the team needs to think through the individual components and set out a series of objectives which are manageable. At this stage it is advisable to identify one or two people who will have responsibility for a specific area. Identifying a date for reporting back will prevent procrastination.

As general practice is such a vast topic it may be

helpful to think in the areas defined by the Royal College of General Practitioners: professional values, availability and accessibility, clinical competence, and communication.[2] This framework should prevent large areas being ignored or forgotten. Each of the four areas will need considerable expansion, and it may be that only one can be managed at a time.

Each problem can be considered in detail. The group should decide what would be the ideal situation, evaluate the current situation, and identify those factors which will motivate change and those which will resist change. The factors promoting change are important to identify but they are likely to be less significant than the factors which resist change. The box gives an example of the considerations concerned in increasing cervical cytology uptake.

Important points for managing change

- The broad aims of the practice need to be defined
- A framework that covers the individual components of general practice should be adapted for setting objectives
- Practice staff are more likely to be committed to changes if they are involved in the decisions
- Consultation must ensure that all staff fully understand new processes
- In managing change the resisting factors should be minimised and the motivating factors promoted
- There are various strategies for dealing with human resistance to change

Implementing change

Managing change consists of minimising the resisting factors and promoting the motivating factors. It is therefore important to identify these as fully as possible before proposing solutions. Once a problem has been identified it is easy to opt for an immediate solution.

EXAMPLE 2

Before the new contract a practice was considering how it would cope with the increased workload concerned in visiting patients over 75. One option put forward was to appoint an additional practice nurse. An audit of the work involved, however, showed that it could easily be managed by the existing practice nurse together with the doctors.

Discussion

Each solution to a problem needs to be evaluated in terms of costs and benefits. These may not be just monetary costs but also time and energy. Sometimes the risks concerned in implementing the change would be too high and the project may need to be temporarily postponed, as shown by the following example.

EXAMPLE 3

A seven doctor practice employed a senior receptionist who was responsible for much of the practice administration. It became clear that the practice was running inefficiently through lack of managerial skills. The senior receptionist was also registered with the practice as a patient. Although the partners felt that they needed a practice manager, they thought that the effect on the senior receptionist would disrupt the practice and decided to postpone the implementation of a manager until the receptionist retired in two years' time.

Discussion

Whenever change is made the new way or working often requires investment of time and energy. If the energy in a practice is being consumed elsewhere, such as coping with imposed change or through personality clashes, the new system may be rejected or not be implemented. It may be prudent to recognise that the change needs to be made but that the present time is wrong.

Dealing with resistance to change

When the task force has decided the most effective way of reaching the defined object not only will it then plan the change programme, it will also need to address the problem of human resistance to change. Change will be threatening for many people in the practice for many reasons, and unless it is dealt with the change process may be delayed, diluted, or even founder.

For any change project resistance may come from a variety of sources and present itself in many forms. Typical forms of human resistance are parochial self interest, misunderstanding and lack of trust, different assessments of the situation and the proposed solution of it, and low tolerance of change.[3] The important thing is to identify the type of resistance which is likely to be met, then to select a strategy for dealing with it. The sort of strategies which could be employed are education and communication, participation and involvement, facilitation and support, negotiation and agreement, manipulation and cooptation, and explicit or implicit coercions.[3] Not all strategies are appropriate for addressing a particular form of resistance, each having their advantages and disadvantages, and some may not be ethically defensible for a particular task force. The box identifies methods for dealing with resistance to change and the situations in which they are commonly used, together with their advantages and disadvantages, the disadvantages often being to do with the pace of change.

Resistance can come from staff, partners, patients, even the family health services authority. The important thing is that it is identified as early as possible, even anticipated. It can then be dealt with as part of the management of the change process, as illustrated by the next example.

Cervical cytology uptake

Where are we now?	What do we need to change?	Where do we want to be?
50% Uptake, poor information about women who have had a hysterectomy	1 Identification of risk group 2 Increased availability of cervical cytology 3 Attitude of doctors to taking smears	80% Or greater uptake in women in whom cervical cytology is indicated

Factors maintaining status quo	Factors facilitating change
Apathy	Financial gain
Patient rights	Good practice
Lack of knowledge	Peer pressure
Inadequate equipment	Patient pressure
Lack of time	

Methods for dealing with resistance to change

Approach	*Commonly used in situations*	*Advantages*	*Drawbacks*
Education and communication	Where there is a lack of information or inaccurate information and analysis	Once persuaded people will often help with the implementation of the change	Can be very time consuming if lots of people are involved
Participation and involvement	Where the initiators do not have all the information they need to design the change, and where others have considerable power to resist	People who participate will be committed to implementing change and any relevant information they have will be integrated into the change plan	Can be very time consuming if participants design an inappropriate change
Facilitation and support	Where people are resisting because of adjustment problems	No other approach works as well with adjustment problems	Can be time consuming and expensive and still fail
Negotiation and agreement	Where someone or some group will clearly lose out in a change, and where that person or group has considerable power	Sometimes it is a relatively easy way to avoid major resistance	Can be too expensive in many cases if it alerts others to negotiate for compliance
Manipulation and cooptation	Where other tactics will not work or are too expensive	It can be a relatively quick and inexpensive solution to resistance problems	Can lead to future problems if people feel manipulated

EXAMPLE 4

A partnership of four doctors was considering upgrading their computer system. Three of the partners had entered the practice within the previous seven years, but the senior partner was considering retiring within five years. The initial proposal was rejected by the senior partner, who could see considerable additional work without much benefit. The younger partners reconsidered the problem and offered to undertake much of the additional work, thus resulting in an acceptable solution.

Follow through

When the proposals have been accepted by every member of the practice the new system can be introduced. The introduction needs to proceed at an acceptable pace—too slow and the task force may become impatient, too fast and the implementers become stressed. In planning a time scale it helps to consider the midpoint of the project and set a target date.

EXAMPLE 5

A five doctor practice wanted to introduce a diabetic clinic; the whole project seemed daunting. A midpoint was determined, a protocol was agreed, equipment was in place, and staff were trained. This was achieved within nine months and the first patients were soon being diverted to the clinic for their care.

Assessment

The task force has a responsibility to assess the impact of the new system, to make sure that it is running smoothly and that minor modifications are made easily. An end point should be identified and although the task force may retain a special interest, it has completed its task.

Conclusion

When introducing change it is important to plan carefully, set achievable targets with clearly defined time limits, communicate throughout the project, listen for rejection, and award praise when success is achieved.

This series has been edited by Dr Mike Pringle.

1 Plant R. *Managing change and making it stick.* London: Fontana/Collins, 1987.
2 Royal College of General Practitioners. *What sort of doctor—assessing quality in general practice.* Devon: RCGP, 1984. (Report from general practice 23.)
3 Kotter JP, Schlesinger LA. Choosing strategies for change. In: Mayon White B, ed. *Planning and managing change.* London: Harper and Row, 1979.

MIRROR OF MEDICINE

In effect Rowland turned the *BMJ* temporarily into "a journal of radiology in miniature." In so doing "he played a crucial part as a medical publicist of the new method at an early stage when its protagonists in London were still seeking clinical credibility." Because the *Journal* was such a widely read and highly respected periodical, it provided the ideal forum for such publicity. Accordingly, Rowland is now recognised as one of the pioneers of early British radiography, while the *Journal* is credited for nurturing the new science. In contrast, the *Lancet* gave it much less space. Such coverage as it provided failed to match the exciting visual impact of its rival's, for it was either unable or unwilling to reproduce high quality glossy photographs.

Notwithstanding the recognition accorded to Rowland's achievements by posterity, his work for the *Journal* earned him scant credit with the mandarins in the BMA. In order to perform his work as commissioner Rowland had purchased the equipment necessary to take *x* ray pictures. The cost of this apparatus was over £98—a not inconsiderable sum when it is recalled that at the same time Hart was trying to have his nephew appointed to the *Journal* staff at a salary of £100 pa. When Rowland submitted his accounts the Journal and Finance Committee resolved "That Mr Sydney Rowland be informed that he has no authority to order apparatus in the name of the British Medical Association, or pledge its credit in any way." Subsequently, Messrs Newton and Co of Fleet Street, who marketed the first focus tube (which enabled sharper pictures than those achieved by Roentgen to be produced), sent the Association a bill for £28 4s in respect of "goods ordered by Mr Sydney Rowland in the name of the Association." As a result, Rowland was summoned to appear before the committee to explain himself. The committee's proceedings have not survived, though we do know that Rowland's expenditure was accepted. That the acceptance was grudging is indicated by the committee's decision, at the same meeting, "that Mr Rowland be requested to furnish the General Secretary with a list of the instruments belonging to the Association in his possession."

From *Mirror of Medicine: A History of the BMJ* by P W J Bartrip. Published jointly by the *BMJ* and Oxford University Press; BMA members' price UK £29, overseas £33, including postage. Obtainable from the Publishing Manager, *BMJ*, PO Box 295, London WC1H 9TE. Non-members UK £35. Obtainable from OUP Distribution Services, Saxon Way West, Corby, Northamptonshire NN18 9ES.