

# What To Do When Needed Change Is Not Happening

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June 21, 2019



No disclosures or conflicts of interest...

# Learning Objectives:

1. Name at least four (4) areas, relevant to the Star Legacy Foundation, that have been resistant to change
2. Be able to discuss the basics of “Change Theory”
3. Recognize the importance of “unlearning,” “new learning,” “multi-directionality,” and “complexity” within the process of change
4. Understand that “good” changes are possible, but that change often requires considerable effort, patience and sacrifice – and the use of multiple tactics

## QUESTIONS:

**Is the current and ongoing rate of preventable stillbirth in the USA essentially just the collateral damage of the way our civilization wishes to provide OB care?**

**If we wish to really change the way that OB care is provided in the USA - so that the rate of preventable stillbirth is significantly decreased - then what methods do we need to use to effect that change?**

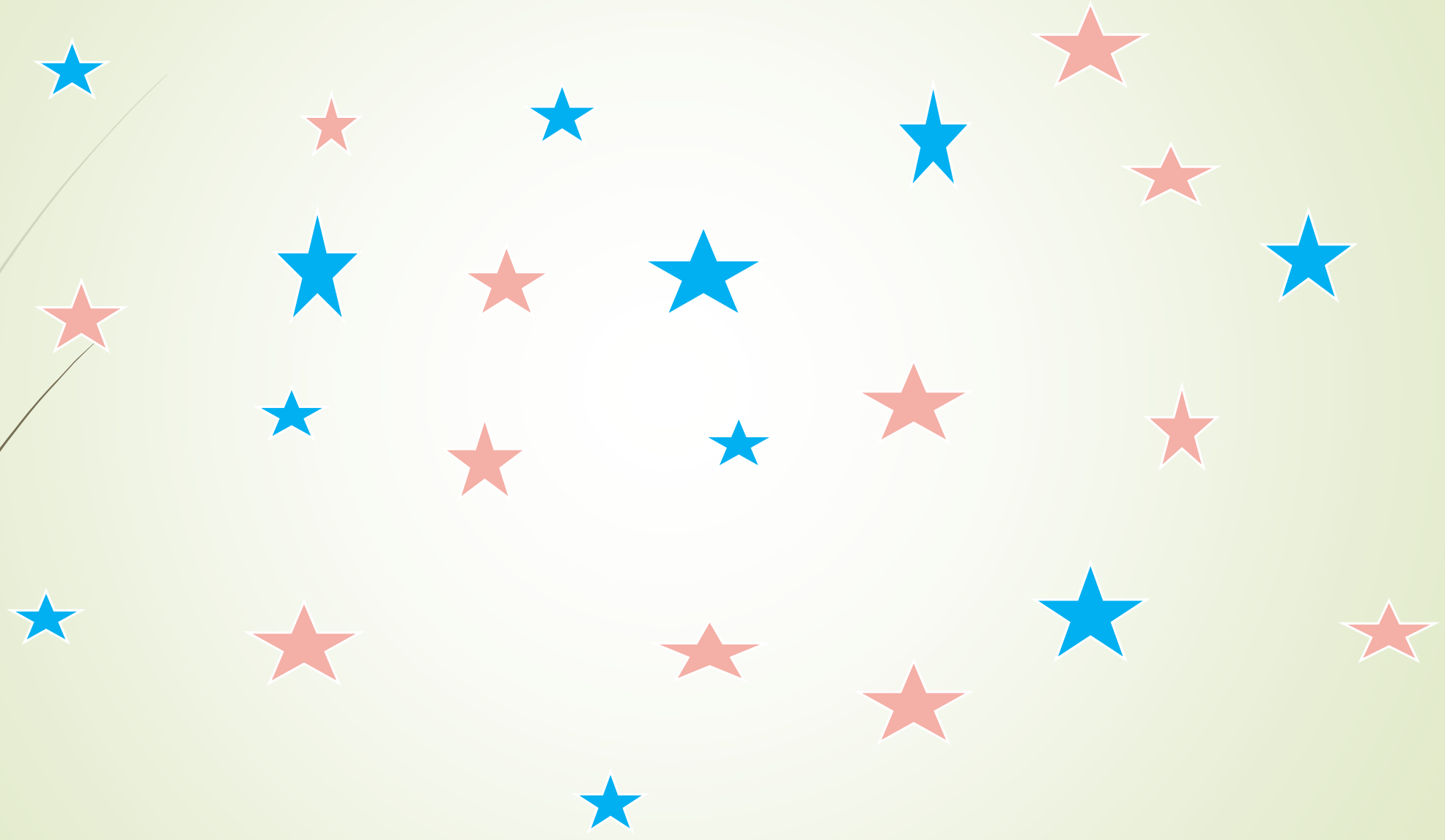
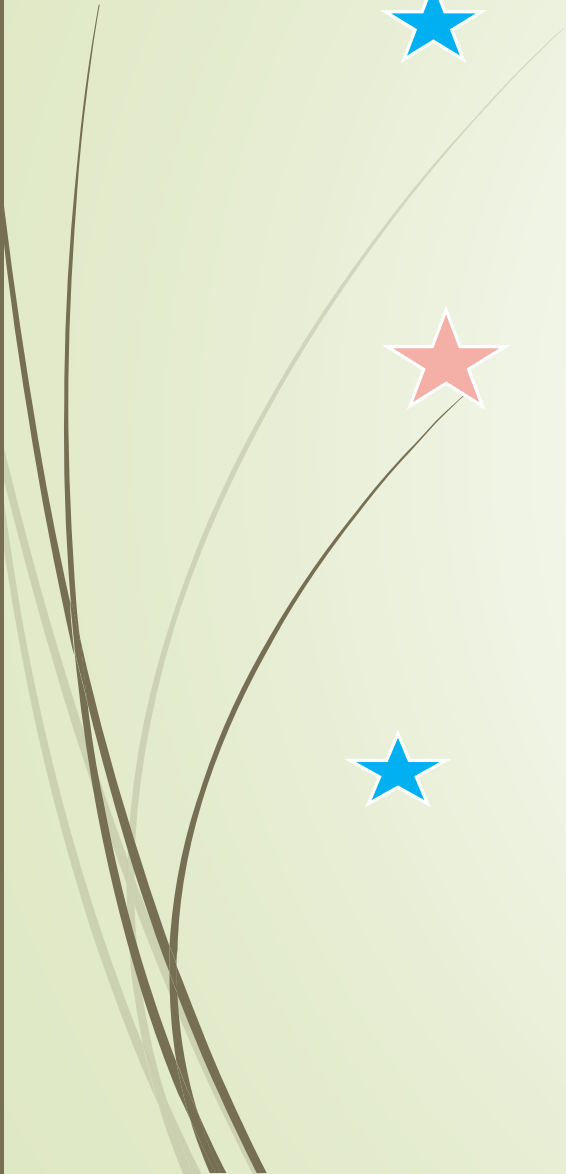
**SHAZAAM!**

## Primary Citation:

Gupta DM, Boland RJ, Aron DC.  
***The physician's experience of  
changing clinical practice: a struggle  
to unlearn.***

Implementation Science 2017;12:28.  
DOI 10.1186/s13012-017-0555-2







# STAR LEGACY

- **Primary USA Stillbirth Organization - Bereavement**
- **Funding of research - STARS Study 1 and 2**
- **Bringing the issue of stillbirth out into the open**
- **Creation of an international forum for the discussion of stillbirth etiology, risk factors, research and prevention**

**But there is still.....**

**.....much to do....!!!**

# USA stillbirth issues requiring change:

1. The ongoing belief that stillbirth is not preventable
2. The fact that stillbirth research is not receiving significant NIH funding
3. The lack of parental autonomy... Irrespective of maternal request, planned “non-indicated” delivery prior to 39 weeks of gestation is not currently possible
4. Following stillbirth, both social support and financial support - for parents - are neither universally offered or provided























TIT FOR TAT.

"Mamma! the governess, who has been put to sleep by my 'tit for tat'!" "But what does 'tit for tat' mean?" "Mamma!" "Say 'tit for tat'!" "Mamma!"







# What To Do When Needed Change Is Not Happening









# What To Do When Needed Change Is Not Happening

## HOW DO WE FOCUS OUR ENERGY?

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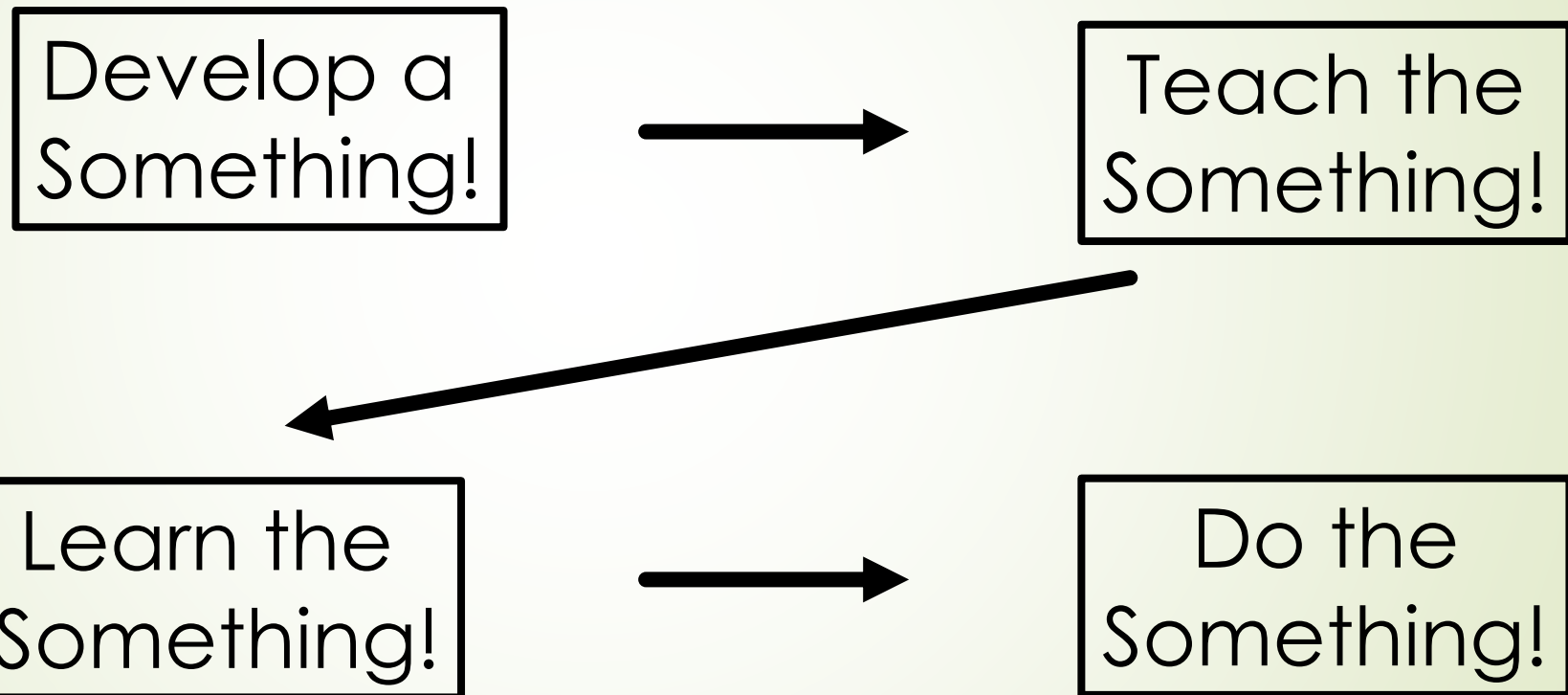


***CHANGE!***

# **TAKE A STEP BACK..... TO LEARNING THEORY**

(cognitive, psychomotor and affective)

# Learning Theory:





ONLY WHEN THERE IS A “**SOMETHING**” FIRST.....

THAT SOMEONE THINKS IS **SUBOPTIMAL**...

DOES **CHANGE** BECOME AN **ISSUE!**

**CHANGE!**





# Early Change Theory: (simple Linear Model – LEWIN\*)

1. Something is learned...
2. That something is used for many years ... and it become “the usual”
3. Then there if found “something new” that is believed to be better than “the usual”
4. So the “something new” is adopted, used repeatedly... and it then becomes “the [new] usual”



(cognitive, psychomotor and affective)

# Flash Medical Examples:

1. Cesarean Delivery for Breech
2. Antibiotic coverage during labor for the presence of Group B Strep bacteria
3. Routine use of Electronic Fetal Monitoring
4. Pertussis immunization during the 3<sup>rd</sup> trimester

# Resistant USA Medical Examples:

1. Disparities in health outcomes
2. Prevention/Treatment of obesity
3. The “epidemic” of narcotic and fire-arms related deaths
4. Persistently high rates of medical errors

# Modified Change Theory – Becker\*

## STEP # 1 – UNLEARNING

- The FIRST step is **UNLEARNING**
  - Acknowledge and release prior learning
  - Unlearning is affected by “drivers” and “barriers” (Theoretical Domains Framework Theory)
    - Relative strength of established belief in the “usual”  
i.e., the status quo
    - Relative strength of evidence challenging the status quo
    - Influence of peer-group-think
    - Fear of uncertainty

\* Becker K. Facilitating unlearning during implementation of new technology. J Org Chg Mgmt. 2013;23:251-68

# Strength of Evidence

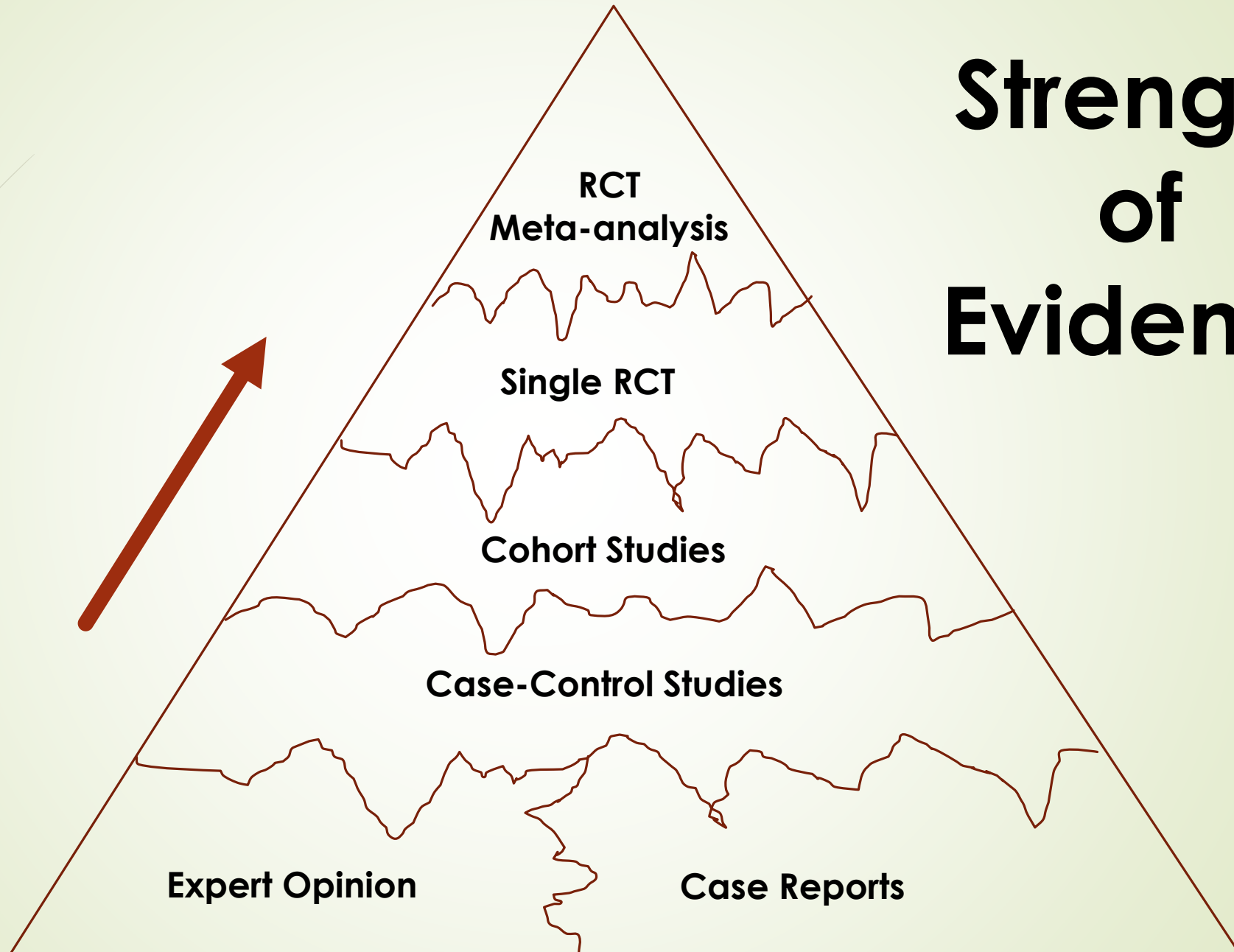


# Modified Change Theory – Becker

## STEP # 2 – NEW LEARNING (create a new status quo)

- The second step is **NEW LEARNING**
  - Accept and utilize new information
  - New Learning is also affected by “drivers” and “barriers” (Theoretical Domains Framework Theory)
    - Strength of new evidence
    - Strength of established belief in the status quo
    - Influence of peer-group-think
    - Financial implications
    - Legal implications
    - Practice/Lifestyle/Social implications
    - Fear of “doing harm” with an unfamiliar approach

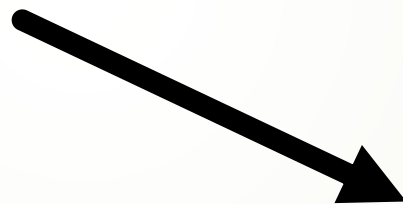
# Strength of Evidence



# Modified Change Theory –

**STEP #1**

(unlearn and give up)



**STEP # 2**

(learn and adopt)



# Modified Change Theory –

**STEP #1**

(unlearn and give up)

*Linear flow*



**STEP # 2**

(learn and adopt)



# Modified Change Theory –

**Unfreeze**

**Remodel**

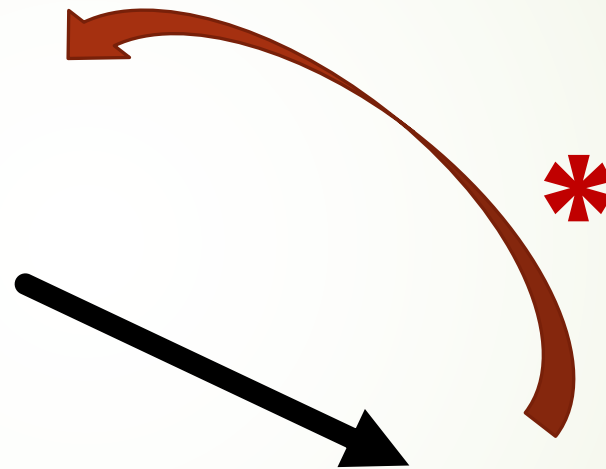
**Refreeze**



# Complex Change Theory –

**STEP #1**

(unlearn and give up)



**STEP # 2**

(learn and adopt)



Gupta et al

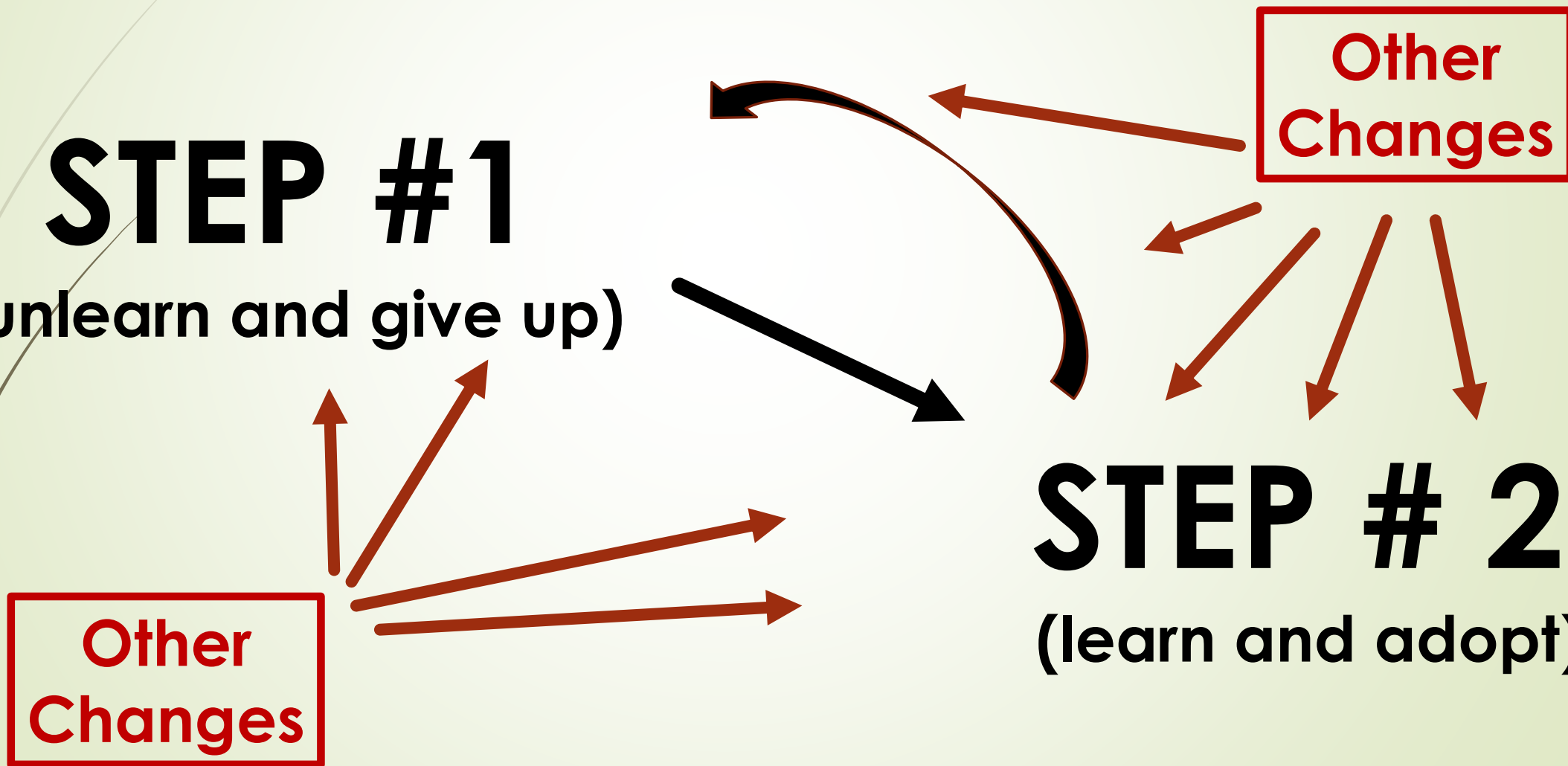
# Complex Change Theory –

**STEP #1**  
(unlearn and give up)

Other  
Changes

Other  
Changes

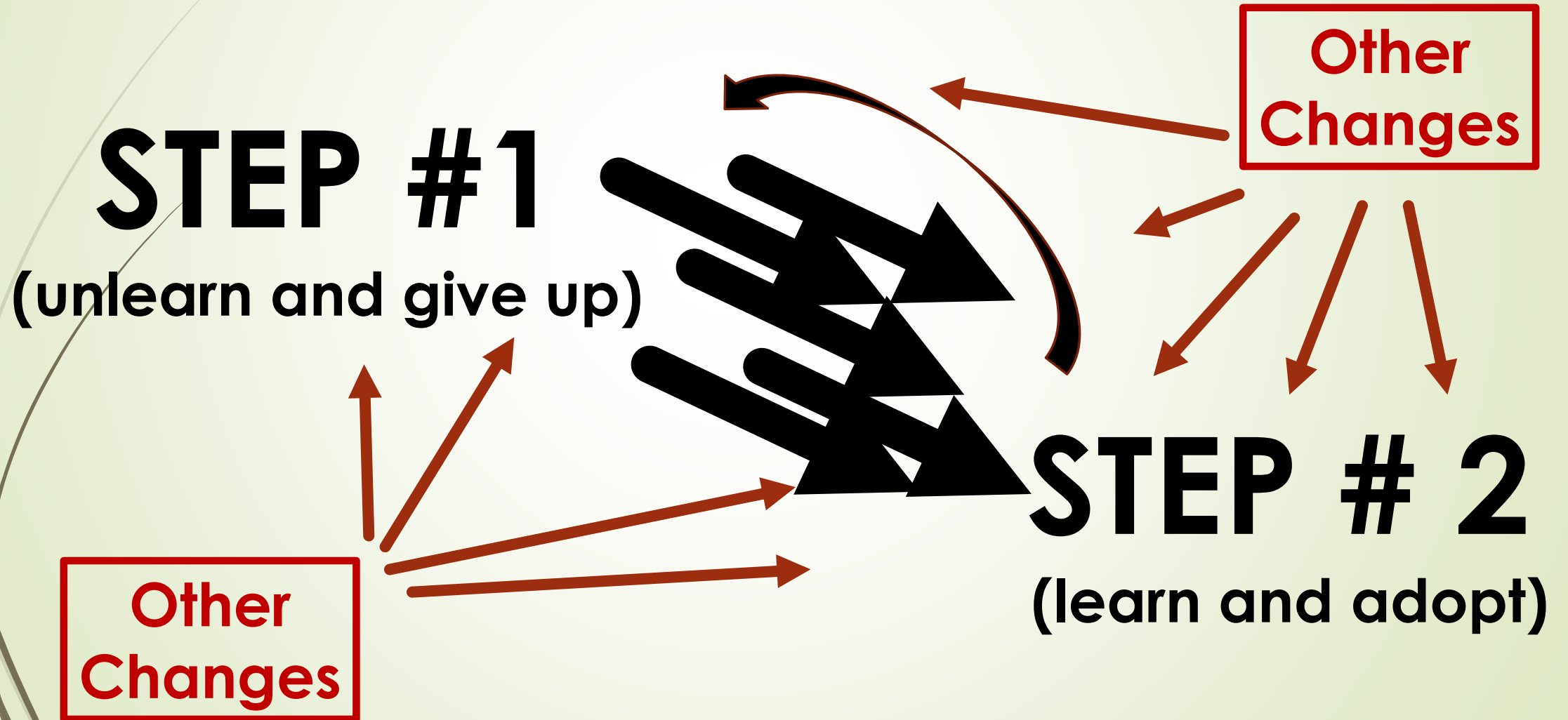
**STEP #2**  
(learn and adopt)



# Reality – issues related to development, use and change of modern human behavior: (cognitive, psychomotor and affective)

1. Learn something “anew”
2. Use that something on a very regular basis (maybe for years!)
3. Become aware that “something” might be better than “the usual” – might be...
4. Start to unlearn “the usual” that you knew – maybe it is “old” – maybe not...
5. Lots of other things going on in my practice and life that might need changing...
5. Consider using the “new” that might replace the “old” – it is probably better...
  - a. Use of the “new” might require alteration in personal habits
  - b. Use of the “new” might be at odds with the opinions of trusted colleagues
  - c. The “new” may be incompatible with established (but “old”) guidelines
  - d. Use of the “new” may impact you financially – maybe in a bad way
  - e. Use of the “new” involves uncertainty
  - f. Use of the “new” may incur legal risk

# Complex Change Theory –





# Implications of the Complex Model:

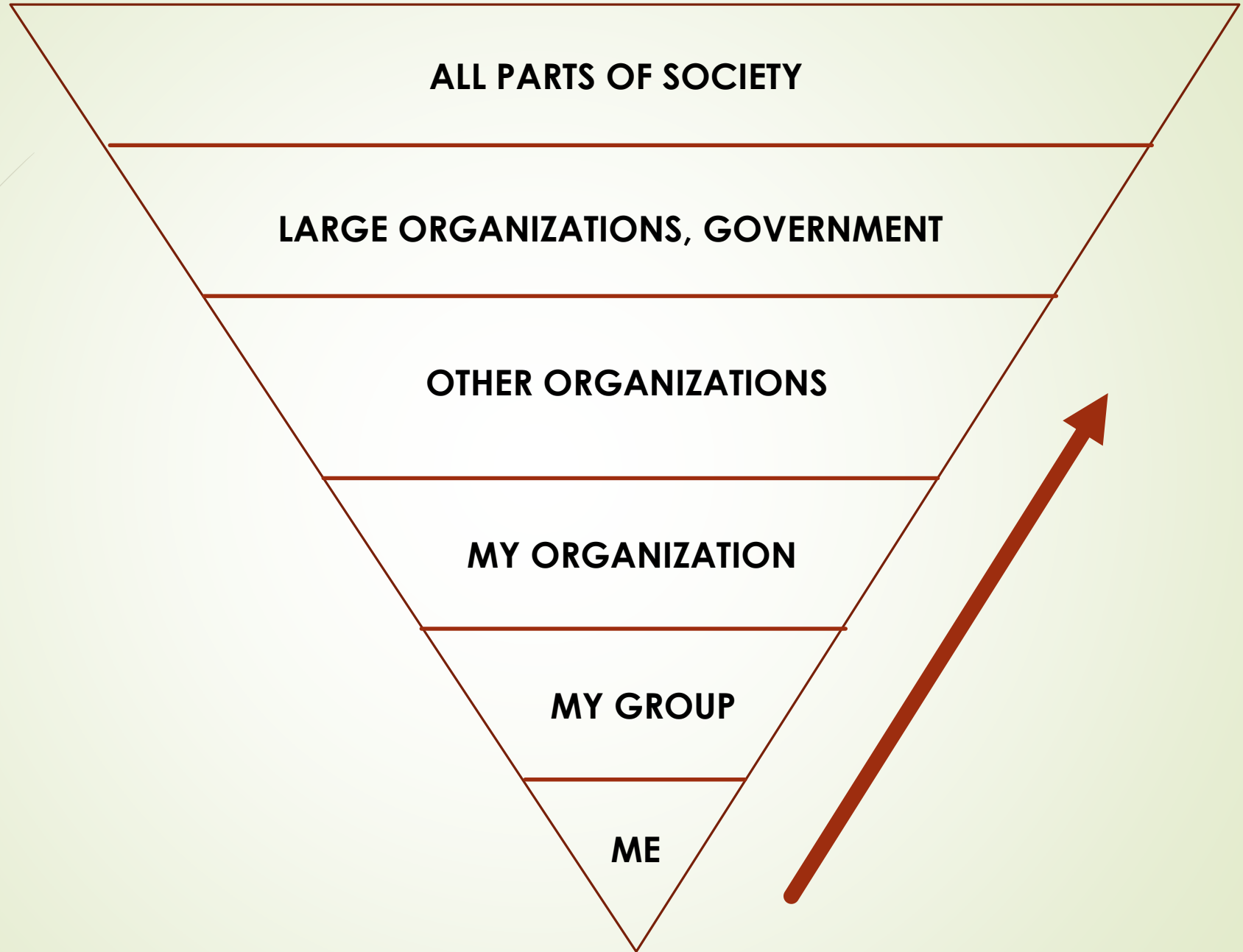
- ➔ Change involving any given medical practice must occur within the complex milieu of ongoing dynamic and always changing clinical medicine...and if the change you desire will be given the attention you think it deserves, **then you must somehow make it stand out** – it must become a priority to either the medical providers, or the patient population, or both..

# Implications of the Complex Model:

- Change involves a dynamic interplay between unlearning and learning – so change rarely occurs over a short period of time. Change requires significant pressure, patience and perseverance

# Implications of the Complex Model:

- Because change requires significant pressure, patience and perseverance, **there is strength in numbers!**



# USA stillbirth issues requiring change:

1. The ongoing belief that stillbirth is not preventable
2. The fact that stillbirth research is not receiving significant NIH funding
3. The lack of parental autonomy - irrespective of maternal request, planned “non-indicated” delivery prior to 39 weeks of gestation is not possible
4. Following stillbirth, social support and financial support - for both parents - are neither universally offered or provided



(cognitive, psychomotor and affective)

# **Additional USA issues :**

- 5. The importance of sleep position is not recognized**
- 6. The importance of sleep pattern is not recognized**
- 7. The importance of altered fetal activity levels is not well known**
- 8. There is a lack of willingness on the part of providers to discuss stillbirth-related issues (risks and preventions) during routine prenatal care visits**

# So What To Do When Needed Change Is Not Happening?

- Identify the Change that needs to occur
- Identify what issues need to be unlearned
- Perform **ACTIONS** that will promote “unlearning”
  - Be aware of, and manage, barriers to unlearning
- Perform **ACTIONS** that will promote “learning”
- Perform **ACTIONS** that will promote “doing of something new”
  - Be aware of, and manage, barriers to “doing something new”
- Be aware that **ALL ACTIONS** may need to continue - for a significant amount of time - if change is to take hold and become “the new usual”

SO WHAT ARE THESE ACTIONS?

# **Modern Change Theory – STEP # 1 - Unlearning**

# UNLEARNING ACTIONS

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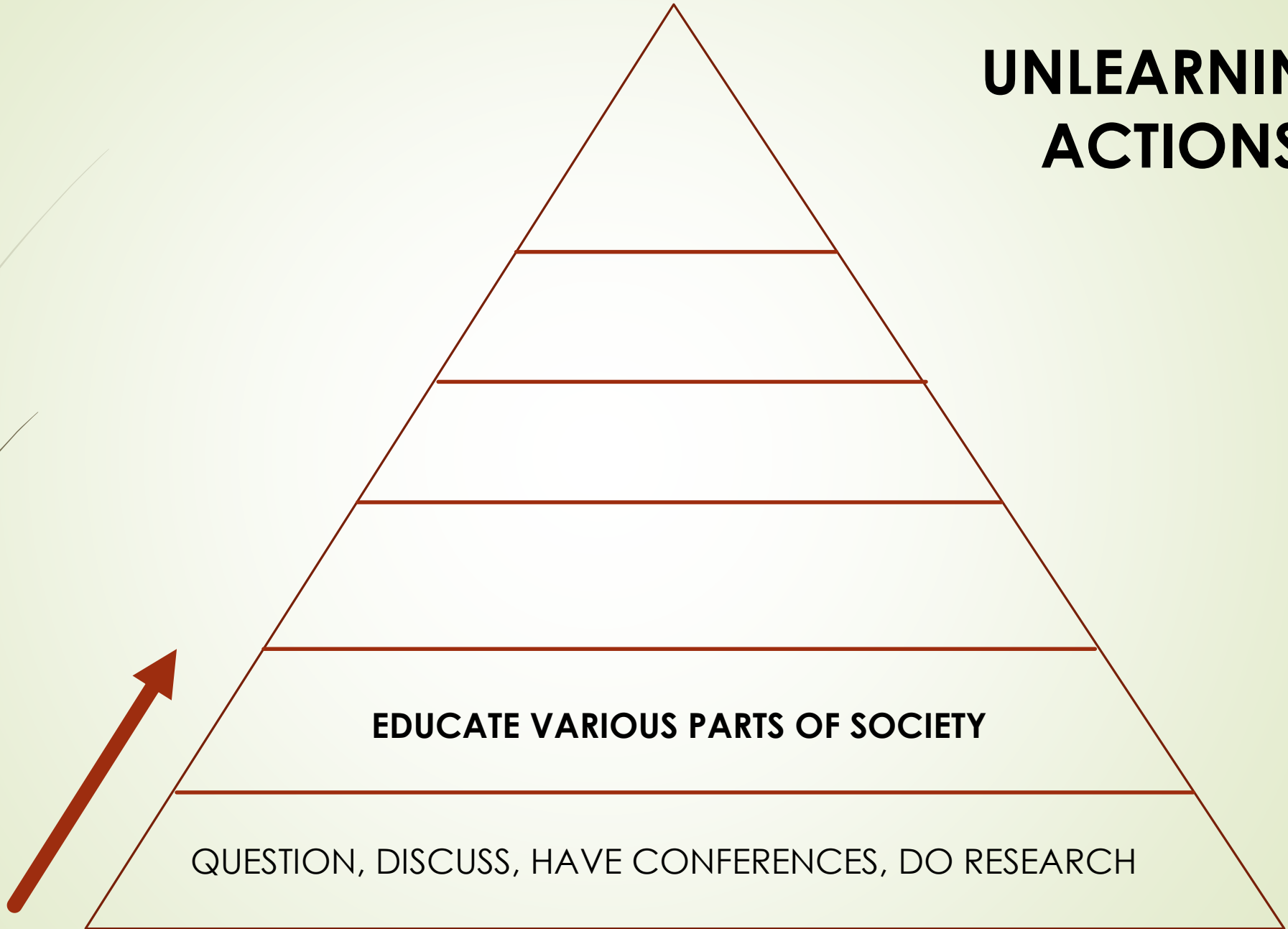


**QUESTION, DISCUSS, HAVE CONFERENCES, DO RESEARCH**



# UNLEARNING ACTIONS

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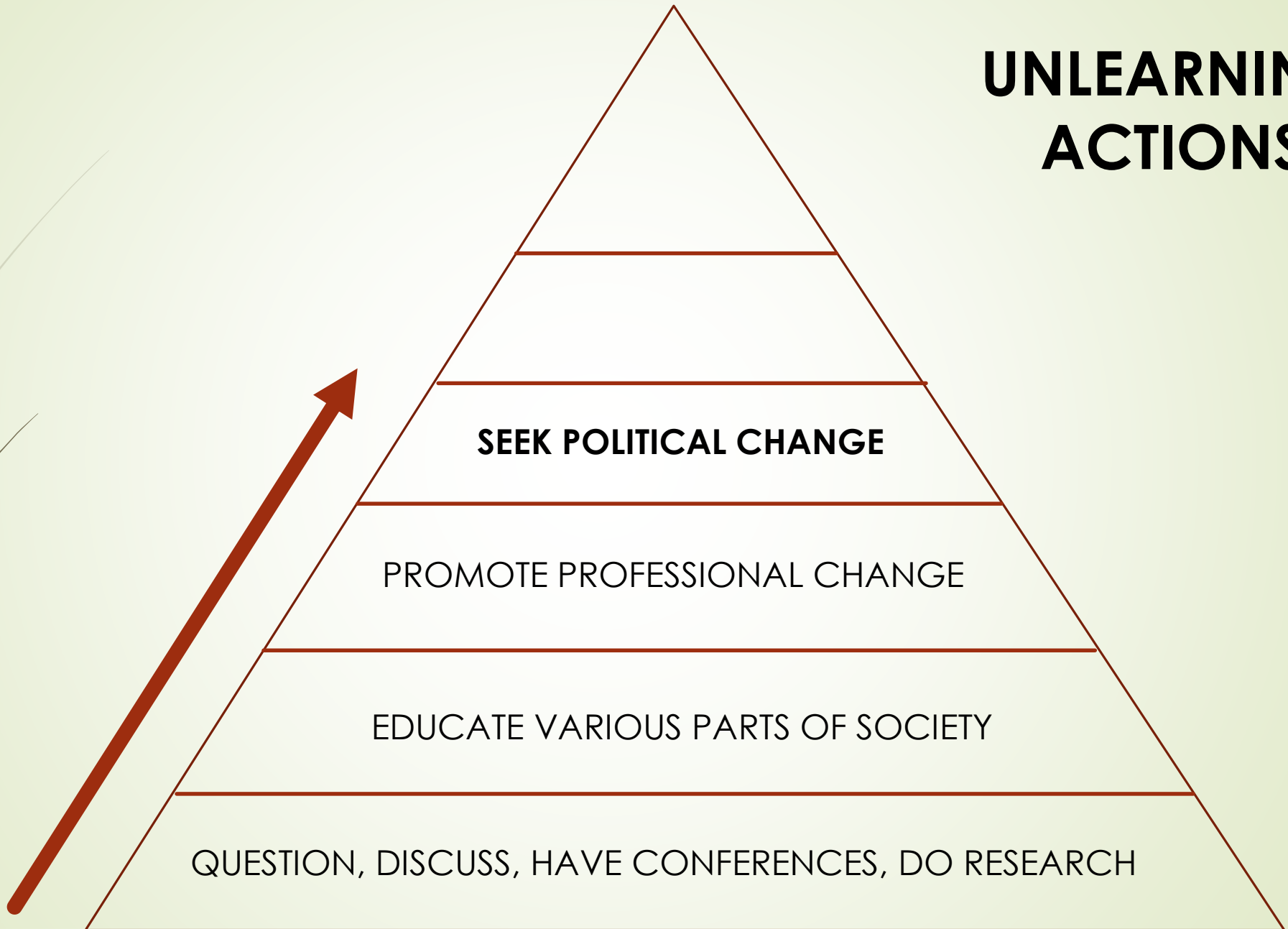


# UNLEARNING ACTIONS

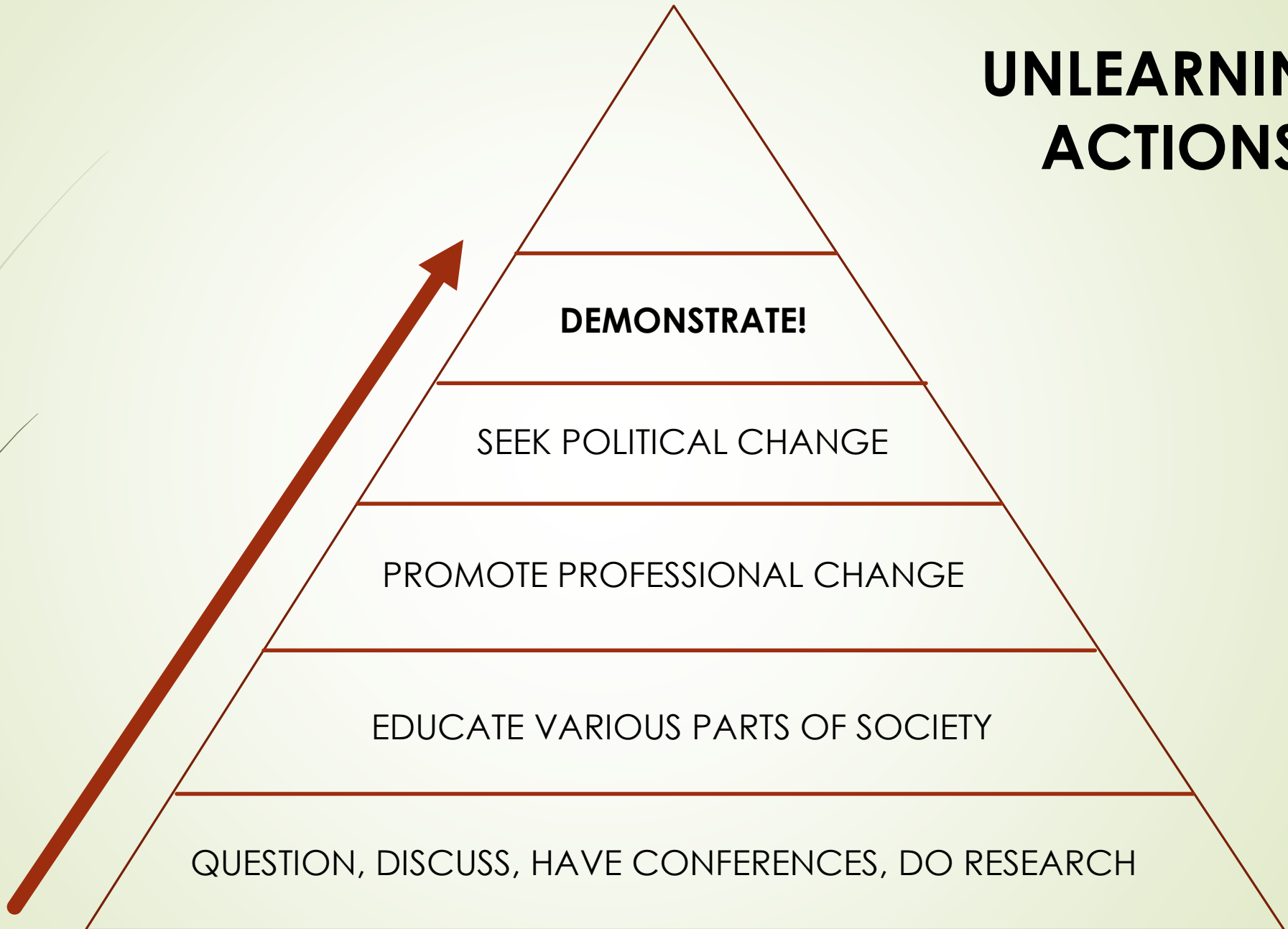
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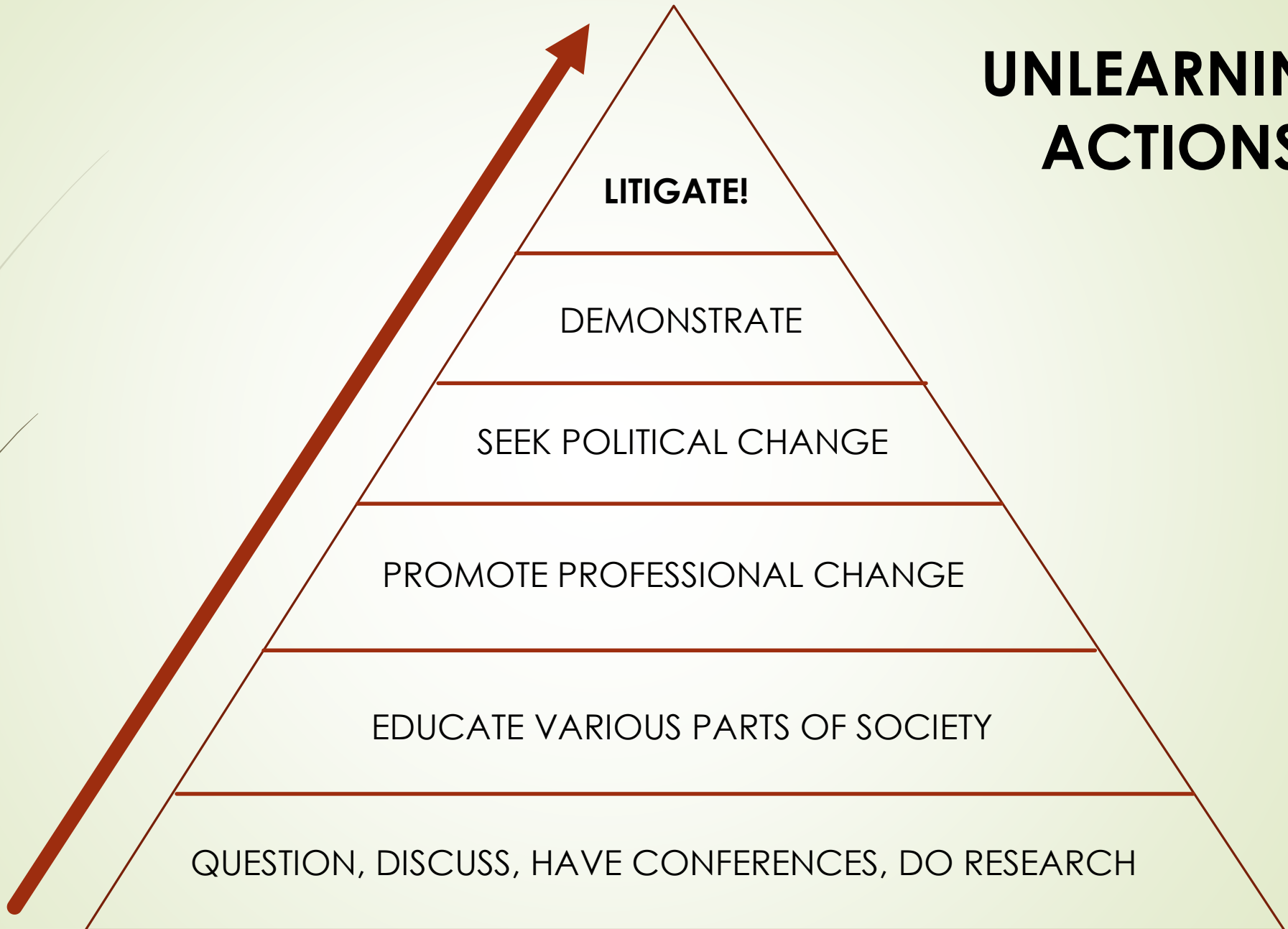
# UNLEARNING ACTIONS



# UNLEARNING ACTIONS



# UNLEARNING ACTIONS





# **Modern Change Theory – STEP # 2 – Learning/Doing**



# TWO EXAMPLES:

# Case #1: Some cases of term STILLBIRTH might be prevented with improvement in sleep position and attention to fetal movement patterns

- Providers learn in medical school and residency that stillbirth is rare and essentially an “act of God”
- In general practice, the outcome “stillbirth” happens rarely, and when it happens it has happened and prevention is no longer an option

# Case #1: STILLBIRTH is generally understood as a non-preventable outcome

- The occurrence of stillbirth comes at intermittent but rare intervals during years of practice. The acceptance of the inevitability of intermittent but relatively rare “cases” of stillbirth becomes part of general practice.



# BUT WHAT IF STILLBIRTH... IS IDENTIFIED AS A POTENTIALLY PREVENTABLE OUTCOME

- We become aware that “a new something” might be better than “the usual”
  - There are reports that maternal side sleep position lowers the risk of stillbirth
  - There is good evidence that decreased fetal movement may be an acute sign of impending stillbirth

# UNLEARN ACTIONS!

- **Inform the public and health care professionals that there is good international evidence that stillbirth is not always inevitable, and that a significant portion of term stillbirths might be preventable...**
  - Develop conference presentations
  - Insist on getting “tables” at OB/GYN, MFM, Family Medicine and nursing conferences
  - Develop social media campaigns
  - Solicit celebrity actions
  - Develop and “roll-out” newspaper and radio adds

# LEARN ACTIONS – Part 1!

- **Inform the public and health care professionals that there is good international evidence that a significant number of term stillbirths are preventable with both modification of sleep position and urgent evaluation in the setting of decreased fetal movement**
  - Develop conference presentations
  - Insist on getting “tables” at OB/GYN, MFM, Family Medicine and nursing conferences
  - Develop social media campaigns
  - Solicit celebrity actions
  - Develop and “roll-out” newspaper and radio adds

# LEARN ACTIONS – Part 2!

- ▶ **Inform the public and health care professionals that there is good international evidence that a significant number of stillbirths are preventable with both modification of sleep position and urgent evaluation in the setting of decreased fetal movement**
  - ▶ Hand out literature inside and outside the offices of providers
  - ▶ Encourage ACOG and SMFM to update its publication concerning stillbirth to include preventive approaches to stillbirth
  - ▶ Encourage legislation to require that information regarding sleep position and changes in fetal movement be provided to all patients by 28 weeks of gestation

## **LEARN ACTIONS – Part 3!**

- **Consider litigation if stillbirth occurs in the setting where advice about sleep position and changes in fetal movement were not provided and where these risk factors were present**
- **Consider litigation against professional organizations if they are unwilling to make such simple/basic recommendations concerning stillbirth prevention**



**Case #2: In the setting of increased risk for stillbirth, but where an accepted “indication” is not present, planned delivery is not allowed prior to 39 weeks of gestation.**

- In the USA, since 2010, “the 39 week Rule” restricts such planned deliveries - irrespective of parental wishes
- This rule is based on relatively low-quality research
- This rule is supported by multiple organizations

**Case #2: In the setting of increased risk for stillbirth, but where an accepted “indication” is not present, planned delivery is not allowed prior to 39 weeks of gestation.**

- Proponents of the Rule claim that neonatal health is improved by delayed delivery
- Proponents of the Rule claim that maternal health is improved through the reduced use of labor induction

## However, the adoption of the 39-week Rule:

- Has not been shown to reduce NICU admission rates
- Has not been shown to improve maternal health
- **Has been associated with an increase in the USA rate of term stillbirth!!!**
- **Does not allow for parental choice (Autonomy)**

**Furthermore, the recently published ARRIVE Trial (n=6000 patients) reported that – for “low-risk primiparous women” – induction at 39 weeks, as compared to expectant management until 41 weeks, led to:**

- **Lower cesarean delivery rates**
- **Lower preeclampsia rates**
- **Decreased neonatal respiratory compromise**

**SO CONSIDER: If 39 weeks is the optimal time of delivery for “low-risk” pregnancies, then shouldn’t the optimal time of delivery for pregnancies at increased risk for stillbirth be prior to 39 weeks?**

- African-American/Asian
- IVF
- Cigarette or cocaine use
- <20 yo, > 35 yo
- Single



**SO CONSIDER: If 39 weeks is the optimal time of delivery for “low-risk” pregnancies, then shouldn’t the optimal time of delivery for pregnancies at increased risk for stillbirth be prior to 39 weeks?**

➤ **African-American/Asian**

➤ **IVF**

➤ Cigarette or cocaine use

➤ <20 yo, > 35 yo

➤ Single

THE POWELLS  
Greyson\*  
Jill  
Keith  
\*@ 39w 6d

# UNLEARN ACTIONS!

Inform the public and health care professionals that term stillbirth is not always inevitable, and that:

- ▶ a significant portion of term stillbirths are preventable ...
- ▶ the risk of term stillbirth is not level across all gestational ages but rather increases with increasing gestational age starting at 37 weeks...
- ▶ the use of labor induction at an earlier gestational age, as compared to expectant management to a later gestational age, does not worsen outcomes...
- ▶ different pregnancies have different patterns of risk, so pregnancies should not be treated identically

# UNLEARN ACTIONS!

- **Inform the public and health care professionals that there is good evidence that the 39 week rule does not represent optimal care...**
  - Develop conference presentations
  - Insist on getting “tables” at OB/GYN, MFM, Family Medicine and nursing conferences
  - Develop social media campaigns
  - Solicit celebrity actions
  - Develop and “roll-out” newspaper and radio adds

# LEARN ACTIONS – Part 1!

- **Inform the public and health care professionals that labor induction at or before 39 weeks should be an option for pregnancies at increased risk of stillbirth**
  - Develop conference presentations
  - Insist on getting “tables” at OB/GYN, MFM, Family Medicine and nursing conferences
  - Develop social media campaigns
  - Solicit celebrity actions
  - Develop and “roll-out” newspaper and radio adds

## LEARN ACTIONS – Part 2!

- **Inform the public and health care professionals that labor induction at or before 39 weeks should be an option for pregnancies at increased risk of stillbirth**
  - Hand out literature inside and outside the offices of providers
  - Encourage ACOG and SMFM to update its publication concerning stillbirth to include preventive approaches to stillbirth
  - Encourage legislation to require parental input into the planning of term pregnancy care – including the timing of delivery



## LEARN ACTIONS – Part 3!

- **Support parents interested in timely delivery with risk assessment and provision of care**
  - Develop computer-based rubrics to estimate the optimal time of delivery
  - Develop centers of care that will respond to requests for timely delivery (similar to the Rainbow Clinic)

## LEARN ACTIONS – Part 4!

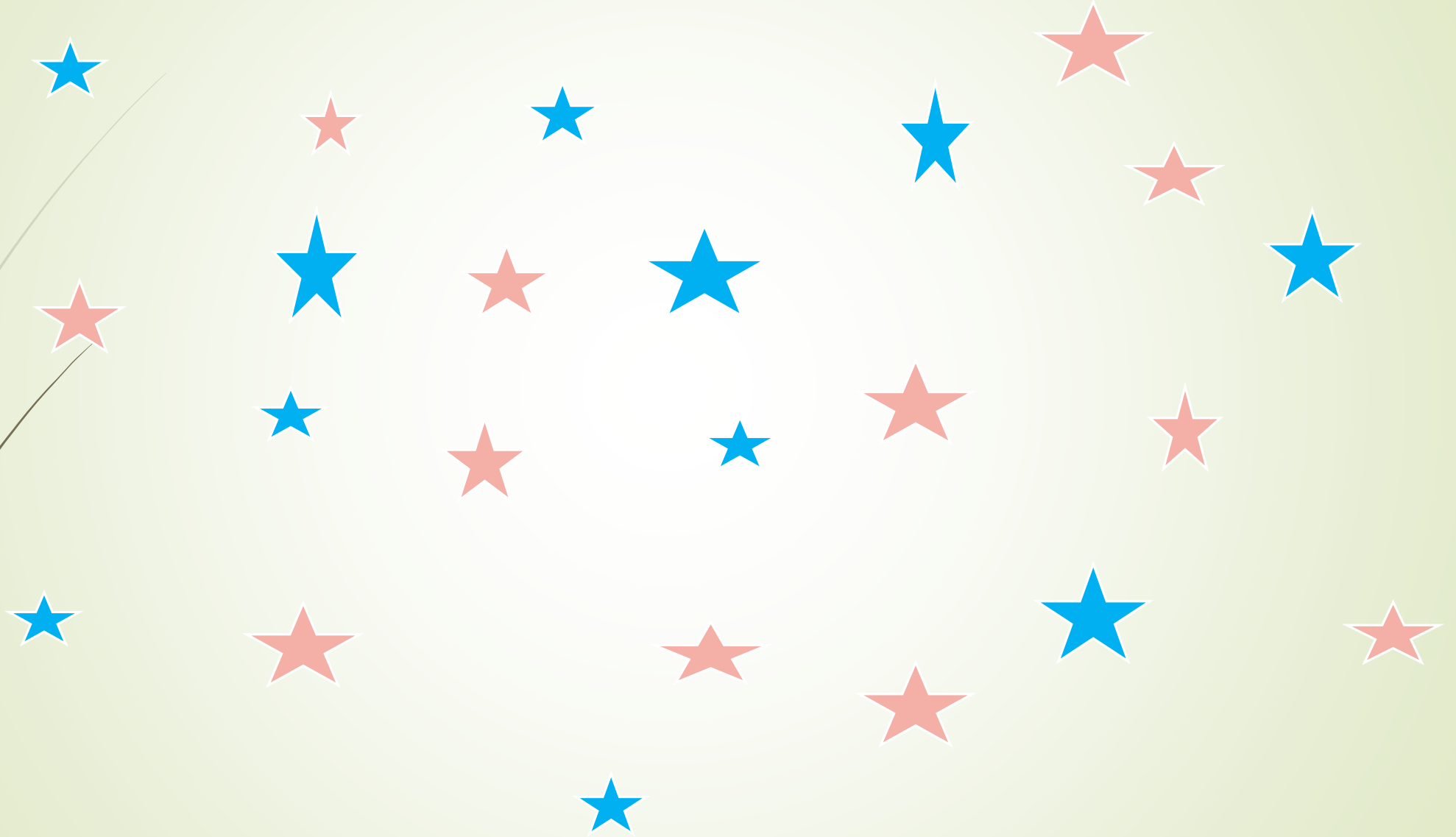
- ▶ Consider litigation if stillbirth occurred during a pregnancy that contained significant risk factors, and where the option of timely delivery before 39 weeks was not discussed
- ▶ Consider litigation against professional organizations if they are unwilling to modify their professional guidelines to allow for parental autonomy in decisions regarding the timing of delivery – especially in the setting of increased risk for term stillbirth

# THE TWIST...

- ▶ In order to effect change when change is not happening.....

.....We need to change ourselves and our approach

- ▶ Because what has been tried has not worked
- ▶ Because opposing influences to our desired changes are very strong
- ▶ Because a continuation of the status quo (i.e., just waiting for change using the same old strategies) is not consistent with our primary goals



# WHAT TO DO?

- Promote “unlearning”
- Promote “learning”
- Promote “doing”
  - Anticipate, and manage, barriers
- Be aware that all categories of CHANGE/ACTION will meet resistance and that all will need to be promoted for a significant amount of time
- Be aware that CHANGE/ACTION often requires significant amounts of stress and sacrifice





**SHAZAAM!**

# SHAZAAM!

Thank You!