Coping with Resistance to Change

Several theoretical constructs of change have been expounded during the past 20 years. Perhaps the most popular proponents of change theory are Toffler in the 1970s, and Naisbit, Peters, and Waterman in the 1980s. Regardless of the author, the imperative to adapt in this era of rapid acceleration has occupied considerable thinking in recent years. To be aware of resistance to change and develop ways to overcome and deal with the problems of adaptation is also essential.

As discussed in Part One, AOTA, as an organization, has reached the first stage in adapting to some changes confronting health organizations: awareness or "knowledge" of the need to make changes in occupational structure. Occupational therapy leaders have also mandated changes in the profession's direction to keep pace with changes in the health system. There have been many attempts to disseminate this knowledge. However, a communication gap among the majority of practicing therapists may still exist.

There are several methods of dealing with resistance. Kotter and Schlesinger (1) outline the following:

- Education and communication
- Participation and involvement
- Facilitation and support
- Negotiation and agreement
- Manipulation and co-option
- Explicit and implicit coercion

Choosing the method with the most impact on occupational therapy is not an easy task. However, the last two methods, although undoubtedly quicker, could foster the very lack of trust that we saw as a major barrier to change in our members. It has taken some time to overcome the feeling that many AOTA activities were "cloaked in secrecy" (2). Feelings of being manipulated or coerced into accepting positions on such matters as continuing competency, name change, a logo for an occupational therapy public image, role delineations, and the appropriate entry level of occupational therapy education, to name a few, resulted in greater resistance to change.

An education program with increased communication would be ideal for those members who resist change because of inadequate or inaccurate information (1). Ideally, the education should take place before the change. "The most reliable way to anticipate the future is by understanding the present." (3, p 2) However, with the rapid pace of today's society, this may not always be possible. Yet resistance to new directions in occupational therapy practice could be allayed if there is a perceived need for change from within the organization. This will require developing good relationships with our state associations, occupational therapy educational programs, and individual therapists if any education/communication efforts are to be effective.

Enlisting the help of the above
groups will be essential both for dissemination purposes and formulation of programs. AOTA has successfully used the task group approach, which involves the people most likely to be affected by a particular change, to develop strategies for implementing new structure. Resistance to new ideas is considerably lessened when the people affected by a decision are part of the process of arriving at that decision. Naisbitt calls this "participatory democracy" (3, p 159), increasing accountability and grassroots involvement. The recent COTA task group is an example of such participatory involvement. This group has presented several excellent methods for dealing with current problems COTAs are facing, both within the organization and in their practice. In addition, participation and involvement frequently lead to commitment. Many therapists involved in decision-making groups at the local or national level have continued their involvement with professional and association matters with even greater commitment at a later date. This technique should be fostered with our students and practicing therapists at the grassroots level.

Supportive techniques to deal with the fear and anxiety that often cause resistance to change may include emotional support and specific skill building. Many innovative programs started in the 1960s and early 1970s have failed because therapists were caught up in the accelerative thrust without carefully considering the need for transitional models of occupational therapy practice to act as buffers to channel the effects of change. Toffler described these as "change-regulators" (4). It is important to be aware of the need for specific personnel skills and manpower needs when starting new programs, to include consideration of other delivery systems within a community, to respond to consumer needs, and to assess the educational needs of current and future therapists. Directors, educators, and professional leaders can help decrease the obstacles to change by lending continued support and a position of authority to new ideas and policies (5).

Negotiation is another effective way to deal with resistance when one party stands to lose something as a result of a change in procedure or policy. This technique has been effective between state associations and AOTA. It can readily be used at the local level between state associations and special interest groups in that state when such issues as manpower, membership, and financial overload appear to be at stake.

Regardless of the situation, any change is apt to create resistance. Techniques to cope with this resistance should be assessed for their appropriateness to the situation, the speed of the effort required, the amount of preplanning, and the cost-benefit ratio. Change efforts usually require several methods of implementation, but, to be effective, techniques must be internally consistent with the situation. Four factors have been described that may improve the chance of success in organizational change efforts:

1. An organizational analysis should be conducted to identify the current situation, problems, and forces causing the problems. The kind of changes needed should be identified in this analysis.

2. Further analysis should be conducted regarding the factors relevant to producing the desired change. Such questions as who might resist the change, who has information that can be used to design the change, and whose cooperation is essential to enlist to implement the change should be answered.

3. The selection of change tactics should be based on these analyses, with greatest consideration that the effort be internally consistent with the situation. The amount of preplanning required, the degree of involvement of others, the time frame required to institute the change, and specific tactics for targeted groups or individuals should also be included.

4. Finally, the key to any successful change effort is careful monitoring of the implementation process.

Strategies for Survival

The imperative for occupational therapy as a profession and occupational therapists as individuals to adapt to the fast pace of change in today's rapidly accelerating society has been mandated. Regardless of resistance, changes have occurred and will continue to occur. However, rarely does the future "sneak up from behind and overwhelm us." (6, p 141)

There is usually ample warning, with signals all around, of the changes that might occur. When we do not recognize, misinterpret, or choose to ignore these signals, problems arise (6). With the fast pace of change in today's society, what strategies must we develop to thrive as a productive, contributing independent health profession in the health care delivery system of the 1990s? This is a period of transformation, a time that Gilfoyle identified as one in which we can direct our own future (7).
Individual therapists, along with our organized groups, must continually scan the environment to ensure that external issues are addressed in management, decision making, education, and practice programs.

Specific strategies based on external trends and our internal philosophy should include:

**Development of Cost-Effective Programs**

The past four years have dealt a blow to many health programs that could not show a positive cost-benefit ratio to government funding agencies. Some programs received across-the-board cuts regardless of fiscal evaluation. In the next four years, a policy of fiscal restraint will undoubtedly be continued. Recent pronouncements from the White House indicate that further cuts in Medicare benefits and programs are essential due to the budget deficit. Administration economists have stated that, despite the economic expansion, the rate of growth will be slower, underscoring the need for continued tightening of fiscal policy.

Health cost increases have been kept to the lowest level in a decade. Yet despite this slowdown in escalation, health costs still continue to grow faster than the overall economy. Health care consumed a record 10.8% of the gross national product. This mounting expense will continue to be studied carefully. The recent move to a system of prospective payment is a prime example of the direction of decreasing health care costs. The future portends greater scrutiny of all health care delivery systems. This behooves occupational therapists to rethink their methods and their locus of practice. Cost containment efforts among health care professionals should include occupational therapists providing services in collaboration with other professions and health agencies (7). This may require a move beyond the traditional institution for provision of health care to a number of community agencies, schools (private and public), work establishments, health and wellness centers, and the home.

**Involvement in Studies to Assess Quality of Care**

To focus only on cost-effectiveness as the sole criterion for program evaluation can be damaging and self-defeating (8). Cost-effective studies must be examined in relation to different service systems and outcome studies of the quality of the care received. In the 1970s, there was considerable emphasis on measurement techniques and the reliability and validity of quality assessment efforts. In the 1980s, the emphasis on cost containment plunged us into an era of fiscal stringency that overshadowed the resources needed for quality of care studies. Some complaints were voiced that several studies failed to show a significant correlation between the health care process and patient outcome, and cast doubt on current techniques for assessment of quality of care (9). However, methods of study have been improved, and such studies have gained even more significance in light of today's political realities. Given the change in social and political directions, it is especially important to prove that health services maximize the health of a population, provide the care purported, and sustain a level of care below which the quality of service would be jeopardized (10).

AOTA's Quality Assurance Division has trained regional consultants to help occupational therapy in clinical practice to conduct studies to assess the quality of their services. Additionally, the Quality Assurance Division is collecting and publishing data on the efficacy and efficiency of occupational therapy. Predictions are that quality assurance will surpass cost containment as the nation's major health care issue by 1990 (11). These regional consultants can provide therapists in their own practice with the necessary training to define and describe thoroughly the fundamental importance and adequacy of their services.

**Participation in Health Policy Decisions**

Just as cost containment cannot proceed in ignorance of the level of the quality of health care achieved, health policy must not be created in a vacuum. Policy makers frequently become diverted by the enormity of health costs. Rather than focusing on health as the issue, dollars become the central feature of health policy (12). Legislators are not health experts, and unless informed by those in the health care system, their judgments will be based on the priorities of politics instead of health. Many of them are willing to listen to health providers in developing health policy in tune with the demands of health care. "Cost containment is not health policy, but good health policies will restrain both disease and costs and promote health." (12, p 779)

If occupational therapy is to be included in health services supported by either government dol-
lars, institutions, community agencies, or third party payers, we must make the profession’s health care needs known to those who develop policy.

It is essential for occupational therapists to become involved in health policy activities, either through advocacy at the local, state, and national levels, or through direct participation on health policy-making boards and agencies. We have an active Government and Legal Affairs Division in AOTA whose staff are vocal advocates for the Association and the profession. In addition, we must involve the general membership at the grassroots level to develop policies that include the possibility of occupational therapy services. We cannot remain complacent in the belief that our services will be automatically demanded by the public or a priority of policy makers. Demonstration of occupational therapy skills and services must be made more dynamic and accessible to those on community planning and advisory boards, and in local, state, and national legislative and government agencies.

Marketing of Occupational Therapy Services

Occupational therapists should not be standing in the wings waiting for cues from others. Instead they should be in the marketplace selling their wares.” (13, p 8) To be in the forefront of health professions, we need to improve our skills, our image, and our visibility. We must be willing to set foot on the territory of both political and economic decisions. This is foreign to the thinking of many occupational therapists, but we must develop skills to be of consequence in the health industry, not just in the health clinic. Health care is now a multibillion dollar industry, moving from not-for-profit to for-profit behavior (12). Occupational therapists must learn to balance the strong ethical, moral, and altruistic motives of the profession with an increasingly good business sense. We can no longer bury our heads in the traditional clinic and let others design, supervise, manage, and control our services. “If we want to protect our treatment principles and standards of care, we must become knowledgeable about profit margins, budget processes, overhead, reimbursement trends, and legislative and regulatory mandates. We are in the business of occupational therapy and we must market our product to be competitive!” (13, p 8)

Development of Innovative Nontraditional Roles in Occupational Therapy

That the goal of health care has moved beyond mere survival to positive health is evidenced by the increasing growth of wellness and fitness centers across our country. Naisbitt (3) projects that health care, nutrition, and fitness will be among the prime economic growth areas in the future. The more recent humanistic approach to health care in the U.S. has been followed by a new self-help paradigm and change in personal habits to achieve a state of wellness (3). Central to the concept of optimal functioning is the existence of a positive state of health in the whole person.

Health, considered in terms of individual and societal fulfillment, accompanied by feelings of purpose and worth, has long been the goal of occupational therapy. However, occupational therapists have not always been concerned with total or comprehensive care, which, by very definition, would include preventive as well as curative approaches. As health professionals, it is essential that occupational therapists devote their energies to extending care to previously neglected populations and develop techniques to improve the social climate that fosters and promotes a healthy society.

Many new “therapies” or wellness-oriented professions have sprung up in the upsurge of self-care and fitness programs. To maintain visibility as a profession interested in the development of the human potential, occupational therapists should use their many skills and basic orientation in programs that promote health, prevent disease, and enhance the quality of life. As directors of and consultants to wellness/fitness programs in a broad spectrum of the population, the occupational therapist has the opportunity to help communities plan appropriate activities for lifelong learning in healthy attitudes and behavior. Involvement in school health and accident prevention programs; workshops in parenting techniques, child development, activities for the well elderly, and leisure time programs for the working population; accident prevention in the workplace; and screening and developmental testing in community preschool are but a few areas in which occupational therapists can move beyond the traditional treatment clinic to innovative roles in promoting a healthy society.

Conclusion

The challenge for the future of occupational therapy is to monitor the trends in this era of change,
anticipate and predict the implications of change in the larger societal context, and identify the significance of these changes for the profession, which include cuts in health dollar program support, the necessity of demonstrable cost-effective programs, and the possibility of a change of locus for our services. Preparation for the future involves understanding the meaning of changes, adaptation through new approaches, assumption of expanded roles, and training "in a new mold rather than a recasting of the prototypes of an earlier time." (14) Change and its concomitant threat and uncertainty can be channeled effectively. Occupational therapists, as part of the team of trustees of the public's health, must accept the challenge and the risks.

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