

Case study: examining failure in change management

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Received 28 June 2019
Revised 9 November 2019
Accepted 14 December 2019

Abstract

Purpose – This case study aims to shed light on what went wrong with the introduction of new surgical suture in a Dutch hospital operating theatre following a tender. Transition to working with new surgical suture was organized in accordance with legal and contractual provisions, and basic principles of change management were applied, but resistance from surgeons led to cancellation of supplies of the new suture.

Design/methodology/approach – Researchers had access to all documents relevant to the tendering procedure and crucial correspondence between stakeholders. Seventeen in-depth, 1 h interviews were conducted with key informants who were targeted through maximum variation sampling. Patients were not interviewed. The interviews were recorded, transcribed and analysed by discourse analysis. A trial session and workshop were participatively observed. A cultural psychological perspective was adopted to gain an understanding of why certain practices appear to be resistant to change.

Findings – For the cardiothoracic surgeons, suture was more than just stitching material. Suture as a tactile element in their day-to-day work environment is embedded within a social arrangement that ties elements of professional accountability, risk avoidance and direct patient care together in a way that makes sense and feels secure. This arrangement is not to be fumbled with by outsiders.

Practical implications – By understanding the practical and emotional stakes that medical professionals have in their work, lessons can be learned to prevent failure of future change initiatives.

Originality/value – The cultural psychological perspective adopted in this study has never been applied to understanding failed change in a hospital setting.

Keywords Case study, Emotion, Operating theatre, Cultural psychological perspective, Failed change, Surgical suture

Paper type Case study

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We thank all research subjects, on both sides of the aisle, for their participation in this case study on a topic that involves them deeply into their professional groups. Also, we thank the anonymous reviewers for their insightful feedback on an earlier draft.



Introduction

In the Netherlands, and more broadly in Europe, the cost of health care is rising and is expected to continue to rise (Jenkner and Leive, 2010; Mot *et al.*, 2016). In light of this development, the challenge for those managing healthcare institutions is to spend smartly and cut costs where possible, while at the same time meeting changing patient demands (e.g. Dent and Pahor, 2015; Thistlethwaite and Spencer, 2008). The fact that managing the work and practices of medical professionals has always been difficult (e.g. Andri and Kyriakidou, 2014; Kennerley, 1993; Kirkpatrick *et al.*, 2005) adds to the complexity of meeting this challenge. Furthermore, health workers increasingly are held accountable for and are expected to be transparent about the outcomes of their work (e.g. Exworthy *et al.*, 2019; Genovese *et al.*, 2017). Although this trend is generally expected to lead to improved results, for medical professionals it also creates a sense of being under constant scrutiny. The emotions and feelings that are triggered in these kinds of processes have a substantial impact, which is acknowledged by both management practitioners and social scientists working in health care (e.g. Kent, 2006; Mark, 2005; Sebrant, 2014). In this case study, emotions and feelings are addressed by adopting a specific cultural psychological perspective. Cultural psychologists Paul Voestermans and Theo Verheggen (2013) call for more detailed psychological investigations into how people acquire embodied skills and mannerisms that are in line with professional demands, preferences and tastes. When emotions and feelings are felt or displayed, this is seen as an indication that something “real” is at stake that deeply involves professionals into their group, department or speciality. This paper demonstrates that this deep involvement can affect the success or failure of a change initiative, in this case the introduction of new surgical suture material in the operating theatre. This affective aspect may be underestimated in change management or only addressed in rather abstract fashion; by prematurely explaining resistance to change with the help of notions as professional autonomy, entitlement, stubbornness, culture and so on. The epistemological problem of discursively turning a descriptive label into an explanation or operational determinant of behaviour has been addressed particularly by discursive psychologists (e.g. Potter and Wetherell, 1987, 1995a) and cultural psychologists (e.g. Valsiner, 2014; Verheggen, 2005; Verheggen and Baerveldt, 2007). Although the concerns in this paper are practical and empirical, they can be traced back to the same problem. In management practice, and especially in the management of medical professionals, certain abstract characterizations of behaviour and change resistance can become problematic when they are no longer just employed as general, imprecise descriptions, but are reified and employed as stopgaps. As such, they preclude deeper and more detailed investigations into what is at stake for the people behind these abstractions. The added value of the approach adopted in this case study is that it does not need the reification and superimposition of notions such as shared values, culture or even professional autonomy, but allows for more holistic, or contextualized investigations into the social patterning of behaviour within professional groups or specialities. Truly delving into the tenacity of certain medical professional practices goes further than positing professional autonomy or entitlement as a cause, for instance. Earlier, this particular cultural psychological approach has successfully been adopted to describe psychological dynamics within the boardroom of a large healthcare organization (Graamans *et al.*, 2014) and, more recently, to better understand and contribute to more effective interventions against the culturally embedded practice of female circumcision (Graamans *et al.*, 2019a, 2019b).

The case: resistance to new surgical suture in the operating theatre of a Dutch hospital

At the end of 2014, a large university hospital in the Netherlands launched a procurement tender exercise for surgical suture material. The rationale for hospital management to initiate this procedure was cost-cutting and standardization. The award criteria were focussed on the

most economically advantageous tender. There were different suppliers on the market that were able to produce and deliver high-quality surgical suture material for a lower price than was currently being paid. Consequently, the tender was awarded to a new supplier. The top managers and purchasing manager who initiated the tender trod carefully and implemented this relatively small-scale change initiative according to some basic change management principles (e.g. Kotter, 2012): they built a guiding coalition that incorporated renowned medical specialists, they consulted department heads and they communicated the change to surgeons through different channels. Furthermore, it was recorded in the tender that the new supplier should provide value-adding services such as e-learning modules for surgeons, facilitate lengthy trial-use periods and offer workshops and support to the operating theatre. Hospital management conceived this first initiative as a test case for more extensive cost-cutting operations that were to follow. This project was supposed to be relatively easy, both in scale and in complexity. However, in the preparations ahead of the trial phase, a concern was raised by the cardiac surgeons to one part of the tender package involving sutures specifically used for cardiac surgery. Nevertheless, surgeons were forced to participate in testing the products supplied in the whole tender, including those products used in their specific specialities. Meanwhile, the initiators of the project felt that careful preparations of the testing phase had been made.

So, what went wrong? In mid-2015 – when this research project started – hospital management eventually met with fierce resistance from some of the hospital’s cardiothoracic surgeons. They adamantly refused to work with the new suture material. The resistance took the form of surgeons expressing anger at management, stockpiling their own supplies of surgical suture, refusing to operate, holding managers accountable for patient deaths that could arise from use of the new suture and threatening to go to the press if such a thing indeed were to happen. Hospital management had anticipated some resistance, but not of this intensity. The end result was that the contract was eventually cancelled for sutures specifically used in cardiac surgery.

This research paper sets out to answer the following question: why are some medical professional practices so difficult to change, and what can we learn from this failed test case?

Theoretical background

As mentioned earlier, to better understand the entrenched nature of professional practices and the emotional stakes involved, we adopted a particular cultural psychological perspective. Following Voestermans’ and Verheggen’s approach (2013), we explicitly take the position that people are embodied and expressive beings who over time attune their emotions, feelings, preferences and tastes to the groups they belong to. People naturally feel more compelled to act in accordance with these preferences than to act upon abstract ideas, rules and protocols superimposed upon them from outside their group. Evidently, medical professionals are not exempt from feeling more compelled to act in accordance with these preferences just because they are a highly educated group of people. To the contrary, as a result of being members of their professional group for so long – through medical school, surgical residency, PhD studies and so on – they have learned to coordinate their actions on the basis of complex sets of agreements, conventions and arrangements that characterize their professional group.

Whereas agreements are easy to articulate, such as taking an oath, Voestermans and Verheggen (2013) reserve the term “arrangement” for the way members of exclusive and often elite groups coordinate their behaviour almost automatically within their own specifically cultivated environments, following deeply embodied patterns. These patterns and practices are group-typical due to the mutual attunement of emotions, feelings, preferences and taste that has taken place over time. The resulting automaticity makes that

they do not need articulation, whereas practices based on agreements do. Evidently, medical professionals have practices founded on highly specialized scholarship and evidence-based research. But it is a mistake to think of their work as a purely cognitive, rather mechanistic affair. These practices are enacted and reenacted in the minutest interactions on an ongoing basis, and get more refined over time, until at one point they are felt and experienced more than that they are talked *about*. It is predicted that groups formed on the basis of such arrangements are particularly difficult to change. The apprehension that is triggered by attempts to change even the smallest element of such an arrangement is immediately felt.

Method

Data collection

Data collection took place in a year starting from mid-2015. In total, 17 in-depth interviews were conducted that each lasted approximately 1 h. The respondents were targeted through maximum variation sampling until saturation was achieved and are listed in [Table I](#). Patients were excluded beforehand. The interviews were audio-recorded after verbal consent was given. All but one interviewee agreed to be audio-recorded. This interviewee was comfortable, though, with the interviewer (EG) taking notes. The interviews were transcribed and anonymized. Apart from formal interviewing, extensive informal conversations on the topic took place with surgeons from different medical specialities.

Field notes were made on the observations of a trial session and a workshop facilitated by the new supplier. These notes were divided into four categories: observational notes, theoretical notes, methodological notes and reflective notes ([Baarda et al., 2013](#)).

Data analysis

To gain an understanding of the different positions people can take up in relation to the introduction of new surgical suture and underlying social arrangements, the interview transcripts were analysed by means of discourse analysis following the example and guidelines of critical psychologist Carla [Willig \(1998, 2008\)](#). Her particular approach to discourse analysis was chosen because it allows for a discursive psychological reading of the interview transcripts whereby interviewees as active agents justify, blame, excuse, request or obfuscate to achieve some objective: the “action orientation” of talking ([Edwards and Potter, 1992, 2001](#); [Potter and Wetherell, 1995b](#)). Her approach also allows for a more Foucauldian, or post-structuralist reading whereby inferences are made on how the discourses interviewees

Professional role	Number
Vascular surgeon	1
Cardiothoracic surgeon	3
Trauma surgeon	1
Unit leader, operating theatre	1
Nurse, operating theatre	2
Nurse anaesthesiologist	1
Legal specialist	1
Purchasing manager	1
Head of operating theatres	2
Department head, cardiac surgery	1
Department head, surgery	2
Chairman of the Board	1
Total respondents	17

Table I.
Respondents targeted
through maximum
variation sampling

draw upon delimit and facilitate behavioural opportunities and experience (Davies and Harré, 1990, 1999; Henriques *et al.*, 1984; Parker, 1992). The latter approach assumes that discourses, on the one hand, and practices, on the other, are closely tied and reinforce each other. Discourse from this perspective is not so much a matter of talking *about* things, but is conceived as an expressive practice in itself. Conceptualized as such discourses can hint at underlying social arrangements in which certain practices, such as operating with tangible surgical suture material, are performed. To come to such a conclusion with a greater amount of certainty, we contend, the inferences made on the basis of discourse analysis must always be triangulated with data from participant observations and cross-checked with key informants.

In October 2017, the findings were tentatively fed back to the management board in a plenary session and to department heads in several individual conversations. Extensive peer debriefing sessions within our multi-disciplinary research team in which both the medical professional and managerial perspectives were represented by its members took place to help with cross-checking and interpreting the data.

Results

Conducting discourse analysis (Willig, 2008) on the interview transcripts revealed several discourses that interviewees drew upon when they talked about the transition to working with the new surgical suture and surgical suture more generally. The main constructions, discourses and implications in relation to the interviewees themselves – in discourse analytic terms called “subject positions” – are summarized in Table II.

Economic/managerial discourse

Transitioning to new surgical suture was often constructed by members of the hospital management as a test case for more extensive cost-cutting operations to follow:

We are confronted with an enormous challenge. We have to drastically cut costs. This was an important test case, because more and bigger cuts are pending. This appeared to us as an easy win. However, . . . [1]. (Head of operating theatres)

This construction is embedded in an economic discourse that provides a legitimate rationale for the change. A prerequisite for providing sustainable, high-quality health care is a financially healthy position. Some managers were genuinely astounded by how inefficient the current purchasing policies of the hospital were. Often managers posited the professional autonomy of medical surgeons as the main barrier to change. Other perceived barriers to change were constructed in ways that characterize particular professional roles. The purchasing manager, for example, typically suggested another barrier:

Construction of suture	Discourse	Subject position	Pro or counter
Debit item, case, project	Economic/managerial	Bookkeeper/strategist	Legitimizes change
Tennis racket, extension of fingers	Competitive/professional	Skilled professional	Counter-discourse
Lifeline	Patient care	Patient's advocate	Counter-discourse
Risk, life or death	Safety/quality	Responsible actor ↔ culprit	Counter-discourse

Table II. Summary discursive constructions, discourses and subject positions

Not only with surgical suture, but in general medical specialists resist change. That is because these suppliers have a powerful and very effective sales force. It is what we call *vendor lock-in*. (Purchasing manager)

As evident in the aforementioned quotation, depending on the formal positions participants took up in this change initiative, they came up with their own hypotheses of why they thought new surgical suture was resisted by medical professionals. In another instance, a proponent of the initiative to replace surgical suture suggested people were being overly emotional:

I get that those boys [cardiothoracic surgeons] . . . what they are doing is very precise and technical. And surgical suture and needles are of crucial importance. On the other hand, there are always these sentiments. I mean, there are many medical centres, also abroad, where cardiothoracic surgeons suture with XXX [brand name of new supplier] and it is not turned into a complicated affair. But you cannot take away these sentiments just like that. We took note of these feelings, and nudged our staff to give it [the new surgical suture] a try and comply as much as possible. But to be honest, according to me at cardiac surgery there is a lot of emotion involved surrounding suture, . . . and it is not working for me. (Department head, surgery)

However, some surgeons, especially cardiothoracic surgeons, presented other considerations as motivating their unwillingness to change, using arguments of quality of the new sutures:

The initiator – the manager that came up with the idea to supposedly cut costs – does not know that suture curls and curls more-or-less depending on the brand. He does not know whether needles are round or angular. And he doesn't care. But for my work this is very relevant. It has nothing to do with professional autonomy. (Cardiothoracic surgeon)

One might argue with this cardiothoracic surgeon that this is exactly what the notion of professional autonomy refers to; in this case, the autonomy to decide for yourself, as a medical professional, which materials to work with. But that is not the point this cardiothoracic surgeon is making *per se*. Apparently, in the daily jargon of healthcare managers, the notion of professional autonomy is employed as a stopgap explanation for resistance so often that this surgeon anticipated its negative connotation related to changing surgical suture and change more general. For him at least, the superimposition of professional autonomy as an explanation does not do justice to how he relates to the issue of changing surgical suture. For him it is not an abstract affair, but genuinely felt, both in a tactile and in an emotional sense. Also note that academic definitions of professional autonomy (conceptual) do not always correspond to how such notions are employed in daily usage (performative). The cardiothoracic surgeons spoken to frequently drew upon a competitive/professional discourse in relation to surgical suture, enriched with examples and in far less abstract manner than those that posited professional autonomy as the main cause of change resistance.

Competitive/professional discourse

In formal interviews and casual conversations with surgeons, the comparison with practicing sports – and the physicality that characterizes both practicing sports and conducting an operation – was frequently made. One cardiothoracic surgeon compared his surgical suture to the shoes of soccer player Zlatan Ibrahimović. Another surgeon name-dropped a famous tennis player in the following manner:

He [Roger Federer] goes down in the history books as the best professional tennis player ever. And that is because he has spent endless hours on the court practising and refining his skills. His tennis racket has become a natural extension of his arm. His tennis racket is his instrument. My instrument is my suture . . . suture and needles. (Cardiothoracic surgeon)

Whilst conversing with surgeons, it became evident that performing cardiothoracic surgery is perceived as practicing a top-level sport. It is both physically and mentally challenging,

only the stakes involved are much higher. Surgical suture is embedded within an arrangement that specifically characterizes members of the cardiothoracic speciality. As such, attempting to change or replace this single tactile element feels like tearing down the entire arrangement. It might seem a bit far-fetched or exaggerated, but the emotions and feelings that were triggered by pushing forward with this initiative were real and so were the consequences of attempting to bypass these emotions and feelings. One cardiothoracic surgeon detailed his professional involvement in the following manner:

I didn't just go to medical school. After that I have done my residency, with a Ph.D., *et cetera*. All in all an extra 10 years. Everything that you are supposed to do, I did that, to become the best possible professional and to be able to deliver the best possible care for the patient. This is not some quick course. This is really . . . six years of medical school and then postgraduate for another six years. That isn't nothing. You have to be motivated, driven and persistent. And you hope to end up working for an institution that enables you to profess your passion. (Cardiothoracic surgeon)

It is important to note that the cardiothoracic surgeons quoted here did not exclusively draw upon this competitive/professional discourse that implies sacrifice, persistence and drive. But when they did, they challenged the economic/managerial discourse without actually talking about finances. In a way, to put it bluntly, money from this perspective should not be an object, or, at least, it should never be a priority.

Discourse on patient care

It would be too one-sided to emphasize the aforementioned competitive/professional discourse that the surgeons frequently drew upon without pointing out another manner in which surgical suture was spoken about. During the interviews and casual conversations with surgeons, it became evident that the well-being of their patients was a primary concern. One cardiothoracic surgeon positioned himself as the patient's main advocate – as opposed to hospital managers, who only maintain quality in a more general, abstract manner – by asking the following rhetorical question:

Let's say . . . I am going to operate your father with XXX [brand name of new supplier], but I am not used to working with that suture. It curls more and the needles go blunt quicker and the needles are square and therefore more difficult to position in the needle holder. So I need to focus more and I need to stress . . . I need to work [with the utmost precision]. Well, I am curious whether that manager would let me operate on his father. (Cardiothoracic surgeon)

Surgical suture was constructed as a lifeline on which the cardiothoracic surgeon relies on behalf of the patient. Replacing surgical suture is perceived as an unacceptable potential cause of failure. So whereas the competitive/professional discourse places the concerns and aspirations of the medical professional front and centre, this discourse on patient care places the concerns of the patient front and centre by means of the medical professional as his advocate. Implicit in both discourses, though, is that money should not be an object. As such, these discourses are counter-discourses to the economic/managerial discourse that legitimizes replacing surgical suture by that of a cheaper brand.

Discourse on safety and quality

Related to the aforementioned construction of surgical suture as a lifeline located within a particular discourse on patient care is the construction of surgical suture as a risk factor. This construction is located within a slightly different discourse on safety and quality, because it relates to health authorities, medical trials, accountability, transparency, statistics, performance measures, institutional reputation, safety and quality management rather than to direct and personal involvement with the patient. The direct relationship between the

surgeons' handicraft and the possibly life-threatening consequences inherent in cardiac surgery amplifies the sensitivity of the subject.

So many things can go wrong. So changing surgical suture presents an additional risk. We prefer to operate a patient's heart only once and then never again. (Cardiothoracic surgeon)

When a medical professional draws upon this discourse, it provides a strong counter-discourse to the economic argument that is more frequently used by those working in hospital management. The Chairman of the Board, even though he formally has the power to push forward, by now has realized he had reached the limits of changeability:

If medical specialists use the argument of safety, patient safety, then you are finished. As an executive it is over. You start thinking, what if he is right; and I force him to work with this suture and something goes horribly wrong. He only has to say: "I told you it wasn't safe!" And then you, as an executive, are gone. Of course, you have to challenge and not be naive, but ultimately it is a show stopper . . . that safety argument. Another factor was, that my colleague in the Executive Board and I are not [cardiothoracic] surgeons. So we could not weigh in from our own experience. (Chairman of the Board)

The best of the best: being part of an elite professional group

Among the surgeons of different specialities, the cardiothoracic surgeons stood out amongst those interviewed in this case study. A theatre nurse prided herself on being a member of this elite group in the following manner:

Those boys [cardiothoracic surgeons] – or men I should say – are so bloody good in what they do. And you [as a nurse operating theatre] also want to be part of that, to pass *cum laude*. They stand for their profession, each time they give it a hundred and ten percent. And they perform procedures that no one else dares to perform. For us it is a joy to assist them. You share in the pride and get into that special workflow. (Nurse, operating theatre)

The Chairman of the Board had learned that in dealing with different professional groups, especially when they are tightly-knit and its members have unique histories, training, skills and responsibilities, one does better to adopt a contextualized approach to change:

Well, our group of cardiac surgeons consists of individuals with a unique history at this hospital. They are not known to be particularly dynamic or flexible. Let's keep it at that. So, to get them on board with our plans requires some extra effort on our part. (Chairman of the Board)

The following account of a cardiothoracic surgeon exemplifies just how difficult it is to understand the actual practice of operating on someone's heart.

I have studied and practiced endlessly. And we [other cardiothoracic specialists] frequently consult one another. But sometimes when I have to decide fast, during a very complex operation, medicine is almost more like an art-form. I feel when something might go wrong and I anticipate what to do. And when someone later asks me: "Why did you do this or that?", of course I will formulate an answer, but in reality I acted upon the experience I have and on what I have learned from my mentors. In these moments everyone in my team knows what to do. I do not even have to tell them. However, I cannot accept that someone who has no idea what we are doing, decides that I have to work with that suture. (Cardiothoracic surgeon)

The prediction that deeply embodied practices that are learned over time through mentorship, explicit instruction and implicit attunement of the senses are not to be changed by outsiders in a pick-and-choose manner (e.g. [Voestermans and Verheggen, 2013](#)) is confirmed by this surgeon.

Discussion

As Willig noted: "It is important to examine the relationship between a source's and a recipient's discursive frames in order to understand the impact of a message" (1998, p. 385).

This paper is not intended as a reproach to either hospital management or those working within the cardiac surgery department. On the one hand, hospital management was faced with the challenge of cutting costs and making the provision of good health care sustainable. On the other hand, cardiothoracic surgeons were trying to keep the environment of the operation room as controlled and predictable as possible. They do not want any additional risks, especially if they feel that the risks have been imposed upon them. Just the fact that the new surgical suture had slightly different qualities – on which everyone agreed – made it an unacceptable change for the surgeons. Both perspectives make sense and, surprisingly, almost all research participants were able to eloquently elaborate on the opposing perspectives. However, it appeared as if the emotions and feelings that were immediately triggered within particular arrangements prevented the research participants from acting upon those insights. The result was a power struggle, and eventually management gave in to the cardiac surgeons by accepting a different supplier.

The failure described probably could have been prevented if those who initiated the change and implemented the transition had accounted for the particular social arrangements in which surgeons from different specialities operate. It could probably also have been prevented if the emotions and feelings that were expressed were acted upon in a timely manner, instead of being dismissed by implicitly juxtaposing emotional expression against rational decision-making. Cardiothoracic surgeons constitute a group with a distinct history and responsibility and to whom surgical suture is a crucial tool. Suture as a tactile element in their day-to-day work environment is embedded within a complex social arrangement that ties elements of risk avoidance, professional accountability and direct patient care together in a way that *feels* secure. The feelings triggered within this arrangement are genuinely felt and, therefore, are as real as the financial cost of surgical suture and evidence-based standards of its quality. These feelings need to be accounted for with the same managerial fervour. For hospital management this means that in planning a consistent overall approach to change in their institution, they must consider exceptions to that approach. It might be an uncomfortable message, but managers here to some extent reached the limits of changeability; the thinnest of sutures used to operate on people's hearts are beyond their reach, so to speak.

There are other aspects that need to be accounted for, that fall beyond the immediate scope of this research, but which nonetheless need to be mentioned to give a more complete picture. First, the main channel by which hospital management communicated about the tendering procedure, the verification process, the actual introduction, trial sessions and workshops was by email. One surgeon confided that he was too busy to systematically go through his emails and, due to a recent reorganization, had lost his personal secretary. The annoyances arising from different cost-cutting operations were thus accumulating. Secondly, although hospital management assumed that it had adequately communicated about and during the transition to new suture, some surgeons felt being presented with a *fait accompli*. Management had failed to ensure that the surgeons had received the necessary communications, and the surgeons did not acknowledge that they had indeed received them. This led to miscommunication and to further polarization. This was especially relevant because cardiothoracic surgeons had previously mentioned their concerns about the use of specific cardiac surgical sutures and were nevertheless then confronted with the new suture. The surgeons felt overpowered and had the impression of not being listened to. This resulted in some cardiothoracic surgeons deciding to present hospital management with a *fait accompli* in return by framing suture as a life-or-death matter and making the management responsible for the possibility of bad results that could be related to the sutures. Lastly, because of this escalation, emotions ran even higher, and interviewees on both sides frequently blamed each other for not having their facts straight. Change practitioners would do well to acknowledge these emotions and feelings, without dismissing them or juxtaposing them against reason

and facts. It is a big mistake to view addressing feelings and emotions as simply the “soft” side of change management (see also: [Steigenberger, 2015](#)) or to superimpose labels on them too quickly.

In conclusion, we have demonstrated that even if all basic principles of change management have been applied in the usual way, procedures may escalate to an emotional level, eventually leading to a counterproductive deadlock. These emotions and feelings should be anticipated by thorough communication between all parties involved. Should they still arise, these emotions need to be accounted for and acted upon bilaterally in a non-judgemental and empathic manner to make informed decisions about pushing forward with a change initiative and, if so, guide its further implementation.

Disclosure statement

No potential conflict of interest was reported by the authors.

Notes

1. The quotations are translated as the interviews were conducted in Dutch.

References

- Andri, M. and Kyriakidou, O. (2014), “Professional autonomy under pressure: towards a dialectical approach”, *Journal of Health Organization and Management*, Vol. 28 No. 5, pp. 635-652.
- Baarda, B., Bakker, E., Fischer, T., Julsing, M., Peters, V., Van Der Velden, Th. and De Goede, M. (2013), *Basisboek Kwalitatief Onderzoek: Handleiding voor het Opzetten en Uitvoeren van Kwalitatief Onderzoek*, 3rd ed., Noordhoff Uitgevers, Groningen/Houten.
- Davies, B. and Harré, R. (1990), “Positioning: the discursive production of selves”, *Journal for the Theory of Social Behaviour*, Vol. 20 No. 1, pp. 43-63.
- Davies, B. and Harré, R. (1999), “Positioning and personhood”, in Harré, R. and Van Langenhove, L. (Eds), *Positioning Theory*, Blackwell, London, pp. 32-52.
- Dent, M. and Pahor, M. (2015), “Patient involvement in Europe: a comparative framework”, *Journal of Health Organization and Management*, Vol. 29 No. 5, pp. 546-555.
- Edwards, D. and Potter, J. (1992), *Discursive Psychology*, Sage, London.
- Edwards, D. and Potter, J. (2001), “Discursive psychology”, in McHoul, A.W. and Rapley, M. (Eds), *How to Analyse Talk in Institutional Settings: A Casebook of Methods*, Continuum International, London, pp. 12-24.
- Exworthy, M., Gabe, J., Jones, I.R. and Smith, G. (2019), “Professional autonomy and surveillance: the case of public reporting in cardiac surgery”, *Sociology of Health and Illness*, Vol. 41 No. 6, pp. 1-16.
- Genovese, U., Del Sordo, S., Pravettoni, G., Akulin, I.M., Zoja, R. and Casali, M. (2017), “A new paradigm on health care accountability to improve the quality of the system: four parameters to achieve individual and collective accountability”, *Journal of Global Health*, Vol. 7 No. 1, 010301.
- Graamans, E., Millenaar, L. and ten Have, W. (2014), “Dynamieken binnen het topmanagementteam van een grote zorgorganisatie: een cultuurpsychologisch perspectief”, “[Dynamics within the executive board of a large healthcare organization: a cultural psychological perspective]”, *Management and Organisatie*, Vol. 68 No. 3, pp. 22-42.
- Graamans, E., Ofware, P., Nguura, P., Smet, E. and ten Have, W. (2019a), “Understanding different positions on female genital cutting among Maasai and Samburu communities in Kenya: a cultural psychological perspective”, *Culture, Health and Sexuality*, Vol. 21 No. 1, pp. 79-94.

- Graamans, E., Smet, E. and ten Have, S. (2019b), "Legislation against girl circumcision: a cultural psychological understanding of prohibition", *Sexual and Reproductive Health Matters*, Vol. 27 No. 1, pp. 1-3.
- Henriques, J., Holloway, W., Urwin, C., Venn, C. and Walkerdine, V. (1984), *Changing the Subject: Psychology, Social Regulation and Subjectivity*, Methuen, London.
- Jenkner, E. and Leive, A. (2010), *Health Care Spending Issues in Advanced Economies*, International Monetary Fund, Washington, DC, available at: <https://www.imf.org/external/pubs/ft/tnm/2010/tm1016.pdf> (accessed 5 May 2019).
- Kennerley, J.A. (1993), "Professional autonomy in the medical field", *Journal of Management in Medicine*, Vol. 7 No. 2, pp. 43-47.
- Kent, T.W. (2006), "Leadership and emotions in health care organizations", *Journal of Health Organization and Management*, Vol. 20 No. 1, pp. 49-66.
- Kirkpatrick, I., Ackroyd, S. and Walker, R. (2005), *The New Managerialism and Public Service Professions: Change in Health, Social Services and Housing*, Palgrave Macmillan, London.
- Kotter, J.P. (2012), *Leading Change*, Harvard Business Review Press, Boston, MA.
- Mark, A. (2005), "Organizing emotions in health care", *Journal of Health Organization and Management*, Vol. 19 Nos. 4/5, pp. 277-289.
- Mot, E., Stuut, K., Westra, P. and Aalbers, R. (2016), "CPB achtergronddocument: een raming van de zorguitgaven 2018-2021", Centraal Planbureau, The Hague, available at: <https://www.cpb.nl/sites/default/files/publicaties/download/cpb-achtergronddocument-30mrt2016-een-raming-van-de-zorguitgaven-2018-2021.pdf> (accessed 9 May 2019).
- Parker, I. (1992), *Discourse Analysis: Critical Analysis for Social and Individual Psychology*, Routledge, London.
- Potter, J. and Wetherell, M. (1987), *Discourse and Social Psychology: Beyond Attitudes and Behaviour*, Sage, Thousand Oaks.
- Potter, J. and Wetherell, M. (1995a), "Natural order: why social psychologists should study (a constructed version of) natural language, and why they have not done so", *Journal of Language and Social Psychology*, Vol. 14 Nos. 1-2, pp. 216-222.
- Potter, J. and Wetherell, M. (1995b), "Discourse analysis", in Smith, J.A., Harré, R. and Van Langenhove, L. (Eds), *Rethinking Methods in Psychology*, Sage, London, pp. 80-92.
- Sebrant, U. (2014), "Emotion, power and identity. Emotional display of envy when taking on management roles in a professional hierarchy", *Journal of Health Organization and Management*, Vol. 28 No. 4, pp. 548-556.
- Steigenberger, N. (2015), "Emotions in sensemaking: a change management perspective", *Journal of Organizational Change Management*, Vol. 28 No. 3, pp. 432-451.
- Thistlethwaite, J. and Spencer, J. (2008), *Professionalism in Medicine*, CRC Press, London.
- Valsiner, J. (2014), "Needed for cultural psychology: methodology in a new key", *Culture and Psychology*, Vol. 20 No. 1, pp. 3-30.
- Verheggen, T. (2005), "Culture alt delete: on the misperception of culture in psychology", doctoral dissertation, available at: [https://www.ou.nl/Docs/Faculiteiten/PSY/Onderzoek/Dissertation%20Theo%20Verheggen_Full%20Version%20\(Final\).pdf](https://www.ou.nl/Docs/Faculiteiten/PSY/Onderzoek/Dissertation%20Theo%20Verheggen_Full%20Version%20(Final).pdf) (accessed 15 February 2019).
- Verheggen, T. and Baerveldt, C. (2007), "We don't share! the social representation approach, enactivism and the ground for an intrinsically social psychology", *Culture and Psychology*, Vol. 13 No. 1, pp. 5-27.
- Voestermans, P. and Verheggen, T. (2013), *Culture as Embodiment: The Social Tuning of Behavior*, John Wiley & Sons, Malden, MA.
- Willig, C. (1998), "Constructions of sexual activity and their implications for sexual practice: lessons for sex education", *Journal of Health Psychology*, Vol. 3 No. 3, pp. 383-392.

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