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Katherine C. Kellogg
Create Relational Spaces for
Transformational Change

Research Symposium

GENDER & WORK:

CHALLENGING CONVENTIONAL WISDOM

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GENDER & WORK.

CREATE RELATIONAL SPACES FOR TRANSFORMATIONAL CHANGE

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A few years ago, I had a remarkable experience. I put on scrubs and a surgical face mask and tagged alongside surgeons for 2 1/2 years as they performed their various tasks, following them into the OR and even staying overnight in the hospital when they were on call. The reason I did this is because hospitals were being required to make a change that challenged their traditional organizational hierarchy and I wanted to see which ones were successful doing this and why.

As I've studied organizational change over the last 15 years, I've learned that there are two kinds of changes organizations make: the first kind of change is change that can be accomplished within the current organizational hierarchy; the second kind of change requires a radical disruption of this hierarchy. Making change that advances women in organizations is this second kind of change.

It turns out that we know much less about this second kind of change, the radically disruptive kind, than we know about the first. And this is a problem. If top managers who want to accelerate the advancement of women try to apply traditional leadership lessons to implementing this second kind of change, they are going to fail, because the barriers to radical change are different and the ways of successfully accomplishing it are different. Today, I want to tell you what I have learned about accomplishing transformational change.

The change I studied began in the late 1980s when Libby Zion, a college freshman, died unexpectedly in a New York hospital after being given the wrong medication by a medical resident who had been on call the night before, so had been working for over 19 hours. Residents are doctors who have finished medical school and are undergoing hands-on training in hospitals before going out to practice on their own. Patient safety activists got together and mobilized resources for a change in resident work hours. They succeeded in winning reform that required surgical residents to work only 80 hours a week.

You may ask, "What do you mean, ONLY 80 hours???" Before this, residents worked much longer hours. In surgery, junior residents were working 120 hours a week: 6 days a week from 4 a.m.to 9 p.m. plus two nights a week overnight on call. To reduce residents' working hours to 80 hours per week, hospitals across the U.S. created separate teams—called night float teams—which worked overnight on call. By eliminating hours residents historically spent overnight on call, their overall working hours were reduced.

But implementing this change was not simple. Years and years of research had yielded this piece of conventional wisdom: the best way to effect this sort of change was to have top managers involve both supporters of the reform and defenders of the status quo in planning and implementing change, getting the two groups together to negotiate a solution amenable to both.

What I found was just the opposite. I found that when the change that needs to be made disrupts the longstanding organizational hierarchy, top managers should not bring supporters and

defenders together but should keep them apart. This is a crucial point for top managers who want to make change to advance women in organizations.

As I will show you, to make this kind of disruptive change, supporters of change must have their own separate meeting spaces—what I call "relational spaces"—that allow them to work across different positions amongst themselves and apart from defenders so that they can build a committed group for change. Relational spaces play a critical role because supporters of change are often uncomfortable trying out new tasks, playing new roles, or discussing non-traditional ideas when defenders of the status quo are present, for fear of retaliation.

Here's how I learned about the importance of relational spaces. I found that one of the hospitals I studied (which I will call Advent) successfully implemented the reform while the other hospital (which I will call Bayshore) did not. In order to reduce work hours, both hospitals introduced "night float teams." Under this new system, junior residents handed off any work not completed by 6 p.m. to the night float team; they did not return to the hospital until 6 a.m the next morning, and they were rarely on-call overnight.

You would think that everyone would embrace this new system as a win-win situation: juniors were no longer exhausted by their 120-hour workweeks and patients were less likely to be endangered by half-awake juniors. And yet, surprisingly, these reforms were initially resisted at both hospitals and resisted so vigorously that in the end the reforms were successfully implemented at only one. How can we account for this extraordinary outcome?

To understand why defenders of the status quo at both hospitals so strongly resisted these seemingly straightforward changes, it is necessary to understand how reform practices ran counter to the traditional identity and status hierarchy in surgery. Historically, surgical residents were expected to be male, individualistic, and single-mindedly focused on work. They demonstrated these characteristics by performing the role of "iron men," "trusting no one" and "living in the hospital." Even though most residents did not always act out all of these idealized characteristics, such behaviors were used to measure performance and they were associated with the highest status in surgery.

Iron Men (as they identified themselves when they described the long weekends on call that only surgical residents engaged in as "iron man weekends") at each hospital aspired to be seen as "go-to guys" with "nerves of steel" who were "unflappable" under pressure. Iron Men were tough enough to work longer hours than any other resident in the hospital; one of their favorite sayings was "pain is just weakness leaving the body." They used battle and war metaphors repeatedly, talking about "rescue missions" and "victories" in the OR. Here is a compilation of their favorite sayings, all of which emphasize decisive action, risk-taking, and toughness:

"Often wrong, but never in doubt." "If you wanna make an omelet, you gotta break some eggs." "Everyone makes mistakes—that's why it's a seven-year program." "Don't let the skin get between you and the diagnosis." "The only prescription this patient needs is hot lights and cold steel." "It's showtime." "Giddyup." "Got it covered." "Fire it up and bring it on."

In addition to Iron Man identity, surgical residents also had the identity of individualistic hero. One saying I heard over and over from Iron Men was "trust no one, expect nothing, suspect sabotage." Taking individual responsibility meant never handing off work to anyone. Residents were expected to avoid the help of physicans' assistants and to discount the input of nurses and other physicians when making their decisions. One staff surgeon said: "You do everything there is to take care of that patient, and you do it yourself. You don't expect anyone else to do it for you."

Finally, Iron Men were expected to be intensely committed to their work. They accepted without question the schedules and vacations they were given and prided themselves on "living in the hospital." They asserted that their "fellow residents were their family" and rarely mentioned caring about others outside of the hospital. Instead, they constantly boasted about breaking commitments with disaffected wives and significant others.

This persona of the Iron Man has its roots in the early history of the profession. In a time when hygienic conditions were atrocious and when medical cures and techniques were primitive, lives often hinged on the heroic actions of such individualistic, hypercommitted male surgeons. In spite of all the advances of modern medicine, because surgical residency has been designed to produce action-oriented male heroes who single-handedly perform death-defying feats and courageously act with certainty in all situations, this image of the ideal surgeon has not only survived into the present, but continues to flourish.

Historically, residents who have acted as individualistic males with a single-minded focus on work have occupied a high position not only in the status hierarchy of surgery, but also in the medical profession and in society as a whole.

The Iron Man identity (an identity equally pervasive at both hospitals) and the power and prestige that had historically been associated with it help explain why some residents resisted a change that seemed to be designed to benefit them. At each hospital, defenders of the status quo were composed primarily of chief and senior male residents who were able to accomplish most of the actions required to live up to the Iron Man ideal. Because they were single or had wives or girlfriends who were willing to cook for them, do shopping and housecleaning, provide childcare, and put up with frequent last-minute cancellations of social plans, these residents were able to differentiate themselves from others by demonstrating the key behaviors that counted for high performance in surgical residency: maleness, individualism, and intense commitment to work.

While, historically, demonstrating high performance had required residents to individualistically accomplish work and be the first ones there and the last to leave, under reform, demonstrating high performance required residents to accomplish work as a team and leave the hospital at the end of the day. The reform thus challenged the traditional measures of performance that had allowed these chief and senior Iron Men to distinguish themselves from others. Thus, the reforms threatened to take away their hard-won status and the privileges associated with it.

But despite this strong Iron Man culture, there were many who did not buy into the traditional surgical beliefs, identity, and hierarchy. I call them reformers. At both hospitals, reformers were composed of residents who held inferior positions in the surgical social world or who had other social identities that conflicted with the Iron Man role and privately questioned traditional practices. Given time constraints, I won't go into details, but the groups who supported reform were both the junior residents—who had not yet been socialized into surgical beliefs—and people who did not fit the Iron Man persona, people such as female residents and male residents with families.

When the new programs were introduced, for a very brief period, juniors at both hospitals tried to hand off routine work to night floats. But very quickly, defenders of the status quo at both hospitals dissuaded junior residents from further handoff attempts. Defenders emphasized the traditional Iron Man identity during signout, rolling their eyes when a junior tried to hand off the checking of tests or films and insulting them with gendered insults such as "weak," "softie," "part-timer," "wuss," "namby-pamby," and "girl." Defenders also retaliated against reformers who attempted change by gossiping about them to staff surgeons and by berating junior residents in what are called "beatings." One senior resident described how he delivered these "beatings:"

"You do the screaming for the effect with others rather than for that individual. You want to draw attention to the fact that 'Moron is over here.' Now, if I'm with a resident one on one, there's no point in me elevating my voice and being like 'Moron's over here.' Then, it's more like 'Listen you knucklehead, you're really fucking up, and you need to get your shit together because I'm not going to tolerate this anymore."

And so, cowed by the defenders' superior positions in the surgical hierarchy, juniors at both hospitals stopped attempting handoffs.

But after this initial defeat by defenders, reformers at Advent rallied and began to build coalitions to challenge the status quo. They were so successful that, in the end, they were able to put the reforms into place. At Bayshore, reformers never overcame the challenge of the defenders, and reform failed. Why was this so?

Advent was successful because, unlike Bayshore, Advent had relational spaces—spaces where, isolated from defenders, reformers could meet face-to-face and challenge the Iron Man culture by trying out new tasks, playing new roles, and discussing non-traditional ideas without fear of retaliation.

At both hospitals, residents on each service gathered together every evening for "afternoon rounds" to review the patient care that had been carried out that day by the juniors. At Advent, afternoon rounds on services staffed fully by reformers provided isolation from defenders because only residents assigned to the service were present in the room. Advent chiefs assigned to particular services had their favorite places to meet, such as conference rooms or quiet areas of patient floors, and, crucially, these areas were "private" in the sense that the staff could meet without being overheard by defenders. In order for a space to be a relational space, it needed to be isolated from defenders of the status quo, it needed to allow for face-to-face interaction, and it needed to include all team members. Spaces like separate conference rooms and even quiet hallways served as relational spaces as long as they met these three criteria of isolation, interaction, and inclusion. One Advent junior acknowledged that these relational spaces enabled him to express nontraditional thoughts more freely:

"As a junior, there's no way I'm going to speak up in front of everyone. A lot of these guys are really against the changes. You'd be crazy to suggest it [in front of the whole group.] . . . When I was on Turner [a general surgery service] with Emily [reformer chief] and Chris [reformer senior], they were both very open to trying new things. So I felt comfortable suggesting things like how to handle pre-ops. We tried things and it worked well."

In contrast, at Bayshore, even on reformer-only services, rounds were not held in "private" places but in an open surgical resident lounge; residents not assigned to the service were usually present. At Bayshore there were spaces, such as cafeteria tables, hallways, and call rooms that provided reformers with isolation from defenders and allowed them face-to-face interaction with one another. In these spaces, I sometimes saw Bayshore reformers identifying problems to one another and even talking about solutions. But reformers who congregated in these spaces often did not work on the same service with one another. Without the presence of reformers on the same service from each of the work positions, reformers were not able to gain a broad perspective on the problems they faced, nor were they able to work out and negotiate solutions with one another.

Advent reformers did several things in relational spaces. First, they tried out new beliefs. Rather than "Juniors should pay their dues and not complain," senior residents suggested things like "I had to do a lot of stupid stuff when I was a junior and want to treat people differently now that I'm chief," and juniors said things like:

"In the beginning, I felt bad about signing out. The [night floats] would be at dinner bragging that they still had a few hours before the juniors were ready to sign out... Now that I'm working with a helpful night float, I look at it differently. I feel like I'm not asking for a favor. I'm just sticking by the rules."

In relational spaces, Advent reformers also tried out new roles. They did this by using language and demonstrating a demeanor in front of one another that supported a new division of labor. For example, reformers at Advent began to refer to chiefs as "coaches" rather than "commanders." Night floats were "members of the team" rather than "stopgaps," and juniors were "rookies" or "good prioritizers" rather than "beasts of burden" or "go-to guys." Surgical residents historically had used the masculine language of sports to emphasize endurance and competition. When psyching up one another to do a tough case in the OR, they would say, "Put your game face on." Now, in contrast, they drew on sports narratives to validate collaborative behavior. Accepting handoffs was now a way to "be a team player," and doing pre-ops was a way for a senior to "take one for the team." This change in vocabulary had an important consequence. Residents were able to accept and even value their new collaborative activity by rejecting the stereotypical female metaphors defenders used to characterize it ("weak, soft") and reinterpreting it using sports metaphors ("coach," "team," "player," "rookie") which were consistent with the highly valued Iron Man persona.

Finally, in relational spaces, Advent reformers tried out new hierarchy relations by collectively identifying task problems and jointly negotiating solutions during their afternoon rounds. Rather than the chief making patient plans, the night float covering only emergencies, and the junior doing routine work, now residents in all positions took on routine work. Since afternoon rounds included members from each of the work positions necessary to bring off a smooth signout practice, a forum for identifying problems was created. Reformers were able to try out new things, and experiment with shorter hours in a way that worked, without having to have all the defenders of the status quo see them and mock them and say, 'You guys are just too weak to do it the old way.'

As reformers developed new beliefs, roles, and hierarchy relations in relational spaces, they began to openly challenge defenders outside of these spaces by attempting and supporting handoffs. By organizing with one another to attempt handoffs in the face of resistance, reformers struck at the very heart of the Iron Man's world. Handoffs challenged not only the traditional practices the defenders were skilled in using but also the traditional measures of performance (maleness, individualism, and hypercommitment to work) that afforded them high status in the profession and in society-at-large.

But Iron Men did not sit idly by as these insurgents challenged their treasured identity, trampled over their hard-won authority, and ran roughshod over their cherished beliefs. Defenders retaliated with "dropped balls." Defender night float members "forgot" to do routine work. One chief said:

(Junior) signed a preop out to the night float the other night. The night float didn't do it. So there I am doing damage control the next morning, running around trying to get this patient the right tests so he can go to the OR. Otherwise, [staff surgeon's] schedule gets all messed up.

But, rather than blaming the night float members, defender chiefs blamed juniors for "dropped balls."

I expect my juniors to get it done. This is not shift work. They are getting a lot of sleep. 6 to 6 is not the right way to go. It is your patient... It is unacceptable and it will be dealt with. It is a major screw-up. The patient was already going to the OR for a 7:30 case when they discovered it.

Up to this point, staff surgeons had been defending the status quo by gossiping about reformers with defenders and withholding teaching from reformers in the OR. But staff surgeons had been uninvolved until this point in the resident interaction up on the floors, which was where signouts occurred. Now dropped balls had led both the department directors and the staff surgeons to pay more attention to the residents' methods of caring for patients.

Reformer chiefs made a point of explaining to staff surgeons how handoffs could be accomplished effectively as long as chiefs, seniors, and night floats were supportive of change. When staff surgeons expressed anger about lapses in patient care, reformer chiefs pointed out that dropped balls were not a necessary outcome of handoffs. They argued that there were not problems with patient care in handoffs between juniors and reformer night floats whenever the chief, senior, and night float on the service were willing to work in a less hierarchical manner by taking on routine work.

By disrupting daily activities, reformers had created a situation where defenders had to become open to new ways of doing things. And reformer chiefs now proposed a new way. The staunchest defender night floats were the rotating seniors who worked only once or twice a week. Reformer chiefs reasoned that they could replace the recalcitrant rotating seniors with a designated junior currently assigned as a "day float" across the general surgery services. The staff surgeons initially resisted it because they did not want to lose the extra help with coverage during the day that the day float provided. However, as the problems caused by dropped balls continued, the failure to agree on a solution created a crisis for staff surgeons. Presented with the evidence of successful handoffs among reformers, ten and a half months after the introduction of the night float program and five months after dropped balls had become a topic of concern, the staff surgeons agreed to have the junior from the day float position replace the senior in the rotating night float position.

Interestingly, this same solution was available at Bayshore. But, as they had initially at Advent, staff surgeons at Bayshore resisted this idea because they did not want to lose extra help with coverage during the day. The solution was not adopted at Bayshore because reformers there had not mounted a collective challenge, so there was no crisis at Bayshore to force the staff surgeons to accommodate reformer demands.

When faced with both crisis and a positive model, staff surgeons at Advent agreed to the change in staffing and surgeons and defender chiefs began to support handoffs. One defender chief said:

"I was definitely concerned that with all of the handoffs patient care would suffer. But it is fine... the night floats actually know the patients better now than the on-call residents did in the old system [every 3rd night on-call] because night floats are here every night."

As a result of this process, change occurred at Advent but not Bayshore. Whereas before the night float team, there had been no handoffs at either hospital, at the end of the year at Advent signouts occurred in 91% of signout interactions versus 0% at Bayshore.

What I'd like you to take away from this research is a key lesson about how transformational change, such as change that advances women in organizations, can be accomplished. Other researchers have found, as I did here, that workplace practices, rewards, and career paths are based on longstanding beliefs that suggest that those who work long hours and continuously are the most able, most committed, most "ideal workers." My findings add to this understanding by demonstrating the importance of relational spaces to organizational change that challenges the traditional gender hierarchy.

While many years of research on planned change says that top managers should involve both supporters and defenders of the status quo in planning and implementing change

as a means of gaining the buy-in of defenders and promoting cooperation, I find that to create transformational change, top managers should not bring people together but should keep them apart. Supporters of change must have their own separate meeting spaces--"relational spaces" of isolation, interaction, and inclusion—that allow them to work across different positions to build a committed group for change. Relational spaces play a critical role because supporters of change are often uncomfortable trying out new tasks, playing new roles, or discussing non-traditional ideas when defenders of the status quo are present, for fear of retaliation. Only by creating relational spaces for reformers to mobilize with one another apart from defenders of the status quo can top managers create the transformational change that supporters of gender equity have fought so hard to win.

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