# Why change fails in medical groups and how leaders can remove the friction

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Healthcare doesn't lack ideas. Every year, medical groups and health systems launch ambitious initiatives to improve access, reduce burnout, redesign care teams, and modernize workflows. The slide decks are polished. The strategy sessions are thorough. The acronyms are plentiful. Yet, too often, little changes where it matters most: the daily work.

Change efforts in healthcare often fail not because people resist good ideas, but because leaders spend most of their energy talking to the wrong part of the brain. Psychologist Jonathan Haidt popularized a framework that helps explain why; Chip Heath and Dan Heath later developed it in *Switch: How to Change Things When Change Is Hard*. Human decision-making has two systems: the Rider and the Elephant.

The Rider is our rational mind: analytical, deliberate, and fluent in dashboards. The Elephant is our emotional side: powerful, instinctive, and far more influential in actual behavior than most leaders care to admit. The Rider sits on top, tugs the reins, and believes it is in charge. Anyone who has ever tried to ignore a warm chocolate chip cookie after a stressful clinic day knows how that arrangement usually works out.

In healthcare, we spend most of our energy directing the Rider. We present benchmarks. We explain the business case. We send the email from leadership. But the Elephant decides whether people actually move. If the Elephant is exhausted,

skeptical, or convinced that this initiative will make tomorrow harder than today, it plants its enormous feet and refuses. At that point, the implementation timeline becomes a piece of fiction. The Elephant is not reading the Gantt chart.

The Heath brothers describe three elements that must work together for change to stick: **Direct the Rider, Motivate the Elephant, and Shape the Path.** After years of leading change across multispecialty medical groups, I've seen each of these succeed, fail, and occasionally backfire in ways that made the next town hall more interesting than anyone wanted.

That same lesson shows up in healthcare improvement literature. The Institute for Healthcare Improvement's Psychology of Change Framework emphasizes agency, relationships, and practice support for the people closest to the work, while the National Academy of Medicine's clinician burnout report points leaders toward system design, workload, and administrative burden rather than individual resilience alone. The framework is a practical way to look at how medical groups make change workable.

## DIRECT THE RIDER: CLARITY, NOT SLOGANS

The Rider needs specific direction. Not "improve access." Not "enhance patient experience." Not "transform care delivery." Those phrases may look nice on a banner, but they're not instructions. They're wishes dressed in business attire.

A clear direction sounds different: open two same-day slots per provider session. Call patients within 24 hours of discharge. Reduce inbox routing by defining which messages require physician review and which can be handled by an MA, RN, or referral coordinator under protocol. People need to know exactly what to do differently on Monday morning. When direction is vague, clinicians and staff default to what they already know, often a broken process, but at least it's familiar.

Healthcare is especially prone to vague mandates. Leaders assume that because clinicians are smart and mission-driven, they can fill in the gaps. They usually can't, not under production pressure and not in the middle of a full patient panel. Clarity is not an insult to intelligent people. It is a form of respect for the cognitive load they already carry.

## MOTIVATE THE ELEPHANT: STORIES, NOT JUST DATA

Data tells people what is true. Stories make them care. These are not interchangeable. Several years ago, I helped lead a same-day access improvement effort across a medical group. We had been presenting access reports for months, tracking third-next-available appointments, comparing performance across clinics, and identifying variation. Clinicians understood the numbers. The Rider was informed. But the Elephant had not moved.

What shifted the conversation was not another dashboard. It was a patient. She described how a delayed appointment led to worsening symptoms, an avoidable ED visit, and a hospitalization that likely could have been prevented. Access was no longer a metric. It was someone's mother. That is when people started moving. You don't replace data with stories; rather, pair each dashboard with a credible amount of what the data mean for patient, clinicians, and/or staff.

I have experienced the opposite failure, too. When we rolled out same-day scheduling, I focused almost entirely on the rationale: the model, the data, the operational logic. At a town hall, a physician raised his hand and said, "This is making things harder, not better." He was right, not because the model was flawed, but because I had not made the first steps feel manageable or connected the change to something worth the disruption. The Elephant doesn't move on logic alone. It responds to emotion, identity, trust, and whether the change feels like something being done *to* it or *with* it.

## SHAPE THE PATH: RESISTANCE IS USUALLY A DESIGN PROBLEM

This is the most underappreciated element of change work. Leaders routinely frame resistance as a people problem, when it is more often a situation problem. Healthcare is full of poorly designed pathways. We build order sets with too many choices and wonder why clinical variation persists. We add inbox categories and wonder why physicians drown in messages. We ask staff to follow workflows stored on a shared drive last updated years ago, then express surprise when the process breaks down. We tell people to do the right thing while designing template rules, handoffs, and systems that make it hard.

I worked with a family physician who, at one point, averaged eight hours of administrative work

after clinic each day, which we call "pajama time." She was working two jobs for the pay of one. Now imagine telling her: good news, we have a new workflow. Unless that workflow removes work, reduces friction, or improves care in a way she can feel, the Elephant is not moving. The question leaders should ask is not, "How do we get people to comply?" It is, "What have we designed that makes the right behavior needlessly difficult?"

## FIND BRIGHT SPOTS BEFORE BUILDING NEW SYSTEMS

When change stalls, the instinct is to build something new: a committee, a platform, a redesigned workflow, or possibly all three at once. But the most efficient path forward is usually already within your organization.

*Switch* calls these "bright spots" — teams already succeeding with the same resources and under similar constraints as those who are struggling. During access improvement work across a multi-site group, several clinics had persistently high no-show rates. One clinic performed significantly better, despite having the same patient population, the same scheduling system, and similar staffing. The difference was behavioral: consistent reminder calls, patient education, and schedule review, supported by providers who treated scheduling as a shared clinical responsibility rather than someone else's problem.

We didn't need a new system. We needed to replicate what was already working. Bright spots also do something important for the Elephant: instead of "you are failing," the message becomes "someone like us is already succeeding." That is a fundamentally different signal. The Elephant prefers hope to shame, as do most of us.

## WHAT LOOKS LIKE A COMPENSATION DISPUTE MIGHT BE FRICTION

A few years ago, I was in a tense conversation about on-call physician compensation. From the system's perspective: real budget constraints, fair market value (FMV) guidelines, and internal equity considerations. From physicians' perspective: the burden of call had increased, while support had not. It looked like a pay dispute. But when we asked a different question, not "What is the right rate?" but "What does covering call actually feel like, and what is making it harder than it needs to be?" the conversation shifted. What emerged was primarily about friction, not money. Call distribution was uneven. Handoffs were inconsistent. Escalation expectations were unclear.

We made targeted changes to the system: rebalancing schedules, clarifying expectations, and reducing avoidable interruptions. Physicians who had been disengaged began attending design sessions, not because compensation changed dramatically, but because the work became more manageable. The goal is not to motivate people to endure broken systems. It is to fix the parts of the system that are breaking people.

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## A WORD ON METRICS

Metrics can move behavior in either direction. I once sat in a quality meeting where the presenter announced that our cervical cancer screening rate was at the 90th percentile, only to learn that our over-screening rate was at the 10th. We had driven hard toward one metric and inadvertently driven past it. Clinicians were being held accountable for doing too much of what they had been told to do more of. My internal reaction was intense, to say the least. When the Rider receives conflicting instructions, the Elephant disengages. Metrics without prioritization don't create accountability. They create measurement fatigue, which we then call resistance.

## A PRACTICAL PLAYBOOK

The organizations that make change work share a few consistent patterns worth naming explicitly.

- **Start with the path, not the pitch**. Before investing in a communication strategy, audit the workflow: Who owns the template? Who receives the message? Where does the handoff fail? Which steps require physician judgment, and which step(s) could be handled by the care team? What makes the desired behavior harder than it needs to be? Reducing two or three friction points often accomplishes more than any change-management campaign.
- **Translate data into human stakes.** Dashboards inform; stories move. For any significant initiative, identify the patient, clinician, or staff member whose experience makes the data real. Present both.
- **Shrink the first step.** One clinic. One team. One measurable behavior. Early wins aren't just morale boosters; they're evidence that change is possible, often the missing ingredient in skeptical organizations.
- **Name the bright spots first.** Before diagnosing failure across your group, identify what is already working. Compare teams with similar constraints, then ask what behaviors, rules, or workflow choices explain the gap. "Someone like us has already solved this" is more motivating than any top-down mandate.
- **Align your measures.** If you ask people to move in three directions at once, you are not setting priorities; you are creating confusion. Narrow the focus and explain the trade-offs.

Durable change is not an event: a kickoff, a town hall, or a leadership email. It is a system that requires clarity for the Rider, motivation for the Elephant, and a path that makes the right behavior easier than the old one. When those elements align, change no longer feels like an uphill climb. It becomes the natural direction. That doesn't make change easy. Nothing in healthcare is easy, except perhaps adding another required training module. But it makes change *workable*. And in healthcare, where the stakes include patient outcomes, clinician well-being, and organizational trust, workable is worth the effort.

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