You can lead a horse to water … : what Self-Determination Theory can contribute to our understanding of clinical policy implementation

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Abstract

There has been increasing reliance on policy 'directives' as instruments for shaping clinical practice in healthcare, despite it being widely recognised that there is a significant translation gap between the development of clinical policy and its implementation.

Self-Determination Theory, a widely researched and empirically validated theory of human need fulfilment and motivation, offers a potentially valuable theoretical framework for understanding not only why the current policy environment has not led to the anticipated improvement in the quality and safety of clinical care but, importantly, also provides guidance about how organisations can create an environment that can 'nurture' behavioural change in their workforce.

We describe an alternative approach to clinical policy-making underpinned by Self-Determination Theory, which we believe has broad application for the 'science' of implementation.

"Who can give water to the horse that will not drink of its own accord?"

Old English Homilies, 1175

Introduction

Clinical policies are the formal guiding principles, rules and regulations through which organisations (health departments/regional health services/health trusts) communicate their strategic intent to set the direction for, and guide the actions and behaviour of, staff in the clinical workplace.

They are potentially an important instrument for improving service quality and outcomes, but there remains a significant challenge in translating policy into practice.[1] The importance of implementation and the complexity of the process are being increasingly recognized and this is reflected in a growing body of research in the area of implementation science.[2] Within this field, there are numerous theoretical approaches and frameworks, which borrow from a range of disciplines aimed at addressing different aspects of implementation.[3]

Eccles et al argue that the science of implementation research could be *"significantly improved by a more systematic approach to the use of theory"*; and particularly by causal theory that can provide practical guidance on how to promote behavioural change.[4]

In a well-designed study aimed at improving the quality of critical care discharge summaries, Goulding et al employed a mix of interventional strategies including regular audit and feedback, championing and education delivered by local opinion leaders and financial incentives. Their inability to demonstrate continuous and sustained improvement across the period of the study led them, like Eccles et al, to propose that future quality improvement projects *"adopt a behaviour change theory or framework"*.[5]

In this paper, we critically review contemporary clinical policy-making, arguing that Self-Determination Theory (SDT), a widely researched and empirically validated theory of human need fulfilment and motivation, provides a potentially fruitful basis for understanding why the current policy environment, with its increasing reliance on standardisation and control, has not had the anticipated impact on improving the quality and safety of clinical care.

There is an extensive body of research on health-related behaviour change interventions for patients based on SDT, such as smoking cessation, medication adherence and physical activity.[6] Although, to date, there have been a limited number of studies applying SDT in the implementation of practice change amongst health professionals, the results have been promising.[7, 8]

SDT, which is concerned with the interplay between extrinsic forces and intrinsic motivation, has the potential to re-shape thinking about what organisations need to do to promote behavioural change. We outline an approach to policy-making that provides practical strategies for creating a workplace climate which supports people's intrinsic motivation, thereby enhancing implementation.

Contemporary clinical policy-making

There are two major schools of thought in relation to organisational clinical policy-making; the 'top-down' and 'bottom-up' approaches. While adherents of the former view it as a largely hierarchical, rational, sequential process, proceeding from problem identification and policy formulation at higher

organisational levels to implementation at lower levels, the latter see it as engaging people from various levels of the organisation in an interactive, flexible process that allows for adaptation to local contextual factors.

In the drive for health care improvement, policy-making has largely taken a top-down approach. There has been an exponential increase in the number and level of prescriptiveness of policies accompanied by the growth of mandatory training and more diligent central compliance monitoring. In Table 1, we have outlined what we have perceived as the thinking that underpins this approach to policy-making based upon our extensive policy development and implementation experience at a national and state level within Australia.

Mindset	Consequences for policy-making
Leadership, power and decision-making is hierarchical and mirrors the organisational chart	Policies are made 'top-down' and issued to service providers for implementation
Organisational culture is singular and uniform	Expectation for uniform implementation/uptake across services with limited scope for local adaptation
Wisdom and knowledge are concentrated at the top	Policy development by a 'policy elite' with the finished product 'transported' to the users
Activity can be precisely controlled with predictable outcomes ('machine' metaphor)	High levels of specification and standardisation to minimise variation (only one 'right' way)
Production of the policy 'document' is viewed as the key outcome	Implementation is given limited and late consideration
Practice change can be achieved through regulation	Policies are issued as mandatory directives with an emphasis on monitoring for compliance
Knowledge and training increase policy uptake	Explain and train and 'they will do it'

Table 1: Top-down mindset and its impact on policy-making

The expectation that greater standardisation and uniformity would remove unwanted variation, that is *"if all units operate the same they will perform the same"*, has not proved to be the case[9]; primarily because insufficient weight has been given to the vital role that staff motivation plays in the implementation of practice change.[8]

The primary focus of the policy-makers has been on the production of policy 'documents' and monitoring for compliance with the responsibility for implementation being largely passed over to the service providers. These centrally generated policies are often experienced by clinicians as overly prescriptive, with little flexibility for local adaptation and accompanied by limited support and resources for implementation.[1] This has contributed to clinicians feeling that their autonomy and professionalism are being undermined, which has resulted in a sense of disempowerment and led to many clinicians disengaging from 'the system'.[10]

Ballatt and Campling argue that insufficient attention has been given to the impact of current thinking on the culture of organisations and their staff and the resultant effect this has had on patient care.[11] Mannion likewise argues that

enabling and supporting compassionate care in health requires *"not only a focus on the needs of the patient, but also on those of the care giver."* He warns that *"threats and exhortations"* are likely to have limited and perverse effects and that attention should be given to organisational arrangements that support staff.[12]

Re-thinking culture

Clinical policy is essentially aimed at changing how things are done at the practice level and this requires fundamental changes in 'local' workplace cultures - i.e. *"the culture that has direct impact on user and staff experiences"*.[9] Davies and Mannion have defined organisational culture at its heart as consisting of,

> *"…. the values, beliefs and assumptions shared by occupational groups …. translated into common and repeated patterns of behaviour …. maintained and reinforced by the rituals, ceremonies and rewards of everyday organisational life."*[13]

There is growing evidence that the 'gap' between policy-making and implementation in contemporary policy-making can be attributed largely to an

unrealistic conception of ‘organisational culture’ that does not adequately reflect its complexity and diversity.

The current approach to policy-making assumes culture to be singular and uniform across the organisation, with power distributed in line with the organisational hierarchy. Reality presents a much more complex and nuanced picture of culture, in which cultural diversity between the various system levels, services, staff and workplace groups is the norm.[13]

The degree to which policies are implemented is influenced largely by the culture of the frontline workplace groups, which is far from uniform within individual healthcare organisations, let alone across the broader health system.[9] Consequently, efforts to roll out a policy or intervention across an organisation or system generally produce a far from uniform outcome.

Davies et al argue that the *“more visible artefactual elements of culture”* may be readily manipulated but the deep-seated beliefs that shape a group’s understanding and perception of the world are more resistant to external regulatory control, particularly when the proposed change does not resonate with a group’s values and meanings.[14]

As the National Advisory Group on the Safety of Patients in England (2013) observed,

> *"In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime".*[15]

The challenge for clinical policy-makers, therefore, is how to establish a climate that is conducive to promoting a change in workplace culture, a pre-requisite for the adoption of new practices.

Creating an environment for change

Self-Determination Theory (SDT), an empirically based theory of human development and motivation, is premised on human beings being inherently motivated to grow and achieve. It postulates that they have three fundamental psychological needs: for *autonomy* (acting in accordance with abiding values and with a sense of willingness and choice), *competence* (sense of proficiency and feelings of effectiveness) and *relatedness* (sense of belonging and social connectedness).[16] Autonomy, in this context, is not the same as 'independence'

but refers to behaviour that can be influenced by external sources as long as the behaviour is personally valued by the individual.

Motivation for an activity may be *intrinsic* or *extrinsic*, the former relating to spontaneous satisfaction derived from activity people find interesting and satisfying, while the latter is mediated by external drivers, such as approval or tangible rewards or sanctions. Unlike many theories of motivation, SDT identifies different *qualities* of extrinsic motivation varying along a continuum from externally *controlled motivation* that emerges from feeling pressured to behave in certain ways, to *autonomous* or *self-motivation,* which emerges from one's sense of self and is accompanied by behaving with a full sense of volition, willingness and engagement.

The striving to be self-regulated or autonomous presents a significant challenge for policy implementation. Socially controlling environments, such as those found in top-down policy-making, are counterproductive to bringing about change and can impede implementation. A key challenge in the implementation of new policies or practices is how to create the sense of self-regulation in a work context when the change can be seen as being externally 'imposed'.[8]

There is evidence that work climates that enhance workers' basic psychological needs for autonomy, competence and relatedness foster autonomous motivation, leading to the full 'internalisation' of previous 'external-to-the-self' motivation. In such settings, people experience work as providing meaningful choices, clear structures and supportive relationships, and more willingly adopt and assimilate the culture, regulations and norms of their workplace into their sense of self.[17] This internalisation process promotes the engagement of staff with their workplace, which has been found to be critical in enhancing staff performance.[18] The relationship between autonomy and motivation is outlined in Figure 1.

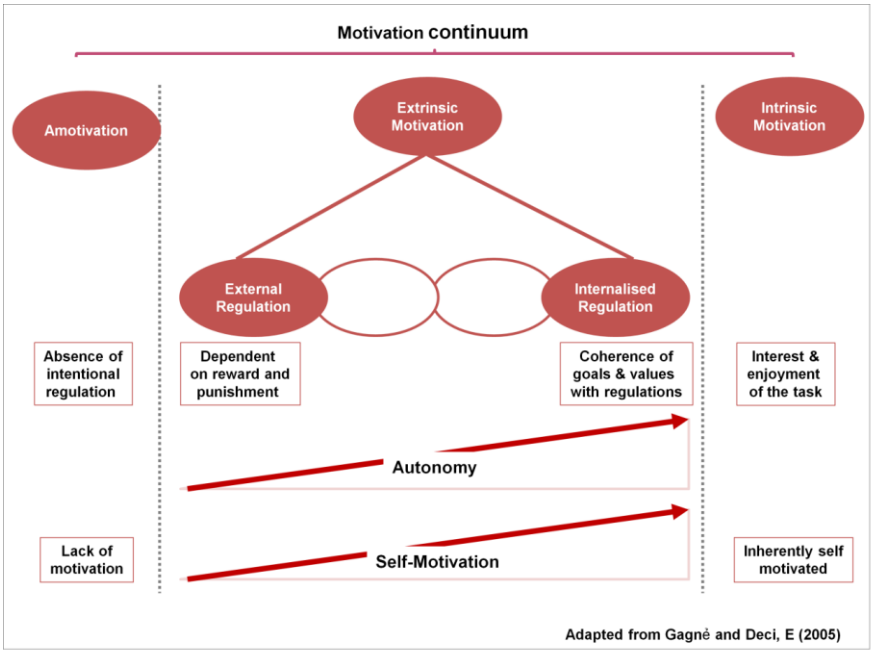

Figure 1: Relationship between degree of autonomy and motivation

The importance of employee engagement in health organisations has been highlighted by studies like that of West and Dawson who found that the more engaged staff were within their organisation, the better the outcomes for both patients and the organisation: including better patient experience, fewer errors, lower patient mortality and infection rates, better patient outcomes, stronger financial management and lower staff absenteeism and turnover.[19] Their description of the key characteristics of staff engagement is outlined in Table 2.[20]

Psychological engagement (a positive, fulfilling, work-related state of mind)
Proactivity
Enthusiasm and initiative
Organisational citizenship behaviours and organisational commitment
Involvement in decision-making
Positive representation of the organisation to outsiders

Adapted from West M and Dawson J, 2012

Table 2: Characteristics of staff engagement

By contrast, it has been demonstrated that climates that are characterised by greater external control result in controlled motivation leading to staff disengagement. Although controlled motivation has been shown to produce a level of 'compliance', it fails to build commitment to long-term sustainable change.[21]

The role of leadership

West and his colleagues provide persuasive evidence for the role of leadership in promoting engagement and in shaping organisational culture. They argue, however, that what is critical in health is a more distributed form of leadership

that they refer to as ‘collective’ leadership. This newer conception of leadership envisages it as a ‘property’ shared by multiple individuals, not a direct product of positional authority, in which:

> *“….the distribution and allocation of leadership power to wherever expertise, capability and motivation sit within the organisation …. depending on situational requirements.”*[19]

This is particularly relevant in the health setting where power is dispersed and clinicians retain considerable discretion to choose the knowledge on which to act.

Ham highlights the importance of needing to understand what motivates professionals in their daily work and, more critically, what might motivate them to change their practice to improve the quality of care.[22] West and his colleagues also make the point that *“more attention needs to be given to the underlying mechanisms and processes by which leaders exert their influence on followers.”*[19]

It is widely recognised that one of the basic functions of leadership is motivating staff. SDT offers not only an important explanatory mechanism for understanding how leadership shapes staff motivation and engagement, but it

also *"helps us understand how we can design organisations and jobs in a way that promotes optimal outcomes"*.[23] Leaders have the power to control many aspects of the workplace but the way they exercise their power has major implications for how staff perceive their work environment and, most significantly, for staff motivation.

SDT postulates that leadership styles that meet the basic psychological needs of staff for autonomy, competence and relatedness, promote autonomous motivation and staff engagement. This is consistent with research demonstrating that there are a number of leadership behaviours that are highly predictive of enhanced staff engagement, including giving staff control over how they did their jobs [24]; enabling them to use a wide range of skills, ensuring jobs are satisfying and providing support, recognition and encouragement[20]; and learning and development opportunities and the quality of leader-member relationships.[25]

As outlined earlier, motivation plays a crucial role in determining the degree to which staff endorse or 'buy into' organisational goals, values and policies. While an 'autonomy-supportive' leadership style can promote buy-in, corrective and controlling leadership, which actively searches for mistakes and monitors

members' work, can undermine the need for autonomy and not only reduce buy-in but foster opposition.[21]

SDT aligns well with the contemporary concept of collective leadership, in that research has demonstrated the importance of SDT in fostering 'self-leadership' at all levels within organisations where people are influencing themselves and emphasising the intrinsic value of the task. Bakker et al argue, engaged staff *"do not just let life happen to them"*, but rather try to shape what happens in their workplace.[25] The concept of 'self-leadership' is congruent with that of collective leadership which West et al have described as:

> *".... everyone taking responsibility for the success of the organisation as a whole – not just for their own jobs or work areas."*[19]

Collaborative policy-making

Many clinicians report *"an endless barrage of policy documents"* being handed down to them and feel that they are being *"over-governed and over-regulated"*, which they experience as undermining their professional autonomy.[1] Health systems currently appear to be stuck in a cycle of increasing control and standardisation in an effort to get traction in combating persistent problems with

the quality and safety of health care; but this approach is having limited effectiveness.

There is now a substantial body of research supporting the key tenets of SDT, demonstrating that staff more willing adopt and assimilate policies and practice change in an autonomy-supportive environment; essentially one that meets their basic psychological needs for autonomy, competence and relatedness. Because clinicians have a large degree of control over decision-making on a day-to-day basis, significant long-term changes in practice cannot be achieved without their effective engagement.

As a result, formal leaders need to negotiate rather than impose new policies and practices and, therefore, ways have to be found of engaging staff at all levels of the organisation in the process of bringing about practice change. McKee and her colleagues explored the views of ‘strategic level stakeholders’ on the form of leadership required for advancing the quality and safety agenda in health care.[26] Participants expressed strong beliefs about the needs for cultural change and argued that there was a need to instill a sense of ‘local ownership’, stressing that:

"Leadership …. needed to be enacted at the ground level and embodied by local leaders with professional legitimacy, practical knowledge and local visibility."

They went on to add that the complexity of health care systems, with the spread of power across broad managerial and professional groups, required *"productive coalitions and alliances"* between clinicians and managers.[26] This 'collaborative approach' to policy-making recognises that each level of the system plays a significant and complementary role, with formal leaders having responsibility for governance, direction-setting, the articulation of values and desired outcomes and resource allocation. Critically, in line with the principles of SDT, leadership displayed by the senior leaders in organisations must be autonomy-supportive for effective implementation of policy and practice change (see Table 3).

Psychological needs	Elements of autonomy-supportive leadership
Autonomy	▪ Sharing decision-making by engaging local sites in the development of interventions. ▪ Providing greater choice and control, allowing workplace groups flexibility to tailor solutions to local conditions. ▪ Providing minimal specifications, leaving room for local creativity and innovation (recognising that only a small 'hard core' of any policy is evidence-informed).
Competence	▪ Focusing on understanding the needs of individual team members and works continuously to provide them with opportunities for continuous learning and development. ▪ Providing services with the tools to enable them to manage their own performance – culture of continuous practice improvement. ▪ Exploiting the diversity of perspectives and the wealth of experiences, strengths and potential in the organisation.
Relatedness	▪ Emphasizing teamwork, collaboration and trust, removing barriers to communication. ▪ Engaging local leadership in the implementation process. ▪ Understand and recognise 'attractors' for change, rather than 'battling resistance'.

Table 3: Elements of autonomy-supportive leadership

Langley and Denis[27] observed that quality improvement initiatives, including policy-making, generally have a 'hard core', the element that is irreducible and carries the key potential for benefit and a 'soft periphery', which potentially offers considerable scope for the setting of minimum specifications, which, in turn, provides work groups with the capacity to tailor policies to local conditions. Minimum specifications not only provide room for innovation, but also:

> *"…. encourage discussion about how they are to be achieved, thereby increasing connectedness and facilitating shared views of what is to be done".*[28]

There is good evidence that promoting employee participation in the planning and implementation of organisational change has a direct link to intervention outcomes.[29]

As highlighted earlier, cultural divergence between the various system levels, services, staff and workplace groups is the norm. This helps to explain why there is a wide variation in uptake of policies 'rolled out' across the health system. As Ham reminds us, *"big bang reforms"* have been found to have little effect and we need to conceptualise the implementation of policies and practice changes not as 'all-or-nothing events', but as continuously evolving practice improvement processes.[22]

In Figure 2, we set out what we consider are the key elements of a framework for 'Collaborative Policy-making'. We draw comparisons between this model and what we have termed the 'Top-down' approach, highlighting their likely impact on staff engagement and service performance predicated upon the principles of SDT.

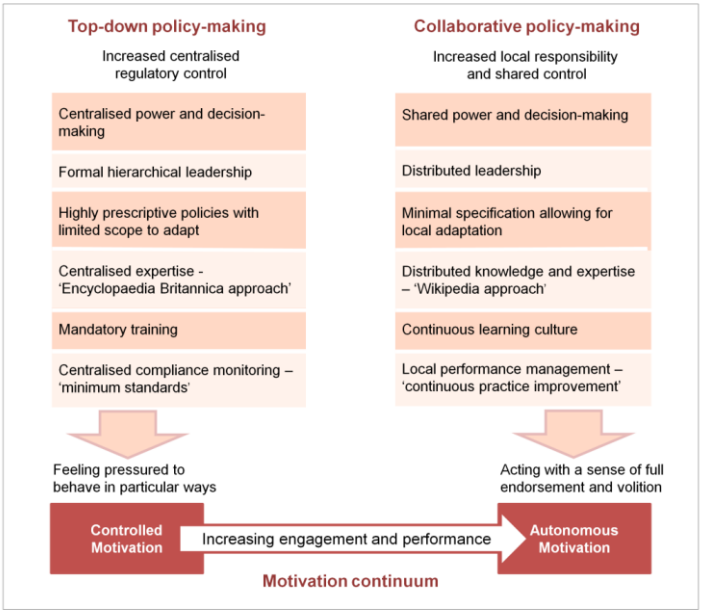

Figure 2: Comparison of features and impact of top-down and collaborative policy-making

Evidence coming out of SDT research, suggests that the delegation of responsibility for the management of service performance to local services can be expected to result in more effective and enduring practice change. Under the collaborative model, the responsibility of formal managers would shift from monitoring for compliance to evaluation of the effectiveness of policy objectives, something that is currently rarely realised.

Conclusions

Despite evidence that the current top-down approach to clinical policy-making has not had the hoped-for impact on improving safety and quality, there has been no significant questioning of the basic paradigm. SDT, with its extensive research base in the work domain, provides a promising model for this paradigm shift.

Our proposed model of Collaborative Policy-making, based on SDT, highlights the importance of autonomous or self-motivation in bringing about workplace behaviour change in the context of clinical policies which can be perceived as largely imposed or externally regulated. Our model sets out the elements of a policy-making framework which are consistent with the evidence coming out of SDT research for how organisations can meet the basic psychological needs of their workforce and foster autonomous motivation leading to enhanced implementation.

While there have been early promising results on behaviour change emerging from studies on the application of SDT in health service settings, to our knowledge there has been no research in the application of SDT to the area of clinical policy implementation. There is a need for future research to test the

validity of our proposed approach, particularly given the complex and diverse nature of health.

Furthermore, we believe that SDT potentially has broad application in the field of implementation science research. Nilsen and his colleagues[2] argue that important learning for implementation science could be gained from the field of policy implementation, particularly issues related to the *"influence of the context of implementation and the values and norms of the implementers (the healthcare practitioners) on the implementation process."*

Declaration of Conflict of Interests

The Authors declare no conflict of interests.

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