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Case Study

Managing Change Through Leadership Discourse: An Experience in the Surgical Ward

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Abstract: *Effective leadership is crucial in managing change within healthcare organizations. While leadership is often associated with formal roles, individuals without designated authority can still influence meaningful transformation through visionary approaches. This case study describes the implementation of a change initiative in a surgical ward using transformational leadership and soft systems methodology (SSM), focusing on the improvement of the process for handling patient investigation samples.* ***Objective:*** *To transform the disorganized process of sending patient samples from the surgical ward to the pathology laboratory, thereby enhancing patient care, improving workflow, and promoting a learning-friendly environment.* ***Methods:*** *A mixed-methods approach was adopted. The initiative was led by a senior registrar without a formal administrative role, using transformational leadership principles and the Soft Systems Methodology. Stakeholders including postgraduate trainees, house officers, and nurses were engaged through meetings, focus groups, and structured interviews. Quantitative data were collected using four core questions, while qualitative themes were derived from focus group discussions. Change resistance and support were assessed using SWOT and force field analyses.* ***Results:*** *All stakeholder groups unanimously recognized the need for change. A majority supported the new process and its implementation method, although concerns were raised regarding staff limitations and resistance from some junior personnel. Feedback revealed that improved organization, reduced patient burden, and enhanced team coordination were key outcomes. The intervention was successfully implemented and anchored in ward culture through leadership influence, motivation, and departmental collaboration.* ***Conclusion:*** *This case study highlights that meaningful change in healthcare can be achieved through informal leadership, ethical motivation, and inclusive stakeholder engagement. Applying transformational leadership and SSM facilitated the successful redesign of a long-standing flawed process, even in a resource-constrained environment. Continuous motivation, feedback, and adaptive strategies were essential for sustaining the change.*

Keywords: Transformational Leadership, Soft Systems Methodology, Change Management, Healthcare Leadership, Surgical Ward, Process Improvement

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Introduction

Learning to be a leader is a popular subject today. The leadership training industry is worth an estimated of more than $50 billion. Scholars and practitioners have attempted to define leadership in different ways, but no consensus has been reached. Some experts have studied it as a trait, others describe it as leaders' behavior, and still more have viewed it as a process. Northouse, in his popular book on leadership, has viewed leadership as having four components: a process, b. Involves influence, c. occurs in groups, and d. has common goals (1). Based on these components, he has defined leadership as "a process by which an individual influences a group of individuals to achieve common goals". A conference on leadership in 1927 defined leadership as "The ability to impress the will of the leader on those led and induce obedience, respect, loyalty, and cooperation" (2). The word 'influence' has been examined from all aspects in the perspective of leadership versus management, and the experts have insisted that "leadership is non-coercive management".

The recent history of leadership theories dates back to the middle of the 19th century when the 'great man' theory was developed. Then emerged the trait theory in the middle of the 20th century. Behavioral theories came in reaction to trait theory (3). In the 1970s, transactional and transformational leadership theories were described. Leadership is a socially constructed phenomenon and develops in social circumstances, interactions, and experiences. Linda Jones has very explicitly described various leadership theories and styles: authoritative, charismatic, transactional, transformational, and distributive (4). Daniel Goleman, in his famous article, has described six leadership styles- Coercive, Authoritative, Democratic, Affiliative, Coaching, and Pace-setting (5).

Distributive leadership gained acceptance rapidly in organizations. It is a group activity that works through relationships, rather than individual action (6). Distributed leadership or shared leadership has been adopted as a policy strand in the UK National Health Service (NHS). Its two necessary features are: 1. Concertive action, meaning institutionalized collaboration and sharing of leadership roles at various levels, 2. Conjoint agency; referring to the quality of interaction among leaders in organizations (7). Dympna Cunnane considers that leadership is not just limited to those who are heads of organizations and have a formal leadership role, instead 'leadership' is using power and influence to create a positive change which can benefit of humans and society by alleviating their difficulties, worries and anxiety (8).

Who is a leader? Former American first lady Rosalynn Carter once observed that "A leader takes people where they want to go. A great leader takes people where they don't necessarily want to go but where they ought to be" (9). She was visualizing a visionary leader. John Quincy Adams stated, "If your actions inspire others to dream more, learn more, do more and become more, you are a leader." (10). Professor Marry Scot identifies 'leaders' as those who create a vision for their organization or team, and also provide the framework to deliver that vision (11). She argues that educational leadership in the field of medicine or any other discipline needs the kind of people who are passionate about education and teaching, about the learners, their empowerment, and achievements. Thus, I realize that it is the visionary goals and passionate efforts to achieve these goals that differentiate leaders from administrators, managers, or ordinary doers.

Change management through leadership has been discussed frequently in the business context, but is applicable and equally important for health care systems. Change management has been defined as 'The process of

continually reviewing an organization's direction, structure, and capabilities to serve the ever-changing needs of external and internal customers' (12). It is, therefore, necessary for organisations to identify where they need to be in the future and how to manage getting there. Change can be characterised by its rate of occurrence as: discontinuous, incremental, bumpy incremental, continuous, and bumpy continuous change. While a type of change, how it comes about, can be planned, emergent, contingent, or chosen (13).

It is interesting to understand the differences between management and leadership, with certain overlaps between them. Both are complementary to each other. Abraham Zaleznik has compared leaders with managers. To him, managers are concerned with continuity, running the existing systems, managing people in organizations, and their performance, for uninterrupted delivery of service. While leaders develop new ideas, they foresee the future needs of people before time and set new directions (14).

To implement a structured and efficient system for handling patients' investigation samples from the surgical ward to the pathology laboratory, aiming to improve patient care, reduce ward congestion, and enhance the learning environment.

Background and Rationale

As a senior registrar in a 56-bedded surgical ward—one of the four surgical units in a 1,400-bedded tertiary care hospital—I observed multiple operational inefficiencies negatively impacting clinical care and medical training. One critical issue was the unstructured process for transporting investigation samples and reports between the ward and the pathology laboratory.

Traditionally, healthcare staff handed over both the samples and investigation slips to patients or their attendants, who were then responsible for delivering them to the laboratory—located approximately 750 meters from the ward—and subsequently collecting the results. This resulted in unnecessary patient and attendant movement (approx. 1.5 km round trip), ward overcrowding, disruption of clinical workflows, and a suboptimal environment for teaching and learning.

This inefficient practice had become ingrained in the ward culture over the years. Recognizing its impact on service quality and training effectiveness, I initiated a change project aimed at transforming the process through a systematic, patient-centered approach.

Leadership Framework

Given my lack of formal administrative authority, I adopted a **transformational leadership** style, aligning with the definitions provided by Goleman and the NHS Leadership Framework. Transformational leadership emphasizes influencing others by inspiring shared purpose, intellectual engagement, and individualized support. Key characteristics include:

- **Idealized influence** (serving as a role model),
- **Inspirational motivation** (articulating a compelling vision),
- **Intellectual stimulation** (encouraging innovative thinking), and
- **Individualized consideration** (supporting team members' development).

This approach was well-suited for initiating bottom-up change within a hierarchical and traditionally rigid hospital system.

Vision Statement

To anchor the project in a shared sense of purpose, I formulated a clear and motivating vision statement:

"To provide excellent patient care in an organized environment conducive to intellectual growth, teaching, learning, and research."

This vision served as a guiding principle to align stakeholders around a common goal and inspire engagement in the change process.

Methodology

From an array of diverse change methodologies, I was immediately impressed by Soft Systems Methodology (SSM) because it was appropriate for my leadership role and the nature of my change project. This method of change management has been successfully implemented in King's College Hospital, London (18). **SSM** is defined to have the following main stages:

1. Finding out about a problem situation and its causes from stakeholders.
2. Articulating the main purpose and dynamics.
3. Debating the situation with those involved: a. depicting activities through process flow diagrams and charts
   b. Comparing models by observation and discussion.
   c. defining possible changes in: structure, process, and/or attitude.
4. Taking action to implement the changes.

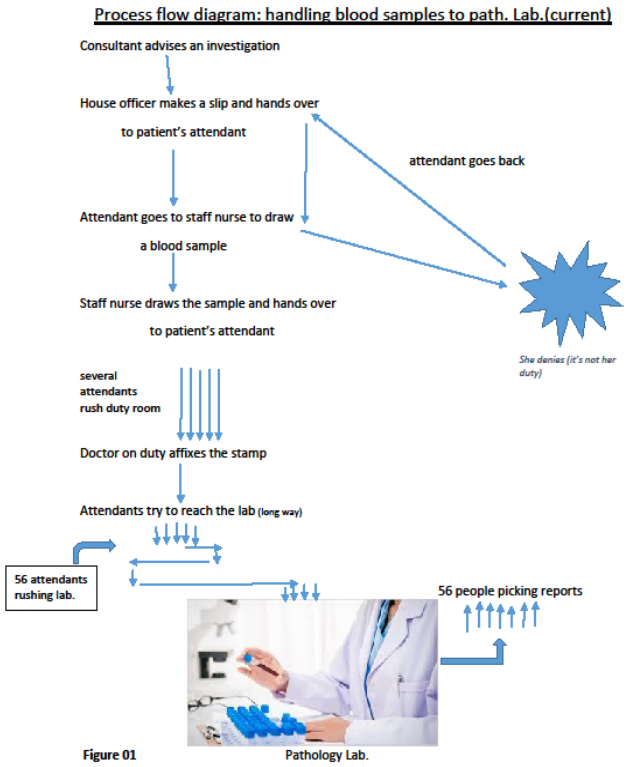

Figure 1: Handling blood sample (Current)

Start of Action

Meeting with Ward Chair: In this meeting, I informed him about the purpose of my change project. He encouraged and advised moving forward carefully.

Preliminary discussions with stakeholders: I conducted preliminary discussions with residents, house officers, and nurses. The residents have a pivotal role in patient management in a surgical ward, while house officers act as their junior team members. In these discussions, I not only identified the problem area but also motivated the residents to become role models for junior doctors and create a culture of responsibility.

Personal Interviews: I conducted personal interviews with my consultant colleagues and acquired their opinions, and created awareness about the project.

I compiled the significant findings of the above-mentioned discourse as below:

1. We are providing good care to our surgical patients within our resources, but still, there is a wide space for improvement.
2. Organized working and comforting patients and attendants can improve the quality of care.
3. Residents' and house officers' learning and training and patient care are interdependent. And there is a need to work on these aspects in our setting.

4. Participants agreed to work on enhancing the quality of patient care and adopting changes required in certain areas of disorderly working.
5. Many doctors, including some consultants, were indifferent, satisfied with the status quo, and hopeless for any change in process and attitudes.

SWOT analysis: These findings helped me to conduct **a** SWOT analysis, which is a tool for planning in organizational change management.[19] It means assessment of internal strengths (S), weaknesses (W) of a situation and/or organization, and opportunities (O) and threats (T) existing outside the same.

SMART targets: By now, it was clear to me that this change effort would not succeed in a linear pattern. Therefore, I formulated the following **s**pecific, **measurable**, **a**chievable, **r**ealistic, and **time-bound** targets:

1. Starting a new process of sample handling as an experiment
2. Monitoring the response through 360-degree feedback
3. Meeting with the Head of the Pathology Department for interdepartmental communication and cooperation.
4. Implementing the change.
5. Anchoring the change in ward' working culture through modifying doctors' attitudes.

The Change experiment-'bottom-up methodology': There were some strong reservations among some staff members of our ward about the new process of carrying patients' samples. Many doctors were not ready to come out of their 'comfort zone'. Therefore, I gave a sudden start to the new process as a "change experiment". On a Friday morning, I briefed the team of house officers and residents involved in taking morning progress of patients and said to them, "Today we will not hand over blood samples and investigation slips to patients or their attendants". I explained to them the new process (Figure 2) of making investigation slips, drawing samples, making entries in the register, and sending the samples of the whole ward collectively, through a ward boy. I also briefed the nursing staff about the new process. They realized its benefits and agreed to cooperate.

The activity was reported to the ward chair by some colleagues and the admin registrar. Later on, I visited the professor's office and explained to him the details and significance of the new process. He agreed and supported the change and expressed the need for a follow-up.

Monitoring with 360-Degree Feedback: I continuously acquired feedback from house officers, residents, nursing staff, laboratory staff, and patients' attendants. Some stakeholders were indifferent, a few were uncooperative, and there were some obstacles to interpersonal relationships, and some problems from the pathology department.

Kurt Lewin's force field analysis: I conducted a force field analysis according to Lewin's method, which assesses the forces driving the change and those resisting it (20). The result is shown in Figure 03. Lewin formulated that increasing the driving forces increases resisting forces and tension in the field (18). Therefore, I focused my efforts on removing obstacles and reducing the resistance.

Meeting with head of pathology department: I visited the lady head of the pathology department in her office, presented the process flow diagrams, and discussed the difficulties and cooperation required from her department. She agreed on the significance of the new process and directed her staff to keep a separate file for lab reports of surgical unit 04.

Motivation of team: I motivated the team of residents and house officers through discussions and delegating tasks dovetailed to their developmental needs, according to Maslow's model (21).

Implementing the Change: After optimizing the climate, we implemented the new process by getting the notification signed by the ward chair.

Conclusion of change project: Working with transformational leadership style and SSM methodology for an ethically motivated vision of "providing excellent patient care" led me and my team to success. Efforts for anchoring the change in doctors' behaviors and ward culture continued even after formal implementation.

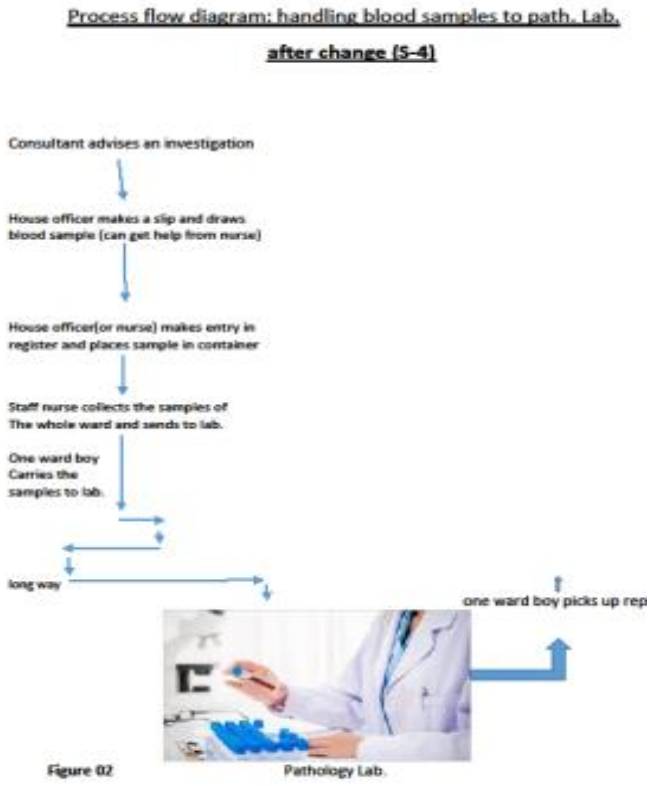

Fig. 2: Handling Blood samples (After cane)

The ontology and epistemology of the research were based on positivism, which assumes that facts can be collected and projected realistically and objectively (22). To assess the outcome of the change project and search out the opinion of stakeholders, l adopted mixed-method research. 'Mixed methods' is a pragmatic approach that argues that the value and contribution of research to policy and practice depend not on methodological quality alone, but on its 'fitness for purpose', which is achieved through 'fit' of the methods to the aim of the research (23). The quantitative method is based on a positivistic approach and on the premise that scientific research can only be meaningful when things can be observed and counted (24). I used a quantitative method by formulating four basic questions regarding the conduct and effectiveness of the change project: **1**- Was the change in the process of handling laboratory samples required? **2**- Was the change methodology adopted to introduce the new process of handling laboratory samples, in your opinion, appropriate? **3**- Do you think that the new process of handling laboratory samples is appropriate/successful? **4**- Are there any threats and obstacles to the new process? These questions were placed in group meetings of postgraduate trainees, house officers, and nurses. Members of each group were selected through purposive sampling, and the meetings were conducted separately for each group. Responses from each participant were collected, and simple statistics were used to formulate the results.

The qualitative methodology is used to study human behavior, motivations, and opinions through bias-free, open-ended techniques of inquiry (25). To gather qualitative information, I conducted focus group discussions with house officers, residents, and nurses. In each focus group, the participants were allowed to express their ideas and beliefs underpinning their opinions in response to the above four questions. The participants freely commented about the need for change, the new process, the method of its implementation, and expected threats/obstacles in the way of long-lasting results. The responses of each participant were

collected by taking field notes. The field notes of each focus group were analysed, and the identified themes have been projected in the results (Table 1).

Results

Focus group of residents: Eight residents participated in the focus group discussion. In the quantitative study of four questions, responding to questions 1 and 3, all the participants (100%) answered in the affirmative. But in response to question 2, 75% (n=6) participants deemed the methodology of change management as appropriate, while 25% (n=2) residents favoured a gradual process of introducing the change. Responding to question 04, 50% (n=4) were optimistic about the result, while the other 50% (n=4) were expecting some obstacle to the permanent results. During the free commentary of the focus group discussion, the main obstacle to the success of the new process was visualized as the behaviour of junior doctors. This was the main reason behind the disagreement about the methodology of change and opinion in favour of adopting a slower process of change.

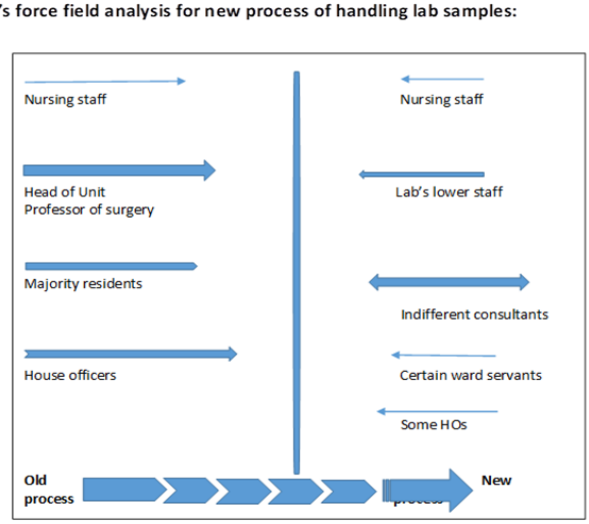

Fig. 2: Handling Blood samples to path lab

Focus group of house officers: Twelve house officers responded to the above four questions and participated in the focus group discussion. All of them were convinced that the change was required (Q1). Responding to Q2, 08 house officers (66.63%) agreed with the method adopted for change, and 04 (33.33%) were not satisfied with the method of change. In Q 3, 10 house officers (83.33%) replied in the affirmative while 2 (16.66%) replied negatively. Opining in response to question no 4, 07 HOs (58.33%) were not expecting any threat to the final success of the new process, while 5 of them (41.66%) deemed that there were threats/obstacles for the new process. During the focus group discussion, those house officers who were not satisfied with the change methodology revealed the reason behind their opinion. They said that they were having difficulty because the timing of sampling in the ward does not match with the 'batch' time in the laboratory. The main threat they realized was coordination with the lab and the deficiency of the ward staff to carry the samples to the lab.

Focus group of nurses: Four nurses, including a ward sister, participated in the focus group discussion. Responding to question no 1, all the nurses unanimously opined that the change was required. In Q2, 03 of them (75%) were satisfied with the method of change, while 01 (25%) were not. The same difference of opinion was there in the responses to Q3. Answering Q4, 02 (50%) of them were not seeing any threats to the future success of the new process, while 02 of them (50%) were expecting threats to the way of permanent success of the new process. During the discussion, when they were probed regarding their opinion, the one who did not favour the methodology was recommended to wait till the additional ward staff are available. And those nurses who were expecting threats for the new process were doing so because of a shortage of staff and the habits of junior doctors. They were deeming problems due to a lack of cooperation from junior doctors.

Table 1: Opinion distribution of stakeholders regarding the change project

Stakeholder Group	Number of Participants	Quantitative Method Responses (n, %)			Qualitative Method – Focus Group Themes
		Question	Opinion in Favour	Opinion Against	
Postgraduate Residents	08	Q1	Yes = 08 100.0%	No = 0 0.0%	- Change is abrupt/fast; better if slow (n=2)- Obstacles: attitudes of junior doctors (n=4)- Lab timing/scheduling is a difficulty (n=3)- Staff deficiency as a threat (n=2)- Recommendation: avoid haste until sufficient staff is available- Problems: doctor habits, staff shortage
		Q2	Yes = 06 75.0%	No = 02 25.0%	
		Q3	Successful = 08 100.0%	Unsuccessful = 0 0.0%	
		Q4	No threats = 04 50.0%	Threats = 04 50.0%	
House Officers	12	Q1	Yes = 12 100.0%	No = 0 0.0%	- Appreciate the change but emphasize need for proper guidance- Concern over increased workload without staff increase- Prefer structured schedule- Mixed views on adequacy of preparation- Suggested phased implementation
		Q2	Yes = 08 66.66%	No = 04 33.33%	
		Q3	Successful = 10 83.33%	Unsuccessful = 02 16.66%	
		Q4	No threats = 07 58.33%	Threats = 05 41.66%	
Nurses	04	Q1	Yes = 04 100.0%	No = 0 0.0%	- Expressed concern about lack of communication from doctors- Highlighted logistic issues (e.g., supply chain, timing)- Resistance from senior staff observed- Need for orientation/training sessions- Staff-to-patient ratio needs improvement
		Q2	Yes = 03 75.0%	No = 02 25.0%	
		Q3	Successful = 03 75.0%	Unsuccessful = 0 0.0%	
		Q4	No obstacles = 02 50.0%	Threats = 04 50.0%	

Discussion

The concept of leadership is significantly associated with individuals' and groups' satisfactory performance in health care organizations (26). Leadership is not just limited to those who are heads of organizations and have a formal leadership role, instead 'leadership' is using power and influence to create a positive change for the benefit of humans and society. My project was similar, as I did not have a formal leadership role, yet I had to influence a positive change in the working of the surgical ward to benefit patients and their attendants.

A variety of change models have been practiced for organizational change management. 'ADKAR' model comprises five steps- awareness, desire, knowledge, ability, and reinforcement, which guide an individual's successful journey through change (27). Kotter's 08 step change model (28) begins the change process by creating 'urgency', which I think is possible only for formal heads of business organizations. Michael Fullan, in his popular book 'Change Leader', gives a seven-step strategy for a change leader. To him, all effective leaders are driven by resolute purpose concerning deep human values and demonstrate "impressive empathy", by which Fullan means 'the ability to understand those who disagree with you (29). A successful change ultimately involves satisfying the masses to win their cooperation. Working on the same principles, when I talked with stakeholders regarding the need for change, all agreed, but when the change was to be practically implemented, there were obstacles like fixed personal behaviours, indifferent attitudes, problems of interpersonal relationships, and a lack of interdepartmental cooperation. I adopted 'Soft Systems Methodology' (SSM) because it was appropriate for my leadership role and had already been successfully implemented in King's College Hospital, London. Moving through SSM, I held discussions with team members, managed meetings with seniors and colleagues, depicted the new process through 'process flow diagrams' (Figure 1,2), aroused the need for change in the minds of stakeholders, and convinced them to work for an ethically motivated purpose.

To search out the effect of change and stakeholders' opinion about it, I adopted mixed-methods research, which is defined as the type of research where the researcher mixes quantitative and qualitative research techniques into a single study (30). The quantitative data comprising the responses to the four questions showed that all the participants in the three groups agreed on the need for change. While the majority (75%) of senior team members were satisfied with the method of introducing the change as well as the new process itself (Q 2 & 3). A minority of participants (25% to 34%) differed in this connection. And when we explored their opinion in a focus group discussion, it was revealed that the PGs were concerned due to the attitude of junior doctors; the house officers and the nurses were thinking so because they had to deal with the lower staff, which was already deficient. It was clear from the project and the change I tried to introduce that it would result in transferring the burden of patients and their attendants to the ward staff. For that purpose, everyone in the team had to come out of his/her comfort zone, which was a challenging situation. The senior doctors needed to change the behaviour of junior ones, and the nurses had to tackle the lassitude and avoidance habits of the ward servants. These were the real obstacles or threats requiring continuous monitoring and feedback. The new process, though adopted as an experiment and later on implemented through the notification of the ward chair, was still to be anchored in ward culture and routine. Obtaining 360-degree feedback from house officers, PGs, nurses, patients, and their attendants directed my efforts to remove the obstacles from the path of change. The problem of a shortage of staff and collaboration between the two departments, surgery and pathology, was solved through discussions with the respective chairs and seeking adjustments in the schedule.

Motivation is important for any change to happen. Motivation through rewards is either not effective or short-lived, and works for manual skills, not for cognitive abilities (31). I worked through the 'transformational leadership' style, which means "influencing the process by arousing and satisfying the higher order motivation of followers towards exceptional performance". This higher order motivation I achieved by referring to the pinnacle of my vision statement, ie, excellent patient care and an organized working atmosphere for better learning and research activities. During meetings and discussions, I persuaded the resident trainees and house job doctors, saying, "We as doctors are dealing with human lives, and better care can only be provided if our work is organized and our attitude is humane and empathetic". Everyone in the team realized the sensitivity of my argument and agreed to work for the change. Transformational leadership is characterized by idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration (16). Referring to the moral and religious values and the Holy teachings about the sacredness of human lives helped me to create inspirational motivation and idealized cooperation among my team members. I influenced the residents through discussions to realize their 'role' as 'model' for house officers and guided them to work for the success of the new process of handling the lab samples. In this way, working through transformational leadership style, I energized and empowered my team members, house officers, and residents, and got their cooperation for change management.

Conclusion

Professor Ralph Stacey says that organizations emerge as a result of the policies and plans of their leadership and the reactions of people to these plans (32). In the beginning, our change effort faced 'complexity' due to disagreement among doctors about the new process, and uncertain policies of two departments- surgery and pathology. Many doctors, nurses, and other staff, though, agreed with the significance and benefits of the new process, but were not ready to come out of their 'comfort zone'. I acted as a resolute leader, combined ethically inspired purpose and empathy, and struggled to maximize 'agreement' among stakeholders and obtained policy decisions from two departmental heads. At annoying occasions and discouraging responses, I adhered to the tools of emotional intelligence: self-awareness, empathy, social expertness, and mastery of purpose (33). Even after formal implementation, I kept the momentum of my efforts, through coaching, discussions, and reminders, to anchor the change in behaviors and ward's culture.

Declarations

Data Availability statement

All data generated or analysed during the study are included in the manuscript.

Ethics approval and consent to participate

Approved by the department concerned. (IRBEC-24)

Consent for publication

Approved

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Conflict of interest

The authors declared the absence of a conflict of interest.

Author Contribution

HNA (Assistant Professor)
Conducting project, study design, manuscript writing, literature, Referencing, finalizing the manuscript
WSM (MBBS final year)
Literature search, manuscript preparation
FSM (MBBS 3rd year)
Electronic and typographical configuration, manuscript, preparation.

All authors reviewed the results and approved the final version of the manuscript. They are also accountable for the integrity of the study.

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