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# Ten Keys to the Successful Use of Appreciative Inquiry in Academic Healthcare

By Anne S. Williams  
and Julie Haizlip

Organization Development professionals work across a broad range of industries. Whether it be banking, accounting, insurance, retail, or home-building, the challenges each organization faces are fundamentally the same—too much hierarchy, unclear goals, disengaged staff, poor leadership, structure that gets in the way, ineffective communication, silos, and so on. Most OD practitioners find that their tools and skills translate relatively easily from one industry to another. One exception to this may be the field of healthcare, particularly in academic settings. Academic healthcare organizations are, I believe, unique, straddled with their own pervasive, subtle, and complex challenges. After working as an OD practitioner in a teaching hospital for the last seven years I believe that OD skills and Appreciative Inquiry (AI) in particular, must be applied differently than in a traditional business setting. This article describes the distinctions between an academic medical center and other typical for-profit businesses, provides two case studies demonstrating the successful application of Appreciative Inquiry in an academic healthcare setting, and finally, based on 3 years of trial and error with AI in a healthcare organization, spells out the lessons learned over time.

## Forming the Center for Appreciative Practice

Prior to 2009 the climate at University of Virginia Health System (Health System) was one of employee disengagement and faculty discontent. At that time the

health system was divided into separate entities—the hospital, the medical school, the nursing school, and the physician practice plan. Independent efforts to improve the culture within each of these silos had little impact. Faculty morale was at an all time low. Our first employee engagement survey highlighted a disturbingly low level of commitment across 6,000 employees in the Medical Center. Marketing studies demonstrated that the Health System’s local reputation was being impacted by this discord. It was at this juncture that executive leaders recognized that a united effort would be required.

In the fall of 2009 the executive team across the Health System tasked a small group of individuals with a special project: help bring positive culture change to the Health System using Appreciative Inquiry. AI was chosen as the change methodology in an effort to help members of the Health System community rediscover the many things that they do well. Thus The Center for Appreciative Practice was formed.

## Distinctions of an Academic Medical Center

Academic medical centers do not follow the typical US business model with their structure, mission, or goals. In academic medicine there are 3 missions—teaching, research, and clinical care. Therefore, most faculty members have three roles at once: teaching, research, and patient care. Each mission has its own bottom line requirements and funding comes from many different sources. The day-to-day reality of

supporting three different missions means that for individuals, teams, and departments there is constant competition for limited resources and allocations of time.

Each faculty member has many different reporting relationships in each arena—a medical director in the clinical unit, a chair overseeing teaching, perhaps a dean overseeing research, and a hospital administrator partnering on equipment and staffing. Culturally, in terms of authority and status within the organization, faculty members are valued based on their credentials and subspecialty skills; often those specialties that have the highest earning potential are valued most. For example, a surgeon who can perform a highly specialized procedure may command greater influence than a primary care provider whose work is equally important but perhaps less glamorous and marketable.

The three-fold mission and the role and structural confusion create an environment in which most faculty view themselves as autonomous, with no real boss, and, therefore, tend to function very independently with little regard for traditional hierarchy. For an OD practitioner this means simple tasks, like defining a team, are difficult because individuals function on so many different teams at the same time; and working through traditional hierarchical structure does not usually work. Staffing is tight so it is difficult to break away from the bedside or clinic for almost anything and in this setting patient care trumps every other need. Getting a doctor or nurse to attend a meeting or an event is challenging at best and sometimes impossible.

Marvin Weisbord shares in his 2004 article the four organizational features where:

Business firms and academic medical centers are mirror images. Business leaders managed “output-focused” organizations, emphasizing quantity and quality of goods and services produced. Output-focused systems typically had (1) Clear-cut formal authority, (2) Concrete goals, (3) High interdependence,

and (4) Agreed-upon performance measures. Customers evaluated businesses on the output end, based on satisfaction with goods and services. Academic medical centers were input-focused, evaluated by the staff’s professional credentials and state-of-the-art technology. Such systems tended to have (1) Diffuse authority, (2) Abstract and often conflicting goals, (3) Low interdependence, and (4) Few or no widely accepted performance measures. (p. 33)

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The financial reimbursement processes used by the government and US insurance companies puts excessive demands on providers, creates cumbersome administrative policies, and often creates conflicting goals for the practitioner. Faculty members must “earn” their own salaries, based on the number of patients seen, their teaching responsibilities, and their ability to secure grant funding. Clinicians are reimbursed more for performing procedures in the doctor’s office or the hospital than for their time with patients; in this way removing a mole becomes a more lucrative way to spend time than talking with a patient about lifestyle adjustments to improve heart health. Thus, a physician’s heartfelt desire to “do the right thing” for the patient often conflicts with the financial earning pressure from the organization, and even the physician’s own personal need for financial stability.

Another factor creating conflicting goals is that the nurses, technicians, housekeepers, ancillary staff, and others in the hospitals and clinics report up through an entirely different structure than the doctors. The result is that the goals and incentives, performance evaluations, and salary decisions are completely separate and often competing with those of their physician colleagues.

In the medical world the regulatory requirements are fierce. Technological advances in the industry are mind-boggling

and the acuity of the patient population rises each year. Caregivers are so pressed for time while on duty, that they often have to forego or postpone basics like sleep, food, and even bathroom breaks. Perhaps most importantly, the day-to-day pressures and stresses of this work are like no other, where people’s lives are, literally, in the caregivers’ hands.

Individuals who join this industry with compassion in their hearts, enthusiastic spirits, and a desire to make the world a better place are often beaten down by a system that is rife with seemingly insurmountable obstacles. The result is a workforce which is bogged down in bureaucracy, pulled in competing directions, unclear how to get answers, under unrelenting pressure, time-crunched, hungry and sleep deprived, unsettled by the high stakes, and, put simply, over-extended almost each and every day.

## The Work

Beginning in the fall of 2009 my colleagues in the Center for Appreciative Practice and I worked with over 35 groups across the UVA Health Systems ranging in size from 10 to 150 people, using AI for process improvement, strategic planning, team building, leadership development, and other applications. We had tremendous success improving workflow or patient satisfaction scores, for example, in about 30% of our work. Case studies one and two are examples of this success. We had solid success in 50% of the projects where groups resolved immediate conflicts, reduced communication challenges, built better relationships, and worked together to improve the overall climate within the group. And, 20% of our efforts just did not work. Analysis of these diverse outcomes helped us formulate our lessons learned.

When the Center for Appreciative Practice opened its doors in 2009 we offered monthly, 2-hour overviews of Appreciative Inquiry to anyone who wanted to learn more about AI as a tool for positive change. After one of these sessions, an enthusiastic nurse from Interventional Radiology approached us and asked if we could bring this process to her unit. With that, we began our first real project using AI.

### Case Study One: Interventional Radiology

Interventional Radiology (IR) is a clinical procedural area of the Health System that serves both inpatient and outpatient populations. Their team includes physicians, nurses, physician assistants, nurse practitioners, radiology technicians, patient care technicians, rotating residents and fellows, and administrative and housekeeping personnel. The group felt they functioned well but wanted to improve the coordination of their team members and assure that they were “all rowing in the same direction.”

My colleague and I helped the IR group form an interdisciplinary core planning team of 12 individuals including physicians, nurses, techs, and office staff to guide this process. We met with

the team to educate them about the AI 4D process (Discovery, Dream, Design, Destiny) and to determine an overall plan. The team decided to hold a retreat and do the Discovery process by interviewing every member of the department prior to the event. We helped the team create the interview guide and the plan for interviewing each other. When the interviews were complete, the team evaluated the stories and identified themes that represented their positive core. The entire department, approximately 50 staff and faculty, participated in a retreat, where themes from the Discovery process were shared and embellished and the entire group Dreamed about the desired future. The first session was so well received that the department elected to hold another three hour retreat to complete their 4D process. Leadership of the group was actively involved in the core planning team and the retreats. Ultimately, action groups were assembled to address three key areas—scheduling/workflow, communication, and innovation/research.

A number of changes were made in the IR department following their retreats. All were done by interdisciplinary teams. The primary physician, charge nurse, and lead radiology technician began a morning huddle to discuss the overall plan for the day. Scheduling templates were changed to accommodate add-on and emergent cases more easily. They developed a new system that created daily teams that work together in specific procedural areas. Protocols were established for how practitioners meet with patients and family members before and after their procedure. Follow-up cards were created for patients that listed the names of the physician, nurses, and technologists that worked with them. The group made a playlist of relaxing music for patients to listen to prior to their procedures, and also implemented an orientation program for inpatient nurses so that the care of intensive care patients would be better coordinated and ICU nurses would be more comfortable caring for their patients in the IR environment.

Anecdotally, members of the IR staff related a greater sense of collaboration as a result of this work. One member noted:

“The biggest benefit from participating in the AI process has been that we meet as an entire team instead of trying to solve department issues in individual doctor/nurse/tech silos.” One of the senior nurses also related that the culture had become much more solution-focused: “The culture is changing. The people who thrive on negativity don’t really have an audience anymore. When they complain, the answer is ‘what would you like instead?’”

This informal data is supported by the formal measurements conducted by the Health System. Over the course of the 1½ years IR worked with the Center for Appreciative Practice, patient satisfaction scores increased from 88% to over 93%, even though they experienced an increase in patient volume during that same time period. Annual employee engagement surveys demonstrated that the IR staff had increasing levels of commitment.

### Case Study Two: PM&R and Health South

Many of UVA Health System’s faculty and residents practice at the local Health South Rehabilitation Hospital, partnering with their nursing and ancillary staff to provide advanced rehabilitation services to patients across the Commonwealth of Virginia. In 2009, however, the partnership had eroded; the doctors and nurses were hostile, the working environment was described as “toxic,” and patient satisfaction ratings hovered near the 50th percentile. We were asked by the Chief Medical Officer of the UVA Health System to help these two groups come together to better serve the patients, and each other. Over the next 2½ years we conducted a series of interventions. We began with the leadership teams of both groups and focused the AI process on “building a shared vision and creating a renewed focus on quality and patient care.” They learned a new language, recognizing that they never described themselves as “we” but rather “us and them”; and they created a new, shared vision for all. The lead physician and the Chief Nursing Officer forged a bond and built trust though this process that was previously nonexistent. During

this time, a new head of Physical Medicine & Rehabilitation (PM&R), the physician group, stepped in. He set clear expectations for the groups to work together well; he actively and verbally supported the use of AI; and he reassigned one of the most divisive doctors. All parties agree that the AI process would not have been as successful without his strong, decisive leadership.

The Chief Nursing Officer created a nursing council to serve as a catalyst for additional, ground-up change. We trained the council in “appreciative practices” and techniques and they used an appreciative

During the retreat, hospital staff realized that nutrition services staff were not invited to nursing social events. Instead they were often asked to prepare the food! The second initiative began a few weeks after the retreat, when the nurses hosted a potluck lunch, inviting nutrition staff to come as guests. The social event was a “small” outcome in the overall scheme of things, but it went a long way toward strengthening relationships among co-workers.

Throughout the two years, the nurse leader consulted with us on how to run

sustained or did not translate to increases into qualitative measures such as patient satisfaction. As mentioned, we also had some dismal failures—areas where, after months of meetings, the process never got off the ground; or where we planned and carried out team retreats and nothing changed as a result. While not ideal, having a variety of outcomes contributed to our key lessons learned.

## Ten Lessons Learned

### 1. Truncate Time Demands for the Groups

#### THE PLANNING TEAM

- » Creating a planning team is a “must,” but you should use their time wisely. Tell them up front what the time commitment will be. We recommend setting up a series of meetings over 30–90 days to plan the process. Ask them to attend all group functions, and be sure to let them know they may be called on to help steer the process after the main intervention. You will rarely get the group to meet for more than one hour. If you can get 90 minute meetings, that is wonderful. Educate the group about the AI process very quickly and get to the heart of the work early. Do not expect everyone to come to every meeting.
- » Do most of the work for the planning team and then let them review it. We created the interview guide, the workbooks, set up all of the logistics for meetings and/or retreats, and created all of the materials. Their job is to guide and review.
- » Use an interdisciplinary planning team that includes representatives from different tiers of the hierarchy. This was key to our success in both case studies above. Use them as a reality check to help keep the logistics and time demands realistic for the group.

#### THE LARGE GROUP PROCESS

- » If you choose to hold a summit or retreat, keep it to a realistic amount

**One member noted: “The biggest benefit from participating in the AI process has been that we meet as an entire team instead of trying to solve department issues in individual doctor/nurse/tech silos.” One of the senior nurses also related that the culture had become much more solution-focused: “The culture is changing. The people who thrive on negativity don’t really have an audience anymore. When they complain, the answer is ‘what would you like instead?’”**

approach to solve a challenging problem: food service to their patients. In 2010 we held an all day AI retreat using the 4D model with Health South’s dietary services staff, nurses, physicians, and therapists, to build “a cohesive team, cooking up positive change around communication, trust, and understanding—with the ultimate goal of improving patient care and nutrition services.” During their retreat new relationships formed and individuals gained better understanding of one another’s roles and challenges.

Specific actions were identified during the Design phase. Immediately after the retreat teams of nurses and dieticians launched the first new initiative. They installed a computerized meal ordering system that immediately increased patient choice and the accuracy of meal orders. It also improved nursing and dietary staff communication. This new system did not cost any money; together they modified a system which already existed.

team meetings, how to introduce procedural changes, and sought guidance on the implementation of other initiatives, always using an appreciative approach in her leadership style. In April 2011, Health South closed the month tied for 1st out of 101 hospitals for their overall rating of patient satisfaction; up from the 50th percentile in 2009. The Chief Nursing Officer said, “I keep the focus on building our strengths as well as building on the success and strength our patients gain each day—whether it is physical gains or in knowledge.... The tools and philosophy changed how I lead, creating success at every turn.”

These two cases highlight some of our greatest successes. The majority of the groups we worked with had an actively engaged, multidisciplinary planning process, had well attended and successful retreats, and were able to implement incremental changes. For these groups the process was regarded as a positive experience, however, the results were not

of time. Two-day summits are hard and a longer one is virtually impossible if you want everyone to be involved. If you can get groups to commit to 12 hours, split it into two 6-hour sessions or three 4-hour sessions. After much trial and error we were able to condense our basic retreat format into an 8-hour retreat! Getting everyone in the room for one day is a small miracle; take it as a gift. We also learned to let people attend parts of the retreat, rather than requiring that they attend all or nothing.

## 2. Tone Down the Lingo

- » Emphasize the science behind AI, and minimize use of words that are perceived as fluffy or are so specific to AI that others do not understand their meaning. Words and phrases we modified or dropped from our vocabulary included—dream, positive core, provocative propositions, improbable pairs, and “what gives life to.” Instead we used the words vision, strengths, guiding principles, someone who is different from you, and energize.

## 3. Involve Everyone

- » Do not compromise on this part. In academic healthcare, providers tend to associate most with those in their discipline or specialty, and not necessarily with others in the area in which they practice. So building relationships across disciplines is essential to improving teamwork at the bedside or in the clinic. Make the process as interdisciplinary as possible and do this from the very start. You can “insist” on this during the “contracting phase” as you would in a traditional OD intervention. Find out which faculty are viewed as formal and informal leaders of the group and involve him/her as much as possible, so they will encourage other faculty to participate. Always use improbable pairs. Always level the hierarchy in the room—mix management and

staff, doctors and nurses, use first names only even if everyone else in the room calls him/her “Dr. Jones.”

- » Be sensitive to night shift schedules. Hold meetings in the early morning or in the late evening so they can participate.
- » Where possible, have the groups offer to pay staff overtime if this process extends work beyond their normal schedule.
- » Offer the same process (a 4-hour retreat for example) multiple times to the same group so that a small group of the staff can attend while the other part of the staff is working. After everyone has gone through the process, hold an “integration” session with representatives from each of the subgroups.

## 4. Build and Keep Leadership Commitment

- » We often coach our leaders as part of this process. Help them understand their role. It is important that they support the process but they do not have to lead it. Help ease their anxiety about losing control and the need to predict or control the outcome. During a retreat or summit the leader may have to wear two hats—as an active participant and as a leader. Help them see when each role is appropriate.
- » We have learned that the role of the leader in the Destiny phase is, perhaps, the most critical. When action plans are being created and ideas are ready to be implemented, the leader needs to step up to pave the way and remove barriers to make things happen. In the groups that did not succeed, the leaders became completely disengaged during the Destiny phase. It is critical that they set clear expectations for action and hold people accountable, including the doctors, for timelines and deliverables. The best leaders help shift the priorities of their staff/faculty and adjust schedules to allow people to participate in meetings and implementation processes.

## 5. Let Go of Having the “Perfect” Space or Environment

- » Holding meetings in back hallways and crowded rooms is part of the normal work day for most health care providers. Of course space makes a difference and hotel and conference facilities are wonderful, but they are usually expensive and participants often need to rush back to work. Therefore, for the caregivers, offsite sessions are not always best.
- » In hospitals a lot of people eat “on the go.” Always offer food and be prepared to have people eat during meetings. Care providers’ pagers frequently need to stay on. And there will always be those who have to come in late and/or leave early. Most care providers are used to it.

## 6. Focus as much on Design and Destiny as Discovery and Dream

- » These are scientific, action oriented, and outcome oriented people. Let people know you will have outcomes, from the very first conversation about the process. Allow plenty of time for action planning.
- » Dream, but dream more cognitively and less dramatically. We had great success using visualization cards, having groups draw on flipcharts, or simply create headlines to capture their hopes for the future. When groups Dreamed by doing skits or performances that was sometimes the most talked about part of the process; the substance and content got lost.
- » Once a common vision has been achieved, immediately turn your focus to determining the key areas of focus and the actions required for the next 6–18 months. Help keep the action planning and implementation processes realistic and tangible. Health care workers have minimal time to devote to committee or group work. If it is not important to them or they cannot see the benefit, they will not prioritize the work. To create success, ask groups



to identify two or three key focus areas and work on them in depth.

**7. Be Flexible with the Process Design**

- » Allow the group to do the 4-D process over time rather than in a retreat or summit. With one group we did one “D” each week for 4–8 weeks. With another group we created a way to do Design in the break room, allowing everyone to generate ideas and prioritize key areas of focus over a two-week period.

**8. Follow up! Stay with the Group During Destiny**

- » Give them support, structure, and guidance during the action planning and implementation phase. Remember to coach the leader during this phase; help him/her set deadlines, hold people accountable, and to find a wide variety of communication methods to share activities and success.
- » Most groups create small action teams or implementation teams. We found that these groups often need guidance. We offered to facilitate their meetings or teach them skills such as brainstorming and decision making processes.
- » Create an interdisciplinary oversight team (often it is the same as the original planning team) to steer this phase and have the leader on the team. We created a “cheat sheet” for the oversight team giving it three important roles—to communicate the work and progress of the action teams; to coordinate the action teams to reduce redundancy and ensure alignment; and to champion and role model appreciative practices back on the job.
- » It is incredibly easy for groups to lose momentum or lose their positive focus. We often do follow up education for the groups, to teach them more about appreciative practices to use every day, such as beginning meetings with stories of

what’s going well, the “flip,” or the art of the positive question.

**9. Supplement Appreciative Inquiry with Other OD Tools and Processes**

- » The AI process cannot address every issue within a team or organization. Poor leadership still needs coaching, bad attitudes need to be addressed through a solid performance management system, and arrogant doctors or crotchety nurses still need self awareness and feedback to adjust their behaviors. Be open and honest with your groups and leaders about what AI can and cannot do and be prepared to offer other solutions from your OD toolkit.

**10. Trust the Process**

You will encounter more than the usual number of skeptics when using this process with a health care audience. Health care workers are inherently problem-focused. Flipping the perspective to “what you do want” and “the ideal” can be a bit unnerving. Do not be dissuaded. Many of our loudest grumblers have become our biggest fans.

Our journey has been an interesting one and the learning curve has been high. We have certainly gained greater clarity and focus, and can now articulate the criteria for success as we begin a project rather than in hindsight. The most recent validation of the success of our grassroots approach to bringing positive change to the University of Virginia Health System was that in November 2011, the executives of the Health System agreed to carry forward the funding for the Center for Appreciative Practice on an ongoing basis.

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