Expanding infection preventionists’ influence in the 21st Century: Looking back to move forward

Mary Lou Manning, PhD, CRNP, CIC
Philadelphia, Pennsylvania

The 5th Decennial International Conference on Healthcare-Associated Infections took place in Atlanta in March 2010. The conference was unprecedented in the variety, depth, and breadth of scientific sessions and research abstracts informing the practice of health care epidemiology and infection prevention. However, noticeably absent were topics or related discussions focused on essential leadership skills and influence strategies required to implement the science into practice.

Key Words: Leadership strategies; influence.

Leadership is often considered the art of influence. Northouse1 describes leadership as a process in which an individual influences a group of individuals to achieve a common goal. Influence is about getting people to change—change that can be expressed as an attitude, perception, or behavior. Infection preventionists (IPs) know that it takes multilevel influence strategies to mobilize people to action, but what are the active ingredients of influence and why have some IPs mastered the ability to recognize and seize influence opportunities while others have not? What is it that IPs must know and do to successfully influence behavior to improve practice? To answer these questions requires a brief look back to more fully understand the power of influence as we move forward.

LOOKING BACK

In 1970 the Centers for Disease Control and Prevention (CDC) recommended that hospitals establish positions for an infection control nurse.2 Soon thereafter, the Joint Commission for the Accreditation of Healthcare Organizations (now the Joint Commission) required compliance with established infection control and prevention standards and guidelines as a condition for hospital accreditation.3 One such standard required that a qualified person manage the infection surveillance, prevention, and control program, leaving it up to the organization to determine the definition of qualified.4 The early IPs were most often nurses who entered the position from clinical practice. Their basic functions included the tasks of infection surveillance and promotion of prevention measures such as handwashing, isolation precautions, and aseptic technique, as well as monitoring staff adherence to regulations and guideline recommendations. Little, if any, attention was given to leadership proficiency.

For the next 30 years, infection prevention and control programs existed primarily to satisfy regulatory requirements and as such were undervalued and poorly supported in the US health system.5 Programs were structured primarily to detect infections and conduct epidemic investigations, not to lead and influence strategic initiatives to improve patient outcomes. This began to change with release of the Institute of Medicine (IOM) reports, To Err is Human: Building a Safer Health System (1999)6 and Crossing the Quality Chasm: A New Health System for the 21st Century (2001)7 as each drew greater attention to patient safety and preventing adverse events and errors in health care. The 2004 IOM report, Keeping Patients Safe: Transforming the Work Environment of Nurses8 called for the adoption of transformational leadership and evidence-based care to increase patient safety and reduce medical errors, such as healthcare-associated infections (HAIs). The CDC and the Healthcare Infection Control Practice Advisory Committee added national momentum by drawing significant attention to the scope of HAIs, as did other initiatives, such as the Institute for Healthcare Improvement 100,000 Lives Campaign and the Joint Commission’s National Patient

From Thomas Jefferson University, Philadelphia, PA.
Address correspondence to Mary Lou Manning, PhD, CRNP, CIC, Thomas Jefferson University, Jefferson School of Nursing, 130 South 9th St, Edison Building, Room 1230C, Philadelphia, PA 19107. E-mail: Mary.manning@jefferson.edu or marylouman@gmail.com.
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As the first decade of the 21st century draws to a close, the field of health care epidemiology finds itself in a formidable position. Never before has the field garnered such intense interest on the part of politicians, policy makers, consumers, advocacy groups, regulatory agencies, mainstream media, and the government. Prime examples include Medicare’s 2008 no pay for errors rule, eliminating reimbursement to all acute care hospitals for the extra cost of caring for patients who develop certain infections during hospitalization deemed reasonably preventable, and legislative mandates requiring public reporting of HAIs in more than half of all states in the United States.

Predictably, as HAIs received more public scrutiny, health care administrators and governance boards became acutely aware of the financial, legal, and public-relation consequences that HAIs impose on health care organizations, not to mention the associated human toll on patients and families. Consequently, the health care epidemiology landscape changed dramatically, and IPs find themselves in the spotlight with a new audience asking different and tougher questions.

Today’s health care environments challenge the skills of even the most experienced IPs. The care and treatment of patients are exceedingly complicated in the increasingly complex health care environment. Emerging infections, new technologies, multiple treatment protocols, numerous providers, and varied health care settings all contribute to patient’s increased risk for infection. IPs are increasingly called on to provide expertise in a wide variety of areas that go beyond traditional infection prevention, such as emergency management, occupational health, patient safety, antimicrobial stewardship, product evaluation, facility design, health policy, and development of surveillance and prevention systems for noninfectious events. In some settings, IPs are expected to lead intraprofessional improvement teams and provide expert consultation as they advocate, champion, develop, guide, implement, measure, and evaluate prevention strategies in movement towards the controversial goal of targeting zero HAIs. Increasingly, they are being invited to the C-suite (a term used to describe the most senior leaders in an organization, such as the Chief Executive Officer, Chief Financial Officer, Chief Operational Officer) to provide expert guidance to health care executives as they strategically plan and evaluate infection prevention and control strategies from operational, financial, and business perspectives. Each venue provides strategic opportunity for IPs to exert influence to improve health care quality and patient safety, while concurrently acknowledging the contribution of programs and colleagues throughout the organization.

Considering these collective events, several critical questions emerge: (1) do today’s IPs have the requisite leadership skills to capitalize on the opportunities, (2) can they recognize and create influence opportunities or are they waiting for an invitation that may never arrive, (3) can they successfully navigate the complex organizational systems and administrative hierarchies to influence organizational decisions to ensure survival and success, and (4) can they break free of the insular focus of infection prevention and control and see their contribution within broader organizational needs and future directions?

MOVING FORWARD

Moving indicates action—moving forward denotes looking over the horizon to anticipate the future. To influence the future requires reflection on the past, understanding the present, and envisioning the preferred future and the role and value of IPs in that future. Future vision requires enhanced leadership and the ability to influence others, a key ingredient for organizational success in the current competitive health care environment. Kirkpatrick and Locke identify influence as an essential competency that differentiates effective from ineffective leaders, and Guo suggests that leaders must actively engage in the practice of influence to exploit opportunities (eg, set priorities on important activities, elicit organizational cooperation, or acquire needed resources and information). As never before, the IPs role provides unprecedented opportunities to influence the care of patients, in a very broad context, at every level of the health care system.

Predictably, as national and international momentum and visibility for reducing HAIs escalated, other disciplines and professional groups became more interested in moving into the traditional infection prevention domain. Consequently, in some settings, there has been a convergence of quality improvement, patient safety, and infection control programs, and as Edmond states, “these groups have different strengths, perspectives, and approaches that, sometimes, leads to conflict.” After years of practicing in the shadows, this blending and sometimes elimination of programs and roles can appear unjust and unwarranted, given the almost 4 decades of health care epidemiology success and proven value.

However, as Marshall Goldsmith explains in his New York Times bestseller, What Got You Here Won’t Get You There, successful people need to make changes to continue to be successful, especially in times of organizational change. He contends that the very same skills that got people where they are may be damaging their current success or preventing them from reaching the next level of achievement. Seth Godin provides
additional support for this idea in *Linchpin, Are You Indispensable?* The author convincingly argues that in today’s hypercompetitive world people must be linchpins, namely, “the person who holds part of the operation together” and “who can walk into chaos and create order, someone who can invent, connect, create, and make things happen.” He writes, “the only way to get what you’re worth is to stand out, to exert emotional labor, to be seen as indispensable, and to produce interactions that organizations and people care deeply about.” Both books are essential readings for 21st century IPs who strive to lead and influence.

**INFLUENCE**

Leadership is a process of influencing aspirations, behaviors, and circumstance and, as such, requires mastery of one’s self; mastery of relationships; and mastery of multiple ways of being, thinking, feeling, and doing to transform problems into desired outcomes (Daniel Pseut; December 8, 2009; personal communication). Influence is the ability to get people to change an attitude, point of view, perception, or behavior.

Few IPs have real power, but they do have significant access to key organizational leaders and clinical decision makers. In 1997, Jackson stressed the importance for IPs to know how informal power structures influence decisions, while other authors stress the ability to learn to influence without authority, influence others at all levels of the organization, and influence discussions. Most recently, Soule wrote of the need for rigorous research on methods to influence behavior and improve practice. Lacking is conceptual clarity of what constitutes influence, motivating the author to describe 3 key influence skills, namely, self-knowledge, strategic relationships, and reciprocity.

**SELF-KNOWLEDGE**

A standard piece of advice given to aspiring leaders and managers by both scholars and practitioners of leadership is “know thyself.” Self-knowledge, in the context of 21st century health care, is described as the ability to understand and develop the self in the context of organizational challenges, interpersonal demands, and individual motivation. Self-knowledge leads to greater self-awareness and the ability to recognize and understand one’s moods, emotions, values, strengths, needs, and drives, as well as their effect on others. Self-aware people have a firm grasp on their capabilities and can be recognized by their self-confidence. They play to their strengths and the strengths of the people around them. Knowing and playing to one’s strengths is an essential IPs influence skill.

Business guru Peter Drucker writes, “Most people think they know what they are good at. They are usually wrong. And, yet, a person can perform only from strength.” A strengths based approach to leadership involves gaining insight and understanding of one’s individual differences, signature themes, and natural talents. The Gallup Organization concurs with Drucker and believes that each person’s talents are enduring and unique and that each person’s greatest room for growth is in the area of his or her greatest strength. The organization surveyed its database of more than 1.7 million workers in 101 companies from 63 countries on the topic of employee engagement and introduced the StrengthsFinder online assessment in the 2001 book, *Now, Discover Your Strengths*. This 180-question Web-based assessment enables people to discover their top 5 signature talents, strengths, or themes. Identifying which of the 34 strength finders themes is dominant enables a person to leverage them for personal and professional success. In 2007, *StrengthsFinder 2.0* was published providing specific strategies and ideas for action for applying one’s strengths.

Whereas the subjective mind is a primary source of knowledge about our selves, it is not the only one. A second potential source of self-knowledge is other people (eg, colleagues, peers, direct reports, supervisors), and, by carefully eliciting how other people view us and appreciating how their perceptions differ from our own, we can consider the possibility that they are correct. Studies indicate that most people don’t see themselves as others see them. In fact, people often disagree with their peers and colleagues about their own personality traits, yet peers often agree among themselves and their views are more predictive of the person’s behavior than the person’s self-views. Such evidence supports the importance and value of seeking feedback from others. Three hundred sixty (360)-degree feedback has long been recognized as an accurate and impactful way of systematically collecting multiple perspectives about one’s capabilities. It provides a more accurate assessment because multiple sources are better than just one source (eg, manager evaluations), and people in different roles see different behaviors. Inviting others to participate in a 360-degree assessment also provides the added benefit of actively demonstrating the value of their opinion. Many 360-degree tools are available including Voices (www.voicesfeedback.com), Manager-view (www.managerview.com), and Censeo (www.censeo360.com). Results are used to formulate developmental goals for areas of growth. If they have not already done so, it is in the best leadership interest of every IP to conduct such an assessment.

A third source for increasing self-knowledge is in making conscious attempts to better observe one’s
own behavior and in taking the time to critically examine one’s actions more carefully. Drucker30 suggests that, “Every time you make a key decision or take a key action, write down what you expect will happen. Several months later, compare the actual results with your expected results. Practiced consistently, this simple method will uncover patterns that will show you what you are doing or failing to do that deprives you of the full benefits of your strengths.”30(p3) This author posits that knowing thyself may be the most important, if not one of the most important influence skills for 21st century IPs.

STRATEGIC RELATIONSHIPS

Understanding systems is a requisite for building strategic relationships. According to Porter-O’Grady and Malloch,35 systems are the sum of all the dynamics that drive them and are best viewed as a set of relationships rather than components (eg, departments or divisions). During the 20th century, IPs, as a new discipline, focused on defining themselves by what separated their work from the work of others (eg, infection surveillance), rather than on what connected them (eg, keeping patients safe). In many cases this resulted in linear thinking and insular departments, with minimal time devoted to building and nurturing relationships or understanding the goals and operational activities of complementary departments. In today’s complex health care, successful IPs build strategic relationships and know that boundaries are fluid and that no department or discipline provides services independent of its relationship to other parts of the organization.

The success of IPs depends on the support of people over whom they have little or no direct authority making it critical to cultivate strategic relationships to achieve desired end goals. The challenge for those who lead without formal authority is to draw attention to the issue or initiative, without drawing too much attention to themselves. Interprofessional cooperation is essential to successful implementation of infection prevention strategies, yet Reeves et al36 suggest that building effective lateral or cross boundary relationships can be one of the most difficult influence skills to master because of established professional hierarchies, strong turf mentality, discipline-specific patterns of socialization, and insufficient time to build relationships. Similarly, leadership support is required for successful infection prevention improvement initiatives, yet based on the findings of 3 studies that examined the effects of leaders’ inner-circle membership and interpersonal influence, inner-circle members exerted more decision influence, and leaders attended to and recalled suggestions from their inner circle more often regardless of argument strength.37 The results of such studies have important implications for IPs who are building strategic professional relationships, including (1) it is not just what you know but who you know; (2) social ties across hierarchal positions enhance influence; (3) inner-circle leader membership can be used to leverage decision-making involvement and gain access to resources and contacts; (4) the importance of nurturing existing influential relationships and investing time in building new relationships with people who are likely to be critical to success; and (5) knowledge, hard work, and persistence are important personal attributes but, under some circumstances, may have limited effectiveness.

Two additional factors in forging strategic relationships include preferred style of interaction and liking. We each have a preferred style of personal interaction, and our style may not fit with others preferred style. For instance, one person may prefer receiving a written problem summary several hours before an important meeting so that they can read and understand the problem. Another may get annoyed with such a summary and prefer to listen to the free-for-all brainstorming session. In other words, one person is a reader, and the other person a listener.30 Obviously, we are not going to change our personality structure, but we must become aware of what it is about us that facilitates or impedes building relationships and, with awareness, modify a behavior to make relationships more effective.

Liking is described as a feeling of connection, yet few of us readily think of liking as an influence skill, but, in reality, people prefer to say yes to individuals they know and like.37 Interestingly, health care professionals often use the word rapport to describe such a connection with a colleague or patient. According to Cialdini38 those who use the power of liking to enhance influence often focus on the related factor of similarity (eg, we like people who are like us) to expedite rapport, compliments, or praise, resulting in positive feelings and behavior. Drucker30 suggests that whether 2 people like each other or not, it is manners (eg, simply saying such things as please and thank you) that enable them to work together. He refers to manners as the lubricating oil of organizations.30

RECIPROCITY

Leadership is a reciprocal process between formal or informal leaders and their constituents, so any discussion of influence must attend to the dynamics of this relationship.38 Reciprocity, the almost universal belief that people should try to repay, in kind, what another person has provided is the basic principle behind organizational transactions and a potent tool to achieve influence.39 In the book, Influence: The Psychology of
Persuasion 39 Cialdini identifies the Rule of Reciprocity as 1 of 6 basic social principles that form the foundation for successful strategies used to achieve influence. He contends that reciprocity is a process of exchanges (or currencies) and that influence is possible because one can offer something that others need and then expect that over time their actions will be repaid in one form or another. In essence, the highly effective reciprocity technique (e.g., you must give to receive) is about gratitude—influence in its purest form.

Reciprocal exchanges occur throughout health care organizations: between an employee and their manager, among peers, clinicians, and administrators. The exchange can be of tangible goods (e.g., salary, personnel), tangible services (e.g., information), or public support (e.g., gratitude, appreciation). The exchange can also be self-generated to fit a belief or value (e.g., cooperation, trust) and thus self-satisfying. For example, IPs encounter self-generated exchanges daily in the form of clinicians adhering to infection prevention guidelines to protect patients from harm.

According to Kouzes and Posner, 40 reciprocity is the most successful approach to daily decisions because it demonstrates a willingness to be cooperative, thus people who reciprocate are more likely to be successful than those who try to maximize individual advantage. The authors further contend that, as long-term strategy, reciprocity minimizes the risk of escalation, for, if people know that another will respond in kind, they tend to avoid conflict. Thus, reciprocity leads to predictability and stability in relationships.

IPs have a significant stake in knowing how to elicit desired actions and behaviors and, as such, must not be perceived as always asking for things (e.g., more resources, greater compliance, less infection) for in such circumstances, cooperation may be virtually impossible. Also, if viewed as excessively dictating or controlling, and having little interest or understanding outside their own issues or initiatives, others may sabotage cross-discipline attempts. Therefore, IPs must find common ground where they can provide help or assistance because, despite the clear need and appropriateness of what is being asked for, a positive response is not always forthcoming. IPs must also appreciate the importance of concessions—understanding that, when people start out with incompatible positions, and one person makes a concession, others feel a need to reciprocate with a concession in return. 37

Finally, it is never a good idea to approach people for the first time when you need something from them. If at all possible, IPs do not want the first conversation with someone they need when an issue arises to be about a problem because there is no preexisting support or obligations on which to draw. Therefore, it is imperative that IPs take full advantage of all opportunities to reach out, introduce themselves, describe their roles and responsibilities, communicate effectively, and provide information pertinent to those they seek to influence. Such people include administrators, nurses, physicians, patient safety officers, performance improvement teams, colleagues, peers, policy makers, or others. Only after an IP has proven their value and credibility, can she or he begin to fully utilize reciprocity to influence events and people.

SUMMARY

The discipline of infection prevention and control has an impressive past, expansive present, and promising future. As we move farther into the 21st century, infection prevention and control will continue to move into previously uncharted territory, and realities affecting health care most likely will dramatically and radically change the landscape for IPs practice. Successful IPs know how to chart their own future and look beyond the issues and activities of the moment to see the emerging shifts and circumstances that will ultimately affect health care and their role in it. They seize opportunities for self-development and engagement. In today’s health care arenas, influence is accessible and available to all, but few understand exactly what makes influence an effective tool. When used separately, self-knowledge, strategic relationships, and reciprocity are 3 powerful tools of influence, but maximum impact is achieved when used collectively.

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