KAI PODCAST 4

DH: Dave Harries

MS: Dr Megan Siebel

RS: Dr Robert Samuel

DH: [0:00:00.0] Welcome to the KAI Podcast Series, 'Building Better Teams and Great Leaders.' KAI, or the Kirton Adaption Innovation Inventory, is the world's foremost measure for problem solving style. It's used widely to create cohesive and productive teams and effective leaders. It's been in use for over 40 years and is supported by a large body of academic research from around the world. In these podcasts, we aim to shine a light on the issues and problems facing all teams as they strive to be effective and productive.

In today's episode, we're going to explore health and healthcare systems in the context of KAI and how the patient to provider relationship at the heart of all healthcare, impacts health outcomes, and what KAI can tell us about that relationship.

My name is Dave Harries and joining me today to talk about KAI in relation to health care I have two distinguished guests. Dr Megan Siebel is an Associate Director at the Centre for Cooperative Problem Solving at Virginia Tech in the United States. She is a highly experienced leadership programme director with a background in health care, she's a registered nurse, higher education and the agricultural industry. She is a KAI Associate Fellow.

Dr Robert Samuel is a healthcare technology executive from Bluebell, Pennsylvania. He is an experienced enterprise architecture manager specialising in emerging technology and innovation in healthcare. He's also a graduate level adjunct instructor at Penn State University, and he has been an accredited advanced KAI practitioner since 2009.

Welcome both of you to the podcast. So popular culture is full of medical dramas that invariably, if not always insightfully, explore aspects of this patient to provider relationship. One of my favourites of the last decade or so has been the American medical drama, 'House,' where a misanthropic but brilliant a doctor played by Hugh Laurie successfully leads his team of diagnostic experts to relieve and cure numerous mysterious illnesses, despite his complete lack of bedside manner and a rather jaundiced view of the world and most of his colleagues and patients as well.

I wonder, Megan, and Robert, if this rather extreme fictional version of a medical practitioner can tell us anything useful about the challenges of that patient to provider relationship? Megan, maybe I can get you to comment on that?

MS: [0:02:21.9] Sure. I think a character like that exemplifies extreme personality aspects, of course. But we know that it also takes teams of individuals in order to solve complex situations and address complex patient dynamics, diagnoses, medical mysteries, if you will.

One of the things that's particularly interesting about Kirton's Adaption Innovation theory is that we know that it takes both adopters and innovators to dance in that really complex problem solving space. And we need to figure out what team dynamic looks like so that as the situation adjusts itself over time, and new bits of pieces of information emerge, we can actually leverage different individuals as leaders in that space so that we can do something with that.

So I would characterise Dr House's character as somebody who's maybe expressing some of the characteristics of more extremely innovative or highly innovative individuals from a preference standpoint, as far as thinking differently about things, disrupting norms and expectations, asking a lot of questions, perhaps disregarding other people in his wake. And yet, at the same time in order to do something with that information, other people will have to come in and be able to put those bits and pieces back together. So it's an interesting dance to watch unfold and I think there's a lot to be said for

where that leaves patients and families even in that dynamic when they're working with their doctors to figure things out.

DH: [0:03:53.8] And his best friend, or his only friend really, is a fellow doctor, an oncologist who I would guess on the face of it, it's probably at the opposite end of the spectrum in terms of the KAI theory. They're supposed to be based on Holmes and Watson from Sherlock Holmes stories and that sort of thing. Robert, I'm making a bit of a joke of it, but do you think there's useful things in there that we can learn?

RS: [0:04:18.9] Oh, absolutely, and 'House' is one of my favourite shows of all time. I think that the unconventional portrayal that he shows in the medical system and the challenges that he introduces towards the hospital rules and procedures, exemplifies this thinking of we are waiting for them to come up with this 'Aha!' moment. We're all sitting on the edge of our seats, watching the show, waiting for House to come up with this 'Aha!' moment.

Now, in real life, most of the time as a patient, you're not waiting for a physician, a doctor, someone in the medical industry to come up with that 'Aha!' moment. You want them to have a protocol, a set of rules, a set of predictable manner. So I think, the role of Watson in the show comes across as that what we're predicting is that constant, reliable heuristic style of clinician that we come to look for in our engagements. And so you get this nice balance and from an AI theory perspective, we like to see these interactions as a balance of what's needed in the overall problem solving approach within healthcare system.

DH: [0:05:43.6] That's true, isn't it, Megan, and I think when most of us go to the doctor, we probably go a little bit reluctantly, and we assume the doctor, or the healthcare professional we're seeing, will have all the answers at their fingertips. So I suppose in that sense 'House' isn't particularly a common occurrence for most of us. But talk to me a little bit about what's going on when we first encounter our health care provider, and the sort of things you know that that happened to us then in our interaction.

MS: [0:06:12.1] So as individuals, any time we're faced with an unknown - perhaps it's a anticipation of a diagnosis, a treatment that's been suggested to us that we may or may not be familiar with, sometimes even what seems like a counterintuitive conversation around what we feel like we're experiencing in our own selves in our own bodies and what the medical practitioner is saying test results are revealing, or what they have seen in their experience - that perception of change is very individual, and how we are viewing that as minor manageable or perhaps catastrophic in what's being conveyed, influences how well we listen, how receptive we are to that, and how willing we are to follow what has been indicated and prescribed.

And depending on how that's being presented to us, and the doctor's perception of what it is that's going on, there sometimes can be a mismatch or an imbalance there. Hopefully, throughout this conversation we'll get into a little bit about how people cope with that gap and how motivated they are to figure out ways to overcome that. But what we do know is that in order to develop any sensibility around belief or willingness to do what is being asked of us, and develop the insight that it takes in order to do that, so that we can take that into the future moving forward, is very motive dependent. There really needs to be a combination of what is being told and asked of us, sort of that external motivation, and then where we are ourselves going into that situation with the ability to gather our own information, and so to speak put our own structure around what it is we're trying to understand to make best use of it for ourselves, that will also help us drive that internally.

DH: [0:08:03.3] It's very interesting that you talk there in terms of motivation. I must admit that it's not something that had occurred to me that that would be a factor in it. But I guess it is.

Robert, I know that you talk about four attributes that impact collaboration and the results of that collaboration. I wonder if you could talk to me a little bit about those? Tell me what they are and why they matter.

RS: [0:08:22.2] Absolutely. So I investigate the relationship between cognitive style, the manner by which we solve problems and how we use technology in

collaborating with others. And I've discovered that there's four basic attributes that impacts this relationship, and it varies based on your cognitive style and your perspective of these four attributes. But the attributes are confidence, and that is how we continuously use technology for its purpose, or don't use it continuously.

We also have expectancy and that is who selected this tool? Who selected this technology? Is it someone of authority or is it myself? Is it an individual choice?

We then have the dependency and it's all about reliability. I'm sure all of us have yelled at our computers or yelled at our phones and said awful things about it because it hadn't been reliable. There's a trust relationship that we build with these devices on how well they perform, and then there's the risk control, which is how technology is used either for a singular purpose, or it's a Swiss Army knife or multiple use kind of technology.

And all these attributes weigh in on Kirton's concept of managing coping behaviours, because the way we operate in society and our risk acceptance for change is all reflected in In our style, and across these attributes when we collaborate through technology working with others,

DH: [0:10:04.0] So tell me about how that affects us in the healthcare environment specifically.

RS: [0:10:09.9] Well, I can't think of a greater example than 2020 and the challenges that we've had with the COVID pandemic, and how a large majority of our interactions with our caregivers and providers, the doctors have gone to virtual telemedicine, remote monitoring. All these other technologies are being inserted in the interface, the interaction between us as patients and the providers themselves.

DH: [0:10:39.6] So, Megan, I appreciate exactly what Robert was saying there about technology getting in the way and how we deal with that, and those four attributes that Robert has identified. But talk to me a little bit more about perhaps that relationship in normal times in terms of the

coping behaviours that Kirton talks about and how we use those in this interaction between us and our caregivers.

MS: [0:11:05.6] Absolutely. So regardless of whether it's what we call normal times - although I'm not sure any of us know what normal is anymore, -or what our new normal might be, or in times of chaos and great uncertainty, the way in which individuals interact with that environment around them and the behaviours that they exhibit, we know is at all times some combination of what their own comfort level is around their preferred style of approaching the problem.

So when we talk about KAI for example, we know that it is how individuals generate ideas, how they implement those ideas, and how they respond to rules and group expectations, and utilise their own internal structures, which could even just be their understanding to do that. Anytime we're interacting in that way then, we are coping to some degree to figure out where those differentiations are between our understanding or our needs, and what's being presented, regardless of whether or not it's a normal time or chaotic time.

And so it's really interesting to think through how we drive through that, so when you think about the four attributes, when those were laid out it really resonates along the lines of how people approach those situations and cope through those. So, for example, the idea of if expectancy and as the selection of whatever it is that's being presented to us - a technology or a treatment, for example, coming by somebody else, or is it something we've selected for ourselves, influences how motivated we may or may not be to engage with it. We know that an aspect of our behaviour and our exhibition of what it is that we do in problem solving space has to do with how risk tolerant we are. And so the idea of using something that is tried and true and reliable and has lots of documentation that we can jump on the internet and research for ourselves, or whether or not it's just intriguing enough to be the first one out of the gate to try it. And I think it'll be interesting to see how people respond, for example, in a time of stress with these new COVID, vaccines and things that are coming online. Other than the people who it will be intentionally administered to first,

who is next in line to want to try it first, and who is a little bit more sceptical of some of the unknown pieces?

So when you think through those attributes, or really anything we're doing in that practitioner patient dynamic, there's a certain amount of unpacking that needs to be done on both sides in order to have people engage with what is being recommended of them.

RS: [0:13:36.5] Megan, you know, I think back about on the 'House TV show. One of the most comical relief aspects is every time House has to do that walk in clinic, how many ways he tries creatively to avoid doing that responsibility, and the coping that he is exhibiting there, I think some listeners can relate to that because we all at times don't necessarily have the motive to do something and we try to creatively find ways to use the rules or work around the rules to avoid doing something unless there was some other higher level motive that we want to exhibit in why we want to do it.

MS: [0:14:17.4] Well, in a way you think about that as managing expectations. So if we need to approach each of these situations and we think about learning as the ability to develop some sort of insight as to what might happen, or develop our own knowledge and internal resources in order to deal with that, when we're trying to navigate those spaces and think through what it is we want to convey and accomplish flanked with what we think the person we're about to approach might be acting like or asking of us, and the song and dance that goes without anticipating and negotiating that space in that relationship, it makes us either want to walk straight into one and just engage right away or really be a little bit more cautious because we would do anything other than go into that situation if we could.

DH: [0:15:02.6] I want to ask you now about something that's probably quite specific to the health provider patient relationship, and that is the issue of anxiety and stress and emotion that often goes with being ill. We're in a situation where we need to use the healthcare system, we need the help of a medical practitioner whoever that may be. And we're already presumably in a situation where we're not particularly happy, let's say, because we're trying to figure out what's wrong with us, hoping that

there's going to be a cure and all that sort of thing. And obviously, depending on the degree of that anxiety, there's going to be some interesting interactions that happen there. So I suppose what I'm saying is, is there any evidence that if you go to your care provider and they are similar to you in terms of the KAI scale, is there evidence that that's going to be an easier process for you?

MS: [0:16:05.8] So we know that in times of stress, people's emotions will outrun their ability to think rationally, and we think from our emotional selves in duress before we can rationalise through things.

So in healthcare we used to say on the clinical side - I worked in a high stakes area where it was paediatric oncology and so you're delivering test results and talking with families about a terminal illness that their child has and what those end of life decisions look like sometimes. And so in that type of a situation, when things are that stressful, you need to say whatever you need to say from a clinical side as much as ten times over and in ten slightly different ways in order for it to really resonate and be heard because people are in different spaces when they're processing through that, or they're comparing it to different bits and pieces of information.

One of the things we know from Adaption Innovation theory is that the less cognitive gap there is, -so this more similar style about idea generating or putting those things into practice or understanding what the expectations of the situation are - the less gap there is there. So the more similarity perhaps between a practitioner and a patient or their family, then the more comfortable it is to think inside of those spaces. And so it stands to reason - and I'm not sure of evidence that's out there -but it does stand to reason that at least if the approach seems somewhat similar, then it's easier to engage people in that space mentally so that they can be rational even in times when they really are being emotional at the same time.

DH: [0:17:45.4] And Robert, by contrast, if the health care provider is a very different problem solver to you, is there evidence to suggest that affects outcomes or the way people approach health care and that sort of thing?

RS: [0:17:58.8] Yes. So many of us have our own personal health journeys to share, and a lot of us have family and friends and co-workers that also have these stories to share. And often, we do see where different styles are involved and sometimes when they're similar.

I can't tell you about research that I did over a decade ago, that was in a different space, it was in the academic space, but it translates well to the healthcare space. During your graduate studies, you're dealing with advisors and reviewers, either doing a thesis or dissertation. and I found it during a study that I did, that as time progressed and the assignment requirements also increased, we often saw either people well-aligned to their advisor because they had similar styles, or we saw a gap between their styles and coping behaviours became more and more obvious.

So more emotions, more anxiety, more interactions of conflict developed. And so when I talk to people about selecting a team and working with others, finding people that are similar in your general approach to risk and your cognitive style, and in the way that you view rules and structure will help minimise the amount of tension in your interactions. However, you have to question. are you addressing the full aspect of the problem at hand? Are you having a breath of different people at your disposal to address the complexities of the problems that we're addressing? Things that require a lot of detail and research and also those that require us to think a little bit beyond our current guidelines and structure that we have today.

DH: [0:19:59.3] So there could potentially be a paradox there. From the patient's point of view you might hope for a care provider that is similar to you in their problem solving style, but you might be better off if you've got people who are not particularly similar to you or perhaps a range of people in the team that's looking after you they're more likely to come up with good solutions. Is that a good interpretation?

RS: [0:20:21.7] Absolutely. Kirton further attests it’s the management of diversity. A lot of times in the healthcare system you will see what is typically known as an advocate. And advocates are either paid individuals that help you navigate the system, or they're your family and friends that are your support group. And

a lot of times, you will see that advocate being a willing and able partner to help you what Kirton referred to as bridge between the different styles within a team. And they help to manage that gap between styles. often between also knowledge, and also between their ability to collaborate and trust others, because you have a bridge or who's acting on your behalf and trying to find the middle discussion area for these complex interactions.

MS: [0:21:16.4] I might add, I think that piece, and the idea of bridging and even where you bring up paradox, we've been intentional about not implying that that happens more with people who are highly innovative or more highly adaptive, or anywhere in the middle. Those gaps can really occur anywhere along that continuum and throughout those relationship dynamics. And I think one of the things that's fascinating about this idea of where you say there's a paradox, we really do theoretically call it the paradox of structure because no matter what the structure is - and it could be somebody's idea about something, research they've done about their health situation on the Internet, a protocol a doctor is following, the use guidelines around a certain type of prescriptive medicine, for example - those are enabling to some people and limiting to others period, across the board, no matter what.

I think it would be, a cautionary piece is to not assume that highly innovative patients are going to go rogue and ignore their doctors or highly innovative doctors are going to try new things without thinking about the needs of the more adaptive individual that's in that scenario.

I was speaking with somebody recently who has a fairly strong preference for adaption, likes to know what's going on, likes to follow the rules, and also has a deference to authority, where I think in patient and doctor relationships we see that a lot where patients are expected to defer that power and that role of caregiver to the doctor. And yet at the same time, she questioned everything the doctor was asking of her because she didn't understand the reason that it was being asked. And so regardless of where people are on that, they're going to ask or put in place more information where they need it and more structure, if you will, and then other people will loosen that up so that they can best navigate that system and feel like they have some independence.

And so that can happen anywhere along that continuum within those relationship dynamics, which makes it very exciting and yet very complex to think about at the same time.

RS: [0:23:18.7] Yeah, Megan, I had a similar situation. I finished a course and one of my students reached out to me afterwards and told me her very personal story, how she was bedridden during this entire course that I was teaching them around KAI. She shared the complexities of the support structure that she had, and she really felt that she had a better understanding of why others were challenging her and why she didn't accept other's ideas - everything from what food was being prepared for her during breakfast, lunch and dinner by her mother in law. She was, "That's not what I asked for. That's not what I want." It didn't develop that trust, but then after exposure and talking about these situations and the different aspects of style, she started to get a better appreciation.

I think that that complexity of the interactions really manifests itself in a level that Kirton really identified within the theory that helps with a framework of understanding.

MS: [0:24:27.9] It's really enlightening when we realise how profound the understanding of that framework is, and what we can attribute to cognitive style differences and how we're approaching situations that aren't about a person's ability or knowledge or attitude or personality. I mean, there's other things there that allow us to resituate ourselves and reground ourselves. I love that. That's a great example. Rob thanks.

DH: [0:24:53.9] I wonder whether KAI has anything to tell us about something that's a very current issue with the pandemic and everything, and that is the anti-vax, anti-science, anti-medical things that go on in social media and that sort of thing, where people are convinced that they shouldn't allow them any medical intervention for whatever reason, whether it's a conspiracy theory or whatever. Is there anything KAI has to say about that?

MS: [0:25:21.0] It's a conundrum, and it's really thought provoking to think about, but the anti-vax movement, I think, has been around for a while for different

things. It used to be the old vaccines that had mercury based preservatives were going to give your child autism, and now it's these things that are unknown, that are coming out of a lab faster than the speed of light, decades faster than would be normally possible. And so what is it that's in there, and the conspiracy theories and things that go with that?

I think what we can think about structurally is the vaccine is an example of a structural implication that has been asked and imposed and offered. And how people navigate and accept that is the part that's interesting to watch. I've spoken with a lot of people who have made the assumption that more innovative individuals - so the ones that more easily bend the rules, so to speak, or think around the rules - are the ones who are not wearing masks or not worrying about social distancing, or those kinds of things. And yet, I find it on the other end of the spectrum too where it's people who are normally very system oriented, but they don't like the person that's imposing it, or they feel like it's not a structure that they have agreed to, so they don't need to follow it. And vaccines and taking vaccines, I think, are an example of what happens when information spreads like wildfire. There's so much information, and so many points of view that are expressed readily on the internet and through social media, that it's harder to discern which are fact based and which are story based, which are expert driven and which are layman driven. And there's a lot of unpacking that needs to be done there.

I don't know. There’s not a simple answer to that, because I think there are anti-vaxxers across that KAI continuum so to speak, but for different reasons, because of how they are viewing the structure. Either they're going to do it their own way, or they're going to agree to it or not.

RS: [0:27:18.6] Generally, if you look at the acceptance of any new medical or health care approach, the data is what drives a lot of the decision making and also protocols. And I think people want that data for their own health knowledge. If you look at how many times people use Google or Web MD, or any of those other internet sites to search for the information and they're asking friends, there comes into this kind of process by which we all go through. We look at the problem and then we do this divergent kind of action

where we start collecting data and information from others and then we converge it together and try to solidify it for ourselves and then we start addressing what the potential solution could be. This happens if you look at the vaccines, if you look at new treatments, if you look at new technology rolling into healthcare, it all happens over a cyclical time within the healthcare industry.

And so there is a kind of a constant challenge of introducing new approaches, along with new social and economical intake or a perception of the challenges that we have. So while the vaccine itself is new to us at the magnitude by which we're looking at it at a global level, we have seen instances at a smaller level of other approaches, and having similar resistance and similar attitudes towards the newer approaches and protocols and techniques.

MS: [0:29:07.2] So I think that data piece is really interesting to unpack as well from the standpoint of, we know stylistically more adaptively, more innovatively, people frame the information, ie the data, in a way that makes sense to them in order to be able to use it. But we also know cognitively that there's this primary filter with how we take information in, in order to make sense of it, that is very much driven by our beliefs and our experiences and our ideas about things. And so when we take into consideration those factors, it further compounds it because even though the data may be based on very good science and tell us that this is a safe thing to do, it's a good thing to do, it is an effective thing to do - at the end of the day, individuals will finally make that judgement call based on religious beliefs, philosophical assumptions. I've seen evidence for example with families who refused to vaccinate their children, even though if one of them brought an illness home from school, it might be catastrophic for their immunosuppressed child who was on treatment, or families that refused to have blood transfusions or bone marrow transplants for their child because it was against their religious beliefs even though they knew the science was good.

And so I think that's where we end up in this more complex situation of it being the healthcare system against the world, and all of the individuals and

their personal beliefs that they ascribe to, complicating their acceptance of that science.

DH: **[0:30:41.4] Well, thank you both very much for such a thought provoking conversation. And thank you also for reminding me how much I enjoyed 'House.'**

You've been listening to the KAI podcast with our special guests, Dr Megan Siebel and Dr Robert Samuel talking about the patient to provider health care relationship in the context of KAI. If you found the discussion interesting, you can find out more about the KAI system and its first class team development potential at www.kaicentre.com. In the meantime, please subscribe and share this podcast.

Stay well and thanks for listening.