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Exploring Leadership Barriers to Patient Experience Improvement in the Acute Care Hospital Setting

James Scott Cooper
Walden University

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Walden University

College of Management and Human Potential

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James Scott Cooper Jr

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Jean Gordon, Committee Chairperson, Management Faculty

Dr. Sheryl Kristensen, Committee Member, Management Faculty

Chief Academic Officer and Provost

Sue Subocz, Ph.D.

Walden University
2026

Abstract

Exploring Leadership Barriers to Patient Experience Improvement in the Acute Care
Hospital Setting

by

James Scott Cooper Jr

MBA, Wagner College, 2017

BS, Temple University, 2016

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Management

Walden University

May 2026

Abstract

Resistance to patient experience initiatives remains a persistent challenge in acute care hospitals, often undermining organizational efforts to improve engagement, culture, and care delivery despite broad acknowledgment of their importance. Healthcare leaders need to understand this challenge as a primary indicator affecting patient experience outcomes. The purpose of this qualitative narrative inquiry was to explore the factors that cause resistance to change faced by patient experience leaders (PELs) in the acute care hospital setting. The theory of planned behavior grounded this study. The participants consisted of 15 PELs working in acute care hospitals across the United States. Data were collected through semistructured interviews capturing participants' professional experiences related to resistance to patient experience work. Participant stories were analyzed through narrative reconstruction and cross-narrative patterning to identify recurring storylines and meaning-making processes. The narrative analysis yielded five shared story patterns: (a) emotional and cultural fatigue; (b) leadership disconnect; (c) professional identity and psychological safety; (d) trust, transparency, and communication; and (e) coping, adaptation, and meaning-making. Healthcare leaders can use these findings to create narrative-informed leadership practices to strengthen public trust in healthcare delivery and improve patient-reported experience outcomes. The implications for positive social change include the potential for healthcare executives, PELs, and organizational change agents to develop and implement strategies that could address resistance through clearer communication, relational trust, and leadership alignment in acute care hospital settings.

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Table of Contents

List of Tables	vii
List of Figures	viii
Chapter 1: Introduction to the Study	1
Background of the Study	2
Problem Statement	4
Purpose of the Study	6
Research Question	7
Conceptual Framework	7
Nature of the Study	9
Definitions	10
Assumptions	12
Scope and Delimitations	13
Limitations	15
Significance of the Study	17
Significance to Practice	17
Significance to Theory	18
Significance to Social Change	18
Summary and Transition	19
Chapter 2: Literature Review	20
Literature Search Strategy	21

Conceptual Framework.....	23
Literature Review.....	27
TBP in Healthcare and Related Fields	28
Role of the PEL in the Acute Care Hospital Setting.....	34
Psychological Dimensions of Resistance to Change in Acute Care Settings	37
Organizational and Individual Narrative Accounts to Change in Healthcare Settings.....	39
Summary and Conclusions	41
Chapter 3: Research Method.....	43
Research Design and Rationale	43
Narrative Research Designs.....	43
Phenomenological Research Designs	46
Grounded Theory Research Designs	46
Case Study Research Designs.....	47
Ethnographical Research Designs.....	47
Action Research Designs	48
Descriptive Research Designs.....	48
Correlational Research Designs.....	49
Quasi-Experimental Research Designs.....	49
Role of the Researcher	51
Bias Mitigation.....	52

Ethical Considerations	53
Alignment of TPB Within a Narrative Inquiry Approach	54
Methodology	54
Procedures for Recruitment, Participation, and Data Collection	59
Data Collection Plan	60
Data Collection Frequency	61
Narrative Analytic Positioning	63
Coding Process and Thematic Analysis.....	63
Treatment of Discrepant Cases	66
Issues of Trustworthiness.....	66
Credibility	66
Transferability.....	66
Dependability	67
Confirmability.....	67
Ethical Procedures	68
Summary	70
Chapter 4: Results.....	72
Research Setting.....	74
Demographics	76
Data Collection	77
Data Analysis	79

Transcription and Familiarization.....	79
Initial Narrative Coding.....	80
Chronological Structuring of Narratives.....	82
Narrative Features and Identity Construction.....	83
Interpretive and Contextual Analysis.....	84
Narrative Reconstruction and Emergent Narrative Patterns.....	86
Evidence of Trustworthiness.....	88
Credibility.....	88
Transferability.....	89
Dependability.....	90
Confirmability.....	90
Study Results.....	91
Participant Narrative Accounts.....	92
Cross-Narrative Sensemaking.....	160
Summary.....	168
Chapter 5: Discussion, Conclusions, and Recommendations.....	170
Tracing the TPB Behavior Across Narratives.....	172
Attitudes Toward Change.....	172
Subjective Norms.....	173
Perceived Behavioral Control.....	174
Integrative Cross-Narrative Sensemaking.....	175

Integrative Analysis: Narrative Patterns and the TPB	176
Attitudes Toward the Behavior.....	176
Subjective Norms.....	177
Perceived Behavioral Control.....	177
Theoretical Contribution.....	178
Interpretation of Findings	178
Confirmation of Existing Knowledge.....	181
Extension of Existing Knowledge	183
Areas of Modest Disconfirmation.....	185
Limitations of the Study.....	187
Recommendations.....	189
Conduct Additional Narrative Studies Across Different Contexts.....	190
Explore the Experiences of Frontline Clinicians to Compare Perspectives	191
Examine the Role of Leadership Behaviors and Structures in Supporting or Hindering PEL Effectiveness	192
Investigate the Impact of Change Fatigue on Patient Experience Outcomes	193
Explore How Patient Experience Data are Interpreted and Used Across Organizational Levels	193
Conduct Longitudinal Narrative Inquiry to Examine How Resistance Changes Over Time	194

Expand Research to Include Health Systems Where PEL Roles are	
Structured Differently	195
Implications.....	195
Individual-Level Positive Social Change.....	196
Family-Level Positive Social Change.....	197
Strengthening Organizational Readiness for Change	198
Methodological Implications	203
Theoretical Implications	204
Empirical Implications.....	204
Recommendations for Practice	205
Conclusions.....	207
References.....	209
Appendix A: LinkedIn Post	230
Appendix B: Interview Guide.....	231

List of Tables

Table 1. Main Storylines, Sub-storylines, and Illustrative Narrative Excerpts Related to
Resistance to Change Among PELs 167

List of Figures

Figure 1. Narrative Patterns and Associated Meaning Structures Illustrating Resistance to Change Among PELs.....	87
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Chapter 1: Introduction to the Study

The significance of patient experience in acute care hospitals extends beyond patients' likelihood to recommend the facility to others. Positive patient experiences, particularly those that involve effective communication and supportive provider relationships, significantly enhance adherence to treatment plans, which in turn improves health outcomes. When patients feel engaged and supported, they are more likely to follow medical guidance, especially in managing chronic conditions, which directly impacts recovery and overall treatment success (Aboumatar et al., 2022). According to Akhiyat et al. (2021), patient satisfaction had been closely linked to the quality of care delivery, with tools such as Press Ganey surveys being instrumental. These surveys prompt patients to reflect on the quality of care they received, which in turn influences the patient-provider relationship and enhances overall patient satisfaction.

Feedback plays a pivotal role in shaping the patient experience, as it provides direct insight into patients' perceptions and experiences. This feedback is multifaceted, encompassing quantitative data from post-visit surveys and qualitative data from free text comments, handwritten letters, and other forms. Godillot et al. (2021) highlighted that healthcare organizations need to actively review various feedback avenues to learn and improve. This continuous improvement is crucial since patient satisfaction is a key indicator of healthcare quality.

The effective application of patient feedback not only helps refine current practices but also contributes to the body of knowledge concerning the processes used by

patient experience professionals. These insights are essential to understand how to best utilize data in change management efforts related to survey feedback. By improving patient and provider relationships, the healthcare industry could drive positive social change, leading to healthier communities through better health outcomes. Effectively leveraging patient feedback enables healthcare organizations to align improvement efforts with patients' actual needs and experiences, leading to enhanced patient experiences and better health outcomes (Gleeson et al., 2016). The remainder of Chapter 1 reviews the background of my study, problem statement, purpose, research question, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study.

Background of the Study

Resistance to change is a well-documented challenge in healthcare organizations, often affecting the successful implementation of patient-centered initiatives. Despite this, not much attention has been given to the unique challenges faced by patient experience leaders (PELs) in acute care hospital settings. PELs play a crucial role in bridging the gap between institutional priorities and patient-centered care, yet they frequently encounter systemic resistance when attempting to implement engagement and experience improvement strategies. Understanding the factors that contribute to this resistance is essential for developing effective change management strategies that supported PELs in fulfilling their roles and advancing patient-centered care. Despite their critical role in bridging the gap between healthcare systems and patient needs, PELs encounter

significant challenges when implementing patient-centered initiatives, particularly for underserved or vulnerable populations. These obstacles contribute to persistent gaps in care quality and patient engagement, ultimately exacerbating health disparities and negatively impacting community health outcomes (Crawford et al., 2022).

PELs play a crucial intermediary role, facilitating communication and collaboration between patients, families, and healthcare providers to ensure care delivery aligned with patient needs and expectations. However, they often operate within systems resistant to change due to entrenched organizational cultures, competing priorities, and resource constraints. These systemic barriers not only hinder the adoption of patient-centered initiatives but also amplify existing inequities in access to and quality of care, particularly for marginalized populations.

With respect to change management in the healthcare setting, most research focused on the general organizational dynamics or the perspectives of clinical staff and executive leaders. For example, Zhang et al. (2024) examined how organizational inertia, specifically cognitive knowledge inertia among healthcare professionals, acted as a barrier to adopting innovation in clinical settings. Additionally, research on cognitive inertia highlighted how entrenched mental models among leadership could hinder the adoption of new strategies, particularly in the face of evolving market demands (Tripsas & Gavetti, 2000). However, these studies often overlook the unique position and experiences of PELs, who are directly responsible for driving patient engagement and experience improvement initiatives. Their role requires balancing institutional priorities

with the demands of delivering equitable and effective care, a tension that has yet to be sufficiently explored in the literature (Crawford et al., 2022). This lack of scholarly attention limits a nuanced understanding of how PELs perceived and interpreted resistance to change within acute care settings, and how these perceptions influence their ability to advance patient-centered care initiatives. Particularly in acute care hospital environments, where patient engagement and quality improvement initiatives are increasingly prioritized, this oversight represents a critical gap in knowledge (Kuipers et al., 2014).

Problem Statement

Systemic resistance to change within acute care hospital settings presents a significant barrier to advancing patient-centered care, directly affecting the ability of patient experience leaders (PELs) to implement meaningful improvements. While healthcare organizations increasingly prioritize patient engagement and quality improvement initiatives, PELs frequently encounter structural, cultural, and leadership resistance that impede their efforts. Existing research on resistance to change primarily focuses on clinical staff and executive leadership perspectives (Rosenbaum et al. 2018), often overlooking the distinct challenges PELs face in their intermediary role between institutional leadership, frontline staff, and patients. This lack of attention leaves PELs without the necessary support, frameworks, and resources to navigate organizational resistance effectively.

Resistance to change in healthcare is often driven by entrenched institutional cultures, rigid hierarchies, misaligned priorities, and resource constraints, all of which create systemic barriers to innovation (Valderas et al., 2021). PELs, who are responsible for facilitating communication and collaboration between patients, families, and healthcare providers, had to navigate these obstacles while advocating for improved patient experiences. However, when organizational resistance prevent patient-centered initiatives from being fully realized, the consequences extend beyond individual hospitals: impacting patient outcomes, exacerbating healthcare inequities, and widening gaps in care quality for marginalized populations (Luxford et al., 2011).

Despite the critical role of PELs in improving patient engagement and healthcare quality, there remains a notable gap in research exploring the factors that cause resistance to change they face within the acute care hospital setting. Without a deeper understanding of these barriers, healthcare organizations lack the evidence-based strategies necessary to support PELs in overcoming resistance, leading to missed opportunities for care improvement and increased disparities in patient experience. Addressing this issue is essential to ensuring that patient-centered care efforts are not only implemented but sustained, ultimately improving healthcare equity and patient outcomes on a broader scale.

The research problem addressed in this qualitative narrative study is the lack of understanding regarding the factors that caused resistance to change faced by PELs in the acute care hospital setting. This issue is significant, as Sumedh et al. (2023) highlighted

that personal apprehension towards trusting patient feedback data, a lack of understanding of its importance and impact, and potential disruptions to daily workflows contribute to care team members' resistance to change management efforts. The relevance of this problem is underscored by extensive ongoing research that investigated these resistance factors.

Further analysis by Heath and Porter (2018) elaborated that the factors influencing organizational change have been examined at both micro and macro levels, indicating a broad academic interest in this phenomenon. Additional complexities could have an impact, such as physician burnout, which not only hinders collaborative efforts to enhance patient experience metrics but also reflects the broader systemic challenges within healthcare environments. These stressors exemplify the underlying forces that may have obstructed the effective utilization of patient-reported feedback for improvement efforts, especially when clinicians are overwhelmed and unable to perform their daily tasks optimally. Understanding these leaders' experiences in detail could pave the way for more effective management strategies, leading to enhanced patient experiences and, ultimately, healthier communities.

Purpose of the Study

The purpose of this qualitative narrative study was to explore the factors that cause resistance to change faced by patient experience leaders (PELs) in the acute care hospital setting. At the outset of this research, resistance to change was broadly defined as the reluctance or opposition within an organization toward initiatives that modify the

existing state (Holt et al., 2017). This resistance arises from various factors, including fear of the unknown, loss of control, poor timing, or a perceived negative impact on personal or group interests. Holt et al. (2017) stressed that recognizing and comprehending this resistance was crucial for effectively managing change. Holt et al. advocated fostering readiness for change as a strategic approach to lessen resistance, aligning organizational members' attitudes and behaviors with the proposed changes. This alignment is suggested to mitigate the barriers to change, facilitating smoother transitions and acceptance among staff.

The insights gained from this study enhance strategies for managing resistance effectively, leading to improved implementation of changes and improved patient outcomes. Angelini et al. (2021) reinforced this viewpoint, noting that resistance to change, organizational culture, and person-centered care were critical constructs in quality improvement efforts within healthcare settings.

Research Question

RQ: What are the factors that cause resistance to change that PELs face in the acute care hospital setting?

Conceptual Framework

This research study was anchored in the theory of planned behavior (TPB), introduced by Icek Ajzen in 1985 as an extension of the theory of reasoned action (TRA), which Ajzen had previously developed with Martin Fishbein in the 1970s. The TPB was created to account for situations where individuals might not have complete control over

their behavior, adding the component of perceived behavioral control to the model. This theory has been widely used to predict and understand behaviors across various contexts. The theory posited that the control individuals had over their behaviors was shaped by six key components: attitudes, behavioral intention, subjective norms, social norms, perceived power, and perceived behavioral control. This framework was instrumental in understanding how individual behaviors influenced patient perceptions and, consequently, patient experience outcomes.

The TPB had been extensively studied, particularly in relation to how attitudes could be altered. Fishbein and Ajzen (1975) highlighted that the topic of attitude change had been the primary focus of research in the field of attitudes. For example, research demonstrated the effectiveness of TPB in predicting and influencing behaviors such as smoking cessation, where interventions focused on altering attitudes toward smoking by emphasizing health risks and benefits of quitting (Rise et al., 2010). Similarly, TPB had been used to understand healthcare professionals' adherence to hand hygiene practices by identifying and addressing barriers in perceived behavioral control and subjective norms (Jang et al., 2010).

The relevance of the TPB to this study lies in its focus on the elements that influenced behavioral control, which was critical for understanding the factors that contributed to resistance to change that PELs faced in the acute care hospital setting. For instance, PELs may have encountered resistance when attempting to influence staff attitudes toward adopting new patient feedback processes. In such cases, negative

attitudes, opposing social norms, or a lack of confidence in executing the changes could have contributed to resistance. By examining these factors through the lens of the TPB, this study aimed to provide deeper insights into why PELs may have struggled with implementing change and how resistance manifested within their roles. The TPB provided a structured way to dissect the psychological components influencing healthcare professionals as they navigated the complexities of interpersonal communication during change management efforts with respect to patient experience.

The application of the TPB in this study was discussed in greater detail in Chapter 2, where it was linked to the challenges of resistance to change management faced by PELs in the acute care hospital setting. This deeper exploration aided in identifying the factors behind resistance to change, thereby informing strategies to mitigate these barriers and enhance patient experience outcomes effectively.

Nature of the Study

In this qualitative narrative study, the research design centered on semistructured interviews with current patient experience leaders (PELs) to explore their experiences with resistance to change in the acute care hospital setting. The narrative approach was well-suited to this study as it allowed for a detailed understanding of individual experiences and the context in which these strategies were implemented (Butina, 2015). Semistructured interviews were chosen for their flexibility in eliciting rich, in-depth narrative accounts while maintaining a consistent framework for comparison. This design aligned with the qualitative paradigm, emphasizing the subjective and complex nature of

human experiences, and supported the study's goal of capturing nuanced feedback through the analysis of interview transcriptions (Kallio et al., 2016). I conducted 15 interviews, continuing until sufficient information-rich narratives were obtained, consistent with guidance from Hennink et al. (2022). This research was necessary for better understanding the factors that caused resistance to change faced by PELs in the acute care hospital setting.

Definitions

Anecdotal patient feedback: Anecdotal patient feedback can come in many forms. Most commonly you will find anecdotal forms of patient feedback in handwritten letters, conversations (over the phone and in person) and even social media posts (Huppertz & Otto, 2018). This form of feedback represents lived experiences on a more singular and descriptive level that is at the patient's level of choosing.

Data utilization: Data utilization is the process of leveraging information, both quantitative and qualitative, for the purposes of continuous improved and positive change in specific outcome measures (Wong et al., 2022).

Improvement outcomes: For the purposes of this study, improvement outcomes are defined as aggregated narrative accounts that are captured through post visit surveys. These measures represent patient narrative accounts to closed ended questions that can then be benchmarked across other healthcare organizations to provide hospitals and health systems with relative performances that can then be used to determine areas of strengths and weaknesses throughout the system (De Rosis et al., 2020).

Patient Experience Leader (PEL): A patient experience leader (PEL) is defined as an individual who is in a position of authority that is directly involved in the decision-making processes that are responsible for achieving optimal patient experience outcomes (Barden et al., 2020).

Patient perception: Patient perception is how one who receives services at a healthcare organization recalls their experience to have gone. This feedback is captured in post visit surveys based on a specific service line the patient was treated through. For example, for a patient who was admitted to a hospital, their perception of how their experience went would be captured on an HCAHPS survey (Hospital Consumer Assessment of Healthcare Providers and Systems).

Patient-reported feedback: Patient-reported feedback is defined as any form of experience-based insight that is provided directly from the patient to another individual or third party (Valderas et al., 2021).

Press Ganey: Press Ganey is a vendor that has been established for more than 35 years, dating back to its creation in 1985. Since its creation, it has grown vastly in the services it provides (Wang C. et al., 2022). From patient experience surveying to employee engagement surveying, to consulting, Press Ganey offers many services to healthcare organizations. For the purposes of this study, we focused on the post visit surveys that Press Ganey provides to patients at their client facilities.

Qualitative patient feedback: Qualitative patient feedback is most commonly seen in the form of free text comments that are provided on a post visit survey that may

provide information relative to their perception of care while receiving treatment (Crubezy et al., 2023). It should be noted that patient comments are viewed qualitatively at the individual level. However, when examined collectively to identify recurring narrative patterns across comments, the resulting insights and key learnings can be interpreted in a more quantifiable capacity.

Quantitative patient feedback: Quantitative patient feedback is most commonly seen in the form of aggregated data that represents patient survey narrative accounts to post visit questions. (Assi & Guney, 2023). These questions can come in many different forms; however, the narrative accounts are captured based upon a predetermined list of options (such as a scale of 1-10, Likert, etc.).

Assumptions

In this study, two primary assumptions underpinned the research methodology. The first assumption was that participants would offer honest and unbiased feedback during interviews. This honesty was crucial as the narrative accounts were transcribed, coded, and analyzed to extract key insights that could significantly influence the study's conclusions. Participant honesty was crucial in qualitative research, as it directly impacted the authenticity and depth of the data collected (Morse, 2015).

The second assumption concerned the uniformity of participants' roles within their respective organizations. It was presumed that all participants, being professionals in patient experience, held similar roles and responsibilities. However, this might not have accurately reflected reality, as the seniority and scope of their positions could have

varied significantly between organizations. Such variations could have affected their perspectives and experiences with using patient-reported feedback to drive change management. Recognizing these differences was essential for accurately interpreting the data and understanding the broader implications of the findings. This study's assumptions about participant honesty and role uniformity were vital for ensuring the validity and applicability of its outcomes.

Scope and Delimitations

This study explored the factors that caused resistance to change faced by patient experience leaders (PELs) in the acute care hospital setting. Cheraghi et al. (2023) suggested that individual, interpersonal, and organizational factors significantly influenced whether healthcare professionals supported or resisted changes aimed at improving patient experience outcomes. This resistance is particularly pertinent as the field of patient experience, relatively new in healthcare, gained prominence and increasingly influenced health systems' operational priorities. Over the past decade, health systems have reallocated substantial resources to enhance their competitiveness in patient experience, reflecting its growing importance as a key performance indicator (Zambrano, 2020).

This study drew on relevant conceptual foundations to contextualize the findings, particularly Ajzen's TPB (TPB; 1991), which emphasized how individual attitudes, social norms, and perceived control influenced behavior in the face of change. While this framework informed the understanding of resistance to change, the study prioritized

exploring the factors that caused resistance to change faced by PELs in the acute care hospital setting.

This study was specifically bound to healthcare leaders whose roles were dedicated to enhancing patient experience within their institutions. These leaders, defined in the study as PELs, were pivotal in navigating and implementing the necessary changes based on feedback from patients. The potential for transferring the insights gained from this study to other sectors underscored its broader relevance. Resistance to change management is a universal challenge across various fields, and the concept of utilizing feedback as a primary driver for change was applicable beyond healthcare. For example, in tourism and hospitality, feedback from hotel guests could prompt similar change initiatives, while in the automotive service industry, customer feedback regarding services like oil changes could serve analogous purposes.

Each industry has its counterpart to the healthcare sector's patient, and their feedback could similarly justify and drive change management efforts. This underscores the transferability of the study's findings, as they could guide other sectors in leveraging consumer feedback to foster improvements. This study's focus on resistance to change faced by PELs in the acute care hospital setting, and the broader applicability of its conclusions, was elaborated in Chapter 3, where the concept of trustworthiness and its role in ensuring validity across different industries is also explored.

Limitations

This study faced several anticipated limitations related to sampling, data collection, and researcher positionality. Accessing suitable participants was essential for eliciting rich, experience-based narratives from patient experience leaders (PELs). To address this, a purposive sampling approach was planned through a formal recruitment request to Press Ganey, a third-party vendor specializing in patient experience surveying. Their willingness to assist increased the likelihood of reaching qualified individuals across diverse healthcare settings. All recruitment procedures followed standards approved by the Walden University Institutional Review Board (IRB), including confidentiality protections and voluntary informed consent. Although anonymity was maintained, narrative inquiry values relational ethics and transparency between researcher and participant (Clandinin & Connelly, 2000). Recruitment materials therefore emphasized both ethical safeguards and the collaborative nature of narrative research.

The scope of the narratives represented another potential limitation. Because narrative inquiry does not require saturation in the traditional qualitative sense, a target of approximately 15 participants was established to capture a range of stories while supporting depth of experience. This goal aligned with recommendations that narrative studies aim for sufficient variation rather than numerical thresholds (Hennink et al., 2022; Polkinghorne, 1995; Riessman, 2008). However, it was anticipated that voluntary participation might limit diversity of perspectives, as individuals experiencing

particularly high resistance, organizational conflict, or fatigue might choose not to participate. Such self-selection could shape the kinds of narratives ultimately collected.

Additional limitations were anticipated in the mode of data collection. Because interviews were conducted virtually, variations in technology, participant comfort, and environmental distractions could potentially influence the conversational flow and depth of disclosure. Virtual interviews also limit the researcher's ability to observe nonverbal cues, which can constrain contextual interpretation in narrative research. Although a semistructured interview guide was designed to promote consistency across interviews (Kallio et al., 2016), the virtual format introduced conditions that could not be fully controlled.

Researcher positionality represented another potential limitation. My professional background in patient experience has the potential to shape data interpretation and the co-construction of meaning. Consistent with narrative inquiry's emphasis on the researcher as an active relational presence rather than a neutral observer (Clandinin & Connelly, 2000), positionality was managed through intentional reflexivity. A reflective journal was used to document assumptions, emotional reactions, and analytic decisions throughout the research process (Finlay, 2002). While these strategies support rigor, they do not eliminate the interpretive influence of the researcher inherent in narrative inquiry.

Finally, transferability of findings was expected to be limited by organizational differences among participants' healthcare settings. Variations in culture, leadership structure, and resource allocation may influence how resistance to change is experienced.

Although rich descriptions would be provided to support reader assessment of applicability, the findings were not intended to generalize across all acute care hospitals.

Significance of the Study

The findings of this study are poised to make significant contributions across several domains by enhancing understanding of factors that cause resistance to change faced by patient experience leaders (PELs) in the acute care hospital setting. These findings could potentially be leveraged to improve future patient care and experiences. Such enhancements might have led to better health outcomes and healthier communities, thus fostering positive social change. The insights gained provide valuable lessons on optimizing the use of patient feedback, potentially transforming approaches to patient care across the healthcare industry.

Significance to Practice

The significance of this study to practice lay in its potential to address a gap in the research related to the factors that caused resistance to change faced by patient experience leaders (PELs) in the acute care hospital setting. This study explored the factors that cause resistance to change faced by PELs in the acute care hospital setting, which could provide useful information for other PELs to consider in their own change management efforts. Understanding these leaders' experiences offers vital learnings for other PELs throughout the healthcare sector. This knowledge could be instrumental in replicating successful strategies or avoiding past shortcomings, thereby enhancing the overall effectiveness of patient care initiatives.

Significance to Theory

From a theoretical perspective, this study aimed to advance knowledge within the field of patient experience by exploring the factors that caused resistance to change faced by patient experience leaders (PELs) in the acute care hospital setting. By delving into the experiences of these PELs, the study lays groundwork for future research to build upon. This could lead to a deeper understanding and a broader theoretical framework regarding change management in healthcare, enhancing academic and practical approaches to tackling resistance within the field.

Significance to Social Change

Regarding social change, the study underscored the critical elements of an optimal patient experience: courtesy, respect, and effective communication. These components are essential for building a strong foundation between patients and care teams, facilitating optimal understanding and compliance. Optimal understanding goes beyond patients grasping what the care team explains; it also encompasses care teams' comprehension of patients' concerns and questions. When such mutual understanding is achieved, it significantly enhances patient compliance and willingness to adhere to care plans. By fostering an environment where optimal understanding and compliance were achievable, healthcare providers were able to influence social outcomes, leading to healthier communities and enhanced patient well-being.

This multifaceted significance illustrated the potential impact of the study's findings on practice, theory, and social change, indicating that understanding and

implementing effective patient experience strategies could profoundly affect healthcare outcomes and societal health. This research underscored the foundational understanding that enhancements in patient experience could catalyze positive social changes, leading to improved health outcomes and, consequently, healthier communities. Such an investigation not only promises to enrich the existing body of knowledge but also provides a basis for more robust and effective change management practices in the healthcare industry. This study aimed to explore the factors that caused resistance to change faced by patient experience leaders (PELs) in the acute care hospital setting.

Summary and Transition

Chapter 1 introduced the focus of this research study, which sought to explore the factors that cause resistance to change for patient experience leaders (PELs) in the acute care hospital setting. This investigation offered PELs a platform to articulate their experiences and insights, thereby contributing valuable knowledge to the field that could inform subsequent research. Furthermore, a deeper comprehension of the factors that foster resistance to change among these leaders could facilitate significant social benefits, considering the established correlation between patient experience, health outcomes, and community health compliance. Chapter 2 reviews the conceptual framework of this study and provides a comprehensive review of existing literature relevant to the factors that led to resistance to change faced by PELs in acute care hospital settings.

Chapter 2: Literature Review

The research problem addressed in this study was the lack of understanding regarding the factors that caused resistance to change faced by PELs in the acute care hospital setting. Considering this, the purpose of this qualitative narrative study was to explore the factors that cause resistance to change faced by PELs in the acute care hospital setting. Bastemeijer et al. (2019) identified common factors such as biases associated with small sample sizes and skepticism regarding the efficacy of changes proposed based on subjective feedback. These insights suggest that resistance is not merely a reaction to change itself but is influenced by deeper perceptions of the validity and reliability of the data driving these changes. By dissecting these influences, the research sought to uncover the underlying reasons for resistance patterns.

This literature review provides the foundation for understanding the challenges PELs faced when navigating resistance to change in acute care hospital settings. It begins by outlining the TPB as the guiding framework for this study, followed by a synthesis of relevant research applying TPB within healthcare contexts. The chapter then examines the concept of patient experience in acute care hospitals, the evolving role of the patient experience leader (PEL), and the principles of change management as applied in these environments. Finally, the review highlights empirical studies related to resistance to change in healthcare leadership. Together, these sections establish a contextual basis for interpreting the findings of this study. This approach not only contextualizes the problem but also sets the stage for identifying the underlying factors contributing to resistance to

change faced by PELs. By linking historical and current perspectives, the study enhances understanding of the challenges PELs faced in implementing change and contributed to leadership and change management strategies within healthcare settings. The comprehensive examination of the factors influencing resistance to change, combined with a historical contextualization, provides a robust framework for understanding and addressing the challenges of change management in healthcare. This chapter presents a comprehensive literature review that supports the purpose and direction of this narrative inquiry. It began by outlining the literature search strategy used to identify relevant peer-reviewed sources published from 2018 onward. Next, it introduces the conceptual framework guiding the study, the TPB, highlighting its key components and relevance to change management in healthcare. The chapter then examines patient experience in acute care hospitals, with an emphasis on operational and organizational dimensions rather than direct patient narratives. This followed by a discussion of the evolving role of PELs, including their responsibilities, influence, and challenges within hospital systems. The literature then shifts to focus on change management in healthcare settings, with attention to leadership approaches, staff dynamics, and resistance to change.

Literature Search Strategy

In conducting this research on patient experience and change management, I utilized the resources available through the Walden University Library to access a wide range of essential literature. Key databases such as ProQuest, CINAHL, ERIC, and MEDLINE were instrumental in providing a comprehensive collection of scholarly

articles relevant to the study. Additionally, Google Scholar served as a valuable supplementary resource, offering further pertinent materials on the subject matter. The search strategy employed a variety of key terms, including *patient experience*, *change management*, *data utilization in healthcare*, *resistance to change management*, and *TPB*. These terms were carefully selected to ensure a thorough exploration of the topic from multiple angles. To maintain the scholarly integrity and relevance of the literature review, I applied stringent filters, including the requirement that sources be peer-reviewed and published from 2021 onwards. This approach ensured that the research incorporated only the most recent, credible, and relevant studies.

By accessing these databases, I was able to gather a diverse array of perspectives and findings that enriched the study's analysis. ProQuest provided a broad range of articles across various disciplines, while CINAHL offered a focus on nursing and allied health literature. ERIC contributed valuable insights from educational resources, and MEDLINE supplied comprehensive medical and biomedical literature. This multidisciplinary approach allowed for a holistic understanding of the intersection between patient experience and change management. The use of Google Scholar as a supplementary resource enabled the identification of additional relevant studies that may not have been available through the primary databases. This tool was particularly useful for locating open-access articles and grey literature, which further broadened the scope of the research.

The methodical approach to sourcing and selecting literature ensured a robust and comprehensive foundation for the study. The emphasis on recent, peer-reviewed articles underscored the commitment to scholarly rigor and relevance, providing a solid basis for the subsequent analysis and discussion of patient experience and change management in healthcare. This meticulous process of literature review not only strengthened the credibility of the research but also facilitated a deeper understanding of the complexities involved in implementing effective change management strategies within healthcare settings.

Conceptual Framework

TPB (Ajzen, 1985) is a psychological framework developed to predict and understand human actions within specific contexts. Expanding on the theory of reasoned action (TRA; Fishbein & Ajzen, 1975), TPB introduces the concept of perceived behavioral control, addressing the notion that not all behavior is entirely voluntary. According to TPB, an individual's intention to carry out a behavior is the most significant predictor of their likelihood of performing that behavior. Intentions are shaped by three key factors: attitudes toward the behavior, subjective norms, and perceived behavioral control.

Attitude toward the behavior reflects an individual's positive or negative evaluation of the behavior based on beliefs about its outcomes and the value placed on these outcomes (Ajzen, 2022). For example, someone who believes that exercise benefits health and highly values health is likely to have a positive attitude toward exercising.

Subjective norms refer to the perceived social pressure to engage or not engage in a behavior. This includes the individual's beliefs about whether significant others (e.g., family, friends, colleagues) support or disapprove of the behavior (Smith & Lee, 2022). For instance, if a person perceives that their peers value regular exercise, and they care about their peers' opinions, they may be more inclined to exercise. Perceived behavioral control pertains to the individual's perception of how easy or difficult it is to perform a behavior, influenced by past experiences and anticipated challenges (La Barbera & Ajzen, 2021). This factor can influence both the intention to perform the behavior and the behavior itself (Ajzen, 1991). For example, if someone believes they have the necessary time, resources, and ability to exercise regularly, they are more likely to intend to exercise and follow through (Ajzen, 2002a).

The TPB posits that attitudes, subjective norms, and perceived behavioral control collectively shape behavioral intentions, which in turn predict actual behavior (Ajzen, 1991). Importantly, perceived behavioral control can also directly influence behavior, as even strong intentions may not lead to action if significant barriers are perceived. Ajzen's (1985) TPB offers a robust model for understanding the complexities of human behavior, considering the interplay of personal attitudes, social factors, and perceived control. This model has been broadly applied across various fields, underscoring its versatility in predicting and explaining behavior.

TPB has been extensively used in health research to explain and predict behaviors such as smoking cessation, physical activity, and dietary choices. For instance, TPB has

helped identify how positive attitudes toward quitting, social support, and perceived control influence smoking cessation outcomes (Rise et al., 2010). More recent studies have continued to apply TPB in diverse healthcare contexts, including predicting COVID-19 vaccine acceptance (Shmueli, 2021), hand hygiene practices among healthcare workers (Zhou et al., 2022), and physical activity adherence in chronic disease populations (Wang et al., 2023). In environmental studies, TPB has been applied to examine behaviors such as recycling and energy conservation, demonstrating how perceived social norms and barriers influence sustainable practices (Kaiser et al., 2005). In organizational contexts, TPB has been utilized to explore employee behaviors, such as compliance with safety protocols or adoption of new workplace technologies, emphasizing the role of attitudes and perceived ease of implementation (Liao et al., 2007). These diverse applications highlight TPB's ability to provide valuable insights into human decision-making and behavior across a range of disciplines.

Recent research, such as the work of La Barbera and Ajzen (2020), enhances TPB by examining the interactions between perceived control factors and subjective norms, which bolsters the model's explanatory power. Traditionally, TPB suggests that behavior is influenced by intentions, shaped by attitudes, subjective norms, and perceived behavioral control. However, La Barbera and Ajzen delve deeper, particularly into how control factors and subjective norms interact to affect intentions and behaviors. Their research indicates that perceived behavioral control and subjective norms do not act independently but instead interact significantly. For example, the effect of subjective

norms on behavioral intentions may depend on the degree of perceived control an individual has over the behavior. When perceived control is high, social pressure (subjective norms) may have a weaker influence. Conversely, with low perceived control, subjective norms might have a stronger impact on intentions. This dynamic shows that people are more likely to be influenced by social expectations when they lack confidence in their ability to perform a behavior (Ajzen, 1991; Armitage & Conner, 2001).

This expanded perspective is crucial for designing more effective behavioral change interventions. For instance, in health promotion, recognizing that individuals with low perceived control are more affected by social influences can guide interventions that build self-efficacy while reinforcing positive social norms (Bandura, 1997). In environmental initiatives, campaigns could focus on enhancing individuals' control over sustainable practices while highlighting supportive social norms. La Barbera and Ajzen's (2020) work thus adds depth to TPB by revealing that attitudes, norms, and control factors interact dynamically and are context dependent. This approach supports a more holistic view of behavior, acknowledging the interaction of individual and social influences on intentions and actions.

In examining resistance to change faced by PELs in acute care hospitals, the TPB offers an effective framework. According to Ajzen (1991), behavior is driven by three elements: attitudes toward the behavior, subjective norms, and perceived behavioral control. Using TPB, researchers can identify how PELs' attitudes toward change, perceived peer and cultural pressures (subjective norms), and confidence in managing

change (perceived behavioral control) affect resistance. For example, negative attitudes toward change may stem from past unsuccessful initiatives, while subjective norms could involve resistance from colleagues accustomed to established routines. Perceived behavioral control represents PELs' confidence in implementing change despite challenges.

By examining the components of the TPB—attitudes toward the behavior, subjective norms, and perceived behavioral control—the study could uncover specific barriers to change, such as lack of resources, support, or training. According to Ajzen (1991), these components shape an individual's intention and ability to perform a behavior, making them critical in understanding resistance to change. This understanding aids in designing targeted interventions that address these barriers, fostering a more conducive environment for change. Therefore, TPB provides a comprehensive lens through which to analyze and mitigate resistance, ultimately enhancing the effectiveness of change initiatives aimed at improving patient experiences in acute care hospitals.

Literature Review

Ajzen's (1991) TPB expanded upon the theory of reasoned Action (TRA) by introducing perceived behavioral control (PBC) as a critical factor in predicting behavior. This addition allowed TPB to address behaviors in which individuals may not have full volitional control, making it a widely used framework across disciplines such as healthcare, education, and organizational behavior. The following review synthesizes studies that employ TPB and related models, highlighting methodologies, strengths, and

limitations in addressing the constructs of interest. Additionally, it examines gaps in the literature and how the present study contributes to knowledge in the discipline.

TBP in Healthcare and Related Fields

Numerous studies have applied TPB to investigate behavioral intentions and actions across healthcare and organizational settings. These studies provide insight into how attitudes, subjective norms, and perceived behavioral control shape behavior, aligning with the constructs under investigation in this study. Alburmawi et al. (2024) conducted a cross-sectional study of patient satisfaction in primary healthcare centers in Jordan, identifying predictors such as provider communication, service accessibility, and provider attitude—factors which align with TPB constructs like attitudes and subjective norms. The systematic approach allowed for broad synthesis, but reliance on existing studies without direct TPB measurement limited construct validation. Similarly, Manzoor et al. (2019) explored patient satisfaction by analyzing the moderating role of physician behavior, demonstrating how subjective norms influence patient attitudes and treatment adherence. However, the cross-sectional design of this study limits causal inference, a common issue in TPB-based research.

Javadi et al. (2013) directly applied TPB to examine patient safety behaviors among nurses, effectively measuring attitudes, subjective norms, and PBC in predicting safety-related actions. This study's strengths include its validated constructs and practical implications for hospital safety protocols. However, reliance on self-reported data introduces potential bias, and its geographic scope may limit generalizability. Sultan et al.

(2020) examined the intention-behavior gap in organic food consumption by integrating moderators such as communication and trust. While not healthcare-focused, this study highlights the complexity of translating intention into behavior, a crucial aspect relevant to behavioral change in patient engagement initiatives.

Shaikh et al. (2022) extended TPB by incorporating moral obligation and perceived risk in predicting healthcare workers' willingness to treat COVID-19 patients, highlighting the role of ethical and emotional factors. Similarly, Nichols and Newhill (2022) integrated stigma theory with TPB to explore barriers to mental healthcare access, demonstrating subjective norms and perceived control interact with deeply ingrained social attitudes. These studies emphasize the need to account for emotional and ethical dimensions in behavioral prediction models.

Keshmiri et al. (2020) used TPB to analyze interprofessional education's impact on shared decision-making among healthcare professionals. The study underscored the importance of perceived control in fostering collaborative behaviors, showing how educational interventions can enhance behavioral intentions. However, its reliance on cross-sectional data limits the ability to track long-term changes in professional practice.

Bakari et al. (2017) integrated TPB with Lewin's three-step model to study authentic leadership's role in planned organizational change. Their findings suggest that leadership styles significantly influence employee attitudes and perceived control over change. While the study provides a comprehensive theoretical approach, it does not fully capture resistance dynamics in high-pressure environments like acute care hospitals.

Guerin and Toland (2020) applied a modified TPB framework to investigate adolescents' workplace safety behaviors, adapting constructs to fit the employment context. While this study offers valuable insights into safety training programs, its focus on adolescents may limit applicability to healthcare professionals and other adult workforces.

The studies reviewed illustrate the versatility of TPB in explaining behavior in healthcare and organizational contexts. Across various domains, TPB components—attitudes, subjective norms, and PBC—consistently emerge as strong predictors of both intentions and behaviors (Armitage & Conner, 2001). However, several controversies persist. A key critique is TPB's assumption of rational decision-making, which does not fully account for emotional and unconscious influences (Ajzen, 2002).

One of the main controversies surrounding TPB is its assumption of rationality in human behavior. TPB posits that individuals make reasoned decisions based on their attitudes, social pressures, and perceived control. However, this rationality assumption has been criticized for oversimplifying the complexity of human behavior, especially in high-stress environments like healthcare settings. For instance, Shaikh et al. (2022) found that perceived risk and moral obligation significantly influenced healthcare workers' willingness to treat COVID-19 patients, suggesting that emotional and ethical considerations play a crucial role, which TPB does not fully account for.

The integration of TPB with other theories, such as stigma theory in Nichols and Newhill (2022), highlights another area of controversy. While this integration provides a more comprehensive understanding of behavior, it also raises questions about the

boundaries and sufficiency of TPB as a standalone theory. Critics argue that the necessity to integrate TPB with other frameworks indicates its limitations in fully capturing the nuances of complex behaviors. For example, the stigma surrounding mental health is a powerful deterrent to seeking care, and TPB alone might not adequately explain these deeply ingrained societal attitudes and their impact on behavior.

While the TPB has been extensively validated, gaps remain in its application to change management within healthcare settings. Many studies focus on behavioral prediction but lack longitudinal assessments of how attitudes and norms evolve over time. For instance, Bosnjak et al. (2020) noted that most TPB-based interventions were cross-sectional, underscoring the need for longitudinal research to understand changes in health behaviors over time. Additionally, TPB has been critiqued for not adequately accounting for emotional and ethical influences on behavior. Sniehotta et al. (2014) argued that TPB is too rational and does not consider the influence of emotions, identities, or other non-cognitive factors on behavior. The present study addressed these gaps by examining the factors influencing resistance to change faced by PELs in acute care hospitals through a narrative research design. By incorporating perspectives on perceived behavioral control and social norms, this study extended TPB's application to the domain of PELs and change implementation. Existing research predominantly employs quantitative methods when applying the TPB, limiting its ability to capture nuanced perspectives. For instance, Klobas and McGill (2010) noted that studies adopting the TPB mostly use quantitative methods. This study employed a qualitative,

narrative approach to understand PELs experiences and decision-making processes, bridging the gap between theoretical constructs and real-world application.

The TPB has been widely applied across healthcare and organizational studies. For instance, it has been used to predict and influence smoking cessation behaviors by targeting attitudes and perceived control (Rise et al., 2010), as well as to examine hand hygiene compliance among healthcare workers by addressing subjective norms and perceived behavioral control (Jang et al., 2010). However, critiques regarding its static nature and reliance on rational decision-making necessitate further exploration of dynamic behavioral influences. The present study contributed to the field by addressing these limitations, providing a qualitative perspective on resistance to change faced by PELs. Through this approach, the study enhances the understanding of how TPB constructs interact with leadership and change management in acute care settings, offering practical implications for improving patient engagement strategies.

Institutionalization of Patient Experience in Acute Care Hospitals

Since the early 2000s, the concept of patient experience has gained prominence in acute care hospital settings, reflecting a shift toward patient-centered care (Wolf et al., 2014). This evolution has been driven by the systematic measurement of patient experiences, implementation of patient-centered care models, technological advancements, quality improvement initiatives, and policy reforms (Luxford et al., 2011; Price et al., 2014). Patient experience refers to the range of interactions that patients have with healthcare systems as well as health plans, physicians, nurses, and hospital staff. It

involves timely appointments, access to information, and effective communication with healthcare providers (Agency for Healthcare Research and Quality [AHRQ], 2023). Understanding and improving patient experience is critical to the delivery of patient-centered care and strongly linked to both clinical outcomes and healthcare quality (Manary et al., 2013).

In the early 2000s, healthcare organizations began systematically measuring patient experience to identify areas for improvement. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, developed by the AHRQ, became standardized tools to assess patient perspectives regarding hospital care. These surveys provided healthcare institutions with actionable data to inform quality improvement efforts and enhance patient satisfaction (Centers for Medicare & Medicaid Services, 2023a, 2023b).

The Institute of Medicine (2001) identified patient-centered care as one of the 6 aims for improving the U.S. healthcare system. This emphasizes care that respects and responds to individual patient preferences, needs, and values, ensuring patient values guide all clinical decisions. Hospitals adopted this to improve both patient satisfaction and clinical outcomes (Epstein & Street, 2011).

Technological advancements have also played a pivotal role in transforming patient experiences. Widespread adoption of electronic health records (EHRs) has improved care coordination and access to real-time patient information (Adler-Milstein & Jha, 2017). Patient portals, for example, are used by individuals to view medical records,

manage appointments, and communicate with providers, contributing to increased patient engagement and satisfaction (Goldzweig et al., 2013). Artificial intelligence (AI) is being piloted in clinical settings to support nursing tasks such as monitoring and information delivery, though overreliance on automation could risk depersonalizing care (Topol, 2019).

Hospitals have also introduced quality improvement strategies aimed at enhancing patient experience. Structured interdisciplinary bedside rounds (SIBRs), for instance, involve collaborative and scheduled visits from full care teams, increasing transparency and improving role clarity, both of which positively influence patient perceptions of care (O’Leary et al., 2010). Such programs highlight the role of leadership in terms of creating cultures of patient-centeredness.

Finally, regulatory and accreditation bodies now incorporate patient experience metrics into their evaluation frameworks. The CMS integrated HCAHPS scores into the Hospital Value-Based Purchasing (HVBP) program, tying financial reimbursement to patient experience performance. This has further institutionalized patient experience as a critical indicator of healthcare quality.

Role of the PEL in the Acute Care Hospital Setting

PELs play a pivotal role in terms of shaping and sustaining patient-centered care efforts within acute care hospital environments. Their responsibilities have expanded in response to the healthcare industry’s growing emphasis on not only clinical quality, but also overall patient experiences (Wolf et al., 2014). PELs are charged with designing and

implementing strategies that elevate patient engagement, improve communication practices, and foster environments that are grounded in empathy and responsiveness (Teixeira et al., 2019).

While PELs come from a variety of professional backgrounds such as nursing, healthcare administration, and customer service, they share a common purpose: ensuring patients feel seen, heard, and valued throughout their care journey (Wolf et al., 2014). According to the Beryl Institute (2021), patient experience encompasses “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care” (para. 1). Their scope of work includes staff coaching, service recovery, patient experience measurement and using feedback data to inform systemic improvements (Luxford et al., 2011).

PELs are instrumental in terms of designing and executing patient-centered care strategies that align with hospital goals. This may include revising workflows, developing new patient engagement tools, and improving existing care processes (Teixeira et al., 2019). They frequently rely on patient experience data, such as HCAHPS scores, to guide improvements and measure success. Results of these surveys help in terms of identifying where hospitals excel and where improvements are needed (Xie et al., 2024).

One of the primary roles of PELs is to foster better communication between patients, families, and healthcare providers. Ensuring patients understand their treatment plans and feel heard and supported is central to improving patient experiences (Wolf et al., 2014). PELs implement programs such as bedside shift reporting, where nurses

update patients during shift changes. This increases transparency, enhances trust, and supports patient involvement in care (Sand-Jecklin & Sherman, 2014).

The connection between patient experience and clinical outcomes is well-established. PELs collaborate with quality improvement teams to integrate best practices that not only enhance patient experiences but also improve safety and clinical outcomes (Anhang Price et al., 2014). For example, nurse leader rounds, where nurse leaders visit patients to address concerns, have been associated with increased satisfaction and better communication (Studer Group, 2010).

PELs also play a key role in terms of educating hospital staff on how to improve patient experiences. This training often includes empathetic communication, cultural competency, and service recovery, all of which are essential to delivering patient-centered care (Johnson et al., 2016). Some organizations use simulation-based training to help staff develop confidence and skills involving navigating complex patient interactions, further enhancing quality of care (Cant & Cooper, 2017).

In addition, PELs often oversee patient advocacy functions. This includes responding to complaints, grievances, and concerns to strengthen hospital overall service cultures. By using active listening and real-time service recovery models, such as offering apologies, clarifying care plans, or following up post discharge, PELs help rebuild trust and ensure patient concerns are addressed promptly (Press Ganey, 2020).

A critical dimension of their role also involves promoting health equity. PELs advocate for language access services, culturally competent care, and inclusive policies

that meet diverse needs of patients (Hardeman et al., 2018). This ensures underserved and marginalized populations receive equitable care regardless of language, race, ethnicity, or socioeconomic status.

Overall, PELs play a significant role in the modern healthcare landscape. Their contributions to shaping patient-centered care, supporting effective communication, influencing staff performance, and promoting equity are important factors in efforts to improve the quality and compassion of care delivery (Daniels, 2023). As the focus on patient satisfaction and engagement continues to grow, PELs remain at the forefront of efforts to improve outcomes and ensure every patient has a positive and meaningful healthcare experience.

Psychological Dimensions of Resistance to Change in Acute Care Settings

Resistance to change remains a persistent challenge in healthcare, particularly among nurses who serve as frontline caregivers. Despite the clear need for innovation to improve patient safety, quality, and operational efficiency, resistance to new protocols, technologies, and workflows continues to emerge (Cheraghi et al., 2023; Ibrahim et al., 2021). This resistance is shaped by a complex interplay of individual, interpersonal, and organizational factors, including fear of the unknown, lack of involvement in decision-making, and perceived threats to professional autonomy. Several studies highlight how openness to experience, fear of the unknown, and psychological safety influence nurse readiness to adopt change. For example, Oreg et al. (2011) found individuals with an internal locus of control or high emotional stability are more likely to adapt to

organizational transitions. A more recent study by Cho et al. (2021) identified self-efficacy, peer influence, and organizational support as significant predictors of resistance among nurses following electronic health record implementation. Peer influence and supervisory support continue to play vital roles; Madsen et al. (2023) found that higher levels of perceived supervisor support significantly increased change readiness and acceptance among healthcare staff during organizational changes. This multidimensional nature of resistance aligns well with Ajzen's (1991) TPB, which suggests that behavioral intention is influenced by attitudes, subjective norms, and perceived behavioral control. This theory provides a useful framework for understanding how internal beliefs and social environments shape reactions to change. Research also underscores the importance of recognizing the emotional and cognitive underpinnings of resistance. Samuelson and Zeckhauser (1988) introduced the concept of status quo bias, a cognitive bias that favors existing conditions even when alternatives may be better. Bandura's (1997) work on self-efficacy further supports this idea, showing that confidence in one's abilities can significantly affect willingness to change. These psychological factors must be considered when designing interventions.

While leadership engagement and staff involvement are commonly recommended strategies, they must be implemented thoughtfully. Not all staff want to participate in change planning—some prefer clear direction and structure. Lines (2005) suggested that successful change management depends on aligning strategies with individual preferences, offering flexible levels of engagement.

Training and education also remain essential. Adult learning theory emphasizes the value of experiential learning to build competence and reduce fear. However, hospitals face practical challenges such as staffing shortages and time constraints. Digital microlearning and peer-led coaching offer more feasible strategies in busy clinical settings, supporting skill development even with limited time and resources (Almefleh & Alqudah, 2021; Hjálmarsdóttir & Jónsdóttir, 2023). Finally, the readiness of the organization to change is crucial. Caci et al. (2025) emphasized that alignment of organizational infrastructure, leadership capability, and culture is essential to successful transformation, especially in healthcare contexts where misalignment often undermines implementation efforts. Resistance to change in healthcare, especially among nurses, cannot be explained by a single factor. It emerges from a confluence of personal attitudes, interpersonal dynamics, institutional structures, and cognitive-emotional narrative accounts. A comprehensive approach that considers these layers may yield more sustainable change and improved care outcomes.

Organizational and Individual Narrative Accounts to Change in Healthcare Settings

Understanding the complex dynamics of resistance and readiness to change within healthcare organizations requires a synthesis of perspectives across individual, interpersonal, and systemic levels. Several studies contribute to this understanding by examining the interplay of leadership, communication, organizational culture, and personal attitudes—elements highly relevant to the work of patient experience leaders (PELs) navigating change in acute care settings.

Nilsen et al. (2019) offered valuable insight into the nuanced narrative accounts of healthcare professionals to workplace change, highlighting themes such as acceptance, resistance, ambivalence, and active participation. These varied narrative accounts were shaped by emotional and organizational factors, including perceptions of leadership, the availability of resources, and psychological safety. Similarly, Schulz-Knappe et al. (2019) emphasized the importance of trust in management and communication quality as predictors of support or resistance to change. Clear, transparent, and timely communication, along with opportunities for employee voice, helped mitigate resistance and fostered a sense of ownership among staff.

Expanding the focus from individual narrative accounts to broader organizational conditions, Vaishnavi et al. (2019) identified structural and cultural enablers of organizational readiness for change. Their findings underscored leadership support, resource availability, training and development, and technological preparedness as interrelated factors that strengthen organizational adaptability. This aligns with Schulz-Knappe et al.'s findings, suggesting that readiness and resistance are not only psychological states but also reflections of how well the organizational environment facilitates change.

Taken together, these studies inform a more holistic understanding of resistance to change. Resistance is not simply a personal trait or opposition to progress—it is often a signal of unmet needs, unaddressed fears, or unclear expectations. For PELs, these insights underscore the importance of shaping a supportive climate for change through

authentic communication, involvement in decision-making, and attentiveness to emotional narrative accounts. Synthesizing these findings supports the notion that successful change in healthcare hinges on relational leadership, shared vision, and an infrastructure that empowers staff to adapt.

Summary and Conclusions

Based on the syntheses of the literature throughout this chapter, it is well-known that resistance to change is a natural and expected reaction among employees. Factors contributing to resistance include fear of the unknown, loss of control, lack of trust in leadership, poor communication, and perceived negative impacts on job security or workload. Effective communication, leadership support, employee involvement, and addressing emotional narrative accounts were critical strategies to mitigate resistance.

However, there were still unknowns in this field. The precise interplay between individual psychological traits and organizational factors in predicting resistance remained unclear. Additionally, the impact of cultural and contextual differences on resistance behaviors was not fully understood. The long-term effects of resistance on organizational outcomes and how to sustainably overcome resistance in large-scale, ongoing change initiatives also required further research. Understanding these aspects could help develop more nuanced and effective change management strategies.

While there was substantial research on resistance to change in healthcare settings, there remained a notable gap concerning the specific factors that caused such resistance faced by PELs in acute care hospitals. Existing studies often focused on

broader organizational or clinical roles, leaving the unique challenges faced by PELs underexplored. For instance, Cheraghi et al. (2023) conducted an integrative review identifying individual, interpersonal, and organizational factors contributing to resistance among nurses. However, similar comprehensive studies focusing on PELs were scarce, highlighting the need for targeted research in this area. PELs were pivotal in implementing changes that directly affected patient outcomes and satisfaction. By examining their unique challenges and resistance factors, the study provided tailored strategies for overcoming resistance in this context. This research enhanced the understanding of how to effectively manage change in healthcare settings, where resistance could significantly hinder improvements in patient care. Additionally, insights from such a study could inform broader change management practices across the healthcare sector, promoting more effective and sustainable change initiatives.

In Chapter 3, a comprehensive description of the research design and its underlying rationale was presented, offering a clear justification for the chosen approach and its alignment with the study's objectives. This chapter also delineated the role of the researcher, highlighted potential biases, positionality, and strategies for maintaining reflexivity throughout the research process. Additionally, the methodology section provided a thorough explanation of the data collection and analysis procedures, ensuring transparency and replicability. Finally, issues of trustworthiness, including credibility, transferability, dependability, and confirmability, were addressed to underscore the study's rigor and validity.

Chapter 3: Research Method

The purpose of this qualitative narrative study was to explore the factors that cause resistance to change faced by PELs in the acute care hospital setting. Chapter 3 outlines the research design and rationale, the role of the researcher, the methodology, and issues of trustworthiness.

Research Design and Rationale

The research question for this study was as follows: What are the factors that cause resistance to change that PELs face in the acute care hospital setting? When exploring the factors that led to resistance to change faced by PELs in acute care hospital settings, the choice of research design was critical. For this qualitative study, a narrative research design was particularly well-suited due to its ability to capture the rich, detailed, and personal stories of individuals who had directly experienced the phenomenon under investigation (Clandinin & Connelly, 2000). This design not only allowed for a deep exploration of the subjective and contextual factors influencing resistance to change but also offered insights that were often missed in other qualitative approaches (Kim, 2016).

Narrative Research Designs

The narrative research design was ideal for exploring the factors that caused resistance to change faced by PELs in acute care hospital settings. By focusing on the personal and professional stories of these leaders, this approach allowed for a deeper understanding of the specific challenges they encountered when implementing patient-centered initiatives. Through their narratives, I could identify the nuanced, often

emotionally charged factors contributing to resistance, providing insight into how these experiences shaped their perspectives on change management (Riessman, 2008). These stories provided a window into the lived experiences of PELs, allowing for an in-depth understanding of how they perceived resistance to change within the complex environment of an acute care hospital (Merriam & Tisdell, 2016).

One of the strengths of narrative research is its emphasis on context, as it allows researchers to understand participants' experiences within the framework of their social, cultural, and historical environments (Polkinghorne, 1995; Riessman, 2008). Clandinin, a leading scholar in narrative inquiry, emphasizes that stories are not isolated events but are embedded within a continuum of lived experience shaped by interactions across time, relationships, and place (Clandinin, 2019). According to Creswell and Poth (2018), narrative research highlights the importance of situating stories within these broader contexts to uncover the deeper meaning and significance of individual experiences. In acute care hospitals, where organizational culture, power dynamics, and patient care priorities significantly influence resistance to change, understanding the context in which PELs operate is crucial. Narrative research, particularly as conceptualized by Clandinin, allows the researcher to explore how these leaders' personal and professional histories, along with the specific circumstances of their work environment, shape their experiences and perspectives.

Narrative research excels at exploring the temporal dimensions of experiences, making it particularly effective for understanding phenomena like resistance to change

(Clandinin & Connelly, 2000). This approach allows researchers to delve into how individuals interpret past events, navigate present challenges, and anticipate future outcomes, all within the context of their lived experiences. By capturing these temporal narratives, researchers can gain deeper insights into the complexities of organizational change and the factors that influence individuals' narrative accounts to it.

As Cunliffe et al. (2004) noted, narrative research provides a framework for examining how people make sense of their experiences over time, emphasizing the fluid and dynamic nature of meaning-making in organizational settings. This temporal focus is crucial for understanding how resistance to change develops and evolves, as it considers the interplay between individuals' past experiences, current perceptions, and future expectations. Change processes in hospitals often unfold over time, with past experiences, current challenges, and future expectations all playing a role in how PELs perceived resistance to change. By allowing participants to construct and reflect on their stories over time, narrative research captured the evolution of resistance and the factors that sustained or mitigated it (Savin-Baden & Major, 2019). In many healthcare settings, the voices of those focused on patient experience may be overshadowed by more clinically oriented perspectives. Narrative research prioritized the voice of the participant, ensuring that the experiences and insights of PELs were fully represented and valued. While narrative research offered distinct advantages for this study, it was important to consider why other qualitative approaches might have been less effective.

Phenomenological Research Designs

Phenomenology, which focuses on the shared lived experiences of individuals, might have seemed a plausible alternative for this study, as it seeks to understand the essence of participants' experiences and how they perceive and make sense of them.

According to Neubauer et al. (2019), phenomenology is a qualitative research approach that focuses on the study of an individual's lived experiences within the world.

Phenomenology often abstracts experiences from their specific contexts to focus on identifying the fundamental essence shared across different instances. This approach aims to distill core elements, allowing researchers to understand phenomena in a way that transcends individual circumstances (Neubauer et al., 2019). This abstraction can be valuable for identifying universal qualities but may overlook situational factors that influence personal experiences. In the case of resistance to change faced by PELs, the variability in personal and contextual factors was crucial. A phenomenological approach might have overlooked the unique narratives that illuminate why resistance to change manifests differently across individuals and settings (Neubauer et al., 2019).

Grounded Theory Research Designs

Grounded theory aims to develop theory from data collected and analyzed during the research process, allowing the theory to emerge directly from observed patterns within the data (Charmaz, 2014). While this approach is valuable for generating new theoretical insights, it might not have been as effective for a study focused on the detailed, individual stories of PELs. Grounded theory requires constant comparison and

coding to develop a theory, which could have led to the oversimplification of complex narratives and a loss of the rich, descriptive detail that narrative research preserves (Bryant & Charmaz, 2019).

Case Study Research Designs

A case study design could also have been considered, as it allows for an in-depth exploration of resistance to change within a specific context, such as an acute care hospital. However, case studies often focus on broader organizational dynamics or particular events rather than the personal stories of individuals. While a case study could have provided valuable insights into institutional factors contributing to resistance, it might not have captured the personal and temporal aspects of PELs' experiences as effectively as narrative research (Yin, 2018).

Ethnographical Research Designs

Ethnography involves researchers immersing themselves within a culture or specific setting to understand the behaviors, beliefs, and social dynamics of a group through direct observation and participation (Creswell & Poth, 2018). While this approach could have offered deep insights into the culture of acute care hospitals, it would have required extensive time and involvement that might not have been feasible for all researchers. Additionally, ethnography tends to focus on group behaviors rather than individual narratives, which could have diluted the focus on the personal experiences of PELs (Pink, 2020).

Action Research Designs

Action research is a collaborative approach where researchers and participants work together to bring about practical change while simultaneously generating insights and knowledge (Stringer, 2014). While this method is powerful for implementing and studying change simultaneously, it may not have been the best fit for exploring resistance to change in this study. The focus of action research is on solving practical problems, which could have shifted the emphasis away from understanding the underlying causes of resistance in favor of finding immediate solutions (Coghlan & Brydon-Miller, 2018).

Descriptive Research Designs

Descriptive research designs aim to quantify and describe characteristics, behaviors, or phenomena within a population without manipulating variables. Common methods included surveys, cross-sectional studies, and observational techniques, which gathered numerical data to identify patterns or distributions (Creswell & Creswell, 2023). These designs were ideal for answering “what” and “how many” questions, providing a snapshot of a population at a specific point in time. The strengths of quantitative descriptive research included its efficiency, cost-effectiveness, and capacity to collect data from large samples. It provided clear, measurable insights that could guide decision-making and hypothesis generation (Polit & Beck, 2021). However, it could not establish causation due to its non-experimental nature. Biases, such as sampling or response bias, might also have limited the validity of findings, and the focus on numerical data could have oversimplified complex phenomena.

Correlational Research Designs

Correlational research designs focus on examining relationships between two or more variables without manipulating them. These studies aim to determine the strength and direction of associations, often using surveys, archival data, or observational methods. The analysis typically involves correlation coefficients to quantify the relationships (Creswell & Creswell, 2023). Correlational designs are particularly useful for exploring natural associations and generating hypotheses for future experimental research. One of the main advantages of correlational research is its efficiency and cost effectiveness, as it allows researchers to study variables as they naturally occur. This approach is valuable for identifying trends and connections that may guide further investigation (Polit & Beck, 2021). However, it has notable limitations, including the inability to establish causation or control for third variable influences, which may confound results. Furthermore, these studies can only identify associations without explaining underlying mechanisms (Field, 2021). Despite these limitations, correlational research provides essential insights for exploring “is there a relationship” questions.

Quasi-Experimental Research Designs

Quasi-experimental research designs evaluate cause-and-effect relationships without the use of full randomization, making them suitable for studying interventions in real-world settings. Common designs include non-equivalent control group studies, interrupted time series, and pretest-posttest designs. These methods are particularly valuable when randomization is impractical or unethical, such as in healthcare or

educational interventions (Creswell & Creswell, 2023). The primary strength of quasi-experimental designs is their feasibility and ethical suitability in applied settings, allowing researchers to investigate interventions while maintaining ecological validity. They provide practical insights into causality and are often more adaptable than randomized controlled trials (Polit & Beck, 2021). However, the lack of randomization increases the risk of selection bias and confounding variables, potentially compromising internal validity. Additionally, findings may be influenced by contextual factors, limiting generalizability (Harris et al., 2006). Despite these limitations, quasi-experiments are widely used for evaluating interventions in natural environments.

A narrative research design offered a unique and powerful approach to exploring the factors behind resistance to change faced by patient experience leaders (PELs) in acute care hospitals. By focusing on the stories and personal experiences of these leaders, narrative research captured the rich, contextualized, and temporal aspects of resistance. According to Tuval-Mashiach (2014), narratives are always situated and bound in different contexts, and a contextualized reading of a narrative adds important insights to the analytic process. This design not only provided a deep understanding of the phenomenon but also ensured that the voices of PELs were heard and valued in the ongoing conversation about change management in healthcare settings (Clandinin, 2019).

Role of the Researcher

In this study, my role as the primary observer and interviewer was to systematically and objectively engage with PELs within the acute care hospital setting. Consistent with a narrative inquiry approach, my responsibility was to create conditions that allowed participants to *narrate* their experiences in ways that revealed temporality, context, and meaning over time. My objective was to gather rich, meaningful, and unbiased stories that contributed to a deeper understanding of the factors that cause resistance to change faced by PELs in the acute care hospital setting. It was essential to ensure that the data collection process remained neutral and that participants' narratives reflected their genuine experiences rather than being influenced by my own position or perspectives.

While none of the participants in this study were individuals who reported directly to me or whom I worked with closely, many were peers within the healthcare industry. The hierarchical nature of healthcare institutions means that these participants may occupy organizational positions either above or below mine in terms of rank or status. This dynamic, while professionally relevant, also presented a challenge. As a PEL in an acute care hospital myself, I recognized the possibility that my own experiences, assumptions, or preconceived notions could influence the ways I engaged with participant storytelling. Berger (2015) noted that when researchers occupy insider roles, heightened self-awareness is essential to manage personal biases. Therefore, I remained highly vigilant throughout the research process to prevent personal bias from shaping the line of

questioning or influencing how participants narrated their stories. My primary goal was to facilitate an environment in which participants felt comfortable recounting their authentic insights, free from any pressure or expectations that could stem from my position.

Bias Mitigation

To mitigate potential bias, I employed several strategies to ensure the integrity of data collection. First, I rigorously followed an established semistructured interview protocol, developed based on current literature, and designed to elicit open-ended narrative accounts. This approach encouraged participants to *narrate* their experiences in their own words, ensuring their stories emerged naturally and were not unduly guided by leading questions. Smith and Noble (2014) underscored the importance of transparency and consistency in qualitative research methods to ensure credibility and reduce researcher bias.

Additionally, I maintained a reflective journal throughout the research process to document my thoughts, reactions, and potential biases. This reflective practice, advocated by Finlay (2002), helped me remain mindful of how my position as a PEL could inadvertently shape participants' storytelling during the interviews. Lastly, I engaged in member checking by sharing preliminary interpretations with participants to ensure their narratives were authentically represented. This collaborative validation reinforced the co-constructed nature of narrative inquiry and helped maintain the integrity of participants' lived experiences and meaning-making over time.

Ethical Considerations

Ethical considerations were of utmost importance in conducting this research. Given the professional relationships that may have existed between me and the participants, maintaining confidentiality and ensuring the voluntary nature of participation were critical. Participants were informed of their right to withdraw from the study at any time without consequence, and all data were anonymized to protect their identities. Additionally, I ensured that the power dynamics inherent in our professional relationships did not influence the voluntary nature of participation or the honesty of their narrative accounts. This was achieved through clear communication, the use of informed consent, and adherence to ethical guidelines throughout the research process (Creswell & Poth, 2018).

My role as the observer in this study required careful attention to the complexities of researching within my professional community. Consistent with narrative inquiry, this included remaining attentive to how relational contexts shape storytelling and how participants construct meaning over time. These insights not only advanced the field of patient experience leadership but also contributed to a deeper understanding of the challenges and opportunities that exist in fostering positive organizational change within healthcare environments. Ultimately, this research has the potential to inform best practices and improve patient outcomes by addressing one of the most significant barriers to effective patient experience leadership: resistance to change.

Alignment of TPB Within a Narrative Inquiry Approach

Although TPB is rooted in a positivist and predictive tradition, its use in this study served a different, interpretive purpose aligned with narrative inquiry. In this research, TPB functioned as a sensitizing framework rather than a variable-testing model. A sensitizing framework offers conceptual guidance for interpreting how participants make sense of their experiences without imposing predetermined hypotheses or causal pathways. Within this narrative inquiry design, TPB provided a helpful lens for understanding how PELs narrated their attitudes, perceived norms, and perceived behavioral control as they encountered resistance to change. The intention was not to measure or predict behavioral outcomes but to illuminate how participants storied their professional experiences in ways that echoed TPB constructs. In this way, TPB supported meaning-making rather than prediction, allowing participant narratives to remain central while offering a conceptual structure through which their interpretations of resistance could be understood.

Methodology

This study focused on current and former PELs working in the acute care hospital setting. A Patient Experience Leader is defined as an individual in a position of authority who is directly involved in decision-making processes aimed at optimizing patient experience outcomes (Barden et al., 2020). These leaders are responsible for shaping policies, strategies, and operational decisions that directly impact the quality of patient experience within their respective hospitals.

The study employed purposive sampling as the primary strategy for participant selection. Purposive sampling is a widely recognized qualitative research approach designed to gather insights from individuals with specific, relevant experiences. It is particularly effective in identifying participants who can provide detailed and context-specific information about the phenomenon under investigation (Patton, 2015). Given the study's focus on resistance to change in acute care settings, purposive sampling ensured that only individuals with firsthand experience in this area were included. Additionally, snowball sampling was used to identify further participants through referrals provided by current participants. This combined approach allowed for both targeted recruitment of highly relevant individuals and the potential for expanding the participant pool through trusted recommendations.

Participants were selected based on their current or prior professional experience in leading patient experience improvement initiatives within the acute care context. They must have held a position of authority that involved influencing policies, strategies, or operational decisions aimed at enhancing patient experience outcomes. These selection criteria ensured that participants possessed the necessary expertise and firsthand experience to contribute meaningful narratives related to the study's focus on resistance to change in acute care settings.

To ensure participants met these criteria, potential participants were identified through my professional LinkedIn network, which includes over 100 current and former PELs in the acute care hospital setting. I published a LinkedIn post (see Appendix A)

inviting individuals to express their interest in participating in the study. Interested participants contacted me directly via LinkedIn message, providing an opportunity to review their professional backgrounds and confirm their relevance to the study. Snowball sampling followed a similar process, with referrals from current participants being vetted to ensure they met the selection criteria. Once eligibility was confirmed, I emailed participants the participant agreement, and they replied with the words “I consent” before being scheduled for an interview.

The sample size for this study included 15 participants. This final number remained consistent with qualitative research guidance. Guest et al. (2020) suggested that approximately 20 interviews are typically sufficient to capture a comprehensive range of narrative patterns in qualitative research, particularly when participants share similar professional backgrounds. However, in cases where participants bring diverse perspectives or the research question is more complex, Hennink et al. (2022) suggested that a sample size of 16–24 may be necessary to achieve sufficient narrative variation—the point at which no new narrative threads, dimensions, or insights emerge from additional data collection. Sufficient narrative variation is a critical factor in determining the adequacy of the sample size in narrative research. It indicates when sufficient data has been collected to fully understand the phenomenon being studied (Fusch & Ness, 2015).

To ensure the sample size adequately addressed the research question, I monitored narrative variation throughout the interview process. After each interview, I engaged in preliminary coding and memo writing to track the emergence of new narrative patterns.

Narrative variation was considered reached when consecutive interviews no longer produced novel information or insights relevant to the study's focus. This approach allowed for real-time evaluation of data sufficiency while honoring the narrative inquiry emphasis on depth, storytelling, and meaning-making over time. Monitoring narrative variation in this iterative manner helped ensure the richness and trustworthiness of the findings (Guest et al., 2020).

Instrumentation

In this study, as the researcher, I was the primary instrument for data collection. In addition, my interview guide served as a data collection tool. Microsoft Teams was used to hold the interviews required to conduct this study. Microsoft Teams, developed by Microsoft Corporation and launched in 2017, has been widely used for virtual communication, particularly since the COVID-19 pandemic (Chick et al., 2020). It has been employed in numerous studies involving remote interviews and virtual data collection with healthcare professionals and organizational leaders, making it highly suitable for this research. Since PELs in acute care hospitals were already familiar with virtual meeting platforms, no modifications to the software were necessary. While Microsoft Teams is not a traditional research instrument requiring content validity, its ability to facilitate communication and accurately transcribe interviews made it an effective tool for collecting qualitative data. Given its widespread adoption across industries, no cultural or context-specific issues were expected. All interviews were

audio-recorded through Microsoft Teams and automatically transcribed to ensure accuracy and completeness.

The interview guide includes the questions located in Appendix B was used to ensure consistency across the interviews while maintaining the flexibility essential to narrative inquiry, which values participants' storytelling and meaning-making. In alignment with narrative research principles, the guide was designed to prompt reflective storytelling about personal experiences with resistance to change. To ensure its relevance and resonance with the target population, I conducted an expert review by sharing it with multiple current and former PELs who have firsthand experience leading change in the acute care hospital setting.

Those who were involved in this step volunteered their time and understood they could not participate in the study due to their participation in this step of the process. The guide itself includes open-ended questions that encourage participants to reflect on their lived experiences, specifically focusing on their roles in facilitating improvement efforts, overcoming resistance, and navigating the complexities of hospital culture and organizational change. These questions were intended to elicit rich, narrative accounts, providing the depth of understanding required in a narrative research design.

Content validity of the interview guide was supported through an expert review process, a recommended strategy for ensuring that qualitative instruments are well-aligned with study goals (Kallio et al., 2016). By engaging experienced patient experience leaders (PELs) in the development and refinement of the guide, the questions

were assessed for clarity, relevance, and their ability to elicit meaningful narrative accounts aligned with the study's objectives (Castillo-Montoya, 2016). Feedback from these experts was used to revise wording and confirm that the questions were sufficiently comprehensive to explore the complexities of resistance to change in the acute care hospital setting.

Additionally, the guide was developed in alignment with both the conceptual framework and the findings from the literature review, further strengthening its construct validity (Creswell & Poth, 2018). The open-ended nature of the interview questions supported the collection of rich, detailed narratives and is consistent with best practices in qualitative research and narrative inquiry (Clandinin & Connelly, 2000). No significant cultural or context-specific concerns were anticipated, as the guide is grounded in widely used change management theories that are broadly applicable to leadership roles in acute care hospitals (Kotter, 1996; Lewin, 1951).

Procedures for Recruitment, Participation, and Data Collection

The primary mode of participant recruitment was a public post on LinkedIn, inviting current and former PELs (PELs) working in acute care hospital settings to participate in the study. While LinkedIn served as the initial platform for outreach, participation was not limited to individuals who viewed the post or had access to the platform. If others became aware of the study through word of mouth or other channels and expressed interest, they were considered for inclusion based on the same eligibility criteria. This approach ensured openness to all qualified participants, regardless of how

they learned about the study. Eligible participants received an invitation (located in Appendix A) detailing the purpose of the study, the voluntary nature of their participation, and the expected commitment. Upon expressing interest, participants were provided with a consent form outlining the study procedures, confidentiality measures, and their right to withdraw at any time. Participation was confirmed once consent was obtained.

Data were collected through semistructured interviews using the interview guide in Appendix B. Semistructured interviews are particularly well-suited for qualitative research, as they offer flexibility in exploring participants' experiences while still maintaining a guided structure—meaning that the interviewer uses a predefined set of open-ended questions to ensure consistency, yet allows for deviations to follow the participant's narrative (Kallio et al., 2016). This approach strikes a balance between systematic data collection and responsiveness to the uniqueness of each participant's story, which is especially important in narrative research. As the researcher and interviewer, I was directly responsible for conducting and recording the interviews, ensuring consistency and deep engagement with the material as it unfolded in real time. Interviews took place via Microsoft Teams and were audio-recorded with participants' consent to ensure accuracy.

Data Collection Plan

Semistructured interviews were conducted using the interview guide in Appendix B. This approach ensured consistency while offering participants the flexibility to narrate

their experiences in a way that felt natural (Kallio et al., 2016). Semistructured interviews are widely used in qualitative research because they facilitate rich, in-depth storytelling while maintaining a structured framework (DiCicco-Bloom & Crabtree, 2006). Each interview took place via Microsoft Teams and was recorded with participants' consent to ensure accuracy in transcription and analysis. The expected duration was no longer than 60 minutes, though some participants took longer to elaborate on their narratives.

As the interviewer, I remained engaged and responsive, using follow-up questions to explore emerging narrative patterns while allowing the conversation to unfold organically. The objective was to create a comfortable environment where participants felt encouraged to express their thoughts freely and recount the stories most meaningful to them. This adaptable format ensured that the flow of conversation and the richness of participants' narrative accounts took precedence over strict time constraints (Braun & Clarke, 2019).

Data Collection Frequency

The scheduling of interviews was intentionally flexible to honor the professional rhythms and responsibilities of the participants. This adaptive approach supported richer storytelling by allowing PELs to engage at times when they felt most present and prepared to narrate their experiences (Hennink et al., 2020). Depending on availability, interviews unfolded more frequently during some weeks and at a slower pace during others. This flexibility fostered a more positive narrative environment and enabled

participants to share their stories without disrupting their daily responsibilities (Jacob & Furgerson, 2017).

The narratives collected in this study came directly from current or former PELs with experience in the acute care hospital setting. These stories offered firsthand, experience-based accounts that illuminated the factors shaping resistance to change. Using interviews as the primary storytelling method allowed the research to capture the emotional contours, relational dynamics, and lived experiences of PELs who had navigated the challenges of implementing change. The narrative richness of these accounts made it possible to explore resistance not only as an organizational phenomenon but as a personally interpreted experience—shaped by culture, leadership, resources, communication patterns, institutional structures, and staff narrative accounts.

As described in the research design section, semistructured interviews served as the foundation for gathering participant narratives. Interviews were held on Microsoft Teams, recorded with consent, and transcribed verbatim to preserve each participant's voice and narrative flow (Halcomb & Davidson, 2006). After transcription, each recording was reviewed alongside the transcript to ensure accuracy and maintain the integrity of the narrative arc. Member checking invited participants to review their own stories, allowing them to affirm the accuracy of their accounts and reinforce the co-constructed nature of narrative inquiry.

Narrative Analytic Positioning

This study most closely aligns with Polkinghorne's (1995) narrative analysis, specifically configurative synthesis, in which events and experiences are assembled into coherent storied accounts that preserve plot, temporality, and identity development. Rather than fragmenting data into decontextualized codes, the analytic process involved restorying participant accounts into narrative wholes that retained turning points, tensions, and meaning-making processes over time. At the same time, the study is informed by Clandinin and Connelly's (2000) relational narrative inquiry, particularly the three-dimensional inquiry space of temporality, sociality, and place, which guided interpretation of how participants' identities evolved within institutional contexts. Elements of Riessman's (2008) interpretive narrative analysis also shaped attention to how participants constructed meaning through language, positioning, and relational framing. Thus, the analytic approach represents an intentionally blended narrative methodology: configurative in synthesis, relational in epistemology, and interpretive in meaning-making. This blended positioning was a methodological choice rather than theoretical inconsistency, ensuring coherence with narrative inquiry traditions while preserving analytic depth.

Coding Process and Thematic Analysis

The data analysis process in this study followed a narrative inquiry approach consistent with Clandinin and Connelly's (2000) three-dimensional inquiry space, which emphasizes temporality, sociality, and place as central components of how individuals

construct meaning through story. Rather than fragmenting accounts into isolated codes, analysis centered on understanding each participant's narrative as a coherent, temporally sequenced story. This ensured that experiences were interpreted within the continuity of participants' past experiences, current contexts, and future expectations.

Analysis began with immersion in each transcript, engaging repeatedly with the stories to understand their structure, tone, and narrative arc. This familiarization phase focused on how participants narrated their experiences, including critical incidents, turning points, and moments of tension or insight that illuminated their interpretations of resistance to change. Attention was also paid to how participants positioned themselves within their stories—whether as advocates, mediators, protectors, or agents navigating organizational turbulence.

Consistent with narrative inquiry, the initial analytic focus was on maintaining the integrity of each story. Each narrative was examined for its temporal flow (past–present–future), the sequencing of key events, and the broader social and organizational contexts that shaped meaning. Narrative segments were identified not as “codes” in a traditional qualitative sense, but as meaning-bearing story units that captured participants' interpretations of significant experiences. These segments reflected how participants made sense of resistance, leadership dynamics, organizational culture, emotional strain, and their evolving professional identities.

After each individual narrative was understood holistically, the analysis moved into a process of “restorying,” or reconstructing each participant's account into a coherent

narrative form (Clandinin, 2019). This process preserved the original voice and intent of each participant while clarifying plotlines, contextual influences, and patterns of meaning over time. Restorying supported a deeper understanding of how resistance was encountered, interpreted, and negotiated throughout participants' professional journeys.

Following restorying, cross-narrative analysis was conducted to identify recurring narrative patterns rather than abstract themes. These narrative patterns represented shared storylines across participants, such as experiences of change saturation, identity disruption, leadership misalignment, or the search for meaning and relational grounding during complex organizational change. Although the structure of Braun and Clarke's (2006, 2022) analytic phases informed the organization and transparency of the process, these phases were adapted to prioritize narrative meaning-making rather than categorical reduction. The emphasis remained on how participants constructed stories about resistance and how these stories reflected continuity, context, and personal significance.

Throughout the analysis, reflexivity played a central role. A reflexive journal was maintained to examine how the researcher's professional background and assumptions interacted with participants' stories. This ongoing reflective practice ensured that interpretations remained grounded in participants' narrative meaning rather than researcher bias. The final analytic stage involved integrating individual narrative reconstructions with the narrative patterns that emerged across participants, resulting in a layered understanding of resistance to change as a relational, temporal, and context-dependent experience for PELs.

Treatment of Discrepant Cases

While the core narrative patterns were consistent, variation emerged in how participants framed authority, fatigue, and resource constraints.

Issues of Trustworthiness

Credibility

Member checks involve sharing the preliminary findings or interpretations with the participants to verify that my understanding aligns with their experiences. After analyzing the interviews, I shared my findings with the PELs to ensure that my interpretation accurately reflected their perspectives. This strategy helps identify any misinterpretations or inaccuracies and allows participants to contribute additional insights that might have been overlooked (Birt et al., 2016).

Transferability

Thick description is a critical strategy for establishing transferability by providing rich, detailed accounts of the participants' experiences and the specific contexts in which they work. By including comprehensive information about the hospital settings, organizational structures, leadership dynamics, and the specific challenges each PEL faces, I offered a vivid and immersive understanding of the environment in which the participants operate. This allows readers to evaluate whether the findings could be applicable in similar or different settings (Nowell et al., 2017). By selecting participants from diverse backgrounds, roles, and types of hospitals, I captured a broad range of experiences with resistance to change. This strategy allowed the findings to reflect a

variety of perspectives, which makes them more applicable to different hospital settings (Palinkas et al., 2015).

Dependability

An audit trail is a comprehensive documentation of every step of the research process, including data collection, analysis, and decision-making. By maintaining a detailed audit trail, I documented how each phase of my study was conducted, ensuring that external reviewers or other researchers can replicate the study if needed. This strategy ensured transparency and consistency throughout the research process (Nowell et al., 2017). I also applied data triangulation by gathering data from a variety of participants, such as both current and former PELs from diverse hospital settings. By triangulating the data, I ensured that the findings were not reliant on a single source but were corroborated across multiple perspectives, increasing the overall dependability of the study (Korstjens & Moser, 2018).

Confirmability

Reflexivity involves actively reflecting on my own assumptions, beliefs, and potential biases throughout the research process to ensure that these do not unduly influence the findings. In this study, I maintained a reflexive journal to document my thoughts, decisions, and reactions during data collection and analysis. By critically reflecting on my role as the researcher, I acknowledged any preconceptions that might shape how I interpreted the data (Berger, 2015). Alongside reflexivity, I maintained an audit trail, which is a detailed account of all research decisions, steps, and processes. This

included documentation of how data were collected, how narrative accounts were constructed and analyzed, and the rationale behind key methodological choices. The audit trail included raw data, coding frameworks, and analytical memos to ensure transparency in how I arrived at the study's conclusions. By providing a comprehensive account of the research process, the audit trail allowed others to trace the logic behind my interpretations, ensuring that the findings were based on the participants' perspectives rather than researcher bias (Korstjens & Moser, 2018).

Ethical Procedures

Walden University's IRB approval number for this study is 10-07-25-1026609. I secured IRB approval before any data collection began, ensuring compliance with ethical research standards. This board is responsible for reviewing the ethical aspects of research involving human subjects. The IRB application outlined the study's purpose, methods, recruitment process, and procedures for protecting participants' rights and privacy. For the dissertation, I included relevant IRB approval numbers in the final report once the approval was granted. To gain access to the participants for my study, I followed a series of formal agreements and permissions. I ensured that participants were contacted voluntarily and ethically.

During the recruitment process, special attention was given to ensuring participants understood the voluntary nature of the study. Recruitment materials had been created and did state that participation was voluntary. If a participant decided not to join or later withdrew from the study, they did not face any negative consequences. The

recruitment process also provided participants with the right to ask questions and clarify doubts before consenting to participate. To address any ethical concerns, I used a clear and concise informed consent form that participants signed before taking part in the study. This consent form outlined their rights, including the right to withdraw at any time without repercussions.

Throughout data collection, I followed strict ethical protocols. Participants were informed of their right to refuse to answer; data they contributed were excluded from the analysis if requested by the participant. Participants were informed of the availability of support resources if they felt uncomfortable or distressed. If a participant experienced any adverse event, the session was paused, and steps were taken to ensure the participant's well-being.

In my study, I ensured confidentiality, but due to the nature of interviews and transcriptions, absolute anonymity was not possible since direct interactions with participants occurred. All identifying information, such as participant names, specific hospital affiliations, or roles that could reveal a participant's identity, was removed from the data. Pseudonyms were used for participants, and any references to specific hospitals or organizational details were generalized.

I executed a robust data protection strategy to maintain confidentiality. Interview transcriptions and any other collected data were securely stored on encrypted devices and password-protected databases. Access to the data was restricted to myself and any authorized members of my research team, such as my dissertation committee. The data

were not shared with third parties, and personal identifiers were removed from any published results or presentations.

Summary

In this chapter, the research design, methodology, and ethical considerations for this study exploring resistance to change faced by PELs in acute care hospital settings were explored. A narrative research design was used to capture the detailed personal stories of PELs, focusing on the emotional and contextual factors contributing to resistance. As the researcher, I carefully managed my role to avoid bias, ensuring neutrality during data collection through a standardized interview protocol and reflective journaling. The methodology involved semistructured interviews with 15 PELs, conducted via Microsoft Teams. These interviews were transcribed and analyzed using Microsoft Copilot software, with narrative patterns related to resistance emerging through the analytic review of participant accounts. Participants were selected through purposive sampling to ensure relevance to the study's focus. Trustworthiness was prioritized through strategies such as triangulation, member checks, and maintaining an audit trail. I created this audit trail to provide a thorough record of the research process, outlining each decision, step, and method used. This included how data were gathered, how narrative patterns were identified across participant accounts, and the reasoning for key methodological decisions. It also captured raw data, coding systems, and reflective notes to ensure clarity and accountability in deriving the study's conclusions. Ethical considerations, including IRB approval, voluntary participation, confidentiality, and

secure data handling, were all ensured. In Chapter 4, a detailed account of the research setting, demographics of participants, data collection and analysis, evidence of trustworthiness, and results were reviewed in detail.

Chapter 4: Results

The purpose of this qualitative narrative study was to explore the factors that cause resistance to change faced by PELs in acute care hospital settings. As discussed in previous chapters, PELs occupy a unique position at the intersection of organizational leadership, clinical operations, and patient advocacy. While they are charged with advancing patient-centered care and engagement initiatives, they often navigate systemic, cultural, and interpersonal resistance that can hinder progress over time.

Guided by Ajzen's TPB, this study sought to understand how attitudes, perceived norms, and perceived behavioral control informed how PELs made sense of resistance and constructed stories about their ability to lead meaningful change within complex healthcare systems. Consistent with narrative inquiry, TPB functioned as a sensitizing framework rather than a predictive model, offering interpretive lenses through which participants' stories were understood rather than variables to be tested. The central research question guiding this inquiry was: What are the factors that cause resistance to change that PELs face in the acute care hospital setting?

To address this question, semistructured interviews were conducted with 15 PELs representing diverse acute care hospitals across the United States. Participants narrated rich accounts of their lived experiences related to organizational change, professional identity, leadership dynamics, and the use of patient experience data to drive improvement. Interviews were recorded, transcribed verbatim, and examined using a narrative analytic approach that emphasized story structure, temporality, and meaning-

making. Narrative patterns, rather than decontextualized themes, were identified as they unfolded across participants' stories, while remaining grounded in TPB constructs as sensitizing concepts that informed interpretation.

This chapter presents the results of that narrative analysis. It begins with an overview of the research setting, participant demographics, and data collection procedures, followed by an explanation of how narrative meaning was derived across participants' stories. Evidence of trustworthiness is then presented to demonstrate credibility, transferability, dependability, and confirmability. The remainder of the chapter includes a detailed presentation of shared narrative patterns. The chapter concludes with a concise summary that transitions to Chapter 5, where findings are interpreted in relation to existing literature, and theoretical implications are examined.

Although this chapter focuses on presenting results rather than interpretation, participants' narratives reflected implications for positive social change within healthcare organizations. By illuminating the emotional, cultural, and structural barriers PELs encounter during change initiatives, the findings highlight opportunities for creating more transparent, inclusive, and psychologically safe environments. Participants consistently narrated that when leadership communication was clear and staff felt heard, engagement improved and resistance diminished, conditions that support both team well-being and patient-centered care.

Research Setting

At the time of this study, healthcare organizations across the United States were undergoing substantial operational and cultural transformation driven by increasing expectations related to patient engagement, workforce stabilization, and financial sustainability. These evolving priorities formed the broader context within which PELs narrated their experiences. Participants frequently described an environment of continual change marked by new initiatives, shifting organizational priorities, and competing performance metrics.

This pace of change often contributed to what participants storied as change saturation; a sense of cumulative exhaustion associated with the constant introduction of new projects and process modifications. As one participant narrated, “We’ve had so many new initiatives that people are exhausted before the next one even starts” (Participant 4). Such stories situated resistance not as isolated behavior, but as a response emerging over time within demanding organizational conditions.

Participants further narrated how competing initiatives and limited resources shaped their capacity to sustain patient experience efforts. Experience work was often positioned alongside other organizational imperatives such as throughput, quality, and financial performance. One PEL reflected, “There are other initiatives outside even patient experience that staff are having to deliver on. And so, when you add another thing in, it’s one more thing” (Participant 4).

Others recounted stories of resource constraints, including limited staffing and inconsistent leadership attention, that disrupted continuity and momentum. One participant narrated, “I was always a department of one... now I have 13 direct reports where prior to March of this year I had none my entire career” (Participant 11). These narrative moments highlighted tensions between organizational ambition and operational capacity.

Beyond operational pressures, participants emphasized how organizational culture and relationships shaped their experiences with change. The prevailing culture within an organization could either enable or obstruct progress. As one participant narrated, “You have to meet the culture where it’s at... you can be the best patient experience leader in the nation, but if the culture isn’t ready, you won’t be successful” (Participant 9).

Narratives also revealed how trust and communication influenced how change was received. Participants often described hearing the “what” without understanding the “why.” As one PEL explained, “We hear the what, but rarely the why. That’s where people disengage” (Participant 1). This absence of relational clarity frequently shaped resistance as a protective or sense-making response rather than outright opposition.

Participants additionally shared stories highlighting the emotional and relational dimensions of their work. Many underscored the importance of peer collaboration and leadership sponsorship as stabilizing forces amid complexity. Several narrated the need for strong executive champions who could model accountability and support. As one participant emphasized, “Make sure you have a very strong executive champion at your

side... they will make or break the success of the initiative” (Participant 8). Others described the sustaining role of collegial relationships, captured in the reflection: “Our PEL group chats are therapy sessions—we help each other make sense of it all” (Participant 9).

Together, these contextual conditions, which are characterized by change saturation, competing priorities, variable cultural readiness, and relational dynamics, shaped how participants experienced and narrated resistance to change over time. Recognizing this setting provides essential context for understanding the narrative patterns presented in this chapter and situates the findings within the lived realities of leading organizational change in acute care hospital environments.

Demographics

In accordance with the approved Walden University IRB protocol, no demographic data were collected beyond the study’s inclusion criteria. The sole criterion for participation was that each individual currently served, or had recently served, as a patient experience leader in an acute care hospital setting within the United States. Additional demographic characteristics such as age, gender, ethnicity, years of experience, or organizational size were not solicited to protect confidentiality and reduce the risk of deductive disclosure.

A total of 15 PELs participated in the study. All participants met the inclusion criteria and represented a range of acute care environments, including community-based hospitals and system-level organizations. Each participant held responsibility for

advancing patient experience initiatives within their respective settings. Because the focus of the study centered on shared professional narratives rather than demographic variation, collecting additional identifying information was deemed unnecessary.

Participants were assigned numeric identifiers (Participant 1 through Participant 15) to preserve confidentiality throughout transcription and reporting. This approach ensured that findings reflected collective narrative experiences rather than individual demographic distinctions, aligning with the study's emphasis on role-based meaning-making among PELs.

Data Collection

Data collection followed the procedures outlined in Chapter 3. Semistructured interviews were conducted with 15 participants who met the inclusion criteria. Each interview was conducted virtually using the Microsoft Teams platform, providing a consistent and secure environment for participants located across the United States. Sessions were scheduled individually based on participant availability, typically during regular business hours.

The data collection period spanned approximately 4 weeks, during which an average of three to five interviews were conducted per week. This pacing supported careful attention to transcription accuracy and early narrative familiarization between sessions. Interviews lasted between 30 and 60 minutes, depending on the depth and direction of participants' storytelling. At the beginning of each session, participants were reminded of the study's purpose, the voluntary nature of participation, and confidentiality

safeguards. Verbal consent to participate and to audio record the interview was reaffirmed prior to recording.

All interviews were recorded using Microsoft Teams' built-in audio recording function. Recordings were securely stored in a password-protected digital folder accessible only to the researcher and labeled with participant identifiers. Audio files were transcribed verbatim using Microsoft Copilot. Each transcript was reviewed while listening to the original recording to ensure accuracy, preserve tone, and maintain narrative meaning. Only inconsequential filler words were removed when doing so did not alter intent.

All data collection procedures were carried out as described in Chapter 3. No modifications were made to the interview guide, structure, or procedures. Each participant completed a single interview session, and no participants withdrew from the study or requested transcript removal. Following each interview, brief field notes were recorded to capture immediate impressions, narrative emphasis, and contextual observations. These notes supported reflexivity during analysis by documenting tone, emotional cues, and moments of resonance observed during interviews. No unusual circumstances occurred during data collection, and all interviews proceeded without technical interruption. The process yielded 15 complete transcripts reflecting the lived professional experiences of PELs leading organizational change in acute care hospital settings.

Data Analysis

Before beginning formal analysis, the interview transcripts were verified through a member-checking process designed to ensure accuracy and credibility. Each participant received their verbatim transcript and was invited to review it for completeness. All 15 participants responded in writing to confirm that their words had been captured faithfully. This validation strengthened the trustworthiness of the dataset and ensured that the narratives used in the analysis reflected the experiences participants intended to convey.

Transcription and Familiarization

The analytic process unfolded as an interpretive, narrative-centered engagement with participants' stories. All interviews were transcribed verbatim to preserve participants' words, phrasing, pauses, and expressions. This level of detail supported a faithful rendering of each participant's story and provided a strong foundation for narrative analysis grounded in lived experience.

Following transcription, the analysis began with deep immersion in each narrative through repeated and deliberate readings. Each transcript was read multiple times to develop an intimate familiarity with the content and to understand the shape, tone, flow, and emotional contours of participants' storytelling. This immersion allowed attention not only to what participants narrated but also to how they narrated it, highlighting shifts in emphasis, narrative tensions, moments of hesitation, and emotionally charged reflections through which meaning unfolded over time.

During this familiarization phase, early narrative impressions and preliminary narrative patterns surfaced, including stories of professional exhaustion, competing priorities, communication gaps, and the emotional weight associated with continuous organizational change. These early insights were documented through analytic notes and reflexive observations, allowing meaning to be traced without prematurely imposing analytic structure or reduction.

This systematic process of transcription and narrative familiarization established a comprehensive understanding of the narrative landscape across participants and served as the critical foundation for subsequent stages of analysis. By engaging deeply with each story at the outset, the analytic process remained firmly grounded in participants' lived experiences and preserved the integrity of their individual and collective narratives throughout the study.

Initial Narrative Coding

As the analysis progressed, participants' stories began to align around recurring structures of meaning rather than discrete topical categories. In keeping with a narrative analytic approach, the initial stage of analysis focused on identifying meaning-centered narrative segments rather than line-by-line thematic codes. Narrative segments were understood as extended portions of text in which participants narrated a coherent experience, a shift in understanding, an emotional tension point, or a moment of insight related to resistance to change.

For example, Participant 4 narrated the cumulative strain of continuous change, stating, “We’ve had so many new initiatives that people are exhausted before the next one even starts,” while Participant 8 described the absence of recovery time between initiatives, noting, “There’s barely time to celebrate progress before something new gets rolled out.”

Rather than fragmenting participants’ accounts into isolated statements, the analysis preserved the integrity, flow, and contextual continuity of each narrative segment. This approach reflects Polkinghorne’s (1995) emphasis on treating narratives as whole units of meaning and Riessman’s (2008) assertion that narrative analysis prioritizes how individuals construct meaning through storytelling rather than reducing accounts to categorical codes. Emotional meaning was often embedded within extended reflections, such as when Participant 2 narrated the instability created by shifting organizational demands, explaining, “Every few months, priorities shift—it’s hard to know where to focus anymore.”

Within these narrative segments, specific phrases functioned as narrative anchors that captured participants’ interpretations of their lived experiences. Expressions related to exhaustion, instability, invisibility, and self-protection signaled critical moments of emotional strain and sensemaking. For instance, Participant 9 reframed resistance as a coping response rather than opposition, stating, “Resistance sometimes isn’t opposition—it’s survival.” Similarly, Participant 6 narrated cultural fatigue when observing that repeated change messages had become “background noise.”

The identification of narrative segments was guided by the study's research questions, with particular attention to how participants narrated experiences of resistance, adaptation, and response to organizational change in acute care hospital settings. Narrative segments were recorded manually to maintain proximity to participants' voices and to support interpretive engagement with their stories. This meaning-centered, narrative-segment approach preserved continuity, temporality, and meaning across participants' lived experiences, consistent with the principles of narrative inquiry.

Chronological Structuring of Narratives

With narrative segments identified, each participant's account was examined through chronological structuring, a central component of narrative analysis. This phase involved mapping each story along a temporal arc to understand how participants constructed experiences of resistance to change across past, present, and anticipated future contexts.

Narratives were reviewed to identify key events, turning points, and transitions that shaped participants' experiences as patient experience leaders (PELs). Attention was given to how individuals narrated their entry into the role, early encounters with challenge, and the ways they navigated periods of sustained organizational change. Particular emphasis was placed on moments in which participants signaled shifts in perspective or emotional response, such as leadership transitions, major initiatives, or changes in organizational priorities that altered their understanding of resistance.

Across narratives, participants commonly storied an initial period of enthusiasm and purpose followed by abrupt exposure to rapidly shifting priorities and escalating demands. For some, turning points emerged during large-scale initiatives that disrupted established workflows or strained relationships with clinical and administrative leaders. For others, leadership transitions marked critical narrative moments that reshaped expectations, influence, and perceived support.

By attending explicitly to time, progression, and change within each narrative, the analysis illuminated how meaning was constructed, disrupted, and, in some cases, reclaimed across participants' professional journeys. Chronological structuring allowed resistance to be understood not as a static condition, but as an evolving narrative shaped through ongoing organizational change.

Narrative Features and Identity Construction

As temporal patterns became clearer, deeper narrative features were examined across participants' stories. This phase focused on how participants constructed their narratives, including plot development, recurring motifs, and the ways they positioned their professional identities within their accounts.

Participants' stories followed recognizable plot trajectories, often beginning with optimism and purpose, progressing through periods of strain or disruption, and moving toward adaptation, persistence, or unresolved tension. These narrative arcs offered insight into how resistance to change was experienced and interpreted over time.

Across narratives, recurring motifs surfaced consistently. Participants frequently returned to storylines involving uncertainty, emotional strain, competing priorities, and the search for stability and meaning. These motifs functioned as organizing threads within participants' narratives, reinforcing resistance as an ongoing condition embedded within everyday professional life rather than a singular event.

Identity construction emerged as a central feature of participants' storytelling. Participants positioned themselves as bridge builders buffering teams from organizational turbulence, advocates striving to sustain engagement, invisible contributors whose efforts felt overlooked, and resilient leaders persisting despite repeated setbacks. These identity positions shaped how resistance was narrated, how challenges were framed, and how narrative accounts to change were justified.

Attention was also given to storytelling strategies, including framing, pacing, and emphasis. Participants often lingered on moments of conflict or emotional intensity while compressing periods of routine work, signaling which experiences held the greatest meaning. These narrative choices revealed how participants constructed coherence, attributed responsibility, and made sense of their roles within complex organizational environments.

Interpretive and Contextual Analysis

Interpretation of participants' narratives occurred alongside ongoing reflexive journaling, which was used to examine how my professional background in healthcare leadership informed analytic decisions and meaning-making. Reflexive notes

documented assumptions, emotional reactions, and moments of resonance to ensure interpretation remained grounded in participants' stories rather than shaped by prior professional perspectives.

Participants' narratives were situated within organizational contexts characterized by leadership turnover, shifting strategic priorities, communication inconsistencies, cultural expectations related to performance and resilience, and persistent resource constraints. These contextual conditions shaped not only what participants experienced, but how they narrated resistance, agency, and responsibility.

Interpretation focused on integrating participant meaning with contextual meaning. Participants frequently storied resistance not as individual reluctance or opposition, but as a relational and situational response to systemic conditions that constrained autonomy, diluted influence, or disrupted continuity. Through this contextualized narrative lens, resistance was understood as a meaning-laden response embedded within organizational life rather than a personal deficit.

Interpretive engagement revealed how organizational culture influenced identity positioning and storytelling strategies. Participants often emphasized perseverance and commitment while minimizing expressions of disengagement, reflecting cultural norms that valued endurance and adaptability. Reflexive analysis allowed meaning to be examined at the intersection of individual experience and organizational context.

Narrative Reconstruction and Emergent Narrative Patterns

Through this iterative narrative analytic process, each participant's account was reconstructed into a coherent narrative that preserved sequence, temporality, and meaning. This narrative reconstruction aligns with narrative restorying, in which individual accounts are analytically reassembled to maintain coherence and lived meaning rather than reduced to decontextualized categories.

Reconstruction prioritized meaning preservation rather than chronological summary or thematic reduction. Participants' language, emphasis, and narrative flow were maintained to ensure reconstructed accounts reflected participants' voices and sensemaking processes. Narratives were synthesized to represent the full arc of experience, including emotional narrative accounts, identity shifts, leadership interactions, and adaptive strategies.

Across reconstructed narratives, five shared narrative patterns emerged that captured how participants storied and made meaning of resistance to change over time. These narrative patterns and associated meaning structures are presented in Figure 1, which illustrates how emotional strain, leadership dynamics, identity disruption, communication and trust, and meaning making were interwoven across participants' stories. Figure 1 visually represents shared narrative patterns and associated meaning structures reconstructed across participant stories. Rather than depicting isolated findings, the figure illustrates how recurring narrative elements were relationally interconnected

and unfolded across time, reflecting the complex construction of resistance to change through lived experience.

Figure 1

Narrative Patterns and Associated Meaning Structures Illustrating Resistance to Change Among PELs



These narrative patterns did not function as discrete findings detached from context. Instead, they represented synthesized meaning structures embedded within participants' lived stories. Participants consistently narrated the emotional burden of ongoing organizational change, instability created by shifting leadership expectations, and vulnerability associated with threats to professional identity. Trust, transparency, and communication emerged as central narrative threads shaping how resistance was constructed and sustained.

As narratives unfolded, participants articulated persistent emotional and cultural fatigue, often describing the cumulative weight of continuous transformation. Others

narrated leadership disconnect and mixed messaging, framing resistance as a practical response to ambiguity rather than unwillingness to change. Professional identity and psychological safety featured prominently, with participants describing moments when new processes diminished perceived expertise and discouraged open dialogue.

Despite these challenges, reconstructed narratives also revealed resilience and meaning making. Participants narrated anchoring themselves in commitment to patients and families, drawing strength from collegial relationships, and reframing their roles in alignment with personal values. Collectively, these narratives demonstrated that resistance to change among PELs was rooted not in opposition, but in emotional fatigue, identity disruption, communication inconsistency, and the demands of navigating complex healthcare environments.

Evidence of Trustworthiness

Credibility

Credibility was supported through strategies designed to ensure the accuracy, authenticity, and trustworthiness of participants' narratives. The primary strategy was member checking. Following transcription, each interview transcript was returned to participants for review, and all 15 participants confirmed in writing that their transcripts accurately reflected their stories and intended meaning. This process strengthened narrative integrity by ensuring that participants' accounts were faithfully represented prior to analysis and aligns with best practices identified by Ahmed (2024), who described member validation as a central pillar of qualitative credibility.

Prolonged engagement with participants' narratives further enhanced credibility. Each transcript was read and revisited multiple times throughout narrative analysis to ensure close alignment between participants' language, story structure, and the narrative patterns reconstructed across accounts. This iterative immersion allowed meaning to be traced across stories over time rather than derived from isolated excerpts, consistent with the emphasis on sustained engagement described by Zainal Abidin et al. (2024) as a safeguard against interpretive distortion. Reflexive notes were maintained throughout analysis to document evolving impressions, analytic decisions, and moments of resonance, supporting transparency and rigor in narrative interpretation.

Transferability

Transferability was supported through the provision of rich, contextualized descriptions of participants' professional environments and the organizational conditions under which they experienced and narrated resistance to change. Although no demographic identifiers were collected, the inclusion of extended participant quotations and detailed contextual framing allows readers to assess the relevance of the findings to other acute care hospital settings.

This approach aligns with the application of Guba and Lincoln's (2023) parallel criteria for assessing trustworthiness in qualitative research, which emphasizes the importance of contextual detail in enabling readers to determine transferability. By situating participants' stories within their organizational realities and privileging

participants' own language, the study provides the depth and situational specificity that Ahmed (2024) identified as foundational to meaningful transferability.

Dependability

Dependability was established through consistent application of the data collection and narrative analytic procedures approved by the Institutional Review Board. All interviews were conducted using the same semistructured interview guide and virtual platform, recorded under uniform conditions, transcribed verbatim, and verified for accuracy prior to analysis. Narrative analysis procedures were applied consistently across all participant accounts, with attention to story structure, temporality, and meaning-making.

An audit trail was maintained to document each stage of the analytic process, including narrative segmentation, chronological structuring, narrative reconstruction, and identification of shared narrative patterns. This documentation ensured that analytic decisions were systematic, traceable, and transparent. These practices align with the guidance of Zainal Abidin et al. (2024), who emphasized procedural consistency and documentation as essential components of dependability in qualitative research. No deviations occurred from the approved methods, reinforcing the stability and reliability of the analytic process.

Confirmability

Confirmability was supported through reflexive documentation, transparent analytic procedures, and secure data management practices. Field notes captured

immediate reflections related to tone, emotion, and narrative emphasis following each interview, enabling ongoing awareness of researcher positioning and potential influence on interpretation. These practices are consistent with Ahmed's (2024) emphasis on reflexivity and transparency as foundational to confirmability.

All analytic decisions, including narrative reconstruction choices and refinement of shared narrative patterns, were documented within the audit trail to ensure that findings could be traced directly to participants' stories. The use of verified transcripts, member checking, and secure data storage further ensured that interpretations were grounded in participants' narrated experiences rather than researcher assumptions, consistent with the principles outlined in the application of Guba and Lincoln's (2023) parallel criteria.

Study Results

The interviews conducted in this study yielded rich narrative accounts from current and former patient experience leaders (PELs) working in acute care hospital settings. Participants narrated detailed stories describing how organizational change was introduced, communicated, experienced, and sustained over time. Rather than presenting discrete categories of narrative accounts, the findings are organized around shared narrative patterns that emerged across participants' stories. These patterns reflect how PELs made meaning of resistance to change as they unfolded within their professional roles and organizational contexts.

Across narratives, participants consistently returned to storylines involving competing priorities and change saturation, organizational culture, varied forms of resistance, human motivation, leadership influence, the role of data and measurement, availability of resources and support, and lessons learned through lived experience. These narrative patterns are presented below as interconnected storylines rather than isolated themes.

Participant Narrative Accounts

Participant 1

Participant 1 did not enter healthcare with the intention of becoming a patient experience leader. His early interests were rooted in marketing, economics, and brand strategy. Unlike peers who pursued clinical pathways, he envisioned a career grounded in consumer behavior and macroeconomic trends. Healthcare entered his trajectory less as a calling and more as a strategic opportunity. A family mentor suggested that healthcare marketing offered both geographic flexibility and specialization. What began as a pragmatic internship in human resources soon expanded into exposure to executive leadership and organizational strategy.

An unexpected circumstance shaped his early professional formation. Because of administrative gaps in onboarding, Participant 1 spent several months seated at the chief executive officer's assistant's desk, performing "other duties as assigned." From that vantage point, he observed executive decision-making in real time. Rather than narrowing his interests, this proximity broadened them. He began to understand

healthcare not only as service delivery, but as a complex organizational system shaped by culture, operations, finance, and politics. Upon graduation, he was invited to design his own role within the organization, a gesture that reinforced both institutional trust and his emerging leadership identity.

His transition into patient experience leadership occurred not through formal succession planning but through convergence of organizational need and executive sponsorship. The role itself was not clearly defined at the time. Patient experience functioned as a peripheral responsibility nested within quality, often described as “a thing” rather than a strategic department. Patient relations operated separately, grounded in grievance management and patient rights. Experience work, by contrast, lacked structure, ownership, and shared language. When offered the opportunity to step into a newly reframed director-level role, Participant 1 recognized both ambiguity and possibility. The position was reshaped around him, signaling institutional investment but also placing him in a domain still seeking identity.

Early in his tenure, resistance manifested less as overt opposition and more as conceptual confusion. Many leaders equated patient experience with superficial courtesy. Comments such as “You want us to smile more?” reflected a limited understanding of the field’s clinical relevance. In a unionized and operationally strained environment, experience was often perceived as additive rather than integrated. Participant 1 described these early efforts as a campaign to redefine meaning. Rather than positioning initiatives explicitly as “patient experience,” he strategically embedded them within existing clinical

and operational priorities. He learned quickly that language mattered. Leading with terms like kindness and clarity proved more effective than invoking hospitality or service.

A defining moment in his early leadership occurred within the emergency department. A nurse leader approached him, expressing both frustration and resolve. She believed deeply in improving the experience for her patients and staff and was willing to partner. Rather than introducing standalone experience initiatives, Participant 1 aligned improvements with emergency department flow redesign and throughput strategies. Experience became inseparable from operational effectiveness. Being invited into operational meetings rather than requesting entry marked a subtle but important shift in legitimacy. He interpreted this inclusion as evidence that experience could earn influence when tied to core departmental goals.

Over time, his understanding of resistance matured. What initially appeared as defensiveness around survey scores evolved into recognition of deeper dynamics. Physicians often challenged data validity, focusing on sample size or methodological nuance. Rather than debating metrics, Participant 1 reframed discussions around the lived experiences represented by the data. He drew clear boundaries, refusing to entertain dismissals of patient voice while acknowledging the need to tailor messaging to audience. He observed that many leaders carried prior negative experiences with patient experience metrics, including public shaming or compensation penalties. Resistance, in these cases, stemmed from professional injury rather than indifference.

Culture further complicated change efforts. The introduction of whiteboard communication practices across inpatient units illuminated the relationship between leadership behavior and compliance. Some unit leaders embedded accountability into daily routines, modeling expectations and coaching in real time. Others struggled to gain traction. Participant 1 recognized that he could mandate transparency but could not manufacture local accountability. Where leaders embraced ownership, compliance approached near universality. Where leaders resisted, adoption remained minimal. Through this experience, he distinguished himself between authority and influence. Experience leadership required partnership with those who held operational control.

Resource constraints shaped his leadership evolution. In periods of staffing loss and limited technology, he relied on creativity and cross-functional alignment. He leveraged internship pipelines, negotiated vendor relationships, and expanded the scope of experience technology to support broader auditing needs. Rather than framing requests for resources solely around parity with peer institutions, he demonstrated value through integration with existing priorities. This adaptability reinforced his belief that experience leadership required both strategic patience and opportunistic action.

A later inflection point emerged during the implementation of value-based purchasing. Financial risk associated with patient experience metrics shifted executive attention. Participant 1's background in business positioned him to translate experience outcomes into fiscal language. His engagement with board leadership deepened, and experience work gained strategic visibility. He observed that motivation varied across

stakeholders: for some, intrinsic commitment to community and patient dignity drove engagement; for others, financial implications catalyzed alignment. Neither motivation was inherently superior, but each required tailored engagement. Across his narrative, Participant 1 reframed resistance not as hostility but as a signal requiring diagnosis. He emphasized the importance of distinguishing between agreement and alignment. Leaders need not fully agree with every initiative, but collective alignment was necessary for forward movement. He adopted a practice of setting temporal boundaries around change efforts, allowing teams to test initiatives, reassess, and, when necessary, pause without labeling efforts as failure. Walking away from poorly timed initiatives became, for him, an act of strategic maturity rather than defeat.

In reflecting on the factors that underlie resistance, Participant 1 distilled his learning into a guiding principle: understanding the “why” behind resistance determines how to respond. Resistance might emerge from prior professional harm, misaligned incentives, cultural inertia, or simple fatigue. Without diagnosing its origin, response strategies risked exacerbating division. Through his evolution, he shifted from attempting to persuade through persistence alone to leading through contextual awareness.

Participant 1’s journey illustrates how patient experience leadership can emerge from unconventional pathways and be shaped by adaptive sensemaking. For him, resistance became less an obstacle to overcome and more a diagnostic lens through which to understand organizational culture, professional identity, and institutional priorities. His narrative reflects a progression from enthusiastic campaigner to strategic integrator,

grounded in the belief that meaningful change requires both relational intelligence and disciplined alignment.

Participant 2

Participant 2 did not conceptualize herself as a “patient experience leader” because of title or departmental structure. Rather, she located the origins of her experience leadership in her tenure as chief executive officer of a children’s hospital. For her, experience was not a discrete function but a behavioral expectation embedded within executive accountability. She understood early that culture change required visible presence. Leading experience meant walking the units, observing interactions between clinicians, children, and families, and identifying root causes of recurring issues rather than treating surface complaints. Experience leadership, in her framing, was inseparable from operational leadership.

She held a strong conviction that formalizing patient experience into a single titled role could unintentionally dilute collective responsibility. When ownership rests with a chief experience officer alone, she believes that others may subconsciously disengage. Experience, in her view, must be anchored at the highest level of the organization. This philosophy shaped how she approached change initiatives throughout her career.

A formative experience occurred when she oversaw system-level efforts to implement hourly rounding by nurse leaders. The initiative was introduced broadly and quickly, positioned as a systemwide mandate. Although well intentioned, she perceived the scope

as overly ambitious from the outset. Nursing leaders immediately recognized the operational impracticality and interpreted the directive as setting them up for failure. Distrust emerged before implementation even began. When compliance faltered, the initiative reinforced skepticism toward centralized experience mandates.

In retrospect, Participant 2 viewed this episode as illustrative of a common leadership misstep: attempting to scale transformation before securing proof of concept. Broad, sweeping reforms may signal urgency, but they often erode confidence when not grounded in incremental success. The failure of the rounding initiative did more than miss its performance target; it strained relationships between nursing and the patient experience function and reinforced resistance to subsequent efforts. This experience reshaped her approach to resistance. She came to value small, localized wins as precursors to enterprise-wide change. Incremental implementation built comfort and credibility. Resistance, she learned, often reflects fear of unrealistic expectations rather than opposition to the underlying goal. By narrowing scope and demonstrating feasibility in contained environments, leaders could generate momentum without triggering defensive reactions.

Participant 2 also distinguished between types of resistance. She expressed a preference for active resistance over passive undermining. Open disagreement provided an opportunity for dialogue and resolution. In contrast, silent compliance accompanied by covert disengagement proved more corrosive. When individuals verbally affirmed initiatives yet lacked genuine intention to implement them, change stalled without clear

points of intervention. For her, the most challenging resistance was not confrontation but quiet withdrawal of enthusiasm.

Organizational culture further shaped the trajectory of change. One notable example involved the integration of family members as formal participants within unit-based care teams. The intent was to leverage lived experience to support other families navigating hospitalization. Initial reactions from staff were marked by suspicion and defensiveness. Some perceived the new role as surveillance or threat. Yet the broader organizational culture emphasized trust, collaboration, and mutual respect. By reinforcing those values and facilitating direct dialogue between staff and family partners, leadership gradually reframed the initiative from intrusion to partnership. Success emerged not from mandate but from modeling inclusive behavior and identifying early positive exemplars.

Participant 2 consistently emphasized presence as a leadership strategy. “Do it because I said so,” she observed, rarely produces durable change. Instead, she relied on hands-on engagement, facilitation, and visible partnership during implementation phases. Whether navigating rounding redesign or onboarding new roles, she prioritized helping stakeholders articulate their concerns and talk through perceived threats. For her, resistance often signaled misunderstanding or misaligned assumptions rather than inherent opposition.

A more complex example of navigating resistance unfolded in efforts to address billing complaints within a children’s hospital. Families struggled to interpret invoices and reconcile them with explanations of benefits. Finance leaders initially resisted

involving families directly in redesign conversations, citing regulatory and payer constraints. Participant 2 persisted in creating structured forums where billing staff and parents could collaboratively examine examples and identify pain points. With the support of an external facilitator, the group gradually moved from defensiveness to problem-solving. Over more than a year, they co-developed clearer billing documents and supplementary educational materials. What began as resistance evolved into a nationally recognized model. In this case, persistence combined with structured communication transformed skepticism into innovation.

Conversely, she recalled initiatives that failed to achieve traction despite increased staffing. In those instances, leadership responded to resistance by adding personnel rather than addressing flawed processes. Throwing additional resources at a dysfunctional system provided temporary reassurance but failed to produce meaningful improvement. For Participant 2, these experiences reinforced the principle that structural defects, not staffing levels alone, often drive performance outcomes.

Motivation for embracing change varied across individuals. She described a pharmacy technician who championed automation of prescription refills after personally experiencing the inefficiencies of the manual process. His advocacy stemmed from lived frustration and a desire to alleviate burdens on families and staff alike. In contrast, she encountered physicians who resisted redesign of physical workspace configurations despite clear data demonstrating improved patient outcomes elsewhere. For some, attachment to established practice patterns outweighed external evidence. She interpreted

such resistance as less about the data itself and more about the discomfort of altering identity and routine.

Her reflections on skepticism toward patient experience data extended beyond healthcare. She framed data denial as a broader human phenomenon: when performance metrics challenge self-perception, individuals may question the validity of the measurement rather than confront the implications. Economic pressures in healthcare compounded this dynamic. Leaders sometimes hesitated to challenge high-revenue clinicians whose resistance could have financial repercussions. In her experience, durable change required senior leaders with sufficient authority and conviction to withstand such pressures.

In distilling her lessons, Participant 2 emphasized the importance of remaining in a learning stance. When leaders become defensive in response to resistance, polarization deepens. Sustained inquiry—asking stakeholders to articulate concerns, exploring underlying assumptions, and collaboratively identifying solutions—proved more effective than argumentative rebuttal. Yet she paired this humility with accountability; listening did not equate to relinquishing expectations.

Ultimately, she concluded that the reporting structure of the patient experience leader significantly influences change outcomes. If the leader's direct supervisor possesses the authority and resolve to reinforce expectations across the organization, resistance can be addressed constructively. Without that executive sponsorship, even the most capable experience leader may struggle to move entrenched dynamics. In her

narrative, resistance to change was not merely a frontline phenomenon but a reflection of hierarchical alignment and influence.

Participant 2's journey illustrates how executive positioning, cultural context, and incremental strategy shape the success or failure of patient experience initiatives. For her, resistance became a predictable feature of organizational life, navigable through presence, structured dialogue, and unwavering alignment between experience priorities and executive authority.

Participant 3

Participant 3 did not enter patient experience leadership through formal designation or strategic appointment. As a practicing physician who moved into executive clinical leadership, he described his entry into experience work as “accidental,” though inevitable. In his view, one cannot separate clinical care from patient experience. A physician cannot exist without a patient, and once one recognizes that patients evaluate care through lived perception rather than technical metrics alone, experience becomes inseparable from value. He framed this understanding not as a departmental responsibility but as an extension of the value equation itself: quality plus experience over cost.

During his tenure as a chief medical officer and later in senior quality leadership, Participant 3 approached experience not as a standalone initiative but as embedded within organizational performance. His early orientation toward experience was strategic rather than programmatic. He did not introduce himself as someone who “leads experience.” Instead, he worked to influence how quality was measured and how patients interpreted

quality. For him, experience represented the interpretive lens through which clinical performance was understood.

A pivotal leadership moment emerged during a relatively recent initiative centered on improving teamwork across underperforming clinical offices. Comparative data revealed variation in experience scores across sites, and executive leadership determined that elevating teamwork would serve as a lever for improving patient perception. Yet the climate within several offices was fragmented. Nurses, physicians, advanced practice clinicians, and front-desk staff operated in silos, often in tension with one another. Participant 3 understood that introducing teamwork as a metric would require more than presenting percentile rankings.

He observed that confronting clinicians directly with unfavorable data frequently generated immediate resistance. Presenting numerical comparisons—top box percentages, percentile rankings—triggered defensiveness rather than reflection. Over time, he learned to sidestep head-on data debates. Rather than arguing the validity of metrics, he redirected conversations toward the human encounter between provider and patient. Patients, he reminded clinicians, do not experience percentiles; they experience interactions. By reframing the discussion around relational connection rather than numerical performance, he diffused confrontation and reoriented attention toward shared purpose.

For Participant 3, culture played a central role in shaping receptivity to change. He distinguished between environments that fostered learning and those entrenched in

long-standing routines. In organizations where curiosity and forward momentum were normative, change initiatives encountered less friction. Conversely, in settings where longevity equated to authority—where practices had remained unaltered for decades—resistance was grounded in familiarity. He noted that such resistance was not inherently irrational; stability offers comfort. Yet in healthcare, he believed, progress demands a willingness to move beyond established patterns.

When asked to reflect on navigating resistance productively, Participant 3 described two contrasting models of change. In operational crises unrelated directly to patient experience, he had witnessed radical restructuring—leadership turnover and financial incentives—produce rapid transformation. These extrinsic motivators demonstrated the power of economic pressure and accountability. Within patient experience, however, change more often unfolded incrementally. He found that the most potent driver of behavioral reflection was not praise but exposure to unfiltered patient grievance narratives. When clinicians read raw accounts describing harm, disrespect, or emotional injury, some experienced a recalibration of self-perception. While positive reinforcement fostered gradual evolution, candid negative feedback occasionally prompted more immediate introspection.

His reflections on motivation revealed a layered understanding of human behavior. Some individuals are intrinsically motivated to do what they perceive as morally right; they require only direction and clarity. Others respond to extrinsic incentives—financial rewards, recognition, or new roles. A third group may be swayed

through vision and shared purpose if they perceive alignment with organizational goals. Yet he acknowledged the existence of individuals anchored deeply in stasis. Drawing upon classical change theory, he described human comfort with equilibrium. Change requires energy, and sustained energy produces fatigue. After periods of transformation, individuals seek return to familiarity. This longing for stability, he suggested, underlies much resistance.

Participant 3 rejected the notion that resistance is always rooted in malice or obstinance. Often, he believed, it reflects attachment to the known. A clinician who has practiced a certain way for decades may interpret critique as a challenge to identity rather than performance. In such cases, resistance emerges not from disagreement with patient-centered values but from discomfort with altering established routines.

Resource allocation further illuminated the complexity of experience leadership. During a public health crisis marked by community distrust, Participant 3 confronted the downstream effects of eroded patient experience. Skepticism toward healthcare institutions impeded public engagement. Through formal risk communication research, the organization discovered that prior negative experiences had compromised community trust. Recognizing this, leadership mobilized extensive institutional resources—academic expertise, clinical ambassadors from within the community, and coordinated outreach efforts—to rebuild credibility. In this instance, investment in experience was not optional; it became foundational to operational survival.

When considering lessons for emerging patient experience leaders, Participant 3 emphasized resilience and epistemic humility. He advised maintaining thick skin in the face of resistance while remaining anchored to the fundamental “why” of the work. At the same time, he cautioned against uncritical adherence to prevailing experience dogma. Social science, he noted, rarely produces universal prescriptions. What works for one patient population may not resonate with another. Leaders must question both resisters and them, recognizing that both may hold partial truths. Experience interventions that assume homogeneity risk oversimplification.

In distilling his understanding of resistance, Participant 3 suggested that it often arises from comfort with familiarity and exhaustion with constant change. Change initiatives require cognitive and emotional investment; sustained exposure to reform efforts can produce fatigue. Leaders must therefore discern when resistance signals principled disagreement, when it reflects identity preservation, and when it simply represents depletion.

Across his narrative, Participant 3 constructed patient experience leadership as a balancing act between persistence and adaptability. Resistance was neither purely adversarial nor wholly justified; it was contextual, relational, and shaped by culture, incentives, and human psychology. His evolution as a leader reflected movement from attempting to confront resistance directly toward engaging it through reframing, humility, and strategic endurance.

Participant 4

Participant 4 entered patient experience leadership during a period of significant organizational transformation. At the time of his interview, he had been in his formal role for approximately 3 months and described inheriting a department still being rebuilt following leadership turnover. His hospital, which had operated independently for more than a century, had recently joined a large health system. This transition introduced widespread systemization, new standards, and cultural realignment, creating the context in which he began defining his leadership identity.

One of the first major initiatives Participant 4 encountered was the implementation of a centralized patient experience call center serving multiple hospitals across the system. Previously, patient concerns had been routed to a single local manager, often resulting in delayed responses and limited accessibility. The new model enabled real-time intake, faster routing, and reduced escalation. Participant 4 recalled early conversations with patients who expressed relief at being able to reach someone immediately rather than waiting days for follow-up. Operationally, the change improved responsiveness. Culturally, however, it signaled a fundamental shift in how accountability for patient experience was shared across the organization.

Although the call center represented a clear improvement for patients, Participant 4 soon began noticing a quieter form of resistance among leaders. Rather than overt opposition, resistance surfaced as fatigue. Long-tenured managers were simultaneously navigating system integration, new workflows, and evolving expectations. Patient

experience initiatives were often experienced as “one more change” layered onto an already saturated environment. Participant 4 came to understand this resistance not as disengagement from patient-centered care, but as the cumulative impact of continuous transformation.

He observed that resistance frequently appeared as competing priorities and cognitive overload rather than intentional defiance. Because patient experience work touched every role and discipline, he viewed it as inherently cultural, requiring shifts in mindset rather than compliance with discrete tasks. One early example involved an initiative encouraging physicians to leave behind business cards or identifiers during patient encounters to improve communication and follow-up. While the practice itself was simple, adoption stalled as questions emerged about ordering, replenishment, and ownership. These small logistical barriers quickly became symbolic of larger alignment challenges.

Progress occurred when Participant 4 partnered with trusted clinical leaders, particularly the Chief Medical Officer, whose established credibility with physicians helped normalize the practice. With visible physician leadership support, participation increased, reinforcing Participant 4’s growing belief that experience improvement depended less on directives and more on relational influence.

Similar dynamics emerged during service recovery efforts. Participant 4 described instances in which nursing leaders hesitated to contact patients following complaints. Rather than interpreting this reluctance as avoidance, he recognized discomfort,

perceived lack of skill, and uncertainty about how to navigate difficult conversations. Change accelerated when the Chief Nursing Officer modeled accountability and joined directors in follow-up outreach. These moments demonstrated how senior leader presence reshaped expectations and reduced fear, leading to more consistent engagement with patients.

Early in his tenure, Participant 4 also prioritized direct patient rounding. He recalled spending extended time at the bedside, listening to concerns and responding to small requests. Through these encounters, he observed that presence and responsiveness often mattered more to patients than formal metrics. These experiences reinforced his understanding that patient experience improvement was rooted in human connection rather than volume-driven interventions.

As he reflected on his early leadership journey, Participant 4 emphasized that credibility in patient experience work was built through data, humility, and adaptability. He described using comparative data from peer hospitals to support change while remaining open to piloting initiatives rather than imposing permanent solutions. Over time, resistance became a diagnostic signal, indicating where alignment, clarity, or readiness had not yet been achieved.

Looking back, Participant 4 characterized his evolving role not as the driver of change, but as a facilitator of connection. He came to see himself as a bridge-builder across systems, leaders, and frontline teams. Through his narrative, resistance was reframed from obstacle to insight, highlighting where relationships needed strengthening

and communication required translation. His story illustrates how patient experience leadership, for him, became less about implementing programs and more about creating conditions for shared ownership during organizational transition.

Participant 5

Participant 5's pathway into patient experience leadership emerged through the intersection of clinical identity and systems improvement. Trained as a pediatric nurse, her early professional formation centered on patients and families as the core of care delivery. Years later, while serving in a corporate process improvement role within a large healthcare system, she became immersed in Transforming Care at the Bedside initiatives. At that time, her focus was operational: conducting time studies, identifying waste, and increasing the proportion of direct caregiver time spent with patients. When organizational leadership identified patient experience as a priority and invited a small group to take on the work, she recognized alignment rather than departure. Although patient experience as a formalized field was new to her nearly two decades ago, the philosophy resonated deeply with her nursing foundation. What began as an invitation gradually became the central arc of her professional identity.

As she evolved into experience leadership, she became increasingly aware of the organizational tendency toward initiative proliferation. Healthcare systems, in her view, often attempted to implement too many changes simultaneously. This "change initiative saturation" produced fatigue and diluted focus. In response, she adopted a "less is more" leadership stance. Rather than launching every recognized best practice, she prioritized

identifying one to three evidence-informed behaviors that aligned with data trends and local context. For Participant 5, sustainability required disciplined selection and deliberate cadence. Change needed to become normalized within daily workflow rather than layered atop existing burdens.

A formative example involved whiteboard utilization within inpatient units. Senior leadership mandated consistent updates during bedside shift report. While frontline nurses understood the rationale—families relied on visible care plans and caregiver identification—the prescribed timing disrupted workflow realities. Resistance surfaced not as philosophical disagreement but as logistical strain. Instead of reinforcing the mandate, Participant 5 paused implementation and returned to the team for co-design. She asked when whiteboard updates could be completed reliably within existing routines. Nurses proposed integrating updates during initial assessments and vital sign checks rather than during report. By incorporating frontline insight, adherence improved. For her, this episode reinforced the principle that those who perform the work must help design the work.

Resistance assumed more explicit form in a recent engagement with nurse managers. While analyzing unit-level experience data, one manager rejected focusing on patient experience measures, citing pressing concerns around falls. The manager perceived experience work as additive and potentially distracting from safety priorities. Participant 5 interpreted this resistance as rooted in workload anxiety rather than opposition to patient-centered care. Instead of forcing compliance, she reframed the

conversation. She explored how experience drivers—such as responsiveness and clarity of explanation—might align with fall prevention efforts. By integrating experience behaviors into existing safety initiatives, she reduced the perception of “extra” work. This reframing allowed the manager to exhale, recognizing that experience and safety could coexist within the same workflow.

This integrative lens became central to Participant 5’s leadership philosophy. She described quality, safety, and experience as existing in harmony rather than competition. Drawing upon the origins of patient experience measurement within quality science, she emphasized connecting experience metrics to clinical outcomes such as readmissions, length of stay, and medication adherence. In her view, resistance often emerged when experience was framed as hospitality rather than health outcome leverage. By articulating the clinical implications of relational behaviors, she sought to reposition experience as foundational rather than ornamental.

Certain forms of resistance proved more persistent. She encountered clinicians, particularly in high-acuity environments such as emergency departments and intensive care units, who characterized experience as a “nice to have.” In these settings, urgency and life-saving interventions dominated identity. Assertions such as “we’re here to keep them alive, not to be nice” reflected a perceived hierarchy of priorities. Participant 5 understood these statements as signals of misalignment rather than malice. In response, she engaged in coaching, education, and literature review to demonstrate that relational communication can coexist with clinical excellence and, in fact, enhance it.

Culture significantly shaped receptivity to her efforts. In organizations with clearly articulated mission, vision, and behavioral expectations, experience initiatives found natural anchoring points. Where purpose statements were integrated into evaluations and daily language, accountability followed. Conversely, she described working within environments lacking coherent articulation of organizational purpose. In those contexts, team members could not describe expected behaviors or shared values. Silos prevailed, and ownership diffused. Without cultural anchors, advancing experience initiatives required greater reliance on patient narratives as moral catalysts. Stories and comments became substitutes for formal mission alignment.

Resource constraints also influenced her trajectory. At one point, she functioned as the sole patient experience professional within a large health system. Recognizing the scale of strategic goals, she constructed a business proposal aligned explicitly with organizational pillars. By linking experience improvements to market growth, online reputation, and financial return, she secured approval for additional personnel dedicated to inpatient, emergency, and medical practice domains. For Participant 5, articulating return on investment was essential in legitimizing the work.

Her reflections on motivation revealed a pattern. Individuals who embraced change tended to be high performers and intrinsically mission-driven. These clinicians and leaders readily connected experience behaviors to their professional purpose. They often already practiced many relational behaviors organically. Those who resisted, by contrast, were not necessarily disengaged but frequently lacked a personally meaningful

“why.” Until she identified what mattered to them—whether patient outcomes, professional pride, efficiency, or recognition—alignment remained elusive. Resistance, in this framing, signaled an unmet motivational connection.

Across her narrative, Participant 5 emphasized relationships as the foundation of sustainable change. Technical expertise alone proved insufficient. Trust, follow-through, and inclusion shaped whether initiatives endured. She believed that even when non-negotiables existed, leaders must create space—however small—for frontline voice. Inclusion fostered ownership; ownership fostered accountability.

In summarizing her understanding of resistance, Participant 5 distilled it into two focal points: people and process. Patient experience work revolves around patients, families, and team members. Yet leaders must also interrogate underlying processes. Often, what appears as attitudinal resistance reflects inefficient workflows or unnecessary waste. Without examining systems alongside behaviors, change efforts risk misdiagnosis.

Participant 5’s story illustrates an evolution from process engineer to relational integrator. Resistance, for her, is rarely purely oppositional. It is contextual, frequently rooted in overload, unclear purpose, or unexamined processes. Through disciplined focus, relational engagement, and integration of experience with quality and safety, she reframed resistance as an opportunity for alignment rather than a barrier to overcome.

Participant 6

Participant 6 entered patient experience leadership at a time when the field itself was still forming. Her professional origins were not rooted in hospitality or corporate

service, but in emergency medical services in New York City. For a decade, she worked as an EMT, much of that time in the South Bronx, where barriers to healthcare access were stark and deeply personal. She described this period as formative—not only professionally but morally. Witnessing disparities in treatment and access challenged her sense of justice. “Sick is sick,” she reflected, and the unequal ways patients were treated based on geography or circumstance unsettled her.

When she completed her master’s degree in 2005—just as HCAHPS was entering pilot phases—she encountered a posting for a coordinator of patient-centered care at New York-Presbyterian. At that time, healthcare organizations often sought hospitality-trained leaders to professionalize service culture. She did not come from the Ritz-Carlton or Marriott. Instead, she came from ambulances and underserved neighborhoods. Yet she believed that to hold healthcare accountable, one needed to understand it from within. She was hired into a corporate role spanning multiple hospitals, ambulatory sites, and a children’s hospital, where she helped construct what she described as an early “blueprint” for enterprise-wide patient experience strategy.

In those early years, she learned that experience transformation was less about innovation and more about consistency, transparency, and accountability. She emphasized the importance of visible senior leadership commitment, structured service standards, training curricula, and unit-based champions. Recognition became a particularly influential lever. One of her earliest major initiatives involved creating a recognition program driven by direct patient feedback rather than traditional HR metrics.

The proposal met significant resistance. Human Resources objected to recognizing employees based on narrative comments rather than quantifiable tenure or performance metrics.

Rather than retreating, Participant 6 piloted the program on select units. The initiative—called the “Shining Star” program—invited patients and families to nominate staff members whose behaviors positively shaped their care experience. Feedback was manually collected and analyzed for service-related keywords. Early results revealed high levels of engagement and an unexpected cultural shift: employees felt seen for behaviors they could control. As participation grew, leadership made a deliberate choice to “over-celebrate” the initiative. Red carpet events, public recognition ceremonies, and executive presence signaled permanence rather than experimentation. What began with skepticism became embedded within organizational culture. Over time, even HR integrated the program into enterprise recognition platforms. For Participant 6, this episode reinforced that resistance can be overcome when leaders refuse to abandon initiatives prematurely and when they visibly align recognition with strategic outcomes.

Not all efforts yielded similar results. She recounted a subsequent initiative centered on modernizing rounding technology within another organization. Senior leadership agreed that rounding was essential for accountability but failed to sustain resource commitment. After a collaborative selection process involving frontline voting on new platforms, the chosen system was never implemented because funds were redirected elsewhere. The organization canceled its previous system without deploying

the new one, leaving leaders without a cohesive rounding infrastructure. In this instance, enthusiasm turned to fragmentation. For Participant 6, the experience underscored the fragility of trust when leadership support evaporates midstream. Without follow-through, change initiatives erode credibility.

Across her career, she identified recurring forms of resistance. One persistent dynamic involved tension between clinical and non-clinical authority. Experience leaders without clinical credentials were sometimes dismissed by clinicians who questioned their legitimacy. Participant 6 rejected the notion that experience leadership required clinical licensure. However, she acknowledged the importance of credibility through presence. To bridge divides, she intentionally worked alongside clinicians, rounding at 3:00 a.m., walking units, and learning workflows firsthand. She believed that demonstrating commitment to the realities of frontline work softened defensiveness and built relational trust.

Another form of resistance emerged in environments deeply anchored in tradition. In some faith-based or long-established health systems, she encountered the “we’ve done it this way for 50 years” mentality. Here, resistance was cultural rather than personal. Change threatened historical identity. Without senior leaders willing to challenge entrenched behaviors, patient experience initiatives stalled. Participant 6 observed that culture is shaped daily through leadership modeling. Where executives picked up litter, engaged staff authentically, and demonstrated visible accountability, culture supported change. Where patient experience existed only as a slogan, progress was limited.

Resource allocation further illuminated the relationship between commitment and outcome. In her earlier recognition initiative, executive presence was the most valuable resource. Leadership attendance at ceremonies, repeated public acknowledgment of the program, and consistent messaging integrated experience into organizational identity. Conversely, in the rounding example, absence of sustained investment undermined momentum. For Participant 6, resources encompassed not only dollars but visible commitment.

When reflecting on individuals who embraced change readily, she noted shared characteristics: diverse life experiences, empathy shaped by exposure to disparity, and a service-oriented mindset. Those with broader perspectives more easily connected relational behaviors to organizational purpose. Conversely, individuals who resisted often exhibited insecurity. Fear that change might threaten role stability or expose deficiencies led to defensiveness. She also observed that not all clinically excellent professionals possess the developmental preparation to lead strategically. Resistance sometimes reflected insufficient leadership coaching rather than ill intent.

In distilling her lessons, Participant 6 emphasized endurance. Patient experience transformation is not rapid. It is a marathon rather than a sprint. Leaders demanding immediate turnaround misunderstand the temporal nature of culture change. Sustainable transformation requires time, relational investment, and unwavering persistence. When asked to summarize her journey, she described the work as both “glorious” and “heartbreaking.” Success is deeply rewarding; failure can feel personal. Yet neither

outcome alters her commitment. Resistance, she concluded, is inevitable. The defining characteristic of effective experience leadership is not avoidance of resistance but refusal to stop trying.

Participant 7

Participant 7's pathway into patient experience leadership was neither accidental nor purely strategic; it was deeply personal. Growing up as the daughter of a pediatrician, she was immersed in healthcare from an early age. Yet her earliest memories were not of clinical excellence, but of vulnerability. She described herself as a fearful child during medical visits, recalling the anxiety of being held down for examinations. Those formative experiences shaped her early awareness that when individuals seek healthcare, they rarely do so at their best. They arrive carrying fear, uncertainty, and stress. From childhood forward, she internalized a sense of obligation: healthcare must ease suffering, not compound it.

Although patient experience as a formal discipline did not exist in the early years of her 30-year career, her professional motivations consistently aligned with relational care. When she later interviewed for a role focused primarily on employee engagement around 2009 or 2010, she was asked whether she would find an employee-centered position fulfilling given her visible passion for patient experience. In that moment, she articulated a belief that would shape her leadership trajectory: caring for healthcare workers is inseparable from caring for patients. If staff feel supported, valued, and psychologically safe, they are better positioned to extend that same care outward. For

more than a decade in human resources leadership, she carried this conviction—that employee experience dictates patient experience.

Over time, her thinking evolved further. Upon joining her current organization, she began to shift away from viewing employee and patient experience as parallel domains. Instead, she conceptualized a unified “human experience.” What does it feel like to work here? To receive care here? To be both employee and patient? Her leadership lens broadened from discrete stakeholder groups to a shared environment shaped by mission, vision, values, and behavior. Culture, for her, became the central driver of sustainable change.

A defining early initiative occurred during the 1990s in a large New York City hospital when she participated in a sweeping redesign of patient care teams. The initiative centralized reporting structures so that nurse managers would oversee not only nursing staff but also environmental services and ancillary personnel on the unit. At that time, healthcare organizations were beginning to recognize that patient experience extended beyond clinical intervention. By aligning the full spectrum of services under a single accountable leader, the hospital sought to ensure that every dimension influencing patient perception was coordinated. The project—aptly named Patient Care Redesign—was complex and highly visible. Because the workforce was unionized, implementation required negotiation, collaboration, and shared decision-making. Staff selected uniform colors by discipline, symbolizing collective ownership of the change. Despite its

magnitude, the initiative was successful, in part because it invited participation rather than imposing uniformity.

Years later, resistance to change manifested differently. In her current role, she leads efforts to redesign grievance tracking and trending processes. Historically, compliance focused narrowly on regulatory timelines—responding to grievances within required timeframes. Her team introduced an additional layer: after resolution, cases would undergo review for systemic improvement opportunities. This expansion required staff to move beyond box-checking toward deeper analysis of root causes. Resistance emerged not from disagreement with the goal, but from perceived workload intensification. Staff members already felt stretched; layering additional review felt burdensome. For Participant 7, this pattern reflected a common dynamic—change often introduces temporary complexity before yielding long-term clarity.

Her experiences with organized labor further shaped her understanding of resistance. Whether cross-training front-desk staff and telephone operators to enhance flexibility and professionalism or adjusting workflows that impacted unionized nurses, she encountered additional layers of negotiation. Even when initiatives included skill expansion and wage increases, union leadership sometimes resisted. She did not interpret this as hostility but as structural reality. Collective bargaining introduces legitimate procedural considerations, yet it inevitably slows change velocity. Resistance, in this context, was procedural rather than ideological.

One form of resistance she found particularly perplexing, involved efficiency improvements. At times, change initiatives were designed explicitly to simplify workflows—shortening pathways, eliminating redundant steps, making it easier for staff to “do the right thing.” Yet some individuals clung to familiar processes even when presented with streamlined alternatives. She struggled to understand why professionals would prefer an inefficient workaround to a straighter path. Over time, she came to recognize that familiarity itself can feel safer than novelty, even when novelty offers improvement.

Culture, in her view, determines whether change is absorbed or rejected. She frequently invokes the maxim that culture consumes strategy. Without shared mission, vision, and values translated into common language and behavior, no initiative—however well designed—can succeed. Foundational alignment must precede ambitious transformation. Once a common cultural platform exists, organizations can cultivate continuous improvement, growth mindset, teamwork, and kindness. Without it, resistance proliferates.

Her reflections on resistance extended beyond operational friction to motivational psychology. Some individuals, she observed, are inherently energized by change. Others recoil from it. Personality, prior experience, and organizational history shape response. Employees who have endured poorly executed change initiatives—those imposed without explanation or input—may carry residual distrust. Conversely, those embedded in toxic subcultures may resist reflexively, their negativity reinforcing itself through

whispered skepticism and collective cynicism. In such pockets, resistance becomes self-perpetuating.

Participant 7 also emphasized the interplay between experience, engagement, and safety. In her thinking, patient experience cannot be disentangled from employee engagement, and neither can flourish without psychological and physical safety. Engagement drives retention; retention stabilizes quality; quality enhances patient outcomes. Experience is not an isolated metric but a reflection of organizational health.

When asked to distill her leadership lessons, she described patient experience work as inherently collaborative. It is a team sport. No single leader can drive sustainable transformation alone. She currently participates in a cross-functional human experience workgroup including human resources, organizational development, high reliability, quality, communications, and workplace belonging. Together, they are constructing a unified human experience strategic plan. For her, this collaborative integration corrects prior structural silos and unlocks synergy.

In summarizing decades of leadership, Participant 7 offered a concise guiding principle: “Every interaction, every time.” Experience is not episodic. It is cumulative and universal. It encompasses staff, leaders, patients, families, vendors—anyone who interacts within the system. Resistance to change, in this framing, is not an aberration but an inevitable feature of organizational life. Sustainable change emerges when culture provides a stable foundation and when leaders engage others with clarity, collaboration, and consistency.

Participant 8

Participant 8 did not enter patient experience leadership by aspiration; she entered through organizational necessity. In April 2018, while serving as Director of Lean Process Improvement at a local facility, she was informed during a period of layoffs that she would either assume responsibility for patient experience or exit the organization. Faced with that choice, she accepted the role. What began as a pragmatic decision quickly evolved into professional transformation.

Initially, she understood patient experience as primarily grievance management—handling complaints, responding to irate patients, and ensuring regulatory compliance. Yet as she immersed herself in the data, her perception shifted. She began to see grievances not as isolated events but as signals. Patterns emerged. Root causes could be traced. Mitigation strategies could be designed. The work expanded beyond the “patient rights bucket” into systemic improvement. For Participant 8, the analytic dimension of experience work—studying data, identifying trends, and preventing recurrence—became the gateway to deeper commitment.

Her early responsibilities were broad and largely unsupported. She functioned as a department of one, overseeing grievances, language services in an exceptionally diverse state, survey vendor relationships, and leader education on interpreting experience data. In addition to managing interpretation services that spanned over one million minutes monthly, she worked to develop patient experience capability among frontline leaders

who were unfamiliar with analytics and action planning. Patient experience, at that time, was not yet fully embedded as a strategic priority.

A significant inflection point occurred in December 2019 when she assumed a corporate vice president role overseeing patient experience across twelve acute care hospitals. The system itself was only 2 years old, and preparations for a multi-year electronic health record implementation were underway. The environment was characterized by both optimism and saturation. “Change saturation,” as she later described it, captured the climate—excitement interwoven with fatigue.

One of her earliest enterprise initiatives involved standardizing patient rounding practices. Upon gathering the twelve patient experience leaders, she asked each to bring their rounding scripts. The variation was striking. Questions overlapped inconsistently with nurse leader rounds; documentation remained paper-based; practices diverged widely across sites. Recognizing the need for cohesion, she embarked on what she would later describe as the most significant and challenging initiative of her career: vetting and implementing a standardized digital rounding tool.

The initial attempt failed. As a non-clinical leader partnered with a digital health colleague, she and her co-lead introduced a template-driven approach without securing robust clinical sponsorship. Nurses perceived the rollout as externally imposed—non-clinicians prescribing workflow adjustments to frontline caregivers. Resistance emerged immediately. Participant 8 later identified this as a profound lesson in peer-to-peer

influence. Without a respected nurse executive champion at her side, the initiative lacked credibility.

Organizational culture further complicated implementation. Variation across the twelve hospitals meant that each site possessed its own local norms and leadership histories. At one large academic facility, a newly appointed executive leader demanded rapid improvement in performance metrics and insisted on being among the first to go live. Despite Participant 8's recommendation to pilot the tool at a smaller site, political pressures prevailed. The facility's culture had endured frequent executive turnover, and staff were accustomed to shifting directives. Trust was fragile. The rollout occurred within a context of skepticism and fatigue, intensifying resistance.

Resource scarcity compounded the challenge. For years, Participant 8 advocated investment in the rounding platform, presenting business cases and pleading during budget cycles. The effort required persistence bordering on relentlessness. Eventually, funding was approved. Implementation was revisited, this time with strong nurse leadership partnership. Over 2 years, rounding templates expanded from a single design to more than a dozen, tailored to diverse clinical environments. As adoption matured, measurable performance improvements followed.

The trajectory of support mirrored the evolution of organizational priorities. Initially told she would never be permitted to hire staff, she created alternative pathways by developing internship programs in partnership with local universities. As patient experience demonstrated outcome impact, executive sponsorship deepened. The hiring of

a Director of Rounding and Insights marked a symbolic shift. Where she once functioned alone, she now leads a team of thirteen direct reports. Investment in analytics, artificial intelligence, and creative communication strategies further signaled that patient experience had transitioned from peripheral to strategic.

Throughout her journey, Participant 8 observed distinct forms of resistance. One involved professional hierarchy—clinical versus non-clinical authority. Another reflected workload overwhelm; leaders resisted initiatives not because they rejected the vision but because they perceived no margin for additional responsibilities. She learned to ask not only for adoption but also what could be removed to create capacity. A third form manifested as cynicism—individuals predisposed to skepticism, often shaped by prior poorly executed change efforts.

Conversely, those who embraced change shared identifiable traits. They disrupted the status quo willingly. They viewed healthcare as imperfect and fixable. They demonstrated long-term orientation rather than fixation on immediate inconvenience. Participant 8 associated this mindset with both intellectual curiosity and emotional intelligence—the ability to see beyond present discomfort toward future improvement. In reflecting on leadership lessons, she articulated the importance of strategic sponsorship. Change initiatives require not only vision but visible executive champions whose professional identity aligns with the affected audience. For rounding to succeed, she needed a nurse executive at her side. Absent that partnership, the initiative faltered. With it, credibility flourished.

When asked to distill her understanding of change management into guiding principles, Participant 8 emphasized clarity of purpose. Every initiative must articulate the “why”—the burning platform or opportunity matrix that justifies disruption. Yet beyond urgency, people must remain central. Change is not implemented upon systems but through individuals. Sustainable improvement requires executive sponsorship, thoughtful sequencing, and unwavering attention to those who must operationalize the work.

Participant 8’s narrative illustrates transformation through adversity. What began as an involuntary assignment evolved into enterprise leadership. Resistance, for her, became both teacher and validator—exposing weaknesses in strategy while affirming the necessity of persistence. Through iterative failure, relational partnership, and eventual investment, she reframed patient experience from grievance management to strategic infrastructure.

Participant 9

Participant 9 did not experience a formal beginning to patient experience leadership; rather, she described it as woven throughout her nursing career. Having entered the profession in 2009, she viewed patient experience not as a department but as an intrinsic responsibility of care. Before it was labeled through HCAHPS or vendor partnerships, it existed as customer service, as bedside accountability, as the responsibility of a charge nurse or house supervisor ensuring that patients felt heard. For her, patient experience did not begin with a title—it began with practice.

Her leadership exposure deepened in 2015 when she assumed an Emergency Department Manager role and shortly thereafter transitioned into a Chief Nursing Officer position within a rural setting. It was during that period that patient experience became operationalized through formal survey implementation. Onboarding Press Ganey required her to map workflows, understand scoring methodology, and interpret emerging data streams. What had once been intuitive relational work now carried numerical consequence. In later roles, particularly around 2018–2019, patient experience became a defined component of her leadership portfolio, and she was charged explicitly with driving initiatives tied to survey outcomes.

One initiative that shaped her trajectory involved the implementation of enterprise-wide leader rounding. Unlike traditional departmental rounding, this effort extended administrative presence into clinical spaces. C-suite executives, facilities leaders, and non-clinical managers were assigned patient rooms outside their functional areas. The initiative required individuals unaccustomed to direct patient interaction to step into vulnerable environments—into rooms where patients were ill, exposed, and uncertain. Participant 9 designed the framework and was responsible for securing buy-in across disciplines.

Resistance surfaced immediately. Healthcare professionals often interpreted patient experience initiatives as “one more thing” layered onto already saturated workloads. Staff believed they were already providing good care. The incremental behaviors required to influence top-box scores felt abstract. When survey data were

introduced, resistance intensified. The HCAHPS scoring model—where “usually” failed to qualify as success and only “always” met the standard—was perceived as unforgiving. Clinicians struggled with the idea that excellence could be negated by anything less than perfection. Participant 9 observed that data denial frequently followed discomfort with methodology. If the grading system seemed unfair, motivation to improve waned.

Culture significantly shaped how rounding was received. In one organization, psychological safety enabled leaders to voice discomfort openly. Introverted managers admitted anxiety about entering patient rooms. Facilities personnel expressed uncertainty about appropriate dialogue. Rather than dismissing these concerns, Participant 9 normalized vulnerability. She paired leaders together during initial rounds and facilitated structured debriefings during morning huddles. As individuals shared small wins—helping a patient adjust room temperature, clarifying discharge instructions—the emotional return became visible. What began as obligation evolved into connection. Participants described feeling unexpectedly fulfilled by brief human exchanges. Recognition of those stories in group forums reinforced momentum.

In contrast, she recalled environments where cultural alignment was absent. There, leadership demanded improved scores without modeling engagement or providing relational support. Patient experience was labeled important but remained peripheral in behavior. Data were scrutinized, yet the organizational climate did not reflect a shared commitment to healing environments. In those settings, initiatives stalled. For Participant 9, survey outcomes served as mirrors; the data told the truth about culture.

She identified multiple drivers of resistance. One involved change fatigue—the perception that healthcare is perpetually reforming, with new initiatives displacing old before stabilization occurs. Another centered on control. Clinicians accustomed to autonomy resisted workflow alterations framed as patient-centered. Particularly in rural environments where providers had practiced in one setting for decades, requests to alter communication patterns or discharge processes felt disruptive. Resistance often masked fear—fear of losing competence, efficiency, or identity.

Data transparency further complicated engagement. In organizations where performance metrics had not historically been shared openly, introducing performance comparisons late in the journey provoked defensiveness. Without early exposure to performance trends, staff struggled to connect personal behavior to organizational viability. Participant 9 noted that linking patient experience to financial sustainability in rural hospitals required careful framing. Change was not cosmetic; it was existential. Navigating resistance required discernment. She distinguished between individuals unwilling to engage and those overwhelmed by competing demands. For the latter, she focused on workflow integration—identifying natural points within clinical processes where patient-centered behaviors could occur without adding burden. Transition-of-care conversations, for example, were chronically underperforming. Rather than attributing this solely to attitudinal resistance, she examined whether discharge timing aligned with patient readiness to absorb information. Resistance sometimes reflected structural misalignment rather than apathy.

Her reflections on resources revealed an unconventional perspective: patient experience is fundamentally relational and therefore largely cost-neutral. While investments in technology, environmental upgrades, or coaching roles have financial implications, core behaviors—eye contact, explanation, responsiveness—require intentionality more than capital. Nonetheless, she acknowledged that sustained improvement demands executive sponsorship and strategic prioritization. Where leadership integrated experience into operational decision-making, progress followed.

When considering those who embraced change readily, Participant 9 described individuals with progressive mindsets—professionals comfortable with adaptation, less tethered to rigid control, and open to long-term vision. She observed that moderate turnover sometimes introduced fresh perspectives conducive to innovation. Conversely, individuals deeply rooted in single-site tenure or accustomed to established routines often struggled most with adaptation. For them, change threatened stability.

Looking back, she identified a defining lesson: culture must be met where it stands. Early in her career, she attempted to impose evidence-based practices without first cultivating relational trust. The result was friction and frustration. Over time, she learned to invest in connection before correction. Influence required understanding frontline workflows, acknowledging historical context, and pacing expectations appropriately. Evidence alone does not compel transformation; integration within lived reality does. In summarizing her journey, Participant 9 described early change efforts as chaotic—trial by fire. With experience came humility. She reframed resistance not as obstruction but as

information about readiness, fear, and identity. Patient experience leadership, in her narrative, evolved from directive implementation to relational influence. Sustainable change required aligning evidence with culture, urgency with empathy, and performance metrics with human connection.

Participant 10

Participant 10's entry into patient experience leadership began not through formal employment, but through volunteerism. His first experience role was as co-chair of a Family Advisory Council at a children's hospital. In that space, he operated as a family partner, representing patient and caregiver voice rather than organizational authority. This early positioning shaped his leadership lens. Before he ever held system-wide responsibility, he learned to see healthcare through the perspective of families navigating vulnerability.

That volunteer role evolved into formal employment within the same system. At the time, the title of Chief Experience Officer did not yet exist, but the responsibilities mirrored what such a role would later encompass. He assumed system-wide accountability for patient experience measurement, patient and family feedback processes, and performance improvement across a multi-state pediatric health system. From the outset, his authority was broad in scope but narrow in direct control. He did not manage physicians or nurses operationally. His influence depended on partnership. One of his earliest and most formative change initiatives centered on provider communication in ambulatory settings. Survey data revealed that interaction with care

providers was the strongest driver of experience scores. In response, Participant 10 designed a shadowing program targeting providers in the bottom performance quartile. Partnering with the Chief Medical Officer, he requested permission to spend full clinic days observing provider–patient encounters. As a non-clinician entering exam rooms, he navigated both professional hierarchy and personal vulnerability. Most providers agreed; a few declined. Those who permitted observation engaged in reflective debriefing afterward, reviewing his notes and discussing potential behavior modifications. Improvement was measured longitudinally.

This initiative illuminated two realities. First, allowing a non-physician into clinical workflow required trust. Second, resistance did not always manifest as confrontation. Some providers declined participation quietly and showed little improvement thereafter. Others accepted feedback, adapted within their comfort zones, and progressed incrementally. The work demanded relational tact and credibility earned through presence rather than title.

A parallel effort unfolded in inpatient settings through the introduction of structured hourly rounding. Here, resistance was shaped less by skepticism of purpose and more by competing operational demands. The organization was simultaneously expanding facilities, managing staffing shortages, and navigating strategic growth. Nurses and leaders acknowledged the value of rounding yet defaulted to a familiar refrain: insufficient staffing made consistent hourly presence unrealistic. As Participant 10 described it, patient experience leaders often lack direct management authority over

those asked to change behavior. Influence required alignment with chief nursing and medical leadership whose priorities included recruitment, retention, clinical flow, and revenue.

In subsequent roles, including within adult healthcare environments, he encountered another form of resistance—contextual skepticism. Having built credibility within pediatric systems, he entered adult care settings where his methodologies were met with guarded curiosity. Colleagues questioned whether pediatric-focused approaches translated effectively to adult populations. Some voiced concerns openly; others expressed agreement publicly while withholding implementation privately. Participant 10 came to appreciate overt resistance more than passive acquiescence. Direct conversation allowed for negotiation and adaptation. Silent resistance eroded momentum invisibly. Over time, he identified organizational culture as the decisive determinant of change receptivity. Culture, for him, was not abstract; it existed at system and unit levels. A culture of transparency and readiness for change accelerated adoption. Conversely, units characterized by burnout and low engagement required cultural repair before patient experience initiatives could succeed. He described using employee engagement data as a proxy for change readiness. Attempting to layer new expectations atop depleted teams compounded dysfunction rather than resolving it.

A defining enterprise initiative involved implementing public transparency of provider experience scores. The endeavor required nearly a year of deliberate sequencing. While the Chief Executive Officer endorsed transparency philosophically, he declined to

mandate compliance. Instead, Participant 10 and his colleagues engaged Chief Medical Officers, department chairs, and division chiefs in iterative dialogue. They presented evidence demonstrating that inclusion of negative comments enhanced credibility and patient trust. Providers first received private letters detailing their individual performance. Subsequent phases introduced internal transparency within divisions, then across practice sites, and ultimately system-wide before public release. This gradual exposure normalized vulnerability. By the time scores were published online, transparency had become internally accepted rather than externally imposed.

Resource constraints shaped his leadership posture consistently. His team was small—often limited to himself, a physician partner, and a data analyst. Budget allocations largely covered vendor contracts rather than discretionary initiatives. Innovation therefore relied on creativity rather than capital. When requests exceeded available funding, he reframed the question: if not this, then what? Rather than abandoning objectives due to fiscal limits, he recalibrated expectations and pursued incremental progress. In his view, scarcity necessitated strategic focus.

When reflecting on motivation, Participant 10 drew a stark distinction. Those who embraced change were typically driven by intrinsic desire to “do the right thing” for patients and families. Financial incentives proved less compelling than authentic recognition. Public acknowledgment of effort, gratitude, and visibility often catalyzed engagement more effectively than monetary reward. Conversely, resistance frequently

stemmed from inertia. Long-tenured professionals comfortable in established routines resisted alteration not from hostility but from familiarity. Change threatened equilibrium.

His lessons for emerging leaders centered on two principles. First, secure a strong senior champion. Executive sponsorship creates psychological and structural safety for change initiatives. Second, articulate the “why” relentlessly. Without transparent rationale, stakeholders construct their own narratives, often inaccurate. Explanation does not guarantee agreement, but absence of explanation guarantees suspicion.

Ultimately, Participant 10 concluded that universal buy-in is unrealistic. Experience leaders should not expend disproportionate energy attempting to convert every skeptic. Instead, he advised focusing on the top quartile or half of willing adopters. As early adopters operationalize change visibly, peer influence exerts pressure on others to align or self-select out. Resistance, in this framing, is not entirely conquerable but is strategically containable.

Participant 10’s narrative reflects an evolution from volunteer advocate to system-level strategist. Across roles and organizations, he reframed resistance from obstruction to expected human response shaped by culture, authority, and comfort. Sustainable change, in his experience, emerges not from mandate but from partnership, transparency, and disciplined sequencing.

Participant 11

Participant 11’s entry into patient experience leadership occurred before the field carried its current terminology. In the late 1990s and early 2000s, while serving as Vice

President of Human Resources for a community hospital, he held responsibility for quality initiatives broadly defined. At that time, improvement efforts were framed through total quality management, continuous quality improvement, and other structured methodologies influenced by industry trends. Patient experience, as a distinct strategic domain, had not yet crystallized. Quality was measured, but experience was implicit rather than explicit.

A pivotal shift occurred when his director of volunteer services introduced him to the Planetree model. Unlike prevailing quality frameworks that emphasized measurement and performance pillars, Planetree centered relational care, transparency, and culture. Intrigued, Participant 11 engaged in site visits to organizations already implementing the model. What he observed was not merely process redesign but cultural transformation. He returned to his executive team convinced that traditional quality initiatives had plateaued. Incremental metric movement had not yielded the relational depth he believed patients deserved. With executive endorsement, the hospital formally partnered with Planetree in 2005.

The early phase of implementation required translating abstract philosophy into operational change. Training programs were introduced, interdisciplinary teams convened, and conversations shifted from compliance to connection. Resistance surfaced almost immediately, particularly around initiatives that disrupted longstanding norms. One such initiative involved granting patients access to their medical records during hospitalization. Historically, medical charts were guarded artifacts—tools of the clinician

rather than shared documents. Physicians and nurses voiced concerns about increased workload, potential disputes over documentation, and erosion of professional authority. Many clinicians were not hospital employees but contracted practitioners, complicating influence dynamics.

Participant 11 and his team responded not through mandate but through education and reassurance. Planetree supplied data demonstrating minimal adverse consequences in peer organizations and highlighting relational benefits. The hospital invested in preparatory communication, clarifying that while patients could review records, structured support would be available if questions arose. Ultimately, the feared surge of conflict did not materialize. Only a minority of patients requested access, and dialogue between clinicians and families often improved. This initiative reinforced a lesson that anticipated resistance frequently exceeds actual disruption.

Throughout implementation, he encountered multiple forms of resistance. Physician hesitancy often stemmed from uncertainty about impact—“How will this affect me?” Staff resistance reflected similar apprehension. To mitigate this, the organization established physician advisory structures, ensuring respected clinical voices participated in rollout planning. Rather than positioning experience initiatives as administrative decrees, the hospital sought visible clinician partnership. By cultivating trusted champions within departments—individuals who commanded peer respect—the organization increased receptivity.

Participant 11 identified culture as both catalyst and constraint. His hospital possessed a strong, established culture that fostered loyalty and pride. That strength provided stability but also created inertia. “We’ve been successful this way” became a common refrain. Changing within a strong culture required careful framing. He emphasized that culture must evolve alongside external realities; otherwise, stagnation follows. Planetree’s structured sessions facilitated open dialogue, helping staff understand not only what was changing but why.

He also noted the strategic advantage of external perspective. As an outside consultant, Planetree’s voice sometimes carried credibility distinct from internal leadership. Staff who might dismiss administrative messaging engaged more openly when peers from other hospitals shared lived examples. Site visits proved especially powerful. When frontline employees observed practical applications—such as simple gestures of hospitality—they returned as advocates rather than skeptics. Change traveled more effectively through peer testimony than executive instruction.

Resource allocation presented additional hurdles. Early in implementation, the patient experience function was layered atop existing responsibilities. A director attempted to balance nutrition services leadership with patient experience oversight. Over time, it became clear that part-time attention was insufficient. Expanding regulatory emphasis on patient satisfaction metrics intensified demands. Participant 11 faced the challenge of justifying full-time leadership and realigning patient advocacy roles to integrate education, complaint resolution, and cultural development. In a fiscally

conservative environment, adding positions required compelling rationale. He learned that structural commitment signals seriousness; without dedicated resources, transformation stalls.

When reflecting on individuals who embraced change readily, Participant 11 emphasized trust and respect. Successful initiatives were anchored by informal leaders within departments—individuals whose influence derived from credibility rather than title. Identifying these “silent leaders” and engaging them early proved essential. Not every employee would convert, but shifting a majority often rendered remaining opposition marginal.

Conversely, resistance often derived from comfort with routine. Long-tenured staff who felt competent within established systems perceived change as unnecessary disruption. Whether implementing open visitation policies, transparency measures, or new technologies, resistance frequently echoed a common sentiment: “We’ve always done it this way.” Participant 11 observed that even positive change generates anxiety because it destabilizes familiarity.

Over time, he came to view resistance less as opposition to patient-centered ideals and more as relational deficit. Where leaders lacked trusting relationships with clinicians and staff, change was interpreted as imposition. Where open dialogue preceded rollout, acceptance increased. He cautioned against divisive tactics or top-down mandates that alienate stakeholders. Sustainable transformation emerges through opportunity rather than coercion.

His reflections on leadership maturity centered on managing frustration. Patient experience leaders often carry visionary aspirations constrained by financial, operational, and political realities. Budget limitations may reduce training scope. Staffing shortages may undermine carefully crafted initiatives. Survey results may fluctuate unpredictably despite diligent effort. Without emotional regulation and patience, leaders risk burnout. For Participant 11, resilience—accepting incremental progress within constraints—proved as vital as strategy.

In summarizing his understanding of resistance, he returned to relationship. Resistance flourishes in the absence of trust and diminishes through transparent communication. Change should be framed as invitation rather than edict. When leaders build relational capital and articulate purpose clearly, they create opportunity for others to step forward voluntarily. In his narrative, patient experience leadership evolved from program adoption to cultural stewardship, shaped by the recognition that sustainable change is relational at its core.

Participant 12

Participant 12's entry into patient experience leadership did not originate from a traditional clinical or hospitality pathway. Her professional beginnings were in finance. With an associate's degree in accounting, she launched her healthcare career in accounts payable within a large health system. At that time, she envisioned a trajectory rooted in fiscal stewardship rather than relational care. That trajectory shifted abruptly and irrevocably when her mother was diagnosed with breast cancer. After a brief remission,

the disease returned aggressively, and her mother died following a short and painful recurrence.

Navigating the healthcare system as both daughter and advocate altered Participant 12's sense of professional purpose. The industry in which she worked was no longer abstract. She experienced firsthand what it felt like to sit in waiting rooms, absorb complex information, and rely on clinicians for hope and clarity. In the wake of loss, she recognized that while she remained committed to healthcare, her place within it had changed. She sought a role that would allow her to influence not balance sheets but human encounters. That search marked the beginning of her transition into patient experience leadership.

One of her most formative initiatives centered on physician communication development. Survey data revealed opportunities within provider communication domains, and she partnered with an international communication specialist to design a structured four-hour workshop for physicians and advanced practice providers. Importantly, the training was not mandated in a punitive fashion. Providers selected sessions voluntarily, preserving autonomy while signaling institutional support. The curriculum emphasized human-centered communication—skills rarely emphasized during medical training yet foundational to patient connection.

Resistance surfaced quickly and predictably. Physicians questioned why they needed communication training. Some wondered whether participation implied deficiency. Others challenged whether leadership would subject itself to similar scrutiny.

Rather than dismissing these concerns, Participant 12 interpreted them as invitations to respond thoughtfully. She recruited respected physician champions within each service line to advocate peer-to-peer. When challenged about leadership accountability, she returned to the executive team and insisted that leaders complete a parallel human-centered communication workshop tailored to their roles. By aligning leadership behavior with expectations placed upon clinicians, she neutralized accusations of hypocrisy. Within a year of implementation, provider communication scores improved by approximately 25 percentile ranks, reinforcing the relational premise of the intervention.

A more intense episode of resistance emerged during rollout of physician transparency. Publishing star ratings and patient comments publicly marked a cultural shift. Participant 12 anticipated resistance not only from frontline providers but also from department chiefs and executive leaders wary of reputational risk. She reframed transparency not as exposure but as reclamation of narrative. Physicians were already being reviewed on uncontrolled online platforms. Transparency through organizational channels offered contextualization, moderation processes, and authenticity. To operationalize the initiative, she once again relied on physician champions—practicing clinicians whose own ratings would be published. These champions participated in shaping comment review processes, including peer evaluation of requests to withhold specific comments. By embedding physicians in governance rather than positioning patient experience as gatekeeper, she diffused perceptions of administrative overreach.

Not all resistance was subtle. During a cardiology service line meeting attended by approximately forty physicians, Participant 12 encountered overt hostility. Questions were raised sharply and publicly: Who authorized this? Were physicians consulted? Why should the organization pursue such exposure? The meeting extended from one hour to nearly two and a half. Her physician champions remained largely silent in the moment, later explaining they did not wish to interrupt a raw and necessary dialogue. Participant 12 navigated the exchange alone, responding calmly, reiterating purpose, and grounding the conversation in shared commitment to patient trust. By the meeting's conclusion, opposition softened into cautious alignment. Over time, some of the loudest early resisters began requesting publication of their comments once eligibility thresholds were met. What began as confrontation evolved into ownership.

Across these experiences, Participant 12 increasingly conceptualized resistance through the lens of trust. Psychological safety became central to her understanding of culture. In environments where individuals felt safe to voice dissent without retribution, resistance could be surfaced and addressed constructively. Where trust was absent, resistance manifested through rumor, passive noncompliance, or prolonged skepticism. She observed that culture operates at multiple levels—system-wide declarations of mission and values coexist with subcultures at the unit or department level. Misalignment between overarching culture and subculture complicates change efforts. A system may espouse transparency, yet a department characterized by historic distrust will resist.

Her experiences with resource advocacy further shaped her understanding of structural resistance. During the transparency rollout, she recognized immediately that reviewing and vetting patient comments would exceed her capacity. Initial requests for a patient experience specialist position were denied due to budget constraints. Rather than retreating, she articulated the operational risk and timeline delays that would result from under-resourcing the initiative. Through persistence, she secured the additional full-time equivalent and maintained rollout timelines.

In contrast, she described a subsequent role in which she oversaw patient experience within a multi-hospital system while functioning essentially as a department of one. Over time, she was assigned additional portfolios—volunteer services, spiritual care, language services, and several other departments—without commensurate staffing expansion. Despite repeated advocacy for patient experience support roles, additional resources were not approved. Improvement occurred incrementally rather than systemically. In her reflection, absence of structural investment constrains outcome velocity regardless of leader capability.

When considering individuals who embrace change readily, Participant 12 identified a shared sense of purpose. Champions possess intrinsic motivation anchored in the desire to make a meaningful difference in patients' lives. They understand how their specific role contributes to that purpose. Resistance, conversely, often signals misalignment—either individuals operating within roles ill-suited to their strengths or individuals embedded within cultures eroded by inconsistent leadership behaviors. She

emphasized that lack of trust—particularly stemming from inconsistent leadership priorities or behaviors—serves as a primary catalyst for resistance. Trust, she noted, is built gradually yet can be eroded quickly.

Her distilled lesson for emerging patient experience leaders is deceptively simple: do not take resistance personally. Lean in. Listen. Learn. Resistance is information. It reveals fear, fatigue, prior injury, or misalignment. Addressing it requires empathy rather than defensiveness.

In summarizing her lived understanding of resistance, Participant 12 returned repeatedly to trust and consistency. When leadership behaviors align with stated values and when communication is transparent and reciprocal, resistance diminishes. When trust fractures or leadership approaches fluctuate unpredictably, resistance intensifies. For her, patient experience leadership evolved from program implementation to trust cultivation. Sustainable change depends less on technical initiative design and more on the relational integrity that surrounds it.

Participant 13

Participant 13's entry into patient experience leadership was shaped less by career disruption and more by professional admiration. When she rejoined her organization in 2020—just before the onset of the COVID-19 pandemic—she did so with clear appreciation for the role patient experience leaders had previously played in her own development as a clinical manager. As a former manager of non-invasive cardiology, she had relied heavily on patient experience partnership to interpret data, translate qualitative

feedback, and identify best practices. Observing the value of that support, she began to see patient experience not as peripheral oversight but as strategic enablement.

She entered the role during a uniquely destabilizing moment. The traditional model of bedside, “at-the-elbow” coaching and direct patient-facing initiative work became untenable almost immediately as pandemic protocols restricted presence and access. Rather than retreating, Participant 13 and her team reframed their purpose. Recognizing that frontline staff resilience had become the most pressing need, they pivoted toward employee wellness and engagement. In her narrative, this shift reinforced a foundational belief: patient experience cannot be disentangled from caregiver wellbeing. Supporting employees during crisis was not a diversion from experience work—it was its precondition.

One of the most significant change initiatives she helped implement involved reintroducing multidisciplinary bedside rounding on a medical telemetry unit. Post-pandemic, silos had re-emerged between physicians and nurses. The team sought to reposition the patient as the center of decision-making by bringing nurses, physicians, case managers, and other relevant disciplines together at the bedside in a structured format. Clear guidelines were developed to ensure discussion of daily plans, discharge preparation, and opportunity for patient and family questions. To prevent inefficiency, physical examinations were intentionally separated from the structured rounding conversation.

Initial resistance was less ideological than operational. Staff expressed concern about added burden. To promote accountability, the team implemented a visible tracking mechanism—a highly conspicuous green binder at the nurses’ station. Each day’s roster included patient room numbers with signature lines for both nurse and provider, documenting whether rounding occurred together and, if not, why. The process signaled shared ownership. However, as the initiative matured, compliance waned. Census fluctuations, workflow timing conflicts, and diffusion of responsibility began to erode consistency.

Revisiting the initiative revealed nuanced forms of resistance. Some resistance stemmed from knowledge gaps. New staff members were being oriented without sufficient emphasis on rounding as a core practice. Preceptors, themselves shaped by years of pandemic-era deviations from bedside expectations, were not consistently transmitting the cultural norms of multidisciplinary engagement. Participant 13 interpreted this not as defiance but as cultural drift. The absence of reinforcement had gradually reshaped expectations.

Other resistance reflected structural misalignment. Case management had initially been tasked with coordinating rounding logistics despite not being mandated participants. This created inefficiencies and diluted accountability. By shifting primary ownership back to nursing—clarifying that if nurse and physician presence was non-negotiable, nursing must lead coordination—the team restored clarity. Adjusting the timing of rounds to avoid medication administration conflicts further reduced friction.

Across these experiences, Participant 13 increasingly framed resistance through the lens of culture and accountability. She described a post-pandemic cultural environment shaped by fear—fear of losing staff amid the “great resignation.” Leaders hesitated to enforce standards, worried that accountability might push employees toward departure. In this atmosphere, best practices eroded quietly. Bedside shift report, once normative, had migrated to hallways and nurses’ stations. Standards became suggestions. Over time, new employees absorbed this diluted culture as baseline.

In response, her organization restructured charge nurse roles into clinical shift coordinators, elevating expectations for leadership presence and operational oversight. Participant 13 became involved in preceptor and charge nurse training, emphasizing that culture is transmitted peer-to-peer. She reframed leadership not as task delegation but as influence. Clinical shift coordinators were positioned as cultural stewards responsible for reinforcing bedside behaviors and holding peers accountable.

Her reflections on motivation revealed distinct patterns. Teams that embraced change often did so under visible spotlight. The emergency department, for example, carried aggressive Net Promoter Score targets that exceeded those of inpatient units. Elevated scrutiny and system-level support galvanized collective effort. Regional leadership engagement signaled seriousness. Improvement became a shared endeavor rather than isolated expectation. In contrast, inpatient units with modest improvement targets and diffuse accountability experienced stagnation. Without senior leadership insistence and tangible consequence, patient experience initiatives lost urgency.

Resistance, in her view, frequently traced back to leadership behavior. When senior leaders failed to drive change or hold mid-level managers accountable, frontline adoption faltered. She recounted working with a nursing director adept at strategic planning yet reluctant to operationalize initiatives. Ideas remained theoretical. Without cascading accountability, unit-level leaders deprioritized patient experience amid competing demands. In such contexts, Participant 13 experienced the limits of influence inherent to roles without direct reporting authority. She could advocate, coach, and present data, but sustained change required executive reinforcement.

Resources, she noted, were less about budgetary abundance and more about team structure. Her small, centralized patient experience team relied heavily on internal collaboration and the expertise of a data consultant capable of translating complex analytics into actionable insight. Cross-disciplinary backgrounds—clinical and non-clinical—enriched interpretation and broadened strategic perspective. In her experience, meaningful data presentation often determined whether leaders engaged or disengaged.

When considering those who readily embrace change, Participant 13 highlighted collaborative leaders who involve champions, distribute ownership, and visibly commit to goals. These individuals view patient experience as team sport rather than isolated project. Conversely, resisters often operate within competing priority structures or lack executive alignment. Without senior endorsement and consistent behavioral modeling, patient experience remains vulnerable to marginalization.

Her advice to emerging leaders reflects pragmatic resilience. Do not become discouraged. Change management is iterative and often nonlinear. Evidence-based recommendations grounded in research strengthen credibility. Mastery of data interpretation and project management methodologies enhances influence. Patience, she emphasized, is essential. Cultural restoration—particularly after periods of crisis-induced accommodation—requires time.

In distilling her lived understanding of resistance, Participant 13 described change as difficult yet potentially energizing when approached collaboratively. Sustainable improvement does not occur overnight. Resistance is not necessarily refusal; it may signal fear, fatigue, or absence of structural reinforcement. For her, patient experience leadership evolved from bedside initiative design to cultural recalibration—anchored in accountability, reinforced through leadership modeling, and sustained by patience.

Participant 14

Participant 14's entry into patient experience leadership did not begin within healthcare. Her professional foundation was in corporate hospitality within the restaurant industry. Following the 2007 economic downturn, she returned to graduate school to strengthen her business acumen. During that period, a classmate recognized her presentation style, communication strengths, and customer-focused mindset, and introduced her to an opportunity in healthcare as a patient experience manager. Although she had long felt drawn to healthcare, she had not envisioned herself in a clinical role.

The invitation offered an administrative pathway to serve patients without direct clinical responsibilities. What began as serendipity evolved into vocation.

Her early career unfolded through a national services organization providing non-clinical support in acute care hospitals. As a vendor-based patient experience leader, she rotated through multiple facilities across states, implementing HCAHPS improvement strategies and rounding initiatives. These early roles shaped her awareness of structural hierarchy and outsider status. Although embedded within hospital environments, she did not hold formal authority over nursing or physician staff. Resistance frequently manifested not as hostility but as structural indifference. Staff members would comply selectively, guided by operational managers rather than by patient experience directives. The absence of direct reporting relationships created a ceiling on influence.

One formative episode occurred during rounding in a hospital where interdepartmental silos were pronounced. She encountered patients in visible distress and sought assistance from nearby nurses, only to be told, “That’s not my patient.” In those moments, she experienced moral injury. She felt responsible for advocating yet powerless to effect response. The resistance she encountered was not overt defiance but diffusion of responsibility embedded within unit culture. Eventually, she withdrew from rounding temporarily, recognizing that without leadership alignment and shared accountability, her efforts risked exacerbating patient frustration rather than alleviating it.

In contrast, at a subsequent hospital, executive leaders invited her into strategic conversations. She presented HCAHPS frequency distribution data to demonstrate that

moving “usually” responses to “always” could significantly elevate scores. Leaders engaged actively, recognized opportunity, and mobilized unit managers to align practices. The cultural difference was immediate. In that environment, patient experience was treated as enterprise priority rather than peripheral obligation. The contrast between these two settings solidified her understanding that culture—not individual willpower—often determines change velocity.

As her career progressed into managed care, large medical groups, and eventually national physician partnerships, she observed similar patterns on broader scale. Mergers and acquisitions introduced cultural instability. During transitions, she witnessed reductions in force, shifting priorities, and fear-driven leadership behaviors. Change initiatives were announced but insufficiently cascaded. Communication lacked depth. She described these efforts not as deliberate resistance but as incomplete change management—transactional decisions emphasizing short-term return over long-term relational trust.

Resistance, in her experience, took multiple forms. Structural resistance arose when reporting hierarchies diluted accountability. Without formal authority, patient experience leaders relied on influence rather than mandate. Passive resistance emerged when clinicians dismissed relational behaviors as “soft skills,” privileging technical proficiency over patient-centered communication. Resource-based resistance surfaced when teams were stretched thin and defaulted to immediate operational demands. In each

instance, resistance was less about rejection of experience principles and more about prioritization pressures, historical burnout, or lack of alignment.

She increasingly reframed her approach from tactical intervention to psychological insight. Rather than focusing solely on rounding frequency or service scripts, she examined human behavior. She recognized that resistance often signaled prior injury—professionals burned by previous initiatives, overwhelmed by competing metrics, or wary of reputational exposure. In physician transparency efforts and patient engagement campaigns, she learned that surfacing underlying fears yielded more progress than presenting additional data.

Resource scarcity emerged as a consistent narrative pattern across participant accounts. Patient experience roles were rarely staffed robustly, and budgets were often minimal. When requesting support, she was often told to “be creative” rather than provided additional personnel or capital. Over time, she pivoted strategically. Rather than advocating solely for patient satisfaction metrics, she linked experience to risk adjustment, quality scores, and financial performance. When initiatives aligned with revenue-impacting metrics such as hierarchical condition coding, leadership attention intensified. Through reframing, she gained traction not by abandoning experience values but by translating them into operational language executives prioritized.

When reflecting on individuals who embraced change readily, Participant 14 identified purpose as the central driver. Those who remembered why they entered healthcare—personal stories of loss, caregiving, or service—demonstrated intrinsic

motivation. Inspiration emerged through reconnecting them to that origin narrative. Conversely, individuals who resisted often did so from protective instinct. They had endured failed initiatives, inconsistent leadership, or cultural volatility. Resistance became coping mechanism. She came to interpret it less as obstinance and more as survival strategy.

Culture, she emphasized, governs psychological safety and growth mindset. In environments where leaders model collaboration and accountability, change diffuses organically. In cultures characterized by fear, inconsistency, or performative endorsement without behavioral modeling, resistance calcifies. She distinguished between teamwork—rowing in the same direction—and collaboration—engaging in dialogue about how to row more effectively. Sustainable change requires the latter.

Her counsel to emerging patient experience leaders reflects both resilience and realism. Passion must be guarded carefully. External skepticism or dismissal of experience as “soft” should not extinguish internal conviction. Finding like-minded allies—individuals who share commitment and can amplify voice—is essential. Change is emotional before it is operational. Data persuade intellectually, but narrative inspires behavior.

In distilling her lived understanding of resistance, Participant 14 described it as natural human response to uncertainty. Without trust, clarity, and shared purpose, individuals default to protection. With alignment, modeling, and relational engagement, even entrenched resistance can shift. Her narrative reflects evolution from tactical

implementer to cultural interpreter—recognizing that patient experience leadership is less about enforcing behaviors and more about cultivating environments where those behaviors feel purposeful and sustainable.

Participant 15

Participant 15 did not enter patient experience leadership through a deliberate career plan. Instead, his pathway emerged through a convergence of timing, exposure, and organizational need. In 2012, while serving as a nurse leader with 24/7 accountability for a clinical unit, he became involved in organizational quality work connected to the Malcolm Baldrige Quality Award, specifically Category 3, Voice of the Customer. At that time, he did not conceptualize patient experience as a distinct professional field. Rather, he understood it as an extension of care delivery, quality improvement, and leadership responsibility.

A pivotal transition occurred when the senior leader overseeing patient experience exited the organization. Because of his involvement in the Baldrige work and his growing exposure to experience-related strategy, Participant 15 was asked to consider stepping into the role. This invitation arrived at a moment of personal decision-making. He had already planned to leave the organization for another nurse leadership position at a different health system. After reflection, he chose to stay, drawn by the opportunity to influence strategy, performance improvement, and what he recognized as an emerging domain within healthcare. This decision marked the beginning of his identity shift from clinical leader to patient experience leader.

Early in his tenure, Participant 15 encountered his first sustained experience with resistance to change. He recalled entering leadership meetings expecting alignment around experience priorities, only to find fragmented messaging and unclear ownership. Although executive leaders expressed commitment to improving patient experience, there was no shared vision that could be meaningfully translated to frontline staff or middle managers. “Everyone agreed experience mattered,” he explained, “but no one could explain what that meant for their teams.” While senior leaders spoke about the importance of “touching hearts, not minds,” readiness for this shift varied significantly across leadership layers.

Resistance emerged most visibly among middle managers. Participant 15 described their response not as overt opposition, but as a tendency to remain anchored in familiar practices and prescribed roles. These leaders were accustomed to operating within clearly defined lanes and were hesitant to assume responsibilities they perceived as outside their traditional scope. Introducing new approaches to experience improvement required careful navigation, as he worked to balance respect for existing expertise with the need to expand collective accountability.

As his career progressed, Participant 15 encountered similar patterns of resistance in different organizational contexts. Reflecting on his experience within a large academic health system, he described ongoing challenges with organizational development partners who tightly controlled training, education, and design work. Efforts to collaborate were met with defensiveness rooted in ownership and professional identity. He interpreted this

resistance as reflective of an entrenched mindset, characterized by adherence to established roles and reluctance to share influence over change initiatives. Rather than attributing these dynamics solely to organizational culture, Participant 15 came to view culture as an expected condition of experience leadership, one that required intentional influence rather than avoidance.

A significant turning point in his leadership approach emerged through repeated experiences of resource scarcity. In one role, Participant 15 oversaw patient experience across an 800-bed organization with minimal dedicated leadership support. Initial attempts to advocate resources using traditional patient experience metrics gained little traction. Over time, he recognized that his framing did not align with executive priorities. This realization prompted a shift in how he positioned his work. He began translating experience initiatives into operational language, connecting them to physician efficiency, network integrity, readmission rates, and malpractice risk. As he described it, he learned to “think like an operator.”

This reframing produced tangible consequences. Participant 15 reported increased executive engagement and greater traction for experience initiatives once he aligned requests with organizational performance and risk mitigation. Through this process, his understanding of resistance evolved. Rather than interpreting resistance as rejection of patient-centered values, he came to see it as a response to misalignment between experience work and institutional priorities. Resistance, for him, became diagnostic rather than adversarial.

Across his narrative, Participant 15 distinguished between individuals who readily embraced change and those who struggled. He observed that openness to experience improvement often stemmed from lived encounters with patient suffering, whether personal or relational. These experiences, he believed, created moral clarity and sustained commitment. In contrast, he associated resistance with insecurity, fear of failure, and lack of humility, dynamics he encountered across roles and levels of seniority.

As he reflected on his journey, Participant 15 emphasized story as both a leadership tool and a mechanism for change. He described learning to navigate informal power structures, build relational credibility, and lead through personal narrative. Looking back, he characterized this evolution as redefining his role. Rather than positioning himself primarily as a change driver, he came to see himself as a translator of purpose, responsible for helping others reconnect with why they entered healthcare in the first place.

Through his story, Participant 15 constructed resistance not as opposition to patient experience work, but as a signal of disconnection from purpose amid competing demands. His narrative illustrates how patient experience leadership evolved for him from clinical advocacy to organizational sensemaking, shaped by turning points that reframed both his practice and professional identity.

Cross-Narrative Sensemaking

When the 15 narrative accounts are read alongside one another, participants' stories revealed patterned ways of meaning-making around resistance to change that

extended beyond isolated incidents or organizational contexts. Rather than presenting as discrete or unrelated experiences, their accounts formed recurrent storylines—shared trajectories that unfolded across time, relationships, and place.

Across the narratives, a recurring storyline involved unintended entry into patient experience leadership. Few participants described a deliberate career plan to become a patient experience leader. Instead, their stories often began at points of disruption or redirection: personal loss, organizational transition, economic downturn, internal promotion, vendor placement, or invitation from a senior leader. These origin stories reflected a shared experience of being “pulled into” the work rather than pursuing it through linear professional ambition. Over time, what began as circumstantial placement evolved into identity commitment. Resistance to change was therefore encountered not as an abstract leadership problem but as something navigated while participants themselves were still constructing their professional identities.

Several participants described similar turning points related to early encounters with resistance that reshaped how they understood their role. In many accounts, initial resistance was interpreted personally—experienced as frustration, dismissal, or moral injury. Some participants recounted moments of standing alone in rooms of skeptical physicians; others described structural marginalization as vendors without formal authority. These early episodes often marked a narrative inflection point. Over time, resistance was re-storied. What was first understood as opposition gradually became reframed as fear, overload, misalignment, or erosion of trust. Across the narratives, this

reframing represented a developmental shift—from perceiving resistance as adversarial to interpreting it diagnostically.

Participants' stories also revealed a shared experience of structural constraint. Across diverse healthcare settings—acute care hospitals, ambulatory networks, managed care organizations, vendor-based models, and national partnerships—participants described occupying roles with responsibility but limited authority. A recurring plotline involved leading change without direct reporting relationships to those expected to adopt it. This structural positioning shaped how resistance was encountered and interpreted. In some accounts, staff deferred to operational leaders rather than patient experience directives. In others, executive endorsement existed rhetorically but lacked behavioral modeling. Across these narratives, resistance was not solely interpersonal; it was embedded in hierarchy, reporting lines, and organizational design.

Another recurrent narrative pattern involved the tension between relational work and metric-driven accountability. Several participants described resistance emerging when patient experience was framed as “soft skills” rather than operational or financial priority. Across the narratives, a common trajectory unfolded: participants learned to translate relational behaviors into the language of executive priorities. Stories of pivoting—from focusing on satisfaction to engagement, from compassion to HCC capture, from rounding to operational efficiency, reflected patterned ways of meaning-making. Resistance diminished when initiatives were storied in alignment with organizational performance, risk mitigation, or revenue integrity. This cross-narrative

thread revealed that meaning-making around resistance was deeply contextual, shaped by what the organization valued at that moment in time.

These accounts reflected a shared experience of culture as both enabler and barrier. Across the narratives, participants described environments characterized by psychological safety and collaborative leadership as more receptive to change. In contrast, cultures marked by fear—particularly during periods of merger, reduction in force, post-pandemic instability, or high turnover—amplified resistance. A recurring storyline involved leaders hesitating to hold staff accountable due to fear of attrition. In these contexts, resistance was intertwined with survival. Participants storied such resistance not as unwillingness to care, but as fatigue and protective adaptation. At the same time, narrative continuities and contrasts emerged. While many participants described resistance as rooted in mistrust or overload, others emphasized personal insecurity, prior professional injury, or entrenched identity. For some, the most difficult resistance was overt and confrontational—physicians challenging transparency in open forums. For others, the more complex resistance was passive compliance—verbal agreement without behavioral adoption. These differences in how participants storied resistance illustrate that while the phenomenon was shared, its expression varied depending on relational dynamics and organizational climate.

Across the narratives, a recurring storyline involved identity evolution. Participants did not remain static in how they positioned themselves in relation to resistance. Early-career accounts often reflected attempts to persuade through data or best

practice. Later narratives demonstrated movement toward relational influence—listening, reframing, identifying champions, cultivating peer credibility, and building coalitions. Participants' stories revealed continuity in purpose but transformation in approach. Resistance became less about winning arguments and more about cultivating alignment. Several participants described similar turning points related to securing executive sponsorship. In accounts where chief executives or medical leaders visibly endorsed initiatives—by attending training, modeling behaviors, or reinforcing expectations—resistance softened. Where endorsement remained symbolic rather than behavioral, initiatives stalled. Across the narratives, this recurrent plotline underscored the relational nature of authority. Change adoption was less dependent on the patient experience leader's expertise and more dependent on visible leadership alignment.

Resonant experiences also emerged around resource scarcity. Participants consistently described operating within constrained budgets, small teams, or single-person departments. Across the narratives, a patterned way of meaning-making involved shifting from requesting resources to adapting creatively. Some described being told to “be more creative” rather than receiving additional support. Others reframed initiatives to align with financial metrics in order to gain traction. These accounts reflected continuity in the experience of under-resourcing, yet contrast in strategy—some persisted within constraint; others pivoted strategically to gain leverage.

Differences in how participants storied motivation further illuminated patterned meaning-making. Participants who embraced change were consistently described as

purpose-driven, intrinsically motivated, or anchored in personal narratives of caregiving and loss. Across the narratives, a shared storyline involved reconnecting resistant individuals to their original reason for entering healthcare. Conversely, resistance was often storied as protective—rooted in burnout, competing priorities, mistrust of leadership, or prior failed initiatives. Rather than depicting resisters as oppositional, many participants reinterpreted them as overwhelmed or historically wounded. This cross-narrative continuity suggests that resistance was rarely framed as moral deficiency; it was more often understood as contextual adaptation.

Across time and setting, participants' stories revealed that resistance was not a singular event but an ongoing relational dynamic. It appeared at initiative launch, resurfaced during implementation drift, and reemerged when cultural reinforcement waned. In this sense, resistance was storied as cyclical rather than episodic. Several narratives described initiatives that initially succeeded, later lost compliance, and required recalibration. These accounts reflected continuity in the fragility of change absent sustained reinforcement.

Taken together, the cross-narrative sensemaking reveals that resistance to change in patient experience leadership is not merely behavioral opposition. It is situated within evolving identities, structural hierarchies, cultural climates, and competing organizational priorities. Participants' stories collectively construct resistance as relational, contextual, and dynamic. While the forms of resistance varied—from overt confrontation to quiet

disengagement—the underlying plotlines converged around trust, authority, purpose, and alignment.

Across the narratives, a shared trajectory emerges: entry through circumstance, confrontation with resistance, reinterpretation of that resistance, and eventual reframing of leadership identity. These recurrent narrative patterns illustrate how participants moved from attempting to overcome resistance to learning to work within it. In doing so, they constructed patient experience leadership not as enforcement of best practice, but as ongoing negotiation within complex healthcare environments.

Table 1

Main Storylines, Sub-storylines, and Illustrative Narrative Excerpts Related to Resistance to Change Among PELs

Main storyline	Sub-storyline	Illustrative Narrative Excerpt
Emotional and Cultural Fatigue from Continuous Change	Change saturation and burnout	“We’ve had so many new initiatives that people are exhausted before the next one even starts” (Participant 4); “There’s barely time to celebrate progress before something new gets rolled out” (Participant 8).
	Perception of instability and overload	“Every few months, priorities shift—it’s hard to know where to focus anymore” (Participant 2); “Staff are tired of hearing ‘this is the next big thing’” (Participant 6).
Leadership Disconnect and Mixed Messaging	Inconsistent communication across levels	“Different leaders tell different stories about the same change. It kills trust” (Participant 3); “You can feel the confusion when frontline teams hear mixed signals” (Participant 7).
	Tokenistic inclusion in planning	“By the time we’re asked for input, the decision is already made” (Participant 5); “We’re told our feedback is valued, but it rarely changes the outcome” (Participant 9).
Professional Identity and Psychological Safety	Self-protection and risk aversion	“Resistance sometimes isn’t opposition—it’s survival” (Participant 9); “Speaking up too much can backfire” (Participant 7).
Trust, Transparency, and Communication Gaps	Limited explanation for change	“We hear the ‘what,’ but rarely the ‘why’” (Participant 1); “Even explaining the rationale would help” (Participant 8).
Coping, Adaptation, and Meaning-Making	Collaborative sense-making	“Our PEL group chats are therapy sessions” (Participant 9); “We can’t control the change, but we can control how we respond” (Participant 7).

Summary

RQ1: What are the factors that cause resistance to change that PELs face in the acute care hospital setting?

Findings related to RQ1 revealed that resistance was rarely narrated as an unwillingness to improve or engage. Instead, participants' stories positioned resistance as a contextual and cumulative response to competing initiatives, change saturation, and ongoing organizational uncertainty. Across narratives, participants narrated how the pace and volume of change often exceeded their teams' capacity to adapt, leading to disengagement and emotional fatigue over time. Resistance was therefore constructed not as defiance, but as a symptom of overloaded systems, shifting priorities, and limited recovery between initiatives.

Participants' narratives further revealed that organizational culture and leadership behaviors played a defining role in how resistance was experienced and interpreted. When leadership was narrated as consistent, inclusive, and transparent, participants narrated greater alignment and readiness for change. In contrast, stories of conflicting messages, inconsistent follow-through, or absent executive sponsorship were often positioned as turning points that intensified resistance. Trust emerged as a critical narrative condition for progress, not only between PELs and frontline staff, but also among executive leaders and peers. Participants emphasized that collaboration depended on confidence that leaders were collectively invested, transparent, and accountable. When that trust eroded, even well-intentioned efforts struggled to gain momentum.

Participants' stories were organized around interconnected narrative patterns that captured how resistance was constructed and navigated over time. These patterns included competing priorities and change saturation, organizational culture, varied forms of resistance, motivation and human factors, leadership and champions, data and measurement, resources and support, and lessons learned through lived experience. Across these narrative patterns, five shared meaning structures captured the overarching story of resistance among PELs: (1) emotional and cultural fatigue from continuous change, (2) leadership disconnect and mixed messaging, (3) professional identity and psychological safety, (4) trust, transparency, and communication gaps, and (5) coping, adaptation, and meaning-making. Together, these narrative patterns illustrate how PELs navigated the emotional, relational, and operational dimensions of change while balancing competing demands.

Collectively, participants' narratives positioned resistance to change as a relational and systemic phenomenon shaped by trust, culture, and communication rather than individual reluctance. PELs consistently narrated their roles as both leaders and mediators, translating strategic directives into meaningful action while simultaneously sustaining their own resilience amid shifting expectations and organizational pressures.

Chapter 5 is built upon these narrative findings by interpreting their significance within the study's theoretical framework, connecting participants' stories to existing literature, and examining implications for leadership practice, organizational strategy, and future research.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative narrative study was to explore the factors that cause resistance to change faced by PELs in the acute care hospital setting. This chapter includes interpretations of how PELs constructed meaning around resistance, leadership, and organizational change through their stories. Building on the participant accounts presented in Chapter 4, this chapter shifts from narrative presentation to narrative sensemaking, focusing on how participants made sense of disruption over time and how their professional identities evolved in response to lived experience.

Rather than treating resistance as a set of contributing factors, this chapter examines resistance as it was narrated by participants across turning points in their leadership journeys. Participant stories revealed how understandings of resistance developed through early missteps, relational challenges, resource constraints, and organizational transitions. Through these experiences, PELs described reframing resistance from an obstacle to overcome into a signal of misalignment, fatigue, or unmet readiness within complex healthcare systems.

The interpretations that follow are grounded in specific participant narratives. For example, Participant 2 reflected on the unintended consequences of rapid, top-down implementation of hourly rounding, which reshaped her understanding of how change must be sequenced to build trust. Participant 4 described entering patient experience leadership amid system integration, where resistance emerged as cognitive overload and cultural fatigue, prompting him to redefine his role as a connector for change. Participant

15 recounted repeated encounters with resource scarcity that led to a pivotal shift in how he framed experience work, moving from clinical advocacy toward operational sensemaking and executive alignment. These stories serve as the analytic foundation for understanding how resistance, leadership, and identity were constructed over time.

Across narratives, leadership identity emerged not as a fixed condition, but as an evolving process shaped by disruption and relational engagement. Participants entered patient experience leadership through circumstance rather than deliberate career pathways, encountering ambiguity in role expectations and authority. Through turning points embedded in their stories, they came to reposition themselves as translators of purpose, bridge-builders across disciplines, and sensemakers within systems marked by competing priorities.

This chapter interprets these narrative trajectories through attention to temporality, sociality, and place. Meaning-making is examined as it was demonstrated within specific organizational contexts, leadership relationships, and moments of change. Resistance is analyzed not as a conceptual category, but as a lived experience that informed how participants understood their work, navigated power dynamics, and constructed their leadership identities.

The chapter concludes with implications for practice and future research grounded in story-based action. Rather than abstract recommendations, implications are derived directly from participants' narratives, highlighting how experience leaders can more effectively sequence change, build relational credibility, and align patient experience

work with organizational priorities. Through this narrative interpretation, the study underscores the central role of PELs as relational leaders whose effectiveness depends on their capacity to make meaning of resistance and guide others through complex change.

Tracing the TPB Behavior Across Narratives

Although this study used the TPB as a sensitizing rather than predictive framework, participants' narratives revealed consistent patterns that aligned with TPB's central constructs of attitudes, subjective norms, and perceived behavioral control. Rather than applying TPB to forecast behavioral intention, the framework served as an interpretive lens to better understand how patient experience leaders (PELs) made sense of resistance to change across time, relationships, and organizational contexts.

Across the narratives, resistance was rarely described as simple opposition. Instead, it emerged as a thoughtful and often protective response shaped by how participants evaluated change initiatives, how they interpreted expectations from others, and how capable they felt influencing outcomes. When examined collectively, participants' accounts reflected sustained alignment with each TPB construct.

Attitudes Toward Change

A recurring storyline across the narratives involved how participants evaluated the value and meaning of experience-related initiatives. Several described entering change efforts with genuine optimism, particularly when initiatives aligned with their professional identity and commitment to patient-centered care. In these accounts, change

was embraced when it felt purposeful and connected to engagement rather than compliance.

However, participants also described moments when their attitudes shifted. When initiatives were experienced as metric-driven, externally imposed, or disconnected from frontline realities, skepticism began to surface. Resistance in these narratives was not framed as defiance. Instead, participants often portrayed it as a protective stance taken to preserve credibility with clinicians or to ensure initiatives were authentic rather than performative.

Attitudes toward change were, therefore, not fixed. Across time, participants moved between enthusiasm and hesitation depending on how initiatives were framed and experienced. These storied evaluations played a significant role in shaping whether leaders leaned into change efforts or approached them with caution.

Subjective Norms

Another prominent pattern involved the social and organizational pressures surrounding change. Participants frequently described feeling positioned between executive expectations, regulatory requirements, and the lived realities of frontline teams. These accounts reflected the influence of subjective norms, particularly the perceived expectations of senior leaders, boards, and benchmarking systems.

At the same time, participants spoke about their relational obligations to clinicians and staff. Many described a tension between honoring system-level priorities and maintaining trust at the local level. In several narratives, resistance emerged when

participants perceived misalignment between what senior leaders were emphasizing and what frontline teams were able or willing to absorb.

There were differences in how these norms were interpreted. Some participants described executive expectations as motivating and clarifying. Others experienced them as disconnected from operational complexity. Across narratives, the meaning assigned to social expectations was shaped by trust, prior experiences with change, and the relational climate within each setting.

Perceived Behavioral Control

A third cross-narrative storyline centered on agency and capacity. Participants often reflected on whether they truly had the authority, resources, or structural support necessary to carry initiatives forward. In contexts where executive sponsorship was visible and cross-functional alignment was strong, participants described feeling empowered and capable of influencing outcomes.

Conversely, when initiatives were introduced without adequate staffing, time, or operational clarity, participants described feeling constrained. In these instances, resistance appeared less about unwillingness and more about perceived limitations. Leaders questioned whether they could realistically execute the expectations being placed upon them.

Turning points were evident in several narratives. As structural support increased, so did confidence and engagement. When support waned, hesitation and guardedness

resurfaced. These patterned experiences reflect variations in perceived behavioral control and demonstrate how agency shaped leaders' responses to change.

Integrative Cross-Narrative Sensemaking

When viewed collectively, participants' stories suggest that resistance to change among PELs was shaped by the interaction of attitudes, subjective norms, and perceived behavioral control rather than any single factor. Resistance most frequently emerged when change efforts felt misaligned with personal values, when social expectations appeared disconnected from local realities, or when leaders perceived limited control over implementation.

Importantly, these constructs did not function independently. Participants' accounts showed that negative evaluations of change were often intensified when accompanied by low perceived control. Similarly, strong personal commitment to improvement could be undermined when social pressures felt incongruent with frontline capacity.

By tracing TPB constructs across participants' storied experiences, this study demonstrates that resistance was constructed through evaluative, relational, and structural dimensions. TPB functioned as a sensitizing framework that illuminated how leaders interpreted and negotiated change within the complex environments of acute care hospital settings. In doing so, the framework deepened understanding of how meaning-making processes shaped engagement with change over time.

Integrative Analysis: Narrative Patterns and the TPB

Although this study was grounded methodologically in narrative inquiry, TPB functioned as a sensitizing framework to interpret how participants described decision-making processes within their lived experiences. TPB was not applied as a predictive or causal model but as a conceptual lens to examine how attitudes, perceived norms, and perceived behavioral control were reflected in participants' stories (Ajzen, 1991). Using TPB in this interpretive way aligns with contemporary qualitative methodology that positions theory as a guiding sensibility rather than a rigid causal schema (Tavory & Timmermans, 2022).

Narrative inquiry places emphasis on temporality, sociality, and place as foundational dimensions of experience, whereby meaning is constructed in and through participants' storied lives (Clandinin, 2022). Within this framework, TPB constructs were examined not as isolated predictors but as narrative patterns that emerge, shift, and interact across participants' accounts over time.

Attitudes Toward the Behavior

Across narratives, participants' evolving professional identities—from implementers to translators and boundary-spanners—reflected shifts in evaluative stance toward organizational change processes. Early stories often conveyed compliance-oriented attitudes, whereas later accounts demonstrated deeper internalization and alignment with the change's purpose. These narrative shifts resonate with TPB's construct of attitudes toward behavior as evaluative judgments shaping intentions (Ajzen,

1991). By attending to how attitudes were narrated over time, this study highlights that attitudes in lived experience are dynamic and co-constructed with professional identity development (Clandinin, 2022).

Subjective Norms

Participants consistently framed resistance, trust, and authority within relational and cultural contexts. Stories revealed that perceptions of leadership credibility, peer expectations, and organizational history shaped role interpretations. While TPB conceptualizes subjective norms as perceived social pressure (Ajzen, 1991), contemporary meta-analytic evidence indicates that perceived norms and control interact in complex ways to influence intentions and behavior (Hagger et al., 2022). In the narratives, normative influence was not experienced as abstract pressure but was embedded in institutional relationships and historical contexts that shaped participants' meaning-making.

Perceived Behavioral Control

Accounts of fatigue, resource constraints, and structural limitations echoed the TPB construct of perceived behavioral control, which refers to beliefs about one's capability to perform a behavior (Ajzen, 1991). Recent meta-analysis suggests that perceived control moderates the link between intention and behavior, with higher control strengthening this relationship (Hagger et al., 2022). In participants' stories, perceived control was narratively constructed through lived encounters with institutional norms, resource availability, and adaptive strategies that shaped agency over time.

Theoretical Contribution

Integrating TPB within narrative inquiry demonstrates that behavioral intention and engagement are embedded in identity development and relational contexts over time. Rather than isolating attitudes, norms, and control as discrete predictors, this study shows how these constructs unfold within temporal, social, and contextual stories. This contribution extends TPB's application in complex organizational settings by illustrating how its constructs manifest within dynamic narrative processes rather than through static cognitive measurement.

Interpretation of Findings

Participants' narratives revealed resistance as a lived and relational experience that evolved over time rather than a discrete barrier to patient experience improvement. Across stories, resistance emerged at moments of organizational disruption, unclear expectations, and competing priorities, shaping how PELs interpreted their roles and responsibilities within complex healthcare systems.

For Participant 2, resistance first became visible through the rapid implementation of hourly rounding. Initially introduced as a top-down mandate, the initiative generated distrust among nursing leaders who perceived the expectation as unrealistic. When the effort faltered, Participant 2 described this moment as reshaping her understanding of change. Over time, she reframed resistance from opposition to patient-centered care into a response to poorly sequenced transformation, leading her to prioritize incremental progress, relational engagement, and psychological safety.

Participant 4's narrative situated resistance within the broader context of system integration. Entering patient experience leadership during organizational transition, he described resistance as emerging through cognitive overload and cultural fatigue rather than direct refusal. Small logistical barriers, such as uncertainty around physician communication tools, became symbolic of larger alignment challenges. Through partnership with trusted clinical leaders and sustained presence on units, Participant 4 came to understand resistance as an indicator of where relational bridges were needed, prompting him to redefine his role as a connector for change.

Participant 15's story illustrated how resistance became meaningful through repeated encounters with resource scarcity. Early efforts to secure support using traditional patient experience metrics proved ineffective. A turning point occurred when he reframed experience initiatives in operational and financial terms, aligning them with executive priorities such as efficiency, risk mitigation, and system performance. This shift transformed how he interpreted resistance, moving from frustration toward diagnostic sensemaking, and repositioned him as a translator of purpose across organizational levels.

Interpreted through the sensitizing lens of the TPB, these narratives illuminate how attitudes toward patient experience work, perceived social norms communicated by leadership, and perceived behavioral control shaped participants' meaning-making. Importantly, these constructs did not function as explanatory variables, but as interpretive frames through which PELs narrated agency and constraint. In participants' stories,

resistance intensified when leaders perceived limited control over resources, when organizational norms failed to reinforce experience priorities, or when clarity of purpose was disrupted. Conversely, resistance diminished when participants described increased alignment with executive leadership, visible modeling by clinical leaders, and reframing of experience work in terms that resonated with organizational values.

Across narratives, PELs positioned themselves as boundary-spanning sensemakers who translated resistance across clinical, operational, and executive domains. Through stories of navigating competing priorities, mediating difficult conversations, and interpreting data alongside lived experience, participants constructed resistance as a signal of moral tension, identity threat, or system strain. These accounts revealed resistance as deeply intertwined with emotional labor, perceived vulnerability, and challenges to professional identity, surfacing not as abstract as abstract organizational deficiencies but as embodied leadership experiences.

These narrative interpretations align with and extend existing literature on resistance to change, change fatigue, organizational readiness, and patient experience leadership (Cadel et al., 2022; Cao et al., 2024; Gabutti et al., 2023). Consistent with healthcare change scholarship that frames resistance as contextual and relational rather than an individual deficit (Nilsen et al., 2019; Schulz-Knappe et al., 2019), participants' stories complicated deficit-based assumptions by foregrounding structural limitations, emotional burden, and relational dynamics. By centering lived experience and story-based meaning-making, this study refines contemporary understandings of organizational

change in healthcare, positioning resistance as an ongoing process of sensemaking embedded within relationships, identity, and organizational context rather than as a problem located within individuals.

Confirmation of Existing Knowledge

Participants' stories revealed how resistance was constructed through lived experience and ongoing sensemaking within complex organizational environments. Rather than narrating resistance as an isolated reaction to patient experience initiatives, PELs described it as emerging through relationships, timing, communication, and the perceived legitimacy of change efforts.

Across narratives, resistance was rarely framed as hostility toward the goal of patient experience improvement. Instead, participants described resistance arising when communication was unclear, involvement in planning was limited, or the purpose of change was not well understood. In these accounts, resistance functioned as a protective and interpretive response, allowing individuals to preserve agency and manage uncertainty during periods of transition. For example, Participant 2 recounted how rapid implementation of hourly rounding without sufficient engagement led nursing leaders to withdraw trust, while Participant 4 described resistance surfacing as cognitive overload during system integration. Participant 15 similarly narrated resistance as emerging when experience work felt disconnected from operational priorities. These stories illustrate how resistance became meaningful through lived organizational conditions rather than deliberate opposition.

Participants also narrated resistance through experiences of cumulative change. Stories of “too many initiatives at once” reflected emotional exhaustion and diminished capacity rather than refusal to engage. PELs described staff disengagement emerging after repeated exposure to overlapping priorities without adequate recovery, clarity, or support. These narrative accounts align with Nilsen et al.’s (2020) findings that healthcare professionals are more receptive to change when they feel prepared, included, and able to understand its purpose, while extending this work by demonstrating how the absence of these conditions shaped resistance through relational experience. Participants’ stories further resonate with Cao et al.’s (2024) conceptualization of change fatigue as the intersection of ongoing exposure to change, emotional exhaustion, and reduced perceived control, as well as Duan et al.’s (2025) findings linking organizational change fatigue to decreased work engagement among nurses.

Readiness for change also emerged as a dynamic narrative process rather than a static organizational condition. Participants described improvement efforts stalling in contexts where leadership support, resources, or follow-through were perceived as insufficient. Importantly, readiness was constructed through leadership behaviors over time, including visible presence, consistency of messaging, and alignment between stated priorities and operational action. These accounts echo Gabutti et al.’s (2023) multidimensional conceptualization of organizational readiness and Caci et al.’s (2025) emphasis on collective commitment and perceived capability, while extending these perspectives by illustrating how readiness was experienced and interpreted through story.

Finally, participants consistently narrated their roles as boundary-spanning, requiring influence without direct authority. PELs described relying on relational credibility, informal power structures, and ongoing translation of expectations across teams. Resistance, in this context, was interpreted as a relational signal of misalignment rather than a failure of individual motivation. These stories align with Frilund et al.'s (2023) descriptions of leaders navigating sustained pressure and complexity during prolonged change processes, reinforcing the understanding of resistance as embedded within relationships and organizational context.

Taken together, participants' narratives both converge with and extend existing scholarship on resistance, change fatigue, and organizational readiness by foregrounding resistance as a form of narrative sensemaking. Through their stories, PELs constructed resistance as an evolving response to uncertainty, identity threat, and system strain, highlighting how leadership meaning-making unfolds within the relational and temporal realities of healthcare organizations.

Extension of Existing Knowledge

While participants' stories converged with much of the existing literature, they also extended prior research by revealing how resistance was made meaningful through lived experience and narrative sensemaking. Rather than identifying new variables or mechanisms, these extensions emerged through how participants narrated their roles, emotional labor, and interpretive responsibilities while leading patient experience work within complex healthcare systems.

Across narratives, PELs described experiencing change fatigue not only as an organizational condition affecting frontline staff, but as a personal leadership burden. While prior studies have documented change fatigue among nurses (Cao et al., 2024; Duan et al., 2025), participants' stories illuminated how experience leaders simultaneously carried responsibility for sustaining momentum while buffering others from overload. PELs narrated this dual role as emotional labor and moral responsibility, describing how they absorbed frustration, managed competing demands, and protected teams from cumulative strain. This story-based portrayal of change fatigue among experience leaders remains underrepresented in existing research and extends current understandings of how fatigue is distributed across leadership roles.

Participants' narratives also deepened understanding of how patient experience data shaped resistance. Although prior studies have highlighted challenges in using experience data effectively (Cadel et al., 2022), PELs in this study described resistance as emerging through how data were framed, communicated, and operationalized. Stories recounted punitive messaging, decontextualized reporting, and inconsistent follow-through, all of which eroded trust and generated defensiveness. Through these accounts, resistance was constructed not as rejection of evidence, but as a response to how meaning was imposed through data practices, highlighting the emotional and relational consequences of measurement strategies.

Leadership identity also emerged narratively as boundary-spanning and interpretive. While leadership behaviors associated with patient experience improvement

have been described in prior reviews (Bastemeijer et al., 2019), participants in this study narrated their identities as ongoing sensemakers who translated organizational priorities, mediated expectations across levels, and reframed resistance as a signal of misalignment or unmet readiness. Through their stories, PELs positioned themselves not as implementers of prescribed change, but as relational actors engaged in continuous interpretation. This narrative positioning extends existing leadership theory by foregrounding interpretive and relational labor as central to PEL identity.

Participants' stories further contributed to emerging scholarship on organizational learning within patient experience improvement. Although Peruzzo et al. (2025) emphasized the importance of infrastructures that support continuous learning from patient experience data, PELs described how the absence of feedback loops and inconsistent follow-through undermined credibility and fueled resistance. Their narratives offered grounded illustrations of how weak learning systems were experienced in everyday organizational life, particularly when learning felt performative rather than meaningful. Through these stories, resistance was constructed as a response to stalled learning rather than resistance to improvement itself.

Areas of Modest Disconfirmation

In addition to convergence and extension, participants' stories also challenged aspects of existing research by revealing how resistance was made meaningful through lived experience rather than individual disposition. Across narratives, PELs rarely constructed resistance as a personality trait, attitude problem, or dispositional deficit.

Instead, resistance was consistently narrated as emerging from structural and contextual conditions such as workload intensity, poor sequencing of initiatives, gaps in authority, and inadequate resources. Within these accounts, resistance functioned as a rational and intelligible response to system strain rather than a failure of individual motivation. This narrative framing aligns with Caci et al.'s (2025) emphasis on readiness as a collective property while challenging change management approaches that prioritize individual-level attitude modification over organizational conditions.

Participants' stories also complicated assumptions regarding patient experience measurement as a straightforward driver of improvement. While patient experience metrics are often positioned in the literature as catalysts for change (Bastemeijer et al., 2019), PELs narrated instances in which poorly supported measurement practices intensified resistance rather than reduced it. Participants described staff skepticism emerging when survey results were presented without contextual explanation, relational support, or visible follow-through. In these narratives, resistance was constructed not as rejection of measurement, but as a response to how data were introduced, interpreted, and enacted within relationships. Rather than contradicting prior research, these stories reframed it by foregrounding the relational consequences of measurement practices perceived as punitive, performative, or disconnected from improvement.

Participants' narratives further challenged simplified notions of leadership support as mere visibility or endorsement. Although existing literature emphasizes the importance of visible leadership commitment (Frilund et al., 2023; Nilsen et al., 2020), PELs

described how highly visible but operationally disconnected messaging often intensified resistance. Leadership support was made meaningful through congruence between message and action rather than presence alone. Participants narrated reductions in resistance when leaders removed barriers, sequenced initiatives thoughtfully, protected teams from overload, and aligned rhetoric with operational reality. These stories refine prevailing leadership models by emphasizing relational credibility and coherence as central to how leadership support is constructed during organizational change.

Limitations of the Study

Several limitations related to trustworthiness emerged through the conduct of this narrative inquiry. Although multiple strategies were employed to support credibility, dependability, confirmability, and transferability, these limitations are inseparable from the study's commitment to privileging story, meaning-making, and interpretive understanding. In narrative inquiry, knowledge is co-constructed through participants' accounts and the researcher's interpretive lens, and these dynamics necessarily shape what can be known.

This study relied on self-narrated accounts provided by patient experience leaders, which were shaped by memory, reflection, and participants' willingness to disclose sensitive experiences. Narrative inquiry intentionally centers subjective sensemaking; however, this also introduces the possibility of selective recall, retrospective reinterpretation, or unintentional omission. Participants chose which moments, turning points, and meanings to foreground as they told their stories, influencing how resistance

was narrated across time. Although member checking was used to support narrative credibility, it could not eliminate the inherently retrospective and interpretive nature of storytelling.

The sample of 15 PELs generated rich narrative accounts, yet the findings remain bounded by the perspectives of those who elected to participate and the stories they were willing or able to share. It is possible that individuals who experienced more severe organizational conflict, burnout, or disengagement declined participation, resulting in underrepresentation of more distressing narratives. Conversely, participants who remained active in patient experience leadership may have been more inclined to share stories reflecting ongoing meaning-making rather than withdrawal. These dynamics reflect common features of voluntary narrative research and likely shaped the narrative constructions represented in this study.

Data collection occurred through one-on-one virtual interviews, which influenced the form and texture of participants' storytelling. While video-based interviews supported rapport and real-time dialogue, they limited access to the full range of embodied and contextual cues available in in-person settings. Variability in technological comfort, environmental distractions, or interruptions may have affected pacing, emphasis, and narrative flow.

The researcher's professional background in patient experience leadership also constituted an important interpretive context. Although reflexive journaling and analytic bracketing were used to surface assumptions and monitor interpretive influence, the

possibility remained that participants' narratives were understood through the researcher's prior experiences with organizational change and patient experience work. In narrative inquiry, the researcher serves as the primary analytic instrument, and meaning is co-constructed rather than discovered, making complete neutrality neither possible nor epistemologically consistent with the methodology.

Transferability was further shaped by the diversity of organizational contexts represented. While geographic and institutional variation enriched the breadth of perspectives, differences in culture, leadership structures, governance models, and resource availability influenced how resistance was experienced and narrated. These contextual variations limit direct comparison across settings and underscore the situated nature of narrative meaning-making.

Despite these limitations, the study employed systematic narrative analytic procedures, member checking, reflexive documentation, and an audit trail to enhance trustworthiness. Acknowledging these constraints provides transparency regarding interpretation and reinforces the study's commitment to understanding resistance as a contextual, relational, and meaning-laden phenomenon. These limitations also offer direction for future narrative inquiry examining how patient experience leaders construct meaning around resistance to change within acute care hospital environments.

Recommendations

The findings of this qualitative narrative study provided insight into how PELs in acute care hospitals made sense of resistance to change through the stories they told about

their work, their organizations, and their roles over time. While participants' narratives illuminated the relational, organizational, and emotional dimensions of resistance, they also revealed opportunities for further inquiry into how resistance is narratively constructed, interpreted, and managed within healthcare systems. The following recommendations are grounded in participants' stories, the strengths and limitations of the current study, and the literature reviewed in Chapter 2.

Conduct Additional Narrative Studies Across Different Contexts

A central strength of the current study was its ability to capture nuanced, contextually embedded narratives of PELs working across diverse health systems. At the same time, participants' stories suggested that resistance may be narrated differently depending on clinical setting, leadership proximity, and operational demands. In their accounts, context shaped not only what resistance looked like, but how it was understood and responded to.

Future research could build on this work by conducting narrative inquiry within more focused clinical environments, such as emergency departments, perioperative services, ambulatory networks, or behavioral health units. These settings are characterized by distinct patient flow pressures, staffing models, and regulatory constraints that may shape how resistance is experienced and storied. Prior research indicates that contextual factors such as workload, unit culture, and leadership presence influence engagement with change (Cao et al., 2024; Gabutti et al., 2023). Context-

specific narrative studies would allow closer examination of how resistance narratives are constructed within particular environments.

Additionally, studying PELs embedded within single-site organizations rather than multi-hospital systems could generate deeper insight into how local culture and leadership shape sensemaking during change. Because participants in the present study represented multiple geographic regions and organizational structures, future research that narrows contextual boundaries may further illuminate how specific environments influence the stories leaders tell about resistance.

Explore the Experiences of Frontline Clinicians to Compare Perspectives

This study centered the narratives of PELs, offering insight into the experiences of individuals responsible for facilitating organizational change and translating patient experience priorities to frontline teams. Participants' stories frequently referenced how resistance was perceived among clinicians, underscoring the importance of understanding how frontline staff construct their own narratives of change.

Future research should examine the stories of nurses, physicians, and allied health professionals who receive and implement patient experience initiatives. Existing literature suggests that frontline acceptance of change is shaped by perceived benefit, workload, readiness, and involvement in planning (Cadel et al., 2022; Nilsen et al., 2020); however, few studies have directly compared how these experiences are narrated across stakeholder groups.

Narrative inquiry with frontline clinicians could reveal whether resistance described by PELs is interpreted similarly by staff or whether additional relational, cultural, or emotional meanings emerge. Comparative qualitative designs, such as parallel narrative studies or cross-case narrative synthesis, could illuminate how different stakeholders construct meaning around organizational change while remaining aligned with narrative methodology.

Examine the Role of Leadership Behaviors and Structures in Supporting or Hindering PEL Effectiveness

Leadership influence emerged as a central narrative pattern in this study, with participants describing how leadership alignment—or lack thereof—shaped how resistance unfolded and was interpreted. Participants narrated how executive sponsorship, middle-management engagement, and clarity of accountability influenced staff willingness to engage with patient experience initiatives.

Future research should explore the narratives of healthcare leaders themselves, including nurse managers, service line directors, and executive sponsors. Narrative studies focused on leadership perspectives could deepen understanding of how leaders interpret their role in supporting patient experience work and how they make sense of competing organizational priorities. Multi-perspective qualitative designs would offer richer insight into how leadership narratives interact with those of PELs and frontline staff, shaping organizational readiness and the perceived legitimacy of change efforts.

Investigate the Impact of Change Fatigue on Patient Experience Outcomes

Change fatigue emerged as a prominent narrative pattern, with participants describing its influence on staff engagement, emotional exhaustion, and resistance to new initiatives. In participants' stories, fatigue was constructed as a cumulative, relational experience rather than a discrete reaction to a single change effort.

While existing literature has documented the prevalence and impact of change fatigue in healthcare settings (Cao et al., 2024; Duan et al., 2025), limited research has examined its relationship to patient experience outcomes. Future studies could examine how narratives of overload and exhaustion intersect with patient experience performance through qualitative, quantitative, or mixed-methods designs. For example, researchers could explore how staff stories of fatigue relate to communication breakdowns, inconsistency in care practices, or diminished emotional presence with patients. Such approaches would deepen understanding of systemic barriers to patient-centered care while remaining conceptually aligned with the current study.

Explore How Patient Experience Data are Interpreted and Used Across Organizational Levels

Participants frequently narrated challenges related to how patient experience data were communicated, framed, and acted upon, noting that punitive messaging or insufficient context often generated disengagement and resistance. These stories suggested that resistance was shaped less by data itself than by how meaning was constructed around it.

Future research should examine how patient experience data are interpreted and narrated by managers, frontline staff, and organizational leaders. Qualitative studies focused on sensemaking processes surrounding survey results could illuminate discrepancies between intended and perceived uses of data. Understanding how data narratives circulate within organizations may help identify strategies for promoting learning-oriented, psychologically safe approaches to performance feedback.

Conduct Longitudinal Narrative Inquiry to Examine How Resistance Changes Over Time

Although participants' narratives reflected experiences spanning multiple change initiatives, data were collected at a single point in time. As a result, the study could not capture how resistance narratives evolve during specific change efforts or how PELs' interpretations shift as organizational conditions change.

Future research employing longitudinal narrative inquiry could follow PELs over time as discrete initiatives unfold, allowing examination of how resistance, adaptation, and sensemaking develop across stages of change. Prior literature supports the value of longitudinal qualitative designs for studying organizational learning and change processes (Gabutti et al., 2023). Such designs would provide deeper insight into the durability of resistance, pacing of initiatives, and relational work required to sustain engagement.

Expand Research to Include Health Systems Where PEL Roles are Structured Differently

Participants in this study represented organizations with varying levels of formalization in patient experience roles. Some narrated clearly defined leadership structures, while others described diffuse or inconsistently defined models. These stories suggested that role design influenced how resistance was interpreted, navigated, and addressed.

Future research should examine PEL narratives within alternative organizational structures, such as systems where patient experience responsibilities are embedded within nursing, quality, or operations rather than standalone departments. Existing literature suggests that organizational structure influences role clarity, authority, and alignment (Caci et al., 2025). Narrative inquiry across different structural models could illuminate how role design shapes resistance, credibility, and effectiveness of patient experience leadership.

Implications

This qualitative narrative study explored how PELs in acute care hospitals constructed meaning around resistance to change through the stories they told about their work, their organizations, and their evolving leadership identities. Participants' narratives revealed not only how resistance was experienced, but how it was navigated through relational engagement, reframing of purpose, and adaptation to organizational constraints over time. The implications that follow are grounded directly in these narrative accounts

and reflect story-based actions demonstrated by participants rather than abstract conceptual alignment.

Drawing from specific participant experiences, including efforts to re-sequence change initiatives, translating patient experience work into operational priorities, rebuilding trust through leadership presence, and engaging resistance through collaborative sensemaking, this section outlines practical implications for advancing patient-centered care. These implications are situated within the emotional, relational, and structural realities described by participants and are offered in support of positive social change at the individual, organizational, and broader healthcare system levels.

Individual-Level Positive Social Change

At the individual level, participants' stories highlighted opportunities to support workplace well-being for both clinicians and experience leaders by reframing resistance as a signal of strain rather than unwillingness to improve care. PELs consistently narrated resistance as emerging from emotional fatigue, competing demands, and diminished capacity. For example, Participant 2 described how nursing leaders withdrew trust following rapid implementation of hourly rounding, while Participant 4 observed cognitive overload among long-tenured managers during system integration. Participant 15 similarly recounted how repeated resource constraints reshaped his understanding of resistance from opposition to misalignment.

Through these experiences, participants described adopting more empathetic leadership approaches grounded in acknowledgment of emotional labor and capacity

limits. Participant 2 shifted toward smaller, sequenced changes that allowed staff to regain confidence, Participant 4 emphasized presence and relationship-building on units, and Participant 15 reframed experience initiatives in operational terms to reduce perceived burden. These story-based actions illustrate how interpreting resistance relationally enabled PELs to engage staff collaboratively, surface concerns constructively, and sustain their own professional identity during periods of change.

These narratives suggest that individual-level well-being may be supported when leaders attend to resistance as an early indicator of overload and respond with pacing, presence, and reframing rather than compliance-driven mandates. Such approaches have the potential to reduce burnout, strengthen resilience, and improve day-to-day work experiences for both PELs and frontline clinicians by honoring lived experience and restoring a sense of shared purpose.

Family-Level Positive Social Change

Although family-level outcomes were not the primary focus of this study, participants' stories suggested important indirect implications for patients and caregivers. PELs described moments in which staff experiencing fatigue, overload, or poorly supported change struggled to remain emotionally present during patient and family interactions. Participant 4, for example, recounted how cognitive overload during system integration affected leaders' capacity to engage meaningfully at the bedside, while Participant 2 described how strained relationships following rapid change implementation diminished relational attentiveness among nursing leaders.

Through these narratives, participants linked organizational strain to reduced quality of communication and emotional availability during high-stress clinical encounters. These accounts align with literature indicating that clinician well-being influences empathy, attentiveness, and communication with families (Bastemeijer et al., 2019). Participants' stories further suggested that when resistance was addressed through supportive sensemaking rather than pressure or blame, staff were better able to restore relational presence, listen more fully, and respond to family concerns with greater patience and clarity.

By identifying organizational conditions that shape resistance and emotional strain, this study offers narrative insights that may support stronger patient–family communication and reduce frustration during hospitalization. Participants' stories illustrate how leadership approaches grounded in empathy, pacing, and alignment can indirectly enhance family experience by creating conditions that allow clinicians to remain emotionally available.

Strengthening Organizational Readiness for Change

Participants' stories revealed how inadequate preparation, competing priorities, and unclear communication repeatedly contributed to resistance, with readiness experienced as a fluctuating condition rather than a fixed organizational state. Participant 2 described how rapid implementation of hourly rounding without sufficient engagement eroded trust, prompting her to shift toward smaller, sequenced changes that allowed leaders and staff to rebuild confidence. Participant 4 recounted how system integration

created cognitive overload, leading him to prioritize relational alignment and collaboration with trusted clinical leaders before advancing new initiatives. Participant 15 similarly described a turning point when reframing patient experience work in operational terms improved executive alignment and resource support.

Together, these narratives suggest that healthcare organizations can strengthen readiness by conducting structured readiness conversations, intentionally sequencing initiatives, and aligning resources with expectations before launching experience efforts. Participants' stories illustrate that when leaders attend to timing, clarity, and capacity, resistance diminishes and engagement increases. Such story-based actions have the potential to reduce frustration, stabilize teams, and support sustained organizational capacity for patient experience improvement.

Enhancing Leadership Practices

Leadership behaviors emerged in participants' stories as central influences on how resistance intensified or diminished. Participant 4 described how engagement increased when the Chief Medical Officer visibly supported physician communication practices, lending credibility that normalized new expectations. Participant 2 similarly recounted how resistance eased when the Chief Nursing Officer modeled accountability during service recovery and partnered directly with directors in follow-up conversations. Participant 15 narrated a turning point when executive leaders began removing operational barriers and aligning resources with experience priorities, enabling greater traction for change.

Across these accounts, leadership effectiveness was constructed not through positional authority alone, but through trust-building, consistency, and visible barrier removal. Participants emphasized the importance of coherent communication, alignment between stated priorities and operational action, and protecting teams from overload. These story-based leadership practices illustrate how resistance diminished when leaders modeled desired behaviors, demonstrated follow-through, and engaged relationally with staff. These narratives align with literature linking transformational leadership practices to engagement (Frilund et al., 2023), while extending this work by highlighting relational credibility and congruence between message and action as central to how leadership support was made meaningful in everyday practice.

Improving Interpretation and Use of Patient Experience Data

Participants frequently narrated resistance emerging from punitive or decontextualized use of patient experience data. Participant 15, for example, described how early reliance on experience metrics alone failed to secure resources or engagement, prompting him to reframe data in operational and risk-based terms that resonated with executive priorities. Participant 2 similarly recounted how staff disengaged when survey results were presented without relational context or visible follow-through, leading her to convene interdisciplinary groups to review feedback collaboratively and redesign billing communication processes.

Across these stories, resistance was directed not at measurement itself, but at how meaning was imposed through data without relational support or shared learning.

Participants described greater engagement when data were contextualized through dialogue, paired with concrete improvement actions, and embedded within collaborative sensemaking processes. These narrative accounts suggest that healthcare organizations can reduce defensiveness and strengthen trust by presenting experience data alongside lived context, engaging frontline teams in interpretation, and closing feedback loops with visible change. Such story-based practices align with Cadel et al. (2022) while extending existing guidance by illustrating how data use becomes meaningful through relationship-centered learning rather than performance surveillance.

Reducing Change Fatigue Among Staff

Participants' stories consistently highlighted the cumulative impact of multiple simultaneous initiatives on emotional exhaustion and disengagement. Participant 4 described long-tenured leaders struggling to adapt amid system integration and shifting expectations, while Participant 2 recounted how rapid, large-scale implementation of hourly rounding intensified fatigue and eroded trust. Participant 15 similarly narrated how repeated resource constraints compounded the emotional burden of sustaining change, prompting him to rethink how experience initiatives were introduced and supported.

Across these narratives, change fatigue was constructed as a relational and temporal experience rather than a discrete reaction. Participants described greater engagement when leaders acknowledged fatigue explicitly, slowed the pace of implementation, and prioritized sequencing over saturation. These stories suggest that

healthcare organizations can foster more humane and sustainable transformation by intentionally pacing initiatives, reducing competing demands, and providing emotional and operational support during periods of change. Such story-based practices align with existing research on change fatigue (Cao et al., 2024; Duan et al., 2025) while extending it by illustrating how fatigue is experienced through leadership relationships and organizational timing.

Societal and Policy-Level Positive Social Change

Although this study did not examine policy directly, participants' stories aligned with broader societal priorities related to patient experience, workforce well-being, and healthcare quality. Through narratives that reframed resistance as a signal of system strain rather than individual failure, PELs described leadership approaches grounded in empathy, pacing, and relational engagement. Participant 2's emphasis on rebuilding trust through sequenced change, Participant 4's focus on relational bridging during system integration, and Participant 15's reframing of experience work in operational terms collectively illustrate how organizational sensemaking can shift cultures toward shared accountability.

At a societal level, such narrative-informed leadership practices have the potential to strengthen public trust in healthcare delivery, improve patient-reported experience outcomes, enhance workforce retention, and support more equitable care through clearer communication and deeper engagement across diverse populations. By addressing resistance through supportive sensemaking rather than blame, organizations may create

conditions that foster dignity, inclusion, and partnership between healthcare systems and the communities they serve (Bastemeijer et al., 2019; Cadel et al., 2022).

Methodological Implications

Methodologically, participants' stories demonstrated the value of narrative inquiry for examining resistance to change as a relational, identity-shaping, and emotionally nuanced phenomenon. Through temporally sequenced accounts, participants illustrated how leadership meaning evolved across turning points, resource constraints, and relational challenges, revealing dimensions of resistance that would have been difficult to capture through thematic or variable-oriented approaches. Narrative methods enabled exploration of how PELs constructed identity, reframed purpose, and navigated organizational complexity over time.

Participants' narratives also illustrated that virtual interviewing can yield rich, storied data when supported by relational presence and reflexive practice. The depth of participants' accounts highlighted the importance of creating psychological safety in virtual settings and attending to pacing, listening, and co-construction of meaning. These experiences underscore the need for ongoing researcher reflexivity, particularly in practitioner-research contexts, where professional proximity to the field shapes interpretation. Future narrative studies examining healthcare leadership and change may benefit from prioritizing reflexive documentation, relational interviewing, and analytic attention to temporality and identity development.

Theoretical Implications

Participants' stories also contributed to theoretical understanding by reinforcing perspectives that conceptualize resistance as an indicator of systemic misalignment rather than individual unwillingness (Caci et al., 2025; Gabutti et al., 2023). Through their narratives, PELs constructed resistance as intertwined with emotional labor, psychological safety, and collective sensemaking, revealing leadership as an ongoing interpretive process rather than a fixed set of behaviors.

Across accounts, participants narrated identity shifts from operational change agents toward relational sensemakers who translated purpose, mediated competing priorities, and navigated uncertainty through story. These narrative constructions suggest that theories of healthcare leadership would benefit from explicitly incorporating narrative identity, relational coherence, and meaning-making as central elements of sustainable change. By foregrounding how leaders make sense of resistance through lived experience, this study extends existing frameworks to account for the emotional and interpretive labor embedded in organizational transformation.

Empirical Implications

Empirically, participants' stories pointed toward several directions for future inquiry. Narratives that highlighted differences between executive, clinical, and experience leadership roles suggest value in comparative narrative studies examining how clinicians and leaders construct meaning around resistance differently. Participants' accounts of leadership alignment and misalignment also indicate opportunities for deeper

exploration of how executive coherence shapes resistance trajectories over time. In addition, the emotional labor narrated by PELs points to the need for focused investigation of affective demands within patient experience roles, particularly as leaders balance advocacy with buffering frontline strain. Finally, variations in how participants described authority, scope, and organizational positioning suggest further examination of how structural differences in PEL roles influence resistance narratives. These directions emerge directly from participants' stories and extend naturally from the present study while remaining within its scope.

Recommendations for Practice

Participants' stories suggested several practical considerations for healthcare organizations seeking to reduce resistance and support patient experience improvement. Across narratives, early engagement of frontline clinicians emerged as essential for building trust and shared ownership. Participant 2 described how limited involvement in early planning contributed to disengagement during hourly rounding implementation, while later efforts that invited collaboration fostered greater buy-in.

Participants also emphasized the importance of leadership alignment. Stories highlighted how inconsistent messaging and fragmented expectations intensified resistance, whereas coherent communication across organizational levels supported engagement. Participant 4's experiences during system integration illustrated how relational consistency among senior leaders enabled new practices to gain traction, and

Participant 15 described how executive alignment around operational priorities marked a turning point in securing resources for experience work.

Narratives further underscored the need to improve how patient experience data are communicated. Participants described resistance emerging when feedback was presented without context or follow-through, while collaborative interpretation and visible action reduced defensiveness. Participant 2's billing redesign initiative and Participant 15's reframing of metrics in operational terms illustrated how pairing data with dialogue and improvement strengthened trust.

Change fatigue also surfaced repeatedly as a driver of disengagement. Participants recounted how overlapping initiatives and rapid implementation strained emotional capacity, whereas intentional pacing and acknowledgment of workload supported resilience. These stories suggest the value of readiness conversations, sequenced change efforts, and emotional support during periods of transformation.

Finally, participants' narratives highlighted the importance of clarifying PEL role authority and scope. Several described navigating influence without formal power, emphasizing how ambiguity around responsibility limited progress. Participant 15, in particular, narrated greater effectiveness once experience work was aligned with executive priorities, reinforcing the need for clear governance structures that enable collaboration across departments. Together, these story-based practices illustrate how resistance can be addressed through early engagement, leadership coherence, relational

data use, intentional pacing, and structural clarity, offering concrete pathways for healthcare organizations to strengthen patient experience improvement efforts.

Conclusions

This study revealed that resistance to change experienced by patient experience leaders (PELs) in acute care hospitals was not narrated as opposition to patient experience work itself, but as a meaningful response to the organizational, emotional, and relational conditions in which that work unfolded. Through their stories, PELs constructed resistance as a signal of system strain, emerging in contexts marked by competing priorities, unclear expectations, misaligned leadership messaging, and cumulative change fatigue. These narratives illuminated how resistance often surfaced when staff lacked the resources, psychological safety, or relational support needed to understand and engage with patient experience initiatives.

Rather than framing resistance as a barrier to overcome, participants consistently narrated resistance as an opportunity for sensemaking, dialogue, and relationship repair. In their accounts, resistance prompted efforts to clarify purpose, strengthen communication, and rebuild trust across teams. Participants' stories emphasized that sustainable patient experience improvement depended less on compliance-driven approaches and more on leaders' capacity to navigate organizational misalignment, translate expectations across levels, and foster environments in which staff felt heard, valued, and able to contribute meaningfully.

Across narratives, resistance functioned as a defining context through which PEL identity was constructed and refined. Participants positioned themselves as boundary-spanning sensemakers, interpreting organizational signals, mediating competing demands, and carrying the emotional labor of change on behalf of both leadership and frontline teams. Their stories revealed that leading patient experience work required relational credibility, emotional regulation, and moral commitment, particularly within systems characterized by ongoing change and constrained capacity.

Ultimately, this study underscores that resistance to change in healthcare reflects the lived realities of people working within complex systems rather than individual unwillingness or deficiency. When understood through a relational and narrative lens, resistance becomes a source of insight rather than conflict. By centering the stories of PELs, this research highlights the importance of compassionate leadership, intentional communication, and organizational readiness in shaping how change is perceived and enacted. These insights point toward the need for healthcare cultures that acknowledge the emotional labor of change and actively support those responsible for leading it.

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Appendix A: LinkedIn Post

Greetings to my LinkedIn network! I hope this post finds you well. I am currently in my dissertation for my PhD in Leadership & Organizational Strategy from Walden University. I am excited to share an opportunity for anyone who may be interested to participate in my study. The purpose of my study is to explore the factors that cause resistance to change faced by Patient Experience Leaders (PELs) in the Acute Care Hospital setting. If you are a current or former PEL with experience in the Acute Care Hospital setting, please feel free to shoot me a direct message right here on LinkedIn should you be interested in participating in my study. Participation will include an interview via Microsoft Teams that should be no longer than 60 minutes, although it will be dependent on how detailed you may choose to be. In this interview, I will ask you various questions pertaining to the topic at hand. Thank you in advance to anyone who might be interested!

Appendix B: Interview Guide

1. Role and Responsibilities

Can you share the story of how you first became a Patient Experience Leader here? What were your early responsibilities?

2. Perception of Change Initiatives

Think back to a time when a change initiative was introduced related to patient experience. What was going on in the hospital then, and how did you personally experience that change?

3. Experiences of Resistance

Can you tell me a story about a time you led a change effort and encountered resistance?

What was happening at the time, and how did you initially respond?

Looking back, how did that moment influence your understanding of resistance and your approach to leadership?

4. Sources and Meaning of Resistance

In your experience, what kinds of resistance have stood out to you — whether from staff, systems, or even yourself? Can you share a moment that's stuck with you?

5. Organizational Culture and Change

Tell me about a time when the hospital's culture played a role in how change was received. How would you describe the environment during that time?

What does that tell you about how culture shapes patient experience work?

6. Leadership and Working with Resistance

Can you describe a time when leadership — including yourself or others — helped navigate resistance in a productive or supportive way?

What leadership choices made a difference in that situation?

7. Impact on Patient Experience

Can you share a story where resistance to change impacted the patient experience, either positively or negatively?

What did that experience show you about the connection between internal dynamics and patient outcomes?

8. Resources and Support

Tell me about a time when you needed support — resources, time, or people — to implement change. What happened, and how did it affect the process?

Looking back, what support would have helped most in that moment?

9. Motivation and Human Factors

Can you share the story of someone — a peer, staff member, or leader — who really embraced a change you were part of?

What do you think motivated their response?

Can you share the story of someone — a peer, staff member, or leader — who really resisted a change you were part of?

What do you think motivated their response?

10. Lessons and Recommendations

Based on your lived experience, what stories or lessons would you share with a new Patient Experience Leader about working with resistance?

If you had to summarize what you've learned about the factors that cause resistance to change that you have faced as a patient experience leader in one sentence, what would you say?