It is a profitable thing, if one is wise, to seem foolish.
—Aeschylus, in Prometheus Bound

BUILD TRANSFORMATIONAL EXPERIENCES
AND ESTABLISH TRUST

Trust is the foundation on which all relationships are based. One of the reasons trust is essential is somewhat counterintuitive. Without trust, a relationship cannot sustain a healthy conflict of ideas (Lencioni 2002). Trust increases in proportion to the frequency of meaningful interactions. A willingness to express vulnerability is essential to establishing trust. This occurs when you allow others to know you outside the formality of your professional role.

If you have ever been in a conversation about a troublesome emotional experience, either as the attentive listener or the speaker, you will know what I mean. At the conclusion of this conversation, the relationship is never the same. A sense of closeness and appreciation results from this connection. An aphorism states, “It is impossible to hate someone whose story you know.”
A willingness to reveal your frustrations, to admit mistakes, to ask for assistance, and to share your vulnerabilities is an integral component of building transformational relationships and establishing trust.

Engaging in personal conversation for 4½ hours while in a golf cart can do more to establish a sense of trust than having superficial conversations in the hallway for 4½ years. Building physician relationships requires the time and the effort of engaging in meaningful one-on-one conversation. Allowing the physician to appreciate who you are outside the pre-existing assumptions that accompany her interpretation of your professional role is essential to establishing trusting and enduring relationships.

Meaningful change does not occur outside of conversation (Shaw 2002). The dialectic that is experienced in conversations that address a meaningful conflict of ideas is the birthplace of synergy. This healthy conflict of ideas cannot occur in an environment that lacks trust.

**ENCOURAGE SELF-DISCOVERY AND SELF-INTEREST**

The most effective way to influence another’s behavior is by nurturing self-discovery. You cannot teach a person anything. You can only help him discover it for himself. Self-discovery—the ability to make sense of new information or to personally reconnect the dots—accompanies the “Aha!” that can occur in open dialogue about subjects of personal importance. Self-discovery is how adults learn and is the most effective way to influence physician behavior.

The dynamic occurs as follows. Five to seven individuals who are involved in creating something meaningful together sit around a table to discuss the relevance of new information related to the work in question. A facilitator introduces new information or new data. The facilitator then encourages the group to discuss the relevance or implications of this new information. How might the new information affect their behavior? The sharing of individual responses in conversation allows the group to begin to collectively make sense
of what is happening. This is the most effective way to allow individuals to commit to new behaviors. Once they understand the relevance of new information and its potential influence on areas they are interested in, then they can consider various options and appreciate the importance of altering their current behavior.

The most challenging aspect of my personal attempts to influence physician behavior is an inability to bring the individuals around the table to have the conversation in the first place. It appears that they are too engaged in the present way of responding to find the time to discover new and potentially better solutions. Seemingly, persisting and complaining are easier than allocating the time to discover creative, new responses.

According to Chuck Dwyer (1992), you can make people an offer they cannot refuse if you change their perception that engaging in the behavior you seek will serve to enhance what they personally value.

A person’s behavior makes perfectly good sense from her point of view. To get her to willingly commit to new behaviors requires changing that point of view. A person’s behavior is in service of her personal hierarchy of needs or values. Whether I choose to attend my son’s soccer game or to stay late at the office is a reflection of my personal hierarchy of needs/values. What I value is important, but the order in which I value them is even more important. When I cannot have them both—when I must choose—I will choose the one that is more important.

While my behavior is in service of my personal hierarchy of needs/values, the choice of specific behaviors is guided by my existing operating assumptions, beliefs, and attitudes. Members of street gangs behave differently from people in mainstream society. You might be tempted to conclude that their needs/values must be different. However, if you talk to a gang member and ask why he behaves the way he does, he will frequently respond that the gang is his family, the gang trusts and respects each other, and the other members love him like a brother. Family, trust, respect, and love are highly ordered values within mainstream society as well. Gang
members behave differently because they believe that those values are enhanced by behaving according to the norms of the gang. The same values are enhanced for mainstream citizens by behaving according to the socialized norms of their peer group. The choice of specific behaviors, then, is guided by existing beliefs and operating assumptions.

To make someone an offer he cannot refuse, you must know what he values. Many individuals, and this is especially true of physician scientists, have never explicitly identified what they value or how they rank order their values. Without being consciously aware of what you value, you cannot knowingly make choices in service of those values. If choices are made without consideration of your personal values hierarchy, you can be unaware of your own contribution to creating a sense of dissatisfaction with present circumstances. Helping individuals identify and prioritize what they value most is a very useful way to begin to build partnership.

In order for someone to willingly commit to new behaviors, she must change her existing operating assumptions, beliefs, or attitudes. This is only possible by presenting to that individual data that addresses the level of belief that sustains the current way of behaving. As stated previously, this dynamic is facilitated through dialogue. Essentially, you allow someone to conclude for himself that changing his behavior better serves his self-interest.

This process is like redecorating a room. The possibilities of what you might select to put in the room have no end. The challenge is deciding what you are willing to take out of the room. Metaphorically speaking, the pieces of furniture you remove are the operating assumptions and existing beliefs that you are now willing to dismiss as invalid. Creativity is intertwined with destruction. To willingly commit to new behaviors, existing assumptions, beliefs, or attitudes need to be destroyed.

An overwhelming number of physicians value respect, control, fair reimbursement, efficiency, improvements in patient care, and time. If you can allow physicians to see that engaging in the behavior you seek, rather than their current behavior, will serve to better
enhance one of these values, they might change that behavior. Remember, however, that the hierarchy of needs/values is of pivotal importance. If control is valued more than time, and what you propose delivering is incremental time at the expense of control, then your offer may well be refused.

Understanding the motivational sequence is important. When you seek to make an offer that cannot be refused, you are offering a quid pro quo. If the person changes her way of behaving, she will get more of something that she values. The motivational sequence involves three specific questions (Elkind 2004):

1. Is what you propose possible? If the answer to this question is no, there is no deal. You must be able to make your case that what you promise will indeed accrue as a result of new behavior.

2. Are you capable? The answer to this question should be rated low, medium, or high. Your challenge is to move the answer toward the high end of the spectrum. Fundamentally, you ask the question, “What would it take to allow you to feel that you are highly capable of this new behavior?” Then, you must provide this resource.

3. Is it worthwhile—that is, do you want to? This question is really the only important one. Again, the answer to this question should be rated low, medium, or high, and your challenge is to move it toward the high end of the spectrum. If the individual does not strongly want to engage in this behavior, then it tends to go to the bottom of his to-do list, where it becomes rather improbable.

**KNOW THE PLAYERS**

Everett Rogers (1995), Tom Atchison (2005), Malcolm Gladwell (2000), and Manny Elkind (2004) have presented constructs that allow for identifying segments within a community that have the
capacity to more rapidly promote and disseminate change. Those
who are attempting to influence physician behavior should become
familiar with Rogers’s (1995) observations on the dissemination of
innovation. Some physicians are disproportionately effective at influ-
encing the general physician community. With respect to a willing-
ness to change behavior, Rogers segments any community into five
distinct groups:

1. Innovators
2. Early adopters
3. Early majority
4. Late majority
5. Laggards

_Innovators_ comprise between 2 and 3 percent of any commu-
nity. They actively seek new ideas and tend to dance at the fringes
of everyone’s paradigm. Their primary contribution to the com-
munity at large is to be magnets for new ideas. All new ideas are
imported. Innovators scan the horizon and identify new possibil-
ities. However, innovators have very little influence on the rest of
the community. Because they constantly flitter from one new idea
to another, others in the community cannot ascertain whether they
are genius or crazy.

_Early adopters_ are like innovators in that they see possibilities in
novelty. Unlike innovators, they are influential in the community
at large and often serve as the opinion leaders for the group. They
take new ideas and “reinvent them locally.” They adapt the ideas to
the local circumstances, taking into account local resources, history,
and other relevant factors.

Unlike the innovators and early adopters, who are open to new
ideas, the rest of the community takes no cues from outside and are
focused internally. The _early majority_ are influenced by the behav-
ior of the early adopters. When the early majority see the early
adopters successfully adapting new behaviors, they will begin to
copy that behavior. Once this occurs, innovation cannot be stopped.
The late majority is even slower to adopt new behaviors, and laggards often refuse to participate. Laggards, however, should not be dismissed. They often represent connections to the meaningful past. Many times, they offer reflections that bridge to the historical purpose of the group and prevent the group from abandoning traditions of importance.

The innovators and early adopters, who together comprise approximately 15 percent of any group and who, according to Rogers, are open to the importation of new ideas, are distinguished from the remainder of the group by their willingness to risk. The others are risk averse. Given constraints on time and monetary resources, it would behoove those seeking to influence physician behavior to focus their efforts on the early adopters.

In an analogous fashion, Tom Atchison (2005) has categorized the physician community into five distinct groups:

1. Proactive leaders
2. Reactive followers
3. Uncertains
4. Skeptics
5. Cynics

Proactive leaders are similar to Rogers’s innovators and early adopters. Reactive followers are like the early majority; they can be influenced to adopt new behaviors, but they do not want to go first. Atchison’s characterization of the uncertain, skeptics, and cynics adds additional understanding. Uncertains, as the title implies, are individuals who can side either with those who are willing to adopt new behaviors and align with the healthcare organization, or with those who defend the historical status quo. If organizational leaders pay a disproportionate amount of attention to those who seek to maintain the status quo rather than nurture the more progressive and aligned members of the medical community, the uncertain may conclude that their individual needs can be met better by complaining than by complying. Many healthcare organization leaders spend a
disproportionate amount of time trying to convince resistors, especially if they are “big admitters,” rather than promoting those who share the organizational vision. In doing this, they risk shifting the uncertain and losing the support of this middle-of-the-road group.

*Cynics,* who comprise approximately 1 to 3 percent of the group, never offer a positive contribution. They seek to enhance their own stature by being critical of others. These constant complainers disproportionately occupy the time of hospital administrators. They never add anything constructive to the dialogue. Atchison advises that you either ignore them or confront them to identify the specifics of their negatively critical attack, state that they never seem to have anything positive to contribute, and challenge them to present a better idea. Most of the time, the cynics will retreat. If, by some miracle, they actually present a positive idea, publicly put them in charge of implementing that idea.

Do not misidentify skeptics as cynics. *Skeptics* make positive contributions by pointing out the negative. Skeptics are very critical thinkers and are quick to identify defects or inadequacies in proposed initiatives. Because the nature of their response is primarily identifying the negatives, too often the skeptic is seen as being unsupportive or as a detractor, rather than as a potentially supportive constructive critic.

If you can pay attention to skeptics’ criticisms and modify your proposal in accordance with their recommendations, they often will move from being a skeptic to being a proactive leader on this specific initiative. Atchison points out that an accrual of support does not exist among skeptics. You must win them over each time you seek to involve them in an initiative.

Early adopters, proactive leaders, and potentially skeptics catalyze change.

Another useful way of segmenting the medical community to maximize your ability to influence physician behavior is described by Malcolm Gladwell (2000). The following list identifies Gladwell’s three types of disproportionately influential individuals who catalyze ideas through a community:
1. **Connectors** are the equivalent of a human Rolodex. They are rapid disseminators of information. They seem to move in a variety of circles and serve to transfer information over a wide area.

2. **Mavens** are individuals who seem to know something about everything and who delight in sharing that information with no personal gain. Because they are not self-serving, others trust them.

3. **Salesmen** have the capacity to tap into and influence the emotional state of other people around them. This group is disproportionately influential.

I strongly recommend reading Gladwell’s book, *The Tipping Point*, in which he describes the adoption of new behaviors as metaphorically analogous to the spread of epidemics. The analogy is quite strong, and the lessons are readily adaptable to initiatives aimed at influencing physician behavior. If you can identify those members of your medical community who serve as connectors, mavens, or especially salesmen, you can more effectively disseminate and promote supportive new ideas and behaviors.

Manny Elkind (2004) teaches a useful distinction. People segregate into groups labeled matchers and mismatchers. Individuals seem to have a propensity to see in either similarity or dissimilarity. **Matchers** are quite comfortable focusing on similarity. **Mismatchers**, on the other hand, have a predilection for focusing on dissimilarity. In the earlier context, skeptics are mismatchers. They primarily focus on dissimilarity. Internists are often mismatchers because they are taught to think in terms of “rule-outs.” Mismatchers make positive contributions by identifying the negatives in any proposal. They are often mislabeled as naysayers, saboteurs, or nonsupporters, when in fact they see their critical remarks as positive contributions to the final product. When engaging a mismatcher, assess their overall response to the proposal that is being presented by asking, “On a scale of 1 to 10 how do you find this proposal?” In this way, you can get an overview of their impressions and avoid quickly
assuming that they reject the idea out of hand because their first comments are negative.

**LEAD TO CRITICAL MASS**

All groups act to defend the status quo. According to Rogers (1995), only 15 percent of any group (innovators and early adopters) can imagine possibilities in novelty and are willing to consider adopting a new paradigm. Since in a town-hall democracy a majority of the group must vote in favor of a proposal for it to be adopted, physicians collectively reject all truly new ideas. Therefore, to promote change, you must be willing to lead not to consensus, but rather to critical mass. Critical mass has been empirically defined as the square root of \( n \). Change nothing, but pilot everything!

I would like to introduce the idea of approaching change using the metaphor of moving a slinky. The early adopters represent the front rings of the slinky, the square root of \( n \). Pilot new ideas with the early adopters. The success of those ideas is analogous to pulling the front rings away from the other rings, creating a tension that will cause the remaining rings of the slinky to seek to catch up with the front rings in their own time.

Managing to consensus would be analogous to trying to push the slinky from behind thereby having to overcome the inertia of the entire group.

**APPRECIATE DIVERSITY**

Appreciate that excellence is a form of deviant behavior. You become excellent because you are doing things that “normal” people do not want to do. This represents a statistical truism. For any observation to be seen as different from others, it must exist outside of two standard deviations of the mean of the population of observations in question. Distinctively exceptional behavior, therefore, represents
deviancy. This concept is synchronous with the notion of piloting new behaviors with early adopters, who are seeking to achieve superior results through innovative, creative approaches.

Another approach differs from the usual attempts to change physician behavior. People have a natural tendency to focus on what is wrong or missing. Through identifying the negative, we seek to transform it or replace it with something that, we hope, will be a more successful behavior. Seeking to achieve change through appreciative inquiry takes a converse approach (Cooperrider and Witney 2005). Rather than focusing on what is missing, appreciative inquiry seeks to identify elements of the desired behavior already in evidence. After analyzing why or how those desired elements are already present, those wanting to create the change import and replicate those critical elements into other areas within the organization.

By understanding the factors that allow for the expression of this behavior in those settings, you can promote its expression in others. By showing that the desired behavior already exists, you can emphasize that segments within the organization are already successfully practicing the new behavior. This promotes a can-do attitude. Others within the organization can readily appreciate that success is possible, because success is already present somewhere else in the organization. Moreover, that it is already present locally creates legitimacy in the minds of the risk-averse 85 percent of the population who only accept cues from inside (Rogers 1995).

One aspect of appreciative inquiry is the concept of positive deviancy (Sternin 2003). The few individuals within an organization who already manifest the desired behavior become the focal point of investigation—the positive deviants. Again, this approach studies what allows the few individuals who already behave as desired to stand out as exceptions rather than focus on those who fail to manifest the desired behavior. By identifying what promotes the successful manifestation of the desired behavior, those variables can be shared in a way that promotes the behavior in the rest of the group. For this to work, the positive deviants must be subject to the same constraints as everyone else in the group; the larger group must be allowed to repetitively
practice the new behavior; and there must be in place a metric that provides positive feedback that reinforces the new behavior.

**PUT IT TOGETHER**

**Identify Shared Interests**

In seeking to influence physician behavior, start at points of agreement. If the interests of individual stakeholders are represented as circles, areas of shared interest and/or agreement are shown where the circles overlap. Initiatives that address the aligned areas of self-interest are desired by everyone and would achieve collective support. This seems to be a simple concept, yet, in my experience, rather than seeking to identify areas of shared and common interest, conversations almost invariably degenerate into arguments over which position is more correct.

**Focus on the Future**

In addition to focusing on areas of agreement, remain focused on the future. Focusing on the future creates hope, whereas focusing on the past degenerates into arguments over who is to blame for the current state of affairs. For the same reason, begin from where things are, not from where they ought to be. I am amazed at the amount of time that is wasted talking about how things should be rather than accepting them as they are. Wishing that things were different is not an effective strategy.

**Remove Barriers**

Remove barriers whenever possible. When you can remove an existing barrier, you become an instant hero. You do not have to convince
anyone of the value achieved by taking away a known negative. Doing so achieves instant credibility and builds trust. Physicians usually appreciate making processes more efficient, thereby saving time and reducing frustration (especially when they do not have to modify their own behavior in the process).

By contrast, attempts to introduce a new and hopefully positive change are far more likely to generate skepticism. Moreover, the adoption of new behaviors is not always met by the hoped-for positive results. This journey into the unknown is often more cautious and less enthusiastic, and failure erodes confidence and trust. For example, physicians have resisted many of the initiatives aimed at enhancing patient safety. They are often reluctant to participate in electronic physician order entry or medication verification, and these initiatives have not resulted in the anticipated benefits.

Remember Columbo and the Veg-O-Matic Salesman

My two favorite role models for influencing physician behavior are Columbo and the Veg-O-Matic salesman, Ron Popeil. Columbo appears as a naïve novice, deferential to the suspect in question. He plants ideas in the form of questions and cautious hypotheses. By analogy, make new ideas appear to be owned by those whose behavior you seek to influence. Planting seeds through Socratic questioning is a very effective approach. No one likes to be told what to do.

The Veg-O-Matic salesman is successful because he never appears to be selling. His approach is to first identify with the frustrations that are experienced by those he seeks to influence. By identifying with their frustrations, he gains acceptance. They appreciate that he understands their circumstances. After identifying with their frustrations, he asks if they would be interested in resolving those frustrations. He then introduces the potential solution to their problems, and, at that point, they are eager to buy.

In a similar way, it is important to appreciate the points of frustration that annoy physicians. In many ways, seek to be a servant
leader, one who understands and empathizes with the perspectives and needs of others. By trying to resolve their needs, you gain acceptance, credibility, and trust.

Too often, we approach physicians because we see them as important to achieving our objectives. We are perceived as selling, and they become guarded and resistant. If we can begin by identifying with their frustrations and allowing them to see that our proposal holds the promise of ameliorating those frustrations, physicians can become eager buyers and willing participants.

Resolve the “Yeah, But…” Response

In seeking to promote new behaviors, a useful approach involves attempting to resolve the “Yeah, but…” response that invariably surfaces (Morgan 1997). Individuals can appreciate the potential value that attends your proposal. As they listen to your proposal, they respond with a series of “Yeahs” as they appreciate the potential positives in what you propose.

At the conclusion of your presentation, however, they are quick to say, “But….,” The “but” identifies elements in their current behavior that they believe produce deliverables that are important to them. So, while they see the potential in your proposal, they fear loss of the deliverables that accompany their current way of behaving. Seeking to resolve this tension allows you to identify middle ground. Seek to introduce the new while preserving the critical elements of the old.

Ask the Right Type of Questions

I would like to caution you against conducting physician focus groups or asking individual physicians to respond to your ideas by asking, “What do you think?” Several potentially negative consequences result:
• If the physician likes what you are proposing, he will likely hold you responsible for creating the result. Asking the question creates an expectation.
• The response to your idea will end up being the sum and substance of the physician’s contribution to achieving the result. Giving the advice would be the equivalent of serving as the architect on the project.

It is far better to approach the physician or physicians by asking, “If this is a good idea, what could we do together to bring it about?” Framing the question in this way achieves two important outcomes. The physician’s response will be much more measured, and, when the time comes to initiate the project, you can seek to engage her in the activities that she identified. What you want is not only input, but also engagement.

Use Dialogue to Reach Collective Wisdom

I would again like to emphasize the critical importance of dialogue. Nothing meaningful happens outside of conversation. The answers to all problems are in the collective wisdom of the assembled group. As Margaret Wheatley (1994) said, “When people of shared purpose are given access to the relevant data and allowed to engage in soulful dialogue, magic happens.”

SUMMARY

A successful pathway to influencing physicians involves the following:

• Develop trust. Remember that you build trust not only through transformational relationships that express vulnerability, but also through a willingness to understand physician needs and perspectives.
• Engage physicians in Socratic dialogue, allowing them to make sense of your proposal, connect the dots for themselves, and create meaning.
• Appreciate that all behavior is in service of an individual’s hierarchy of needs and that the choice of specific behavior rests on existing beliefs and operating assumptions. Getting others to commit to new behaviors requires changing their perception to believe that engaging in the behavior you seek will serve to enhance what they value.
• Create change as you would move a slinky, focusing on the disproportionately influential early adopters, proactive leaders, and converted skeptics.
• Focus on success by utilizing appreciative inquiry, starting from where things are and not from where they ought to be. Emphasize points of agreement.
• Remove barriers.

Also, understand the importance of positive vision. A negative vision seeks to make something go away. The intensity of the negative stimulus will cause people to commit to action. While negative vision can galvanize people to act, it never sustains change. In essence, the intensity of the need to respond generates the response. The response reduces the intensity of the stimulus, simultaneously reducing the motivation to act. The result is a saw-tooth pattern of activity. Positive vision, on the other hand, seeks to bring something new into being. People embrace a vision not for what it says but for what it does, not because it is probable, but rather because it is irresistible. Positive visions are sustaining. Articulating that positive vision is the primary responsibility of leadership.

NOTE

REFERENCES

Atchison, T. 2005. Personal communication with the author.


Elkind, M. 2004. Personal communication with the author.


