



positive action

A new management technique called positive deviance has helped to reduce childhood malnutrition in 41 countries, and achieve a 31 per cent drop in MRSA in US hospitals. But is the UK ready to spot 'deviants'? **Jane Lewis** investigates

In the early 1990s, Jerry Sternin of Save the Children was faced with what seemed an impossible task – to improve infant nutrition problems in Vietnam with no money, limited time and in a potentially hostile environment.

He used an approach based on the work of Dr Marion Zeitlin, a leading nutritionist, in the 1980s. She had discovered that in most communities, even very deprived ones, there were some families that fed their children better than others, within the same constrained resources. It involved identifying 'positive deviants' (PDs), in this case, people whose children were well nourished, but who had access to exactly the same resources as everyone else.

Jerry, along with wife Monique, knew that there were women in each village who were paid to weigh the children and report back to the relevant authorities. They trained these women to plot the weights of children on a scattergram which identified that there were a small number of well-nourished children. Then the women were trained to ask those families with the well-nourished children questions about what they were fed, how they were fed and any other relevant practices such as hygiene.

The results were shared with village elders, and they showed that even in the poorest families, some children were significantly better nourished than others. They observed what these PDs did differently so that the community could share PD meals, see how well the children gained weight and practise how to feed their children in the same way.

As a result, malnutrition in the community dropped by an astonishing 85 per cent. These new

feeding practices broke with the local convention that children should only eat rice. The PDs were feeding their children small shrimps and crabs, cooked with the rice, and the tops of sweet potatoes. The practices were then used by mothers with subsequent children and passed on to new mothers so that when Jerry returned three years later, gains in infant nutrition had been maintained.

The PD approach has since been used successfully to tackle malnutrition in 41 countries, producing sustainable reductions in malnutrition of between 65 per cent and 85 per cent.

Jerry and Monique Sternin also used the PD technique to address other deep and intractable social problems, such as female genital mutilation in Egypt, girl trafficking in Indonesia, reducing teenage pregnancy in the US and in improving the health and welfare of transsexual sex workers in Indonesia. During these projects, he learned that society's view of the problem may not be the way that those affected see it.

For example, teenagers do not worry about having sex and producing babies, but through the PD enquiry process, the Sternins learned that teenagers did later worry about missing out on education. This project then involved the teenage community finding ways to stay in education which had a longer term impact on the levels of teenage pregnancy. The approach enabled the teenagers to identify their own solutions.

PD in business

The technique of 'amplifying positive deviance' was first brought to the attention of change managers in

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2000, in *Surfing the Edge of Chaos*, a textbook on managing change and complexity by Richard Pascale, Mark Millemann and Linda Gioja. Since then, Richard Pascale and Jerry Sternin have collaborated on publications and projects that bring PD to the corporate and organisational environment in the

Case study: Genentech

The example of pharmaceutical company Genentech clearly shows the benefits of PD and how it differs from copying best practice or benchmarking. In 2003, Genentech introduced a highly effective preventative drug for asthma. Despite its proven effectiveness, sales languished.

Trying to find an answer, managers spotted that two of their 242 sales people were selling 20 times more of the drug than their peers. Two women in Texas had overcome resistance in their target audience. Inquiry revealed that allergists and paediatricians were not used to administering medication by intravenous drip, and that the two PDs had identified that a standard sales pitch would not work. They supported doctors and their administrative staff to learn about the benefits to the lifestyles of children, and how to administer and record infusions of the drug.

However, management insisted on scrutinising results, believing that the territories must have been configured unfairly. Eventually, when it was proved that there had been no unfair advantage; an edict was issued by conference call to adopt the PD practice. Reps were not involved in understanding the PD approach nor shown in a practical way how to do it, with the result that only a few of the other reps adopted the practice. If the community is involved in identifying and solving the problem, it is less likely that you will hear the cry of 'it can't work here', or 'we're not like them'.

developed world. Successful organisational PD projects include the development of thermal transfer technology in Hewlett-Packard, significant improvements in pharmaceutical sales in Merck and Genentech, and the turnaround of the private investment arm of Goldman Sachs in New York. In each case, a few PDs were found whose successful practices were identified by their peers and shared, as in the case study below.

Six years ago the Sternins won a grant from the Ford Foundation to spread PD practices worldwide, for community and organisational purposes, and the Positive Deviance Initiative at Tufts University, in the US city of Boston, was born. Jerry and Monique are now its directors and the globally recognised leading exponents of the PD approach.

In the last year, they have been involved in a project with the Veterans Health Administration Hospital Group that has reduced levels of MRSA infection in hospitals by between 20 and 50 per cent across the US, again using the PD approach. It has been particularly effective in changing the behaviour of consultants and doctors.

PD is one of a number of asset-based approaches to change, such as appreciative enquiry. Its unique feature is the highly practical approach to formulating and re-framing the problem and in learning from existing practice within resources that are already available. It is about discovering the wisdom you already have, then acting on it. See figure 1 for a comparison of PD with more traditional change methods.

The four stages of a PD project

Whilst ownership of a PD project must rest

Figure 1. PD versus traditional change methods

Traditional approach to change	PD approach to change
Management identifies the 'problem' and benefit to the organisation of solving it	The people affected identify the problem and the benefits gained for themselves by solving it
Management owns the data that measures the problem and monitors progress	The people are facilitated to develop their own data and use it to make the problem concrete and to quantify solutions
Ownership and momentum for change come from above – leadership is through traditional project management processes	The people are offered help to solve their own problems; they own the problem and its solution; those affected are coached and facilitated through the journey of change
Deficit-based – finding what's wrong	Asset-based – finding what's right, amplifying successful practices
Improvements are brought in from outside, through experts, benchmarking and so on	Improvements are spread from the inside outwards, through finding existing solutions and amplifying them
Improvement strategies are driven by logic – people are expected to think their way into a new method of acting, emotion and other non-rational resistance tend to be underrated	Improvement comes from seeing and experiencing a different way of working – acting their way into a new way of thinking, using their own data to see improvement
'Transplant rejection' can occur through resistance to practices imported from outside (the 'not invented here' syndrome)	Self-replication occurs – latent wisdom is tapped and tangible/visible benefits are delivered quickly by the people, for the people
Flow of thought is from problem identification and solving to solution identification; best practices are applied within defined parameters	Flow of thought starts with problem definition but moves straight away to those who have found a solution within the community and context
Focus starts on those who are directly associated with the problem – easy to fall into a blame culture	Starts by getting perspectives from all potential stakeholders and focuses on those who have found a solution without 'putting them in the frame'

with the people who need to deliver change, facilitation of the process is critical.

Define the problem and the desired outcome

The first step is to find the right people to work on the problem. This can involve a cross section of staff and stakeholders. They are the experts. A core group of champions is likely to emerge if the PD approach is clearly explained.

Sometimes the problem is shared and easily definable – most people can relate to the need to feed children well, or to reduce deaths due to MRSA, and it becomes even more personal when your unit goes from MRSA negative to positive.

However, sometimes, as in the instance of teenage pregnancy, the 'establishment's' view of the problem may be different from that of those directly involved. It is critical to frame the problem in such a way that those affected can own – which

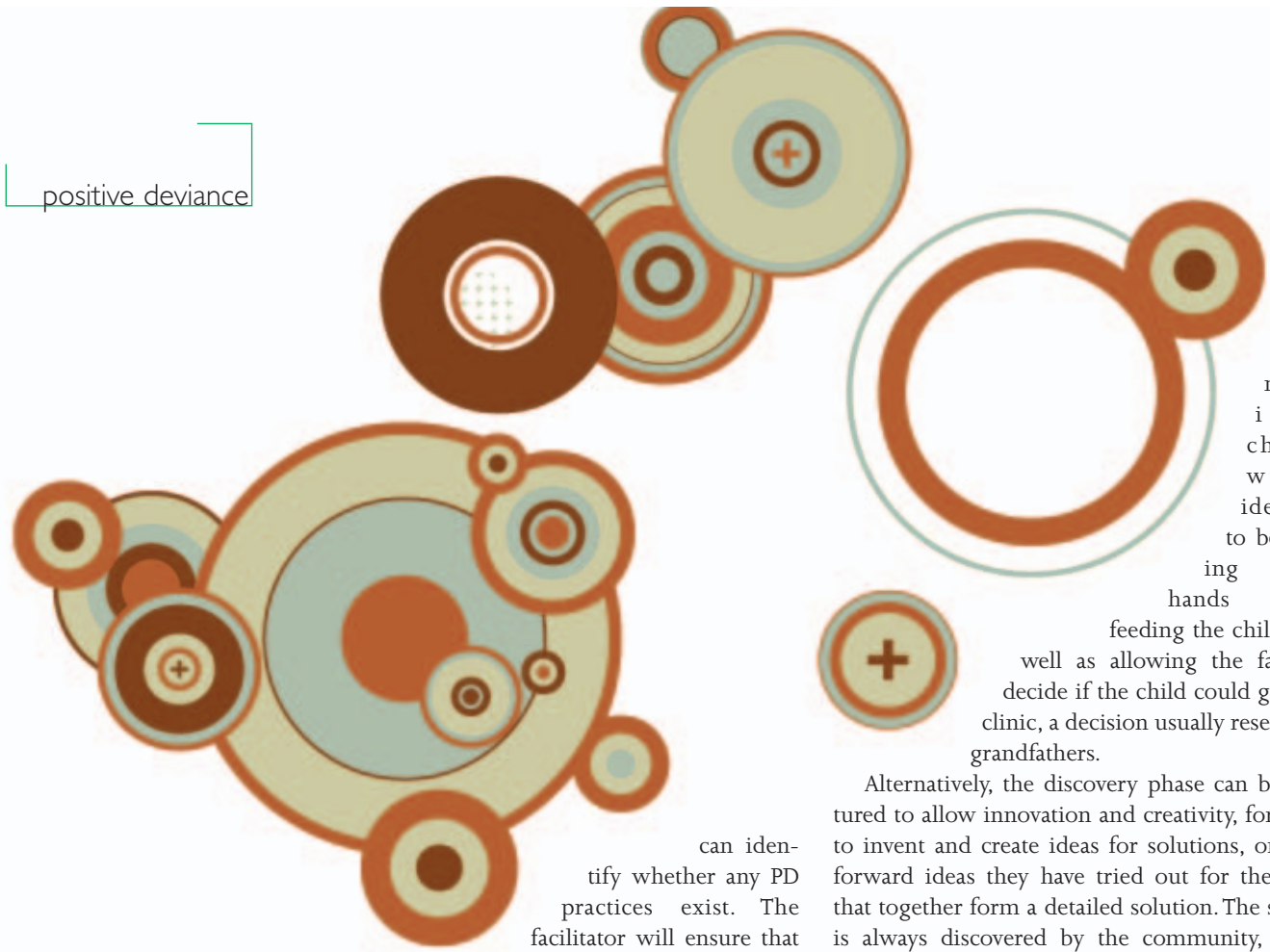
is personal to them – and to define an outcome-based, measurable solution. There is no typical team for PD enquiry – the main factor is that it should include members of the community that needs to change and others with natural authority in that community, such as the women who weighed the children in Vietnam.

Jerry says he always invests time in watching and observing what goes on, finding the formal and informal power structures, before deciding who to involve. In sub-Saharan Africa, faced again with the problem of infant malnutrition, he found it was the grandfathers who needed to be recruited as they had significant influence over child-rearing.

As with all change initiatives, it is essential to find the 'what's in it for me?' factor.

Determine if there are any PDs

By talking to members of the community, the team



can identify whether any PD practices exist. The facilitator will ensure that the community starts to define key measures, for example, sales volumes, specific customers, territory and the ratio of successful to unsuccessful sales calls all keep track of progress. The inquiry process can be very simple, using five or six powerful questions such as: 'How do you prepare for a sales call? What do you do when you visit the customer? What happens next?'

In an organisation, these measures may well be the same as those already used by management, but it is important that baseline data is collected or at least understood by the community so that they own it and believe in its veracity. This data will show up any PD results.

It may be that, as in the Genentech example, one or two people outperform all the rest, and may have the whole answer. In other cases, the answer or answers may not be so immediately obvious. Data collected will need to highlight positive results across a range of relevant processes and/or individuals.

Discover what the PDs do

Having identified through measurement where PDs exist, the community now needs to find out what they actually do that makes the difference. Observation is critical, again focused around key questions and critical incidents. As in all stages of a PD exercise, it is the people involved who carry out the observation. Results do not need to identify individuals, only what they do. In Mali, PDs with well-

nourished children were identified to be washing their hands before feeding the children, as well as allowing the father to decide if the child could go to the clinic, a decision usually reserved for grandfathers.

Alternatively, the discovery phase can be structured to allow innovation and creativity, for people to invent and create ideas for solutions, or to put forward ideas they have tried out for themselves that together form a detailed solution. The solution is always discovered by the community, for the community.

This happened in the case of the Veterans Hospital Administration, Pittsburgh, where teams including nurses, doctors, porters and cleaning staff worked together to share ways of reducing hospital acquired infection. Adding to the work started by the hospital's adoption of the Toyota Production System, the Veterans Hospital drove down the rate of MRSA by generating a sense of shared responsibility for infection control.

Design a way of sharing PD practices

The key to sharing the practices is to design a very practical way of copying them, and to have a feedback mechanism that gives you immediate access to results, as a computer game does. It is well-recognised that much of the addictive power of computer games comes from the immediate feedback and recognition of success the player gets.

In Vietnam, each day a different mother learned to cook a balanced meal for the community and each member brought some ingredients based on the PDs' practices. The children were regularly weighed and were seen to be growing and well nourished.

In the Pittsburgh MRSA project, a nurse who had been very suspicious of the improvement project found her views were being listened to. Well aware of the pervasive nature of the superbug, and realising that people were not as aware as she was, she

designed a way of showing everyone how germs spread using a product that glowed in ultra-violet light. Having spread it onto the pens that people used to sign in, a check later in the day showed that the glowing product was to be found all over the ward. MRSA was no longer an abstract idea. People then learned, adopted and sustained handwashing, cleaning and gowning practices.

Why and when PD works

PD projects deliver change quickly and without resistance by stakeholders. Key factors that make it successful are:

- co-defining outcomes with key stakeholders, such as top management, but in terms that address the ‘what’s in it for me?’ factor of the people whose behaviour needs to change
- making the problem as concrete as possible – as the nurse did with MRSA by using the powder that glowed under UV light
- ownership – people will adopt practices they have created themselves. Even if the manager knows that the practice has been done before somewhere else, the sense of creation and ownership by the team and for the team is essential
- measurement – PD projects must be, in Jerry Sternin’s words, ‘bathed in data’. Measurement gives the group the lens with which to focus, and the feedback to progress.

Why has the PD approach been slow to take off?

Blogs on the internet suggest it could be the next big thing. PD works on the reverse principle to most quality initiatives. It is a totally practical, non-intellectual approach.

Most quality and change programmes start from the premise that knowledge influences attitude, which then changes practice. Sternin asks change champions to reflect on whether providing knowledge in itself really changes behaviour – for example, how many people know doctors that smoke and drink?

A concern voiced in workshops, is that managers in most organisations would be reluctant to delegate the level of authority required for teams to solve their own problems – hence the need to involve them and share data.

‘Tongue-biting’ is an essential requirement for managers in a PD project. It is important that man-

agers are included in the projects and have a voice, but also are encouraged to let the team work things out for themselves using the data they produce.

PD may be seen as a way of doing without expensive consultants, and therefore may not be attractive to consulting firms and institutions that are used to promoting proprietary models and standards, and enjoying the revenue that instruction, audit and compliance activities deliver. Without their marketing and promotional power, PD remains low key.

Its success depends very much on the communities and particularly on the quality of facilitation. There is, therefore, still a need for facilitators who will apply an approach that has many similarities to coaching. The community, rather than the individual, identify the goals, the options and the way forward – but in the case of PD, it is all based on measurement and data, which reduces the risks of going off-track, a common concern about coaching.


PD in the future

PD has delivered huge social changes worldwide. It has been instrumental in making important behavioural changes to combat MRSA, and high-profile companies have been enjoying its benefits.

Their lead is likely to be followed by others. In the Pittsburgh Veterans Administration Hospitals, everyone now sees infection control as their responsibility.

Amongst the alumni of the Consulting and Coaching for Change programme at Oxford, interest in PD has been ignited. This community consists of global change specialists who recognise where some elements of their own practice and experience share common ground with the PD approach.

A few management consultants have already started using the PD approach, some in conjunction with the measurement offered by six sigma and the excellence model.

PD is a highly practical way of delivering change and cuts through the psychobabble of some change management approaches. It also boasts high-level current thinking about the human aspects of change, employee engagement, and how to overcome resistance. All in all, PD is a rich tool for change management which yields creativity, innovation and long-term solutions 

Jane Lewis is a partner at Woodward Lewis, a consultancy that specialises in offering organisations practical help to support their staff and leaders and has organised the UK’s first public seminars on positive deviance. She is a member of the Change Leaders, a community practice of HEC Paris and Oxford University’s Consulting and Coaching for Change programme alumni.

The Waterbury Hospital PD experiment

A medium-sized community and teaching hospital in Connecticut, Waterbury is licensed for 357 beds. Each year it cares for approximately 15,000 inpatients, treats more than 21,000 people in its outpatient medical clinics and handles more than 56,000 emergency department visits. In its Xpress Care facility, for non-emergent injuries and illnesses, staff treat over 540 patients per month. Its behavioural health centre, one of the largest in the region, logs more than 50,000 outpatient visits per year. Meanwhile, its one-day surgery department serves approximately 6,000 area residents annually, including adults and children.

Dr Tony Cusano, an attending physician at the hospital (and assistant clinical professor at Yale) noticed that patients were complaining about the number of medications they had to take following hospital visits.

Nurses let him know that on discharge from hospital, it seemed that many patients were confused about their medications. This issue had been discussed before, and committees established to find solutions, but little progress had been made.

Cusano decided to test it out and enrolled the help of some colleagues to call patients after discharge to check compliance with their drugs regimen. To their dismay, they found that 61 per cent of patients were not taking their prescribed medicine correctly. At around the same time, the CEO of the hospital, Dr John Tobin, had learned about positive deviance, and asked Jerry Sternin to run some workshops.

Cusano and his nursing and administrative colleagues implemented the PD four-stage process to identify and spread PD behaviour. Following PD practice, they focused on the 39 per cent of patients who were taking their medication correctly.

The Waterbury team phoned a selection of the PDs at home within 48 hours of discharge (initially, about 80 calls by 22 nurses and physicians). They used seven standard questions such as: 'Did you have any new

medications? Were you instructed on how it works and what to watch for?' They also asked logical follow-up questions if indicated, then tabulated the findings, and documented the details. They spoke to the patients themselves, as well as their families.

The use of a small number of powerful questions is an important feature of the PD approach.

During this process, they discovered simple things mattered – having a correct list of medicines to take, insisting on getting explanations about the medication prescribed, and having a structured way of taking the medicine. The staff took these ideas on board and also created their own, such as making post-discharge calls to patients and designing a pink card with the patients' medication, dosage and frequency of use.

The phone calls revealed some interesting stories and patient perceptions: 'I was on drug A prior to arrival. I was given a prescription for drug B at discharge. My discharge instructions said, "resume previous medications", so I did.'

A patient was instructed to take a blood thinner every other day. The patient interpreted 'every other day' as Tuesday and Thursday – the week, of course, only consisted of Monday to Friday, not the weekend.

The team also identified actions that the staff had control over that made a big difference to patients:

- properly documenting admission/discharge medications
- adequately communicating the medications to the patient/family
- educating patients on how to solve medication problems if they arise
- addressing patients' financial or logistical issues
- enlisting the patients and their family to take the responsibility to assure their own safety
- following up to assure that the treatment process was in order

People did know that these actions were a

good idea – they just did not do them before. After the follow-up phone calls were made, the team discovered that virtually 100 per cent of the patients were taking their medication appropriately. The staff who made phone calls uniformly expressed pleasure with their ability to make a real difference for the patients, and with the positive feedback they received.

There was resistance to the team's enquiry in other areas of the hospital but the data Cusano presented and the team's success showed that this approach had succeeded where other approaches, including reengineering, had not. Cusano says that he had to have faith in the process and in his team, and allow them to learn by giving up hands-on control.

The impact on the team was that time was saved – two admissions to the hospital each month had been as a result of not taking follow-up medications properly – and that staff-patient relationships improved.

The hospital now has 100 per cent use of the tools designed to eradicate the medication problems and 85 per cent of all its patients are taking medicines in the way they should. The CEO, Dr Tobin, felt that the programme worked because it was in keeping with the caring and healing nature of the organisation. It reached and engaged physicians and nurses, traditionally resistant to changes in working practice.

