

Communicating What Works!
Applying the Positive Deviance Approach in Health Communication

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“It [positive deviance] is the most fascinating idea anyone has had to solve the problem [of hospital-acquired infections] in a century”.
Gawande (2007, p. 27).

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Most health communication campaigns, especially those that draw upon the diffusion of innovations tradition, are premised on the following tenets (Rogers, 2003; Singhal & Dearing, 2006; Singhal, 2010): That new health information or ideas come from the outside, are promoted by a change agency through expert change agents, who use persuasive communication strategies to educate their client audience.

In this short essay, an alternative conceptualization of diffusing health innovations is broached whose premise is that innovative ideas are often lurking within the system, where the change agents' primary role is to facilitate a process whereby which the community can self-discover these ideas, and where dialogue and “social proof” results in an organic spread of the innovation in contrast to passive adopters buying-into a change agency's prescription.

This alternative approach to diffusing health information or ideas is known as the Positive Deviance (PD) approach. PD *is an approach that enables communities to discover the wisdom they already have, and finds a way to amplify it* (Pascale & Sternin, 2005; Singhal & Dura, 2009). We illustrate the key tenets of the PD approach through an example of its application in dramatically reducing hospital-acquired infections in U.S. health care settings.

Despite being 100% preventable, hospital-acquired infections (HAIs) kill 100,000 people each year in the U.S., mainly because hygiene protocols are compromised. That is more deaths than breast cancer, HIV/AIDS, and road accidents combined. Adherence to hand hygiene protocols in U.S. hospitals is pitifully low -- averaging between 35 to 40 percent (Singhal & Greiner, 2008). That means an interaction between a health care worker and a patient in a US hospital, more than likely, carries the risk of infection transfer. A leading bacterial source of HAIs is Methicillin resistant *Staphylococcus aureus* (MRSA), a deadly pathogen resistant to commonly-used antibiotics. MRSA infections have quintupled in the U.S. in the past decade, and MRSA is a formidable enemy for it can survive for up to six weeks on surfaces and transmits easily through contact.

Amidst this alarming reality, a handful of U.S. hospitals – Billings Clinic in Montana, VA Hospitals in Pittsburgh, Albert Einstein in Philadelphia, Franklin Square Hospital Center in Baltimore, and the University of Louisville Hospital Center -- have shown sharp, almost

unbelievable, declines in MRSA infections in the past three years, ranging from 84 to 30 percent (Buscell, 2008; Lloyd, Buscell, & Lindberg, 2008; Singhal, Buscell, & McCandless, 2009; Singhal & Greiner, 2008).

What are these hospitals doing differently? As opposed to the traditional approach of focusing on what does not work, and communicating with, motivating, and rewarding employees to fix those problems, these hospitals are focusing on what works, believing that among its employees are individuals who practice certain simple yet uncommon behaviors that prevent MRSA transmission. For instance, in these hospitals, the following uncommon behaviors were observed:

*A patient who refuses to make eye contact with a doctor or nurse if he does not hear the tap run or the sanitizer's dispensing swish. He then alternatively looks at the wash basin and the health care provider until the non-verbal equivalent of "please wash your hands" is understood.

*A pediatric anesthesiologist who carries her little patients in her arms to the operation theater. She notes that the act of carrying a child, in contrast to wheeling the child in, has a calming effect on the baby, is highly reassuring to the parents, and creates a compassionate ambience in the surgical theater. Further, a calm baby means that it is easier to administer anesthesia, hook IVs, and such.

*An ICU nurse who is not afraid to hand a sanitized gown and a pair of gloves to a surgeon who drops in to check on his patient. While most nurses dare not verbally confront a surgeon, she knows that a cordial attitude and warm smile helps her overcome the power differentials.

These individuals are "positive deviants" because their "deviant" behaviors, many of them communicative, are not the norm; and "positive" as they model the desirable MRSA-prevention behaviors. These positive deviants – patients, doctors, and nurses – make distinctive and valuable contributions to enhancing quality of care and patient safety. In the PD approach, through a set of dialogue and discovery processes, essentially communicative processes, the multiple identities and contributions of the positive deviants are collectively mobilized and amplified for the larger public good. As more people discover these positive deviants among them (social proof), and learn how they practice safety, the norm across the institution begins to shift (Singhal, 2010).

Evaluations of PD initiatives in the U.S. and in over three dozen countries show that one of the main reasons why PD works is because the community owns the solution, self-discovers it through dialogic inquiry, and there is "social proof" that those ideas can be implemented locally with no extra resources (Pascale, Sternin, & Sternin, 2010; Singhal & Dura, 2009; Dura & Singhal, 2009). Positive deviance is now being applied widely in U.S. hospitals to address such diverse issues as medication reconciliation, diabetes control, end of life diagnosis, and HIV/AIDS prevention. In overseas contexts, PD has been used to address malnutrition, childhood anemia,

the eradication of female genital mutilation, curbing the trafficking of girls, increasing school retention rates, and promoting higher levels of condom use among commercial sex workers.

Health communication scholars and practitioners can gain much from further incorporating this asset-based approach in their quest to improve the quality of life of individuals and communities.

References

- Buscell P. (2008). Mapping the positive deviance/MRSA prevention networks at Pennsylvania and Montana health care *facilities* shows promise." *Prevention Strategist*, Autumn, 41–45,
- Dura, L., & Singhal, A. (2009). Will Ramon finish sixth grade? Positive deviance for student retention in rural Argentina. *Positive deviance wisdom series, Number 2*, pp. 1-8. Boston, Tufts University: Positive Deviance Initiative.
- Gawande, A. (2007). *Better: A surgeon's notes on performance*. New York: Metropolitan.
- Lloyd, J., Buscell, P., & Lindberg C. (2008). Staff driving cultural transformation diminishes MRSA. *Prevention Strategist*, Spring, 10–15.
- Pascale, R.T., & Sternin, J. (2005). Your company's secret change agents. *Harvard Business Review*. May, 1-11.
- Pascale, R.T., Sternin, J., & Sternin, M. (2010). *The power of positive deviance: How unlikely innovators solve the world's toughest problems*. Boston: Harvard University Press.
- Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York: Free Press.
- Singhal, A. (2010). Turning the diffusion of innovations paradigm on its head. In A. Vishwanath & G. Barnett (Eds.) (2010). *Advances in the study of the diffusion of innovations: Theory, methods, and application* (pp. in press). New York: Peter Lang Publishers.
- Singhal, A., Buscell, P., & McCandless, K. (2009). Saving lives by changing relationships: Positive deviance for MRSA prevention and control in a U.S. Hospital. *Positive deviance wisdom series, Number 3*, pp. 1-8. Boston, Tufts University: Positive Deviance Initiative.
- Singhal, A., & Dearing, J.W. (Eds.) (2006). *Communication of innovations: A journey with Ev Rogers*. Thousand Oaks, CA: Sage
- Singhal, A., & Dura, L. (2009). *Protecting children from exploitation and trafficking: Using the positive deviance approach in Uganda and Indonesia*. Washington D.C.: Save the Children.

Singhal, A., & Greiner, K. (2008). Do what you can, with what you have, where you are: A quest to eliminate MRSA at the Veterans Health Administration's hospitals in Pittsburgh. *Deep Learning*, Volume 1(4), pp. 1-14. Complexity-in-Action Series. Allentown, NJ: Plexus Institute.