Physician as Leader V: From Theory to Practice Regarding the Diffusion of Innovative Practices

William Bergquist, Ph.D.

Having explored some of the styles and competencies that enable a physician to be successful in leading a healthcare organization, we are now ready to look at the processes to be engaged by a physician leader in helping to diffuse innovative medical practices. I will turn one last time to the wisdom offered by Mindi McKenna and Perry Pugno (2006), who place great emphasis on the role played by a physician leader in supportive and enabling innovative ideas to be engaged, reviewed, and revised in their organization. We see this emphasis displayed as part of an extensive quote they offer from Daniel Sands, MD, MPH, who at the time was a faculty member at Harvard Medical School, and Chief Medical Office and Vice President of Clinical Strategies at the Aix Corporation. Dr. Sands offers this important insight regarding the role played by the physician leader in the diffusion of innovation (McKenna and Pugno, 2006, p. 106):

> People who aspire to lead should choose the level and field they want to impact. Many people who make medical discoveries are not leaders, or agents of change. It takes a certain type of person to create new innovations, but these skills are different from the skills required to bring about the dissemination and adoption of innovation. For example, I didn’t invent email, nor was I the first to use it in clinical care. I did spread the idea—at policy levels, and through speaking and writing.

In this final essay in my series on physicians as leaders, I further explore the specific skills and styles needed by leaders to bring about the dissemination and adoption of innovative perspectives and practices.

McKenna and Pugno (2006, p. 106) contribute themselves to this exploration of the dissemination process when presenting an informal description of the stages of dissemination first presented by William Frist, MD (cardiothoracic surgeon and US Senator) and Norman Shumway, a noted medical innovator:

> In the first stage, doubters all around you say 'It won't work; it's never been tried before.' After several successful experiences with animals, you enter the second stage, and the same doubters say, 'But it won't work in man.' One successful clinical patient later, they tum around, shake their heads, and mumble, 'Very lucky. But the patient really did not need the operation in the first place. Too bad the tragedy occurred; they'll probably try it again.' ... After four or five clinical experiences, critics call it 'highly experimental. Too risky. Probably immoral. Certainly unethical.' And someone in the back adds in a whisper, 'I understand that they probably had a number of deaths that they have not reported.' The fifth stage is characterized by critics saying, after 10 or 15 successful patients, 'May proceed cautiously in carefully selected cases, but most patients with this defect don't need the operation anyway.' In the sixth stage, after a large series of success, some critics, say, 'I hear that a number of their patients are now dying late deaths,' while other critics are saying, 'So-and-so elsewhere cannot get the same results.' Finally, in the seventh stage, the critics now say, 'I know this is a very fine contribution. A straightforward solution to a difficult

> problem. I predicted this. In fact, I had the same idea long before they even started. Of course, we didn't publish.

This portrayal of the barriers and pitfalls associated with medical innovations offers us a quite candid view of what seems to be occurring in many medical settings. Drs. Frist and Shumway should know given their own record of innovative (and controversial practices).

I would suggest that this portrait complements a more detailed description offered by Everett Rogers and his research companions (Rogers, 1962) based on their own extensive work in bringing about innovative practices (such as water purification) in communities throughout the world. In this essay, I offer my own description, based on Roger's five stages of diffusion. I will insert quotes from McKenna and Pugno's book where appropriate, and further enrich my description with the insights offered by Drs. Frist and Shumway.

Diffusion of Innovation

Physician leaders are often seeking to offer new ideas to those they are seeking to influence. The old world and old ideas are no longer of great value. Something new is present or on the horizon. McKenna and Pugno(2006, pp. 93-108) devote an entire chapter to the notion of physician and pioneer—leading innovation in health care. They quote J. Peter Geerlols, MD (Family Physician, Chief Medical Officer, Allscripts Healthcare Solutions, Inc.), who notes that: " Not all executives are leaders. Not all physician executives are physician leaders. One of the characteristics of leaders is that they constantly test new and better processes that lead to improved quality and effectiveness."

In alignment with Dr. Geerlois's conclusion, a visionary physician leader might declare:

> I am the one to introduce this innovation; furthermore, I keep ahead of other healthcare leaders by offering the new idea before they do. This might mean that I am encouraging the world to embrace an innovation that is absurd or even dangerous. I might instead be offering an innovation that is indeed valid and potentially of great use.

There would then be a pause, as the visionary leader finds they are also in alignment with Drs. Frist and Shumway:

> The problem is that I can't get anyone to accept this innovation or even take it for a "test run." The resistance to my new idea is great. It is indeed hard to learn how to do something differently if we have learned how to do it successfully the "good old way."

The crisis of medical innovation often resides in the matter of diffusing a new idea. This crisis is exacerbated in a VUCA-Plus world of volatility, uncertainty, complexity, ambiguity, turbulence, and contradiction (Bergquist, 2025a). These conditions in the world of healthcare create a swirling storm of competing ideas that contradict one another and are constantly being revised, removed, or reconsidered.

My colleague, Suzi Pomerantz, identifies this world as a snow globe filled with "*flitter*" (a combination of flakes and glitter). We can't see the scene in the middle. We can't see through the snow globe, because all the flitter is in the way. Ms. Pomerantz suggests that the flitter inside is clouding everything. The globe is constantly shaken and thrown around, so the content inside never settles. Given all of this, an appreciation of innovation diffusion stages is critical for the physician leader.

For the past half century, a model of innovation diffusion, offered by Everett Rogers (1962), has guided the thinking and perspectives of many people who are involved in innovative initiatives of all kinds (ranging from water purification systems to the distribution and use of contraceptive devices to the introduction of new digital technologies in a "flat world"). While popular with certain people (especially in public health), the diffusion of innovation model and research, ironically, has not itself diffused very successfully. It did find some visibility in the writing of Malcolm Gladwell's *Tipping Point* (Gladwell, 2002). He offered a somewhat condensed and (some would say) distorted version of Rogers' diffusion model. Following the publication of Gladwell's best-selling book, some leaders in the field of medicine began to pay attention and began looking for tipping points.

I propose to do some diffusion of Rogers' model (hopefully without major distortion) by applying it in a preliminary manner to the approach a physician leader might take in seeking to diffuse an innovative idea. I will borrow from the work of Sally Kuhlenschmidt (2010), who has provided an insightful metaphor regarding diffusion. I begin with the birthplace of new ideas in healthcare.

Innovators/Explorers

These are the men and women who boldly go where no one has gone before (to borrow from the intro to Star Trek). These are the brave (and sometimes foolish and often impractical) people inside (and often outside) health care organizations who declare that they are going to be the first to venture out into the healthcare wilderness, bringing only the bare essentials to stay alive. They usually haven't gathered much information about the terrain into which they are going to travel. They often are not really clear about why they are moving out into the wilderness or what they expect to find when they get "out there." As McKenna and Pugno suggest, these innovators and explorers are sorely needed in mid-21st-century health care.

Types of Innovators/Explorers

I would suggest that there are several clusters of innovators/explorers in health care. The first cluster consists of the "idea people." They produce new ideas that seem to come "out of the blue." Second, some produce new combinations of old ideas. Third, there are those innovators who bring an old idea over from one field or discipline to another field or discipline, often combining medical research findings with those in biology, psychology, or sociology.

In each of these instances, the Innovator/Explorer is likely to experience a high rate of failure. Either the idea doesn't work, or there is great resistance to the idea—and it is never accepted. At the extreme, this new idea will produce a paradigmatic revolution that threatens to alter the very way in which we view our world. As Everett Rogers notes, "The more we know about how to do something, the harder it is to learn how to do it differently."

There is a second cluster of innovators in which we often find physician-leaders. These are the practice leaders. They have innovated not primarily with new ideas, but rather with new programs or new strategies for change. They are the first to offer a training program in the use of a new technology (or the first to fund a new program). They are the first to embrace a new surgical procedure or the first to install a new pay-for-service policy in their hospital. Like their fellow innovators who produce a new idea or product, these practice-leader innovators (as Frist and Shumway note) are rarely received, at least initially, with enthusiastic support. Their new programs and strategies often meet with failure. They feel out of step with everyone else and wonder if they really belong in this hostile healthcare setting.

Role of Physician Leader

How might a physician leader best address the needs of the Innovator/Explorer? First, we know that all learning and new ideas emerge within a threshold between profound challenge and substantial support (Sanford, 1980). On the one hand, if there is a great deal of support and not much of a challenge, then the person dwelling in the threshold is unlikely to find much motivation to take a chance. He might remain contented on the threshold or is more likely to grow bored and return home. This is rarely the condition being faced by the Innovator/Explorer. It is much more likely that there is too much challenge and not enough support. If there is nothing but challenge, then the anxiety can be overwhelming.

The person dwelling in the threshold is overwhelmed with anxiety and the desire (perhaps need) to survive; "The wilderness is too much for me. I'm being attacked on all sides." What is the response to this challenging condition? Sometimes it is counterattack: "I will have to spend all my time and energy fighting off the attackers." This is the response, as the old saying goes, when someone spends all their time fighting off alligators and soon forgets that they were sent there to clear out the swamp. A second response is also common. This is the flight (rather than fight) response: "I need to get out of here!" Or there is the freeze response: "I won't survive unless I sit absolutely still, and maybe they won't see me."

Under these challenging (and often overwhelming) conditions, a primary role to be played by a physician leader is the provision of sufficient support to counter the challenge. This doesn't mean taking over from the Innovator/Explorer: the leader can't take on the Innovator/Explorer challenge; however, it does mean the leader can provide assurance, can point out where small successes have already been achieved, and can help members of her healthcare system craft a strategy for something more than just survival.

The physician leader and other members of the healthcare organization can be a bit more realistic and a bit more focused regarding the direction in which their organization is moving. This strategizing often involves moving through three domains: (1) the domain of information (where the organization is right now), (2) the domain of intentions (where the organization wants to be at some point in the near future) and (3) the domain of ideas (how the organization can get from where it is right now to where it wants to be) (Bergquist and Mura, 2011).

The Innovator is often comfortable dwelling in the domain of ideas. They frequently love to generate many new ideas. On the other hand, the Innovator is frequently indifferent to or even uncomfortable dwelling in the domains of information and intentions. They aren't very realistic or practical, nor do they have a clear direction. While a physician leader doesn't want to take away the spirit of adventure and the willingness to journey out into the wilderness, this leader can help temper the Innovator's (or the organization's) inclinations to stay only in the domain of ideas. The leader can ask something about the resources the Innovator is bringing with her into the wilderness, while other members of the organization might identify resources that the Innovator might need to survive their journey.

The leader might ask what other people think about the Innovator's venture (and how they might react to her ideas). This leader might also inquire about how the innovator will return home from the healthcare wilderness. Thoughtful advice can be provided to the Innovator/Explorer about how she might best portray her journey to other members of the organization. The leader might also ask the Innovator a difficult question (from the domain of intentions): Why is she going out into the wilderness? While the leader might not expect a clear answer, they will at least encourage some pondering about the motivation on the part of the Innovator. From an assessment perspective, the physician leader might ask the Innovator about her criteria of success: “How will you know whether or not this new or adopted idea works?”

The physician leader can work in yet another way with the Innovator. They can become a “learning coach” by periodically asking the Innovator to identify what she is learning from this new venture. This might be considered *Formative Learning*—gaining new insights while in the midst of a project and modifying the project based on these insights. This learning probe can take place instead at the end of the project or a major segment of the project. This might be considered *Summative Learning*: “What did you learn from this project and how will you make use of this learning in the future?”

Finally, there is the crossing of boundaries when medical innovations and explorations emerge from the combination of two or more old ideas or from the use of an old idea in a new field or discipline. When this occurs, resistance is often found among those who have been using the old ideas for many years. As Frist and Shumway observed, they resent the “newcomer.” The leader can help the Innovator confront this resistance. The (communications) expert can be particularly helpful in suggesting ways in which the Innovator can make effective use of metaphor, story and language that the holders of the old ideas can appreciate and that honor their contribution. The old idea-holders will themselves feel like innovators if they can see how their old idea is being engaged in new ways and with new effects. Furthermore, a physician leader can help the Innovator frame the criteria of “truth” or “success” in ways that appeal to both the original holders of the old ideas and those who are about to discover the recombined or reapplied idea for the first time.

Early Adopters/Pioneers

The Early Adopters are the ones who are willing to “venture West” after the explorers map out the healthcare territory. The Early Adopters are willing to embrace or at least try out a new idea – often because in other areas they have themselves been innovators. As a result of their own past experiences, these pioneers do not need much convincing. They will try out a new idea or procedure, find its faults, assist in its improvement, and tell the world that it has great potential. In many instances, the Early Adopters are the “make or break” folks. If they don’t support or try out the new idea, then no one else is likely to get on board the covered wagon (or train) as it “heads West.”

Types of Early Adopters/Pioneers

There seem to be several different types of Early Adopters. First, there are the funders. They pay for the wagon or train (and often the wagon master/facilitator). While funding sources is very important during the early stages of an innovation, there is a second cluster of men and women who are invaluable in moving this innovation to early adoption. These are the sponsors of innovation. They let the world know that this is a “good” idea. These sponsors often hold institutional status and have credibility, so their “say” about an innovation can make a difference.

These may be the leaders to whom McKenna and Pugno often refer in their book on physician leadership. McKenna and Pugno (2006, p. 63) lead off one of their chapters with an appeal made in this regard by Randall Oates, MD (Family Physician Founder and President, Docs, Inc.): “It is tough to come up with names of widely recognized physician leaders. The fact that I can't immediately list recognizable physician leaders is in itself telling. We physicians lack leaders who can influence, thus raising the bar for the profession. Leadership is needed - individual or through professional organizations." Where are the sponsors and influencers in health care? Where are the leaders who run interference for doctors like Frist and Shumway who are seeking to bring an innovative idea to fruition in contemporary health care?

Closely related to this second cluster are those women and men who actively promote the innovation. These promoters neither have the money (funders) nor the formal institutional position of authority and credibility (sponsors) to bring about early adoption of the innovation. The promoters are like Johnny Appleseed—moving across the land planting seeds. They are likely to bring in credible endorsers who don't plant the seeds; rather, the endorsers are eating the apples. The promoters make sure that other people see the endorsers eating the apples!

A fourth cluster of people who help move innovations to early adoption are those who bring order to the innovative process and identify how best to administer these innovations. These are the early managers who take over from the Innovators (who are often disorganized). Seymour Sarason (1972) identified the critical role played by these managers when describing the creation of new settings. From his perspective in the 1970s, Sarason noted that managers are often bringing concepts and practices from the old order into the new order. In this way, they could thwart the efforts of healthcare Innovators who are particularly involved in the creation and promotion of new products and processes rather than improved administrative or customer services). His insightful analysis still seems to hold true.

McKenna and Pugno (2006, p. 63) turn once more to insights offered by Dr. Geerlofs. An important distinction is drawn between those who leaders in healthcare who focus on project and those who focus on patients. Geerlofs then suggests that some project-oriented members of the healthcare community are the Innovative pioneers, while others, as Sarason suggests, are those who manage the innovations:

> Some of us are driven to improve the healthcare system. It's hard to know where that motivation comes from. Others derive satisfaction from helping individual patients.
>
> Pioneers don't worry about status quo. They're interested in what's new that could make a difference - perhaps a new technology or financing innovation. Executives, on the other hand, are primarily responsible for helping their organizations be financially successful in the next quarter. So they're under a lot of pressure to be conservative. But they, too, make an important contribution because they can help their organizations take bite-sized steps toward innovation and transformation. They are in a position to put the innovations into action.
>
> Sometimes unrecognized as physician leaders are the 'nuts and bolts' action takers; those physicians (and others) who by themselves won't change the world, but are open to taking the necessary small steps, one after another, to move us forward. Organizations would do well to identify these practical pioneers and find a way to mentor some of them into future leadership roles.

In their role as "executive" or "nuts and bolts action taker," the physician leader can make all the difference regarding the success of an innovative perspective or practice. I turn now to the various rules that the physician leader can take in this regard.

Role of Physician Leader

What then are the ways that a physician leader can assist the Early Adopters? It is usually more than nuts and bolts. First, it is important to acknowledge, as in the case of the Innovators, the Early Adopters are often enamored with ideas. They are inclined to move forward without sufficient information and not a clear set of intentions. They will try out any new idea and are the Innovator's best friend with regard to taking a risk. A physician-leader working with the Early Adopters often nudges them into becoming more realistic. They are encouraged to do a little more data gathering before devoting themselves to a new idea. Those who serve as leaders in the Early Adopter's organization are likely to find themselves in the business of helping the Early Adopter clarify the reason(s) for taking on a new idea. Early Adopters are often overwhelmed with new projects. They are frequently not very disciplined in their allocation of time and resources. They need to clarify their intentions and set priorities—this is where the supportive (but challenging) leader can be of greatest assistance.

The physician leader who is working with Early Adopters will be of great value in encouraging reflection—particularly with regard to the lessons to be learned from both successful and unsuccessful projects. Typically, the Early Adopter is not only a risk-taker but also someone who often jumps from one bright new idea to another.

As a physician leader on whom McKenna and Pugno (2006, p. 97) often rely, Peter Geerlofs has offered a cautionary note in this regard, especially regarding the "Geek physician":

> [These physicians] who love technology aren't always the best leaders to help an organization transform. The nature of early adopters is that they are sometimes more interested in the technology itself than the transformed process the technology could enable. They tend to quickly move from one new technology to another, never pausing to discover what it could do for the organization.

What can be learned from the project already engaged? Were the time and resources devoted to this project worth the outcome that was achieved? While Early Adopter are to be commended for supporting new ideas and innovations, they are also likely to become disillusioned when many of the new ideas and projects they embrace don't work out.

Rather than backing away from support for new ideas, the Early Adopter needs to begin asking the right questions before supporting the new idea. Their physician leader can play an important role in this regard. The leader should begin asking the right questions in the midst of (formative learning) and at the end of (summative learning) of a new project. A thoughtful and provocative leader can assist the Early Adopter in identifying these questions and, more generally, can encourage the Early Adopter to pause and become more of a learner throughout the process of embracing a new idea.

There is also the matter of interpersonal relationships. The early adopter (perhaps even more than the lonely innovator) can "get under other people's skin" as "know-it-alls" or "naïve enthusiasts." McKinna and Pugno (2006, p. 97) turn once again to Dr. Geerlofs' caution about the "geek physician":

> Most importantly, non-technological physicians cannot relate to [these geek physicians]. "Of course he can make an EMR work—he's really into computers." And thus [early adopters] aren't really helpful in accomplishing the mainstream adoption of technologies that offer real value for the practice of medicine. True physician leaders are not seen as "technologists" but as respected clinicians who're interested in improving the underlying process of healthcare.

As pioneers, Early Adopters have much to learn about the new terrain in which they are traveling and about how best to navigate this terrain with others working with them in a healthcare system. A skillful physician leader can assist in this challenging process of continuous learning regarding ways to be effective and influential in the challenging world of mid-21st-century healthcare.

Early Majority/Settlers

The next two diffusion categories are filled with men and women who are most likely to need a nudge from the leaders of their organization. The Early Majority generally seeks clarity and consistency. Above all, they want to settle down in a safe place rather than venturing forth into new territory. This is especially important in contemporary health care systems that are filled with VUCA-Plus. The leaders of their organization can provide this clarity and consistency, thus setting the stage for hesitant acceptance of the innovation by the Early Majority.

Members of the Early Majority also like to see evidence that new ideas are valid and proven. Frequent research updates and attendance at healthcare workshops and conferences can be invaluable in this regard. Members of the Early Majority often request guidance offered by leaders of their organization because something new (innovation) has happened in their organization. They must adjust to this change. They are good “organization men” and “organization women” (to use an old phrase from the mid-20th Century). They want to cooperate and adapt to the changing conditions in their organization. Like settlers on the frontier, those in the Early Majority are primarily in the business of surviving in a healthcare environment that can sometimes seem quite hostile.

The Challenges

The primary challenge is immediately apparent with regard to assisting someone in the Early Majority. Those in the Early Majority must be convinced that they need the new procedure or program in their organization. Certainly, as “loyal” members of the organization, they look to their leaders for guidance and support. They also want assurance that the evidence they are receiving regarding the innovation is credible and of value to them. Members of the Early Majority are much more selective than the Early Adopters.

Those in the Early Majority want some proof before committing to anything—procedure or program. How do I know that this new health care procedure will work? Can you assure me that this innovative program will be effective and of value to me? Do we have any evidence that this procedure or program is worth the money we must spend to bring it into our health care system? In populating the American West, these are the settlers who waited until they knew that there was something to settle into. They waited for reports from the pioneers and checked to see if these reports were accurate. They looked to the Lewis and Clarks of their world to provide credible accounts of the “true” West.

Role of Physician Leader

What kind of issues are those in the Early Majority likely to bring up if they are working with a physician leader? First, those in the Early Majority are likely to be attracted to the domain of information. They not only want evidence that the innovation can be of value; they want information about everything associated with the innovation before moving forward. The Early Majority are often trapped by “analysis paralysis.” They keep waiting for sufficient information and evidence to be accumulated so that risks are minimal. They don’t want to be surprised. They are settlers who move West only after the pioneers have mapped out the territory and blazed a trail that is clearly marked.

The physician leaders of an organization will often have to nudge members of the Early Majority forward and help them identify one or more compelling reasons to take a risk and move forward. These compelling reasons reside in the domain of intentions. The Early Majority are motivated first and foremost by security. This is their primary career anchor--to engage Edgar Schein’s career model (Schein, 2006). This, however, is not their only anchor.

What stirs their passion other than just security? Perhaps it is technical/functional competence, general managerial competence, or even service to other people (to mention three of Schein's other anchors). The leader might ask: "What are the important rewards that you (member of the Early Majority) envision will be waiting for you at the end of this journey?" "In what way(s) is the journey itself going to be rewarding?"

Physician leaders should be aware of several dynamics that are unique to the Early Majority. First, reasoning is highly valued by most members of the Early Majority. They not only like to linger in the domain of information, those in the Early Majority also like to assign this information in clear and tidy categories. However, with the encouragement of their leader, members of the Early Majority also need to trust and honor their own intuition—as Jonah Lehrer (2009) suggested in his provocative book, *How We Decide*. Second, those in the Early Majority need to know that they are not alone. A member of the Early Majority wants to know that they are in the Early Majority rather than being an isolated outlier. They want to settle in a community, not live alone out in the wilderness. An effective leader will help this member of the Early Majority to find an enduring network of support amid a challenging healthcare world of innovation and change.

Third, in keeping with their orientation toward rationality and information, those in the Early Majority are likely to be quite tactical in their approach to problems they confront in their healthcare system. As settlers rather than explorers or pioneers, they will look for short-term, low-risk solutions to their problems. They are unlikely to project very far into the future or look very far beyond their settlement. An effective physician leader should encourage these reticent members of their organization to engage in more strategic thinking—to look a bit more into the future and at the big picture. This does not necessarily mean taking more risks; however, it does mean examining and reflecting on how various elements of their healthcare system fit together and how the actions they do take impact other parts of the system (thereby appealing to their desire for reason and information).

Late Majority/Burghers

The term "burgher" was used in Europe to identify a person who resided in a formally chartered town. I will use this European term because it conveys the essence of Rogers' Late Majority. These people only embrace an innovative idea after it has been fully certified and accepted as a legitimate idea or operation. In Western America, these were the folks who only moved in when the town was "well-established"—with the requisite schools, paved roads, general store, and church. Gladwell uses the term "tipping point" when describing this broad-based acceptance of an idea that has been legitimized. The term "bandwagon" is also appropriate in that the acceptance of a product or service by the Late Majority often means a substantial increase in the number of people using this product or service.

This is the diffusion population most likely to follow leaders (and listen to outside advice) for the wrong reasons. These men and women are also inclined to misuse an innovative product or service or find the experience of using a new procedure to be disappointing. The Late Majority follows the recommendations of leaders or the advice of outside experts for one of three reasons: (1) it is the "thing to do" ("everyone else uses the new version of this software so I guess I should too"), (2) it is the way to "look good" ("maybe it will enable me to get a promotion or at least avoid a negative performance review") ("it makes me look cooperative, seeking to improve myself, ready to change"), or (3) it is a "shiny new toy" that could keep me "entertained " or an "exciting" fad that could "really transform me" (an unrealistic expectation often built on the over-promising of those promoting this procedure or program). The Late Majority are often "immature" about innovation and vulnerable to pitches that don't really represent the real world.

While the “bandwagon” phenomenon can initially be very gratifying to someone who has been laboring for many years to get a new healthcare procedure or program accepted, it can also create major problems—because this new procedure or program is typically not fully understood by the Late Majority and is often misused. This can lead to “casualties.” For instance, the prescription of a new medication may become an “in-thing”; however, Late Majority joggers are likely to over-prescribe this medication. The bandwagon can also lead to failure and anger: “Why doesn’t this darn thing work?” Alternatively, uncritical Late Majority acceptance of a new procedure or product can lead to neglect or inefficiency. The newly purchased top-of-the-line diagnostic tool, for instance, may sit unused. The fancy new hand-held device might serve as nothing more than an alarm.

Role of Expert and Leader

What does all of this mean in terms of working with the Late Majority? First, it means that the physician leader must spend quite a bit of time exploring with those in the Late Majority the reasons for wanting to adopt the innovation. The physician leader can help those in the Late Majority to discover a legitimate and potentially beneficial reason for adopting the innovation. Even if the innovation is adopted for use by members of the Late Majority, the physician leader often must help members of this group differentiate between fads and foundations (viable ideas) in their organization. How does a physician leader differentiate between perspectives and practices that are sound (based on a solid base of valid and useful information) and those that are based on nothing more than good marketing and superficial acceptance by many people in the healthcare world?

How does one determine that a new idea is aligned with the mission, vision, values and purposes of one’s organization? When is a new idea being accepted not because it is based on a solid (and organizationally aligned) foundation, but because it is convenient, low-cost, exciting, or not very complicated? A physician leader can provide invaluable service in helping members of their organization address these difficult issues and discern which healthcare procedures and programs are viable and which are not viable.

Second, the security anchor identified by Schein is even heavier for the Late Majority client or subordinate than it was for members of the Early Majority. Those in the Late Majority/Burgher population often have a very primitive sense of what they expect from their organization in terms of job stability, public recognition, and rewards. Schein writes about the psychological contract that exists in the head and heart of members of organizations. This contract consists of the expectations (conscious and unconscious) that the member has of what they will receive from the organization in exchange for the work they do and attitude they exhibit on behalf of the organization’s welfare.

While I agree with Schein’s observation that these expectations exist in virtually all organizations, I propose that it is not a psychological contract, but rather an enduring covenant that is not easily renegotiated in a health care system (Cassatly and Bergquist,2011). Furthermore, as a covenant that is often unconsciously held, it is not revoked by the organization and is considered a betrayal if not honored by the organization’s leaders. Anger, harassment, and even violence in an organization can often be attributed to this sense of betrayal. Someone who comes from the Late Majority inevitably has embraced a covenant that is unconscious, non-negotiable, and considered external to the Late Majority’s own personal and collective psyche.

Locus of Control

It is important to differentiate between an internal and external locus of control when working with men and women in the Late Majority. Members of this group tend to view the healthcare world from the perspective of an external locus of control. They believe that most of the important things happening in their organization (and in their life) are outside their control. These men and women are inclined to feel helpless and hopeless when considering their own role in the large and complex healthcare system in which they work. They typically don't have the anger that we will witness when considering the mindset and emotions of the last diffusion group (the Laggards). They are more likely to experience low-grade depression.

Those in the Late Majority are particularly inclined to feel betrayed if something changes in their organization that impacts their work or challenges their mindset (attitudes) about their organization. The unconsciously based covenant appears on the surface to be nothing more than a desire for security and organizational stability. Yet, the covenant is much more than this. And it is often emotionally charged. An effective engagement by an organizational consultant or coach who focuses on personal issues often can lead to the surfacing of this covenant. The consultant or coach can assist their client to more realistically address their expectations regarding what they should be doing in the organization and what the organization, in turn, should provide them as a dedicated and hard-working member of the organization.

We often find healthcare burghers entering the scene when there is a stable source of support and funding for a new procedure or program. This is often a chicken-and-egg phenomenon. There is greater support and funding because more people and organizations are involved, and more organizational leaders (Late Majority) are involved because there is greater support and funding. Given the financial instability found in many of our contemporary healthcare systems, we may find a retreat in the funding of new procedures and programs—and a retreat in the number of leaders willing to take a risk. The "burgher" (member of the Late Majority) may return to safer financial ground (the chartered town).

I can identify a set of promotional principles that hold the potential of drawing in members of the Late Majority: surveys, focus groups, and advisory committees. In each of these instances, it is not so important that one make use of the data gathered from these initiatives; rather, these research tools are engaged as promotional tools. Participants in the survey, focus group, or advisory committee get the sense that they are not alone—other people are involved. Furthermore, since they are being asked for their opinion, this activity must be legitimate and mainstream: "If it was not legitimate then they wouldn't be among those being asked." Psychologists, such as Kurt Lewin, have counseled us for many years that cognitive dissonance is created if people participate in something that they don't value. Once they agree to participate, these men and women must support (at least minimally) the activity in order to restore cognitive equilibrium (Marrow, 1969).

An effective promotion of a new procedure or program should target several populations, with different communication strategies being used for each of them. One of these populations can be the Late Majority and cognitive dissonance-based marketing can be an effective leverage point for this constituency. At a more fundamental level, innovative practices will become acceptable if they are associated with other traditions, values, and activities that are already widely accepted and respected by the Late Majority.

Laggards/Homebodies

What about those folks who remain back home? They won't move West under any conditions. They can't be convinced, bribed, or cajoled. In many instances, they are actively engaged in efforts to discourage the widespread adoption of an innovation. They might be silent at first; however, once the innovation begins to pick up steam and threatens to be accepted by the Early Majority, they may become quite vocal. In many instances, the objections of the Laggard to a specific innovation can be attributed to their differing perspective regarding this innovation. They may view the innovation as being representative of a subculture in their organization that is alien to the subculture they prefer (Bergquist, Guest and Rooney, 2002; Bergquist and Brock, 2008). The discarding of managerial "fads" is illustrative. Laggards are likely to assign this term to those who are promoting a "management improvement" or "organizational reform" strategy.

There is yet another source of Laggard opposition to a new healthcare procedure or program. Their objections, in many instances, don't arise from the flaws and threats associated with the innovation—after all, we all appear to be Laggards about certain new ideas that we consider ill-advised or oversold. For many true Laggards, the issue is much more personal. These men and women were innovators themselves many years ago and were unsuccessful or burned out regarding their innovation.

The Laggard led a major initiative looking into the reform of some outdated practices. However, they never witnessed the enactment of this reform. They championed the use of a major new technology, only to see their colleagues casually dismiss this technology as a gimmick. They devoted many hours to designing a new training program that was thrown out only two months after being installed in their organization. If a new initiative is successful, then what does this say about a Laggard's past failure(s) as an innovator? An important lesson can be learned from the passionate objections voiced by Laggards. When we isolate or dismiss an innovator, we not only lose this person's ideas and potential leadership but also create a Laggard who can be a persistent enemy of innovation for many years to come. Many of the barriers to innovation that were identified by Frist and Shumway may be erected by burned-out innovators who have become Laggards.

What to do with the Laggards

How should physician leaders engage those Laggards who oppose an innovation for very personal (and usually undisclosed) reasons? We can try to isolate them, but this is rarely effective. Alternatively, we can bring in Laggards as historians and advisors: "What can we learn from you about what happened many years ago? What can you teach us? If you were to plan for the successful use of this new procedure or program, what would you do?" Yes, this is a co-option strategy. Laggards will see right through it if this request isn't legitimate and if one doesn't seriously consider the advice they offer and listen patiently to the stories they wish to convey. There are certain repeated patterns (fractals) that are found in most organizations (Weitz and Bergquist, 2024). We can identify these patterns with the assistance of our colleagues, who happen to be Laggards, and can effectively leverage these patterns to our advantage and to the advantage of the healthcare organizations in which we work.

What about providing a Laggard with assistance? We first have to ask why a Laggard would ever seek out assistance. We suggest three reasons. First, we can provide a safe setting in which the Laggard "vents" their frustrations. An organizational consultant or coach can serve as a witness and empathizer. Second, a setting can be provided in which the Laggard can tell "their side of the story," having often been turned off (as a bore) by their colleagues inside the organization. The organizational consultant or coach doesn't just listen. They offer their own reframing of what has occurred (Bandler and Grinder, 1983; Bergquist, 2025b). They can encourage an exploration of the identified Laggard's role in past innovations.

There is a third reason to bring in an expert. In their resistance, the Laggard can demonstrate that assistance is of no use. Ironically, resistance can be used by the physician leader to bring about change. We can use the analogy of the function served by trim tabs on a boat. These devices (located on the rudder of the boat) actually move in the opposite direction to the rudder. This brings about more effective planning (resulting in greater stability and control of speed).

In proving that any assistance is of no use, the Laggard suddenly reasserts their independence. They become active (once again) and will produce some interesting ideas (based on their past history with innovations). They might not only increase the diversity of change strategies being produced in their organization but also bring about the active involvement of other Laggards. Suddenly, those who stay at home begin their own innovative journey in rebuilding their own community of "innovative resistance".

Appreciative Leadership

In short, physician leaders can help Laggards by being thoughtful and appreciative. There are difficult (but sometimes very gratifying) challenges inherent in working with the highly resistant Laggards. First, a leader can be appreciative. They can help to identify (or reinforce) the contributions made by this Laggard in the past (given that the Laggard was often an innovator in his former life). Second, a physician leader can engage in reframing the information, intentions, and ideas presented by the Laggard. Information can be reframed through the reinterpretation of the current issues facing the organization (and comparing these issues/conditions to those in the past when the Laggard was an active innovator). "What can we learn from the past?" Reframing of intentions occurs when a physician leader encourages their Laggard to identify and clarify the broad goals, vision, and values of the organization on which the Laggard and the leader can agree. Finally, the reframing of ideas occurs when the leader can provide an appreciative perspective regarding the insights and actions the Laggard is offering. "Which of the ideas from the past are still relevant?" "What are appropriate actions to take given the objections you have made to the new procedure or program? How do we make things better?"

Third, the leader can ask the tough questions: (1) "Why are you still working in this setting?" (2) "Where might you be more fully appreciated?" (3) "How do you help to create conditions in which your background, talents, skills, knowledge are more fully aligned with what an organization needs and appreciates?" Without becoming a therapist, the physician leader can help the Laggard grieve for lost opportunities, lost battles, and lost recognition and appreciation. The appreciative leader can also help to empower the Laggard. She can help her colleague (as in the case of the Late Majority member) move away from a sense of helplessness to one of hopefulness. This is a crucial movement from an external locus of control ("I am a victim and can do nothing about it other than grin-and-bear it") to an internal locus of control ("I can do something about this and don't need to stay in the current, destructive circumstance"). In this process of empowerment, the physician leader is not only appreciative but also coach-like in her work with a Laggard colleague.

Conclusions

At the heart of any diffusion process are the quality of relationships that exist in the healthcare organization and the extent and duration of credibility. First, with regard to relationships, it takes a village to not only raise a child but also raise a valid perspective or practice. Especially in the siloed, specialist-saturated world of contemporary healthcare, it is often the case that solo practitioners are pushing out into the healthcare wilderness without much support or even understanding from those who remain back home. As we have seen, there are many different voices and diverse motivations and perspectives that swirl around any new idea. All of these voices, motivations, and perspectives must be taken into account if serious attention is being given to a particular idea.

Typically, it takes a particular type of physician leader to bring together these differing voices, motivations, and perspectives. Often referred to as *Servant Leaders*, these physician leaders do the hard work needed to bring together all of this diversity and find the glue to hold this diversity together on behalf of a new idea. In his original presentation regarding servant leadership, Robert Greenleaf (Greenleaf, 1970) described the work of a servant in preparing meals and cleaning the latrines for a group of people seeking to find a guru with the truth (this guru eventually being acknowledged as the servant). While physician leaders should not have to clean the latrines, they do have to do the often-underappreciated work of bringing people together and facilitating constructive and appreciative dialogue among those with diverse needs and outlooks (Gergen and Gergen, 2004). Under skillful servant leadership, good ideas are not only eventually embraced but also enhanced. With diversity comes creativity (Page, 2011).

Nikitas Zervanos MD is a retired Residency Program Director, who has spoken about the role of a servant leader in the engagement of a strategy and set of tools for effective diffusion of innovation in healthcare systems. McKenna and Pugno (2006, p. 149) quote Zervanos:

> Great ideas reflect ancient wisdom and have the power to bind people together while creating unity and making good things happen. But no great idea exists alone. Without the innovators and servant leaders with heart and soul, no system can live for very long.

Along with the interpersonal skills and wholeheartedness associated with servant leadership comes the establishment of convincing credibility if an innovative perspective or practice is to be broadly accepted. From the perspective of a potential individual, departmental or organization-wide three fundamental diffusion questions should be addressed. First, why should I (we) want to consider this new perspective or practice? What need could it potentially meet? Second, how is the credibility of this idea to be assessed? What kind of expertise would be most appropriate in providing this assessment? Obviously, leadership is often required in considering these two questions. At the heart of the matter for both the leader and members of an organization is the third question: What are the ingredients that make an innovation "respectable"? How does an innovation become "mainstream"—or will it always linger at the fringe of organizational life or in the minds and hearts of innovation "geeks."

What about the credibility of other ideas that are being offered to or generated by members of the organization? A physician leader can be of great assistance in helping other members of her healthcare system sort out the credibility of potential innovations in her organization. Is there a solid base of evidence to support the credibility of this innovative idea, practice, product, or service? This doesn't necessarily mean that the innovation is already proven to be successful—there certainly is great value in the encouragement of exploratory and pioneering work. The innovation, however, should be linked to information that already exists regarding organizational needs, resources, and opportunities. It should also be aligned with the core intentions (mission, vision, values, and purposes) of the organization. Organizational leadership plays a major role in the successful diffusion of any innovation.

What about the even more fundamental credibility issue: are the services offered by the physician leader themselves credible, especially when this physician is operating as a servant leader? There is a crisis of leadership in mid-21st-century health care systems. And "servant leadership" has often devolved into nothing more than P.R. for the "caring" attitude of a healthcare leader who must make tough decisions regarding personnel, policies, and finances.

The concepts and strategies associated with the diffusion of innovation are directly relevant to those seeking to establish and maintain a caring health care system. An appreciation of diffusion processes is of great value in assisting the challenging processes associated with the diffusion of innovations in the VUCA-Plus world of mid-21st-century healthcare.

____

References

Bandler, Richard and John Grinder, (1983) Reframing: Neurolinguistic Programming and the Transformation of Meaning. Palo Alto, CA: Science and Behavior Books.

Bergquist, William (2025a) The New (Ab)Normal. Harpswell, Maine: Atlantic Soundings Press.

Bergquist, William (2025b) Reframing as an Essential Coaching Strategy and Tool, Coach Quad. Link: Reframing as an Essential Coaching Strategy and Tool - Coach Quad

Bergquist, William and Vikki Brock (2008) "Coaching Leadership in the Six Cultures of Contemporary Organizations" in D. Drake, D. Brennan and K. Gørtz (eds), The Philosophy and Practice of Coaching: Insights and Issues for a New Era. San Francisco: Jossey-Bass.

Bergquist, William, Suzan Guest and Terrance Rooney (2002), Who is Wounding the Healers. Sacramento, CA: Pacific Soundings Press.

Bergquist, William and Agnes Mura (2011) coachbook: A Guide to Organizational Consulting Strategies and Practices, Santa Fe, NM: IPPS.

Cassatly, Michael and William Bergquist (2011) The Broken Covenant in US Healthcare, Journal of Medical Practice Management. Vol 27 (3), pp. 136-139.

Gergen, Ken and Mary Gergen (2004) Social Construction: Entering the Dialogue. Chagrin Falls, Ohio: Taos Institute Publications.

Gladwell, Malcolm (2002) The Tipping Point. New York: Little, Brown and Co.

Greenleaf, Robert (1970) The Servant as Leader. Peterborough, NH: Windy Row Press.

Kuhlenschmidt, Sally (2010) "Issue of Technology and Faculty Development" In Gillespie, K., Robertson, D., and Associates. (2010) A Guide for Faculty Development. Second Edition. San Francisco, CA: Jossey-Bass, pp. 259-274.

Lehrer, Jonah (2009) How We Decide. Boston, MA: Houghton Mifflin Harcourt.

Marrow, Alfred (1969) The Practical Theorist: The Life and Work of Kurt Lewin. New York: Basic Books.

McKenna, Mindi and Perry Pugno (2006) Physicians as Leaders, Oxford: Radcliffe Publishing.

Page, Scott (2011) Diversity and Complexity. Princeton NJ: Princeton University Press.

Rogers, Everett. (1962) Diffusion of Innovations. 5th Edition. New York: Free Press.

Sanford, Nevitt (1980) Learning After College. Berkeley, Ca: Montaigne Press.

Sarason, Seymour. (1972) The Creation of Settings and the Future Societies. San Francisco: Jossey-Bass.

Schein, Edgar (2006) Career Anchors. 3rd Ed. San Francisco: Pfeiffer.

Weitz, Kevin and William Bergquist (2024) The Crises of Expertise and Belief, Harpswell Maine: Professional Psychology Press.