How to Perfect Your Marketing ?

With the Help of a Few Good... Nurses?

This story ventures down an unusual road into what I like to call, the 'Land of And'–a place where seemingly unrelated topics come together serendipitously, creating unexpected synergy and insight. In this case, psychiatric nurses meet derivatives marketers. Sound odd? Well, OK, maybe to follow me down this seemingly impassable road you will require some context . . . maybe even a business context. Fair enough.

In fact, my adventures with the nursing profession started out innocently enough, with a business problem: how do I help a group of very successful fixed income and derivative products marketers get better at building long term client relationships? My client, the fixed income group of a major international banking organization, was recently faced with this problem. It seems that the business climate has changed over the past few years, as the VP of Fixed Income reported to me, and just coming up with ever more complex and esoteric financial instruments is no longer the key to success.

In today's banking environment, everyone has access to the latest and greatest products, and the real differentiator is proving to be client relationships. So here was the problem set before me: what can we do to raise the performance level of a highly skilled marketing team, one which has taken and integrated most of the well-worn sales skills training available. What then?

The standard approach these days would be to develop a competency model based on high performing marketers and use this as a tool for designing development programs for the rest of the team. Yet, to be honest, I was less than excited about this idea. This bank already uses a variety of competency based tools for selection and appraisal. I wanted to do something that would open them up to a more radical shift, to not just change behavior but to deepen their understanding of how relationships, in this case, with clients, really work. At this point I had no idea what that might look like–but as a good consultant I was quite used to starting out in this position.

A few weeks after I signed on to solve this little corporate "concern", I began to realize that they would want a solution, and soon. My partner and I started to design a fairly standard organizational assessment tool. Yet, my intuition told me that we could do more–but what? One night, while basking in my quandary, I received a phone call from a friend who wanted to stay with me in NYC for a few days while she did some research for her doctoral dissertation. An assistant professor of nursing at a university in Massachusetts, Carol is an eclectic and accomplished professional–a nurse, writer, dancer, teacher, mother and life-long student.

The night she arrived we had our one opportunity to visit, and so, over a few glasses of red wine, I told her of my dilemma.

"That's an interesting predicament", she told me. "I can relate to the feeling that you just know there is a better way...yet you are unsure about where to begin or where to look. I have that feeling with my nursing students all the time."

"You do?" I asked, "I would have thought that as a professor you were supposed to know the ropes..and be just passing on your wisdom."

"Ah, if it were only so simple," she replied, and proceeded to tell me that she often experimented with teaching tools and ideas that she couldn't be sure would "work". Yet, she would take a "leap of faith" with her students, offer them a possibility and wind up learning as much from them as they did from her.

"Learning and growth is a two-way street," She reminded me, "my students are my best teachers." Then she proceeded to tell me about her "experiment" with what had been always a most intractable problem: how to reach the unreachable. How do you "nurse", that is, care for, the patients in the psyche ward who appear to really be "out of it"? The nursing students experienced a great deal of anxiety and stress with these mental health patients, because so many of their basic nursing techniques failed to work.

Categories of Connection

1. DATA
empirical facts
("all I want are the "cold hard facts")

2. FEELINGS
emotions
(Enthusiasm, excitement, sadness, happiness, joy)

3. ETHICS
"shoulds and oughts"
(Appealing to a sense of duty, obligation)

4. AESTHETICS
sense of design, symbolism
("I admire its complexity . . . and simplicity")

5. IMAGE
sense of power, prestige
("red, sleek, fast, powerful– makes one feel important")

6. TEACHING
sales person as expert
("I'll teach you everything I know . . .")

7. LEARNING
client as expert
("You seem to know a lot about this . . . perhaps you could enlighten me . . .")

8. TIME
response to a particular pace/rhythm
('I care about fast turnaround– I need it now . . . or the opposite: "let's take this slow. That's not a no, it's a not now . . .")

by JEFF HULL

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They would often come to the teacher at a loss.

Then one day, after reading a wonderful article about the “art” of relationships, and having sat and watched how some of the nurses did relate with some of the patients, Carol connected a few dots of thinking–what she’d read and what she’d seen–in her head. She offered the following suggestions, just as an experiment, to her frustrated students. The first was that they stop trying to “connect” with the psyche ward, or with the “patients”, or with any “group”. What they needed to see was that each patient was unique, an individual, just as they were. Even so-called normal people don’t connect with whole groups, or “wards” or teams, at least not deeply. They always connect with individuals, and some more deeply than others. So, she suggested that they just wander around the ward and see what happens. Who responds to you? Who doesn’t? Leave the latter alone and pursue a connection with the former. Choose specific individuals and see what makes them respond to you. Don’t try to nurse the whole place!

The second idea had come to her from the article she had read recently by Barbara Carper called “Fundamental Patterns of Knowing”. The author suggested that there may be deep-rooted ways that people relate to each other–different levels of “knowing”–that are unique to each particular individual. We always assume that we know each other, at least initially, through the five senses, through data. But maybe this is just one possibility. Carol told her nursing students to consider other ways of knowing their patients, to try the following four “ways” of knowing when working with them:

1. Data/empirical knowing–this is the one most of us know by rote. Do what the data would prescribe. Look at the patients needs, the prognosis, the characteristics of behavior–then respond accordingly.

2. Knowing through the heart, through feeling–this is the level of emotional knowing. Responding to the patients feelings first, sometimes in spite of what the data might say.

3. Ethical knowing–this is a knowing of another through the eyes of what is right and wrong, what must be managed with integrity, through a sense of should’s and ought’s.

4. Aesthetic knowing, that is, knowing through symbols or metaphor. The nurses might connect with a patient through a symbolic representation of their pain and suffering, through what they view as beauty, or some “art” work they create.

Above all, Carol refrained from prescribing how they should relate to any particular patient. She suggested that they start simple, with one or just a few patients, and that they look beyond the data, to deeper ways of knowing and touching. Beyond this, they were on their own.

Wonderful things began to happen. Every one of her students found a patient to work with, many found more than one. Their interactions led to increased patient response, yet were as unique as each pairing.

In some cases, the patient and the nurse worked together on what the patient should do to get well. Some patients showed an amazing sense of obligation, a sense of conscience and duty, even if they had an unfocused sense of reality. Other patients responded when the nurses shared their own feelings of anxiety and fear–the patients too were scared, of the nurses, the doctors, the world. Thus, in shared feelings they found a bridge to connect. Still others responded to music, to poetry, to spending hours with the nurse just drawing pictures. No words were spoken in some cases, yet the pictures seemed to draw out the patient, and the nurse.

As I sat listening to this simple, yet inspiring story, my mind made a mental leap (I love those moments!!) and I could just see myself having this conversation with a sales person, asking these questions: how do you connect with your clients? Is it always only through data and dollars and business needs? Do you ever study how your client views right and wrong, duty and obligation? Do you ever take the tack that what you care about is doing what’s right for them? That your relationship starts with integrity and grows from there?

Or better yet, do you ever connect with your client’s feelings, emotions, fears? What excites them? What excites you in working with them? Do you share this feeling with them? Perhaps the sheer exhilaration of doing a great ‘deal’ for them is as much a part of the connection for you as it is for them. How might we explore this possibility? And finally, do your clients ever

respond–and do you–to the beauty, the aesthetic simplicity for example, of the products you sell? Do you ever talk with your clients about what touches them in the realm of art, beauty, or symbol? Maybe they go home and play the piano at night and you do too. Connections with individuals can come in all shapes and sizes. We only have to look at each client as unique, and be willing to take the time to look beyond the data, to a whole realm of possible ways of knowing.

These thoughts streamed through my mind as she finished her story. I was very moved by the courage and willingness of her nurses to experiment, to work through their fears. I was even more moved by the humility and strength of the wonderful teacher who sat across from me. She was a student too, as am I.

During my next encounter with the client, the conversation flowed easily. “Building relationships is all about finding that connecting point, that way of knowing, which will bring together two individuals,” I heard myself saying. “There are different ways in, beyond the data models and the product definitions. It just takes practice, and a willingness to experiment with a variety of ‘categories of connection’.”

They’ve invited me back..so I guess I struck the right chord. A quantum leap in performance is right around the corner.

Funny though, as I made the leap from nursing psychiatric patients to marketing swaps and options, I couldn’t help but wonder which “ward” makes relationships between people more difficult to achieve. Finding the connection between individuals–beyond the models of forward pricing, the computer screen, the telephone, and the frenzied trading floor–strikes me as equally daunting as reaching out to a paranoid schizophrenic who stares out the window all day in silence. These corporate environments, I chuckled to myself, can be rather alienating places. Oh well, at least my nursing professor, truly an angel of mercy, has offered me a way in. For that, I am grateful.

Think about it: what makes the relationship “work” when you have been extremely happy with a marketing or sales person? How did they build a relationship with you? Did they navigate through any of the following? You probably use all of the categories of connection in your relationships with clients, friends and relatives. What if you practiced being more aware of the category or categories that you (or the other person) tend to use in a given situation?

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