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CSPL Canadian Society of Physician Leaders
SCLM Société canadienne des leaders médicaux

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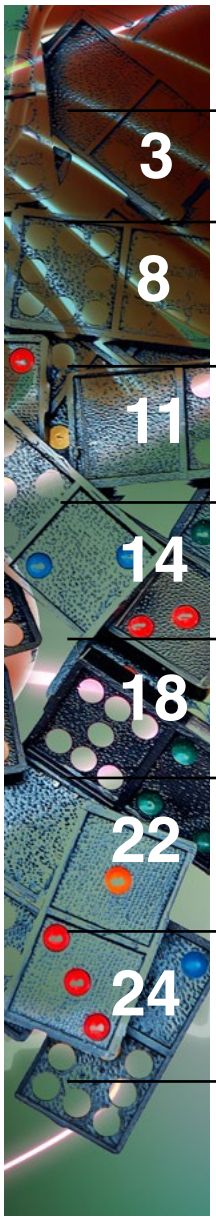

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OPINION

Needed: physician leaders

by Johny Van Aerde, MD, PhD

Why is the Naylor report doomed, even if those who commissioned it had supported it? This article refers to new evidence of the link between creative health care reform, government involvement, and quality of care. Based on this analysis, it looks at what role physicians can and should play in health care reform.

No one will blame you if you missed it. Most Canadians did! The Naylor report,[1] *Unleashing Innovation*, was released and shelved faster than the New Horizons probe flew past Pluto.

A year ago, the federal government commissioned the report, but, when the time came, the same government canceled its press release. The report's existence was announced tepidly on a Friday afternoon in the middle of a hot, lazy summer, with no scheduled parliamentary sessions until after the federal election. The media opined on why this announcement was followed by a roaring political silence.[2,3]

The Naylor report is a synthesis of quantitative and qualitative evidence obtained from the literature; from conversations with thousands of Canadians who deliver, administer, and use our health care system; from entrepreneurs in business and industry; and from new research commissioned specifically for this report.

This information was carefully analyzed and reflected on by a group of knowledgeable people from the worlds of academia, health care, and business, led by Dr. David Naylor, past-president of the University of Toronto. The committee's mandate was to identify the five most promising areas of innovation in terms of reducing growth in health spending, creating financial sustainability, and improving accessibility and quality of care. It was also charged with recommending five ways in which the federal government could support innovation in these areas.

The more than 150-page report is well written. It provides clear definitions of all words that could be open to misinterpretation, and it contains a good summary of the evolution and history of the Canadian health care system. It goes on to identify key themes emerging from the research and how they were derived. It also contains information on present and potential stakeholders affected by the need for innovation. The report describes how all this information was obtained and culminates in thoughtful analyses, reflections, and recommendations made by the committee. Although it contains many warnings that our health system has aged badly and is underperforming compared with other developed countries, it also exudes praise for many positive aspects of potential and ongoing successful local initiatives.

The five areas proposed for innovation are:

- Patient engagement and empowerment.
- Modernization of the workforce and integration of fragmented health systems. This section includes topics on governmental integration, integration of care for First Nations, and inter-professional integration with bundled payment models.
- Investment in technological transformation, i.e., digital health and "precision medicine."[4,5]
- Better value from procurement, reimbursement, and regulation. This section includes pharmacare, new models of physician reimbursement, and waste reduction.
- Engagement of private industry as a partner, economic driver, and innovation catalyst.

Although other writers have addressed many of these items previously,[6-8] the Naylor report juxtaposes and integrates them. What is new and refreshing are the two actions the report suggests to make these innovations happen: the creation of a new

Healthcare Innovation Agency of Canada (HIAC) and a health care innovation fund (HIF). The HIAC would be formed by consolidating and expanding the mandate of the Canadian Foundation for Healthcare Improvement, the Canadian Patient Safety Institute, and, after completion of its current ongoing projects, Canada Health Infoway. It would be an arm's length organization, without direct governmental influence, with the mandate to manage the flow of dollars from the HIF to "coalitions of the willing."[1]

The overall objectives of the HIAC and HIF would be to support high-impact initiatives proposed by stakeholders and governments, to break down structural barriers to change, and to accelerate the spread and upscaling of promising innovations. Allocations would be based on "rigorous adjudication against transparent specifications, having particular regard for measurable impacts on health outcomes, creation of economic and social value, sustainability, scalability, and a commitment by partners to sustain those innovations that are demonstrably successful" (p. 122).[1]

One of the final sentences in the report reads, "The Panel has been left in no doubt that a major renovation of the system is overdue, and is chagrined and puzzled by the inability of Canadian governments — federal, provincial, and territorial — to join forces and take concerted action on recommendations that have been made by many previous commissions, reviews, panels, and experts" (p. 125–6).[1] That triggers the following questions: in general, what are the chances that reviews and recommendations by panels and commissions actually lead to action and, specifically, what are the chances of this policy report surviving, even before it was released and buried?

In *Paradigm Freeze*, Lazar and colleagues analyze 30 cases from five provinces (Saskatchewan, Alberta, Ontario, Quebec, and Newfoundland) around six representative health policy issues: regionalization, needs-based funding, alternate payment plans around primary care, for-profit delivery, wait times, and drug cost coverage.[9,10] In essence, the authors compare the reforms that actually took place with the recommendations set out in well-researched, major reports commissioned by government-appointed commissions, task forces, and advisory councils between 1990 and 2011. Taking the five provinces as a whole, the outcomes of policy reform have been meager with almost no change.

In looking at the underlying reasons for the lack of policy reform, the authors note two independent variables that had a major positive influence on reform decisions in the 30 cases: change in government or political leader, when the election platform included health care reform (13/30); and a fiscal crisis or perception thereof (13/30). The barriers to reform were insider interests, mainly of provincial medical associations (27/30), public opinion (9/30), and values Canadians held around their health care system (16/30) as reflected in

the medicare model or the *Canada Health Act*. The influence of media was weak by comparison (4/30). Knowledge from interjurisdictional learning and from the research community worked in favour of placing items on the reform agenda of the government (12/30), but did not necessarily influence the choice of policy.

Physicians are also the translators of policies in the health care organizations in which they work. Physicians not only play a key role in running clinical services and in enabling safe care of high quality, they are also the most effective translators and occupy the space between reform policy and organizational functioning and clinical care.

Lazar et al.[9] conclude that there has been little fundamental change in Canadian health policy over the past four decades and the interplay of ideas, interests, and federal/provincial institutions has led to a "paradigm freeze" by perpetuating the status quo. The evidence they present suggests that the chances of reform on a very large scale — the type of transformational changes Naylor and other writers advocate — are slim at best. "Without some sort of insurmountable disruptive force, either a major shift in medical science or technology or a catastrophic economic or political crisis, fundamental health policy reform in Canada is unlikely."[9] In short, based on historical evidence across Canada, the Naylor report was doomed even before it was released, no matter how good the content.

However, although not the focus of *Paradigm Freeze*, Lazar et al.[9] note that small-scale reform has occurred through the creative efforts of health care professionals and health systems managers, independent of government influence. According to the Naylor report, those same abundant, yet fractionated and dispersed, creative efforts and forces in the Canadian health system could have been integrated and coordinated by an HIAC through collaboration within and between provinces, with the federal government.

Although Lazar et al.[9] do not substantiate their statement on creative initiatives without governmental policy and reform, that topic is exactly what Braithwaite et al.[11] researched recently. In a study of 30 developed and developing countries, not including Canada, they asked whether big-picture reforms and policies at the national level improve quality of care and patient safety and, if so, how. In all countries, the aim was to enhance delivery of quality health care and, thereby, improve the health system and the health of society. Despite the barriers and rampant inertia against change in all health care systems, people refused to give up and believed that initiatives by those in authority would ultimately have a positive effect.

One finding stood out very clearly: the relation between governmental reform policies and quality or safety outcomes at the frontline was absent (or weak, at best) and it was situation-dependent.[11] In other words, big reforms, i.e., national or provincial initiatives and policies, are often not well linked to local quality and safety initiatives, and there is no guarantee that any particular reform measure or series of measures will result in improved quality and safety. Politicians' claims that their reform policy has caused an improvement are often made without any baseline measurement or without a stringent method for measurement.[6,11] Similarly, most politicians hide failures; thus, no one learns from the mistakes.[6,11] In short, globally, quality and patient safety are influenced most by local initiatives and work by people who are close to the action, where the rubber hits the proverbial health care road, not much or not at all by any national policy or reform initiative.

In view of these findings, and given that the Naylor report now lives in the dungeons of Ottawa, our health care system will continue to age with minimal reform — and a real danger of becoming extinct. What can we, physicians, do? How can we play a leadership role in the reform of our health system?

Braithwaite[12] found that medical leaders make things happen. Using sophisticated collaborative leadership skills, they have the capacity to influence upper echelons of health systems and policymakers (in some countries even as ministerial advisors). Physicians are also the translators of policies in the health care organizations in which they work.

Physicians not only play a key role in running clinical services and in enabling safe care of high quality, they are also the most effective translators and occupy the space between reform policy and organizational functioning and clinical care. Therefore, physician leaders seem to be the key players who can make or break reform,[12-15] using modern leadership skills for successful systems transformation.[16]

Our study concluded that "health system transformation toward improved patient care requires physicians to engage in life-long leadership development for which the system will have to find resources.

Whereas politicians and policymakers tend to employ the tools of management and micromanagement, they do not practise leadership in the area of health care. Braithwaite[12] suggests that this is a void into which physicians can and should step. This is where physicians can and have to provide leadership: of health care reform in policy arenas and of clinical care processes leading to quality improvement.[12] To optimize the chance for success, physicians must acquire the necessary leadership skills, as identified in a recent study on Canadian physician leadership by the Canadian Society of Physician Leaders (CSPL).[17,18]

The Naylor report[1] also mentions that physicians should take on leadership roles in the innovation and transformation of the Canadian health system: "Canada's physicians have made huge contributions to healthcare, but the current mode of organizing and funding healthcare is holding them back from a larger leadership role" (p. 7). The CSPL's study not only revealed this same point, but also, "The lack of training in physician leadership skills was identified as a strong barrier to physician leadership."[17]

Our study also found that we like making life miserable for those among us who try to innovate or be creative: "The negative attitude toward medical leaders is present throughout the entire medical system — from medical school through residency to clinical practice — and it is a limiting factor for physicians who want to develop leadership skills and take on leadership roles."[17] Often, this attitude originates from fear of losing the profession's autonomy when changing from an individual to a systemic level of engagement with health care. This fear is overstated, as there are many examples in the United States health care system of very high-quality organizations — the Mayo Clinic, the Cleveland Clinic, Kaiser Permanente, the Geisinger Health System, Virginia Mason Medical Center, Intermountain Healthcare, and McLeod Regional Medical Center — where each physician fulfills a leadership role and still maintains her or his autonomy, sometimes even within a fee-for-service model.[1,19]

Our study concluded that "health system transformation toward improved patient care requires physicians to engage in life-long leadership development for which the system will have to find resources. The identified need for learning and for attitudinal changes toward physicians who want to engage in leadership activities constitutes a large void that can be filled by the combined efforts of the CSPL and the CMA's Physician Leadership Institute. The question is whether the health care system and the organizations within it are willing to make the structural and cultural changes required to make

this happen and to free up the necessary time and finances."[17]

Because the Canadian health system is complex and, like an aging patient, is becoming less and less adaptive, it may well soon end up on life support. If physicians choose not to become engaged in its reform, it will die. The evidence shows that a federal, collaborative reform policy is unlikely to appear in the foreseeable future; reform initiatives leading to improvement and patient safety are driven locally rather than at a governmental scale; and physicians with modern leadership skills are the natural elements of the health system to take up leadership roles in its transformation. In view of that evidence, we need to ask ourselves how can all physicians develop the skills they need to become engaged as leaders in our health system's reform? What personal, cultural, structural, or political barriers need to be removed and why? And, finally, how can our organization, the CSPL, help us on the difficult road toward that goal? Think about it, before it is too late!

Please share your ideas on our LinkedIn forum at https://www.linkedin.com/grp/home?gid=8357779 or drop us an email at johny.vanaerde@gmail.com

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This paper has been reviewed by a panel of physicians.

Professionalism and disruptive behaviour: strategies for physician leaders

by James Sproule, MD, and Tracy Murphy

Abstract

Physician leaders play an essential role in addressing the disruptive behaviour of physicians in their institutions and, as such, should be aware of the impact of such behaviour and know how to handle these difficult situations effectively.

Although only a very small number of physicians exhibit recurrent disruptive behaviour, such behaviour can have a serious impact on patients and families, other physicians and health care providers, and the workplace environment. The Canadian Medical Protective Association (CMPA) shares the perspective that disruptive behaviour by physicians should be addressed by the health care institution where the conduct occurs. Health care institutions are well positioned to attend to these matters, given their knowledge of any given situation, their workplace, and the individuals involved.

Leaders can foster a culture of respect and address disruptive behaviour by establishing clear expectations, modeling first-rate professional behaviour, and emphasizing positive values and behaviours throughout the organization. Promoting civility is also important.[1] Establishing a workplace culture and providing regular feedback (both formal and informal) to professional staff can help physicians gain insight and understand the impact of their behaviour on others.

Physician leaders should communicate their organization's expectations for professional behaviour and establish and communicate a clear, tiered approach and response to incidents of unprofessional behaviour. Physician leaders should also be involved in monitoring physician behaviour, which may include direct observation and team member evaluations.

Approaches to address disruptive behaviour

When occurrences of disruptive behaviour become known, physician leaders must take appropriate steps aimed at managing the issue, assisting the physician to improve his or her behaviour, decreasing the risk of medical-legal consequences, and improving the workplace. A tiered approach that educates and improves behaviour and, where appropriate, keeps the physician in practice through remedial actions is preferred.

Isolated, non-egregious behavioural incidents are best handled with an informal "coffee cup conversation" between the physician in question and a colleague or, in some circumstances, his or her direct supervisor. Such simple feedback will often lead to insight and positive behavioural change.

Recurrent disruptive behaviour generally requires intervention by the direct physician supervisor and should include communicating the impact of unprofessional behaviour, documenting the intervention in the personnel file, and setting expectations for change.

A pattern of persistent disruptive behaviour requires escalation to a higher level of authority and a documented action plan with clear deliverables, timelines, and consequences if behaviour does not improve. Physicians unable to change and improve their behaviour in spite of a staged or tiered remedial approach could then face significant disciplinary intervention.[2]

At the institution level, workplace assessments may uncover contributing factors or triggers, such as human, financial, or informational resource issues, excessive workload, lack of engagement in decision-making, and competing interests. Efforts to address these types of issues can be very effective.

Physician leaders should also cultivate a culture of respect that includes providing regular

feedback to physician staff. Although collegiality and mutual respect cannot be imposed, leaders can send a strong message about the importance of medical professionalism.[3]

Reporting physicians

Physician leaders should be familiar with the legislation and college policies in their province or territory that deal with reporting physicians. Most statutes or policies require that there be reasonable grounds for reporting; however, the triggering criteria can vary considerably among jurisdictions. Doctors may have a legal duty or ethical responsibility to report a physician colleague to a health care institution, public health agency, or college when there are reasonable grounds to suspect that patients might be at risk due to a physician's mental or physical health or where privilege suspensions or other practice restrictions are imposed.

The principles of natural justice and fair process are equally important when a physician assumes a new leadership role.

Failure to report may heighten the risk of a legal action or complaint if that failure can be linked to a patient safety incident that resulted from an unreported doctor's incapacity, health status, or behaviour. In most cases, it is preferable for the physician leader to inform the other doctor why the report must be made. Demonstrating support and empathy toward the colleague may be helpful.

Resolving conflicts

Conflict among physicians or between physicians and others can strain teamwork and have an impact on the delivery of care. When physician leaders become aware of colleagues in conflict, they should attempt to address the issue and recommend helpful resources. Demonstrating and encouraging mutual respect is the best way to cultivate a positive workplace environment with minimal conflicts, whether among staff or with patients. The professionalism displayed by physician leaders should set an example for other health care providers.

Handling legacy complaints

The principles of natural justice and fair process are equally important when a physician assumes a new leadership role. For this reason, physician leaders who are new in their positions and who inherit historical complaint files need to consider a measured approach.

There should generally be continuity and consistency in the way such files are handled by the leadership of the facility. Consider, for example, whether it would be fair for a new physician leader who learns of a complaint regarding a doctor's behaviour to write a strongly worded letter to the doctor without first determining what steps have already been taken by the previous administration. In most cases, a preferred approach in these circumstances is to gather existing information about the incident or complaint, determine what action has already been taken and whether the matter still needs to be pursued, plan next steps, and proceed fairly.

Consider, as well, a situation in which a new physician leader learns about historical concerns regarding a doctor who has allegedly been disruptive for many years. Where the previous administration chose not to take any action against the doctor in response to such issues, would it be fair for the new physician leader to criticize or penalize the doctor for past behaviour in the absence of any new complaints?

Without a new complaint, an immediate sanction based on previously unaddressed complaints would not be considered fair process. This is because the doctor would not have been given the chance to improve his or her behaviour. If there has been no new complaint, but the new leader is aware of multiple previous complaints, it may be quite appropriate for the physician leader to advise the doctor of the concern citing the previous history. Depending on the circumstances, it may be suitable to advise the doctor of the unacceptable behaviour and caution that a recurrence of the behavior could result in disciplinary action. Thus the doctor would be given a chance to correct the behaviour. On the other hand, if a new complaint is filed, the facility's established procedures for responding to such complaints should be followed.

Support from the Canadian Medical Protective Association

The CMPA monitors changes in the law and in the medical practice environment, as well as evolving leadership models. Physician leaders should ensure that they have the appropriate liability

protection for their specific role in their institution, including liability protection that may be provided by the hospital or regional health authority.

Physicians in administrative roles within health care institutions should generally expect liability protection from their institution. Members with questions are welcome to contact the CMPA to speak with a medical officer.

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This is the second of three articles written by the Canadian Medical Protective Association (CMPA) for physician leaders. The topics are: natural justice and fair process; professionalism and managing physicians who exhibit disruptive behaviour; and the physician leader's role in managing patient safety incidents. More information on all these topics can be found in the CMPA's Medico-legal Handbook for Physicians in Canada (2015). https://www.cmpa-acpm.ca/en/legal-and-regulatory-proceedings/-/asset_publisher/a9unChEc2NP9/content/a-medico-legal-handbook-for-physicians-in-canada

The CMPA also has a discussion paper on The role of physician leaders in addressing physician disruptive behaviour in healthcare institutions. https://www.cmpa-acpm.ca/documents/10179/24871/13_Disruptive_Behaviour_booklet-e.pdf

This paper has been reviewed by a panel of physicians.

NOTICE TO ALL CSPL MEMBERS

A number of changes are taking place at the Canadian Society of Physician Leaders, starting with our name. In early April at the annual general meeting in Vancouver, the change from Canadian Society of Physician Executives to Canadian Society of Physician Leaders was approved by a quorum of members. This led to our new domain name — **www.physicianleaders.ca** — and a slight modification of our logo.
A second major change will take place at the end of August when we move to a new office. For the past 16 years, since our inception, we have been thankful to the Canadian Medical Association for welcoming us to share office space with them, but we are now venturing out on our own. The CMA and CSPL will continue to host both the Canadian Conference on Physician Leadership and the Canadian Certified Physician Executive credential, but the CSPL will now become the secretariat for both activities. Our new office space is located within the Canadian Medical Protective Association (CMPA) complex at 875 Carling Avenue, Suite 323, in Ottawa. This move will also mean a number of changes that will affect members. To start, we will be building our own membership database system. Once we launch the new member portal at the end of September, every member will be asked to create a new user id and password and review their profile for any discrepancies. However, once that housekeeping is done, the new portal and database system will allow members to track and manage their own information, membership, conference participation, and more.
Please watch out for email changes. Although our old email addresses and website will remain functional for the next 3–6 months, please make a note of our new addresses to ensure that we are able to respond to all your requests.

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Canadian Conference on Physician Leadership:
www.physicianleadershipconference.com
Canadian Certified Physician Executive (CCPE) designation:
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These are exciting times at CSPL, and we are looking forward to what the future holds.

Carol Rochefort, CAE
Executive Director

Physician communication as a key factor in patient experience

by Mamta Gautam, MD

Abstract

Patient experience is fast becoming one of the top priorities for hospital leaders. Understanding a patient's experience during his or her hospital stay is central to improving patient-centred care.

Patient experience is the sum of clinical quality and service quality. Clinical quality is *what* we deliver to patients: the technical and cognitive skills to medically manage a patient, procedures performed, patient safety practices, and the science of medicine. Service quality is *how* we deliver the care; it includes professionalism, kindness and respect, clear communication, and the art of medicine.

Measuring patient experience

In Canada, capturing and reporting information on the patient experience is an important part of the Canadian Institute for Health Information's (CIHI) effort to measure health system performance. CIHI has worked with a variety of experts to develop the Canadian Patient Experiences Survey—Inpatient Care (CPES-IC) and the Canadian Patient Experiences Reporting System (CPERS).[1] This standardized questionnaire enables patients to provide feedback about the quality of care they received during their most recent stay in a Canadian acute care hospital. It also provides standards and supporting documentation for those who are administering the survey. The survey was created by leading experts and includes 22 items from the United States' Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, as well as questions relevant to the Canadian context (e.g., discharge and transitions) and demographic information. Starting in spring 2015, the CPERS was to start receiving CPES-IC data, and during 2015–2016, field tested data will be used to validate the survey measures.

The HCAHPS is a US survey instrument and data collection method for measuring patients' perceptions of their hospital experience. In use since 2006, the survey asks discharged patients 27 questions about their recent hospital stay, including 18 core questions about critical aspects of their experience. As the first national standard for collecting and publicly reporting information about patient experience of care, it allows valid comparisons across hospitals locally, regionally, and nationally.[2,3]
Three specific questions make up the HCAHPS's "communication with doctors" domain. These same questions are included in the CPES-IC survey. Patients are asked: During this hospital stay, how often did doctors:

1. Treat you with courtesy and respect?
2. Listen carefully to you?
3. Explain things in a way you could understand?

In each case, patients are given four choices: never, sometimes, usually, and always. Doctors are only given credit if a patient rates them as having "always" done this. A US report from April 2015 shows that a patient response of 82% "always" is the national average. After "discharge information," this is the second highest scoring HCAHPS domain. The best performing hospitals in the country (95th percentile) get 85% or more "always" choices in this section.[4]

Other countries have also instituted or are planning to institute similar patient surveys. In the United Kingdom, the National Health Service (NHS) patient survey program systematically gathers the views of patients about the care they have recently received, on behalf of the Care Quality Commission.[5] In 2012, the Australia Commission on Safety and Quality in Healthcare conducted a comprehensive review of patient experience and satisfaction surveys in use, with the goal of informing the development of a national approach to measuring hospital patient experience.[6]

Focusing on communication

With an increasing amount of revenue at stake in the US,

hospital leaders there are looking for strategies to improve the patient experience and boost their HCAHPS scores. Regardless of the existence of a direct impact on hospital revenues, hospitals everywhere are now focusing on performance measures and efforts to improve patient satisfaction. It is my understanding that doctors consistently score well in the first question above, but have room for improvement based on responses to questions 2 and 3. In recent years, I have consulted at several US hospitals to assist them in boosting their patient experience. Understanding the patient experience of care is not an add-on activity: it should be a fundamental element in other hospital improvement efforts. Patient-centred care is a driver of clinical outcomes. Changing hospital culture and processes to improve the patient experience can lead to substantial improvements in safety and quality.[7]

Typically, I shadow identified physicians to observe their interaction with patients, and then offer detailed individual feedback on communication skills and several follow-up coaching sessions to help them enhance this interaction. It is hoped that this will, in turn, lead to improvement in patient satisfaction and patient care.

Factors affecting physician communication

HCAHPS scores in the area of physician communication are known to be influenced by three main factors: physician behaviours, team communication, and system issues.[8] Although I focus on physician behaviours, I have also been able to recognize key issues related to team communication and system issues and offer strategic and practical recommendations to address these.

From a patient perspective, positive aspects of physician communication behaviours include:

- Treating patients as a partner
- Allowing patients to participate in decision-making
- Offering full explanations
- Eliciting and responding to patient concerns
- Modifying a plan based on input from the patient
- Demonstrating care
- Being available
- Appearing unhurried
- Taking time to answer questions
- Providing emotional comfort
- Exhibiting competence

Physician behaviours become problematic for patients when there are longer wait times, less responsiveness, greater complexity of communication by specialists, disorganized care, and lack of team communication.

It is important to be aware of differences in patient and physician perspectives. Olsen and Windish[9] found that 98% of physicians said they discussed patients' fears and anxieties at least sometimes; but 54% of patients said their physicians never did this. Patients correctly identified the diagnosis 57% of the time and the name of their physician 18% of the time; physicians thought that patients knew the diagnosis 77% of the time and their name 67% of the time.

Physicians often ask me why they should focus on the patient experience. They know the clinical quality of the care they provide is high; should that not be enough? Focusing on patient experience is good for the physician, patient, and organization.

- For the physician — it is the right thing to do. These results are being publicly reported; there is an association between higher patient satisfaction and lower risk of physician lawsuits.
- For patients — there is a positive correlation between clinical and service quality.
- For hospitals/health care organizations — health care reform and new reimbursement formulas require measuring patient experience.

Enhanced team communication results in greater consistency and continuity of care and leads to improved patient satisfaction. System issues are also critical to ensuring patient satisfaction. There must be a strategic organization-wide focus on creating a culture of care. The Cleveland Clinic has invested in this area and, in 2007, created an Office of Patient Experience. The clinic offers lessons for achieving similar success: focus on culture, quickly; get physicians on board, despite

their recalcitrance; and just get started.[10] They suggest aligning organizational culture around a "patients first" philosophy, engaging all employees, mandating physician communications training, and just getting started without waiting for the perfectly defined initiative.

Turning resisters into allies

Continued attention to improving and sustaining positive physician behaviours, team communication, and system issues will ensure success. However, patient engagement cannot occur without physician engagement. Hospitals must be simultaneously patient-centred and provider-centred.[11] Providers, especially physicians, are the biggest resisters of change and often the main barrier to community engagement. Involving them proactively and including them in the process by also addressing their needs will be a key step. As hospital physicians and staff feel engaged, supported, and valued by the hospital, they will become the greatest allies in this process. The biggest barriers can become the biggest enablers.

Translating data into action

The increased emphasis on patient satisfaction data collection systems in North America is important. Yet, it is only the first step. To be truly valuable, it must inform and translate into action. The Cleveland Clinic has effectively used its data to change hospital culture; modify processes; and improve patient safety, quality, and satisfaction.[7] Such positive action will be a greater challenge at a national level.

There are lessons to be learned from other health care systems. In the UK, the NHS has been collecting data for over 10 years, but relatively few providers systematically use the information to improve patient services.[12] Coulter and her associates[12] suggest the establishment of a national institute of "user" experience to draw the data together, determine how to interpret the results, and put them into practice.

There will likely be other solutions; we will need to keep exploring options. As health care leaders, we must focus not just on obtaining these data, but also on how to use this knowledge to best effect positive changes in the delivery of health care.

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This paper has been reviewed by a panel of physicians.

THE FACILITATIVE LEADER:

Group decision-making

Part 4 in a 5-part series on facilitation skills for physician leaders — an emerging necessity in a complex health system

by Monica Olsen, MHRD and Mary Yates, MEd

Abstract

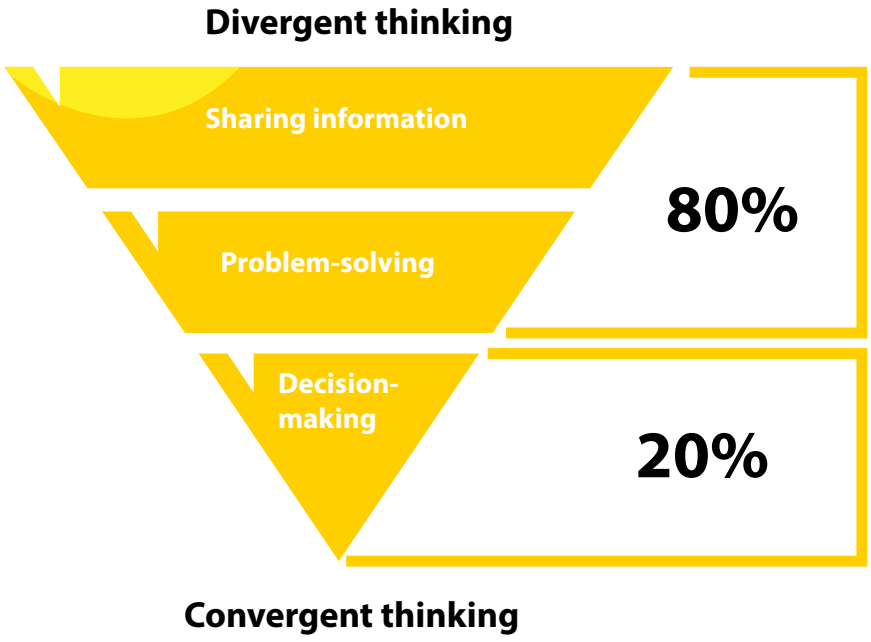
Facilitative leaders guide their team through information-sharing, problem-solving, and decision-making. In this article, we look at why ineffective decisions are made, explore five decision-making options, provide two tools for determining the extent of agreement among team members, and describe some of the common pitfalls associated with this important group process.

Many physicians express concern about how departmental or broader organizational decisions are made or implemented. Here are some common workplace refrains. "We took a vote on this issue and yet no one is following through." "I thought this was decided already. Why are we rehashing it?" "It's always the same people who monopolize the conversation." "I was asked for my opinion and I feel like I was ignored." "They've already made their decision and are pretending to get our input."

In an earlier article,[1] we described the practice of basic facilitation, the conscious focusing of the leader's attention on guiding the group through three processes: sharing relevant information, problem-solving, and decision-making that builds long-term commitment.

Divergent thinking	Convergent thinking
Generating alternatives	Evaluating alternatives
Free-for-all open discussion	Summarizing key points
Gathering diverse points of view	Sorting ideas into categories
Unpacking the logic of a problem	Arriving at a general conclusion

Figure 1. The processes that lead from divergent to convergent thinking and the time devoted to them



People who share the same information, *tend* to make the same decisions

Both divergent and convergent thinking (see text box for definitions) are necessary for group decision-making (Fig. 1). Decision-making that results in commitment follows the sharing of information (facts and data along with personal biases, values, perspectives, and assumptions) and time dedicated to exploring all options. The inverted triangle represents the amount of time that should be committed to

each of these processes. If 80% of the team's time is allocated to sharing information and problem-solving, then the team is more likely to reach agreement and make decisions that all team members are able to "own."

Facilitating meetings effectively requires clarifying up front how decisions will be made and what will happen in the event that agreement cannot be reached. This step is typically part of the broader conversation when a team is developing a team behaviour charter or meeting guidelines.

Knowledge of decision-making processes is essential for facilitative leaders if they truly want productive meetings and meaningful commitment. An old adage, "People tend to support what they help create," implies that if team members do not participate in a meaningful way and own the solution to the problem, commitment to the decision will be mediocre at best. In addition, a decision that does not reflect what is important to team members may contribute to a sense of apathy or cynicism with respect to the future work of the team.

Symptoms, causes, and cures for ineffective decisions

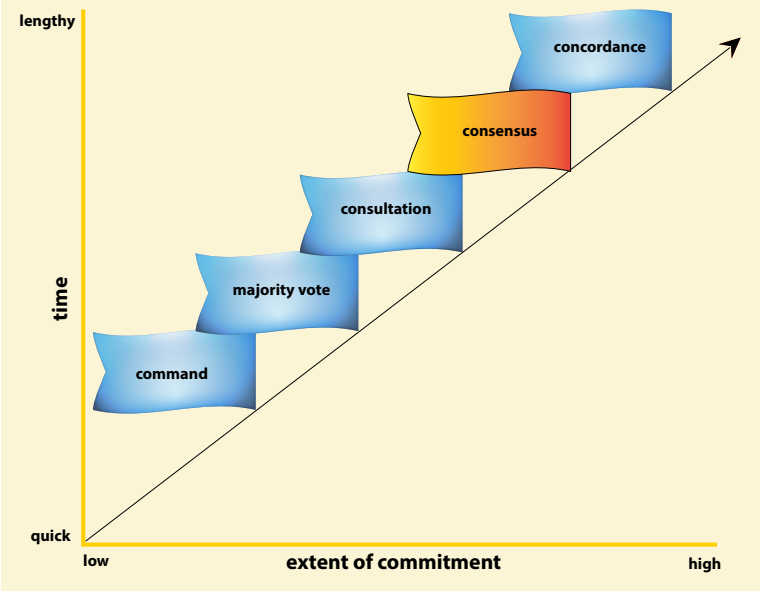
If team members are expressing frustration with the decision-making process or if they are unable to reach agreement, then it makes sense to apply a diagnostic approach, as summarized in Table 1.

Table 1. Diagnosing the problem, finding a cure

SYMPTOM	CAUSE	CURE
Aimless drifting and random discussions	No plan or process for approaching the decision	Adopt a structured approach to decision-making that uses the right tool
Vote used to decide important items where complete commitment is critical, and consensus used for minor issues	Lack of understanding of various decision-making options	Familiarize team with five main decision-making options and decide which to use *before* launching into any discussion
Time runs out just when important decisions get on the table	Poor time management	Create an agenda before each meeting and ensure leader keeps discussion on track[2]
When an important item is on the table, team members get heated and confrontational. No one l istens to opposing viewpoints. Some push their point in an attempt to "win." Some dominate, unconcerned that others are silent.	Poorly developed group interaction skills.	Develop group effectiveness skills* so that team members support each other through active listening and building on ideas. Leader should ensure that members are acknowledging each other's contributions.
It becomes clear that team members are operating on different assumptions about the problem and the constraints or possibilities	Failure to check assumptions	Use probing questions to uncover assumptions underlying statements. Clarify and validate assumptions so that all team members are operating within the same context.
Endless circling of discussion	Failure to check on the meeting process	Stop the discussion periodically and ask how things are going, i.e., Is the purpose clear? Is the pace right? Is progress being made? Is the right approach being taken?

Source: Adapted from Bens 2005.3
*For example, Physician Leadership Institute PMI courses, such as Engaging Others, Meeting Effectiveness (new in 2016), and Crucial Conversations ™.

Figure 2. The relation between time taken to make a decision and commitment to that decision



The five decision-making options

The longer the time taken to make the decision, the greater the commitment to following through (Fig. 2).

A few words about consensus
A common misconception is that consensus means everyone has to agree. Instead, all team members must feel that they have been consulted and involved in a meaningful fashion, so that even though the final solution is not necessarily the one they would have chosen individually, they can readily "live with it."

Table 2. Five ways to make decisions

Option	Description	Advantages	Risks	Uses
Command	The leader makes the decision unilaterally without input from team members	Fast Clear accountability	Lack of input can result in low commitment No synergy	When one person is the expert Leader is willing to take sole responsibility for the consequences In a crisis
Majority Vote	The decision is made by the majority of the team members (50% + 1)	Fast Can be high quality if *effective* dialogue/ discussion (versus debate) precedes the decision Clear outcome	Winners and losers Little or no dialogue Influenced choices Low commitment by dissenters	For trivial matters When there are clear options May be embedded in some medical staff bylaws If division of group is acceptable
Consulation	The leader makes the decision after consulting with members of the team	Can be fast Clear accountability	Possible lack of input from all group members Low commitment Low synergy	When one or more are experts and willing to take the responsibility
Consensus	A point of maximum agreement when all team members say "yes" or "I can live with it"	Collaborative Systematic Participative Dialogue-oriented Encourages commitment	Takes time Requires data and willingness of group members to say what's important to them Requires dialogue skills, including respect and patience	Important issues When full support matters
Concordance	Agreement is reached when all team members say "yes," i.e., unanimity	Highly collaborative Results in high commitment	May require intense and lengthy dialogue	Sometimes occurs spontaneously When complete agreement (versus support) is crucial

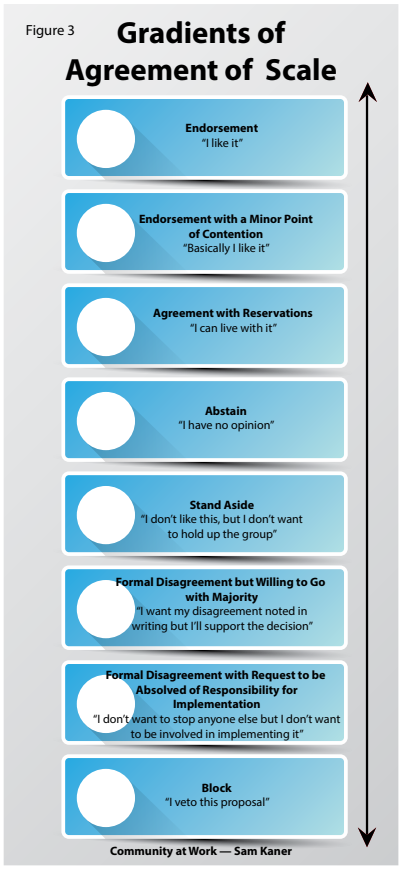
Determining the extent of agreement among team members

Option 1
A scale developed by Sam Kaner[4] (Fig. 3) makes it easier for team members to be honest in declaring their less than whole-hearted support without fear that their comments will be misinterpreted as a veto. The scale can be modified to fit any context; for example, some committees do not allow members to abstain so the "abstain" column may be eliminated. The scale can be used in a variety of ways. For example, if there is ambiguous or meagre support for a decision, the leader may ask:

- What prevents you from supporting this idea/solution?
- What changes, revisions, or additions would make this an idea/solution that you could live with?

We have often witnessed these two questions stimulate deeper dialogue and, when members' reservations or concerns have been explored without judgement, then trust and commitment increase.

Figure 3 **Gradients of Agreement of Scale**



Option 2
When the leader believes the team is ready to make a decision, he or she clearly states the decision and then asks to see the thumbs of the team members. All team members are asked to show their thumbs; there is no opting out. Thumb up means "Yes, I agree and I will actively participate in the implementation of the decision"; thumb to the side means "I can live with it and I won't get in the way of implementing the decision"; thumb down means "No, I don't agree and I may, in fact, interfere with the implementation of the decision." In this option, consensus is achieved when all thumbs are up or to the side, i.e., all members agree to the decision or can live

with it. Consensus is not achieved when one or more thumbs are down. In that case, the leader is advised to ask those with their thumbs down, "What would it take to get your thumb to the side." In our experience, often a minor modification to the decision is all that is needed to move those thumbs from down to the side.

Common problems encountered in group decision-making

Moving too quickly
Most teams attempt to bring discussion to a close too quickly. This often occurs in situations where there *appears* to be an obvious solution, where issues are too complex to be resolved with current thinking or responses, or where the meeting environment does not support new perspectives and thus inhibits input. As a general guideline, teams should spend 80% of their time in the information-sharing and problem-solving stages; then only 20% of the team's time will be needed for reaching agreement and making a decision (Fig. 1). Unfortunately, this ratio is most often reversed.

The handclasp decision
The leader proposes a decision and one or two team members indicate their agreement. This is then interpreted as agreement shared by the entire team. In this case, the leader is encouraged to use either of the options described above to probe and determine more accurately the extent of agreement.

Silence
When a proposed decision is met with silence, this may be falsely interpreted as agreement. If this case, the leader is encouraged to ask, "How should I interpret this silence?"

Lack of clarity about the group's decision-making processes
When the leader is using a consultation approach (Table 2), team members may believe they are engaged in achieving consensus. A team leader who chooses consultation must be clear about this process at the outset, i.e., at the beginning of the information-sharing phase. Similarly, leaders sometimes believe that obtaining input from team members is achieving consensus. Obtaining input is the first step to achieving consensus, but it is not consensus.

Pseudo-consultation
The leader has made a decision, but chooses to seek input from the team members in an effort to help them feel as if they have been involved in the decision-making process. The use of the phrase "buy-in" is sometimes indicative of a pseudo-consultation process. Although it is okay for leaders to make decisions, he or she must be clear about that with the team. The team may still be engaged in providing input with respect to implementing the decision.

Mistaking majority vote for consensus
Majority vote is not consensus. It means that up to 49% of team members may not agree with the decision, and this might impede any action that follows the decision.

Lack of attention to creating an environment of psychological safety
Leaders should create an environment in with team members feel safe in saying what is truly important to them. Decisions can and should be influenced by facts and data. However, decisions are also influenced by values, biases, perspectives, and feelings. Leaders who make it safe for team members to "tell their truth" create an environment in which agreement is more likely to occur, thereby enabling the team to make decisions they will support.

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Voir différemment : la théorie des contraintes appliquée aux soins de santé

Alex Knight, MBA, CEng, et Ruth Vander Stelt, MD

Résumé

Devant l'augmentation des coûts en santé et la demande grandissante, la majorité des pays doivent relever le défi de fournir en temps opportun des soins de haute qualité qui demeurent abordables. Pour améliorer la productivité, il faut adopter une nouvelle perspective : au lieu d'aborder la gestion des systèmes complexes en les décomposant en sous-éléments, il faut voir ces systèmes sous forme de chaîne d'activités où la performance est tributaire de quelques contraintes sous-jacentes. Cette approche, fondée sur la théorie des contraintes, se concentre sur l'amélioration continue obtenue grâce à des cycles rapides d'identification et de renforcement du maillon le plus faible de la chaîne.

Dans toute société, les soins de santé sont une nécessité fondamentale, mais ils ont un coût. Les dépenses totales de santé augmentent année après année, et le Canada affiche l'un des niveaux de dépenses par habitant les plus élevés au monde (Figure 1). Ainsi, les soins de santé représentent souvent un pourcentage important et croissant du produit intérieur brut (PIB) d'un pays (Figure 2). Cette croissance ne peut être attribuée simplement aux actions des dirigeants du système. Dans de nombreuses administrations, toutefois, il devient urgent de réaliser des percées rapides et durables pour améliorer la productivité, et d'énormes pressions incitent à la réduction des coûts, même dans les pays les plus prospères.

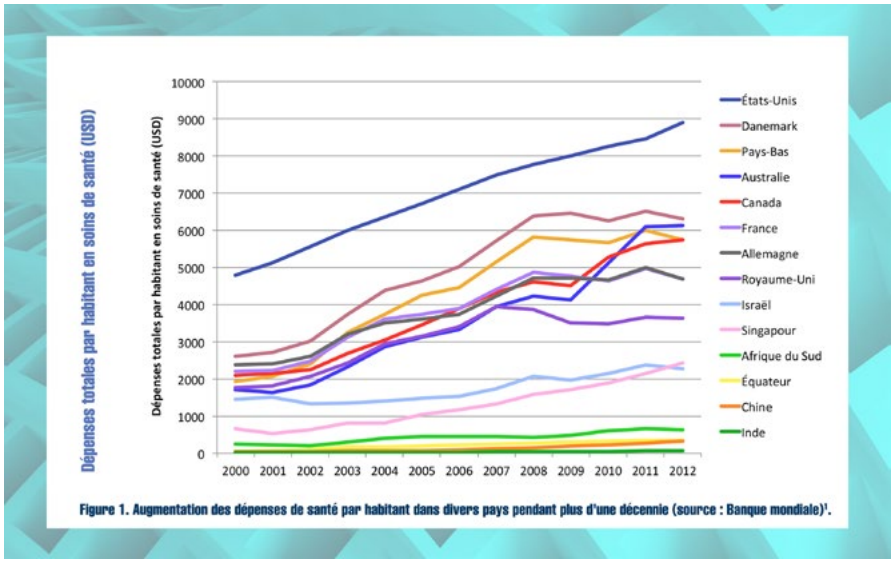


Figure 1. Augmentation des dépenses de santé par habitant dans divers pays pendant plus d'une décennie (source : Banque mondiale)[1].

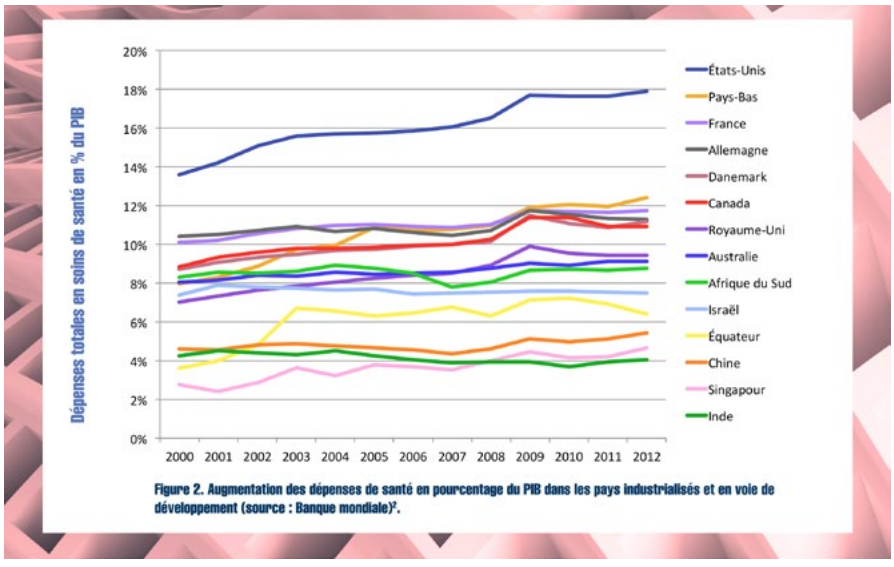


Figure 2. Augmentation des dépenses de santé en pourcentage du PIB dans les pays industrialisés et en voie de développement (source : Banque mondiale)[2].

Figure 3. Un conflit qui s'intensifie dans les soins de santé.

Les salaires des travailleurs cliniques de première ligne représentent le poste de dépenses le plus important dans la majorité des budgets en soins de santé. En outre, les professionnels de la santé, le constatent fréquemment, lorsque le personnel de première ligne subit une pression croissante, la qualité des soins en souffre et le nombre d'incidents catastrophiques augmente[3].

Malheureusement, de nombreux pays sont coincés entre l'arbre et l'écorce. La réussite d'un système de soins de santé se mesure à sa capacité de fournir en temps opportun des soins de haute qualité aux patients, tout en demeurant abordable (Figure 3). À mesure que s'intensifient partout dans le monde les préoccupations relatives à la qualité des soins et aux listes d'attente, on peut comprendre qu'il soit tentant d'accroître les ressources de première ligne ou d'investir encore davantage dans des initiatives de stimulation de la productivité et de l'innovation. Des pressions égales incitent toutefois à réduire les ressources de première ligne pour garder les services abordables et à remettre en question la rapidité et le rendement produits par des investissements dans de nombreux efforts d'amélioration.

« Lorsque le personnel de première ligne subit une pression croissante, la qualité des soins en souffre et le nombre d'incidents catastrophiques augmente. »

Il ne suffit pas de se ranger d'un côté ou de l'autre du conflit. La réduction des ressources de première ligne pourrait améliorer la stabilité financière à court terme, mais pourrait aussi porter atteinte à la qualité des soins ou pis encore, causer une défaillance catastrophique du système.

D'autre part, ajouter plus de ressources en période de contraintes budgétaires appelle à l'examen et à la remise en question. Essayer de faire des économies de bouts de chandelles sous prétexte d'un « équilibre entre la capacité et la demande » peut mener à des résultats négatifs inattendus, par exemple l'apparition de goulots d'étranglement « errants » à travers le système, qui deviennent un

cauchemar à gérer et qui mettent en péril la qualité, la prestation en temps opportun et le coût des soins. Ce qu'il faut, ce n'est pas équilibrer la capacité, mais plutôt équilibrer les flux.

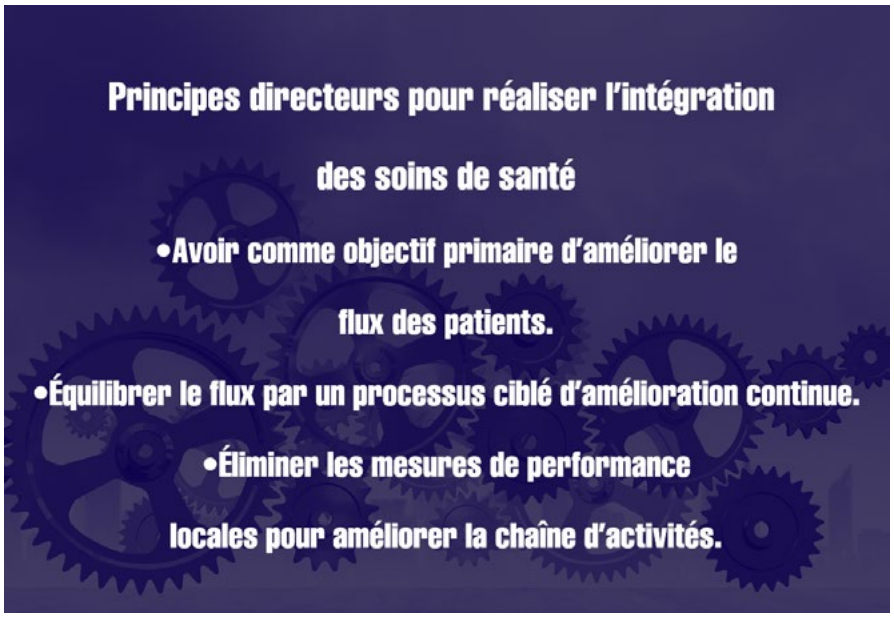
La théorie des contraintes

La théorie des contraintes (*theory of constraints* – TOC) a été formulée en 1984 par le physicien Eliyahu M. Goldratt[4]. Essentiellement, l'approche de la TOC vise à identifier les quelques secteurs qui influent sur la performance de l'ensemble d'un système, ce que M. Goldratt appelle des « contraintes ».

Notre réaction habituelle face à la complexité apparente du défi consiste à décomposer le système en plusieurs éléments et à tenter de maximiser la performance de chacun pour améliorer l'ensemble du système; mais cela ne fonctionne pas. Une optimisation locale ne mène presque jamais à une optimisation globale parce que les mesures locales ne tiennent pas compte de l'importance des contraintes ni de leurs liens avec le reste du système.

Il suffit plutôt, pour renforcer une chaîne, d'identifier et de renforcer son maillon le plus faible. Pour faire une percée en matière de performance, nous devons consacrer tous nos efforts à cerner et à éliminer les causes sous-jacentes d'une situation de rendement médiocre, plutôt que nous éparpiller sur ses multiples effets.

Pour améliorer la productivité, il faut adopter une nouvelle perspective : au lieu d'aborder la gestion des systèmes complexes en les décomposant en sous-éléments, il faut voir ces systèmes sous forme de chaîne d'activités où la performance est tributaire de quelques contraintes sous-jacentes. Cette approche, fondée sur la théorie des contraintes, se concentre sur l'amélioration continue obtenue grâce à des cycles rapides d'identification et de renforcement du maillon le plus faible de la chaîne



Ce changement de perspective — au lieu d'aborder la gestion des systèmes complexes en les décomposant en sous-éléments, les voir plutôt comme une chaîne d'activités où la performance du système est tributaire de quelques contraintes sous-jacentes — a des répercussions profondes sur tout effort d'amélioration. Plutôt que de se lancer dans une amélioration de grande envergure touchant tous les éléments du système, l'approche de la TOC est axée sur l'amélioration continue obtenue grâce à des cycles rapides d'identification et de renforcement du maillon le plus faible de la chaîne.

Viser haut

La TOC a été appliquée au secteur des soins de santé, comme l'explique l'auteur de *Pride and Joy*[5], un ouvrage didactique de gestion rédigé sous forme de roman. La TOC a donné des résultats marquants en permettant d'atteindre les trois objectifs suivants :

- Améliorer rapidement la qualité et les délais de prestation des soins dans l'ensemble du système de santé.
- Améliorer la performance budgétaire du système.
- Éviter d'épuiser le personnel ou de prendre des risques imprudents.

Pour réussir la mise en œuvre de la TOC dans le domaine des soins de santé, l'intervention doit avoir pour objectif primaire l'amélioration du flux des patients. Les cliniciens et les membres du personnel ont besoin d'un mécanisme robuste de synchronisation des ressources qui permette de répondre à la

question suivante : « Parmi tous les prochains patients que je pourrais traiter, lequel devrais-je traiter en premier afin d'améliorer le flux de tous les patients dans le système? » (c'est-à-dire une fois pris en charge les cas cliniques urgents). La synchronisation des ressources améliore considérablement le flux des patients dans le système et les soins sont dispensés plus rapidement.

« Décomposer le système en plusieurs éléments ne fonctionne pas. »

En deuxième lieu, un processus ciblé d'amélioration continue visant à équilibrer le flux des patients est indispensable. Posez-vous la question suivante : « Parmi tous les aspects que je pourrais tenter d'améliorer, lequel aura la plus grande incidence sur la performance de l'ensemble du système? » Cette démarche est essentielle pour repérer et éliminer les causes sous-jacentes de délais dans le système, améliorer le flux des patients et soulager le personnel clinique du stress lié à la gestion des interruptions dans le soin de leurs patients. Libérer cette capacité offre de nouveaux choix stratégiques au système de santé.

Troisièmement, l'abolition des mesures de performance locales éliminera les comportements moins productifs. « Dites-moi comment je serai évalué, et je vous dirai comment je me comporterai. » Si vous continuez à évaluer les gens uniquement en fonction de leur partie du système, il ne faut pas vous étonner de voir s'éroder les liens entre les maillons de la chaîne. Remplacer certaines mesures de rendement par quelques objectifs bien définis, fondés sur le flux des patients, permet à la direction de comprendre et d'améliorer la performance du système dans son ensemble.

Mise en œuvre de la théorie des contraintes : centrée sur les patients, dirigée par les médecins

Toute percée dans le système de santé peut être jugée comme réussie si elle répond aux critères suivants : offrir une approche centrée sur les patients et dirigée par les cliniciens, axée à la fois sur l'amélioration de la qualité et sur la prestation des soins aux patients en temps opportun. Un temps de rétablissement prévu, estimé à partir de données cliniques, est établi pour chaque patient – non pas en fonction d'une moyenne nationale ou des meilleures pratiques, mais en fonction du temps cliniquement prévu de rétablissement de ce patient en particulier. Cette date peut servir à coordonner les activités de toutes les ressources et à éliminer l'optimisation locale. Tout retard dans les soins au patient est analysé pour cerner la combinaison tâche-ressource qui cause le plus souvent le plus de délais pour le plus grand nombre de patients. C'est cette optique qui permet de garantir que des mesures considérables produisent des avantages immédiats et importants.

Le leadership de nos cliniciens est indispensable pour que cette approche demeure centrée sur le patient et soit viable. Les cliniciens de première ligne fournissent les soins et par conséquent il faut veiller à ce qu'ils interviennent pour diriger l'amélioration du système de santé. Cela relève du simple bon sens.

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OPINION

Our health care system: designed for the convenience of doctors,not patients

by André Picard

At this year's Canadian Conference on Physician Leadership in Vancouver, André Picard moderated a debate, "Be it resolved that physicians are an impediment to transforming the health care system." He is a well-known health reporter and columnist at the *Globe and Mail*, and a best-selling author of several books related to the Canadian health care system. On May 14, 2015, André Picard, received an honorary doctorate from the University of Manitoba. Below is an extract of his convocation speech delivered to graduating MDs.

For almost 30 years I've tried to help Canadians understand their health system and their medical care. In that time, I've seen tremendous advances in medicine and I've met, quite literally, thousands of health professionals, from students to Nobel Prize winners, and patients, from those with rare genetic mutations to those with everyday ailments, from those cured miraculously to those who died needlessly. Today, I'd like to take few minutes to share some of what I've learned from telling their stories.

One of the greatest privileges in our society is to have the letters MD after your name. Those two letters confer great power. And with that power comes great responsibility, to quote Voltaire —or Spiderman, depending on your literary predilections. Shortly, you will be taking the Hippocratic Oath. You've probably all heard that it says: "First do no harm." It doesn't actually — that's just bad media reporting. But it does say a lot of important things. I think the line that matters most in the oath is this: "Whatsoever house I may enter, my visit shall be for the convenience and advantage of the patient."

Sadly, too many physicians fail to honour that part of the pledge. We have built a sickness care system rather than a health system. We have designed that system for the convenience of practitioners, not patients. Modern medicine has become so specialized that many physicians treat specific syndromes and body parts, and the patient herself gets lost in the process. We have filled our temples of medicine with such bedazzling hi-tech tools that we've forgotten that we should treat people where they live.

In our desire to cure, we over-treat. We fail too often to say the three most important words in medicine: "I don't know." We see death as a failure, instead of aspiring to make patients comfortable and at peace at end of life.

In our unrelenting quest for efficiency and measurement, we too often lose sight of what really matters: the patient. What does your patient want? What are his or her goals? Those are the questions that must guide your practice. For some of your patients, the goal is to repair their acute woes, to help them live long. But most of your patients will be older and have a number of chronic conditions and be nearing the end of life. Their goals are different. They're not going to be cured.

You have to focus on their quality of life. They want to be at home. They don't want to fall. They don't want to be in pain. They don't want to be a burden. They don't want to be alone. They don't expect miracles, but they would like respect. They don't fear dying. They fear losing their autonomy and their dignity. They don't care about your metrics, or your age-adjusted mortality rates, or your fancy new genomic test. They want to be listened to, and heard.

We hear a lot these days about personalized medicine, about drugs and treatments that can be tailored to specific genomic and epigenetic markers. But you know what people really long for: personal medicine, not personalized medicine. They crave a human connection. Not just care, but caring. The very best medicine you can offer your patients is a listening ear. The very best treatment you can offer them is a compassionate heart.

Now you may be sitting there thinking, this is all feel-good nonsense. It's not. The more sophisticated and complex

medicine becomes, the more the basics matter. What did you learn in medical school? Anatomy, biochemistry, genomics, countless mnemonics to help you remember bits of knowledge. You know how to deliver babies and treat cancer and diabetes and depression and asthma, take out people's appendix and do MRIs and PCIs, and countless other things.

What you're going to learn now, in the real world, is that physical woes are the least of patients' worries. Their health problems aren't strictly caused by mutating cells, opportunistic pathogens and poor genes, but by poverty, lack of education, poor housing, stress, and social isolation. Sooner or later, you're going to learn humility. And, the earlier you do, the better the doctor you're going to be.

In this, the Internet age, we are drowning in information, but starving for wisdom. I urge you, as you forge long, successful, and prosperous careers, to not just be smart, but be wise. In every interaction you have, embrace the ancient wisdom of Hippocrates: "Whatsoever house I may enter, my visit shall be for the convenience and advantage of the patient."

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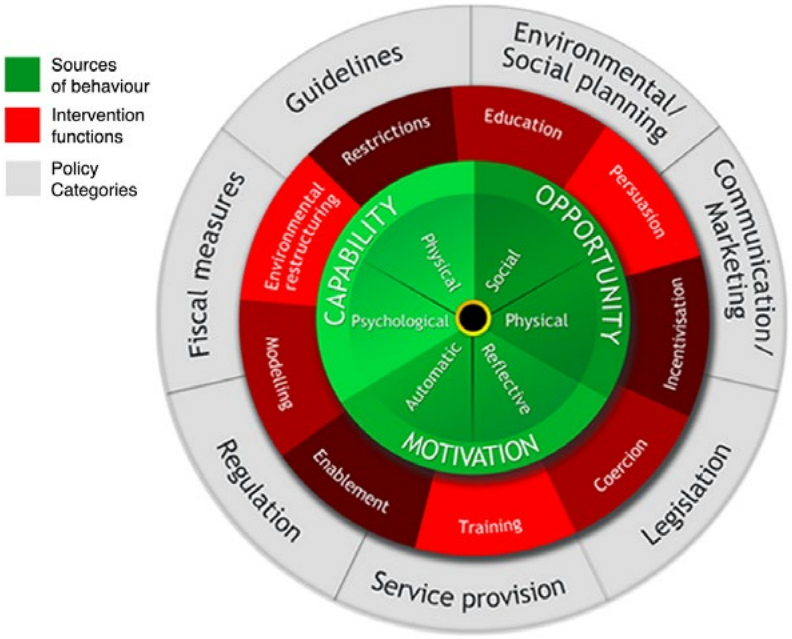
BOOK REVIEW

The Behaviour Change Wheel: A Guide to Designing Interventions

Susan Michie, Lou Atkins, and Robert West
Silverback Publishing, 2014

Reviewed by
Johny Van Aerde, MD



Changing behaviour in a population, a group, or an individual is challenging for many reasons. *The Behaviour Change Wheel* is the result of a consensus study by more than 30 researchers in health psychology and implementation sciences. After reviewing the literature, they identified 33 theories and 128 constructs. That review and the consensus study formed the basis for a "behavioural change wheel" (BCW) consisting of three concentric circles. The inner circle or hub is the sources of behaviour that cause and maintain it and/or prevent it from changing. The middle circle contains the intervention functions, and the outer circle or rim of the wheel is built on categories of policy (see figure).

The hub of the wheel helps us understand the situation by defining the problem, specifying the target behaviour, and identifying what needs to change. The authors use the COM-B model to understand and define the behaviour, where B stands for behaviour, C for capability (both physical and psychological), O for opportunity (both physical and social environment), and M for motivation (reflective and automatic mechanisms). Motivation, capability, and opportunity each influence behaviour in different and synergistic ways. The six subdivisions of the hub are similar, but not identical, to the six sources of influence in *Influencer: The New Science of Leading Change*,[1] i.e., the personal, social, and structural motivations and abilities that affect behaviour and behavioural change.

Once the target behaviour has been identified, there is a choice of nine evidence-based intervention functions that make up the middle circle and are aimed at addressing the deficits identified with COM-B. Each is defined and well explained in the book. The outer circle identifies seven policy categories to support the delivery of the intervention functions. Policy categories are the types of decisions that must be made by authorities to support and enact the interventions determined to be effective. The policy categories apply less to behavioural change in the individual and more to changes in an organization or population.

The book makes the approach to the BCW model quite practical. Although it might make the novice to behavioural change management gasp at first, a second look will bring an appreciation of the eight logical and well explained steps, each with plenty of examples. Health-related examples include improvement in hospital hygiene practices, use of assessment strategies for cardiovascular disease assessment by general practitioners, habit formation for cystic fibrosis treatment, use of a smart phone app by parents of obese children, evidence-based care of elderly with suspected cognitive impairment in general practice, and intervention to prevent melioidosis in Thailand. With the help of the book's many worksheets, the reader can ease

into developing his or her own project to change behaviour and form new habits.

The first four steps (the hub of the wheel in Figure 1) help the reader understand and define the behaviour; the fifth identifies the appropriate intervention (middle circle in the wheel); and step six (the rim) identifies the supportive policy categories. Because these six steps by themselves are not specific enough to lead to action and measurable change, the researchers added two more crucial steps: identification of behavioural change techniques (BCT) and identification of the mode of delivery.

The BCTs, which are evidence-based, are lists of active ingredients within the intervention, designed to change behaviour[2]; they are observable, replicable, and irreducible components of an intervention and can be used alone or in combination. In other words, the seventh step, BCT identification, supports the delivery of the intervention function(s), as defined in step five using the middle circle of the wheel. The eighth and final step, which supports the sixth step, helps identify how best to deliver the entire package.

In summary, this is a good reference source and a book worthy of a spot in your library. Although perhaps overwhelming for the beginner, it contains the most up-to-date evidence available in the literature. The BCW model is structured in such a way that it will provide the best chance for success in changing the behaviour of a population or an organization, although, for changing personal habits, the BCW is less suitable. Purchase of the book includes access to more resources on the BCW website (www.behaviourchangewheel.com).

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