

Why do we do what we do?

Practical insights into behavioural science for medical leaders

Dr John Wakefield PSM

MB CHB MPH (research) FRACGP FACRRM FRACMA

Deputy Director General

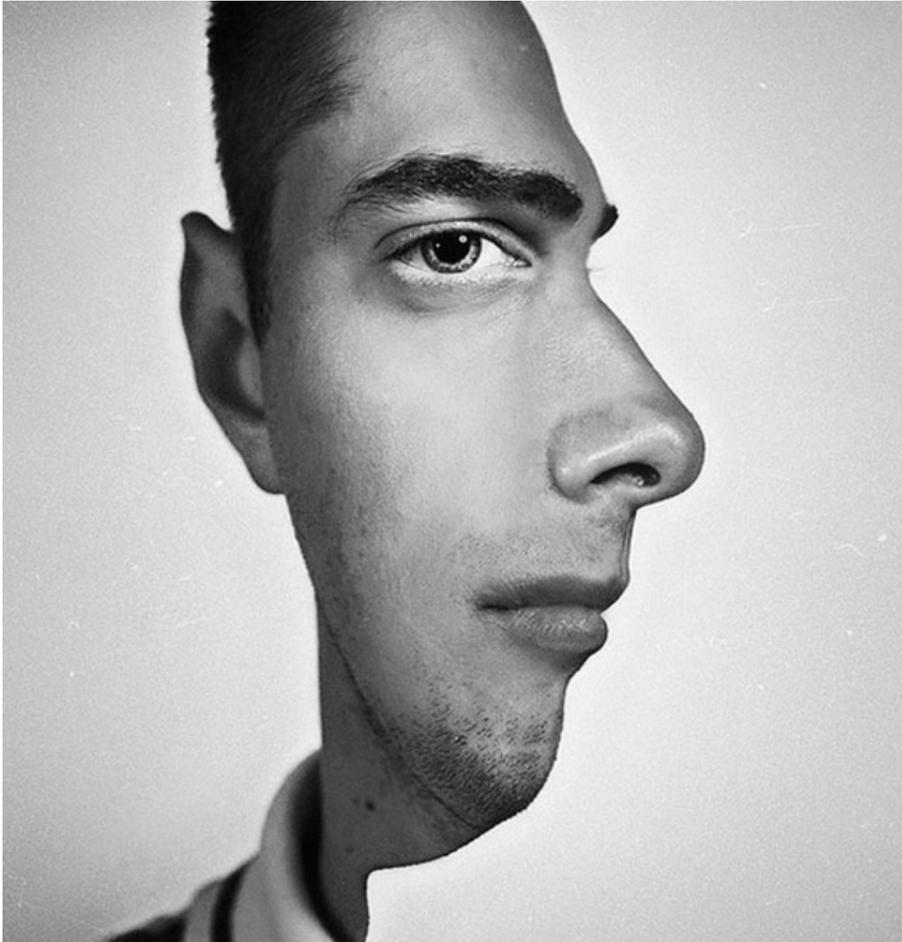
Clinical Excellence Division

Department of Health, Queensland

Adjunct Professor Public Health QUT

22 March 2016

My job today...

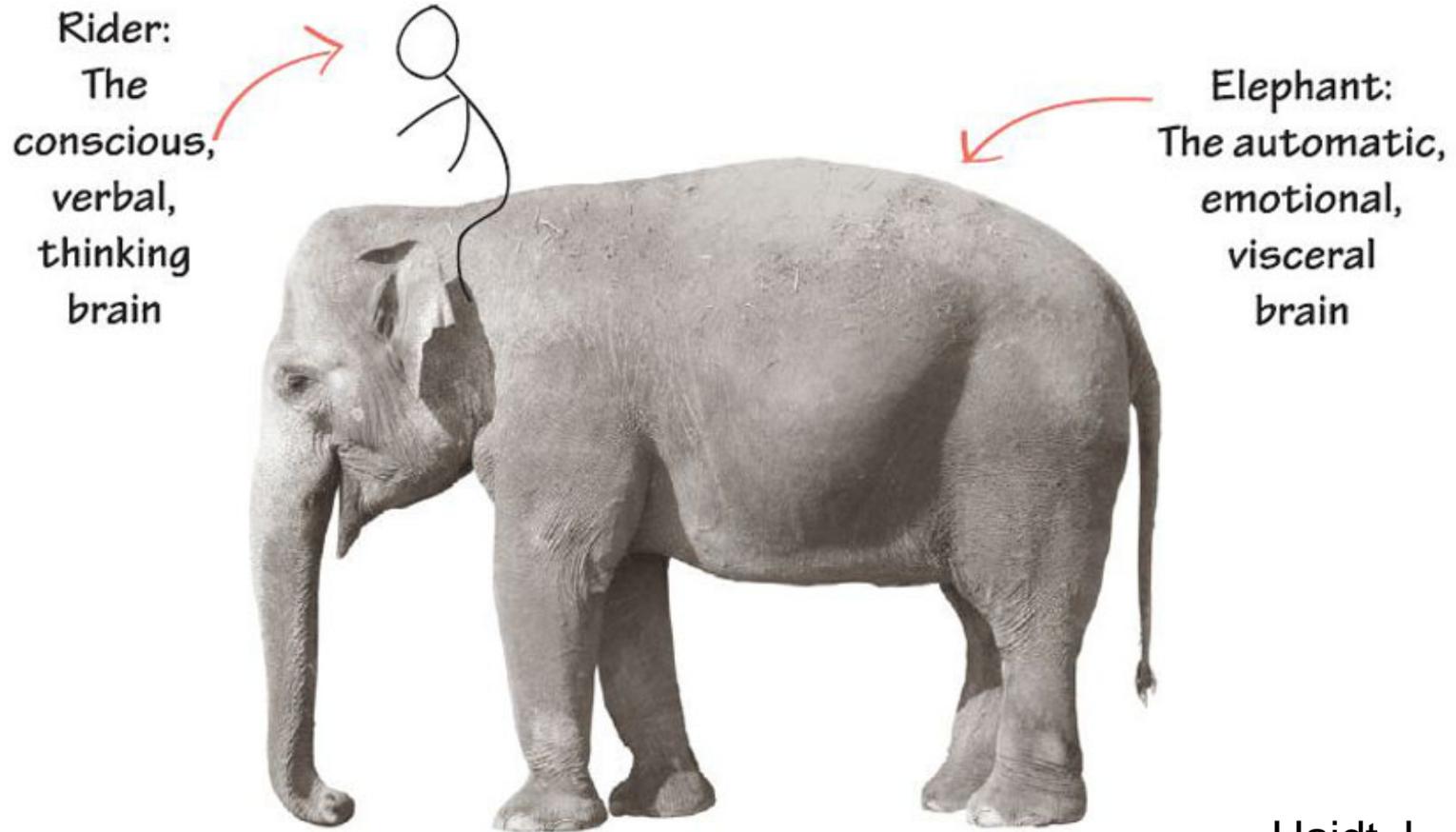


To mess with your head a little...

To challenge your assumptions of your own behaviours..

To get you to question our usual approach to change...

All day; every day



Haidt J

Re-thinking behaviour change



A sacred cow

We have all been brought up to believe that as doctors and scientists, it is knowledge acquired through education (pedagogy) that drives the practice (behaviour) of doctors...

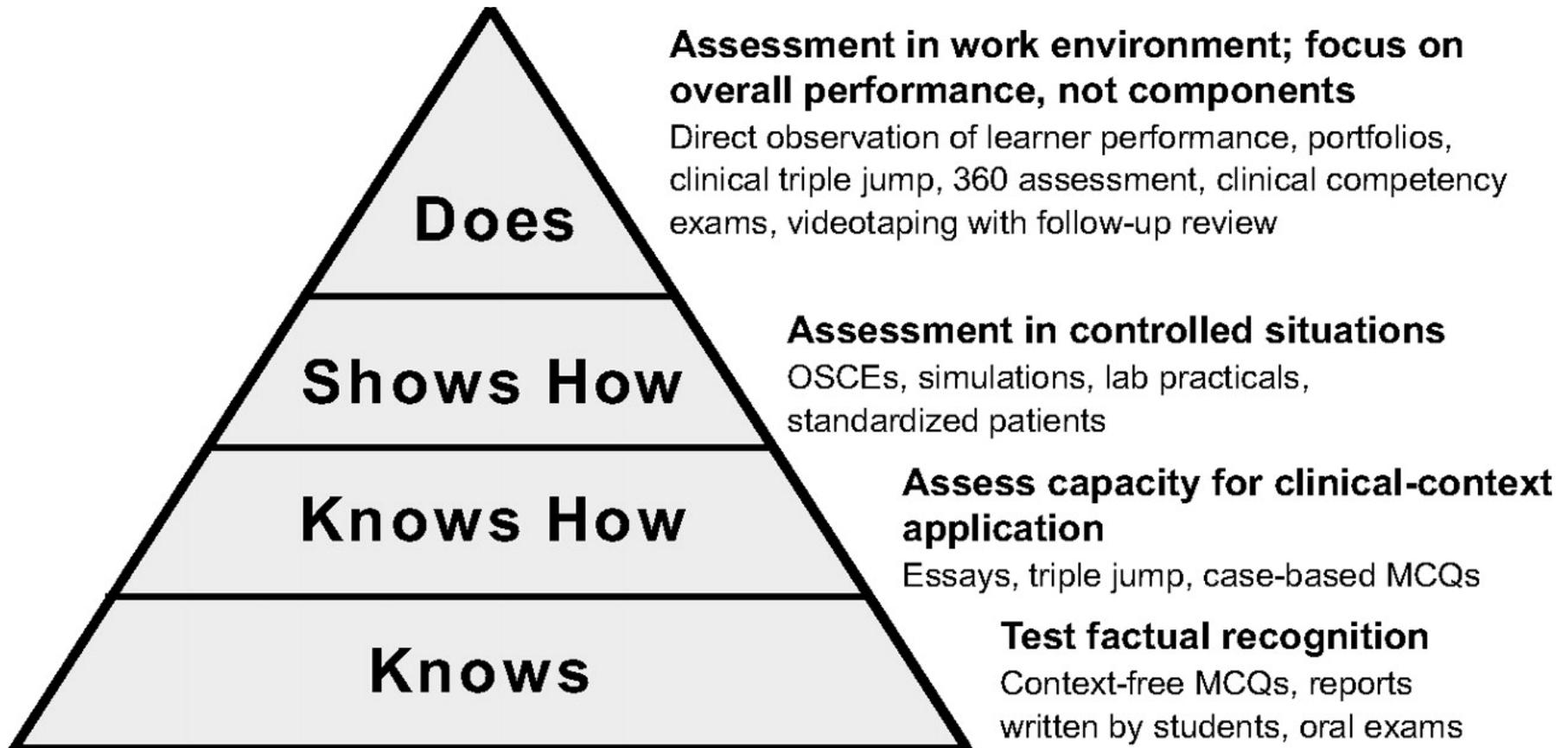
Is this true?

An example...



Whitby, McLaws, Ross (Infect Control Hosp Epid 2006)

Cognition and behaviour

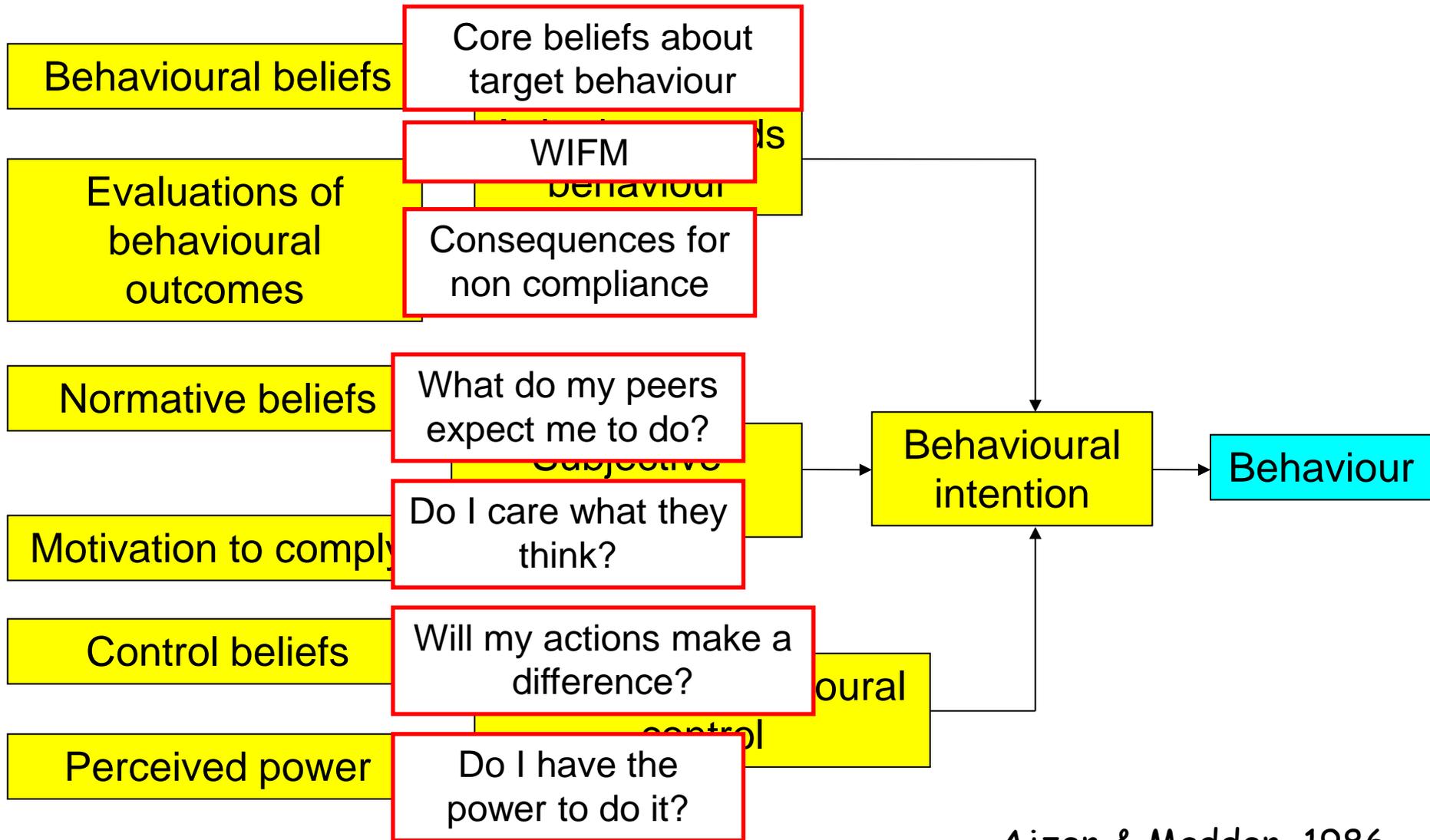


Adapted from Miller GE Academic Medicine 1990

“There is nothing so practical as a good theory”

Kurt Lewin (1952)

Theory of planned behaviour



Ajzen & Madden, 1986

Using science to stack odds in our favour...

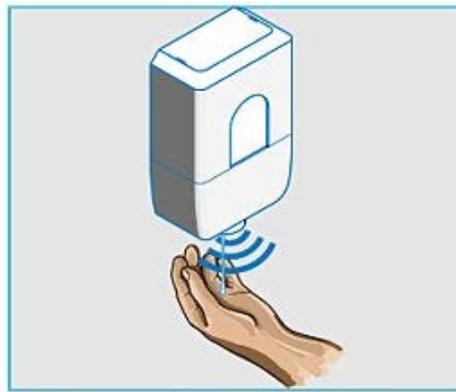
- How do we build a model?
- How do we stack the model in favour of the target behaviour?

Reflection – What is the role of pedagogy (education) in this?

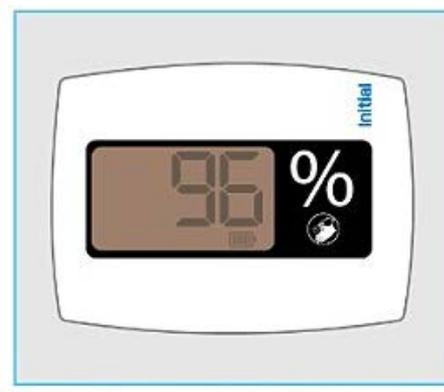
Applying behavioural model



1. Sensor on the door detects when employee enters washroom



2. Sensors on soap dispensers measure how many people wash their hands



3. Real-time data on % of people washing their hands is displayed on hygiene compliance monitor outside washroom



4. Seeing this data makes other users more likely to wash their hands



Lessons for medical leaders

- STOP – don't leap to education as a fix
- Apply the science! – build a model
- Beware of 'rational' and 'managed' solutions with blunt levers – they rarely sustain and we are masters of workaround
- Make it easier than the old way or even make it 'fun' at the change
- Get the boss doing it first – you do it