Child & Family Behavior Therapy


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literature and also enhances his book with many examples, forms, and charts. The integration of sound behavioral principles into school discipline is both exciting and needed. Regrettably, most school systems still utilize an authoritative, zero tolerance, rigid, and insensitive style of punitive consequences to achieve student control and discipline. This book clearly outlines better, research informed, strategies to manage and maintain positive student behavior while enhancing self-discipline. Using these behaviorally generated procedures increases the odds that children will learn morality and self-control, to be used not only in school but for life. $35.00 is a remarkable bargain given the possible impact of this fine book.

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Atul Gawande is a general and endocrine surgeon at the Brigham and Women’s Hospital in Boston. He is also a staff writer for *The New Yorker* and is an associate professor at Harvard Medical School and Harvard School of Public Health. He leads the World Health Organization’s Safe Surgery Saves Lives program and he is the author of *Better: A Surgeon’s Notes on Performance* and *Complications: A Surgeon’s Notes on an Imperfect Science*.

Through professional experience, Gawande has identified that a common problem in most fields is consistently and correctly applying what is already known. Gawande posits that this problem exists because the amount and complexity of information available exceeds people’s capacity to incorporate information into practice. For Gawande and others, the solution to this problem is to use checklists.

The reader of this book is taken through professional experiences wherein checklists have proved their worth in three fields: aviation, medicine, and construction. In aviation, pilots have manuals that consist of checklists. The recent emergency landing of the plane in the Hudson River was successful because the pilot and co-pilot relied upon the checklists of what steps to take in an emergency landing. At Johns Hopkins Hospital, a checklist for central lines (a method for obtaining venous access) was implemented, and in 15 months there were only two infections. The use of a checklist is estimated to have prevented 43 infections and 8 deaths and saved $200 million in costs. In construction, builders use checklists to ensure that the group of specialists working on the building come together, discuss the project, and make team decisions. One result is that we have buildings that withstand the test of time. The author looks at the checklists used in these three areas and identifies the components of an effective checklist.
An effective checklist has five to nine specific items, using simple and exact wording that is in language familiar to the profession; it is only one page long; it is free from both clutter and unnecessary colors; it is written in uppercase and lowercase text; it identifies key stop and check points; and it is tested and revised, as needed. In essence, a checklist that Applied Behavior Analysts call a task analysis, is a breakdown of the steps needed to complete a task.

Gawande conducted his own study to see whether an effective checklist could be developed to generate surgeries that are safe and in accordance with current, state-of-the-art knowledge. His study used eight hospitals around the world; four in high-income locations; and the four in busy, low- or middle-income locations. The goal was to determine whether the checklist could improve care. After the checklist was introduced, the results were examined at each hospital for 3 months, yielding statistically and clinically significant results. In all eight hospitals, the rate of major complications fell 36%, and deaths fell 47%. The checklist had again proven its worth. One attractive aspect of the study is that measures of social validity were taken. When staff were surveyed, 78% reported that the checklist had prevented errors. In addition, 80% reported the checklist as easy to use. Interestingly, 20% complained that the checklist took too long to use and felt that it did not improve care. Yet, 93% indicated they would want a checklist in place if they were patients.

Why did the 20% object to the checklist? Even with real world examples, where checklists have proven their value, some professionals still object to their use. Gawande found that some people considered themselves already well-trained experts and some felt that they did not need checklists to conduct their duties properly. Some professionals, Gawande also notes, find checklists both offensive and embarrassing. How then, do we get people to use checklists, given their demonstrated value? Pilots, for example, use checklists because they have been trained to do so, and checklists have proven their worth. (Pilots also go down with their falling planes.) The answer may be found in the Premack Principle (Premack, 1959) which states that people will engage in a low frequency activity if it leads to a more preferred, high frequency activity (i.e., a more enjoyable activity). Thus, people’s behavior can be rewarded with more advanced steps in a sequence (such as going home or receiving permission to carry out an intervention), only when all items on the checklist have been satisfied. In addition, checklists are antecedents that that can be made salient with positive reinforcement for compliance.

Effective checklists can be implemented in every field, ensuring that acquired knowledge is carried out correctly and consistently. In schools, teachers could use a checklist for writing an Individualized Education Program. Nannies could use a checklist to prepare for a day of childcare. Lawyers could use a checklist to ensure all steps are taken to prepare and file a
specific document and deliver it to the proper court. Chefs already use recipes to make preferred dishes. The recipes they use are checklists. Police officers could use a checklist for making an arrest, ensuring that all procedures are properly followed. Various professionals could use checklists to bill insurance companies for services rendered. Psychologists already use checklists (modularized treatment manuals) that have been shown to improve treatment efficacy. In fact, when therapists diverge from such standardized treatment delivery, the results are often inferior to when fidelity to such treatments is maintained.

Gawande has written a very readable book that can be useful to professionals and the public alike. He shares both personal experiences and those of his colleagues, in a clear and upbeat writing style. One possible flaw is that his reported study did not use a multiple-baseline design (Baer, Wolf, & Risley, 1968) in which implementing the intervention is staggered across settings (in this case, hospitals). Instead, after a baseline period in each hospital, adopting the checklist procedure appears to have been done simultaneously in each hospital. This leaves the study open to a possible challenge of internal validity. It does raise some interesting technical notes on re-utilizing multiple-baseline measures, which have grown out of favor in large studies of empirical efficacy. Nevertheless, the real-world examples of checklists and the means for developing them are compelling. Gawande clearly makes a case for checklists in any field, as a way to improve consistent and correct application of what is known.

REFERENCES


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In the mid-1970s I received a faculty appointment at what was then Rutgers Medical School. In lecturing to the psychiatry residents I mentioned that I