

health systems

Physician Leadership “Group Responsibility” as Key to Accountability in Medicine



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Introduction: Leading Physicians Back To Health Care Leadership

Physicians who attend a popular leadership development course sponsored by Kaiser Permanente (KP) are sometimes asked, “What does a person need to become a leader?” The simple answer, they are told, is “followers.” But that answer only begs the tougher question of how to get a group of naturally independent, self-assured physicians—every one of whom is regarded as a leader or authority figure by patients and staff—to behave as followers as well as leaders. “I can call spirits from the vasty deep,” boasted Owen Glendower in Henry IV (Act III, Sc 1). “So can I,” said, Hotspur, “or so can anyone. But will they come when you do call them?”¹

This chapter addresses two related questions about physicians and leadership: 1) Why is the leadership of physicians relevant to American health care and how can it most effectively be reaffirmed? And 2) What are the leadership qualities necessary to persuade physicians to act together in fulfilling that role?

Why Physician Leadership Matters

It was not so long ago that physicians held a god-like sway over the health care universe. After all, it was a universe that consisted, for the most part, of tens of thousands of highly personalized, independent solo practices, each tending to the health care needs of hundreds of individual patients, one at a time. Within that intimate relationship between physician and patient, the physician held all the knowledge, all the power, all the authority. And the physician and patient were indisputably the only actors who really mattered. Even in the relationships between physicians and hospital administrators or, later, physicians and insurers, physician authority—to set policies and to determine the cost for services rendered—was rarely challenged.

That pre-eminent status over the entire health care environment is today the stuff of nostalgic TV reruns. For the last decade, especially, much of the physician community has been in steady retreat in the face of a daunting array of powerful challengers for influence: larger and ever-more powerful, for-profit “managed care” insurance companies; megalithic hospital systems (with the capital to buy up, and then

break up, unprofitable physician practices); physician practice management firms focused on Wall Street; state and federal regulators responding to populist political agendas; increasingly activist employers/payers motivated by soaring health care costs; and, most recently, health care consumers and patients themselves, empowered by the information revolution and their own growing financial stake in the cost of their health care. The result, proclaimed in every medical trade publication, is that physicians, as a profession, have lost more influence more rapidly than any profession in history.

But does it really matter beyond the immediate interests of the medical profession? Is American health care in any way less effective or valuable because physicians have ceded so much leadership in health care to other actors—insurers, accountants, regulators, purchasers, and patients?

We believe the void in physician leadership does matter. The evi-

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dence can be read virtually every day in newspaper headlines attesting to the growing turmoil, confusion and public distrust toward health care institutions. Health care costs have soared at double-digit rates, far outpacing overall inflation. Inevitably, the number of uninsured Americans is rising again, and even the best-insured are beginning to take notice of their higher out-of-pocket costs as employers shift the growing cost burden to employees via higher deductibles and copays.

The growth of managed care with its cost containment strategies in the 1990s prompted an unprecedented outpouring of consumer resentment and backlash (fed in large part by physician backlash) that tarnished the entire enterprise. At the same time, a series of landmark, well-publicized quality studies by the Institute of Medicine (IOM) documented widespread failures in the area of patient safety and an alarming “chasm” between the medical quality standards that are routinely delivered and the enormous quality improvements that are possible but have not been widely realized. “Many patients, doctors, nurses, and health care leaders are concerned that the care delivered is not, essentially, the care we should receive. The frustration levels of both patients and clinicians have probably never been higher,” said the IOM’s *Crossing the Quality Chasm* report. “Yet the problems remain. Health care today harms too frequently and routinely fails to deliver its potential benefits.”²

In many ways, American health care entered the 21st century both bloodied and bowed—and with no effective leadership. As others have observed, the contest for influence among physicians, insurers, regulators, politicians, and purchasers that ensued in the 1990s turned into a mass retreat by the end of the cen-

tury, leaving the field to the de facto, somewhat reluctant leadership of the consumer (for whom retreat is not an option) and a few scattered purchaser coalitions.³ Since then, the mainstream physician community has failed to step forward and accept responsibility and accountability in the critically important arena of clinical decision making, and no other stakeholder has stepped up to the broader responsibilities for the daunting financial, technological, and other health challenges that have come to full fruition in health care over the last 15 years.

Given the great and growing complexity of health care over the last half century, a whole new, pluralistic model of leadership is now required—one in which responsibilities and accountabilities are widely shared among players who are willing and able to act as true partners in a health care system that is worthy of the name.

Yet even within such a leadership alliance, the physician, together with his or her patients, must inevitably occupy a special place. For no other party has the professional responsibility, dating back 2500 years, to always place the interests of the patient above self-interest in all forms, and to maintain the highest standards of competence, knowledge, and integrity in the interest of patients’ welfare. The acceptance of that ancient responsibility, deeply ingrained in the profession, is the basis for the time-honored social contract on which the medical profession traditionally has derived its special status in society and its special claim to leadership in health care.

A New Medical Landscape Requires a New Leadership Model

Unfortunately, that social contract no longer obtains in the age of mod-

ern medicine. Physicians themselves may bear part of the responsibility for the breakdown by having allowed modern commercial pressures and entrepreneurial opportunities to sometimes compromise the fundamental ethical principles that define medical professionalism. The intrusion of the administrative bureaucracy of many managed care institutions into the patient-physician relationship in the interests of utilization management and other cost-containment strategies also helped undermine the patients’ and the public’s confidence and trust in their relationship with physicians. But undoubtedly the most powerful force at work has been beyond the influence of either individual physicians or managed care institutions: It is simply the fundamental disconnect between the traditional organizational model of solo-practice, independent physician autonomy, and the vast complexity of modern, evidence-based medicine.

Medicine, it is often asserted, has changed more in the past 50 years than in the previous 500 years, and it will change more in the next 10 years than in the last 50 years. By the end of the last decade, a proliferating number of scientific journals were annually publishing an estimated 10,000 research articles based on randomized clinical trials (RCTs), the strongest source of new medical knowledge.⁴ That compared to about 500 RCT articles per year as recently as the 1970s—a pace that even then challenged the ability of individual physicians to keep abreast of relevant new clinical knowledge.

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The remarkable pace of the development of new scientific knowledge is only part of the problem. Even if physicians were able to keep themselves adequately informed of the latest research, the traditional, cottage-industry model of physician organization offers no systematic means to reliably institutionalize that knowledge as standard practice. Thus, despite the availability of information about important, evidence-based advances in clinical care, vast, inappropriate variations in “standard practice” continue to be the rule from community to community, and even within communities, meaning that too many patients are not receiving the quality of care that they have every right to assume and expect.⁵

Thus, in a very fundamental way, the traditional, mainstream model of physician organization is not living up to the health care demands of the 21st century. It can no longer support physicians in delivering on the professional obligations of competence, knowledge and best practice on which physician leadership depended in the past, and on which it must rebuild its credibility and its right to leadership in the future.

Redefining Leadership Through Group Practice

Physician leadership in the health care industry is needed today to help define and propagate a new model of care for the 21st century. That new model must meet each of the six challenges set out in the IOM’s *Crossing the Quality Chasm* report. Thus, to paraphrase the IOM report, it must help to:

- Redesign evidence-based care processes to meet the needs of the chronically ill for coordinated, seamless care across

settings and caregivers;

- Use information technology to automate clinical information and support clinical decision making;
- Manage the explosion of new clinical knowledge through processes and tools for lifelong learning and ongoing licensure and credentialing;
- Coordinate care across conditions, services, and patients’ lifespans;
- Promote and advance team-based care through appropriate professional incentives and cultural change strategies;
- Incorporate accountability for all levels of performance and outcomes into clinicians’ daily work and professional expectations.²

This is a tall order—one that requires a fundamentally different model of care delivery than what many physicians know today. But the good news is that the foundation of the model exists, and in fact has been demonstrating an increasing ability to meet exactly the kind of challenges we are facing. That model is the large, multispecialty group practice, especially as it operates in a prepaid environment. Some 70 years after its basic outlines were forged by far-sighted physician pioneers, the evolved large, multispecialty group practice model remains the most fertile basis for the rejuvenation of medical professionalism and a new model of physician leadership.

What is it about large, multispecialty group practice that lends itself to meeting the challenges of physician leadership today? The best group practices, whether operating in the fee-for-service or prepaid environments, share a small number of fundamental principles (some refer to them as their DNA, or “genetic code”) that shape their culture and drive

their performance. These principles also compel members of the group to accept, and even to demand, a range of responsibilities and accountabilities for the care they provide that reach well beyond those of traditional, solo-practice medicine. Taken together, these accountabilities constitute a credible basis for rebuilding physician leadership, for they respond directly to IOM’s vision for improved quality of care. They include the accountability of the collective medical group for:

- Effective care, as reflected in standardized measures of patients’ clinical outcomes;
- Patient trust and satisfaction with the cost and quality of the care they receive, as measured by scientific surveys;
- A focus on prevention and wellness that looks beyond the traditional boundaries of illness-oriented health care;
- Safe care, as defined in the IOM’s patient safety report;⁶
- Cost-effective care to keep quality as affordable as possible; and
- Timely patient access to care that meets both patient and provider needs.

The Principles That Drive Accountability

What is the conceptual basis that drives such a broad range of accountabilities? The chief underlying principle of group practice is the notion of “group responsibility,” which refers to the responsibility of all the physicians within a medical group, both individually and collectively, for the health of all the patients within the population served by the group—including those who rarely if ever appear in a clinic demanding services—regardless of the payment mechanism. It is this dual responsibility to a population of

patients, complementing the traditional, Hippocratic commitment to every individual patient, that most distinguishes large group practice from the traditional medical mainstream. And it is this principle, more than any other, that accounts for group practice’s deep level of clinical collaboration, the coordination of care among specialties, and the sharing of information and knowledge among all clinicians—practices that are increasingly essential to the delivery of quality care.

The core principle of group responsibility includes a commitment to quality care—a cultural characteristic that permeates the entire group structure and philosophy. This commitment underlies the existence in most group practices of a sophisticated quality improvement infrastructure, including effective peer review procedures, processes for the sharing of evidence-based best practices, and routine processes for monitoring and feedback on physicians’ clinical performance, as well as the monitoring and reporting of overall group performance. The quality commitment, along with the resource efficiencies that flow from quality, is also the source of the readiness of most large group practices to invest in the clinical information systems and automated medical record technology that can produce quantum leaps in the quality of patient care. And finally, the commitment to quality drives processes to encourage shared decision making that improve quality and patient satisfaction through deeper patient involvement in care.

In sum, group responsibility has been the cultural key to the success these organizations have quietly enjoyed for the past half century or more. It drives the creation of critical systematic processes and organizational infrastructures that enable

the accountabilities referred to above: quality outcomes, patient satisfaction, prevention and wellness, safe care, cost-effective care, and timely access to care. And it is the establishment and nurturing of group responsibility that is the key imperative for rebuilding effective physician leadership in American health care.

Translating Group Principles Into Practice: The Challenges Of Leading Physicians In Group Practice

This chapter began with the observation that physicians tend to make poor followers, having been socialized throughout long years of medical training to think and act as independent and individually accountable leaders. Certainly all physicians perceive themselves as leaders, and all are trained to make life and death decisions and to be held accountable to them. But the particular leadership attitudes and behaviors inculcated into young physicians are effective mainly in the clinical environment—in relationships with patients, physician peers, and other clinicians. They are not necessarily effective beyond that special milieu, as when a physician takes off the white coat and is expected to act as a strategist or an administrative and managerial leader. In that situation, traditional physician leadership skills may actually be counterproductive. A whole new set of skills and perspectives is needed—behaviors such as delegating rather than always doing, collaborating rather than acting independently, planning rather than acting, acting proactively rather than reactively, and many more.⁷ In short, the notion that physicians make poor followers does not imply that they make good leaders in nonclinical situations.

If this is true, then the challenge of promoting a renewal of physician leadership through group practice, which depends upon collaboration, group responsibility, stewardship over shared resources, peer review, teamwork, and that mysterious something called “groupness,” must confront a two-headed problem: how to lead, and how to follow—how to get eagles to fly in formation.

In fact, the problem is really more one of leadership than of followership, thanks to the self-selecting nature of medical practices, whereby more independent-minded, entrepreneurial physicians gravitate naturally to the fee-for-service, solo- or small-group practice world, while those who value collaboration, team work and shared learning are attracted to group practice. But while group practice physicians may be more inclined than their solo or small group colleagues to follow a leader, the particular skills and competencies required of successful group practice leadership remain a work-in-progress—one being “written”

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today, with many variations on the theme, among large, prepaid group practices throughout the country. The following observations on physician leadership generally, and leadership of prepaid group practices specifically, is drawn in large part from the authors’ personal experiences in group practice leadership.

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Leadership Through Vision

To transcend the professional traditions of individual autonomy and independent practice, physicians need, first and foremost, a compelling, motivating vision—an irresistible promise of a better way of working and living. If it is to drive the long-term success of a group of physicians, that promise, or vision, must also serve as the source of a set of principles and values capable of guiding the everyday activities of the group. In most cases, the source of that motivating vision is an individual—a visionary. And when a visionary is also charismatic, energetic, pragmatic, driven, and committed to the realization of his or her vision, amazing things can happen. Eagles can be made to fly in formation—physicians to practice together.

Sidney Garfield, MD, the founder of the Permanente Medical Groups, was such a leader. Dr Garfield's remarkable ability to articulate his vision of the combined power of group practice and prepayment won over not only one of the most powerful and wealthy industrialists of the mid-20th century, Henry J Kaiser, who would finance his dream, but a core group of young, idealistic physicians who were willing to face the wrath of organized medicine to help him make it a reality. Yet those same physicians would later reluctantly acknowledge that although Dr Garfield virtually created the Permanente model of prepaid group practice, he lacked the skills needed to manage and administer a large, multi-million-dollar medical care program. When Henry Kaiser removed Dr Garfield from his role as Medical Director of Health Plan and key liaison to the medical group, Dr Garfield's physician colleagues did not object; they recognized, sadly, that the organization needed a new

kind of leadership for the phase of development it had reached.

Visionaries such as Dr Garfield, or Charles Mayo, MD, and William Mayo, MD, who founded the Mayo Clinic, may be needed to launch successful medical groups, but not to sustain them once the vision is embedded in a group culture. Rather, leaders of mature groups need to function as the "keepers of the culture," continually explaining and reinforcing the principles that emanate from the vision and modeling in every way possible how those principles guide daily behaviors. They also need to be able to translate the seminal vision into contemporary and future terms. Physicians will follow a leader who can paint a vivid and credible picture of what is coming, or is likely to come, and then demonstrate the ability to plan for it in a way that conforms to the group's foundational principles.

In short, a powerfully motivating vision articulated by a charismatic and determined leader may be enough to get things started. But to sustain a group, a lot more is required—everything that follows, and then some.

Leadership by Influence and Values

A leader whose values are explicit and consistent with those of the group's culture, and who consistently behaves and plans in accordance with those values, making it not only possible but easy for colleagues to follow suit, exerts a seemingly "effortless" influence over peers and subordinates. This is leadership by example and by influence, by ability to plan, by organizational knowledge and its application, by creation of effective support systems—not the heavy-handed control of an authoritarian in a hierarchical structure.

Leaders who try to micromanage physician behavior in a group face an impossible, self-defeating task. The wiser course is to set a range of explicit, well-understood expectations about how decisions are to be made and link those expectations to basic values. In a prepaid group practice, this means, for instance, communicating the expectation that physicians will take care of the needs of the individual patient in a way that also considers the needs of the entire patient population for which the group is responsible—and then provide the supporting procedural infrastructure and information tools that make that balancing act possible.

Communication

In a recent discussion about leadership styles among Permanente physicians, one physician commented that "leadership is a storytelling profession." Another physician responded, "That's right, but in the end, the story had better be backed up with data."

Perhaps the most important story a group practice leader can tell is the "creation myth" of one's own group, for it is the source of the group's sustaining values and culture. Leaders of mature medical groups, such as the Permanentes, the Mayo Clinic, the Palo Alto Medical Foundation, Group Health Cooperative, and some of the other very early group practice pioneers, have a significant advantage in this respect—a rich source of stories and examples, drawn from the group's own heritage, that can be told over and over again to illustrate and reinforce the meaning of enduring values. Where that resource exists, it should be carefully documented, preserved and made accessible to members of the group in every way possible and as often as pos-

sible. Such a heritage is one of the group’s most valuable assets.

Successful leaders spend more time communicating with their staff and with members of the group than in any other executive activity—and they understand that effective communication requires a balance between listening and talking. Effective leadership means conducting a virtual symphony of information interactions between and among all levels of the group hierarchy (and the fewer the better) and between the group and all-important external stakeholders—patients/members, purchasers, regulators, policymakers, the media, and professional colleagues.

Strategic Direction

In a large group practice, leaders can be easily overwhelmed by the daunting range of issues that lands on their desks. A key attribute of effective leadership is learning to delegate most of those problems to others for resolution and focusing one’s own time and attention on that handful of critical tasks that will determine the success or failure of the group. Among that small set of ultimate leadership issues, none is more important than setting the group’s long-term strategic direction—the strategy for continued success in a future environment characterized by a mix of probabilities, possibilities, and huge uncertainties. Obviously that strategy must be based on a close, educated reading of the external environment, including likely trends among the competition, regulators, consumers, policymakers, and society at large (the aging of society, for instance, has enormous implications for health care). And, almost by definition, it must leverage the competitive advantages of group practice—the population health perspective, superior clinical quality, the

ability to invest in shared technology, for instance, to create added value for the group’s customers: its payers and its patients.

The ability to scan current environmental trends and use them to postulate future directions may be more art than science, but the effort is no less necessary for devising strategy. One of the key roles of leadership is to maintain enough environmental connections to detect even potential shifts that might have implications for the group. The threats—and the opportunities—come from many directions, including the regulatory environment, marketplace attitudes about what constitutes value in health care, demographic changes that impact membership and/or the clinical workforce; and new technologies. These latter two issues deserve special attention.

Leader as Change Agent

As much as the group leader is the “keeper of the culture,” he or she must also function to manage major course corrections. When changes in the external environment bump up against group culture, the leader must chart, explain and model the cultural adaptations that support any needed changes in group behavior. There are, for instance, growing expectations today for health care to become more “patient-centered” by, among other things, enhancing the patient’s role in decision making, which may require some adjustments to the traditional patient-physician relationship. New kinds of benefit packages may force adaptations regarding the values that prepaid group practice brings to the provision of “comprehensive” care. Where cultural change has succeeded in the Permanente context, leaders have cultivated extensive physician input

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and have carefully instilled new values on the basis of the existing group culture, not in contradiction to it. They have also focused as much attention on communicating and explaining the vision behind the adaptation of values as they have on ensuring that the group’s systems and policies will support them.

Leading Through Representative Governance

Permanente Medical Groups (PMG) operate on the principle of self-governance, which means that physicians determine the policies of their own medical group through direct participation and through elected, representative physician leadership. Whether this type of physician leadership is desirable or necessary in all models of practice is a fair question for debate, since some successful group practices are in fact led by appointed physician leaders and board members. The argument for the appointed leadership model is that such leaders are better able to represent the interests of the entire group and its shareholders because they are not beholden to any particular constituency, whose interests may not be identical to those of the entire group. For instance, leaders and board members elected to represent the interests of physicians in a particular clinic, may (and often do) promote those interests over the broader perspectives and longer-term goals of the group as a

whole—a problem not unfamiliar to any representative democracy.

The challenge of the non-elected model of governance is satisfying the need of bright, assertive physicians to feel that they have an adequate say in the policies of their group. How do you win physician "ownership" for policies that physicians have no direct role in creating or even approving?

Sorting out this difficult question, in both elected and non-elected models, is the job of the group leader, and it is a core piece of the related job of leadership development.

Leading Through Physician Development

Where do the leaders come from with the skills to create the vision and manage a complex organization through change? Some of the innate leadership capabilities may be "born, not made," but creating an effective environment to "grow" physician leaders is a critically important activity.

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The first characteristic of such an environment is the expectation that all group members should contribute to activities that improve the group. Most large group practices have orientation processes that foster such expectations from the start of employment. As physicians acculturate into the group, it is not difficult to identify those with a knack for strategic thinking and those who possess communication styles that engender trust and respect. Once identified,

there should be a systematic approach to the development of basic management skills, such as meeting management, personnel evaluation, and conflict management, for such individuals. This approach should not only provide didactic training but opportunities for more and more complex experiences, with monitoring and feedback by mentors. Sophisticated groups create individual leadership development plans for those with the most interest and promise. Many large groups avail themselves of university-based leadership development programs for their promising candidates.

Over time, using mentoring and coaching, didactic training, and progressively more complex experiential management challenges, a group can create a "pipeline" of physicians both willing and able to meet the challenges of leadership.

Leadership in Partnership

This final observation regarding effective physician leadership applies emphatically to that handful of large group practices that are fully integrated with health plans, as in the KP and Group Health models. For the most part, the same observations should apply to a lesser degree to any group practice that is even closely associated with a health plan.

The partnership between the PMGs, which care for KP members, and the regional and national Kaiser Foundation Health Plan(s), which enrolls and collects dues from those members, constitutes a core principle of the groups' practice philosophy, known as Permanente Medicine. The degree of integration and collaboration between medical group physicians and Health Plan managers and employees in KP is so close as to constitute what looks to those outside the system like a

single organization (Kaiser Permanente), rather than separate medical groups and health plans joined through contracts.

While this integration has been a vital element of KP's success over the past six decades, it has also complicated the role of leadership at all levels of the system. It is not enough, for instance, for a medical group leader to act like a "shop steward" and hard-nosed contract negotiator for an organized group of physicians selling medical services—as leaders do in some independent practice associations, which exist for just that purpose. PMG leaders (as well as Health Plan leaders) need to understand the pressures and needs of both sides of the relationship, communicate the "big picture" to the entire group, and then translate that picture into concrete plans by which the medical group can promote the success of the entire organization. In practice, this means that leaders working in partnership have to learn to "fit in one another's shoes," or to represent each other's interests when one's partner is not in the room.

Conclusion: Seizing The Leadership Opportunity

A historic opportunity exists, right now, for the leaders of the country's large, multispecialty group practices to step up to the challenge of articulating and promoting a vision of health care delivery that will meet the needs of the 21st century. A good roadmap has already been created in the IOM's Crossing the Quality Chasm report.² It remains only for those delivery systems that are capable of moving along that pathway to excellence to show the leadership that has been lacking for so long from American health care.

Seizing the opportunity will require some significant changes in

the way group practice leaders have played their part in recent years. Physicians, generally, have been in a defensive mode, more often protecting and shielding the profession from the pressures and demands of a rapidly changing environment than boldly striking out in new directions. By and large, national physician associations have been fighting rearguard actions against change on behalf of a nervous physician community. The entire industry, including hospitals, insurers, and physician organizations, has been caught up in a largely unproductive state of turmoil without direction.

What will it take for physicians—specifically the leaders of group practice—to break free from this "Brownian motion," as the IOM calls it, and help propel American health care into the 21st century?

The above observations on the qualities of effective physician leadership suggest much of what is needed. In fact, nothing is needed more than a compelling vision—and evidence—that a better way is within our grasp. Both patients and their physicians, not to mention those who pay for most of the care, are seeking desperately for a care delivery model that preserves the essential intimacy and trust of the patient-physician relationship while adapting to the new opportunities of evidence-based medicine. Yet, after more than half a century of documented success, the group practice model that best delivers on that vision is absent in many parts of the country and is poorly understood even where it has flourished, in parts of the Midwest and the West Coast. The greatest challenge for group practice leaders is to find ways to share the vision and reality of group practice more aggressively and more broadly—with opinion leaders, the academic community, political leaders, and the public.

The group practice vision will be best served by promoting its real-world accomplishments in the areas of quality outcomes, wise resource management, and value creation. Group practices have been challenged in demonstrating their success due to the absence of comparable clinical data from the solo-practice non-system of care. How can organized systems compare themselves to nonsystems? But independent quality-advocacy groups such as the National Quality Forum, the National Committee on Quality Assurance, the Foundation for Accountability (FAACT), Leapfrog, and others are looking for new approaches to quality measurement at the level of the care delivery system, rather than at the health plan level. This presents a potent opportunity for group practice leaders to come together and help define tomorrow's quality agenda in ways that could be far more meaningful to patients and purchasers—and that will ultimately demonstrate the superior outcomes of the group practice model.

Finally, the point cannot be over-emphasized that the leadership model demanded by these challenging times is a pluralistic one—physicians, of all stripes, partnering with hospital administrators, insurers, policymakers, purchasers, and especially with patients. Within that broad partnership, group practice leaders can play an especially valuable role—not by urging their model on everyone else, but by pushing the entire American health care enterprise toward greater clinical collaboration, systematic integration, and patient-centered accountability, whatever the particular organizational model. In the end, quality and affordability are our objectives. That's the challenge, and that's the opportunity, and we believe that physicians as effective leaders can make it happen. ♦

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