COMMENTARY

Changing physician behavior: what does it take?

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Think about your own clinical practice. When was the last time you substantially modified one of your well-established diagnostic or therapeutic approaches? What were the factors that led you to make that change? Now remember the last time, as a result of reading the report of a study or attending a meeting, you thought, "I am convinced that making this modification to my clinical practice will help my patients." Perhaps, despite your good intentions, you ended up not adopting the new method. What factors led to your continuing what you recognized as an inferior approach?

The factors that lead us to or prevent us from changing are complex. What is clear is that clinical practice, like any ingrained or habitual behavior, is difficult to alter. This is particularly true in the busy, fast-paced environment in which we work. But the stakes are high. How we provide care for our patients has a profound effect on their health. Unfortunately, we are slow to use the results of well-designed clinical trials to change our practices, which means that our patients do not receive the best care available.

The literature on changing physician behavior suggests that the determinants of change are multifactorial.[1] Traditional continuing medical education has focused on just one of these factors: providing information. But it is clear that knowledge alone—although necessary for change—is not sufficient. Other important factors are remembering the new information at the time a decision must be made, believing that the information fits in the present situation, believing the information is correct, having the skills to make the change, being able to influence patient preferences, and having systems that support the new approach.

It is therefore no surprise that use of a "fixed physician reminder system" by Frances and colleagues did not lead to an improvement in the management of patients with coronary artery disease. Computer reminders are promising tools to assist us in clinical decision making, but unless they are used in conjunction with a multipronged educational intervention, they are unlikely to cause us to change well-established habits.

Those of us who devote our time to designing and delivering medical education have a challenge before us. Increasingly, we are being asked to demonstrate results or "outcomes" from our educational programs. It thus becomes our responsibility to devise programs that integrate all the approaches needed to change physician behavior, including reminders, findings of published studies, didactic presentations, one-on-one or small-group sessions, video conferences, skills demonstrations and practice sessions, case-based learning, and personalized feedback on performance. In the past, many of us were satisfied with educating health care professionals without being concerned whether these efforts were actually making a difference. But times have changed and expectations have increased. In the future, perhaps, we will find satisfaction as educators in knowing that our efforts are helping to improve the health of our patients.

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Reference

1 Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance. A systematic review of the effect of continuing medical education strategies. *JAMA* 1995;274:700-705.

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