Behavior change is difficult—and not least in medicine. In a world where rapid results are expected, the adoption of treatment guidelines is measured in years, and medical education can have limited impact on accelerating this change in practice.1

Why should behavioral science be integral to any medical education program?

Any medical education program should be built on a deep understanding of healthcare practitioners (HCPs) and patients; this means insight into behaviors, attitudes, and beliefs.

“We need to walk in the shoes of HCPs and patients, understand their environment, motivations, and challenges if we are to design effective programs that improve health outcomes”

The ultimate purpose of medical education is to improve patients’ lives by helping translate evidence to clinical practice (“activation of evidence”).

In most areas of healthcare, there is a discrepancy between what happens in clinical practice and the latest clinical data—a clinical care gap. Accelerating change is fundamentally a behavioral challenge, and to develop effective education, we need to understand the drivers of current behavior. Then we can develop programs that address the barriers and harness the enablers to evidence-based clinical practice.

How do HCPs and patients live their lives and make decisions?

We need to get to the heart of the decision-making process by applying a behavioral lens to gain insight into the perspective of both HCPs and patients and the dynamic of their interactions. The environment, internal (current beliefs, existing knowledge) and external (peer influence, time pressures) factors, trusted information sources, and preferred channels build a holistic picture of how they live their lives—emotionally, socially, culturally, and technologically.

This behavioral picture unveils the drivers and barriers to evidence-based clinical decisions that provide a focus for communications. For example, in many disease areas, HCPs tend to have a few common diagnoses in the front of their minds at the beginning of a patient consultation. This intuitive “System 1” thinking can result in the failure to consider alternatives and in premature diagnostic closure. Biases such as these are common barriers. Two universal issues in healthcare are the reluctance to give up tried and trusted management approaches (a consequence of loss aversion and other biases) and the prioritization of short-term/immediate outcomes over the long term.

“We are biased toward the status quo and short-term benefits rather than long-term outcomes”

In view of this challenge, it is not surprising that behavioral science is regarded as critical to the future success of healthcare in a recent survey of over 100 pharmaceutical/healthcare professionals by McCann Health and pharmaphorum. This reflects a growing awareness of the science of human behavior and how we make decisions—both with intuition (“System 1”) and with reasoning (“System 2”). Yet, there is currently limited and inconsistent application of behavioral science in medical education and a reluctance to discuss the topic in the context of education, despite the positive impact on patient outcomes.
Another common theme is the discrepancy between HCP and patient perspectives—for example, a difference in objectives for treatment or the reluctance of an HCP to engage in a “difficult” discussion because of past experiences or lack of management options. For example, most pharmacological treatments in major depressive disorder (MDD) address mood. HCPs are familiar with this focus, but an unconscious outcome of this familiarity is that cognition, another important aspect of MDD, is less likely to be considered when treating patients.

It is overly simplistic to view HCPs and patients as homogeneous groups behaviorally. HCP and patient personas, which summarize distinct behaviors, including how they engage with information sources, are useful tools to guide the development of multichannel communication tactics.

How should we design interventions to drive and maintain real change?

However compelling the evidence, it is unlikely to be actioned unless there is specific focus on addressing the behavioral barriers to evidence-based practice.

“In the previous MDD example, this requires tactics to move HCPs from their embedded intuitive (“System 1”) response, to encourage reflective thinking (“System 2”), and to embolden them to think about addressing other aspects of the disorder, such as cognition. This debiasing is a common approach and relies upon initially appealing to “System 1” with appropriate triggers and framing; for example, these might be emotive case studies, a provocative question, or an immersive app. Initial engagement by appealing to “System 1” provides a springboard to engage logical reasoning through “System 2” and critical evaluation of the evidence and its practical implications.

“Behavior change is not certain to result from new knowledge and an intent to act”

Individual interventions are unlikely to achieve sustained behavior change, and part of the solution is a longitudinal program of engagement tailored to the HCP/patient personas. However, the question “How do I apply this new knowledge?” often remains. To increase the likelihood of change, additional tailored tools (such as disease assessment tools or mnemonics) should be implemented to make it easier to adopt the new behavior.

“Simply communicating clinical evidence is by itself insufficient to change behavior”
What are the golden rules for effective and affective communication?

While we have focused on understanding and addressing the specific behavioral context for medical education, there are some basic behavioral science principles to apply that can increase the effectiveness of any communication. Among the simplest approaches is EAST, a model developed by the UK government’s Behavioral Insights Team. Critically evaluating a communication to ensure that it is Easy, Attractive, Social, and Timely ensures that universal barriers to change are minimized and common enablers are harnessed to support change.

What benefits does a behavioral mindset bring to medical education?

A behavioral mindset can transform medical education by providing laser focus on the end goal. It reframes thinking to define educational objectives in behavioral terms, to understand how HCPs and patients think, and to apply this knowledge in tactics tailored to maximize the likelihood of positive behavior change. It is about smarter, more effective communication, not more communication—something that is increasingly relevant in a world of information overload.
References


About the author

Robert Poole (PhD) is Director of Scientific Services at Complete HealthVizion, a McCann Health company. He has 19 years of experience in healthcare communications, working collaboratively with clients to transform innovative science into communications programs that empower HCPs to improve patients’ lives. He has a particular interest in applying behavioral science to drive smarter, more effective communications.

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E-mail us at insight@complete-hv.com to connect.