

## Opinion

# Physician Behavior: Are We Creatures of Habit?

Over the years, I have acquired a set of habits that my family lovingly calls “quirky.” For example, when drying off in a shower, I make a snorting sound like a horse in a barn stall. Or when waiting for something to finish, like the microwave, I sing “tra-la-la-la” to no particular tune. If anyone asks me directly about these behaviors, I sometimes deny they exist at all. Other times, I claim that I can avoid doing them at will.

This got me thinking that a lot of what I do every day in the office also falls into the category of habit. Patients with the same general presentation and diagnosis may get the same management plan. Of course, I claim that my care is always tailored to an individual patient, which is true if you factor in the explanation and the Q&A. If you factor those out, however, a dispassionate observer might find my clinical care decisions at least occasionally formulaic. And they might even be at variance with a current *Preferred Practice Pattern* or evidence-based recommendation.

It turns out that these medical practice habits are exceedingly hard to break. Continuing medical education, especially didactic lectures, do a poor job of changing practice behavior. Targeted feedback sessions and practice improvement models seem promising but have yet to accumulate much evidence showing that they work better. Personal financial incentives do work,

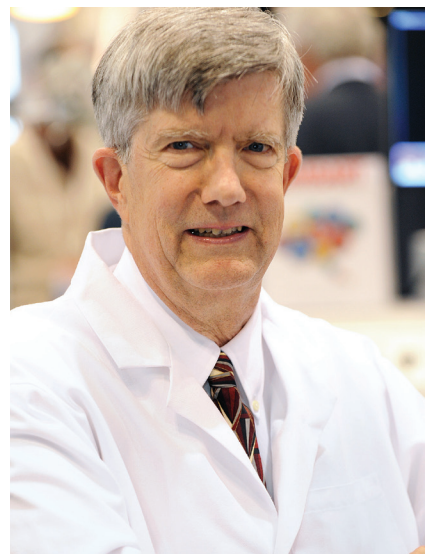
but there’s a limit on how many can be effective at the same time, and the government seems to have reserved all of those options well into the future.

Pharma has long recognized the difficulty of changing behavior in physicians—and is willing to pay a high price to do so. For example, witness the Ocular Hypertension Treatment Study results that were dutifully read and filed away by most ophthalmologists. That is, until drug manufacturers decided that the results justified prophylactic IOP reduction in most, if not all, ocular hypertensives, so they began a multiyear, multipronged education effort that included visits by drug reps, lectures by key opinion leaders, webinars, samples, and print literature. Sure enough, after several years the message got through. The average ophthalmologist could quote OHTS results better than those of other studies reported at around the same time, such as the Collaborative Initial Glaucoma Treatment Study. Pharma’s strategies for changing physician behavior are motivated by potential profit and are exceedingly well funded. Unfortunately, funding is simply inadequate for behavior change intended to improve compliance with *Preferred Practice Pattern* guidelines and recent evidence-based recommendations, as specialty societies would like to accomplish.

A related phenomenon mystifies me, and I’d like some help from the

readership. Residents enter their training eager to fill their brains with new information. By the time they have finished, they have acquired many of their mentors’ habits, rejected others as quirky, and formed some of their own. But these habits are still very plastic, subject to change in the face of new evidence or on the basis of a patient experience. At some point, though, the habits begin to become more entrenched. So, I ask you: When do these habits become so difficult to change? And is there hope they can be modified cost-effectively?<sup>1</sup>

1 Mason J et al. *JAMA*. 2001;286(23):2988-2992.



RICHARD P. MILLS, MD, MPH  
CHIEF MEDICAL EDITOR, EYENET