Developing Good Habits in Clinical Practice – *Part One*

By Dr Wong Tien Hua

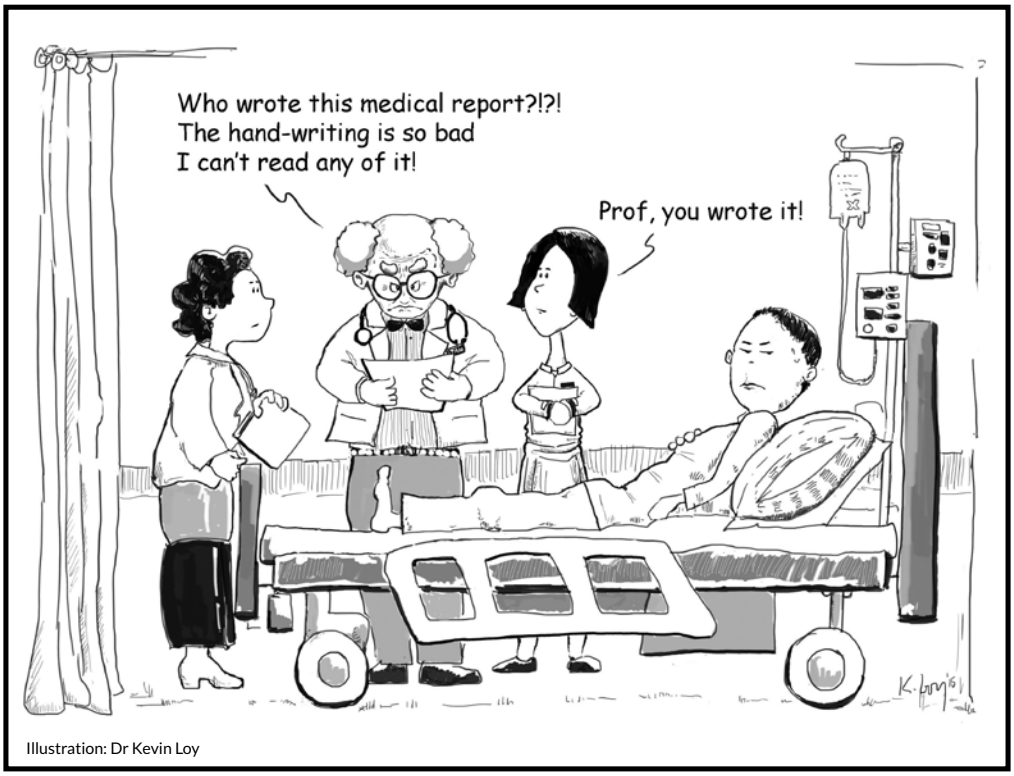

Illustration: Dr Kevin Loy

IN THIS issue, we focus on doctors in training. The term "doctors in training" is interesting to me because, in my view, doctors never really stop training. Constant learning and relearning is a lifelong habit that we develop to keep ourselves abreast of the changes and advances in medicine. As doctors, we want to achieve excellence in our clinical practice, which is impossible if we stop learning just because we have completed a prescribed training programme.

Aristotle wrote: *"We are what we repeatedly do. Excellence, then, is not an act, but a habit."*

Our lives are regulated by habitual actions, the things that we keep doing over and over again until they become automatic. Every morning, we get out of bed from the same side and stumble to the washroom to begin our routine. The amount of toothpaste we use, the sequence of brushing of teeth, even the amount of water we fill in the rinsing cup is more or less consistent. A cafe manager once told me that the regular customers who patronise his establishment typically order the same item on the menu every time and that most people like their morning coffee or tea prepared in a specific way with very little variation.

Habits are, therefore, very useful patterns of behaviour that our brains have developed over time to save "processing power" and energy. The term "automaticity" is the ability of humans to do things without having to occupy the mind with low-level details, and we sometimes call this the "autopilot mode". In clinical practice, we often hear doctors commenting that they carry out their tasks at a "spinal level", which means that it has been repeated so often that the action, akin to a reflex arc, does not seem to pass through the brain.

Driving a car is a good example of automaticity since driving is a very complex task involving coordination of sensory and motor function. I recall my first few driving lessons, where I struggled in remembering to adjust the rear view mirror, fasten the seat belt, ensure that the seat is correctly positioned and check that the gear shaft was disengaged – all before even starting the car. Parking the car was also a difficult and highly complex

process, requiring presence of mind to note the surrounding traffic conditions and a sense of direction of the car's movement as it reverses into the parking lot. If the brain is unable to adapt and develop an automatic neural pattern to driving, then every driving trip will be as stressful and emotionally draining as the first. Thankfully, this is not the case because we are able to drive with relative ease, especially on familiar routes, while listening to the radio at the same time.

The good, the bad and the ugly

As doctors, we constantly develop habits in our daily clinical practice. Some examples of routine tasks include:

- Communication – Eliciting a clinical history from patients, addressing their ideas, concerns and expectations, and building rapport.
- Clinical examination – Performing a focused examination and picking up clinical signs without missing important information.
- Medical records – Keeping good and detailed medical records.
- Medical procedures – These include performing venepuncture, ECG and infection control procedures such as proper handwashing.

Good habits can help us work more efficiently and effectively. The fact that doctors are able to excel in every test and examination, leading to a medical degree, testifies to our good habits of discipline, determination and effective time management.

Good habits in communication help to establish rapport with patients and maintain an effective doctor-patient relationship. Maintaining a high standard of hygiene and infection control is a good habit that has a direct impact on patient safety and public health. A seasoned medical officer who can insert an intravenous cannula smoothly into a neonatal vein seemingly without thinking is only able to do so through repeated practice and the forming of habitual reflexes.

Bad habits, on the other hand, are professional landmines lying in wait to sabotage our practice even when we have the best intentions.

Seemingly innocuous bad habits such as poor handwriting may lead to errors that can have serious consequences to patient safety and clinical care. In prescribing medicine, a wrongly placed decimal mark translates to an incorrect dosage by a factor of at least ten times. Bad habits in communication can lead to misunderstandings with patients and consequently, dissatisfaction with the consultation process. We know the importance of maintaining eye contact and practising active listening in patient communication, but the realities of a busy clinical environment with computers, phones and other equipment competing for our attention can be distracting for the doctor.

Habits form not only in individuals but also within teams and larger organisations. For example, as doctors we work in teams that are part of larger medical departments or units within a hospital. How an individual interacts with others often forms habitual patterns and result in what we call "organisational culture". When there is poor teamwork or safety culture, or when team leaders foster a hostile work environment, communication may break down, and this can cascade into catastrophic events that end up as horror stories in the newspapers. The accumulation of collective bad habits can thus snowball into something rather ugly.

Two recent Singapore Medical Council cases of wrongful administration of drugs highlight the importance of individual responsibility and the role of teamwork. The first case was that of a young medical officer who was censured for administering chemotherapy intrathecally instead of intravenously because she failed to check the route of administration at the bedside. Such an error could have been avoided if the steps of administration were followed and hardwired into a mental routine. The second case was that of a cardiothoracic surgeon who gave undiluted cardioplegic to a patient. He was initially convicted of willful neglect, but a court of appeal later overturned the ruling. The judges noted that in this case, there was systemic failure at play, which contributed to the error. In the above examples, communication within the team had broken down and bad habits were allowed to snowball.

Starting right

For every clinical activity, there is thus the potential of developing either good or bad routines. Unfortunately, our brains do not seem to be able to distinguish between them; it is as easy to pick up good habits as it is bad ones, depending on our frame of mind.

Medical training should not be confined only to the notion of technical skill training and accumulation of medical knowledge. During the course of our instruction, we are also training ourselves to develop good habits in clinical practice. Therefore, we need to *consciously learn* good clinical habits before bad habits seep in and establish themselves in our subconscious behaviour. There is no better time to inculcate a culture of good clinical habits than at the beginning of one's professional career. Senior doctors have an important role to play as role models and in setting the standards for good clinical practice.

For those of us who are keen to improve our behaviour, change is only possible if we are aware of how our habits are formed, as well as what triggers and rewards fuel them. I will explore these factors in a separate article. Watch this space. ■

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