# ALWAYS ROOM FOR IMPROVEMENT

## DEVELOPING GOOD HABITS IN CLINICAL PRACTICE — PART 2

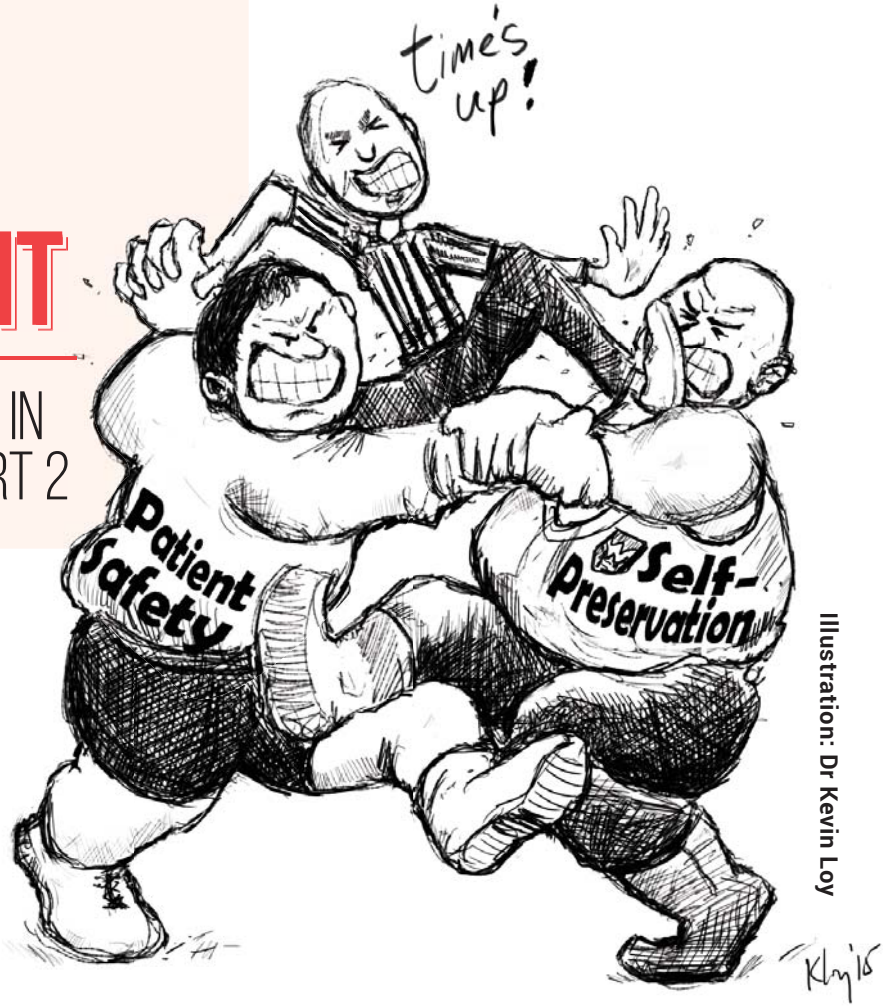



Illustration: Dr Kevin Loy

In July's issue of *SMA News*, I wrote about how habits are integrated into our subconscious routine in clinical practice. The term "automaticity" is the ability to do things without having to occupy the mind with low-level details, thereby reducing stress and additional demands on brain function. Many daily actions may seem to be voluntary decisions, but they are, in fact, subconscious habitual behaviour.

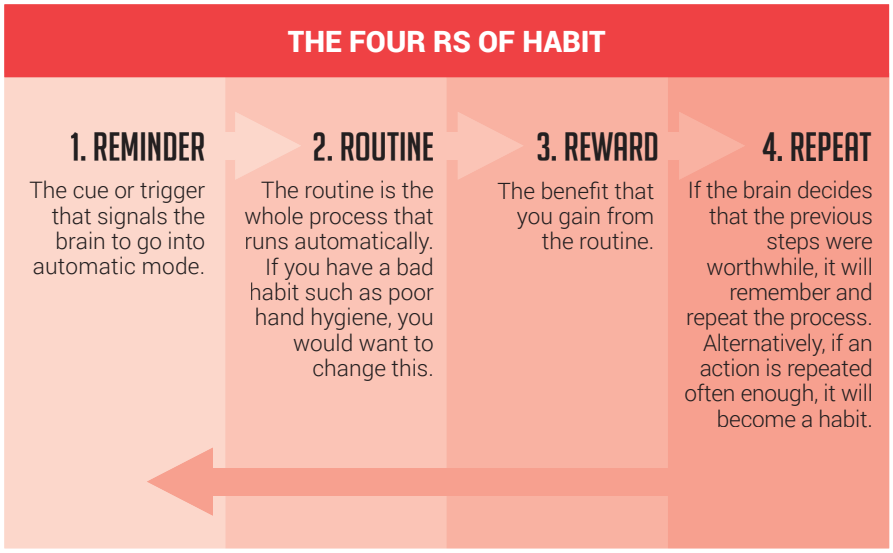
It is important to develop good habits early in one's professional career because it is difficult to change habits once they are adopted. Another difficulty is in differentiating between good and bad habits; one can fall into the latter pattern if not careful. Bad habits typically form when we try to take shortcuts in order to save time or minimise energy expansion. This is especially relevant in a busy and stressful practice environment. In the midst of high patient load and multiple demands requiring our professional expertise, time is indeed a commodity in short supply and doctors have to be extremely efficient. We learn to zoom in on critical action items and rank less important tasks further down our internal workflow.

Patient communication is one area that often suffers. Dense data from medical records that require processing can easily distract us, and we forget to smile or even acknowledge the patient with simple eye contact. In clinical assessment, we employ focused clinical examination pathways but often forget to check basic parameters (eg, blood pressure) that can reveal critical information. We need to save time; a perfunctory hand wash saves time, skipping a troublesome per rectal examination saves time, and scribbling a few cursory observations in the notes is faster than keeping concise clinical records.

Developing good habits early is an important piece of advice for junior doctors starting their professional careers. However, many among us who have been in practice for years, if not decades, have developed habits that have served us for better or for worse. Old habits die hard, and since no one is perfect, we all have behaviours that can be improved. However, it is not good enough to convince ourselves that we can change; consciously willing ourselves to correct an ingrained habit is an exercise in futility.

*New York Times'* reporter Charles Duhigg, in his book *The Power of Habit: Why We Do What We Do in Life and Business*, explored the science and psychology behind habits and how they can be optimised. According to Duhigg, in order to better understand how habits form and how we can change them, one needs to understand the habit loop. His three-point loop consists of Cue, Routine, and Reward.

Since doctors are so fond of mnemonics, I have adapted Duhigg's habit loop into the four Rs of habit: **R**eminder, **R**outine, **R**eward and **R**epeat. This breakdown of the habit process is very useful when we are trying to change a habit.




## SETTING REMINDERS

A reminder is a cue that can be visual or situational. For example, the placement of hand washing facilities in prominent locations reminds us to wash our hands in the ward. Alcoholic hand rubs at the foot of every bed are visual reminders to practise strict hand hygiene when moving from one bed to another, examining patients. A patient that knocks and enters the consultation room is a typical situational cue. Do we immediately look up, greet and offer the patient a seat to build rapport, or do we dive into the notes and sift through the history and data, expecting the patient to wait for us to initiate the conversation?

We can train ourselves to respond to reminders and follow through a sequence of actions based on information that presents during the consultation. If a patient offers a history of smoking, we should pursue further instead of merely checking off a box on the case records. Before administering injections, we can use the act of retrieving the equipment as a reminder to check the expiry dates and to ask the patient about drug allergies.

## GETTING THE ROUTINES RIGHT

Established routines are the backbone of clinical practice because many of the actions we perform daily are repetitive. How we interact with our patients and colleagues, perform procedures and record our findings follow patterns of behaviour that are refined through repeated action.

Good habits need to be consciously learned, preferably from the start. Once a bad routine sets in, change becomes difficult. It is said that one cannot actually change a bad habit; one can only replace it with another. We need to find a more powerful new habit to replace the old one.

Let's take the process of setting an intravenous line, which involves many steps, as an example. First, we ensure that the right equipment is at hand. Then we explain the procedure to the patient, followed by insertion of the cannula and proper disposal of wastes. Doctors who are doing this for the first time need to strictly follow every step and keep repeating it in order to train the brain to learn the right routine. If some steps are left out and shortcuts taken to save time, we may eventually adopt the wrong routine.

## REFOCUS ON LONG-TERM REWARD

We adopt habits, both good and bad, for the payoff. Charles Duhigg describes this as a kind of craving — a combination of anticipation and desire. For instance, people who exercise regularly develop a craving for the emotional and physical high that comes after a session of intense activity, while those who play video games excessively develop a habitual craving for the stimulus and become frustrated when denied access.

In clinical practice, there is a conflict between self-preservation (saving time and energy) and patient safety. Like everyone else, we doctors must sometimes rush home on time to attend to personal matters; however, making it a personal policy to try to beat the clock every day can turn into a bad habit. Taking shortcuts to save time and skipping steps in a procedure to save energy may be more efficient, but patients suffer from substandard care and are exposed to an increased risk of medical error.

To change our established habits, we must refocus on the long-term reward of patient safety. We have to keep reminding ourselves of our ethical conviction to do no harm and to put patient's safety first and foremost.

The reward we can expect is the sense of satisfaction that we have done our best for each of our patients. We should crave for the emotional high that comes from relieving suffering and giving comfort to a fellow human being. We owe this to our patients and to ourselves. ◆

PROFILE

TEXT AND DIAGRAM BY

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