



EDITORIAL

Influencing Health Behavior: Why It Matters; Learning What to Do

In a series of three articles in the prior two issues of *Education for Health* (EfH), Pauli *et al.* (2000a, 2000b, 2000c) challenged us to take a fresh look at some of the fundamental assumptions underlying our traditional approaches to health care and the education of future health professionals. They identified ways in which our current practices derive from and may have been suited to the past but are not appropriate for the present or the future. Few areas are as seriously in need of a fresh look as is our preoccupation with “curative/controlling” health care. We are overdue for a shift to a “preventive/empowering” mindset, the theme of this special issue, which is a collaboration between EfH and the *Annals of Behavioral Science and Medical Education*.

“Curative medicine” has long been the dominant force in health care, internationally. This approach, which focuses on intervening after disease has set in, is increasingly being challenged. Recognition that a change is needed is hardly new. Nearly a century ago, Abraham Flexner, the most influential observer of medical education of that era, stated, “The physician’s function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain, and through measures essentially educational, to enforce the conditions that prevent disease and make positively for physical and moral well-being” (Flexner, 1910). Clearly, Flexner’s visionary insight did not take into consideration the task of overcoming the powerful forces that work against reforming health care and educational systems.

The curative approach has had a profound impact on health care priorities, in part by monopolizing the allocation of educational and health care resources. This situation has been systematically challenged for more than a quarter of a century, but little has changed. The Lalonde Report (Canada) identified four major determinants of health: lifestyle behaviors, human biology, environment, and the health care system (Lalonde, 1974). Shortly afterward, the US Surgeon General’s report (USDHEW, 1979) estimated that the major causes of death could be attributed as follows: 50% to unhealthy behaviors, 20% to environmental factors, 20% to human biological factors, and 10% to inadequacies in health care. Similar premature mortality patterns have been observed internationally (Charlton & Velez, 1986). Recent reports have again emphasized the need for health promotion and disease prevention (Canadian Task Force on the Periodic Health Examination, 1994; Preventive & Community Medicine Committee, 1996; US Preventive Services Task Force, 1996; Friede *et al.*, 1997; WHO

Working Group, 1999). Our failure to address the behavioral determinants of health has been described as a scandal (McAvoy, 2000).

Regular readers of our two journals probably understand better than most that our current educational programs' dominant focus on complex and late-stage diseases is less than rational. As has been observed, we are devoting most of our energies to helping students learn how to pull drowning people out of a river when they need to be learning how to help people stay out of the river in the first place (McKinlay, 1975). In the US, probably mirroring what is true for most of the world, at least 50% of premature mortality is the result of behaviors, such as smoking, excessive alcohol use, poor diet, obesity, lack of exercise and unsafe sexual practices (McGinnis & Foege, 1993). Yet, in spite of what we know about these problems, tobacco use will remain the leading cause of death internationally for the foreseeable future (<http://www.who.int/toh/>). Currently, four million deaths a year are due to tobacco. This disturbing figure is expected to rise to 10 million deaths per year within 20–30 years, causing one in eight deaths worldwide. Developing countries will account for 70% of these preventable, premature deaths. Also, currently, in some parts of the world, there is no greater threat to human health than AIDS. For both tobacco and AIDS the key to effective care is prevention, in the form of behavioral change.

Until now, because we've given it so little attention and are still so poor at doing it, we've made only limited progress in reducing the prevalence of risky health behaviors (McGinnis & Lee, 1995). We are still badly in need of finding ways to create practitioners who are committed to exerting constructive influences on other people's health behaviors, and who are expert at doing so. In many schools and in many practices, we still face considerable resistances to these needed changes. Those of us who are convinced of the urgent need to help prepare this new kind of clinician must seek to have educational programs everywhere make doing this a high priority goal.

Introducing a fundamentally different way of preparing new health professionals, as we are considering here, raises a profound challenge. Partly, we face a "chicken and egg" problem. What comes first? Where and how do we break into the self-perpetuating cycle we are now in? Learners are influenced primarily by the values and models offered them by those who are their teachers and those who are the practitioners who serve as their role models. Inescapably, attitudes, approaches and assumptions from the past shaped these teachers and practitioners. If we are to produce a genuinely new kind of graduate, where will we find sufficiently large numbers of teachers and practitioners whose values and behaviors reflect the future, not the past? Since an insufficient number exist, they will need to be created. So, somehow, our current teachers and practitioners need to undergo substantial changes, if they are to help guide the creation of the new kind of practitioners we need. In other words, we need to learn how to change our educational institutions and our professional roles before we will be regularly producing new practitioners who are effective at helping people change their unhealthy behaviors.

The magnitude of the needed changes and the implications of these changes for our educational institutions, teachers, practitioners and learners are huge and well beyond the scope of any one issue of any one journal. Yet, the multiple authors from diverse parts of the world who have contributed to this special issue have managed to embrace an impressively wide spectrum of important subtopics of this theme. They have given us ideas and insights that are important to the future of education and practice in health. We commend these fine contributions to your careful attention.

The Content of This Issue

The papers that make up this theme issue provide helpful clues to what needs to be done. The two opening papers set the context. The subtitle of the paper by Dovey *et al.* emphasizes the virtual reversal of attitudes that will be needed if we are to transform our teaching and practice patterns in ways that are needed. Although the findings they present suggest that we may be on our way toward this needed attitude change, many of the other papers clarify how far we still need to go. Chin *et al.* offer a striking point of view on the magnitude of the challenge we face. They ask us to do nothing less than seek to recognize and help reshape the profound social patterns and attitudes that underlie so much of people's health difficulties.

From three of our papers we can learn lessons about possibilities and problems in our work with students. Furber & Ritchie provide a helpful reminder that the work we need to do extends beyond learners who are directly in the health professions. And Haas & Gregory, while offering an interesting instructional model, unexpectedly reveal how firmly old-style attitudes can already be established in the minds of even beginning medical students. Somewhat alarmingly, many of their first-year medical students, when in the "doctor" role, turned out to be control-oriented advice-givers, rather than prevention-oriented or empowering, even though many of them preferred working with empowering/facilitative doctors when in the "patient" role. We have our work cut out for us before the more needed image of what it means to be a good clinician is firmly and widely established.

Borkan *et al.* give us an example of a school-wide curriculum that seeks to move learners toward being the sort of clinicians modern health care requires. As would be true in most schools, the forces seeking to perpetuate past attitudes and approaches were not inconsequential. They and we will need to follow such reform efforts for a number of years before we can be confident that such an alternative approach has truly taken firm root and is bearing long-term fruit.

Reed & Jernstedt offer a nice example of something that has been shown in various ways in a growing number of institutions. Programs that place students in community settings can turn out to be good for everyone. The students and the communities both benefit from the experience. Yet, follow-up will be needed

to help us know if these students are subjected to opposite messages in their subsequent learning experiences and, if so, which messages prevail. Lee and his colleagues give us a glimpse of another example of the potential multiple benefits of community involvement, this time with a program that can have far-reaching implications for entire school systems. Again, only long-term follow-up will reveal the extent of the lasting impact on the children who are the ultimate target of this appealing initiative.

And, in still another illustration of a way to have an impact on health behaviors, Noble *et al.* introduce us to an innovative approach to capturing the attention of young people. Their age-linked arcade game may well be a way to make a meaningful difference in one of this age group's important health behaviors, the abuse of street drugs. Of course, we will need to wait and see whether the positive outcomes they demonstrated in the short run will be sustained.

Thevos and her colleagues offer us some important lessons from their work in Zambia searching for the best ways to influence a form of behavior that is central to the health of families and communities there and in many other countries. Insufficient access to safe, clean water has become a massive and worsening world problem. Without immediate prospects for improved access to this diminishing, vital resource, programs that help people become committed to and capable of preparing their water for safe consumption will be a key to significant reductions in serious health risks for enormous numbers of people. Valuable early lessons, which will be generalizable to other health and school settings, can be found in this paper.

Keller *et al.* raise some key questions about our approaches to helping change clinical practices. As they found, a one-day workshop is unlikely to be sufficient for achieving sustained change in practitioner behavior, especially when they are meant to adopt behaviors that are meaningfully different from those learned previously. We will need to find ways to have a more substantial influence on practitioners, which will likely require repeated reinforcement, changes in their support systems, education of the entire team, and more.

Runkle *et al.* have given us some strong guidance on what it will take to make lasting changes in the capacity of health professionals to exert motivational influence on their patients/clients. More is likely to be needed than an occasional workshop or two. Fundamental "cultural" changes are needed in the organizations in which clinicians work.

Repeatedly, in response to the reports presented in this theme issue, we have had to acknowledge the many countervailing forces that can undo the worthy, educational and motivational efforts described. We need to move beyond our reliance on the "quick-fix" approaches of curative medicine. Instead, we need to address the "long haul" challenge of promoting healthy behaviors. This long-term goal requires lifelong learning that helps practitioners develop the skills needed to organize and improve comprehensive behavior change programs that work proactively with populations. Whether it is teachers, students, practitioners

or patients, consistent new behaviors are most reliably adopted when they are supported by the dominant cultural attitudes. Our challenge, as educators and administrators, is to help establish and sustain attitudes that are consistent with our best understandings of what will be most responsive to the real needs of the communities we exist to serve. We hope you agree that this special issue is a positive step in that important direction.

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