# BRIEF COMMUNICATIONS

## Practitioners' Ability to Predict the Educational Value of Their Patients

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In 1987, 53 (79%) of 67 patients admitted in one month to a resident teaching service in a 250-bed community hospital originated from one private office of five general internists. At the time of admission for each of these 53 patients, the admitting practitioner was asked to predict the educational value that the assigned first-year resident would receive by admitting and caring for that patient. At the time of discharge for each of these patients, the first-year resident who had cared for the patient was asked to judge the educational value received from that patient. The practitioners and residents used the same five-point ordinal scale for educational value, and remained unaware of each others' scores during the study.

The practitioners' predictions of the educational value for each patient and the residents' rating of the educational value actually received were highly correlated (Spearman correlation coefficient = 0.368, $p = .003$). The five practitioners were equally accurate in their predictions (Kruskal-Wallis test, $H = 6.68$, df = 5, $p > .05$). The most commonly cited reasons given by the residents for a case's being of above-average educational value (29 cases) were that the patient presented a diagnostic challenge (16 cases) and that new therapy was learned (nine cases).

How patients are selected for admission to teaching services is often based on factors other than the educational value of the patient. This study suggests that practitioners can accurately pick their best teaching cases and may, through proper selection of patients, be able to improve residents' educational experiences.

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## Behavior-change Strategies Used by a Sample of Physicians for Patients at Risk of Coronary Problems

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The behavior-change strategies used by physicians that have been shown to facilitate successful behavioral changes in patients include specifying the behavior to be changed, providing information about the health risks of the behavior, explaining the benefits of making the change, seeking a commitment to change, initiating behavioral counseling via information or a referral, promoting patients' self-efficacy, and making a definite follow-up appointment.[1,2] The present (1989) study sought to identify the strategies actually used by physicians for patients at risk for coronary artery and heart disease.

Two standardized patients (SPs) were trained to interact with and evaluate the physicians' performances. One SP presented with a history of cigarette smoking, the other, with a history of hypercholesterolemia. The authors recruited 29 physicians at different levels of training from two large metropolitan hospitals in Chicago, Illinois, provided them with detailed written case summaries of the two SPs, and asked them to present treatment recommendations. Interactions were videotaped, and the SPs scored the participants' behaviors for key elements of effective behavior modification.

Almost all the physicians sampled (93%) advised each of the SPs to modify his or her behavior. Factual information about the correlation between behavior and heart disease was provided by 85% of the physicians. Offering literature or making a referral was initiated by 74%. While two-thirds of the physicians referred the SP with elevated cholesterol to a nutritionist, only one-third referred the smoker to a behavior therapist or a smoking cessation program. Follow-up visits were scheduled by 63% of the physicians, with 86% scheduling follow-up with the hypercholesterolemia SP, but only 41% scheduling follow-up for the smoker. Commitment to change was solicited by only 43% of the physicians. Interestingly, less than 30% sought a commitment to change from the hypercholesterolemia patient, while nearly 60% sought a commitment from the smoker. While 41% of the physicians advised the hypercholesterolemia patient that reducing serum cholesterol would reduce cardiovascular risks, only 14% advised the smoker that smoking cessation would reduce the risks associated with heart disease. Regardless of type of case, only 17% attempted to enhance patients' self-efficacy by offering assurance that they could be successful in changing their behavior.

The fact that all behavior-change strategies were used to some extent by the physicians in this sample suggests that the strategies themselves are reasonable behaviors to expect of physicians and that they can be performed in less than 15 minutes. The results also suggest that physicians may treat smokers as having a behavior problem, whereas patients with elevated cholesterol are seen as having more of a medical problem.

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### References

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2. Jenkins, C. D. Diagnosis and Treatment of Behavioral Barriers to Good Health. In *Public Health and Preventive Medicine*, J. M. Last, ed., pp. 1109–1122. Norwalk, Connecticut: Appleton-Century Crofts, 1986.