Session Guide

Principles of
Face-to-Face Education
Principles of Persuasive Face-to-Face Education

SESSION GUIDE

PURPOSE AND CONTENT

As discussed in a previous session (Framework for Changing Drug Use Patterns) direct face-to-face educational interaction with prescribers has been found to be one of the more effective strategies for improving prescribing practices, especially when combined with other approaches such as graphic printed materials and standard treatment guidelines. Previous research conducted in the fields of health education, marketing, and behavioral science has suggested a number of important principles which may be useful in developing face-to-face education programs to improve the knowledge and practice of health workers. In this unit we will review, discuss, and apply some of these lessons. Some of the techniques may be more appropriate than others in the specific context of your society, culture, and economy. Part of your job will be to help pinpoint the most useful elements of this approach.

OBJECTIVES

[VA 1]
To develop your ability to:

1. Recognize the unique advantages of face-to-face education in comparison to other approaches.
2. Identify the most important principles and techniques of face-to-face educational programs.
3. Understand how to carry out persuasive face to face education.
4. Gain expertise in the training of other health care workers to conduct effective face-to-face educational programs in their countries.

PREPARATION

1. Read the Session Notes.
FURTHER READINGS


Principles of Persuasive Face to Face Education

SESSION NOTES

The commercial industry has been very effective in promoting their drugs to earn profits for their companies. We can learn from their techniques and methods to improve the use of medicines. This module takes these commercial experiences and applies them to essential drug programs. Imagine that inappropriate use of antimalarials and over-use of injections is still a problem in your region, despite some preliminary improvements in practice due to an essential drug program and widespread dissemination of printed educational materials to all relevant health workers. You are now considering the implementation of a face-to-face prescriber education program to reach health workers in all government funded primary health care centers and outpatient departments of hospitals. How would you approach this task? Who would be the trainers? What general principles should be emphasized in preparing the pharmaceutical educators? These are the questions to be answered in this session.

A. PRINCIPLES OF EFFECTIVE PERSUASIVE APPROACHES
[VA 2]
For persuasive approaches to be effective they need to be:

- Relevant to actual therapeutic decisions and actions.
- Need to understand the reasons for behaviors you wish to change.
- Emphasize only a few key messages.
- Use graphic educational materials to refer to in face-to-face educational sessions.
- Use simplicity of language and common dialects.
- Repeat key messages.
- Credible.

Educators should establish their credibility in the first educational session with particular prescribers (or groups) by introducing themselves as a representative of an unbiased, objective, and respected professional organization committed to providing the prescriber with new and objective information in drug therapy.
Understanding motivations of prescribers is critical in attempting to change prescribing patterns. Common examples of reported influences include:

1. Patient demand
2. Intentional use of placebos
3. Clinical experience

[VA3]

B. SITES FOR FACE TO-FACE-EDUCATION

Persuasive face-to-face education is a flexible strategy which can occur in any setting where educators are able to talk to prescribers (and, perhaps, patients). For example:

- health centers
- hospitals
- pharmacies
- continuing education seminars held at district level.

It is likely that one-on-one or small-group presentations will be more effective than large-group sessions, although research in some developing countries has found that large groups which use interactive methods are also effective.

[VA4]

2. UNIQUE ADVANTAGES OF PERSUASIVE FACE-TO-FACE EDUCATION

Face to face education can occur in many situations. These include:

- Training
- Supervision
- Regular Support visits
- Clinical Consultations

The lower the level the health staff, the more appropriate is the method of face-to-face education.

The following are some unique opportunities, principles, and techniques of persuasive face-to-face education:

[VA 5]

1. Two-way Communication

Simply sending out educational monographs, no matter how well illustrated, does not give prescribers a chance to express their particular motivations and reasons for using a drug "incorrectly." An important principle is to involve physicians in two-way and not one-way communication. Research suggests that:
• Provider participation in educational interactions is often necessary to change their behavior.

• Two-way communication provides a way to assess an individual's motives for prescribing, and the educator can then discuss these motives with the provider.

Prescribing educators should be instructed to ask prescribers why they use a particular drug when they feel comfortable asking this question. For example:

"Doctor, do you sometimes use injections as a first choice treatment for dysentery?" [If yes]: "What do you think are the advantages of this?"

The prescriber may reply:

"I know that oral antibiotics are just as effective. But, the patient believes that injections are stronger, and I do not have the time to convince him to take oral medications. In fact, if I don't give an injection, the patient won't take any medicine at all!"

This information allows the educator to assess specific obstacles to appropriate care, and may lead the educator to suggest that the prescriber counsel the patient effectively. For example, in the above case, the prescriber can:

• Emphasize the potential dangers of injections compared to oral antibiotics.

• Give the patient a brief educational pamphlet on the best treatment for dysentery based on the advice of a local respected health institution or authority.

2. Presenting of Both Sides of Controversial Issues

When trying to persuade a knowledgeable audience (e.g., physicians and nurses) who have been exposed to a counter argument, it is better to deal with that issue openly, rather than ignore it. For example:

• Prescribers in a particular region may have been told by drug company representatives that they should use expensive medicines for pain because the patient will believe they are more powerful, and that the prescriber cares more about the patient's pain. Therefore, the effect of the pain-reliever will be greater because of placebo effects.

This represents a strong and effective counter-argument to the educator's message to use simple, but effective pain killers like paracetamol. If the educator chooses to ignore
this counter-argument in the educational session, he or she will lose credibility in the prescriber's eyes. However, if the educator raises the issue of patient demand for prescription drugs and, gives the prescriber some useful techniques for convincing patients that paracetamol is equally powerful, the prescriber will be more impressed with the educator's understanding of both sides of the argument. This will lead to a greater likelihood that the physician will follow the educator's advice.

[VA5]
3. Targeting Opinion Leaders

In many health care settings there are community leaders -- respected individuals who may be medically trained or traditional healers -- who, by their authority and respect have a strong influence on the drug use decisions of many health workers and patients who routinely come in contact with them. Health workers rely on the recommendations of these opinion leader and even accept their prescribing rules or guidelines as a matter of faith because of their perceived competence or expertise. Examples include:

- Senior house officers or chiefs of service in teaching hospitals.
- Dominant and experienced physicians in community settings.
- An important and respected traditional healer.

One of the strengths of face-to-face approaches is that educators, through interaction with health workers, can:

- Learn who the opinion leaders are in a particular community.
- Include these leaders in the educational program.
- Tell other prescribers that these leaders support the program's recommendations.

In an American study researchers approached the head of an obstetric department to ask permission to undertake a project to replace Cefoxitin with Cefazolin for caesarean sections. The professor reviewed the papers prepared to support this change. A week later he told the researchers that he had discussed the issue with his department staff and they had agreed to change. As the data below show, the change was dramatic and sustained.

**Percent of all Caesarian Sections Receiving Cefazolin and Cefoxitin**
4. Reinforcement of Improved Prescribing

Research has suggested that positive reinforcement of desired changes in practice (e.g., through verbal praise or acknowledgments) increases the chances for lasting improvements in prescribing behavior. For example, after health workers are initially introduced to the idea of recommending simple analgesics for mild pain, it is effective to re-visit them to assess their success in changing prescription practices. At this point, their actual experiences can be discussed. For example, if they were successful in convincing patients to accept paracetamol these positive results can be congratulated, and the prescriber may even be encouraged to provide details on the techniques they used for the benefit of other prescribers. For example:

- In a study of an American face-to-face education program, it was found that physicians visited twice reduced their inappropriate prescribing twice as much
as physicians who were visited only once. Opportunities to reinforce correct prescribing practice accounted for this difference.

Effect of Reinforcement on Reduction in use of Targeted Drugs

• In response to an attempt to reduce antibiotic use for colds, physicians in Aceh Province, Indonesia disputed the relevance of studies conducted in developed countries to the special characteristics of bacteria and the population in their Province. As a result, a clinical trial was conducted in local health centers to provide the needed evidence which would persuade physicians to change their behavior.

It may also be helpful to combine follow up visits with feedback of actual prescribing practices based on a review of clinical records. By confronting a prescriber with his or her own performance in relation to recommended practices, the educator has an opportunity either to explore in depth reasons for failure to change or to reinforce evidence of positive improvements in practice.
RESULT OF PERSUASIVE EDUCATION

In the United States in the classic study by Avorn and Soumerai (1983) prescribers were divided into 3 groups. One group was a control group, one received printed material and the third group received written maternal and face-to-face individual visits by trained educators. When the study was evaluated there was no significant effect of print material alone but a highly significant improvement in print and visit group.

Effect of Persuasive Education on Prescribing of Target Drugs in the US
In another classic study in Indonesia, Santoso, et al, compared large groups training with small group face-to-face training about diarrhea. Where the behavior was already
quite good, the use of ORS, neither method made any difference but where a major problem existed,

The inappropriate use of antibiotics, both the seminar and face-to-face education were effective. However, the long term effect was greater for the face-to-face group

[VA 10 & 11]

In a third important study in Kenya and Indonesia, Ross-Degnan, et al, used small group face-to-face education and pharmacy sales staff. In both countries there were significant increases in ORS sales and corresponding decreases in antidiarreal sales.
The fourth important study was conducted by Hadiyono, et al (?) in Indonesia. In this study she identified that prescribers and patients had different ideas about injections. By bringing prescribers and patients together in a neutral environment with clinical experts the injections practices of prescribers were dramatically changed. While this intervention was a little different to the conventional face-to-face educational activity this showed how important understanding the motivations of the prescribers.

E. SELECTION AND TRAINING OF EDUCATIONAL STAFF

The educators selected for these activities could either be existing Ministry of Health personnel or new staff hired specifically for the program. Often supervisors can be retrained to become effective face-to-face educators. Although the skills and training of educators would obviously vary from one setting to another (e.g., rural health centers vs. urban teaching hospitals), the following qualities are usually considered important:

[VA 12]

- *Facility with language* -- ability to communicate salient points persuasively.
- *Energy* -- enthusiasm for program and willingness to travel.
- *Alertness* -- awareness of surroundings and health worker needs and reactions.
- *Good interpersonal skills* -- courteous, outgoing manner.
- *Poise under pressure* -- ability to handle rejection.
- *Some science or technical background* -- to aid in understanding material and enhancing credibility.

In developed countries, both pharmacists and physicians have proven capable of successfully persuading other physicians to improve their prescribing practices. It might be possible to train less highly skilled health workers to perform this function in rural areas; however, the messages and approach may need simplification.

Depending on the qualifications of personnel, the training time necessary for a typical program may last from a minimum of one week for a well-trained clinical pharmacist or experienced nurse to as much as one month for non-professional workers.
Training should include the following elements:

[VA 13]

• Important clinical and drug-specific knowledge necessary for the specific target problems of the educational program (e.g., basic microbiology and drugs of choice for treating childhood diarrhea).

• Major messages and recommendations to be emphasized.

• The major "selling" points for each behavior change recommendation.

• The principles of effective communication and persuasion.

• Role-playing of educational sessions before actual program implementation (e.g., practicing the presentations on colleagues).

• Pilot tests of the program in real-world settings to refine the approach (e.g., testing the presentation on two to three prescribers).

• How to make contacts with prescribers (e.g., dropping in on health workers at a time when they are least busy versus planned seminars).

[VA 14]

F. MANAGEMENT OF A FACE-TO-FACE EDUCATION PROGRAM

Like any other program, it is important that the activities be structured and managed efficiently and effectively.

• If possible, the program should target prescribers who prescribe targeted drugs at a high enough frequency to make the program relevant and cost-effective for their practice. For example, only physicians or health care workers who prescribe drugs frequently for diarrhea would be targeted in an educational program to promote ORT. (The prescribers don't need to be told that they are excessive prescribers, however.) This information may be easily available from the medical stores which supply the facility.

• A letter is then sent out to each targeted prescriber or facility from the sponsoring program -- either a Ministry of Health, medical school, or professional society -- introducing the new program and the plans for informational visits and sessions.

• At the first session, the educator explains the sponsorship and purpose of the new program (e.g., to bring up-to-date drug therapy information to prescribers). He then begins to provide information on the target drug therapy problems.
• A follow-up visit is scheduled to allow enough time for the prescriber to test out the prescribing recommendations in his/her practice (perhaps 2-3 months later). This follow-up will allow the prescriber and educator to discuss problems and reinforce successes.

Outreach education can be difficult to manage. It is usually necessary for a project manager to keep in close contact with the outreach staff. In order to effectively monitor staff and solve problems which may develop, it will be helpful to develop simple encounter forms to collect data on each educational session. Useful data to include on this form are:

• A record of the dates and times of all attempted visits or educational seminars.

• Non-participation rates and completed sessions.

• Time spent waiting before the educational session (if applicable).

• Time spent in the actual educational session with prescribers.

• The overall receptivity of the prescribers to the recommendations.

• Most importantly, a brief description of any obstacles encountered. These include reasons given by prescribers to dispute the recommendations. For example:

  - Unusual patient demand for drugs despite the prescriber's knowledge that they are ineffective.

  - Patients expect some definitive action by the prescriber regardless of the appropriateness of action in this case.

  - Clinical experiences of particular prescribers which disagree with the scientific evidence -- e.g., "My experience with these drugs proves that what you say and what the scientific studies say is wrong."

The above information can be reviewed periodically by the project manager and used to:

• Discuss and correct common problems the educators may have in gaining access to prescribers (e.g., too busy times, obstructive nurses, etc.).

• Develop methods for overcoming common obstacles to change mentioned by prescribers (see above).
• Evaluate the educator’s ability to carry out the required activities effectively (e.g., through analyses of visit completion rates, refusal rates, common obstacles encountered, etc.).

When possible try to evaluate the impact of face-to-face activities on drug consumption or on drug use indicators.

CONCLUSION

[VA 15]
Persuasive educational interventions have been evaluated thoroughly in many different environments and have been shown to be effective when done well. Although they may be intensive and difficult to manage, the large potential impact of persuasive educational programs should make them a primary choice to consider for improving of important prescribing practices.
ACTIVITY ONE

A Teaching Script for a Face-to-Face Training Visit with Prescribers at Centro Health Center

INSTRUCTIONS:

1. All participants should read the background section and become familiar with this teaching script.

2. Each group reviews the script and allocates roles.

3. The facilitator selects a group to present their training session which is followed by a discussion.

4. Finally, discussion of the process will conclude the session.

BACKGROUND:

The following "play" describes a hypothetical visit by a pharmacist, Dr. Onyango, who is working in a program to rationalize drug prescribing in the Northwest region of Mashiriki. The program is being sponsored by the Ministry of Health, the World Health Organization and the national Association of Physicians. It is based at the region's most prestigious medical school, the Mashiriki School of Medicine.

One of the first goals of this program is to reduce excessive use of antidiarrheal drugs which are ineffective, expensive, and sometimes dangerous in children under five. Modern concepts of childhood diarrhea treatment that are being promoted include: to target treatment on major effects of diarrhea (dehydration and malnutrition), to improve safety and to reduce cost, oral rehydration salts, other home-made fluids and proper advice on nutrition.

Dr. Onyango has already made an appointment to see the staff of the health centre. He already knows from a review of drug supply records that antidiarrheal drugs are among the top ten drugs prescribed at the facility.

At the health center there is a doctor, Dr. Aziz, a medical assistant, Mr. Bofu, and three nurses, Ms. Clotilda, Mrs. Dhama, and Mr. Ephraim. All staff prescribe at different times.
Dr. Aziz sits with the facility staff in his office at the health center waiting for Dr. Onyango to enter. Dr. Aziz is looking at his watch as if he has very little time to spare.

Dr. Onyango enters the room and shakes hands with the staff before he sits as well.

Dr. Onyango: "Hello, I am a Drug Information Advisor from the Mashiriki Medical School's Drug Information Program.

Dr. Aziz: Drug Information Advisor, "What is that?" (Looking surprised and skeptical, as if he suspects that this is really a drug salesman in disguise).

Dr. Onyango: "I'm a Pharmacist working for the Drug Information Program at Mashiriki Medical School. We are trying to provide an information service to physicians and other prescribers who treat children in their practice. You will agree with me, Dr. Aziz, that children are very delicate, and there's an enormous amount of new information coming out every year on drugs to prescribe for them, and it's almost impossible to keep up with it. The main goal of our service is to provide important, up-to-date information on drugs you may be prescribing so that your patients get appropriate treatment. The information and recommendations were prepared by pharmacology experts at the Medical School and consultants from the World Health Organization."

Dr. Aziz: "Thank you for coming, but I have very little time. I have 10 patients waiting in the other room."

Dr. Onyango: "I realize that, and I will try to be very brief. If necessary, I can finish up another day."

Dr. Aziz: "O.K., but please hurry."

Dr. Onyango: "I'm sure that a few of your ten patients waiting in other room are mothers with children suffering from diarrhea. At one time or another, you may have used many different mixtures, including the so-called antidiarrhea drugs..."

Dr. Aziz: (Nods head, agreeing.)

Dr. Onyango: "Could any of you tell me which ones you commonly use?"
Mr. Bofu: "Well a few of them. Let me try to remember the ones I have used in last couple of days... Streptomagna, Dialin, Septrin. Why do you ask?"

Dr. Onyango: "I ask because conclusive evidence has now been found that all of the mixtures used in treating childhood diarrhea are really useless, and sometimes can even be dangerous. Let us just see how effective these drugs are. *(Takes out the brochure on antidiarrheals, "Do antidiarrheals and other drugs have a role in the treatment of diarrhea in children of 0-5 years?"). According to WHO and UNICEF, and pharmacology experts at the medical school, these mixtures have no role in the management of childhood diarrhea which is self-limiting in 90 to 95% of cases. At the same time antidiarrhea drugs can be dangerous to your patients. *(Turns to inside of front page). You see, Doctor, diarrhea is nature's way of eliminating harmful substances from the body. The antidiarrhea drugs may superficially stop the diarrhea, but the pathologic effects on the body of whatever caused the diarrhea in the first place will continue. On top of that, fluid loss from the body into the gut continues as well. Adding insult to injury, antidiarrhea drugs can also cause side-effects *(points to list of side-effects) which you will agree can be quite dangerous for babies. That's why our program is recommending the modern scientific treatment of diarrhea *(points to sign of hand on inside-back page): ORS+Fluids+Food. What do you think about this, Doctor? Does it make sense to you in your own practice?"

Ms. Clotilda: "You say these drugs are dangerous. But how come our government has approved their use in the first place?"

Dr. Onyango: "You see, Dr. Aziz, new knowledge about drugs comes every day, and the whole point of this drug information service is to periodically provide you with such information so that you can better treat your patients. There is agreement among the worldwide community of scientists that antidiarrhea mixtures are of no use, and could be even potentially dangerous in childhood diarrhea. We are working with the government to change regulations regarding these dangerous drugs. Such changes take time. Many countries have banned them already."

Mrs. Dhama: "Those scientists may be right. But many of my patients come expecting a fancy drug for their illness. In fact, their illness seems to be helped the most if I prescribe a drug with a name they can't pronounce. If they think it's more powerful, the effect on diarrhea seems to be greater! A plain packet of ORS will disappoint them as many of them think that ORS is just water, and not a drug."

Ms. Clotilda: "Yes, that happened to me yesterday when a patient demanded an
injection but I convinced him that ORS was better."

Dr. Onyango: "I understand your objections. But we feel that if ORS is presented in the proper way, you can convince patients that ORS is truly the best drug for their children's diarrhea. *(Takes out ORS pamphlet.)* In fact, we have these patient information flyers that I'll leave with you. If you give these to the patient with a prescription for ORS, you are emphasizing the potency of ORS and creating your own "placebo effect." You can actually write a prescription for ORS. Some other patients will still be unwilling to take "plain ORS" because of their strong beliefs in drugs that look different, or have fancy names. For these patients there are some flavored ORS brands such as Servidrat which may be more appealing."

"In summary, Doctor, ORS is the drug of choice for uncomplicated diarrhea in children. It is the only drug which is effective in correcting dehydration and restoring health in your patients, and free from the side-effects which antidiarrheals have."

"Will you try ORS for the next child you see with uncomplicated diarrhea?"

Mr. Ephraim: "What you say makes sense, and may be worth trying."

Dr. Onyango: "I'll come by in a month to see if your new approach works. Our group will be very interested in hearing your results. Is there anything else I can help you with today?"

Dr. Aziz: "Well, you mentioned that WHO has done detailed research into the role of antidiarrheals. Quite frankly, the materials which you showed me are very basic. Do you have more detailed information which I could share with my junior colleagues?"

Dr. Onyango: "That's no problem. I'll leave with you few copies of what we call the "pink book". Do you think it would help if I spent few minutes with your colleagues as well?"

All Staff: Oh sure. Do let me know what they have to say.
Dr. Onyango: I will, Dr. Aziz. Thanks very much for your valuable time.