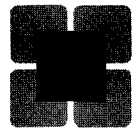

Influencing health behavior: physicians as agents of change

WHAT WE DO and how we think are influenced by the past. Many of our current approaches in medicine can be understood by knowing something about the nature of disease and medicine's ways of responding to disease earlier in this century. At that time, the dominant causes of disease and premature mortality were primarily infectious: tuberculosis, pneumonia, diarrhea, enteritis, bronchitis, and diphtheria. Given the limited understanding of infections and their management during that era, it is not surprising that a central ethic emerged in our profession in which the physician's task was seen largely as that of a combatant against external invaders, always searching for medications and procedures that would counteract or destroy these foreign contaminants. Penicillin was more than a "wonder drug": it became a metaphor for the achievements of modern medicine.

We now live in a very different era, but many of the assumptions shaped earlier in this century persist. Even though the nature and frequency of illness and premature death have changed considerably, our assumptions and attitudes in the 1990s bear a strong resemblance to those of our turn-of-the-century predecessors. We still behave largely as interventionists, although our efforts—especially for those of us in primary care—should be largely focused on prevention. Now, instead of infectious diseases, the major causes of disability and premature death are heart disease, cancer, stroke, injuries, bronchitis, emphysema, chronic obstructive pulmonary disease, suicide, chronic liver disease, homicide, and the acquired immune deficiency syndrome, all of which derive, in large part, not from external assaults by mysterious organisms but from the consequences of controllable, changeable human behavior.

Once we accept that much of death and disease is the result of personal behavior, it follows that clinicians must be equipped to help patients take an active role in changing their habits. Put another way, if we are to be optimally effective in responding to current medical needs, we must become effective teachers.

This problem and need were recently acknowledged in an important report that derives from a major international study of pharmaceutical use. A central conclusion of that work was that half the patients in Western Europe, Japan, and North America do not take the drugs that physicians order for them as prescribed, and that "...the fault lies with health care professionals who are ineffective patient educators."[1]

Paradoxically, this is not a plea for something new and different, it is an urging that we return to our roots. Historically and etymologically, teaching is basic to our profession. The Latin word "doctore" means teacher. Yet, for most of us, the skills required for effectively influencing the behavior of our patients were not part of either medical school or residency instruction. Nevertheless, at whatever stage we may now be in our profession, if we are involved in direct patient care and want to have a lasting impact on illness and mortality, we have to understand how people change and how we can help with that process. In other words, most of us have to start understanding our patients and the process of change better than our education prepared us for. As an introduction to what we need to do, the following is an overview of the change process.

From the Center for Instructional Support, Boulder, Colo. Adapted from a presentation at The Cleveland Clinic Foundation.

CHANGE: SOME BASICS

These are five basic principles of change. First, *people change in stages*, seldom in a sequential, linear fashion. Much of meaningful change is erratic, with considerable backsliding and retracing of steps.

Second, *people change slowly.* Significant change, ie, altering well-established habits, tends to take a significant amount of time for most people.

Third, change requires multiple attempts. One of the more successful organizations devoted to helping people make lasting changes is Weight Watchers. They have concluded that establishing a genuinely new habit requires success in using the new habit at least 37 consecutive times, without backsliding, before the new habit can be considered truly adopted. Almost everybody backslides at first, so patients should not unduly castigate themselves, or be demeaned by us or others, for doing so.

Fourth, *change often involves relinquishing what is familiar* and may involve acknowledging mistakes. Many clinicians, especially those who are also parents, will be especially aware of this principle. People tend to resist giving up their familiar ways, even when they recognize that what they have been doing is not especially helpful, and they will often defend their current practices. In fact, the inclination to cling to what is familiar explains much of the difficulty we have getting patients to change their behavior.

Fifth, *helping patients change is often a thankless job*, which is one reason many physicians seldom try. Yet in the long term the payoff can be very satisfying. Patients and other learners are more likely to attempt significant changes when they have a sense of control of their choices and their situation. Most people need to feel that proposed changes are not being inflicted on them by an outside authority (doctor or teacher), but that they are making the choice themselves. They want to feel they are meaningful participants in the decision to change. Furthermore, learning and change proceed most reliably when those who need to change are involved in monitoring their own progress.

All habits are difficult to change, but habits associated with pleasure (even highly undesirable habits) are especially hard to change. And those of us in the medical profession who are trying to bring about change in our patients' behavior must shift from short-term to long-term thinking.

STEPS TO LASTING CHANGE

The process of making lasting changes in behavior typically involves several steps.[2] The inescapable but difficult first step is *acknowledging that something is not right.* Given the widespread tendency toward denial, months or years may elapse before people acknowledge that they are eating too much, exercising too little, using alcohol excessively, being abusive to someone in their lives, or not behaving healthfully in other ways.

A second critical step is *deciding to make a change.* This decision is important but insufficient. Even if people have admitted that they need to make a change and have decided that they want to, they must then take the difficult third step of actually *committing* to change. Commitment is demonstrated by action, not only words. Subsequent steps include *setting a desirable and achievable goal* (eg, losing 10 pounds in 6 weeks), *exploring options for achieving the goal* (eg, diets, exercise), and *deciding on and trying to implement a particular plan* (eg, regularly eating low-fat foods and exercising for 20 minutes, four times a week).

While implementing a plan, people also need to *assess their progress* (eg, by weighing themselves). Quite commonly, goals and plans need to be modified (eg, extending the number of weeks for achieving a target weight). Even after they have achieved their goal, people typically need to *guard against backsliding.* As many of us know from painful experience, it is easy to regain excess weight, stop exercising, or resume smoking. In fact, most people seeking to alter established habits find they backslide several times and need to make several fresh starts on their way to ultimate success.

FROM CONCEPT TO PRACTICE

Applying these steps to our society's most serious health problem, I will briefly summarize steps you can take in helping a hypothetical patient who smokes. Let's take her through the initial steps in curtailing her long-term, self-destructive habit.

Perhaps the most basic and important step is asking the question "Do you smoke?" Assuming her answer is yes, the second step is asking, "How do you feel about your smoking?" If she says, "Oh, it's fine. It's no problem. I really enjoy it," then she's obviously far from making a commitment, which she needs to make before the other steps are worth try-

ing. Your kind but firm encouragement, combined with assuring that she is aware of all the risks to herself and to those with whom she lives, can go a long way toward helping her over this threshold. This step may require months.

If on the other hand she says ironically, "I can give up smoking very easily: I've done it thousands of times," then at least she recognizes there is a problem and has considered making a change. Even if she has not yet succeeded, she deserves credit for having taken the vital first two steps on her way to giving up smoking. At this point, the foundation is set on which to build a plan.

Commitment is reinforced and confirmed in a number of ways, and the choice of approach should reflect your sense of what is likely to work best for the patient. Some patients may be encouraged to carry through on their intent by writing and signing a contract that summarizes their commitment to a specific goal (eg, "Within 3 weeks of today I will have begun a systematic program to quit smoking, and no later than 6 months after that date I will have stopped smoking completely"). Others need a more open-ended approach (eg, "Let's work out a plan and then stay in touch by phone every week for a few minutes, and in person when we need to, for the next few months, and see what works best for you"). The better you know each individual patient, and the more established your relationship, the more likely you are to be a helpful advisor and to be able to recommend an approach that is well suited to the patient's personality and patterns.

It is important to have a plan, to customize it as best you can to the uniqueness of each patient, and to have a sense of direction in what you are doing. For more on developing an effective program of smoking-cessation in your office, Glynn and Manley[3] offer a good approach.

THE TEAM

For some physicians, the challenge of becoming more effective at helping patients make lasting changes also means learning to function more effectively in a team setting. Having a meaningful and lasting impact on patients' behaviors is rarely possible without the help of others. Helping patients to quit smoking or to change other habits usually requires a range of skills and a coordinated effort among all those who have contact with the patient. In many instances, the entire system in which we provide care may need to change.

Vital Signs

Pulse: _____

Temperature: _____

Resp. Rate: _____

Blood Pressure: _____ / _____

Smoking Status: ___ Current ___ Former ___ Never

FIGURE. Proposed vital sign stamp. Adapted from Fiore, reference 4.

A nice example of a small but significant system change was proposed by Fiore.[4] He pointed out that most physicians have a standard vital-signs stamp or entry that is placed on every patient's chart. These vital signs are a direct derivative of what were the dominant health problems of the era that shaped our present thinking, ie, they are mainly indicators of infection. Fiore proposed that the modern vital-signs stamp should include the dominant health issue of this era: smoking (*Figure*). Using this stamp, everybody in the practice is automatically reminded to ask what might be the most important question during a patient's visit. Without reminders that help make certain steps systematic, they tend not to be taken.

Confirmation of the need for change in the *system* as part of improving the way we provide health care comes from a study by Cohen,[5] who followed a fairly large number of consecutive visits by diabetic patients to an internal medicine clinic. He and his colleagues were concerned that peripheral neuritis and peripheral vascular disease—preventable sequelae of diabetes—were not being monitored by many of the clinic physicians. Few of these physicians were routinely examining their diabetic patients' feet. He studied the conditions that determined whether or not physicians examined their patients' feet as part of their routine follow-up care. By far, the most important variable turned out to be whether the patients' shoes and socks were already

off when the physician began the examination. So, instituting the step of having a member of the staff check that each patient's shoes and socks were removed before being seen by the physician became the small but important system change that helped ensure a consistent improvement in the care provided by the doctors. The lesson for us is straightforward: if we decide something is important enough to be done routinely, we must find ways to ensure that members of our team help arrange for the needed steps to be taken.

BEING A 'CHANGE AGENT'

Ultimately, being an effective physician at the end of the 20th century requires that we function as agents of change for our patients. For us to be good "change agents" we must develop our capacity as good educators, as well as the patience and indulgence our patients deserve if at first they don't succeed fully in adopting our recommendations. As I indicated above, few people succeed in staying on a new diet or fully giving up smoking, or adopting an exercise program, or adhering completely to a new long-term prescription the first or even the second time. Unless we are able to remain supportive of our patients, even in the face of delays and setbacks, we are unlikely to be optimally helpful.

EFFECTIVE COMMUNICATION

In many areas of medicine, understanding how we are doing requires that we ask our patients. And that is what the Miles Institute of Healthcare Communications did. They contracted with the Gallup organization to do a national survey of adults, asking them what they want most from their doctors. The dominant responses involved aspects of effective communication. Many respondents indicated that they wanted better explanations of their choices, clearer understandings of what the doctors thought about their condition, and a greater sense of power in making decisions about their care. They wanted to be asked what they thought their problems were and they wanted a chance to explain all their concerns.

Of course, patients are often the only source for such important information as their level of understanding of their conditions and of what they think should be done. They are the ones who know their level of readiness to take needed action, whether they have told us all of their concerns, and their level of worry about their situation. In multiple studies, when patients are asked immediately after emerging from an encounter with a physician what they were told and what they are expected to do next, a worrisomely large proportion of patients respond with some variation on, "I'm not really sure what I was told. I am confused. It wasn't explained well. It all went by too quickly, but the doctor seemed so rushed that I was embarrassed to ask for more of an explanation." Not surprisingly, in studies of patient adherence, between 30% and 60% of physicians' orders are not carried out adequately to achieve the intended therapeutic purpose.[6]

Most of us have had little or no systematic preparation for the complex tasks involved in being effective communicators, skills that are becoming increasingly central to the new demands of medical care. Merely having said something to someone is not the same as having communicated successfully. What we tell patients and how we tell it to them are only part of a sequence of events that make up the process of successful communication. Then, after communicating, we need to ask some variation of the question, "What do you understand that I told you?" Until you hear your words played back from the patient, you may not know what filters your statements went through. You cannot be sure how much got through, and what conclusions were reached by the patient.

Our lack of preparation for communicating effectively and for doing what is necessary for achieving high levels of adherence is an understandable consequence of our medical education. Most of us were trained in hospital settings and seldom had to think about patient adherence. In that setting, patients don't have choices. In the hospital, we have representatives who ensure that our orders are carried out, so that our effectiveness in securing adherence is not tested. Our communication activities typically amount to conveying orders to the nursing staff or others, who then ensure that these orders are carried out. In such a setting, there is little opportunity to learn the skill of working with patients to secure adherence to a jointly agreed upon plan.

ADHERENCE vs COMPLIANCE

When patients are outside the hospital setting they are usually responsible for taking care of themselves. If they don't agree with our recommendations, our advice often goes unheeded.

I will end by summarizing what we need to do if we are to be successful in achieving what I prefer to call adherence, as contrasted with compliance. The contrast is more than semantic. Many of us grew up professionally with the goal of achieving "patient compliance" with our recommendations. Inviting you to start thinking about adherence as an alternative term is not meant to imply any special virtues for this replacement word. Rather, it is that compliance has taken on undesirable baggage from the past. It is part of an outdated, authoritarian heritage from which we are now emerging. The dictionary meaning of compliance, as well as its typical use in practice, implies an authoritarian relationship in which an unquestioning following of orders is expected. Adherence is a less loaded term. It is closer to the notion of collaboration, the sense that medical decision-making and health care planning are cooperative undertakings between clinician and patient.[7] The term adherence communicates to patients that: "This is your life; these are your decisions. I'm here to help, to serve as your advisor, but you need to take as much control of your health behavior as you can. Neither I nor any other health professional will be with you. Most of the time you will be on your own, and we both have to trust that you will make the right choices on a day-to-day basis. We can make the initial decisions and plans together, but you've got to believe in them and be committed to them, so that, ultimately, you will choose to carry them out."

We can facilitate adherence in patients by taking five important steps. We need to make sure that any regimen we develop with our patients 1) is readily understandable, 2) is not any more difficult to carry out than the patient is ready to handle, 3) is backed up with a written explanation, 4) includes some form of reminder, and 5) provides for follow-up and reinforcement. Some of our recommendations are complex and require special arrangements to ensure needed support. Often, families or those playing the role of family members must be recruited to assist in achieving adherence. If, for example, we want a patient to change his diet, it's often not sufficient to tell him what is needed. If his wife does the cooking, she should be involved in the decision process.

In addition, we have to ensure that the costs of our recommendations are within the means of our patients. And we should guide patients to approaches that make adherence as simple as possible, eg, telling them about such devices as electronic pill boxes that can help them remember when to take their medication.

PERSONAL CHANGE

Achieving effective adherence in our patients is a complex process, requiring numerous steps and tactics,[2] and I've only scratched the surface here. But as we try to become more effective at helping patients make changes, we must realize that this means finding ways to change ourselves. Many of us need to alter our established professional habits. Learning how to help people take action and then to maintain whatever changes they've made is a major challenge. For most of us, the habits of a professional lifetime are unlikely to be optimally suited to this growing task of medical care. Among other things, we need to be effective as motivators, explainers, reinforcers, and supporters; skills for which few of us received preparation.

If you are persuaded that changes are needed in what you do, you face the interesting challenge of adhering to your own intentions. If you don't adopt the needed behaviors, your goals for your patients' long-term health may not be fully met. Again, there are approaches that have been found effective, some of which I've already suggested in mentioning the importance of altering the systems in which we work. We are most likely to adopt new routine behaviors by providing ourselves with checklists and reminders, office protocols, and chart stickers. For example, fluorescent stickers that remind you to ask about smoking or to follow up on issues of concern from prior visits, or to explore some other area of concern with each patient, can help you make real changes. In addition, your colleagues and staff must be involved in planning and supporting what you want to do. They have to be trained, if necessary, and they have to participate. Computerized reminders can make a big difference in helping us adhere to our own intentions.

Of course, none of this is easy. At the top of the list of requirements is the need for better reimbursement arrangements for the time needed to communicate effectively and focus on prevention. While some third-party payers such as Blue Cross and Blue Shield are beginning to reimburse for certain screening and prevention procedures, much remains to be done, and we have to convey our expectations to those who pay if we are to achieve better reimbursement patterns.

SUMMARY

In summary, physicians in the 1990s can no longer be satisfied with merely being interventionists. We have a different job at hand. While there will always be interventional tasks to be done, we must shift our mind-set so that we also anticipate and prevent, so that we are doing the job that is increasingly expected of us by the public and demanded of us by the nature of illnesses in the current era. We will be most effective as a profession when we return to our roots and become effective educators of our patients, to help them make lasting changes in their health behavior.

But in order to become really good agents of change, as good as we are at intervention, we have to start at home. We have to change ourselves and the systems in which we work.

In brief, our challenge—which many of us have not yet responded to adequately in our professional behavior—is to help people avoid the self-inflicted damage caused by accumulated small and large indiscretions.

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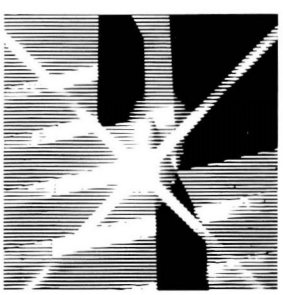
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