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ETHICS CASE

Meeting Patients Where They Are

Commentary by Mark T. Hughes, MD, MA

Mr. Kresser was on his way to see his primary care physician, Dr. Patterson, when his wife phoned to say that she had to work late and he needed to pick up the children from their afterschool activities. Mr. Kresser knew he could not leave his children at their activities but was concerned since he had been late for his last appointment with Dr. Patterson a month before when he was stuck at a job interview. The month before that, he cancelled his appointment because he was out of work and could not pay for the visit. Mr. Kresser also worried that Dr. Patterson would be upset with him because, with all the stress in his life, he had not stopped smoking, a behavior that Dr. Patterson had been telling him for years to stop. Even worse, he had not lost any of that extra weight Dr. Patterson was always on his case about. Mr. Kresser knew that his eating habits were not helping with his weight, but, frankly, his weight and smoking were not the aspects of his life that he was most worried about.

Mr. Kresser picked up his kids, dropped them at home, and then rushed to get to Dr. Patterson's office, arriving more than an hour and a half late. The receptionist told him to wait while she asked whether Dr. Patterson could see him. Dr. Patterson had had a busy day and was running behind his schedule also.

The receptionist told Dr. Patterson that Mr. Kresser had arrived for his appointment an hour and a half late and asked whether Dr. Patterson could see him. Dr. Patterson said "sure." He wanted to find out whether Mr. Kessler was making any progress on his weight control and smoking. As Dr. Patterson closed the exam room door, he said, "You just caught me. I was about to leave. What's going on?"

Mr. Kresser felt ashamed at his inability to make better choices for his health. He said, "I have been so busy, and I was on my way on time for my appointment, but I had to pick up the kids at the last minute." Dr. Patterson took a deep breath and said, "Well you made it. Now how are you doing on the changes to diet and smoking that we talked about?"

Mr. Kresser looked down at the floor. He believed that Dr. Patterson wanted the best for his health, but didn't think the doctor appreciated all that was going on in his life that was making it difficult for him to change his eating and smoking habits. He felt like he was doing the best he could with everything he had to worry about.

Commentary

It is interesting that the case is presented from the perspective of the patient, Mr. Kresser. The judgments attributed to his physician, Dr. Patterson, are speculations by the patient, and we do not know if they actually represent the mindset of his physician. Attitudes such as disappointment and anger cannot necessarily be assumed based on the interaction described. Whether these may have been expressed in previous encounters is not certain. If anything, the fact that Dr. Patterson agreed to see Mr. Kresser despite his being late for the appointment suggests that the physician is subordinating his own interests (e.g., going home or attending to other responsibilities after a busy clinic day) to the interests of his patient.

Before addressing the core issue of the case, namely behavioral counseling, it is worthwhile to comment on clinic scheduling as an issue of professionalism. In today's health care setting, physician appointments are largely doctor-centered. Some physicians have become more consumer-oriented by offering evening and weekend hours, but the majority of appointments occur during the day and are geared toward the availability of the physician, not the patient. Patients have to schedule appointments around (or in place of) other commitments, such as work, childcare, or household responsibilities. This is not patient-centered. Truly patient-centered scheduling might mean a return to home visits, rather than requiring the patient to come to the doctor's office.

Set appointment times in doctor's offices entail expectations and responsibilities for both physicians and patients. Physicians need to keep on schedule, so as not to inconvenience other patients scheduled later in the day. It is accepted, however, that extenuating circumstances can arise in which the complexity or acute nature of a particular patient's condition necessitates giving him more time than was allotted for his appointment. It is also an expectation in the system that patients will arrive on time for their appointments, so as not to inconvenience other patients or the doctor. But patients can also have extenuating circumstances, from delays in finding a parking spot to having concomitant duties like picking up children at daycare. When an expectation cannot be met, the responsible party should extend the courtesy of notifying the other person and determining how the situation can be resolved to mutual satisfaction.

Time is one of the most valuable (and scarce) resources in health care. Appointment times have been shortened in an effort to increase clinical productivity. Time management has become a crucial skill for health professionals. The patient's responsibilities for keeping appointments on time are generally not considered. In viewing the clinical encounter through the lens of beneficence, whatever is in the best interests of the patient should dictate the time allotted to the patient. Patients are not obliged to consider their impact on the doctor's schedule; they may accept it (or be resigned to it) as a reality of the system that the doctor's time is short, but this is in some respects buying into the doctor-centered view of clinical time.

It would be a vastly different world if patients could schedule visits for a length of time that correlated to their conditions or symptoms or they thought they needed. Billing mechanisms would have to change, doctors would have to be more receptive to the patient's goals, and more clinicians would most likely be needed to fill the need. But this is a "pie in the sky" dream; we have to work within the system as it currently exists. If a patient's agenda requires more time than the scheduled time permits, then the physician and patient need to negotiate how to best manage the time they have.

Negotiation is the key strategy to achieving lifestyle changes for patients. Physicians need to meet patients where they are, not where they want them to be. Each can have agreed-upon goals such as improved health, prevention of disease, and reducing or eliminating unhealthy behaviors, but how to get there has to be negotiated. The physician has to balance respect for autonomy (allowing patients to make choices, even if some of their decisions are bad or counterproductive to achieving health and healing) with beneficence (working toward the patient's best interests). Acting in the extremes of either principle can have undesired consequences. Simply letting the patient persist in unhealthy behaviors in deference to self-determination can lead to poor health outcomes. Going too much in the opposite direction and pushing the patient toward doctor-centered goals can result in paternalism. The middle ground is for the physician to be a guide or a coach.

Using the analogy of the patient being on a journey, the physician's role is that of a tour guide, providing direction on the trip but leaving the itinerary up to the patient. Advice can be given, and facts can be presented to educate the patient about guideposts along the way, but the physician follows the lead of the patient. The journey may involve detours, pit stops, and backtracking, but the guide is there to lead the patient to the final destination.

As an alternative analogy, the physician is a coach who is there to inspire and motivate the patient. The challenge comes in knowing when to push the patient, when to comfort and console, and when to cheer. A good coach or team manager may have his or her own style of managing, but also needs to adapt to the needs of the players over the course of a game or season. For the physician, this entails knowing the patient well enough to know what strategy will work in which instance.

Part of knowing the patient is determining what stage of change the patient is in. The physician's approach to the patient will differ depending on the stage of change [1, 2]. In order to have any success in lifestyle modification, the patient has to be ready to make the change. Pushing the patient to change when he is not ready sets him up for failure—leading to the sort of guilt, shame, and disappointment that Mr. Kressler feels. Fostering these negative emotions in the patient makes future attempts that much more difficult and ultimately is not compassionate. The physician's task is to understand the patient and diagnose his readiness to change. If there is too much going on in the patient's life (as seems to be the case for Mr. Kresser), the present might not be the time to advocate for significant lifestyle modification.

As the guide or coach, the physician should help the patient achieve the stage of change that is needed next in the process [2]. If the patient is in precontemplation, then the physician should help with consciousness-raising by providing information about health benefits of changing a behavior or helping the patient to reevaluate his or her circumstances to identify the barriers to change. When the patient is in the contemplation stage, the goal is to help him or her move toward making a change. The physician should facilitate the patient's process of thinking about options for change and barriers that may be encountered.

Once the patient is in the preparation stage of change, the physician should establish the patient's commitment to change and assist the patient in picking realistic goals that he or she feels confident about achieving. When the patient is in the action phase, the physician should praise him or her for accomplishments and work through obstacles to success. Empowering the patient's autonomous decisions and agency is important in this stage and in the maintenance phase. The patient has to discover for himself or herself what works in a given situation. With open-ended questions, the physician can help the patient with this self-directed learning to continue the lifestyle changes and potentially build on them. If the patient relapses, the physician has to help him or her identify what stage he or she is in currently and start the process over again. Rather than focusing on the failure, past successes should be praised and the patient's willingness to change should be reassessed. If one of the goals of the healing relationship is to make the patient feel better, then keeping a positive focus is crucial, especially in the relapse phase.

Returning to the case, Mr. Kresser has not achieved the goals established during his previous visits with Dr. Patterson. We do not know how those goals were established. Generally with lifestyle changes, it is best to create specific, measurable goals (e.g., picking a smoking quit date or reducing the number of cigarettes per day; keeping a food diary or eating fewer sweets 3 days a week). From the gist of the case, it does not sound as if there was any specificity in the plan other than trying to achieve the healthier lifestyle goals. If this is the case, it could set the patient up for failure, especially when there are major obstacles in his life, such as unemployment and other stressors. Perhaps now is not the right time for the patient to be making major lifestyle changes (i.e., he is in the contemplation stage). If the patient was in the preparation stage at the last appointment, was Dr. Patterson aware of these concerns at the time? Did they discuss strategies to overcome these challenges? Did they simplify behavior modification goals in light of these potential barriers? We learn from the case that Mr. Kresser feels that the doctor does not appreciate all that is going on in his life, but we do not know if these issues have been overtly discussed at previous encounters.

Thus, a different approach by Dr. Patterson in the encounter described may have been more helpful. It is a natural inclination on the part of the physician to "cut to the chase" when the appointment and clinic are already running late. Hence, it is understandable that Dr. Patterson asked, "Now how are you doing on the changes to diet and smoking that we talked about?" But a more appropriate response to the

patient's first statement would have been to be more open-ended, such as repeating his initial question of "What's been going on?" Or Dr. Patterson could have responded, "You've been busy? What's been going on in your life?" or "What's been happening since the last time we met?" Keeping the question general allows the patient to direct the flow of the conversation (and makes it more patient-centered). It also enables the physician to understand the patient's context, so as to be better able to counsel him about lifestyle changes.

Discussing the patient's stressors may be more than enough to cover at this visit. But if there were a need to discuss lifestyle changes attempted since the last visit, then keeping the focus on positive results (what things the patient was successful with or how long the patient was able to institute some changes) would be preferable. A judgmental tone could engender more shame for the patient, whereas praising the patient, even for small changes, may make him more motivated to get additional positive reinforcement in the future.

Behavior change is one of the most difficult tasks for anyone to accomplish. The person has to feel that the change is important. He has to be committed to the change and feel confident that he can accomplish it. Success has its own rewards and can lead to reinforcement of the behavior and an incremental increase in goal-setting. Having an ally in the fight, a trainer in the corner, or a guide on the journey can aid a person in achieving his goals. The physician who is able to be all of those for his patient is likely to achieve better results.

References

1. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: applications to addictive behaviors. *Am Psychol*. 1992;47(9):1102-1114.
2. Levinson W, Cohen MS, Brady D, Duffy FD. To change or not to change: "sounds like you have a dilemma." *Ann Intern Med*. 2001;135(5):386-391.

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