

Virtual Mentor

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STATE OF THE ART AND SCIENCE

Health Coaching

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Four principles undergird the ethical provision of health care: beneficence, nonmaleficence, respect for autonomy, and justice [1]. We believe that these golden rules cannot be implemented for every patient in our current system of health care. In particular, the stresses engulfing primary care thwart attempts to comply with the four principles. A new model is needed to transform primary care so that these ethical obligations can be met. This new model creates a paradigm shift that we call “health coaching.”

Our Failure to Provide Universal Ethical Care

Beneficence is the obligation of health care professionals to do everything possible to improve people’s health. Commonly, beneficence is equated with the provision of evidence-based medicine. However, evidence-based medicine has serious limitations. For many clinicians, evidence-based medicine is a three-step process: (1) research uncovers the evidence, (2) clinicians learn the evidence, and (3) clinicians use the evidence in creating care plans for their patients. For patients to benefit, however, clinicians must also (4) make sure that patients understand the evidence and (5) do everything possible to encourage patients to incorporate the evidence into their lives [2].

We will use the highly prevalent conditions of diabetes, hypertension, and hyperlipidemia to ground this discussion in reality.

Evidence-based medicine steps (4) and (5)—which take considerable time—are impossible in the rushed 15-minute visit that dominates primary care. In the United States, half the patients with hypertension, 43 percent of people with diabetes, and 80 percent of people with hyperlipidemia have not reached the clinical goals set by national practice guidelines [3-5]. If everything possible were being done to improve people’s health, greater proportions of the population should be reaching those goals. On a population level, beneficence is not universally achieved.

Nonmaleficence is the duty of health care professionals to do no harm. Harm comes from errors of commission and also of omission. Millions of people have not met their evidence-based glycemic, blood pressure, and lipid goals and are at elevated risk of severe and fatal cardiovascular complications. Harm is being done by omission of maximal efforts to make sure that all patients understand the risks of uncontrolled blood sugar, blood pressure, and cholesterol and are properly counseled on how to minimize those risks.

Autonomy is the right of persons to choose and follow their own plans of life and action. Patients have the right to choose whether or not to accept the health care being offered them. Yet, according to a study of more than 1,000 audiotaped visits with 124 physicians, patients participated in medical decisions only 9 percent of the time [6]. While half of patients surveyed preferred to leave final decisions to their physician, 96 percent wanted to be offered choices and to be asked their opinion [7]. Patient autonomy is exercised in the medical context through informed patient consent or refusal of the treatment alternatives offered. Typically, physicians give patients a care plan without consideration of patient exercise of autonomy. Moreover, 50 percent of patients do not even understand the medical options that are offered them [2]. As a result, patients do not know why they should follow their care plans, are not involved in creating them, and exercise their autonomy by not adhering to them. Only one-third of patients with diabetes adhere to recommended guidelines for lifestyle changes [8]. If patients were adequately informed to make these life-affecting decisions, adherence to lifestyle changes and medications would be greater [8].

Justice refers to treating everyone fairly and equitably. The pervasive health disparities haunting our health system demonstrate that justice is not being achieved. For hypertension, diabetes, and hyperlipidemia, lower-income patients and those who are part of historically marginalized groups have poorer outcomes than higher-income patients [9]. In part, these disparities are associated with poorer communication between higher-income, well-educated physicians and lower-income patients who have less opportunity to acquire health literacy and other forms of education [10].

To implement the basic ethical principles more fully, a new model is needed that moves beyond the 15-minute physician-visit syndrome. Such a model requires that health care workers—called health coaches—with a collaborative style, good training, and ample time are available for patients who have inadequately controlled chronic conditions. In the remainder of this paper we explore how health coaching can improve our health care system's performance on the four ethical principles.

What Is Health Coaching?

Health coaching can be defined as helping patients gain the knowledge, skills, tools, and confidence they need to become active participants in their care so that they can reach their self-identified health goals. The familiar adage “Give a man a fish, and he eats for a day. Teach a man to fish, and he eats for a lifetime,” demonstrates the difference between rescuing a patient and coaching a patient [11]. For chronic conditions, patients make the salient decisions every day: what will I eat, will I exercise, will I take my medications? Patients with chronic conditions need to learn how to fish.

Health coaching could be performed by clinicians (physicians, nurse practitioners, physician assistants), but the 15-minute visit makes that impractical if not

impossible. Thus health coaching is best done by another member of the primary care team. Health coaches might be RNs, pharmacists, health educators, trained medical assistants, or other patients called peer coaches. Health coaches must have the training and protected time to provide this essential service and must be on the clinician's team so that the clinician and health coach coordinate their messages to the patient. Health coaching has the potential to assist the health care system to perform better in the four domains of medical ethics.

The Content of Health Coaching

Some people understand the term “coaching” to mean a supportive activity in which the coach's main job is to encourage the patient to do better. Indeed, providing emotional support and motivation is an important part of coaching. But true health coaching does far more, offering patients assistance in five concrete areas: understanding, knowing their numbers, shared decision making, behavior change, and medication adherence.

Understanding

In a 2003 study, when physicians asked patients to restate the physician's instructions, the patients responded incorrectly 47 percent of the time [12]. Fifty percent of patients, when asked to state how they are supposed to take a prescribed medication, did not understand how the physician had prescribed the medication [13]. While physicians frequently attribute medication nonadherence to patient behavior, in fact, 3 of 4 physicians in one study failed to give patients clear instructions on how to take their medications [2]. Low health literacy, more common in lower-income patients and those from historically marginalized groups, is associated with greater lack of understanding of clinician instructions [10].

A key function of health coaching is to make sure that patients understand the care plan made by the clinician. This function is carried out by “closing the loop,” also known as “teachback.” To close the loop, the coach asks the patient: “Just to be sure we were clear, how will you be taking your medication starting tomorrow?” The patient then states the clinician's instructions in his or her own words. If the information is incorrect, the coach corrects the patient and asks again. This is repeated until the patient can accurately state what the clinician's instructions were. In a study of patients with diabetes, those whose coaching included this technique had better HbA1c levels than those whose coaching did not [12].

The understanding step in the coaching process enhances beneficence and nonmaleficence by improving patient outcomes. Because understanding is a greater problem for lower-income patients, and because health coaching is more often performed in safety-net settings, this coaching function can also reduce health disparities and bring more justice to health care.

Knowing Your Numbers

Most patients with diabetes do not know their actual HbA1c number or their HbA1c goal [14]. A randomized controlled trial has demonstrated that patients with diabetes who are taught their actual HbA1c level and their HbA1c goal improve their glycemic control more than a control group [14]. Diabetic patients with low health literacy have worse glycemic control than those with adequate health literacy [15]. A central function of health coaching is to teach patients their ABC numbers—A for A1c, B for blood pressure, C for cholesterol (specifically LDL-cholesterol). Coaches also teach patients their ABC goals (for example A1c of 7, blood pressure of 130/80, and LDL cholesterol of 100), and explain how patients can get from their current numbers to the goals—generally by healthful eating, physical activity, and taking medications. Because knowing your numbers improves outcomes and because knowing your numbers improves health literacy that is often inadequate in lower-income populations, this health coaching function enhances beneficence, nonmaleficence, and justice.

Shared Decision Making

Clinical outcomes improve when patients are involved in clinical decisions, i.e., when the principle of respect for autonomy is honored. A participatory relationship between patient and physician is one of the most decisive factors in promoting healthy behaviors [16, 17]. In a study of 752 ethnically diverse patients, information giving and collaborative decision making were associated with better adherence to medications, diet, and exercise [18]. In an intervention study, patients who were encouraged to participate more actively in the clinical visit reduced their average hemoglobin A1c levels from 10.6 percent to 9.1 percent, while hemoglobin A1c levels in the control group increased from 10.3 percent to 10.6 percent [19]. For patients with diabetes, significant associations exist among information giving, participatory decision making, healthier behaviors, and better outcomes [20-22].

Because clinicians often lack the time to engage in shared decision making, this crucial medical care function can be provided by health coaches. Health coach training begins with the concept of ask-tell-ask: rather than telling patients information that they may already know or may not be interested in learning, good coaches ask patients what they want to learn, what choices they want to make, whether they agree with the clinician's instructions, and what behavior changes they are motivated to make. If there is one fundamental principle of health coaching, it is shared or collaborative decision making with patients. Health coaches are trained not to tell patients what to do.

One common situation that arises in coaching is that clinicians tell patients what to do, then coaches ask patients what they are willing to do, and coaches must then go back to the clinician and say that the patient will not do what the clinician instructed. For that reason, everyone providing health care, clinicians included, should be trained using the coaching paradigm. Getting mixed messages does not help patients.

Behavior Change

It is commonly believed that information alone promotes healthy behavior change, but telling a patient that eating less fat will reduce LDL cholesterol and prevent heart attacks rarely has the desired result. While information is necessary, it is not sufficient. A review of diabetes patient education found that in 33 of 46 studies, education improved patients' knowledge about their condition, but in only 18 of 54 studies did patient education improve glycemic control [17]. Sixteen randomized controlled trials of patient education on hypertension found that education alone is not associated with reductions in blood pressure [23]. Nor does education by itself increase the extent to which patients take prescribed medications [24].

In helping patients adopt healthier behaviors, two things seem to work: shared decision making and realistic goals. These two things form the basis of behavior-change action plans, also known as goal setting. Action plans are central tools in a health coach's toolbox. First, patients—after learning their numbers, their goals, and how to get from their current number to their goal—are assessed for their motivation to get from their number to their goal. If motivated, the patients are asked to choose which behavior they would like to work on; the most common choices are healthful eating, physical activity, and medication adherence. Once the patient has made this choice, he or she is encouraged to make an action plan for a behavior change—for example walking for 15 minutes per day or eliminating sodas and substituting water—that the patient is confident he or she can succeed at. Action plans are a stark contrast to the unrealistic instructions clinicians often give: “You need to stop eating sweets and need to walk 30 minutes each day.”

A recent randomized controlled trial demonstrated that goal setting using action plans was effective. Patients were randomly assigned to traditional patient education or goal setting with action plans. The group doing action plans had a significant reduction in HbA1c compared with the patient education group, whose A1c levels did not change [25]. The success of properly performed health coaching is bolstered by evidence. Moreover, the replacement of the doctor's order by the shared decision making displayed in collaborative goal setting and action planning enhances patient autonomy.

Medication Adherence

Approximately one-third of patients take all their medications, one-third take some of their medications, and one-third take almost none of their medications [26]. Many studies and reviews address the issue of improving medication adherence. A participatory relationship—shared decision making—between patient and physician appears to be the most significant factor in medication adherence. The more actively the patient is involved, the higher the level of adherence [26, 27]. Health coaching focuses a great deal of energy on medication adherence, since medications for diabetes, hypertension, and cholesterol are highly effective in assisting patients to reach their clinical goals. This effort enhances all four ethical principles.

Summary

Faithful adherence to the four principles of medical ethics is not possible in the rushed, 15-minute primary care clinician visit. Health coaching—performed by other members of the health care team—can increase the chances that the ethical tenets will be followed for every patient. The coaching must assist patients to understand their care plan; know their current state of disease control, their goal, and how to get from here to there; engage patients in shared decision making, which increases the likelihood of good clinical outcomes; help with realistic behavior change that the patient agrees with; and work with patients to overcome barriers to medication adherence.

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