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Policy Forum

"You Can Pay Me Now, Or You Can Pay Me Later"

Physicians can take an active role in disease prevention by learning counseling skills and helping patients to cease medically destructive behaviors.

Geoffrey C. Williams, MD, PhD

Evidence clearly indicates that the health care system's and health care practitioners' greatest impact on quality and length of life comes from intervening to change health-related behavior [1-5]. Even the short-term costs of medical care are higher for patients who smoke, are physically inactive, or overeat than for those who have healthy lifestyles [6]. It is exactly like the oil filter commercial where the mechanic suggests it would be wiser to pay a few dollars now to change your oil filter, rather than paying thousands of dollars later for a new engine. Yet, few health care systems, insurers, or practitioners incorporate behavioral counseling services into everyday care [7]. Research into human motivation [8], principles of clinical biomedical ethics [9], and recommendations by the Centers for Disease Control and Prevention (CDC) [2,4,5] indicate the importance of supporting physicians and patients who take responsibility for improving behaviors in order to manage the current epidemic of behavior-related disease.

Behavioral Counseling by Physicians

The importance of behavioral counseling by physicians came into focus in 1993 when the CDC recognized that an estimated 50 percent of all deaths in the US are caused by unhealthy behaviors [1]. By 2001, the CDC had further clarified which of the many available preventive measures physicians should employ to have the greatest impact on improving quality and length of life for their patients [2]. Impact is a function of the efficacy of the intervention multiplied by the proportion of the at-risk population that receives the intervention. While brief behavioral counseling by physicians is efficacious [2,4], it tends to have lower efficacy than intensive interventions by behavioral specialists (eg, 10 percent versus 40 percent for tobacco-dependence counseling). However, physicians have much greater reach into the population than do behavioral specialists (eg, 70 percent versus 3 percent for tobacco-dependence counseling). Thus, brief physician counseling would have about 4 times the impact on the burden of disease caused by tobacco than behavior specialists alone. Effectiveness of physician behavioral counseling for secondary prevention in other diseases has also been established. For example, physician counseling for patients with diabetes was found effective in lowering cholesterol, achieving 2-year sustained weight loss, and encouraging smoking cessation [10].

Brief behavioral counseling by physicians is further justified by its impact on extending individual patient's life expectancy and improving quality of life. Woolf argues that interventions for tobacco dependence (where the Number Needed to Treat to prevent one death = 9), diet (where NNT=34), and physical activity (where NNT=16) have greater impact on reducing mortality than most if not all traditional medical interventions (eg, beta blockers after myocardial infarction where the NNT=120, or treatment of hypertension where the NNT=31) [5]. Thus, brief behavioral counseling is important to the health of individual patients and to the health of the population. However, physicians provide these treatments to only about 20 percent of their patients [2,7].

Physicians need to have more than knowledge of the impact of an intervention to incorporate behavioral counseling into daily practice. They also need to have effective strategies that can be easily learned and applied in the busy practice setting. The US Preventive Services Task Force [4] recommends the 5As counseling as a brief behavior

counseling model for physicians:

- **Assess:** assess behavioral health risks and patient goals.
- **Advise:** give clear and personalized behavior change advice.
- **Agree:** establish treatment goals collaboratively.
- **Assist:** aid the patient with behavioral counseling to achieve goals:
    - Provide positive interpersonal support for change,
    - Assist in skills building/problem solving,
    - Recruit social/environmental support,
    - Provide pharmacotherapy where appropriate.
- **Arrange:** schedule follow-up contacts.

The 5As model has a strong evidence base in tobacco and alcohol counseling. For the health of the population to improve, the 5As model needs to be adopted by physicians as the standard of care [11].

While the potential impact of physician counseling for reducing behavior-related diseases underscores its importance, it is the principle of autonomy from biomedical ethics [9] and motivation theory [8] that mandates the adoption of brief behavioral counseling by physicians. Patients need to be fully informed in order to make autonomous health decisions. In turn, patients who are autonomously motivated are more likely to adopt and maintain the healthy behaviors that improve health over time [12,13]. Physicians who fail to counsel patients about the health benefits of lifestyle change actually fail to fully inform them of their treatment options. For example, the current national guidelines for cholesterol [14] and stage 1 hypertension [15] indicate that physicians should recommend patients try 3 to 6 months of lifestyle change before adding medications to reach treatment goals. A modest weight loss of 10 lbs is expected to result in a reduction in 10 mm Hg in blood pressure and improve the patient's cholesterol [15]. The established impact of counseling and the ethical standard of informed decision making necessitate the widespread adoption of brief behavioral counseling by physicians.

Patients rely on physicians to inform them of their risks and interpret the absence of advice as tacit approval of their behavior. Even today, in spite of tobacco industry warnings, many tobacco users remain poorly informed about the risks. Researchers report that more than 90 percent of smokers believe they are adequately informed of their risks [16]. However, 2 surveys found that almost half of smokers believe they are not at higher risk of heart disease or cancer than nonsmokers [16,17]. Even simple advice from physicians (eg, saying "you should quit smoking") increases long-term abstinence for smokers in 2 meta-analyses by 30 to 70 percent [3,18]. Smokers who are advised about abstinence by their physician report greater satisfaction with their care [19].

Further, given that physician counseling is uniquely effective, and that patients rely on physicians to inform them about their health, failure to counsel has the consequence that physicians may unwittingly profit financially from the more expensive care that patients will require when they develop diseases caused by the unhealthy behaviors. By not providing counseling, physicians are falling below ethical standards of care because they are failing to support patient autonomy and informed decision making and may also may be profiting financially from their neglect.

Patient Accountability

Holding patients accountable for their behavior can lead to initiation and maintenance of behavior change if it is done in a manner that supports patient autonomy and competence [8]. If these attempts leave patients feeling controlled or manipulated, they will undermine patient motivation. Patient accountability is best accomplished by fully informing patients of their risks and the benefits of lifestyle change, eliciting their perspectives, providing advice and a clear rationale for change, and briefly helping them process their emotional reactions to the information. After patients have been informed, those who indicate a desire to change their lifestyle need competent support—a safe plan for change, skills training, problem solving, and follow-up [3,4].

Some argue that patients should be held accountable for the costs of the treatment of the diseases their behaviors cause. People quit smoking when the cost of cigarettes is increased through taxes [20]. Taxation is particularly effective in reducing tobacco use if the taxes collected are devoted to tobacco control [20,21]. Similar arguments might

be made for alcohol, and food intake, though lack of physical activity would be difficult to tax.

Holding patients accountable for copays for preventive services (eg, mammography or tobacco dependence counseling), however, has been shown to decrease the utilization of the services, as does making smokers pay out-of-pocket for medication and counseling that lead to successful treatment [22-23]. Charging patients for trying to change their behavior may leave them feeling even more controlled, first by their addiction or inability to regulate their behavior and then by the system that might have helped them. Taxing tobacco and alcohol purchases seems likely to decrease the burden of diseases caused by these behaviors, whereas holding patients accountable for paying for the treatment of their lifestyle disorders is likely to result in an increase in disease.

In a free society, where lifestyle is chosen and where physicians decide whether or not to intervene with their patients, evidence suggests that lifestyle behavioral counseling will be more likely to occur under systems that focus on supporting patient and physician autonomy and competence. With effective counseling available to prevent lifestyle-related diseases, it is no longer an acceptable standard of care for physicians or health care systems to fail to provide behavioral counseling, thereby passively allowing lifestyle-related diseases to develop, and then subsequently accepting payment for treatment of these diseases.

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Geoffrey C. Williams, MD, PhD, is an associate professor in the Departments of Medicine and Clinical and Social Sciences in Psychology at University of Rochester, Rochester, NY. Dr. Williams is upported by grant R01-MH5954 cofunded by NIMH and NCI.