REFLECTION

A Change Will Do You Good

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ABSTRACT

The primary care physician is described as many things—generalist, information manager, chronic care coordinator, and specialist in disease prevention. But midlevel clinicians, the Internet, and self-motivated patients can provide most of these services quite ably on their own. Why, then, are we here? One indispensable role for the family doctor is to be an agent of change for our patients and our communities. Through the groundbreaking work of Michael Balint, William Miller, and Stephen Rollnick, we have a solid framework for understanding our role in the change process. It is through working with patients, however, that we learn of their extraordinary capacity for change—and by extension, ours.

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> *It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.*
>
> Clarence Darrow[1]

NOTES WHILE WAITING

Change comes slowly to a small town. The tides rise and fall, seasons turn, the newborn nursery and the grounds of Mt. Repose Cemetery form bookends in a natural balance. Nary a brick has been added or subtracted to our downtown since the Great Conflagration of 1869. Pleasant chatter at the Beano Hall, Thompson's Barbershop, or deli counter at Hannaford's drifts ineluctably toward sports, kids, and illness. And the census has not budged for a century and a half, though employment shifted from shipbuilding to shoe manufacturing to poultry processing to telemarketing, tourism, and the service sector.

I am part of that sector. For 23 years I have cared for an endless stream of knotted joints, nagging coughs, and niggling doubts of a rural patient panel that has aged imperceptibly in the watch of their aging physician. Then one day, a death or diagnosis changes everything. In its wake, the patient and family doctor struggle to patch their shattered world. When I began the practice of medicine, I was drawn to the high-decibel drama of life: birth and death, emergencies, and intensive care. But I have come to appreciate the more delicate and nuanced branch points: where the most dramatic change is our realization the world around us has has moved on. We must choose between living in the present or locking ourselves in the past.

CHANGE OF LIFE

Patients often enter crossroads where obvious decisions abound: quit smoking or it will kill you; leave the abusive relationship or crazy job before it is too late; risk a total hip replacement while you can still survive and enjoy it. These are questions I dance around each day. But a sharper thorn digs my side: why do some patients grasp for help while others are swept past, beyond reach, isolated in their self-destruction and despair?

The agencies of timing and luck confound my search for more consis-

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tent clues. I do not so much orchestrate change as listen closely for it. William Miller and Stephen Rollnick see the process of change through a framework they call motivational interviewing. Their work is indebted to the client-centered approach of Carl Rogers. It is less technique than a manner of communication that seeks to spring clients from the trap of indecision. For the patient facing a choice, as doctors see it, other options compete. Only the patient can resolve his ambivalence by choosing among them. And resolution takes time. Empathic clinicians can offer their time, space, self-awareness, and self-confidence, and they recognize that the patient's resistance to change is often a reflection of the doctor's own haste and indelicacy. When commitment to change finally comes, Miller and Rollnick assert, it is always a positive choice:

> People don't change because they haven't suffered enough. Constructive behavior change seems to arise when the person connects it with something of intrinsic value, something important, something cherished. People often get stuck, not because they fail to appreciate the downside of their situation, but because they feel at least 2 ways about it. The way out of the forest has to do with exploring and following what the person is experiencing and what, from his or her perspective, truly matters.[2]

THE PATIENT

I am called to the Emergency Department to admit Mr V, a 52 year-old truck driver with unstable angina. The physician on duty carefully noted the progressive symptoms of chest tightness, shortness of breath, and sweating during the previous week. Intravenous metoprolol, subcutaneous enoxaparin, and 4 chewable baby aspirin were given in timely fashion. New-onset diabetes was documented, along with the strong recommendation that the patient be hospitalized for observation, provocative cardiac testing, and diabetes education and treatment.

What the doctor failed to record was a pending court date, scheduled for the following Tuesday, to resolve a neighbor's complaint against the noise and pollution of his rock quarry. Nor did he document a notice by the Department of Environmental Protection that they intended to investigate the complaint. Or the 12- to 16-hour days he had been working to make ends meet. Or the anxiety attacks and insomnia that resulted, and the Michelob Lite he drank to calm his nerves. How does a beaten brow or oil-stained work cloths skew our judgment of a patient's capacity for change?

In the corner, a woman—his wife—wipes tears from her eyes as I talk about the blessing that these events can sometimes bring, the chance to look at our lives and reorder priorities. She takes me aside and whispers that a similar episode occurred last year; his left arm went numb and weak for several days but improved before she could convince him to see the doctor.

What will happen after the acute coronary syndrome has been ruled out and his blood glucose returns to normal? This question in its varied expressions has absorbed me for more than 2 decades. The scientific method is no match for the barrage and blare of problems I face in the social arena. Patients live and work within social groups that explain their illness and provide the motivation to rise above it. Doctors, inside our own social enclave, develop treatment goals that drift away from the patients' base of reference. Thus it is possible for a manufacturer to claim therapeutic advantage for a drug that improves biomarkers and disease-specific mortalilty but worsens the quality of life and overall death rate.

In the 1950s, the Hungarian-born psychoanalyst Michael Balint coined the term *patient-centered care*, thus turning the focus of professional concern and scrutiny back on the patient's social context. Balint's other great contribution was to imaginatively explore the role of the doctor as drug. He saw that clinicians could just as easily contribute positively or negatively to a reciprocal therapeutic relationship. Work with groups of general practitioners at the Tavistock Clinic (London) culminated in his seminal work, *The Doctor, His Patient, and the Illness*, in 1958.[3] This book had a profound effect on the training of primary care physicians, even in the United States, where it has been said:

> No factor has influenced the evolving nature of family medicine more profoundly than its ties to the behavioral sciences. And no work has exemplified this link more trenchantly than Balint's *The Doctor, His Patient, and the Illness*.[4]

Balint groups are established in nearly one-half of the family medicine residency programs in the United States. An overreaching goal is to challenge each physician with the question, "What kind of doctor do I need to be for this patient today?" In addition to promoting awareness in the doctor-patient relationship, there is also an element of self-help. Jonathan Gore, a Balint group leader, sees these groups as a way of helping physicians treat difficult patients without resorting to those human defenses that tend to distance or denigrate. The hope is that young doctors could cope with caring for difficult patients while maintaining their own equanimity and mental health.

Like my seasoned colleagues, I know that the doctor-patient relationship is both a gold mine and a land mine, a source of gratitude and pride, a bounty of inside secrets about the requirements for human survival and the costs of caring for those who suffer. Change is not a solo flight. People in crisis need com-

panionship and guidance. They often need another to shift their gaze from the conflict at hand to its unconscious origins. They need assurance that the shift is not only possible but worth the effort.

A LIFE OF CHANGE

I recently returned to part-time teaching after 15 years in private practice. It has been edifying and humbling to supervise residents who have so readily mastered the medical corpus. What could I teach them about the care of patients in a setting (the family medicine center) that self-selects for some of the most difficult and marginalized I have ever encountered? How could I convey what my patients have taught me, or what I learned by living in one place for 2 decades, or what marriage and children and life and death have hewn in my bones? What could be said in a 5-minute consultation that does not ring of cheap anecdote and sentimentality? I found myself repeating a few whispered warnings that spared me from many an unseen but ever-present danger.

First, command the science that underpins our authority. Yet, understand that—in the words of Kafka—"to write prescriptions is easy, but to come to an understanding of people is hard."[5]

Second, understand that patients who insist "you're the doctor" are here for themselves. Offer them a mirror, or better, a portrait painted in layers by an unhurried listener who works in oils of word and touch. But the artist must know his footing, as Anais Nin warns: "We don't see things as they are, we see things as we are."[6]

Third, realize that good advice is as worthless as all the prescriptions written to quell our insecurity or deflect the patient's inscrutable complaints. Most patients change when life-altering diagnoses compel them to or when years of self-neglect begin take their toll. It is then that we can probe again for the shifts in awareness or readiness for change.

Change in others is beside our control. So we do what we can: order tests, prescribe drugs, and perform procedures—necessary or not—that prove our good intentions. We offer a hand of friendship. Patient care is more than a series of transactions, an accountant's log of money exchanged for itemized service. At every step it harbors the chance to express tolerance, affection, weakness, and commonality. Broken, confused patients seek a stronger ally; the doctor, in turn, recognize himself in their illness.

It is through the open door of relationship that a new kind of authority emerges, at once personal and deeply moral, one that offers honesty as an invitation instead of a demand. I have practiced long enough to know that my actions have lasting consequences, intended or not, with or without legal or ethical aftershocks. I am forever bound to my patients, my wounds alloyed to theirs. There was never a more sensitive and astute observer of this stage in a doctor's career than the poet-laureate William Carlos Williams. He was keenly aware of the flawed human being he threw at his patients, prompting Robert Coles to remark of him that "presumptuousness and self-importance are the wounds this life imposes upon those privy to the wounds of others," and later, remarking himself, "There's nothing like a difficult patient to show us ourselves."[7]

RETURN

Mr V reappeared one late afternoon, 6 weeks after his hospital discharge. Little surprise that his stress echocardiogram was normal and his morning blood glucose readings, jotted on a legal pad, clustered around 100 mg/dL. Mr V was relieved to report that the lawsuit was dismissed. He returned to driving truck with its attendant 14-hour days. I met the eyes of his wife, as they once met in the Emergency Department. We both felt the window of opportunity shimmy down. Though a change might have done him good, Mr. V is alive, and so am I. We are working still, and putting our trust in the strength of a handshake.

I don't know what change I had hoped for, or on what criteria I might have judged it. Perhaps we will meet again at another crossroads. Change takes time, and is meted out in the mutuality of human relationship—where the doctor and patient cling to a common log on the rising river.

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