

## Patient Counseling and Education: Should Doctors Be Doing More?

Only 3% of U.S. citizens adhere to the 4 key healthy lifestyle characteristics—not smoking, maintaining healthy weight, eating adequate amounts of fruits and vegetables, and exercising regularly—according to a recent telephone survey of 153 000 adults published in the *Archives of Internal Medicine*. Almost 10% of the respondents adhered to none of the 4 characteristics. The ramifications of such poor health behaviors are much more important than most people realize. Smoking, poor eating habits, and inactivity contribute to more than one third of deaths in the United States, according to the U.S. Centers for Disease Control and Prevention.

Although smoking rates in the United States have declined from 42% in 1965 to about 20% in 2005, obesity rates have skyrocketed. Today, 65% of U.S. adults are overweight (body mass index  $\geq 25$  kg/m<sup>2</sup>) compared with 33% in 1950. The increase portends an epidemic in weight-related complications that U.S. Surgeon General Richard Carmona, MD, calls the greatest threat to public health today.

The trend can be reversed, of course: Smoking cessation reduces the associated risk for lung cancer, stroke, chronic obstructive lung disease, and coronary heart disease. Improved diet and exercise habits reduce the risk for diabetes, sleep apnea, cancer, hypertension, and heart disease. United States citizens know this, but too few practice the eating and exercise habits that are good for their health. Maintaining these habits in today's car-dependent, excess-prone society is not easy, and breaking bad habits is hard.

Should doctors be doing more to help? Prevention is, after all, a core tenet of medicine, and health promotion can result in healthier patients. But whether doctors recognize and embrace this responsibility is another matter. Few physicians have training

in the specific skills of health promotion. Doctors are already stretched to the limit in caring for their patients' more immediate health concerns. Reimbursement for patient counseling and education is spotty at best. "Of course it is the doctor's job to promote healthy behaviors," said Eric B. Larson, MD, MPH, the director of the Center for Health Studies at Group Health Cooperative in Seattle, Washington. "The challenge is: Do we know how? Are we any good at it?"

### THE STARTING POINT

The answer to Dr. Larson's questions is, "Not really, at least not yet." For one thing, doctors do not consistently provide prevention counseling. Researchers in a study published in *Preventive Medicine* in 2004 found that fewer than one half of adult patients with hyperlipidemia, hypertension, obesity, or diabetes mellitus received diet counseling and just about one third received physical activity counseling. In a 1999 *JAMA* study of the content of routine checkups, researchers found that physicians counseled just 42% of obese adults to lose weight. In 2004, the National Committee for Quality Assurance reported that only 66% of smokers received advice about quitting from their doctors.

Conversations about sensitive subjects like weight or smoking can be uncomfortable and may even be unwelcome. Some patients may be in denial, others may not want their doctor to tell them that they have harmful health habits, and some are already aware of their habits and are discouraged at their inability to change. Doctors who do not have good health behaviors may have difficulty preaching what they do not practice. Not surprisingly, research has shown that personally practicing healthy habits was 1 of the most powerful predictors of whether doctors talked to their patients about a

related prevention issue. This is true for diet, exercise, alcohol, tobacco, and various other preventive activities, noted Erica Frank, MD, MPH, a professor in the Departments of Health Care and Epidemiology and Family Practice at the University of British Columbia in Vancouver, Canada.

When doctors do counsel patients about healthy behaviors, however, they are often rushed and take a dogmatic approach, prevention experts said. This style of practice is not surprising. Office visits are already short, leaving little time for sensitive discussions about health behaviors. "Doctors aren't very sophisticated about how to do counseling. We tend to be rather preachy rather than building on what patients are inclined to do," Frank said. "But it's not that complex to learn how to do it better, and even when done poorly, it seems to make more of a difference for patients than not doing it," she added.

### BECOMING AN EFFECTIVE MESSENGER

Research has repeatedly shown that the physician is an effective messenger of prevention. Patients seem to respond well to doctors who show confidence that patients can change behaviors. Experts point to findings from the Centers for Disease Control and Prevention that patients advised to lose weight by their doctors are 3 times more likely to succeed than if their doctor does not advise them to lose weight. The same message about the physician's golden touch applies to counseling about weight management, studies show. A review by the Agency for Healthcare Research and Quality found that good-quality, brief, repeated behavioral counseling interventions reduced risky and harmful alcohol use by primary care patients.

Counseling by a physician is not

always effective. The U.S. Preventive Services Task Force found inconclusive evidence in 2002 on whether counseling primary care patients to increase physical activity was effective, perhaps because the counseling was inadequate. Although a 30-second intervention in which a doctor asks a few questions and provides information on cessation resources doubles a smoker's likelihood of quitting, other behaviors like diet and exercise require lengthier interventions and repeated office visits to be effective.

Simple advice like "eat less fat" or "exercise more" is not enough. "You have to actually provide people with tools to improve their skills and give them tips on what to do when they're tempted to splurge or when they're served a high-fat meal," said Shirley A.A. Beresford, PhD, a professor of epidemiology at the University of Washington in Seattle. Her research on dietary interventions has shown that a self-help manual can accomplish substantial behavior modification for a large number of people. In 1 study, when doctors or their staff provided primary care patients with a few words of encouragement and a manual on dietary changes—which included information on setting goals, keeping track of food intake, and making simple food changes, plus some easy recipes—the patients read it and made minor dietary changes as a result. "Although these changes were small, they might lead to bigger changes over time, and the program took almost no effort for the doctor to implement," Beresford said.

Most professional organizations provide continuing education on prevention and on techniques for patient counseling and education. Many also offer a range of self-help materials for physicians to give their patients. Over the course of a career in practice, doctors develop their own techniques for health promotion, too. Larson has found in his 30 years as a general internist that providing context is an effective tool.

Handing patients appropriate medical information—like the patient summary that accompanied an article in *Annals of Internal Medicine* showing that low-carbohydrate diets do work—encourages some people to change their health behaviors, too, he said. Researchers have also found that physicians who talk for an extra 30 seconds about their own health practices are considered more believable and more motivating to their patients

sources, such as support groups and adult education classes, can help patients to break bad habits and stay on track. Making such referrals is important because time with patients is precious, Larson said, and fitting health promotion into the office visit is a challenge. "Time is an issue. Health promotion has to be incorporated into everything else doctors do," he said. "But primary care doctors have multiple times to help peo-

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than those who do not.

Larson said that he also likes to use a prescription form to write an "Rx" for exercise. This practice, called a "green prescription" in New Zealand, was recently shown to be effective in promoting increased physical activity.

Explaining the ill effects of certain behaviors can add gravity to health promotion, as can bringing patients face to face with evidence of their deteriorating health. For instance, taking a treadmill test can lead some patients to change bad habits like smoking or inactivity, Larson noted. Measuring liver enzymes can provide patients with clear evidence of the damaging effects of excessive alcohol consumption, he said. Similarly, tests that show rising cholesterol or elevated blood sugar levels can motivate change in diet and exercise.

Doctors do not have to do it all themselves. They can refer patients who are overweight to a nutritionist for help starting a diet and exercise program. They can refer smokers interested in quitting to a smoking cessation program. Community re-

ple because we see them over the course of time. We just have to keep at it."

## IMPROVING PUBLIC HEALTH EDUCATION

"Keeping at it" is a message that has not always found its way into daily medical practice in the United States. However, this may be changing. Today's medical students are learning more about prevention than previous generations of students did. During the previous decade, many medical schools added a nutrition curriculum and prevention program, and the emphasis on effective patient counseling and education has increased. Some schools now offer a course on obesity management as well. "We have a responsibility early on in our training to assure that medical students are exposed to the concepts and value of prevention and health promotion. We cannot expect doctors to promote healthy behaviors in the vacuum of not understanding why it's important," said Linda Rosenstock, MD, MPH, dean of the School of Public Health at University of California, Los Angeles.

Rosenstock is co-chair of the Institute of Medicine's Committee on Educating Public Health Professionals for the 21st Century. The committee's 2003 report, titled "Who Will Keep the Public Healthy?", focused on medical training and recommended that one fourth to one half of medical students earn the equivalent of master's level training in public health. Today's physician appears to be less interested in advanced education in public health techniques. About 10% of the student body at schools of public health today are physicians, compared with 60% in the 1960s, she noted. "The pendulum has swung too far. We should be building on the strength of each working together," she said.

Rosenstock acknowledges that recommending up to one half of doctors train in public health may sound implausible. However, she argues that tackling this ambitious goal is the key to achieving a healthier population in the future. She credited the combined efforts of the medical and public health communities with most of the major health advances in the past 100 years, such as the decreases in infectious diseases, infant mortality rates, and cigarette smoking. Solutions that will lead more people to stop unhealthy behaviors and start practicing healthy ones are likely to come from a coordinated effort involving medical care and public health communities, she said. Unless today's young adults adopt a suitable diet and exercise program, some longevity experts predict that for the first time in modern history these people will have shorter, less healthy lives than their parents.

Unfortunately, funding for public health and prevention is increasingly limited. Last year, the U.S. Congress cut public health programs by more than \$1 billion despite an outcry from health organizations that funding was already too limited. Major cuts have also occurred in federal funding for primary care training. The high costs of treating diseases caused by unhealthy living are creat-

ing a fiscal crisis that is undermining efforts to prevent the very diseases that are costing so much to treat.

### MAKING MONEY AT PREVENTION

In one respect, physicians can take heart: Insurers are adopting reimbursement policies that pay physicians to provide health promotion. In 2003, Medicare began to classify obesity as a disease, and obesity and morbid obesity now have diagnosis codes (278.0 and 278.01, respectively). Some health care companies are starting to pay doctors for weight loss treatment, as long as it comes in the course of treating another disease to which obesity contributes, such as hypertension. To justify reimbursement, physicians must carefully document the counseling and recommendations that they provide.

with metformin. The study was published in *Annals of Internal Medicine* by the Diabetes Prevention Program Research Group in 2005.

Ongoing research targets how employers may benefit from health promotion. Beresford is currently studying the effects of a work-site collaborative obesity prevention project on changes in weight for height and other health effects, including days absent from work due to illness. "As part of this research, we're trying to find out whether there are direct employer benefits for work sites to sponsor health promotion programs," she said.

Meanwhile, many overweight people are not losing weight or exercising more. They are relying, increasingly, on pills and even surgery for help. United States health care

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Research documents how health promotion can be more cost-effective than ignoring conditions until treatment is required. For instance, researchers for a large, randomized, controlled study of overweight people with impaired glucose tolerance demonstrated that those who followed a low-fat, low-calorie diet and exercised moderately for at least 150 minutes a week reduced their incidence of diabetes by 58%. By comparison, people who took metformin (850 mg twice daily) experienced a 31% reduction. The lifestyle intervention would cost society about \$8800 per quality-adjusted life-year saved compared with about \$29 900 per quality-adjusted life-year saved

supports this approach. The lifestyle-related medication market is estimated at \$20 billion. A pill can be an efficient weight loss intervention and not necessarily at great cost. Patients receiving drugs like the fat blocker orlistat and the appetite suppressant sibutramine, for instance, typically lose an average of 5% to 10% of their original weight. Bariatric surgery is costly and risky, but it can also be effective—average reduction of excess weight (the difference between actual weight and the ideal body weight for a given height) is 60%, and many patients experience improvement or resolution of diabetes, hyperlipidemia, hypertension, and obstructive sleep apnea. Up to 30% to 40% of

patients, however, require additional surgical interventions in order to maintain the acquired weight loss, according to a 2005 *JAMA* meta-analysis and review article. Surgeons in the United States performed more than 120 000 bariatric surgeries last year, double the number just 3 years earlier. Many insurance companies cover the cost of the surgery, which ranges from \$20 000 to \$40 000 on average, as long as patients meet certain criteria.

Physicians are supposed to prescribe diet and exercise to accompany such weight loss medications and surgical interventions. "All people really want, though, is a pill or some surgical procedure. Lifestyle changes require more of a commitment than most patients are willing to give," said Thomas L. Schwenk, MD, pro-

fessor and chair of the Department of Family Medicine at the University of Michigan Health System in Ann Arbor. He sees little hope for change with the current cultural emphasis on fast food, sedentary television watching, and long work hours, coupled with health insurers' focus on short-term profits instead of long-term health. "There are all kinds of data about how lifestyle modification and behavior change lead to improvements in population-based health parameters as well as significant cost savings, but patients and the health system in the United States are not interested," he said.

Despite this gloomy prediction, the medical community is focusing more and more on disease prevention. Doctors and their office staff will increasingly act as messengers of

health promotion. "I can't imagine anyone seeing a diabetic patient and not talking about diet for at least a few minutes. It's not only their ethical obligation, it's simply the right thing to do, and the best way to get sustainable improvements," said Dr. Frank. Doing the right thing now, she promises, opens the door to a future in which today's young adults will have longer, healthier lives than their parents.

—Jennifer Fisher Wilson  
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None disclosed.

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