Person Centered Medical Practice

by Susan Bonner Schwarz, Ph.D., PA-C

Abstract: This paper looks at the possibility of applying a person centered approach to medical care within an HMO. It discusses the difficulties and rewards of such a practice. The author presents a further challenge to all interested in PCA to continue to influence behavior and policy within the managed care model.

PERSON CENTERED MEDICAL CARE

For the past 25 years I have worked within the medical model from a person centered perspective. This has never been easy but it has usually been rewarding. From my early days at Yale medical school to my present job at an HMO clinic I have been challenged to remain a quiet revolutionary from within a system that traditionally works from an expert model that is diagnosis and disease oriented. Humanistic approaches have been disenfranchised from this medical model as more technical knowledge and skills have taken precedence. Despite academic emphasis on the impersonal, the daily practice of concerned medical practitioners has often included a more integrated personal connection. Now, however, the fast pace of economically oriented managed care threatens to officially limit resources including time needed to provide comprehensive health care which takes the whole person into account. I find it is increasingly important for those of us interested in providing comprehensive health care to people to speak to the emotional, relational and existential needs of the individuals caught up in these fast changing and disorienting times. We cannot influence the future of health care in this country if we are not present, vocal and involved. From this perspective I would like to share with you some of my experience bringing person centered awareness into medical practice.

Personal Background

I was born into a medical family. My father was a surgeon, my mother a nurse. I have two sisters and two brother's in law who are all practicing surgeons. My father used to say, "There are the talkers and then there are the doers." I used to wonder what happened to the listeners. I was never comfortable with the expert model and instead of traditional medical school accepted a position in an alternative and experimental program at Yale Medical School for Physician Associates. This was a twenty four month intensive graduate program aimed at training health practitioners to work in medically under served areas. After graduating I spent some time in England training at Saint Christopher's Hospice, the first hospice in the UK. I came back to Yale to set up one of the initial Hospice programs here in the United States. From there I moved to the South West and practiced for several years in a small desert town (population 200) with the local family doctor. We knew the people and were able to take into account their families, their work lives and their belief systems. Unfortunately a large managed care group took over when the local doctor retired. The emphasis was no longer on family practice and as a result I moved to Los Angeles where I worked at a free clinic for street people and

undocumented aliens. My interest in the plight of many of my clients led me to medical work in Latin America. Several years later I moved to West Africa to set up village run health clinics. It was during this time that I reread the ideas of Carl Rogers and was exposed to the writings of Paolo Freire. Both had an influence on how I approached my work. After 6 years in the bush I returned to the United States where I began my present position with an HMO in Southern California. For the past 12 years I have worked in the area of primary care which has included work in an urgent care setting, in family practice and in internal medicine.

I mention all of this to point out that there is not "one medical model'. Experience and practice in health care are extremely varied and changing. All of my initial experience, though within the field of medicine, was outside of the main stream. The people I worked with were disenfranchised due to economics or language or geography. In order to have some impact on their health I had to admit that I didn't know what the other person needed. I didn't really know where they were coming from or where they wanted to go. I did my best to speak their language, literally and figuratively. Many times I learned more from them than they did from me. Honoring the person's frame of reference, appreciating their involvement and trusting an open ended mutual exploration became more important than any skill I had learned in medical school. I found that I could trust the person to know what was appropriate for them. If I could be respectful, present and open, on a level beyond words, they would sense that I could be trusted too. If I could be there with them, without expectations of how they had to change or what I had to do we could find an answer together. I learned a lot about healing and wholeness from the people I met and worked with over those years. I got used to doing things differently and being open to what comes.

Managed Care

Coming back to the United States I wanted to experience a mainstream involvement in health care. I am now part of a primary care team in a managed care setting. This is the first time since graduating from medical school that I find myself part of a busy practice working primarily from the standard disease model. The way many physicians and other health professionals view disease and the person with the disease has been shaped by the current medical system. Advanced technology with its emphasis on diagnostic and treatment procedures, the partition of practice among several medical specialties, and the size and complexity of our medical care institutions, all of these are factors that have tended to diminish the expression of medicine as a healing art that centers on understanding the patient as a person. Unlike twenty years ago when

academic theory stressed the disease model while most daily practice saw the patient and family as a whole and in context, today's theory is beginning to look at the need for an integrated body-mind approach (Engel, 1980. Sobel, 2000) while the average managed care practice increasingly focuses on numbers and economics rather than people. Research increasingly documents that the individuals' capacity to cope with illness and to achieve progress in recovery depends critically on the degree of human support, personal acceptance, and "caring" they receive from their health care provider. Yet, year by year the health system in this country is becoming more dehumanized. It is dehumanizing not only to the person seeking health care but to the health practitioners as well. Although there are efforts to emphasize preventive care and wellness there are usually too many patients and not enough time or energy to work outside of the formula of diagnose the complaint and treat the symptoms. Cost cutting issues relentlessly pressure medical clinics to increase the pace, cut back on staffing and decrease support. There is often frustration and burnout among health care professionals because they know from experience, as I do, that this standard medical disease model is an inadequate model for effective healthcare.

Healthcare when done well integrates biological medicine and the psychosocial sciences into daily medical practice. It gives recognition to the role that emotions, expectations, fears, and interpersonal relations play in our everyday health. A medical practitioner who is locked into the biologic medical model is much less effective in the long term than one who appropriately places the whole person, physical, psychological and social, at the center of health care. I know few health care professionals who would disagree with the statement that "quality health care must take into consideration the body, the mind, the family, and the culture." Most would go on to agree that it includes more than acute care interventions and addresses continuing care to include proactive education and facilitating positive lifestyle changes. Yet with the fast pace of medical appointments (usually 10 minutes or less) taking "everything" into consideration seems daunting. For many practitioners it is threatening to move away from a learned method that is controllable, simple and straightforward: You walk in, make a diagnosis, decide what is needed and provide it. This academic model creates a structure for examining, classifying and treating a disease. It fits quickly and easily into S.O.A.P. notes and covers most legal expectations. (S.O.A.P. is an established charting tool which organizes information into S. subjective, O. objective, A. assessment and P. plan.) The diagnosed "disease" is viewed almost in isolation from the person.

This type of clinical reasoning lends itself particularly well to the need for a system that simplifies the approach to a waiting room full of a diverse group of unknown people who have varying and unorganized signs, symptoms and problems. When the pathology becomes the focus

it is easier to sort through a variety of medical data in an efficiently organized fashion and arrive after a very short time at an understandable conclusion that calls for a specific solution that the patient is directed to follow. This directive approach seems to be the most effective way of "getting" a person to do something. But, when you want to facilitate healing, you don't want to "get" cooperation as much as you seek to develop and mobilize the patient's own healing potential. Assisting the individual to take responsibility for her own care and renew her own strengths and tendencies toward wellness are at the center of a comprehensive approach to health.

Person Centered Care

People presenting for medical care are complex, multidimensional human beings, and they bring a variety of problems to the average office. Some are quite obvious, while others take the form of hidden agendas. After practicing in Latin America and West Africa I was amazed at what brought people to a primary care appointment here in the United States. Frequently there were few external clues as to the nature of the problem. Often the signs were unorganized and nonspecific. I was afraid I was missing some hidden pathology. Eventually, I had to drop my own evaluative notions, forget my judgments and try to hear the person's problem and especially to hear her feelings as she was experiencing and perceiving them. Gradually I came to accept that 35% of medical visits are for problems that do not have a definite physical cause, and up to 50% more reflect the stress of illness or lifestyle (Schwarz, 1998). Often the presenting problem (which can frequently be handled with little difficulty) is not the main reason for the person's visit. Even if people are fortunate enough to have their symptom relieved by some intervention this may not serve their overall health needs. Sometimes by "turning off" the physical symptom (which is the signal that something is wrong) the practitioner removes the evidence without addressing the problem. It is increasingly evident to me that dealing purely with the physical realm is in almost all instances dealing only incompletely with the patient's problem.

I realized after a short time that if I was going to continue working in the area of health care in this country I was going to have to find a way to address more than presenting physical complaints. As a result I studied current medical and psychological literature. I turned to the ideas of Carl Rogers and the person centered approach, taking courses in humanistic psychology and spending 6mos of intensive work at the Carl Rogers Institute for Psychotherapy Training and Supervision. I also found a group of individuals at the Center For Studies of The Person

interested in exploring and dialoging around similar issues. Eventually I finished my Ph.D. in psychology.

I continually work with the question of how to come from a person centered perspective into a situation that is not primarily one of personal relationship. The dramatic proliferation of information, the growth of technology, sociological changes and material constraints all affect our lives in many different arenas. It is increasingly important that we begin to look at what we believe and how it fits into the changing face of our lives. For medical practitioners that means dealing with the paradox that results when increasingly complicated technology calls for the isolation of an illness by reducing it to isolated symptoms, while the people themselves present with multiple needs which are all interrelated. It is important to reevaluate the traditional disease-oriented medical model and incorporate person centered insights so that we can develop skills and attitudes that help foster a therapeutic encounter which will support the inherent strength of the person and promote her own healing powers. How can we expand to address the whole person in a routine medical visit meant to take care of physical problems, while at the same time accepting that managed care requires us to increase productivity and reduce health care costs? Finding a successful way of adapting to the changing circumstances while maintaining our humanistic focus becomes a primary task.

Healing is essentially a personal rather than technical process (Cassell, 1979). Focus on the person, development of a trusting relationship and total care rather than just on the treatment of a particular disease has long been recognized within the medical profession as a significant part of good health care. The importance of "bedside manner" (an aspect of what I mean by person oriented vs. disease oriented approach), is not new. What is new is the increasing concern over how theses "quality human skills" can be practiced in a system that is increasingly focused on the bottom line of efficiency and cost cutting. If we as professionals are convinced that the process of interpersonal communication is central to the health provider-patient encounter then we are faced with the challenge of influencing and reshaping the evolving system of American health care delivery to consider that fact on a daily basis.

I would like to give you an idea of how coming from a person centered perspective works in my medical practice and how this has influenced our clinic to develop a medical model which focuses on the process of the healing relationship as well as the individual's psychological and social environment.

Beginning a healing relationship

I realize I have my own mission statement; "I'm going to see people here and I'm going to work with them in a healing relationship. I'm going to do that in my own person centered way." This is where my excitement comes in and what gives me energy. The quality of the interpersonal encounter with the patient is one of the most significant elements in determining long term effectiveness of health care interventions (Stewart, 1995). A medical appointment that involves the patient in their own medical care has been found to improve the patient's health, increase the satisfaction of both patient and health professional, and decrease overall costs (Rosenberg, 1997). The training of most health professionals focuses primarily on the task of developing the needed clinical knowledge to diagnose a disease and the technical knowledge to treat the disease once diagnosed. As a result the quality of the patient encounter is highly variable from one health provider to another. In addition to this the time demands in a managed care setting allow about ten minutes to diagnose and treat a physical ailment in someone never seen before. This in itself takes considerable skill. Adding the desire to understand another's frame of reference with an ongoing interest in their inner and interpersonal world demands a high level of sensitivity and an ability to empathize with people who may have very different values and needs. It means being present and aware of multiple levels meaning while simultaneously tending to the physical questions at hand. When Rogers was asked by a physician how he could imagine reconciling this task with the lack of time available for each patient, Rogers answered "If a person is really seeking help, and I'm willing to give myself as a listening, attentive, responsible human being, that can be very meaningful. So the fact that time is short should not be taken as an excuse for not relating as a person " (Rogers, 1975).

Connecting to the person I meet during each appointment is central to my practice of medicine. It is as though we engage in a kind of dance which has many interacting parts; there is establishing an affective bond, empathetically listening to more than the verbal message, evaluating symptom history and physical signs, coming to a clinical assessment, respectfully eliciting participation and mutually agreeing on a treatment plan while mobilizing the patient's own healing power. All of these layers intuitively flow into each other while the content of the appointment take place. This touches more on art and when all comes together I find it very satisfying.

Rogers demonstrated in his research that there are certain qualities in a relationship which are quite uniformly found to be associated with personal growth and change (Rogers, 1962). These have come to be known as the Core Conditions of genuineness, empathy and acceptance.

These elements do not consist of technical knowledge or sophisticated skill. They are personal qualities, something you experience, not something that you know. Rogers also thought that in order to be effective these attitudes have to be to some degree communicated to the client and perceived by her (Rogers, 1957). So in working to facilitate a participatory clinic visit I need to be sensitive not only to what is going on in me, and sensitive to my patient. I also need to be sensitive to the way she is receiving my communications. I want to behave in ways and communicate in ways that are meaningful to this specific person, so that what I am experiencing in relationship to her is also perceived by her. Achieving this is difficult and complex. What each person needs for healing and what each person expects in a clinic appointment varies tremendously, even if they share the same physical diagnosis.

A General Medical Appointment

My meeting with someone begins before we even meet. How the appointment is obtained, how the individual is received by the receptionist, even the information displayed in the waiting room gives an impression of what kind of encounter can be expected. It is rare that my patients ever have to wait. I personally call them by their full name from the waiting room and greet them with a handshake, introducing myself as Susan Schwarz a Physician Associate. I usually begin with some social talk, sometimes about how to pronounce their name correctly, the weather or traffic getting to the appointment. This short chat in non clinical matters allows us to begin interacting as persons. It opens our meeting to include more than physical complaints and often provides a window into the individual's psychological and social world. I consciously try to be open to what is going on in the patient. Although I may lead with introductory niceties, I try not to let my own wish to seem approachable interfere with the patient's agenda and underlying process.

RD is a 53 year old woman who was scheduled to address elevated cholesterol levels. She had cancelled her appointment 3 times before and checked in 10 minutes late for her appointment. She appeared rushed, was trying to put several things in her purse, handle her papers and shake hands with me at the same time. I remarked "It looks like you've got a lot to handle." This simple remark led to her story of being up until 2am with her 85 year old aunt who she just placed in a nursing home after her uncle's death the week before. As we settled into the exam room she continued to tell me about her feelings of conflict. She had spent 4 difficult years caring for her mother, finally placing her in a nursing home. RD felt during those 4 years she never had time to take care of her own needs or even keep her

medical appointments. She gained weight and felt increasingly depressed. Her mother died 6 months ago and RD was starting to take time to care for herself. She now found herself back in a caretaker position.

She was clearly taken up by this change of events. I heard her struggle and the feelings she was experiencing. I followed her. Although there were moments when I wondered how cholesterol was going to enter the conversation I realized she had to put this new state of affairs into perspective before she could address something else. As she finished her explanation she said "I quess this time I have to be sure to take care of myself too." From there she moved to interest in her diet and lifestyle. We engaged in a conversation about fitting exercise into her day, choosing food that would not take too much time or effort to prepare and support systems that might help her when she felt overwhelmed. We discussed medication and follow up.

By following her agenda we were able to address RD's health concerns from her present situation. She was able to integrate conflicting parts of her life and move in a health direction that felt appropriate and important to her.

In most situations when the patient and I reach the examining room I mention the official agenda item (which for most of my current patients is cardiovascular, endocrine or renal disease) and ask them if that is what they are here to talk about. I encourage the individual to describe the problem in their own terms, to communicate her thoughts, feelings, issues and expectations in a free-flowing manner. Often a patient will ask "Isn't that in my chart?" I show them that I keep the medical chart handy if we need it but let them know that in my opinion they are the expert in their health and that is why I ask them to tell me their medical story in their own words. I have found this an invaluable way of letting the person know that not only is what they tell me very important but that I see them as fully participating in their health care.

At times I ask facilitative open-ended questions such as "What else is going on?" or simply "What else?" This can bring out a wealth of unexpected information that gives me insight into the individual's perspective on illness or family and social concerns. I have found that the expectation to be listened to is rare for most managed care participants. My very shift to listening signals a different type of relating. The usual concern about time management has generally not proven true because health concerns are the primary reason most people have taken time to visit the clinic. If this is not the main reason for the visit, then neither of us waste time while a physical concern is used to mask something more important to the patient.

Many patients do not express their concerns directly but reveal them indirectly through subtle clues, testing to see if their wants or needs are acceptable. Cultural backgrounds and communication styles may affect how information is given or received. Body language often says more to me than words. I make it a point not to "interpret" physical clues but mention and check out my observations. Sometimes I ask the person to exaggerate a movement or posture until both of us can sense what the body might be telling us. Active listening skills help me to gain a clearer understanding of the patient's thoughts, unstated concerns and expectations. I also explore with the individual my own perceptions and questions.

Often this listening and reflecting leads to a person's emotions about the experience of being ill, or about issues seemingly unrelated to the presenting problem. Exploring feelings validates the importance of emotions and allows the individual to tell her story. Sometimes the effective use of silence or nonverbal behaviors such as a concerned look or a hand on the shoulder will convey the message of empathy. Other possibilities include wondering out loud ("I wonder if…") or restating emotional content ("It seems that you are really upset...") An experience of being heard and accepted is often enough for the patient to feel supported.

NB is a 46 year old man who came to me for follow up of an irregular heart beat. He is taking medication to keep his heart beating more regularly. He is also taking medication to keep his blood from clotting inappropriately. When I ask him "How are things going?" he answers "Fine". He has stopped smoking and has lost some weight. I take his blood pressure. I tell him the reading as I write it in the chart and let him know that the reading is normal. I them proceed to ask him about his medications. He seems to become uneasy and I get the feeling that he is disturbed about something. I mention my observations by simply saying "You seem to be upset about something." At this point he tells me that he found out that one of the medications he is taking is given for high blood pressure. He thought that at least his blood pressure was normal. I respond to a note of deeper feeling in his voice by saying, "You have been able to deal with the irregular heart beat, the hospitalization, the doctor's visits and the medication but the thought of having to deal wit high blood pressure too seems more than you can handle." He said something like "Yeah, I've been wondering if this is just the beginning of the end." He then reveals to me that his mother was told she had high blood pressure and she died one year later at age 47. Ever since he read about the medication he has been worried about his blood pressure. He is starting to think he feels some chest pressure when he walks. He is can't stop thinking that he might be having early signs of a heart attack.

I acknowledge his distress. We spend some time talking about his recent experience of having heart problems. We talk about his memories of his mother's illness and his concerns that he will soon be the same age she was when she died. After his fear is validated he seems more at ease. I go back to the clinical reasons he is taking the medication in question. We talk about the fact that one medication can be useful for several conditions, in this case rapid heart beat or high blood pressure. We look at his chart record which never records a high blood pressure reading. We then explore his concerns about his heart and the experience he has had of chest pressure. I schedule a treadmill test, several lab tests, have him keep a record of his activity and feelings. I make sure he knows what to look for and who to call if he experiences chest pressure, pain or shortness of breath. I tell him what I know about the effects of his medical treatment at the moment and that his active participation in his care and his recent lifestyle changes are already making a difference in his health.

Finding a Plan

Another focus of a person centered visit is including the patient in the decision making process for treatment and follow up. This usually means considering the patient's perspective and educating about the illness in an understandable manner. It involves negotiating a treatment plan that is acceptable and workable for the individual and their family. If the plan doesn't seem to fit for the patient (they are not ready to begin medication or change their lifestyle for example) I accept and talk about the differences in our opinions in a respectful way. I then focus on their readiness to change (Prochaska, 1994) and negotiate what might be an acceptable plan for them. I realize that medical interventions are only one among many determinants of personal health. People ultimately follow their own decisions. If the person does not really agree with my plan the likelihood of their taking medication, of "complying" after they leave my office is minimal. One of my major aims is to assist the individual to take responsibility for her own health and renew her own strengths and tendencies toward growth. This means helping the patient to clarify personal needs and goals, and then select actions which support personal values.

N.H. is a 46 year old woman who is seeing me for a follow up 3 months after having a heart attack and subsequent cardiac bypass surgery. As we check in she tells me she still smokes 1 pack of cigarettes a day, has gained 15 pounds and usually has one or more servings of alcohol in the evening. As she is telling me this I sense some frustration in her voice. I mention this to her. She goes on to say she knows what she is supposed to do but "

If I were to follow what I know I should do I wouldn't be me! I would have to change all of my friends, separate from my husband and find a whole new life. We've been married for 23 years. Our idea of a good time is to go to a club with friends, have a nice steak dinner, some drinks, smoke a few cigarettes, and stay up until dawn. I can't imagine drinking carrot juice and riding a bike with those tight little shorts."

We both laughed. I assured her that only she could decide what changes fit into her life and what was important to her. "I don't know anyone who finds it easy." I continued. "I do know that you will find something that works for you. I think that's one of the reasons you made the effort to come today, to figure some of that out." This shifted the energy in the room a bit. She said she realized that there were some changes she wanted to make but in her own way. We began to explore what those changes might look like.

I have come to experience that the source of lasting and creative change lies within each individual. I know this partly because I have experienced it in my own life. I attempt to live my own message. That means that I participate in the daily exercise, diet, yoga, meditation and all the other activities that I suggest to patients. I know it is not easy. I know that ultimately I have to figure out what I think is worth it and what works for me. I have been know to skip a workout and have a bowl of ice cream instead. I have to find my own daily motivation. We all face very human physical realities. In that way we are inextricably connected and equal. I don't expect the people I work with to be perfect. In fact I often find their ways of coping to be inspiring. Sometimes experiencing this with me allows them to realize they don't have to be perfect. It frees them up to find a lifestyle that is healthy and acceptable to them at the same time. I don't aim to control the individual's process but to provide the conditions and information for successful and healthier change.

Content and Process

A person centered medical visit is not meant to be a substitute for a psychological treatment session. It is meant to shift from the traditional disease oriented focus to a focus on the whole person, who is presenting with a physical complaint. There is a preset agenda which is scheduled to be addressed in a relatively short period of time. There is a focus on outcome and future action. Although a pure process-focus is not possible, that does not make awareness of process less important. The experience of a professional-patient encounter which emphasizes mutual participation and negotiation while minimizing dependency on a medical expert can actually shift the experience of the source of healing. Encouraging the patient to listen to how her

body communicates and respect her resources is paramount to the healing process. Clarifying her experience, thinking about her role in the situation and reconsidering her actions can lead to new personal insights about lifestyle patterns and basic goals. This can alter health related decisions in the future.

Within the medical visit there is always a juggling of preset agenda (diagnosing and treating the physical symptoms) with responding to and following the patient (facilitating and dialoguing in the here and now). In addition physical problems and symptoms do require assessment and suggestions for appropriate interventions. However, keeping in mind that persons themselves possess decisive healing resources (Rogers, 1951) it is important to realize that other than the health professional suggesting a particular plan it is the patient who is the expert on her life and the patient who will ultimately decide on what is implemented and followed.

Follow Through

Because a medical visit is only a short contact I write out steps of action that have been agreed upon. I also make use of educational handouts, individualized follow up letters and phone calls to remain in touch with people I have seen. As I write up my chart notes I automatically print a letter reviewing some of the points covered in our visit along with a reminder about follow up labs or appointments. This has been made easier by my clinic manager who installed a computer program which makes writing, printing and documenting such letters very easy. In addition to this practice I often call people a week after their appointment to ask about concerns they might have mentioned during their visit or inquire about how the medication seems to be working for them. This not only answers my questions but gives the patient opportunity to address things that they might have forgotten or are now wondering about. My department has set up a program that tracks when patients are due for return appointments or lab follow up. If there is no action by the patient I am reminded a week later. This lets me call them or send them a letter to find out what is happening in their lives.

RS is a 68year old man who has been in my practice for the past two years. He transferred to me because he was fed up with his former doctor who couldn't control his diabetes. He has lost most of his kidney function because of poor blood sugar control and is being considered for dialysis. He is routinely scheduled to do lab work every two months to monitor his blood sugar, cholesterol and kidney functions. He goes through periods of not taking his insulin or other medications. I know from past conversations that he has little

interest in following a healthy diet preferring bacon cheese burgers, double french fries and hot fudge Sundays. He is overweight and is not interested in exercise. "

Initially it was difficult for me to connect with RS. I had to ask myself if I could really prize this person, and continually try to understand and genuinely care for him as he is. When he repeatedly did not take his health care seriously while complaining that I did not keep his blood levels normal I expressed my frustration by telling him "I'm not sure I can help you Mr. S. It seems to me that you do not take your place in this partnership seriously. When I see your situation getting worse every month it scares me. Frankly I don't know what to do." His response was one of shock and astonishment. He acknowledged my frustration and said a little about his own. Eventually we worked out an arrangement that was mutually agreeable. This led to a better relationship because both of us were able to be honest and real. His behavior didn't change but our connections did.

He does his lab work every two months. Routinely his results are poor and result in a phone call or follow up visit. This month his lab work is more than 3 weeks late. I am concerned and call several times leaving a message to call me back. I send him a letter with new lab slips and a note to call me.

After several days I receive his return call, "I guess my levels are up" he said. I do not mention watching his diet or the importance of taking his medication, instead I ask "So what's going on for you Mr. S." He mentions something about stress, which is a common response for him. This time however I sense something different in his voice, a heaviness and a deliberateness that is not usually there. I mention my impression. "You sound different Mr. S." There is silence. Also uncommon for him. "Do you want to talk about it?" There was another long pause. Then he quietly answered, "My wife left me. She's filed for divorce this time." He talked briefly about feeling alone, how he knew he was difficult to be with. "I guess I gotta get my act together or call it quits." He said "Thanks for listening." Two days later he called to say he was checking his blood sugar twice a day but was having trouble adjusting his insulin. We set up an appointment to go over his medications together. At the moment his blood sugars remain in good control.

My experience with Mr. S. reinforces my trust in the person's ecologic wisdom. Compliance was not required as a condition of our relationship. He moved at his own pace and in his own direction. When he was ready to change he did. So far it looks as if this is more than a momentary shift.

As communication and mutual understanding improve through a person centered approach, I experience my daily practice as more satisfying. I am able to connect more effectively with individuals, couples and families. The dynamics differ but the fundamentals remain the same. I am told by patients that they feel listened to and understand their situation more clearly. This usually leads to better follow through with the agreed upon prescriptions and treatment. Less medication is needed in the long term as the individual takes active part in self care and lifestyle changes. I have also found that in general fewer follow up appointments and phone calls are needed.

Beyond the individual

I am fortunate to work with other professionals who are interested in focusing on the person in their medical practice as well as emphasizing the patient's own involvement in long term treatment and prevention. When I come across literature in medical or psychological journals which discuss or confirm the value of a person centered approach I make sure to circulate copies. Over the past five years I have been asked to direct several in-service training programs as well as present continuing education within our department on the subject of communication skills, and empathy. Rogers' work has been the foundation of most of these programs. Within this framework we discuss more recent literature, do experiential exercises and participate in round table discussions. Most recently we looked at sections from "How Clients Make Therapy Work" (Bohart, 1999), and how these ideas might have an impact on our practice.

Our organization as a whole is influenced by what is called evidence based medicine. That means that outcome studies which reveal benefit, risk and cost are important in determining the direction of future policy. Collecting the right data and using it drives behavior and policy. With this in mind I have helped to set up several projects which look at outcome studies and cost benefit considerations for person centered programs in our daily clinic practice. The first was a three year program in Primary Care. I set up a group appointment called the "Co-Operative Clinic". It was set up to address common medical and psychosocial issues of elderly health plan members who required frequent interactions with the health care system. The monthly meeting, conducted under direction of the group members, focused on patient education and interaction which addressed biopsychosocial needs. These meetings were attended by the individual patient, any family member which they invited as well as the primary physician, the clinic nurse, a psychologist and any expert that the group had asked to speak. The statistics and follow up from this pilot program showed increased satisfaction on the part of the patient, the family and the

medical staff. It gave strong evidence to the importance of addressing the biological, psychological and social needs of the person by demonstrating outcome studies which revealed more involved self care, significantly lower utilization and a moderated decrease in cost to the managed care organization (Schwarz, 1998). At the moment this type of group model has been set up to address the needs of individuals dealing with IBS, AIDS, hypertension, and diabetes. We are in the process of starting a group for people in our practice dealing with hyperlipidemia. A similar group encounter is being planned for individuals who have recently experienced a myocardial infarction.

Another recently completed project, for which my administrator obtained research funds, compared usual care following a myocardial infarction (which varies) to the care by one health professional who worked with the patient in a person centered manner. The health care provider proactively connected with the patient initially sending a personal introductory letter. She then telephoned the individual to find out what was going on with them and how they felt about being followed for their cardiac condition. Ultimately the two met in a mutually scheduled encounter. The patient was then followed for a year, usually at 6 to 8 week intervals or until their cardiac condition was considered stable (whichever was the longer period of time). The foundational purpose was to explore what the individual patient was feeling and thinking, obtain their perspective of the event, elicit their concerns and preferences, while presenting treatment options and ultimately agreeing mutually on a future plan. The opportunity for some sort of personal relationship with a health care professional was established. Within that ongoing relationship the patient was engaged in follow up care and lifestyle changes that were seen as appropriate by the individual most affected, the patient. This person to person approach proved to be 3.6 times as effective as current usual care. Outcome studies showed that people stayed in contact with the medical team, needed medical treatment (to include medication) was obtained, and acceptable lifestyle changes were initiated. The effect of this approach in this post MI population was significant enough to project significant long term savings due to the decreased morbidity and mortality of recurrent myocardial infarcts (Dudl, 2000). These were very exciting findings for those of us interested in finding a way to return to relationship as a healing element in medicine, while encouraging quality of treatment and considering long term fiscal possibilities. At the moment our department of Internal Medicine is looking at ways to implement a similar program on a larger, more permanent basis.

Presence & Influence

Until now I have focused directly on the interpersonal relationship between the health care professional and the person presenting for medical care. I am also aware of the impact that someone who maintains a humanistic presence can have on a staff, a medical team and ultimately a system. Realizing the uniqueness of the person is an attitude that forms the basis of all relationships, not just therapeutic relationships. A similar complex process of interpersonal communication is operating with every encounter and with every dialogue. Traditionally the medical culture has been highly weighted from the top down, with authority and educational status determining the distribution of power. Engaging in a mutual relationship across boundaries of professional status has been seen as threatening an important power base. Although a high value is placed on relationships within a medical team or within a department there are usually indications that mutuality or interdependence is seen as threatening to professionalism or the "job at hand". Hierarchy and lines of individual power and dominance are developed as assurances that instructions will be carried out, responsibilities will remain clear and the decision of the head (head physician, head nurse) will prevail. Sometimes there is a strong emphasis on productivity and "healthy competition" that is seen as enhanced by some interpersonal distance and competition. At present, most work settings are not structured to attend to, let alone foster, mutuality or relationship. With a focus on the individual and the value that each personality and job position has to the whole the inevitable interdependence that underlies the medical structure is more evident and appreciated.

Over the years the clinic where I work has developed interpersonal attitudes that are fairly compatible with a person centered approach. Being human and open in our work relationships has become part of our experience as a group. This is most evident when a new staff member arrives from the outside and does not yet share this type of interdependent experience. As team members we have become more aware of what otherwise seems natural and appropriate. Our staff usually consists of ten or twelve individuals. The receptionists, clerks, nurses, nurse practitioners, physician associates, pharmacists and physicians interact in a respectful, mutual manner. Interpersonal hierarchy is significantly decreased. When we meet as a team once a month, input from each individual is sought and valued. People listen, take time and are fairly candid. There is a general feeling of appreciation and belonging.

When it comes to clinical decisions the appropriate professional takes responsibility for making decisions within the protocol accepted by our department. I often confer with the head physician in cases that I think require consultion. After discussing possible treatments we come

to a mutual agreement which I then present to the patient. I have no problem considering his suggestions or voicing my own opinions and those of the patient. At the same time, when a decision does not require the head physician's medical expertise we look to the individual in the department who has the most experience and knowledge in that area. For example when we are looking at problems that the receptionists or clerks deal with daily they become the "professional" respected for their knowledge base.

Becoming a part o f the solution

I have worked in the medical system for the past 24 years, 12 of those have been within managed care. It has been rewarding and challenging, never easy. There are certain parts of me that no system can take away and I know I will work within an organization from an authentic place. For example I transferred out of Primary Care when the number of required appointments was increased from 22 to 28 patients per day. I cut back my clinic days in Internal Medicine to three days a week when I found I needed more time to find and maintain my own pace and perspective. Over time I have shifted my practice from acute care to longer term chronic care, a field which accepts the need for relationship, patient participation and emphasizing the person's own healing powers. I have actively sought out other professionals and areas with in my department that recognize and value what I find most important.

There is a current tendency to demonize the health care system, managed care in particular. The fact remains that the medical system with all of its variations is real and evolving. We face changes and new challenges of a magnitude that have never before been imagined. In order to provide quality health care to the general population in our country many factors need to be considered. Among the many changing elements are the new complicated knowledge and technologies, social and cultural changes, increased longevity and the accompanying elements of chronic illness, never ending material constraints and redirection of financial resources. Accepting the system as real does not imply loyalty to all of the tenants that are being followed at the moment. It does mean that I consent to take my place in it to work and influence its evolution. When I slip into a place of moral purity I easily move into a we-they mentality. I can get stuck or marginalize myself and my ideals. I begin to lose sight of my faith. It is easy to say what I don't want, but not realistically what I do want. When I can see myself as being a vital part of the system and my dissent as an essential part of my belonging, then I can take my place as an active professional person. I am open to dialogue with other persons within the system. This involves my empathy as well as my congruence. It means being unconditional

and hoping to find a place of positive regard, as an individual or if possible, together. It means being faithful to my fundamental belief that person centered theory is possible in the ever changing world of reality.

Summary

Change in any large system takes place very slowly. Sometimes as slowly as one encounter at a time. It is important to remember to express our belief as we participate in a time when mainstream psychotherapy and healthcare are becoming more and more symptom and pathology centered instead of person centered. What we have to offer as clinicians most effectively benefits the people who come to us if it respects and mobilizes their own natural capacities for intrinsic healing and well being. Our basic attitude toward the patient insures that medications and medical interventions are recognized as tools to help utilize the person's own healing powers and abilities. We become an ally in the healing process.

It is increasingly important for those of us interested in quality health care to address the multidimensional needs of the individual. If we truly believe that person to person relationships are healing then we must be sure that our actions as health care providers clearly incorporate these beliefs. We need to move beyond our person centered peer group and move into wider arenas. It becomes paramount that we take our part in influencing the evolution of our health care system (or education system or corporate system) by voicing our ideas and acting on them. By our example and the data we present we have the opportunity to influence our immediate surroundings as well as organizational behavior and policy in a direction which attempts to return the person to health care. Working in a relationship that supports the inherent strength of the individual and her own healing powers leads to improved health outcomes, higher levels of personal awareness and an enhanced quality of life for the patient and eventually for the practitioner. I think this approaches what healing is all about.

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