A PARADIGM CHANGE IN INTEGRATED HEALTH CARE DELIVERY: ELIMINATING THE CONCEPT OF PATIENT “NON-COMPLIANCE”
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AS MEDICALLY TRAINED PSYCHOLOGISTS BECOME MORE INVOLVED IN INTEGRATIVE HEALTH CARE WE CAN BE GRATEFUL FOR A
SEAT AT THE TABLE OR WE CAN HELP TO LEAD THE REFORM

• CAN WE CONTRIBUTE ADDED VALUE TO INTEGRATIVE HEALTH CARE?
• CAN WE SHOW LEADERSHIP IN SOME AREAS OF EXPERTISE?
• WHAT SKILLS AND KNOWLEDGE CAN WE ADD TO THE VERY IMPORTANT PROBLEM OF PATIENT COMPLIANCE?
PATIENT COMPLIANCE IS A -

FUNDAMENTAL ISSUE IN HEALTH CARE

AND

A CENTRAL ISSUE IN HEALTH CARE REFORM
TODAY’S PRESENTATION INCLUDES

• A DISCUSSION OF WHAT IS WRONG WITH THE CURRENT USE OF THE TERMINOLOGY “NON-COMPLIANT PATIENT”

• ALTERNATIVE WAYS OF LOOKING AT PATIENT COMPLIANCE THAT CAN POTENTIALLY HELP THE PATIENT IMPROVE

• SUGGESTIONS FOR A NEW FORM FOR GIVING FEEDBACK TO THE REFERRING DOCTOR ABOUT COMPLIANCE

• SUGGESTIONS TO THE PRACTITIONER ABOUT POSSIBLE INTERVENTIONS TO IMPROVE COMPLIANCE
WHAT IS NON-COMPLIANCE?
NON-COMPLIANCE IS A BLACK AND WHITE CONCEPT

GOOD PATIENT VS BAD PATIENT

SANE PATIENT VS CRAZY PATIENT

MOTIVATED PATIENT VS LAZY PATIENT

WORTHY PATIENT VS UNWORTHY PATIENT
TO BE COMPLIANT A PATIENT NEEDS TO BE FULLY COMPLIANT

• THEY NEED TO FOLLOW EVERY ONE OF THE DOCTOR’S RECOMMENDATIONS

• A GOOD EXAMPLE OF A FULLY COMPLIANT PATIENT IS A PATIENT WHO IS RECOVERING FROM A HEART ATTACK

• FEAR OF DEATH CAUSES THE PATIENT TO MAKE RADICAL CHANGES- STOPPING SMOKING, EATING HEALTHIER FOODS AND READING LABELS ON PACKAGES, TAKING CHOLESTROL LOWERING DRUGS, EXERCISING, AND MANAGING STRESS

• PEOPLE MAKE THIS TYPE OF TOTAL CONVERSION TO HEALTH OUT OF FEAR. SOME POST MI PATIENTS DO NOT MAKE THIS “CONVERSION”
NON-COMPLIANT  FULLY COMPLIANT
MOST PEOPLE DO NOT HAVE THIS FEAR EXPERIENCE AND DON’T HAVE THE SAME MOTIVATION TO IMPROVE COMPLIANCE

• END STAGE DISEASE TAKES YEARS

• “MY DIABETES WAS NEVER A PROBLEM FOR ME”

• “I DIDN’T KNOW THAT DIABETES CAUSED HEART DISEASE”

• “I KNOW I SHOULD LOSE WEIGHT TO TAKE THE STRESS OFF OF MY KNEES BUT MY WHOLE FAMILY IS HEAVY. IT’S IN OUR GENES”
MEANWHILE BILLIONS OF DOLLARS ARE WASTED ON HEALTH CARE THAT PROVIDES LITTLE TO NO IMPROVEMENT. IT IS DOCTOR CENTERED WITHOUT MUCH PATIENT INVOLVEMENT. THIS IS WHY-

IMPROVING PATIENT COMPLIANCE IS
TODAY SHOW
THE TREND - FORGET TRYING TO HELP THESE PATIENTS BECAUSE THEY CAN’T CHANGE

• NEW MEDICAL DEVICE APPROVED BY THE FDA FOR BARIATRIC PATIENTS TO REMOVE STOMACH CONTENTS AFTER MEALS

• A MODIFIED G TUBE IS SURGICALLY PLACED THROUGH THE PATIENT’S ABDOMINAL WALL AND PERFORATING THE STOMACH

• A PUMP IS USED TO SUCK THE FOOD OUT OF THE STOMACH AFTER MEALS INTO A CANISTER WHICH IS DUMPED INTO THE TOILET

• ONLY 30 PERCENT OF THE CONTENTS CAN BE REMOVED THIS WAY

• THE PATIENT LIVES WITH A PORT IN THEIR SIDE RATHER THAN LEARNING TO EAT IN A HEALTHY MANNER

• AL ROKER WAS APPALLED AND TALKED ABOUT IT ON THE TODAY SHOW
ARE BARIATRIC DOCTORS AND THE FDA GIVING UP ON THE CONCEPT OF USING GASTRIC SURGERY AS THE STARTING POINT OF TEACHING PATIENTS TO EAT IN A HEALTHY MANNER?

AND -

IS THIS REFLECTIVE OF A TREND IN ALL AREAS OF MEDICINE?
ONE WOULD HOPE NOT, BECAUSE....
HEALTH PROBLEMS ARE HEAVILY LIFESTYLE AND BEHAVIORAL IN ETIOLOGY AND CAN’T BE CURED OR EVEN TREATED CORRECTLY WITH JUST DRUGS AND SURGERY.

NONETHELESS ARE PHYSICIANS DECIDING TO “GO IT ALONE”, TRYING TO FIX PEOPLE WITHOUT EXPECTING THE PERSON TO DO ANYTHING THEMSELVES TO HELP THE PROCESS AND OUTCOME?
THE REALITY- BRIEF ATTEMPTS TO GET A PATIENT TO BE FULLY COMPLIANT ARE LIKELY TO FAIL

- Doctors usually introduce a referral with the idea that the patient should try it once
- Behavioral change takes time and is usually gradual
- We can’t fix problems in a single visit
- You start to decrease table salt a little at a time
- There are so many things to work on it is overwhelming
- Defense mechanisms have to be carefully negotiated
- If you press a patient too much they will not come back and you will not be able to help them
BECAUSE WE ARE WORKING WITH PHYSICIANS WE CAN MAKE THE MISTAKE OF ADOPTING THEIR FRAME OF REFERENCE

• PHYSICIANS MAY FEEL THAT PATIENTS CAN BE TALKED INTO BEING COMPLIANT IN ONE OR TWO VISITS

• WE MAY FEEL OBLIGED TO TRY TO MAKE THIS WORK

• WE MAY FEEL WE NEED TO FIT WHAT WE DO INTO THE PHYSICIANS’ MODEL OF MEDICINE

• WE MAY FEEL THAT WE COULD ALIENATE DOCTORS BY DOING SOMETHING DIFFERENT THAN THEY EXPECTING

• BUT WE SHOULD NEVER VEER FROM OUR OWN KNOWLEDGE OF HOW BEHAVIOR CHANGES
MARCUS WELBY, M.D.
THE MARCUS WELBY M.D TV SERIES WAS A FICTIONAL FANTASY ABOUT PATIENTS BEING “CONVERTED” TO BETTER HEALTH IN ONE VISIT WITH A CHARISMATIC, FATHERLY DOCTOR. BUT THIS IS NOT HOW REAL NON-COMPLIANT PATIENTS BECOME COMPLIANT. IS THIS HOW PHYSICIANS FEEL BEHAVIORAL CHANGE OCCURS?
WE ARE THE EXPERTS ON BEHAVIORAL CHANGE

- CHANGE OCCURS THROUGH SUCCESSIVE APPROXIMATION OR SHAPING, AND THE DEVELOPMENT OF INSIGHT, AND BY CAREFULLY NEGOTIATING THE PATIENT’S DEFENSES, NOT BY FLIPPING A SWITCH

- WE CAN BECOME CAUGHT UP IN THE LESS SOPHISTICATED WAY THAT PHYSICIANS THINK ABOUT BEHAVIORAL CHANGE

- WE CAN FORGET WHAT WE KNOW ABOUT BEHAVIORAL CHANGE
PSYCHIATRY IS NOT GOING TO SOLVE THIS PROBLEM

• PSYCHIATRY AS A FIELD IS BEING RE-POPULATED BY IMMIGRANTS FROM THE CONTINENT OF ASIA (70 PERCENT OF VACANCIES)

• THEY DID NOT SPECIALIZE IN PSYCHIATRY THERE

• THEY DO NOT HAVE ANY NATURAL INTEREST IN PSYCHIATRY

• THEY RE-SPECIALIZE BY TAKING A TEST

• THEY IN SOME CASES DO NOT DIAGNOSE OR TREAT EXCEPT BY WRITING A PRESCRIPTION

• THEIR EVALUATIONS ARE 20 MINUTES AND FOLLOW-UPS 10 MINUTES

• THEY HAVE A LIMITED NUMBER OF DRUGS TO USE
WHICH DRUGS WILL FIX PATIENT COMPLIANCE?

- ANTI-DEPRESSANTS?
- ANTI-PSYCHOTICS?
- ANXIOLYTICS?
- MOOD STABILIZERS?
- PSYCHOSTIMULANTS?
IMPROVING PATIENT COMPLIANCE IS UP TO US

• IT IS NOT FOR PSYCHIATRISTS

• IT IS NOT FOR SOCIAL WORKERS

• IT IS NOT FOR LICENSED PERSONAL COUNSELORS

• IT IS NOT FOR NURSES OR NURSE PRACTITIONERS
LET US TALK ABOUT HOW THE NON-COMPLIANT PATIENT GETS REFERRED TO A PSYCHOLOGIST
"I HAVE A PATIENT TO REFER TO YOU. THEY REALLY NEED YOU"

• THEY ARE REALLY CRAZY (TRANS. DRIVING THE DOCTOR CRAZY)
• THEY THINK I’M NOT HELPING THEM
• THEY CALL ME UP AND COMPLAIN
• THEIR PROBLEMS ARE IMAGINARY
• THEY DON’T WANT TO GET BETTER. THEY DON’T WANT TO BE HELPED
• THEY DON’T DO WHAT I TELL THEM TO DO AND THEN THEY COMPLAIN
• EVERY ONE OF MY (NORMAL, GOOD) PATIENTS WHO GETS THIS SAME TREATMENT GETS BETTER
THE CURRENT CONNOTATION OF
NON-COMPLIANCE IS A VERY
NEGATIVE ONE

• THE PATIENT IS BLAMED FOR THEIR FAILURE TO GET BETTER

• THE PATIENT IS VIEWED AS A DEFECTIVE PERSON WHO WON’T
COOPERATE WITH THE DOCTOR’S ATTEMPT TO HELP THEM GET WELL

• BESIDES BLAMING THE PATIENT LITTLE ELSE IS ACCOMPLISHED
PATIENTS ARE VIEWED AS NON-COMPLIANT BECAUSE OF VARIOUS CHARACTER DEFECTS

- THEY ARE LAZY

- THEY ARE STUPID, UNEDUCATED, UNINFORMED

- THEY ARE EMOTIONALLY IMMATURE, CHILDISH, INFANTILE

- THEY ARE “ADDICTED”, UNABLE TO CONTROL THEMSELVES, PATHETIC
THE REAL REASONS FOR NON-COMPLIANCE ARE MORE COMPLEX THAN THE USUAL CHARACTER ASSASSINATIONS

- EG THE BARIATRIC PRE-SURGICAL PATIENT
- A LIFELONG HISTORY OF COMPLEX PSYCHOLOGICAL ISSUES CAUSING ABNORMAL EATING
- PSYCHOLOGICAL DEFENSES ALLOW THE PATIENT TO TUNE OUT WHAT SHOULD BE THEIR REAL CONCERNS IN FAVOR OF IMMEDIATE PLEASURE OR AVOIDANCE OF OTHER ISSUES OR CONCERNS
- ADDICTION TO PARTICULAR FOODS
- AVOIDANCE OF HEALTHY FOODS
THE REWARDS OF NON-COMPLIANCE ARE IMMEDIATE AND HIGHLY REINFORCING AND THE NEGATIVE CONSEQUENCES ARE FAR OFF IN TIME (END STAGE DISEASE)
Does calling a patient non-compliant help them?

- No!
- At- whose fault is it that this patient is not doing well?
- At- we need to find out whose fault it is and blame them!
- RT “but how does blaming help?”
- Is this just another instance of blaming the “victim”?
- Condemnation turns to characterization
- Characterization justifies negative judgements about the patient
QUESTION - WHO BENEFITS FROM CALLING THE PATIENT NON-COMPLIANT?
ANSWER- THE DOCTOR!
MR. X. JONES PROGRESS NOTES

- January 5 Patient non-compliant with diabetic management.

- March 23 Patient non-compliant with diabetic management.

- May 10 Patient non-compliant with diabetic management.

- July 15 Patient non-compliant with diabetic management.

- September 3 Patient non-compliant with diabetic management.
THE DOCTOR DOCUMENTS THE PATIENT’S NON-COMPLIANCE AND BENEFITS IN TERMS OF REDUCING MALPRACTICE RISK AND LIABILITY

IT ALSO HELPS DOCTORS COPE WITH A PROFESSION WHERE MORE THAN 80 PERCENT OF PATIENTS CAN NOT BE CURED OR “FIXED”

IT IS A MEANS OF DEFENSE AGAINST FEELINGS OF IMPOTENCE

OFTEN THIS TAKES THE FORM OF A NARCISSISTIC DEFENSE

“THIS PATIENT DOESN’T DESERVE ME!”

“I CAN FIX ANY GOOD AND COOPERATIVE PATIENT OR AT LEAST MAKE THEM A LITTLE BETTER”

IF I CAN’T, THEN IT IS THE PATIENT’S FAULT
EASY TO ACCEPT STATUS QUO AND JOIN IN ON A FAILED CONCEPT OF HEALTH CARE

• MAKE BRIEF EFFORT AT GETTING NON-COMPLIANT PATIENT TO WANT TO BE COMPLIANT

• WHEN PATIENT FAILS TO MAKE RADICAL (FOR THEM) CHANGES IN THEIR HEALTH HABITS WE CAN “GIVE UP” AND AGREE WITH THE REFERRING PHYSICIAN THAT THE PATIENT IS INDEED ‘NON-COMPLIANT’

• SEND REPORT TO DOCTOR THAT YOUR ATTEMPTS TO INTERVENE HAVE FAILED
DOES AGREING WITH YOUR REFERRING DOCTOR THAT A PATIENT IS NON-COMPLIANT PROVIDE ANY ADDED VALUE TO THE PATIENT’S PLAN OF CARE?

- THE DOCTOR MAY BE SECRETLY PLEASED THAT EVEN A MEDICAL PSYCHOLOGIST CAN’T HELP THIS PATIENT (VALIDATION)

- THE DOCTOR CAN DOCUMENT THIS ADDITIONAL FAILURE AND FURTHER REDUCE MALPRACTICE RISK

- BUT HOW DOES IT HELP THE PATIENT?
CASE EXAMPLE - A VERY OBESE CARDIAC REHAB PATIENT

- Attending lifestyle change group for first time
- Some members of the group have tried diligently to avoid a heart attack and they feel angry – this is unfair
- The patient who “deserves” a heart attack (Rotter’s I/E)
- Embarrassment about physical condition
- Uncomfortable being in front of others
- Uncomfortable with group format
- Fearful of pressure from group to change diet, exercise, stress management, and any food addictions
- Defense – attend group. Please cardiac rehab nurse, never
DO WE GIVE OUR PHYSICAL HEALTH PATIENTS THE SAME EMPATHY AS MENTAL HEALTH PATIENTS?

- WE ARE TRAINED TO BE SYMPATHETIC TO OUR PATIENTS’ PSYCHOLOGICAL SUFFERING

- HOW DO OUR OWN VALUES AND AUTOMATIC THOUGHTS AFFECT OUR ABILITY TO BE SYMPATHETIC TO PATIENTS WITH PHYSICAL HEALTH PROBLEMS?

- GROWING UP YOU ARE TOLD: GET OFF THE COUCH, DON’T BE LAZY, YOU’RE GOING TO GET FAT AND HAVE A HEART ATTACK (THE STEM OF AN AUTOMATIC THOUGHT)

- HOW WOULD IT FEEL TO BE THAT PATIENT?

- HOW CAN THEY BELIEVE THEY HAVE THE ABILITY TO GET BETTER WHEN THEY HAVE A LIFETIME OF EXPERIENCE THAT LEADS THEM TO
WE CAN HELP EVEN THIS CARDIAC REHAB PATIENT IF WE HAVE THE RIGHT APPROACH
A START- CAN WE ELIMINATE NON-COMPLIANCE AS A HEALTH CARE CONCEPT AND INSTEAD FOCUS ON RELATIVE DEGREES OF PATIENT COMPLIANCE?
CAN WE.....???

• GET RID OF PUNISHMENT AND CONDEMNATION WHICH DON’T HELP

• SUBSTITUTE A POSITIVE ATTITUDE TOWARD EVERY PATIENT
CAN WE ASSUME …

• THAT ANYONE CAN IMPROVE IN TINY INCREMENTS

• THAT THERE ARE NO PATIENTS THAT WE NEED TO GIVE UP ON
AS THE EXPERTS IN BEHAVIORAL HEALTH CARE WE CAN SUCCEED IN PROVIDING AT LEAST SOME MINIMAL GAINS IN PATIENT COMPLIANCE IF

- WE CAN DISENGAGE FROM BLACK AND WHITE THINKING (FULL COMPLIANCE)
- WE CAN THINK IN INFINITE SHADES OF GREY (PARTIAL COMPLIANCE)
- WE THINK OF COMPLIANCE AS MULTI-DIMENSIONAL RATHER THAN ONE DIMENSIONAL
- THIS GIVES US A LOT OF DIFFERENT FOCUS POINTS FOR INTERVENTIONS
POSSIBLE DIMENSIONS OF COMPLIANCE

- KEEPING MEDICAL CARE APPOINTMENTS
- TALKING ABOUT GOALS AND PROGRESS
- GAINING ADDITIONAL INFORMATION AND KNOWLEDGE
- INCREASING PERSONAL EFFORT / TAKING INITIATIVE
- TAKING ACTION TO FOLLOW UP ON RECOMMENDATIONS
- OWNING THE PROBLEM / INCREASING PERSONAL RESPONSIBILITY
- OBSERVING AND TALLYING TARGET BEHAVIORS (OBSERVER EFFECT)
- IMPROVING OPENNESS TO SUGGESTIONS OF ALTERNATIVE BEHAVIOR
POSSIBLE DIMENSIONS OF COMPLIANCE

- IMPROVING MOTIVATION - INCREASING PERCEIVED REWARD VALUE
- IMPROVING MOTIVATION - PERCEIVING GOALS AS MORE ACHIEVABLE
- DECREASING NEGATIVE OBSESSIONS/COMPULSIONS
- REDUCING ADDICTIVE BEHAVIOR
- REDUCING EXCUSE MAKING
- DECREASING DEFENSIVENESS

WHAT ARE YOUR IDEAS???
MEASURING PROGRESS

- ASSIGN POINT VALUE (1-5) FOR EACH ITEM
- TALLY POINT TOTAL PER ITEM (5 POINTS FOR THERAPY SESSION?)
- + MULTIPLY BY NUMBER OF DAYS
- THE STARTING NUMBER FOR EACH SCALE SHOULD BE HIGHER THAN ZERO - ? 25 ? 50 ?
- DEMONSTRATE GAINS WITH RED MARKER ON EACH SCALE AND BY POINT TOTAL IN RIGHT HAND CORNER
- INDICATE TREND WITH ARROW – UP, DOWN, UP AND DOWN,
- ONE PICTURE SAYS IT ALL – LIKE AN X RAY AND WHAT DOCTORS ARE USED TO SEEING IN THEIR FIELD OF PRACTICE
FOCUS OF CURRENT COMPLIANCE EFFORTS

TALKING ABOUT GOALS AND PROGRESS

GAINING ADDITIONAL INFORMATION

INCREASING PERSONAL EFFORT

NAME_______________________________ DATE______________

TIME INTERVAL____________ TO _________________
A MEASURING STICK OF PATIENT’S CURRENT EFFORTS WITHIN IDENTIFIED TIME INTERVAL

• NOT A DEPICTION OF CHRONOLOGICAL PROGRESS

• DOESN’T SHOW THEIR BASELINE (PRELIMINARY ASSESSMENT)

• VARIES ACCORDING TO WHAT IS HAPPENING WITHIN THAT TIME PERIOD (SNAPSHOT)

• PROVIDES REFERRING DOCTOR WITH INFORMATION TO HAVE A BRIEF CHAT WITH PATIENT ABOUT HIGHLIGHTS OF THEIR CURRENT EFFORTS AT INCREASED COMPLIANCE. THIS COULD ALLOW THE DOCTOR TO ADDRESS COMPLIANCE IN A POSITIVE WAY DURING EVERY PATIENT VISIT RATHER THAN WAITING FOR SOME CRISIS TO OCCUR

• DOCTOR: “SO IT LOOKS LIKE YOU ARE FOCUSING ON FOLLOW THROUGH RIGHT NOW. THAT’S GOOD”
SMALL GAINS IN COMPLIANCE ADD UP

- COMPLIANCE ‘CHART’ WILL VISUALLY DISPLAY THESE SMALL CHANGES ALONG WITH AN INCREASE IN HIS OVERALL POINT TOTAL AND UPWARD ARROW

- PHYSICIAN CAN BE ADVISED THIS IS A LONG-TERM PROJECT BUT PATIENT HAS THUS FAR BEEN COOPERATIVE AND IS GETTING BETTER

- YOUR INPUT IS NEEDED TO ADD ITEMS TO SCALE OR SCORE ITEMS APPROPRIATELY WITH CONSENSUS (WEIGHTING OF ITEMS)

- IF WE CAN ATTACH AN AMP OR NAPPP LOGO TO THE COMPLIANCE MEASURE WE CAN MAKE DOCTORS AWARE THAT THERE IS A DIFFERENCE BETWEEN REFERRING PATIENTS TO SOCIAL WORKERS OF LPCs VERSUS MEDICAL PSYCHOLOGISTS
OUR ASSOCIATION WITH NAPPP AND AMP SHOULD BE “ADVERTISED” TO PHYSICIANS

• WE NEED TO FIND WAYS TO MAKE PHYSICIANS AWARE OF THE ADVANCED KNOWLEDGE AND ABILITY TO DIALOGUE WITH EXPERTS THAT COMES FROM BELONGING TO THESE ORGANIZATIONS
SOME DIMENSIONS OF THIS SCALE MAY OVERLAP BUT HOW CRITICAL IS THAT?

• WE ARE SO TRAINED IN TERMS OF TEST CONSTRUCTION THAT WE MAY FEEL THE NEED TO SEPARATE OUT THESE DIMENSIONS TO PREVENT OVERLAP BEFORE WE START OUR INTERVENTIONS

• SHOULD WE TAKE 5 YEARS TO DO THAT WHILE HEALTH CARE REFORM GOES ON WITHOUT US?

• GETTING IT PERFECT IS FINE FOR ACADEMICS, LESS SO FOR PRACTICING PSYCHOLOGISTS WHO NEED TO BE PRAGMATIC

• THE TRAINING OF PHYSICIANS IS MUCH MORE PRAGMATIC (TRADE SCHOOL)
DISCOVERIES IN SCIENCE START WITH IDEAS. THE RESEARCH COMES LATER

- IDEAS LEAD TO RESEARCH AND MATHEMATICAL PROOFS TO VERIFY THE NEW CONCEPT RATHER THAN VICE VERSA
- LATER RESEARCH PROVES THE IDEA TO BE TRUE
- OUR TRAINING BY ACADEMICS LEADS US IN THE OPPOSITE DIRECTION – STARTING WITH WHAT WE “KNOW” TO BE TRUE AND TRYING TO INNOVATE FROM THERE
- THIS LIMITS OUR IMAGINATION AND CREATIVITY AS WELL AS OUR OVERALL RESULTS
- ONLY 30 PERCENT OF PSYCHOLOGICAL RESEARCH CAN BE REPLICATED
MY TAKE ON THE SITUATION IS THIS –

LET’S NOT WORRY ABOUT WHETHER WE HAVE THE PERFECT METHOD FOR SOLVING A PROBLEM BUT JUST GO WITH SOMETHING REASONABLE AND SEE WHERE IT LEADS US (AND MAKE ADJUSTMENTS ALONG THE WAY)
DO THE MULTIPLE DIMENSIONS THAT WE HAVE COME UP WITH OFFER ANY OTHER ADVANTAGES TO US IN OUR WORK WITH PATIENTS?
YES - THE MULTIPLE DIMENSIONS OF COMPLIANCE PROVIDE MULTIPLE SUGGESTIONS TO THE PROVIDER FOR HELPING THE PATIENT

• WE NEED TO HAVE A LOT OF IDEAS AT OUR DISPOSAL IN WORKING WITH THIS TYPE OF PATIENT

• WE NEED TO THINK IN INFINITE SHADES OF GREY

• WE MAY NOT BE THINKING IN TERMS OF SMALL ENOUGH GOALS TO GIVE OURSELVES A BETTER CHANCE OF HELPING THE PATIENT
CASE EXAMPLE – AN OBESE HIGH SCHOOL STUDENT ATTENDING THERAPY TO PLEASE HIS DOCTOR AND PARENTS
- DIABETIC ISSUES LOOMING

- CARDIOLOGY ISSUES AFFECTED BY BARIATRIC ISSUES

- CHOP DOCTORS CONCERNED

- REFERRAL TO LOCAL PROVIDER (ME) RATHER THAN HAVING HIM TRAVEL TO CHOP

- FATHER IS PROFESSOR OF HEALTH AT LOCAL COLLEGE
· ATTENDS PRIVATE DAY SCHOOL WITH UNLIMITED STUDENT BUFFET

· MEALS SERVED ARE GEARED TO PLEASE TEENAGERS
I CHANGE THE FORMAT OF THE SESSIONS

• “I’LL BRING UP A SUBJECT AND YOU TELL ME HOW YOU CAN IMPROVE ON THAT”

• First subject- Diet: “I HAVE DECIDED TO EAT ONLY EIGHT FRENCH TOAST STICKS FOR BREAKFAST”

• WHAT ELSE? “I THINK THAT’S ENOUGH”
“DO YOU KNOW HOW MANY CALORIES ARE IN A SERVING OF THOSE FRENCH TOAST STICKS?”

“How many servings are eight French Toast Sticks?”

“I want you to do the math and tell me what the total calories are at our next session”.

Give patient one point for initiating goal of reducing number of French Toast Sticks

Give the patient one point for follow through on calculating the number of calories
· GIVE THE PATIENT ONE POINT EACH DAY FOR FOLLOWING THROUGH ON REDUCING NUMBER OF FRENCH TOAST STICKS

· IF PATIENT DECIDES TO REDUCE NUMBER OF TOAST STICKS FURTHER GIVE ADDITIONAL POINT FOR INITIATIVE

· IF HE CHECKS ANY OTHER CALORIES OF FOOD SNACKS GIVE A POINT FOR EACH INSTANCE
ADDRESSING LACK OF MOTIVATION – ENHANCING REWARD VALUE

- HAVE PATIENT SPEND TEN MINUTES EACH DAY THINKING ABOUT HOW IT WOULD FEEL TO DO HIS POOL JOB AT THE ‘Y’ WITH A SLIMMER BODY OR BEING ABLE TO FEEL OK TAKING HIS SHIRT OFF

- HAVE PATIENT THINK ABOUT HOW IT WOULD FEEL GOING BACK TO SCHOOL AGAIN IN THE FALL AND HAVING HIS FELLOW STUDENTS SAY- “LOOK AT YOU, YOU’RE A STUD!” “HOW DID YOU SLIM DOWN? YOU LOOK GREAT”!
ADDRESSING DISBELIEF IN THE ACHIEVABILITY OF THE GOAL

- PATIENT HAS BEEN OVERWEIGHT SINCE AGE EIGHT
- HE CANNOT VISUALIZE HIMSELF AS SLIMMER
- CAN HE IMAGINE HAVING HIS WAIST BAND OF HIS PANTS BEING MORE ROOMY?
- CAN HE IMAGINE PLAYING BASEBALL AND BEING ABLE TO RUN THE BASES FASTER, FEEL MORE FLEXIBLE SWINGING THE BAT, ETC
- CAN HE IMAGINE HIMSELF FEELING LIGHTER?
- HE CAN EARN ONE POINT FOR SPENDING TEN MINUTES EACH MORNING THINKING ABOUT THESE IDEAS
BEHAVIORAL COMPLIANCE COULD BE A LONG TERM AND CONTINUOUS GOAL OF TREATMENT
· MEDICAL DOCTORS “FOLLOW” A PATIENT, MONITORING THEIR PROGRESS OVER UNLIMITED VISITS

· THEY CHART THEIR PROGRESS – SLOW AND CONTINUOUS DOWNSLIDE, TEMPORARY PLATEAU, UP AND DOWN, OR TEMPORARY IMPROVEMENT. MOST PATIENTS NEVER GET WELL OR ARE CURED

· TREATMENT IS OFTEN SYMPTOMATIC – EG REDUCE PAIN IN CASES OF SPINAL STENOSIS RATHER THAN ATTEMPT SURGERY, ORDER MORE X RAYS, REDUCE RISK FACTORS (RISK FACTOR MEDICINE)

· BY CONTRAST, PSYCHOLOGISTS HAVE WORKED WITH TIME LIMITS
A PROFESSIONAL OPPORTUNITY (?)
WHY DOESN’T EVERY PHYSICAL HEALTH PATIENT HAVE ONGOING
EVERYONE HAS BEEN SAYING FOR YEARS THAT PATIENTS’ HEALTH PROBLEMS ARE DUE TO THEIR OWN BAD HABITS, LIFESTYLE, STRESS MANAGEMENT PROBLEMS, OR EMOTIONAL ISSUES

WOULDN’T EVERY PATIENT BENEFIT FROM SEEING SOMEONE IN OUR FIELD?

IF THE PATIENT IS DOING WELL AND VERY COMPLIANT THEN THEY COULD HAVE THESE VISITS LESS AND IF THEY HAVE MAJOR ISSUES THEN THEIR FOLLOW UP SHOULD BE MORE FREQUENT

THE 96150 AND 96152 CODES IF UNIVERSALLY ADOPTED COULD ALLOW PSYCHOLOGISTS TO SEE PATIENTS IN 15 MINUTE INTERVALS OR MULTIPLES OF THESE INTERVALS INDIVIDUALIZE TIME SPENT)

COULD WE “FOLLOW” A PATIENT THROUGHOUT THEIR LIFETIME LIKE PHYSICIANS DO?
THINK ORWELL’S “1984” – THE FUTURE

- CAN YOU IMAGINE MEDICAL PSYCHOLOGISTS DOING THIS TYPE OF WORK?
- DOES IT MAKE SENSE?
- CAN WE MAKE IT HAPPEN?
IF YOU ARE INTERESTED IN HELPING WITH THIS PROJECT OR WANT TO CONTACT THE SPEAKER, SEND AN E-MAIL TO drkeith1@verizon.net.