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ABSTRACT

Nutrition is well-recognized as a necessary component of educational programs for physicians. This is to be valued in that of all factors affecting health in the United States, none is more important than nutrition. This can be argued from various perspectives, including health promotion, disease prevention, and therapeutic management. In all cases, serious consideration of nutrition related issues in the practice is seen to be one means to achieve cost-effective medical care. These modules were developed to provide more practical knowledge to health care providers, and in particular primary care physicians. This module describes some general counseling and educational skills and techniques that can be useful for physicians and their staff for promoting behavioral changes in patients. The focus is on nutritional care. The module also provides a model for delivering nutritional care in the office setting that utilizes common resources. Included are learning goals and objectives, self-checks of achievement with regard to goals, and references. (CW)

16 An Office Strategy for Nutrition-Related Patient Education and Compliance

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Nutrition in Primary Care

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The Nutrition in Primary Care Series Contains These Modules:

1. Nutrient Content of Foods, Nutritional Supplements, and Food Fallacies
2. Appraisal of Nutritional Status
3. Nutrient and Drug Interactions
4. Normal Diet: Age of Dependency
5. Normal Diet: Age of Parental Control
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12. Dietary Management in Hyperlipidemia
13. Dietary Management in Gastrointestinal Diseases
14. Dietary Management for Alcoholic Patients
15. Nutritional Care of Deteriorating Patients
16. An Office Strategy for Nutrition-Related Patient Education and Compliance

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16 An Office Strategy for Nutrition-Related Patient Education and Compliance

Introduction

As a physician, you are involved in the totality of health care of individuals. This totality includes not only treating illness and other problems as they arise but also advising patients of ways to prevent illness and maintain health. Health maintenance is estimated to take as much as 20% of a family physician's time.[1]

You and your staff are faced not only with the challenge of providing sound nutritional information to patients but also of motivating these patients to incorporate this information into their lifestyles. The success of any treatment plan usually requires the patient to make some type of behavioral change ranging from following simple instructions to making major lifestyle adjustments. This places a tremendous demand on the patient to assimilate new information and frequently change well-established behaviors. As the patient's physician, you find yourself in the role of nutritional counselor, educator, and motivator — roles for which you may feel unprepared.

This module describes some general counseling and educational skills and techniques that can be useful to you and your staff for promoting behavioral changes in patients. The focus is on nutritional care, but these principles are applicable to all aspects of health care. The module also provides an "Office Procedure Model" for delivering nutritional care in the office setting that utilizes common resources available to you.

The information presented in this module should be read and reflected upon in terms of how it could be implemented by you in your own practice. The module is not a fingertip resource, as are many of the others. Because you do not have the time nor the depth of education that clinical dietitians have to counsel patients on nutrition, dietary modifications, and foods, we wish to encourage you to avail yourself of the suggestions made in this module *and* to acquaint yourself with a clinical dietitian to whom referral of patients should be made when necessary.

Goals

Have you ever . . .

. . . realized that nutrition is an important component of patient care but felt insecure when discussing it with your patients?

. . . had an obese patient who you felt must lose 50 pounds or more to improve health status, but you did not know how to go about motivating the patient?

. . . felt that your patients did not always "open up to you" when discussing their nutritional problems?

. . . recognized the importance of effective patient education both for the success of the treatment plan and for health maintenance but you did not know how to incorporate an educational program into your busy practice?

. . . discovered that you need concise, up-to-date nutrition information and handouts but did not know how or where to get them?

. . . had a patient requiring in-depth nutritional assessment and education but did not know where or how to obtain the services of a registered clinical dietitian?

If these situations describe some problems you have faced in providing nutritional counseling to patients, then you should find the information in this module useful. As a result of this unit of study, you should be able to:

1. *Identify a "patient-type" with whom an appeal to "reason" might be an effective behavioral change motivator;*
2. *Identify two techniques you might employ in order to improve your patient counseling skills;*
3. *Discuss one approach that might be effective in motivating a "recalcitrant" patient to follow health care recommendations;*
4. *When given a case description of a patient with a nutritional problem, outline how you would counsel the patient, utilizing the five stages of nutritional counseling;*
5. *Formulate long-term and short-term goals for a patient who needs to make lifelong adjustments in eating behavior; and*
6. *Plan your office space and staff responsibilities in a way that would facilitate the provision of nutritional information to patients.*

Counselor "Helping" Characteristics

Several helper characteristics are useful in developing relationships with patients and promoting behavioral changes. If patients perceive you as an *expert* in your field, *trustworthy*, and *attractive* or *compatible* in beliefs and attitudes, they will be more likely to listen to the health message and attempt to follow recommendations.

Research in counseling psychology has indicated that certain "helper" characteristics can greatly enhance the effectiveness of physicians as promoters of behavioral change in patients. If patients perceive you as being an *expert* in your field, *trustworthy*, and *attractive* or *compatible* in beliefs and attitudes, they will be more likely to listen to the message being given and attempt to follow recommendations than if these characteristics were not projected.[2]

Expertness

Most patients perceive you to be an *expert* with regard to medical knowledge and skills. Appropriately displayed diplomas, certificates, medical texts and journals; the use of technical medical equipment; the traditional white lab-coat attire; along with the popularized adage that "doctor knows best" — all enhance your image as an expert. This trait may often be successfully maximized by you to promote patient cooperation. However, if it is present but trustworthiness and attractiveness are not present, the "expert" role can create an unnatural barrier between you and the patient, closing all avenues of useful communication. This can result in either a hostile patient who refuses to comply with recommendations or a totally dependent patient who is unable to make meaningful decisions without your help. Neither is desirable.

In the area of nutrition and patient counseling, you may *not* be perceived by the patient as an expert. In this case, you need to take some steps to enhance this quality. Some suggestions for enhancing nutritional expertise are:

1. Develop a strong knowledge base through readings, seminars, and conferences in the area of nutrition.
2. Prepare for each patient interaction; review the chart and ascertain the patient's nutritional status and the patient's nutritional problems.
3. When interacting with your patient, listen attentively to his concerns, look directly at him, touch him, and ask appropriate questions.
4. If you are not knowledgable in the area under discussion, admit it and refer the patient to an appropriate "expert," such as a registered clinical dietitian. This not only enhances your own expert image but also that of the person to whom you are referring the patient. As you know, the quality of "expertness," although very useful, alone is not sufficient to promote patient behavioral change.

Trustworthiness

A trustworthy person considers and respects another person's needs and feelings. The opinions and information you offer are believed by the patient to be for his benefit, rather than for selfish purposes. A sense of trust in you by patients may come from your reputation among patients for being trustworthy, from holding a professional degree, title, and position believed to denote trustworthiness, or from the content and manner of your communication.[2] Some ways you can enhance your trustworthiness are:

1. Be candid with patients regarding their medical problems, treatment, fees, and other important concerns.
2. Assure patients of the confidentiality of information discussed, and explain any limits to confidentiality. The design of office space can do much to enhance or reduce patients' feelings that confidentiality is being maintained.
3. Provide direct and understandable responses to patients' inquiries rather than couching them in complicated medical jargon.
4. Project a trustworthy manner by speaking *sincerely* and *directly* to the patient, leaning toward the patient, and using open hand and arm gestures.
5. Never discuss another patient by name with the patient in your presence.

If you can successfully develop and maintain the patient's trust, you can be highly effective in obtaining the patient's cooperation with health recommendations and suggested behavioral changes.

Attractiveness

The third helping characteristic that can enhance your effectiveness as a change agent is *attractiveness*. Attractive persons are those toward whom others feel similarity, liking, or compatibility. They do not talk "up" or "down" to others. The content and manner of their communication indicates a commonality and an understanding of the beliefs and attitudes of the person with whom they are communicating.[2]

It is unreasonable to expect you to have beliefs and attitudes similar to *all* patients. However, you can take steps to enhance this quality, if lacking, in your relationships with patients. Some helpful examples in enhancing this quality include:

1 Greet patients warmly, shake hands, and make sure they are comfortable, and try not to keep them waiting in a cold examining room too long.
2. Find some area of common interest to comment on such as a hobby, sport, movie recently seen, similar value or concern — anything that would indicate to patients that there is some common ground between you and them.
3. Praise patients when appropriate, such as for weight lost, adhering to a drug protocol, or asking good questions.
4. Talk to patients on their level; give instructions and explanations using understandable language. *Do not assume anything!* On the other hand, do not make patients feel as if they are children. Become familiar with educational backgrounds and approach them at the appropriate level. This may require several interactions and a good deal of sensitivity to patients' verbal and nonverbal communications.

The qualities of expertness, trustworthiness, and attractiveness can increase your degree of influence with patients. However, these qualities alone do not ensure patient cooperation. The following section provides an outline of the general stages of patient counseling that you can use as a guide for patient counseling endeavors in order to foster patient cooperation.

Stages of Nutritional Counseling

The patient counseling process consists of five identifiable but overlapping stages.

The patient nutritional counseling process begins by *developing a relationship* with the patient to ensure his trust and cooperation. This facilitates the accurate *collection of information* through the medical exam and nutritional history that is necessary to *develop suitable goals, objectives, and a nutritional care plan* with the patient.

1. *Develop a helping relationship with the patient.*

Although this stage is continually developing throughout the duration of the physician/patient involvement, the first interaction with the patient is critical because at this time the direction of the helping process is established. The helper characteristics discussed earlier — expertness, trustworthiness, and attractiveness — should be communicated to the patient. You should make patients feel comfortable, show interest in their problems and concerns, reveal some compatibility in values, and express liking and caring for them. Patients should be encouraged to participate in the interview and become involved in their own health care. You need to understand the patients' motivations for seeking help and be sensitive to their value systems before trying to suggest changes in their behavior and lifestyles.

2. *Collect and analyze information.*

Data collection and analysis provide the basis for the development of the nutritional care plan and are on-going processes. Areas of data collection important for planning and implementing a successful nutritional program for a patient include the following:

a. A thorough *medical history, nutritional history,* and *physical exam* (see Module 2 on

appraisal of nutritional status for nutritional assessment criteria essential to collect before planning a nutritional care plan).

b. *Diet history:* When nutritional assessment and dietary alterations are required, a detailed record of the patient's usual eating patterns is necessary. This information can be obtained directly from the patient or family using the food diary or 24-hour recall methods (refer to Module 2 for advantages and disadvantages of, and how to collect food intake data from, the various methods).

c. Family input: Family members can be useful in supplementing information about the patient. For example, a wife or mother may be more aware than her husband or children of accurate serving sizes and ingredients used in food preparation which are important in collecting and analyzing dietary information.

Long-term and short-term goals should be set by the patient and physician which reflect the patient's overall health care objectives. Goals should be specific, attainable, and measurable so that the patient's progress can be assessed and appropriate goal changes can be made.

3. *Develop suitable goals, objectives, and a nutritional care plan with the patient.*

This stage requires in-depth patient involvement before successful change in behaviors can occur. You can suggest a variety of methods and alternatives for achieving a desirable health objective, but it is the patient who ultimately decides what course of action is most feasible and suitable.

A variety of health care objectives can be identified. Some common objectives include weight loss, reduction in serum cholesterol, reduction in blood pressure or attainment of normal blood glucose levels.

At this point in the educational process reasonable goals, reflecting the overall objective(s), are negotiated between you and the patient. Here it is that the helping relationship and the assessment data, previously obtained, become of primary importance. Your medical/nutritional goals and the patient's personal goals may or may not be congruent. Compromises may be essential in order to achieve some degree of patient cooperation and health improvement. The establishment of feasible and workable goals is essential in helping the patient to focus on specific, identified problems and to comply with these goals. Establishment of goals also provides opportunities for positive reinforcement from you as the goals are attained.

Both *long-term goals*, which reflect the ultimate health care objectives for the patient, and *short-term goals*, which are the steps in the process that are met along the way, should be identified. The goals should be specific and attainable, and above all, measurable so that you and the patient can evaluate the patient's progress and reassess and rewrite unworkable goals.

For example, a common health care objective for many patients is weight loss for better control of adult-onset diabetes (as well as the other benefits of permanent weight loss). Some examples of long-term goals for weight control might be:

a. A weight loss of 25 pounds within a specified period of time, such as four months.
b. Maintenance of the 25 pound weight loss for three months, six months, or one year. This ensures adequate follow-up of the patient.
c. A permanent measurable change in a particular maladaptive eating habit, such as eating while watching television or tasting while cooking, which may be some of the factors contributing to the patient's overweightness.
d. Participation in a regular exercise routine, such as jogging two miles a day for three days a week as a means of improving muscle tone.

Some short-term goals that should be evaluated on a weekly or monthly basis might include the following:

a. The patient will keep a daily food record of *all* foods consumed each day for two weeks. The foods will be recorded immediately after they are eaten. (This will help the patient become aware of the total amount of food consumed and particular "problem" eating behaviors.)
b. The patient will eat three meals per day rather than only one large meal in the evening.
c. The patient will watch only one hour of television per evening for one week and will not snack while watching television.
d. The patient will *not* eat items such as potato chips, candy, carbonated beverages, or any particular "problem food" for one month.
e. The patient will walk one-half mile three days a week for two weeks.

Goals may vary with each patient and with particular eating problems. Be careful not to set too many goals at once; two or three at a time may be sufficient or all a patient can attain. Make sure all members of the patient's family are aware of the goals that the patient is striving to achieve.

It is essential that any nutritional plan be adapted closely to the patient's present lifestyle. This requires in-depth assessment of the patient's daily routine and eating patterns followed by careful planning with the patient to develop a plan he can be expected to follow. For any length of time, standard "form" diets printed on a few sheets of paper are unacceptable. These diets, which are often provided by drug companies, contain rigid meal plans and a list of formidable "do's and don'ts." They are often handed to the patient by a busy physician with the brief instruction, "You need to . . . (lose weight, control your diabetes, rest your ulcer). Follow this diet and come back in one month." Patients are automatically set up for failure, which usually follows!

If you do not feel you have the skills or the time to assist the patient in developing a nutritional care plan and educating the patient on how to incorporate necessary changes in eating patterns into his lifestyle, you should refer the patient to a registered clinical dietitian for appropriate counseling. (See Module 2 for how to obtain the services of a registered dietitian.)

Implementation of the plan is the next stage during which time the diet is explained to the patient. Questions are asked, and the plan is made practical and relevant to the patient and his lifestyle.

4. *Implement the plan.*

Once you and your patient have developed long-term and short-term behavioral goals, the patient must be assisted in implementing them. For example, it is not sufficient to teach a hypertensive patient the food sources and medications high in sodium. After the patient is made aware of the fact that he should restrict his sodium intake to help control his blood pressure, along with a brief explanation of what sodium does and some sources of sodium, it would be useful to ask the patient what problems he might anticipate in restricting his intake of sodium. The patient might respond that making foods taste good without added salt would be a problem, or purchase of low-sodium foods would be difficult due to cost.

You and your patients may want to make a list of the patients' anticipated problems; next, encourage them to think through possible solutions to the identified problems and help them with your own suggestions for solutions. This process helps the patient plan ahead for situations in the "real world" that might hamper the most sincere effort to follow recommendations. While discussing possible solutions to anticipated problems, patient education will truly have occurred and will likely be practiced. For a patient on a sodium-restricted diet, certain salt substitutes could be suggested at this point. In addition, lists of alternative seasonings could be provided along with low-sodium recipes. Show the patient how to read labels on foods so that all sources of sodium which can be avoided are observed. Actual products from the supermarket are very helpful teaching aids in this regard.

It is up to you to determine just how much information the patient can assimilate at any one time. The approach described above makes the nutritional plan meaningful to patients and assists them in trying to independently manage their own diets. Because all contingencies and prob-

lems cannot be determined in advance, follow-up and reinforcement are essential in any treatment plan.

Continuous evaluation of the goals and objectives of the nutritional care plan is essential in order to make adjustments when necessary and provide the patient with positive reinforcement along the way.

5. *Continuously evaluate the plan.*

Not even the most intelligent and highly motivated patient is able to follow *all* aspects of *any* treatment plan after only one physician/patient interaction. All plans, whether they are drug protocols or dietary modifications, if they require behavioral change, need to be continuously reassessed and reinforced. Since the last office visit, perhaps additional problems have been encountered. Follow-up visits are necessary to deal with these problems. Do the patients truly understand the information received? Can they answer appropriate questions? These are a few questions that need to be asked during follow-up sessions with patients.

The amount and type of follow-up is as varied as the patients encountered in practice. The less-educated or poorly motivated patient will require more interactions than the intelligent, highly motivated patient. Patients who are asked to make drastic changes in their lifestyles will need much more support than those making modest alterations. The newly diagnosed diabetic may need several weeks to accept the fact that he has diabetes before meaningful patient education and behavioral changes can take place. Information about health and illness is meaningless, unless patients are ready to receive and act upon the information.

Evaluation should take place throughout the educational process. Changes in medical status, patient situations, and patient attitudes require continual re-evaluation of goals and plans. Knowing just how much information to give at the appropriate time is difficult. The patient is almost always the best indicator of when to provide additional information. Information should be given as the patient expresses a need. However, this is not always practical or possible. The following section includes some methods available for assisting patients in becoming aware of their health care needs and enhancing their willingness to change.

Motivating the Patient

Motivating factors for behavioral change vary with each patient. Some respond to *fear* of their illness and its consequences, others to the *reasonable* benefit of making a desired behavioral change. Some patients make changes because of respect for the physician and a *trust* that "he knows best." Many respond to a combination of these motivating factors.

Patients come to you with varying attitudes toward health care. These attitudes are often in conflict with those you hold to be acceptable. In order to promote "good" health with patients, you are often concerned with changing such behaviors as food and drug consumption, smoking, and physical exercise. Attitudes and behaviors are closely aligned, although there is some disagreement as to which should change first, the behavior or the attitude. Nevertheless, you are in the business of changing attitudes toward health care. How can you do this with the wide variety of patients and attitudes with which you are confronted daily?

Assess Present Attitudes

Give patients opportunities to express their feelings about their needs and abilities to make recommended behavioral changes. This requires both careful questioning and *listening* within a climate conducive to open discussion. Do not allow patients to tell you what you *want* to hear, but rather how they *really* feel. When these feelings are in the open, you can then decide on what method or methods you will use to convince patients that a change is needed and to help them find an acceptable way of doing so. Since patients must perceive a need in order to make a recommended change in behavior, appeals can be made through one or a combination of approaches, fear, reason, and trust are three such motivating approaches.

1. Fear

Many people seek health care initially out of fear — fear of discomfort, illness, or death. Fear can be a powerful motivator for attitudinal and behavioral change, especially if the precipitating problem is immediate, such as the heart attack victim for whom quitting smoking, losing weight, and eliminating salt from the diet are important treatments. Historically, health professionals have relied heavily upon fear as a motivator for inducing behavioral changes. The anti-smoking campaign is an example of fear-motivating propaganda.

Physicians often try to convince patients to make behavioral changes by emphasizing the negative consequences of their actions. This can be useful to a degree, but as the problem becomes less immediate, fear decreases as a strongly motivating factor.

Another example of a patient in whom fear may motivate behavioral change is the out-of-control diabetic. Describing to the out-of-control diabetic the consequences of not taking insulin on schedule or of not eating regular meals might motivate him to change his behavior. Fear is less likely to motivate changing a present behavior if the consequences are likely to occur years in the future. For example, warning the heavy drinker of the possibility of developing liver disease, the smoker of lung cancer, or the hypercholesterolemic adolescent of atherosclerosis when he becomes 55 years old frequently has little impact. Other motivators need to be found for these cases. You should use fear/threat arguments with care. Although patients should be made aware of the consequences of their actions, greater emphasis on the positive aspects of *desired* behavioral patterns rather than the negative effects of prolonging undesirable patterns is more likely to motivate them toward *long-term behavioral changes.*

2. Reason

In some instances, and particularly with certain patient types, information about, reasons for, and the benefits of a desired behavioral change (such as health and well-being, appearance, decreased need for maintenance medication, and longevity) are sufficient to motivate patients. This information should be given to all patients; however, an appeal solely to reason is most likely to be effective with the "independent patient type," one who is already self-motivated. Such patients usually have positive health care values. When presented with a problem and the resources available to help solve the problem, they will seek an appropriate solution. Such patients usually require an unstructured learning situation and will ask many questions and independently seek information. You can best help these patients by logically presenting information and alternatives and by directing the patient to appropriate resources (such as readings, community resources, and other "experts"). An open, straightforward approach with independent patients will develop their trust and maintain their interest in solving health care problems.

3. Trust

Trust between you and your patient is necessary for any degree of attitudinal and behavioral change. Methods of developing trust were discussed previously. In certain situations, trust must be relied on solely to motivate the patient toward a desired health care goal. This is especially true with the "dependent patient type." Such patients want to be specifically told what to do and generally believe "the doctor knows best." They generally require a highly structured learning situation with specific instructions from you. Although this may appear to be an ideal situation for patient cooperation, blind trust in the physician can backfire when things do not work out as predicted.

When results do not occur as predicted, a decreased confidence in the physician and possible hostility toward future recommendations may be felt by patients. Efforts should be made to foster some degree of independence in patients by presenting alternatives and having the patients set their own goals for desired behavioral changes. When patients are encouraged to set their own goals, however, you must respect their right to make decisions which might be contrary to your goals and which might enhance risks that you instructed them to avoid.

Enhancing and Maintaining the Climate for Attitudinal and Behavioral Change

Once patients have recognized a need for changing their behavior, they will need assistance in maintaining the motivation to change. For example, many dieters begin their weight loss attempts with enthusiasm and confidence, only to become discouraged along the way. How can you help these patients incorporate the necessary changes into their lifestyles on a *permanent* basis? Changing attitudes and behavior is a difficult task, especially with regard to eating habits which are developed from birth and strongly tied into social and emotional factors.

Behavioral programs can be useful in helping the patient meet health-related objectives. Such programs stress individual patient responsibility for his actions. The identification of short-term and long-term goals and adequate assessment by the health care team of the patient's needs, abilities, and progress toward desired goals are other essential components in behavioral programs.

In recent years, the behavioral sciences have made progress in developing techniques for both changing human behavior and ensuring permanent change in eating behaviors. It is not within the scope of this module to describe these techniques and programs in depth, but a short description and discussion of behavioral modification techniques for weight loss is included in this section. Some excellent references are included in the Resources for the Physician and the Patient at the end of this module which describe various behavioral programs for nutritional problems. These resources indicate how you can implement these programs in your practice.

Behaviorists believe that the health-related habits of persons must be viewed in the context of their environment. This is sometimes referred to as the "ABCs," where behavior ("B") is sandwiched between antecedents ("A") and their consequences ("C"). Antecedents are stimuli which cue a behavior, such as a television commercial about food or a candy machine. Consequences, on the other hand, are stimuli which follow the behavior. They may be positive ("rewards"), negative ("punishments"), or neutral. Generally speaking, reward is a much more effective strategy than punishment. This means that your feedback on patients' eating behaviors should emphasize what has been done right — no matter how small the progress — rather than exercising the common tendency to look for and focus on failures.[3]

Behavioral programs have 3 basic elements:

1. Encouragement of the patient to take responsibility for his own contribution to behavior change.
2. Identification of short-term and long-term goals.
3. Adequate assessment of patients' needs, abilities, and progress toward desired goals.

Behavioral programs focus considerable attention upon finding the patients' individual motivating factors for achieving their desired goal(s). Such individual motivating factors may be physical (purchasing a desired object for "good behavior"), emotional (encouragement and support from family, friends, significant others, and groups), or intellectual (positive self-statements).

Of course, there will be patients for whom the best programs and efforts will not be helpful. These are the recalcitrant patients, the alcoholics who will not attempt to stop drinking or the obese patients who will not stop overeating. In these cases, you can make these patients aware of the long-term consequences of their behaviors and be available in case of a future change in attitude. However, you should try to respect patients' rights to make decisions about their personal health care which you might know are not conducive to their good health.

Behavior Modification Techniques

The ultimate goal of behavioral therapy is to help the patient develop self-management skills that will enable him to continue with the behavioral changes in his own environment for as long as necessary.

Behavior modification techniques are believed by most physicians and dietitians to be essential to a multidisciplinary program for weight reduction. Module 9 on obesity includes a detailed description of behavioral modification techniques and includes patient handout materials and discussion materials you could use with patients.

Behavior modification techniques are aimed at the counselor and patient seeking together to:

1. Identify patients' habits that have contributed to overeating.
2. Identify specific techniques which will change these habits.

Patients should be taught that their eating habits are a learned response to certain stimuli. For example, people eat because of several stimuli, such as the meal hour, the sight or smell of food, hunger pangs, and several others which are much less defined or clear-cut. For example, emotional stimuli such as boredom, anxiety, depression, and many others may be obscure cues to eating. Whatever the stimulus, the following pattern occurs:

Antecedent	Behavior	Consequence
(anxiety, hunger)	→ (eating)	→ (relieve boredom, hunger)

The approach of behavior modification is to identify antecedents and find specific alternatives other than eating which can effectively deal with the antecedents.

According to several authors,[4] techniques used in behavioral therapy to make patients more aware of and to restructure their eating habits include:

1. Recording of food intake and activities associated with eating.
2. Identifying behaviors or situations that lead to overeating.
3. Eliminating inappropriate cues to eating.
4. Slowing the act of eating by such measures as putting the fork down between each bite of food.
5. Teaching patients to solve problems such as how to adhere to a diet while eating out at a restaurant or dinner party.

A total weight reduction program includes several components. behavior modification therapy, an appropriate weight reduction diet, short-term use of anorectic medications, and a physical activity program. For an in-depth discussion of all these components, including specific behavior modification, refer to the Resources for the Physician at the end of this module and see Module 9 on dietary management in obesity.

The Physician's Office as a Nutrition/Health Care Education Center

The previously discussed counselor characteristics, counseling stages, and techniques for motivating behavioral change can be utilized most effectively by you if they are incorporated into a defined and planned office procedure for dealing with patients' nutritional and other health care problems. Following is a suggested model that can be adapted to your office, depending on available personnel, talents, and resources. Before setting up such a system, you need to be aware of the resources that can be utilized for patient education.

Physical Resources — Waiting Area, Examining Rooms, Consultation Room, Patient Education Room

The physician's office provides any number of areas for patient education. These include the reception area, the examining room, and the physician consultation room. A patient education room may also be established for conducting group classes and family conferences and providing audiovisual aids for patient education such as movies, tape recordings, and additional printed materials.

1. The Waiting Area

The waiting area could be used easily for patient education. It can be especially useful for drawing the attention of otherwise uninformed or disinterested patients to a variety of health care concerns. This can be done by displaying eye-catching posters, pamphlets that can be taken

nome by patients, and magazines and books on various health-related topics. A special area, such as a table along the wall, could be set aside where information on a particular health topic could be displayed. The topic could change periodically and cover such areas as "Diabetes Mellitus," "Atherosclerosis," "Weight Control," and "Normal Nutrition."

Care should be taken in selecting appropriate materials for display. Materials should be carefully reviewed by you for the validity of their content. Useful materials for patient nutrition education can be obtained from a wide variety of resources (see Appendix A at the end of this module).

2. Examining Rooms

Examining rooms and consultation rooms also provide excellent settings for patient education. They should be arranged in a manner conducive to patient/physician interaction. In the examining room, posters displayed on walls give patients the opportunity to read, learn new information, and ask questions regarding something that may have caught their eye. If time does not allow you to talk with patients before the examination room encounter or in an office or consultation room after the examination, the time in the examining room must be made conducive to both gathering and giving information. Use of the examining table paper to draw pictures, explain concepts (such as how sodium "holds in water" and how a low-sodium diet will decrease the amount of water in a patient's foot) is a practical use of the physical resources in the examining room.

3. The Physician Consultation Room

Your consultation room can be used for any prolonged physician/patient interaction and should be arranged so that patients feel comfortable while talking with you. A table and a couple of chairs arranged in one area of the office is more conducive to conversation than when you sit behind a desk and pronounce dictums regarding health care.

4. The Patient Education Room

If space is available, a patient education room can be set aside for group classes, movies, and other audiovisual aids such as cassette recorders, as well as additional printed materials. Family conferences can be conducted here, as well as staff patient-care conferences on the various treatment educational plans for individual patients. Other physical resources available for inclusion in the patient education room include the following (see Appendix A for addresses of nutrition resources appropriate for display and use in the patient education room):

- *Printed materials* — posters, diagrams, photographs, drawings, pictures, pamphlets, handouts, books, magazines, learning modules, programmed instruction booklets.
- *Visuals* — food models, food containers and packages, measuring cups and spoons.
- *Audiovisual* — movies, slides, cassette tapes, cable television, Dial-a-phone access, teaching machines.

Staff Resources — Receptionist, Nurse, Dietitian

1. The Receptionist

The receptionist can make arrangements with patients for future appointments or classes. While patients are waiting to see you, the receptionist can distribute patient medical and nutritional history questionnaires and instruct them on how to complete these forms and estimate portion sizes of foods eaten.

2. The Nurse

A nurse trained in patient health education is an invaluable resource. Nurses can assume many teaching responsibilities as well as act as needed support persons in providing encouragement and reinforcement toward written handout information previously discussed with patients. Your nurse can keep you informed on the patients' progress and problems in dealing with their treatment plans and can offer suggestions for modifications when necessary. The nurse/educator can also conduct group classes on the many health problems and put patients in contact with community resources dealing with their particular problems.

Appointments may be made with the nurse/educator for patients to monitor progress toward achieving short-term goals. When this plan is followed, the goals and parameters for measurement should be precise, and there must be an explicit understanding between you and the nurse regarding division of authority and management criteria.

A qualified dietitian, as an active member of the family practice team, can assess the patient's nutritional status, plan an appropriate nutritional care program with the patient based upon his lifestyle and abilities, educate the patient in the intricacies of necessary dietary modifications, provide feedback to the health care team on the patient's progress, and refer the patient to additional nutrition resources when necessary.

3. Dietitian

A qualified consulting dietitian can provide you with innumerable services. The dietitian may be employed on a part-time basis by one or several physicians and may be available to the patient at designated times. Dietitians' background in nutrition, nutritional assessment, foods, and food preparation enables them to do the following:

a. *Assess* the present nutritional status of patients based on their dietary intake, anthropometric measures, and biochemical parameters.
b. *Evaluate* the patients' present lifestyles and eating patterns and evaluate their abilities to incorporate necessary changes into their routines.
c. *Educate* patients on various principles of nutrition and foods, such as optimal nutrition, and on all aspects of dietary modifications, help patients adapt diets to their lifestyles; provide reinforcement and encouragement to patients on subsequent visits.
d. *Document* valuable information concerning patients' willingness and abilities to follow health care recommendations, as well as make recommendations for modifying the nutritional care plans to best meet their needs.
e. *Teach* group nutrition education classes (in coordination with classes by other team members if appropriate).
f. *Refer* patients to nutrition-related community resources.

There are many persons who claim to be nutritional experts but who in reality are not. Therefore, when requesting the services of a dietitian, be sure the person holds the title of Registered Dietitian (RD). In many states, the cost for the services of an RD is reimbursable. In other states, legislation is slowly being changed allowing for reimbursement when preventive as well as therapeutic nutrition services are rendered by an RD.

Community Resources

There are many community resources available to you for providing nutritional and other health-related information. These include both national and local organizations within the public and private sectors of society.

The local health department (such as the state or county department of health) as well as university-affiliated cooperative extension services are excellent places to inquire for nutrition/food and health-related information. Community dietitians are associated with most local diabetes associations, Weight Watchers programs, dialysis centers, heart associations, nursing homes, elderly feeding programs, women-infant-children feeding programs, adolescent health programs, accredited hospitals, and other institutions. Persons associated with these programs can often refer you to other areas for specific information.

The Office as an Educational Center

Reception Area

Whether patients are new or not to your practice, the receptionist can instruct them to fill out patient medical and/or nutritional history forms previously designed by you and your staff. Suggestions should be used which are offered in Module 2. When using these forms, valuable time can be saved both by you and by the nutritionist, for routine information can be obtained easily this way. You, the nurse, and/or the nutritionist should briefly review the information with patients to fill in information gaps and clarify the information given. Another benefit of using the form technique is that it enhances patients' involvement in the process as well as their expectancy levels for receiving help for their problems.

In addition, it might result in receiving more accurate or truthful information from patients, especially with respect to eating habits, since patients are not:

1. Placed in a position of "trying to please" an interviewer, or
2. Receiving subtle feedback from an interviewer on how they should respond.

Examining Area

If necessary, further information may be gathered in the examining room by the nurse before the patients see you. During the physician/patient interactions, all the traits and principles which were discussed earlier should be put into use. Do not walk in on an undressed patient and immediately begin the physical exam. Meet the patients before they disrobe, introduce yourself, shake hands, and explain the reason for the exam. Remember that lack of time is not an excuse for insensitivity on your part. Physicians and staffs who work hard toward building trusting and supportive relationships with their patients will have greater patient cooperation when it comes to following health-related instructions and recommendations than had a trusting and supporting rapport not been built.

Patient education can be initiated during the examining room encounters particularly when it is in response to a direct inquiry about health needs or problems. You must be careful not to give too much information too soon. Patients overwhelmed with information are less likely to remember any of it and are reluctant to ask pertinent questions.

If hand-outs are to accompany discussions, give them to your patients before discussing them so they can listen to your instructions without the anxiety of hoping they can remember everything you are telling them.

Physician's Consultation Room

Patients (such as a new diabetic, an obese patient, or a hyperlipidemic patient) who will require extensive education should have an in-depth interview with the physician and a dietitian. All of the previously discussed recommendations on relationship building and counseling skills and stages should be put into action at this time. You should accomplish 3 things during the initial interview:

1. Define the patients' problems,
2. Explain the alternatives, and
3. Set goals.

What you expect of the patient in future sessions for education, reinforcement, and assessment you should clarify at this initial visit.

Often patients fail to return for follow-up of health care for a variety of reasons. Some are not ready to accept that they have a medical problem or do not feel vulnerable to the possibility of developing a problem. Some patients are overwhelmed with the quantity of information on the first visit and feel incapable of following recommendations.

Patients do not return to their physician, nutritional counselor, or other health care providers for a variety of reasons. Some common reasons include:

1. Patients are not ready *emotionally* to face medical problems or make the recommended behavioral changes. Perhaps they do not want to believe that they have a problem, or they may not want to make necessary lifestyle changes no matter what the consequences. This patient-type is often heard saying, "You've got to die of something" or "I'd rather eat and smoke and be happy than persecute myself." Persuasion is usually not successful with such patients. They do not feel vulnerable, and until a serious medical consequence occurs, they are unlikely to listen to advice. You should seriously inform these patients of the consequences of their actions but accept their decisions of noncooperation. The health care team members should leave the door open for a future change of heart, and, without nagging, remind patients during future appointments that their medical problems are still of concern to you.

2. Patients were so *overwhelmed* with information given by an overearnest physician and staff that they did not feel capable of either understanding what was said or changing their lifestyles as rapidly and drastically as was suggested. This situation can be avoided by setting short-term goals, along with allowing patients to dictate how much information they need and at what time. When patients are set up for immediate success, rather than failure, positive reinforcement helps them go one step further in achieving their long-term goals. For example, asking patients to switch from regular salt to a salt-substitute for one week may be a more reasonable goal than giving them lists of high-sodium foods that *must* be avoided. Asking the diabetic to change from regular pop to diet pop instead of no pop at all is another example conducive to fostering compliance.

Patient Education Room

Patients who require in-depth education should be referred to a nurse educator who can assess their learning styles and abilities and develop educational plans suited to their needs. If your patients' problems require a dietitian, the dietitian may also work out of this education room. Resources in the education room can be utilized depending upon the patients' needs; group classes, family conferences, and follow-up visits can be conducted in this room.

This model is suggested as a guideline for establishing a patient nutrition/health care education center in your office. Modifications should be made depending on the particular needs of your medical practice and your available resources. If you do not have a consulting clinical dietitian on your staff, Module 2 includes suggestions for obtaining such services.

To avoid unnecessary information overlap and provide valuable communication between the health care team, weekly patient care conferences are recommended for new patients, problem patients, and brief up-dates on regular patients. The patients' progress, educational goals, and particular problems can be discussed at these conferences; during these conferences, suggestions should be offered for modifying and improving the total patient care program.

The most important feature of the patient education room is the visibility to your patients that you give high priority to their being well-informed. The opportunities afforded are limited only by the degree of your commitment and ingenuity. As you get more involved in this activity and see the benefits from patient feedback, you may wish to even produce your own scripts and audiotapes in the areas of your special interests.

Summary

Because the goal of your practice is optimal health care and health maintenance for all patients throughout their life, health counseling/education must be an integral component of your practice. This module has discussed some helping characteristics, patient education approaches, and behavioral change motivators that can be useful to you and every member of your team for promoting patient behavior changes consistent with desirable health care goals. It has also outlined an office model that can be used to plan for patient education and provide for the efficient use of the office staff.

It should be emphasized that the major objective of any health education attempt is that the patients will take independent and active roles in their health care. These patients internalize the information given and apply this knowledge toward coping with future health problems. If the concept of an independent patient becomes the focal point of your and your staff's philosophy, and if all members cooperate in emphasizing this objective, then good health habits will be adopted by the patients who seek your medical help. The good health habits you teach will be transferred by your patients to future generations.

Test Your Knowledge

To help you become an effective health care counselor and educator, considerable practice of suggested skills and techniques discussed in this module is recommended. This is especially true for nutritional counseling. Following are some recommended activities in which you can participate to improve your nutritional counseling skills.

1. Observe a registered clinical dietitian counseling a patient (preferably one of your own patients) for a nutritional problem. Listen for the features listed below. It is recommended that you observe an initial interview which includes taking a diet history from the patient in a counseling session, as well as at least one follow-up session. Discuss the interview with the dietitian after it is completed to clarify such things as counseling style, patient receptivity and comprehension, and the dietary plan.

    a. *Introductions.* Does the dietitian make the patient feel comfortable? A little small talk is always a good icebreaker.
    b. *Talking/listening.* Who does most of the talking? If the interview is dominated by the counselor's lecturing and questioning with an occasional response from the patient, it will not be productive. Patients should express their concerns. Use of *open-ended* questions as much as possible is recommended. These questions require more than a simple yes-no response from patients such as "What do you feel will be the least desirable aspect of this salt-restricted diet?" and "How do you think you can avoid eating 'salty' snacks while watching television?"
    c. *Pauses.* Pauses are important in an interview. They give patients time to absorb what is being presented and give the counselor a chance to plan a strategy based upon the patients' responses.
    d. *Counselor characteristics.* Listen for comments that might reflect the counselor's characteristics of expertness, trustworthiness, and attractiveness.
    e. *Organization.* There should be some plan to the interview, utilizing the stages of counseling discussed in this module. Jumping from one topic to another without resolving anything leaves patients confused and likely to remember nothing.
    f. *Patient responses.* Listen to how patients respond to the counselor's suggestions. Did the counselor note statements or ignore them? Notice subtleties and whether or not the counselor noted the patients' verbal and nonverbal cues.

    Although taping and reviewing patient interviews is a time-consuming process, it can provide invaluable feedback of counseling skills and styles and help the counselor make appropriate adjustments in order to become a more effective educator and counselor.

2. After several observations of nutritional counseling, conduct an interview with one of your patients who needs to make some adjustments in eating patterns, such as a patient who should restrict sodium intake because of heart failure or hypertension. Tape record the interview (after receiving the patient's permission) and review it later. When reviewing the tape, listen for the features identified previously.

3. Complete the following 2 care studies.

Care Study #1

Mr. Atkins is a hypercholesterolemic patient who needs to adhere to a low-cholesterol, low-saturated fat diet in an attempt to lower his serum cholesterol level toward the normal range; his current level is 320 mg/dl. Mr. Atkins is 45 years old, he is employed as an insurance adjustor, and he has never restricted his eating patterns in the past. He eats 3 regular meals per day, the noon meal being eaten in the company cafeteria. Mr. Atkins regularly uses butter, cream, and has eggs four times weekly. He enjoys luncheon meats, baked items, potato chips, red meat, and ice cream. He is not much of a "fruit eater" but does like most vegetables and salads. Mr. Atkins does not engage in any regular daily exercise program but does enjoy a game of golf on the weekends.

1. List 2 long-term goals and 4 short-term goals you might set with Mr. Atkins to help him make appropriate adjustments in his lifestyle. (See the Answers section following these care studies for suggested responses.)
   Long-term Goals
   1. _____
   2. _____
   Short-term Goals
   1. _____
   2. _____
   3. _____
   4. _____
2. What problems do you anticipate during your health care program with Mr. Atkins, and how do you think you will overcome them?

Care Study #2

Mrs. Rutherford is a 38-year-old homemaker who has recently returned to college to fulfill the requirements for her teaching certificate. She is married and has 2 high-school-aged children. She is 5 feet 5 inches tall and weighs 165 pounds. During her first visit to your office two weeks ago, she described symptoms indicative of diabetes mellitus, and a subsequent glucose tolerance test confirmed this diagnosis. An oral agent plus weight loss should control her diabetes adequately. Proper diet and exercise may eliminate the future need for medications. She now visits you for the second time. You ascertain that she is not well-informed about diabetes and its treatment. She appears anxious about her disease and expresses a fear of "going blind" from diabetes just as her matron aunt did several years ago.

1. Briefly outline an office education procedure that might be useful in helping Mrs. Rutherford learn about diabetes and make the necessary lifestyle changes to keep her diabetes under control. When done, refer to the following pages and compare your plan with a suggested one.

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Stuart, R.B., and David, B.: *Slim Chance in a Fat World. The Behavioral Control of Obesity.* Champaign, IL, Research Press Company, 1972.

Answers

Care Study 1

1. Suggested goals might include the following; many others are acceptable.

Long-term Goals

1. Reduce present serum cholesterol of 320 mg% by 25% (to 240 mg%) within a six month period.
2. Engage in a regular exercise program, such as jogging 2 miles per day, three days a week, or walking 3 miles daily, or swimming 20 laps three times per week. (An exercise program such as this must be begun gradually.)

Short-term Goals

1. Reduce egg consumption to no more than 3 eggs per week by replacing eggs with cereal and skim milk for breakfast.
2. Read food labels carefully for cholesterol and saturated fat content.
3. Keep a food intake record for one week and circle in red all foods considered to be high sources of cholesterol and saturated fats.
4. Make a list of foods that can be substituted for those circled in the intake record that are low in cholesterol and saturated fats. For example:

High Cholesterol and Saturated Fat in Diet	Substitute Low Cholesterol and Saturated Fat Foods
Butter	Polyunsaturated margarine
Whole milk	Skim milk
Steak	Chicken (without skin)
Ice Cream	Sherbet
Roquefort dressing	Italian; vinegar and oil

5. Take lunch to work from home on days when the cafeteria does not offer "low cholesterol" items. Check menu ahead of time.
6. a. Mr. Atkins's job as an insurance adjustor will pose problems in changing eating patterns. He can be expected to travel frequently and to have no set work or eating schedule. His job may be highly mentally stressful.
   b. Mr. Atkins has never restricted his eating patterns in the past; therefore following a restricted eating regimen demands an eating discipline which he will need to learn.
   c. Obtaining cholesterol and fat restricted foods in the company cafeteria at noon may be a problem. You should stress that he choose broiled or baked low-fat meats and skimmed milk and dairy products. Mr. Atkins should be told to omit butter, cream, potato chips and ice cream from his diet and to limit egg consumption to three eggs per week. Encourage Mr. Atkins to continue eating vegetables and salads and to include at least one citrus fruit daily in his diet. He may be able to purchase low-fat prepared foods at the cafeteria if the cafeteria operation is small enough to allow for individualized food preparation.
   d. Since Mr. Atkins does not engage in a regular daily exercise program but does enjoy a game of golf on the weekends, encourage him to continue his golf playing and to begin a regular exercise program if medically advisable.

Care Study 2

The information included throughout this module will help you answer this question. Be creative! Patients learn well and remember when creative methods of teaching are used. Although there is no one correct answer to this question, a sample answer follows:

1. On this office visit you might:
   a. Develop an expert, trusting, and attractive rapport with Mrs. Rutherford. Acknowledge her anxiety about her disease and her fear of going blind. Reassure her of medical advances since her aunt's experience with diabetes several years ago.
   b. Discuss diabetes mellitus.
      What is it?
      What causes it?
      How is it treated?
      Is it curable?
      Why are weekly medical care follow-up visits important?
   c. Discuss the oral hypoglycemic agent you have prescribed.
      What is it?
      What will it do?
      When should she take it?
   d. Ascertain Mrs. Rutherford's typical eating patterns. Ask her to keep a one-week food record, recording time of eating, what she ate, amount of each item eaten, how she felt, and what she did while eating. Request that she bring the one-week food record to the follow-up visit planned for the next week.
   e. Reassure Mrs. Rutherford; emphasize that she will be able to control her disorder well with medication and diet and will be able to lead a normal, well-integrated life.

2. On subsequent follow-up visits:
   a. Determine Mrs. Rutherford's health goals and reconcile the patient's goals and your medical goals if necessary.
   b. Review her one-week food record and plan an appropriate diet with meal spacing recommendations and sample menus which are individualized for her. (Use guidelines for assessing kilocalorie intake and developing the nutritional care plan as described in Modules 9 and 10 on obesity and diabetes.)
   c. Set long-term and short-term goals. At all subsequent visits, evaluate the nutritional care plan and long-term and short-term goals.
   d. Discuss behavior modification therapy. (Use handouts and recommendations for discussing behavior modification techniques included in Module 9.)
   e. Prescribe an anorectic drug if you feel it is medically appropriate, and discuss its use with the patient.
   f. Discuss the need for a regular exercise program. Determine what sports or activities should constitute Mrs. Rutherford's program.
   g. Reinforce the need for regular blood sugar checks and daily urine sugar checks.

h. Determine the factors that are motivating the patient to cooperate or not cooperate with the health recommendations. Encourage Mrs. Rutherford to be an accurate observer of the consequences of her own actions.
i. Encourage Mrs. Rutherford to take responsibility for her own health program, the diet, long-term goals, and short-term goals.
j. Provide positive reinforcement often to Mrs. Rutherford.
k. Consider designing your office space and using your staff in ways that would be conducive to evaluating the nutritional care plan, long-term goals, and short-term health goals. Fill your office with reading materials in the waiting room, examining room, physician consultation room, and patient education room. Use posters, handouts, and pamphlets identified in Appendix A. Use the receptionist to give and explain to the patient the one-week food record. The receptionist can also review the record with the patient at the follow-up visit. Use the nurse's skills in explaining to Mrs. Rutherford how to measure urine sugars daily. Use your personal dietitian or consulting dietitian to work with Mrs. Rutherford to plan, implement, and evaluate the total nutrition plan.

Appendix A

Nutrition Education Resources

Nutrition and health care resource materials may be obtained from the following agencies:

American Diabetes Association, Inc.
600 Fifth Avenue
New York, NY 10020

American Dietetic Association
430 North Michigan Avenue
Chicago, IL 60611

American Heart Association
44 East 23rd Street
New York, NY 10010

American Home Economics Association
2010 Massachusetts Avenue, Northwest
Washington, DC 20036

American Medical Association
535 North Dearborn Street
Chicago, IL 60610
Attn: Department of Food and Nutrition

Arthritis Foundation
1212 Avenue of the Americas
New York, NY 10036

Metropolitan Life Insurance Company
1 Madison Avenue
New York, NY 10010

National Dairy Council
6300 North River Road
Rosemont, IL 60018

National Foundation — March of Dimes
Box 2000
White Plains, NY 10602

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402

U.S. Department of Agriculture
Consumer Information
Public Document Distribution Center
Pueblo, CO 81009
A catalog of U.S. Department of Agriculture publications is available from the Superintendent of Documents (stock No. 001-003-5)($2.00)

U.S. Department of Health, Education, and Welfare
Public Health Service
Health Service Administration
Office of Maternal and Child Health
5600 Fisher Lane
Rockville, MD 20852

U.S. Department of Health, Education, and Welfare
Food and Drug Administration
5600 Fisher Lane HFO-107
Rockville, MD 20852

Many of the listed resources have regional chapters or agencies, so check first for a local listing before contacting the national office. State and community public health departments, cooperative extension services associated with state universities, departments of home economics, nutrition, and medical dietetics of local universities, and dietetic departments of area hospitals or other health care facilities are other valuable resources for nutrition education, materials, and personnel.

Some Abbrevations Used in the Nutrition in Primary Care Series

ATP	adenosine triphosphate
c	cup
cc	cubic centimeter
CNS	central nervous system
FDA	Food and Drug Administration
gm	gram
IBW	ideal body weight
IU	International Units
kcal	kilocalorie
kg	kilogram
lb	pound
lg	large
MCV	mean corpuscular volume
MDR	minimum daily requirement
med	medium
mEq	milliequivalent
mg	milligram
MJ	megajoule
ml	milliliter
oz	ounce
RDA	Recommended Dietary Allowances
RE	retinol equivalents
sl	slice
sm	small
Tbsp	Tablespoon
TPN	total parenteral nutrition
tsp	teaspoon
USDA	United States Department of Agriculture