THE PHYSICIAN AS COACH
IN THE MANAGEMENT OF CHRONIC DISEASES

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Treating chronic diseases has become a major challenge to our health care system. The costs of managing chronic conditions have become enormous and successful health outcomes often require significant behavior and lifestyle modifications from patients in addition to medical procedures and medications. As the major deliverer of health care to patients, physicians are in a natural and unique position to help patients create the changes necessary to successfully manage their condition and, as a result, create better health outcomes. However, such a role has become difficult or even impossible given the deterioration of the doctor-patient relationship over the last fifty years, as detailed by Roy Porter in his history of medicine *The Greatest Benefit to Mankind*, and given the financial pressures of health maintenance organizations on doctors. It is in this context that health insurance providers are pioneering the use of non-physician health coaches as a complement to the doctor-patient relationship. This implementation of coaching separate from the doctor-patient relationship is, however, risky for both patients and physicians. Instead, coaching should become the heart of the interaction between physicians and patients. In addition to bringing health benefits to patients, coaching could revitalize the doctor-patient relationship by reducing the current polarization between the old paternalistic and the new consumerist models of the doctor-patient interaction as analyzed by Deborah Lupton in *Medicine as Culture* and "Consumerism, Reflexivity and the Medical Encounter" in the journal *Social Sciences & Medicine,* and could ultimately help meet the challenges chronic illnesses are creating throughout our healthcare system.

Coaching may be new to medicine but it is commonly used in many disciplines and professions. Originating in the performing arts and professional sports, coaching is also being used both in business and in personal development and has given rise to a whole new professional field. According to the International Coach Federation, an organization of business and personal coaches,

> **[p]rofessional coaches provide an ongoing partnership designed to help clients produce fulfilling results in their personal and professional lives. Coaches help people improve their performances and enhance the quality of their lives.**

> **Coaches are trained to listen, to observe and to customize their approach to individual client needs. They seek to elicit solutions and strategies from the client; they believe the client is naturally creative and resourceful. The coach's job is to provide support to enhance the skills, resources, and creativity that the client already has. ("About Coaching")**

In this definition, some of the key distinguishing features of coaching become apparent. The objective of coaching is to produce tangible results. It is therefore action-oriented and focused on reaching specific goals defined by the individual. Coaches need to be effective listeners and need to tailor their approach to each individual. A significant part of the coaching process involves eliciting and defining goals and objectives as well as strategies to reach them. Finally, the most important feature of coaching is the relationship between the coach and the coachee: a partnership based on the premise that the client has a lot to bring to the process and he is taking responsibility for the achievement of his goals.

These characteristics are consistent with the ones medical programs are trying to incorporate in their use of coaching. Margarite Vale et al. in the *Journal of Clinical Epidemiology* describe such a program in which coaching is defined as a "method of training patients to take responsibility for the achievement of the target levels for their particular modifiable risk factors [in this example, cholesterol level]" (Vale 246). A recent article by Dagmara Scalise in *Hospitals & Health Networks* states: "Good coaches produce good athletes through encouragement, training and discipline. Now some [health care insurers] are betting that the same approach will produce better patients—leading to better outcomes and saving money. Their method: a form of disease management known as health coaching" (1). Health coaching is therefore using the same key elements as the other forms of coaching such as ownership, encouragement, focus and discipline. One example of such providers is Sentara Health Management which recently implemented a "Disease Management Program Utilizing 'Life Coaches' for Children with Asthma" as described by Randy Axelrod et al. in *The Journal of Clinical Outcomes* (38). The focus of this program is "to provide education and support that promotes optimal independent functioning, thus reducing the need for more intensive and higher-cost services" (Axelrod 38). Across these examples, there is a consistent objective to support patients in taking greater responsibility and ownership for the effective management of their conditions, often by making some behavioral change. The expectation is that such "better" patients will be more effective at

self-managing their conditions, reducing their need for doctor visits and expensive procedures and therefore meeting the ultimate objective of these coaching programs: saving money. The need for insurance providers to find innovative solutions—such as coaching—to the mounting costs of treating chronic conditions is not surprising. According to a recent article by Laura Landro in the *Wall Street Journal*, "Chronic diseases affect at least 125 million Americans and cost more than $500 billion last year" (D1). Furthermore, "Meeks [MD and CEO of The Haelen Group] estimates that coaching saves to $2 to $3 for every dollar spent" (Scalise 2). Given the magnitude of these potential cost-savings, it is not surprising to find health care insurers at the forefront of new approaches incorporating coaching.

Not only is coaching delivering cost-saving, it also seems beneficial for patients. For example, Sentara Health Management mentions that their program "has not only met the cost-saving goals for Sentara Healthcare but has made a major contribution to improving the quality of life of asthma patients" (Axelrod 42). The coaching approach seems therefore well-suited for reducing treatment costs as well as creating long-lasting changes in behavior, which are often required to adhere to the constraining treatment plans of chronic illnesses.

One of the central elements of the implementation of coaching is the coach-coachee relationship. Interestingly, in the implementation of health coaches reviewed, the coach is never the physician but a different health care professional such as a nurse or dietitian working in conjunction with a physician. In one such implementation, the coach is a registered nurse certified in asthma disease management (Axelrod 38) who works closely with the primary care physician. In another example, it is a dietitian who coaches patients (Vale 247). One possible explanation for this separation of the role of the coach from that of the physician is the fact that coaching has, so far, been pioneered by health insurers—driven by the need to reduce costs—rather than by the medical profession.

The details of one particular program do, however, point to another explanation for the separation between the coach and the physician. The coaching methodology used for the treatment of coronary heart disease incorporates a step called "assertiveness training" in which "the patient is trained to be assertive in the relationship with the treating doctor, so that patients can negotiate treatment needs with the doctor" (Vale 247), and one of the conclusions of this article and study is that "Effective coaching teaches the patient to get the most from a consultation with their usual doctors" (Vale 247). This suggests that coaching is a necessary add-on to the interaction with the physician in order to compensate for the

limitations of the physician-patient relationship. This point is reinforced by another conclusion of the study: "Coaching does not involve prescription of medication and hence, coaching does not seek to take over the medical management of patients" (Vale 251). This conclusion demonstrates the exclusive focus of the physician-patient relationship—in particular in the management of chronic illnesses—on diagnosis and prescription of the right medications, and supports the view of coaching as separate from the medical management of the patient. The need to use coaching in addition to a narrowly focused physician-patient interaction suggests that coaching is presently used and is actually beneficial to patients because of the limited focus of the physician-patient interaction on medications and procedures.

The fact that coaching seems to be used to compensate for a deficient doctor-patient relationship also finds support in the larger evolution of this relationship. According to Porter's analysis, the physician-patient relationship has been increasingly moving away from a relationship to a dehumanized delivery of goods and services. Surprisingly, Porter's suggestion is that it is the advancement of science that has primarily contributed to this gradual reduction of the doctor-patient interaction:

> **But though doctors became therapeutically more potent, in large measure they ceased to give patients what they want. With effective weapons against organic disease, they tended to forget the psychological significance and benefits of the doctor-patient relationship. (671)**

This disinvestment in the relational aspects of the doctor-patient interaction has led physicians to focus solely on delivering science at the expense of nurturing a relationship with patients. The result has been a gradual narrowing of the scope of the doctor-patient relationship and its dehumanization. In addition, the benefits of a strong relationship between doctors and patients have been slowly de-emphasized and lost and it is those benefits that are now greatly needed for helping patients managing chronic illnesses. The result is that, at a time when these benefits are most needed, the current state of the doctor-patient interaction makes it very difficult for physicians to help patients create the behavior and lifestyle change needed to manage their chronic illnesses. In this context, the use of coaching is an attempt to recapture the benefits of a stronger relationship between patients and healthcare providers.

While coaching does bring a solution to the current deficiencies of the doctor-patient relationship, its use as a separate process from the physician-patient interaction also works to accentuate and perpetuate the role of physician as a scientific expert delivering diagnosis and prescription services, and can only work to further degrade the importance of this relationship. For physicians, this constitutes another step towards a dehumanization and a narrowing of their role. Furthermore, this trend is not only problematic for doctors, but also presents a number of issues and dangers for patients because physicians have a key contribution to make in many of the non-clinical parts of patient's care and have a unique position to yield considerable influence and support for the patient. In her article "Consumerism, Reflexivity and the Medical Encounter," Lupton highlights the increasingly popular "consumerist view" of the relationship in which "medical services should be treated just like any other commodity . . . Those who adopted this model of doctor-patient relations view doctors simply as suppliers of services" (Lupton 373). However, Lupton warns that:

> **the consumerist approach may be counterproductive, undermining the very trust and faith that is central to the healing and comfort that very ill people desperately seek in the medical encounter. We need doctors to provide us not only with medical expertise and knowledge but with emotional comfort, concern and empathy towards our suffering and personalized care. (380)**

Her analysis suggests that many patients, in particular those suffering from chronic conditions, need the physician to play the dual role of expert knowledge deliverer and counselor. She continues by highlighting the risks of separating these two roles when she says:

> **If we cannot invest our trust and faith in the expertise of at least some of the medical practitioners to whom we have access, relying on embodied and affective experience and judgment as guides, the alternative may be paralysis and distress in the face of conflicting options. (Lupton 380)**

Lupton's arguments therefore suggest that, even though patients definitely want more empowerment in their interaction with doctors, they still need the guidance of the physician in making the best decisions for themselves, especially when confronted with complex choices. To be effective, this guidance has to take into account the patient's desires, needs and emotions, and, as a result, cannot be delivered via the mere communication of medical facts but instead through a human relationship. Patients may seek this relational component

outside the interaction with their physician and may find some relief with separate health coaches or alternative therapists, but Lupton concludes that "[n]evertheless, the authority and expertise that attend biomedicine and those who are medically trained still carry much weight, and no participants [in the study] had completely rejected biomedicine in favour of alternative therapies" (378). Lupton, therefore, points to the importance of the physician's role beyond the one of clinician and, in fact, suggests that physicians must find a way to address the emotional, relational and personalized needs of patients because from the patient's perspective, they are uniquely positioned to do so.

Such an example of the need to integrate coaching within the physician's role can be found in a study of the importance of goal-setting in clinical medicine. An article written by Elizabeth Bradley, et al. in *Social Science & Medicine* clearly articulates the value of goal-setting:

> **By promoting outcomes-based plans of care, enhancing acceptance of clinical recommendations, and facilitating the resolution of conflicting goals, a clear statement of goals may increase the chances of achieving desired outcomes, a result valued by clinicians, patients and families. (Bradley 267)**

In other words, desired results are more likely to be attained if they were set as clear goals at the outset of the treatment. In addition, the study findings emphasize the importance of goal-setting in the treatment of chronic diseases:

> **Conflicts about goals, both among clinicians and between clinicians and patients or families, may be especially prevalent in cases of chronic illnesses when multiple parties are involved in patient's care, and the goals of care are not always obvious since "cure" is not feasible. (Bradley 268)**

The conclusions of this study point to the notion that goal setting is central to the care of patients with chronic conditions because it is the place where conflicts between the various parties involved in the treatment and the patients can be addressed. Finally, the importance of the role of the physician in goal setting is strongly emphasized:

> **The translation [of general goals into specific goals to the patients] is especially complex in clinical medicine in which identification of feasible and meaningful specific goals may require substantial experience and knowledge concerning diagnosis and treatment of disease. Patients and families, who**

> **possess general goals, must depend on clinician's expertise for identifying specific recommendations. (Bradley 276)**

As a result, because of their medical expertise, physicians have a crucial role to play in goal-setting, also a major part of the coaching process. This role requires them to partner with their patients in order to assist them in translating general goals into meaningful and tailored goals consistent with their clinical conditions and desired outcomes.

Physicians are therefore in a unique position to leverage the benefits of the coaching approach not only to improve patients' health outcomes—and create cost-saving—but also to create a new middle ground between the various antagonistic forces straining the doctor-patient relationship. By becoming coaches, physicians have an opportunity to redefine the doctor-patient relationship into one acceptable to today's more empowered patients while, at the same time, reaping the benefits of the more paternalistic interaction of the past. As Lupton makes clear, patients are increasingly experiencing the polarization that exists between the "consumerist" and the "passive patient" views of the physician-patient relationship.

> **In a socio-cultural context in which autonomy and rationality are highly privileged and dependency upon others is largely viewed as evidence of weakness and irrationality, lay people may feel a continual tension between wanting to behave in a consumerist manner and avoid dependency on doctors . . . and their equally strongly felt desire. . . to take on the "passive patient" role. (380)**

This tension and confusion combined with the limited focus of physicians on delivering diagnosis and treatment rather than on a comprehensive relationship with their patients epitomizes what has gone wrong with the doctor-patient relationship. In contrast, coaching, because of its inherent features, respects patients' autonomy while using a compassionate, supportive and sometimes brutally-honest relationship as a foundation. As a result, coaching can easily accommodate the sometimes-contradictory needs of patients for autonomy, guidance, reassurance and comfort from their doctors. The result would be a reduction of tension and confusion experienced by patients, an improved dialogue and a relationship focused on defining and achieving individual health goals consistent with the patient's clinical condition and life circumstances.

To reap the benefits of coaching, physicians must therefore make it central to the way they interact with patients. But the transition to a coaching-centered doctor-patient relationship will not be easy because, while appearing to be a mere change in communication technique, the adoption of coaching suggests and implies a profound change in the role of physicians. Concentrating on the person and his goals and his needs in the face of a disease shifts the primary focus of physicians away from the disease towards the whole person. The importance of a personalized process that is not primarily focused on disease management but on the patient's unique desires and needs is starting to be recognized in the medical community, but also faces similar considerable challenges. In "The End of the Disease Era" published in the *American Journal of Medicine*, Tinetti and Fried, both physicians, advocate for the shift of medical care away from disease towards the attainment of individual goals (Tinetti 179). Their premise is that:

> **the changed spectrum of health conditions, the complex interplay of biological and non-biological factors, the aging population and the inter-individual variability in health priorities render medical care that is centered primarily on the diagnosis and treatment of individual diseases at best out of date at worst harmful. (Tinetti 179)**

They recommend an "integrated individually tailored" model extremely consistent with the coaching approach—even though they never mention the word coaching— and that is designed to elicit the priorities, preferences and objectives of each patient. Similarly, they conclude that:

> **Perhaps the greater barrier will be that the disease model is so entrenched that most clinicians and patients are unaware of its existence. What was once itself a new model, developed as a means of translating emerging scientific knowledge into better medical care, is now accepted as "truth.." (Tinetti 184)**

Similarly, the transition to physicians acting as coaches will not happen easily given the enormous structural and economic investments in the current disease-centered view of medicine. However, efforts to integrate coaching into the doctor-patient relationship should continue because the emergence of the physician as a coach could constitute the first concrete and tangible step towards a more profound paradigm shift over time.

But are patients ready to be coached, and are physicians ready and willing to act as coaches? Patients want greater autonomy in their interaction with doctors but, as Porter

suggests: "there is still a longing . . . for that old doctor, ever available, avuncular and conveying hope" (685). In particular, when suffering from chronic illnesses, patients want a committed partner that can help them manage their conditions successfully. However, coaching may not be suited for everyone since it requires an active patient participation. Considering Lupton's view in *Medicine as Culture* that: "The health problem of the patient . . . has an obvious impact on the extent to which the patient may feel empowered or wish to take control of the encounter" (115), severe and disabling illnesses may preclude patients taking on the role of coachee in their interactions with doctors. Fortunately, the coaching approach is inherently flexible and the amount of the patient's responsibility and ownership can be adjusted. The physician, with a knowledge of the impact of various clinical conditions on the patient and equipped with a higher level of listening and understanding of the patient's situation, is best positioned to bring such modifications to the coaching process.

As far as physicians are concerned, in his recent book *Your Money or Your Life*, Cutler summarizes the position of many doctors on providing their chronically ill patients with active help for behavior modifications such as diets and smoking cessation:

> **When asked why [physicians] do not provide these services [counseling for behavioral changes], physicians have a uniform answer: they are not paid to provide them, and so cannot afford to invest in them . . .They cannot do for patients what they know needs to be done. (30)**

Physicians do recognize the role they could play in a patient's behavior modifications but are constrained by the way they are currently remunerated. It seems that, unless our healthcare system and the way physicians are paid for their services are overhauled, it is difficult to imagine that many physicians will fully embrace coaching despite its long list of benefits for all constituencies of the health care system. Paradoxically, the same economic factors that are driving health care insurers towards coaching are also an obstacle to physicians taking on the role of coaches. Given some of the risks involved with separating the coaching process from the doctor-patient interaction, perhaps health care insurers should pay physicians to be coaches rather than some other health care workers.

Coaching is part of the answer to the challenges chronic illnesses pose to our health care system, but leaving the initiative of leveraging the power of coaching to health care insurers is ultimately dangerous for both patients and physicians. By taking the lead in promoting and incorporating coaching at the center of their interaction with chronically-ill

patients despite the current obstacles, physicians could improve health outcomes, achieve significant societal cost savings, and be the catalyst for a redefinition of the purpose and goals of the clinical encounter more suited to deal with the treatment and economic challenges of chronic illnesses. Such leadership from physicians could ultimately create a new momentum for a much needed overhaul of our health care system that supports what is right for patients, physicians and society as a whole.

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COMMENTARY

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The utilization of coaching within the context of the doctor patient-relationship is a fairly new phenomenon. In Pascal Scemama de Gialluly's essay, "Physician as Coach," the act of coaching is introduced as a concept originated by health insurance providers as a means to decrease the mounting financial costs incurred by patients as a result of chronic illnesses. While firmly establishing the position of the coach as separate from the role of the physician, Scemama also clearly fosters a connection between the two roles, constructing a foundation upon which to emphasize his theory that integrating the duties of the coach with the obligations of the physician will give the patient the maximum level of medical support needed to assist him with autonomously managing his illness. One of the more intriguing aspects of Scemama's analysis is the fact that a key aspect of coaching is "assertiveness training." As explained in Scemama's paper, this type of training is used to empower the patient when discussing treatment options and other vital information with the physician. Scemama comments on the conflicts that may arise when the doctor's authoritarian nature and exclusive focus on the disease rather than the needs of the patients clashes with the patients' "contradictory needs for autonomy . . . and comfort from their doctors." In order to further establish a need for the convergence of these two roles, Scemama might have stated that if the physician were to assume the position of the coach, then he would simultaneously stimulate the patient's desire to take responsibility for his illness while offering advice on medical options for treatment, and as a result there would be no conflict involved. Furthermore, the physician would be more than simply a counselor or a support system, as Scemama stated, but the doctor would also be training the patient to be assertive and to govern his own disease.

Scemama's project inspires a multitude of questions which leave the reader interested and motivated by the essay to uncover additional information about the use of coaching in the health profession. A few of these questions surround the physician's unwillingness to act as a coach because of the lack of financial compensation. One may question the sincerity of a physician whose chief concern is not the well-being of the patient but the payment for the treatment. As Scemama states, the vital doctor-patient relationship has been transformed into merely a relationship of goods and services. Overall, Scemama offers an excellent proposition for a newly-emerging coaching field within the medical profession. Chronic

illness often drains the spirit and livelihood from an individual, leaving him with a diminished desire, if any desire at all, to take control of the situation and therefore to take control of his life. Furthermore, many patients feel powerless and uninformed about their disease even after consultations with their doctors. However, through their relationship with a physician-coach, these same patients could be empowered and encouraged to be self-reliant. Therefore, Scemama's suggestion to incorporate the roles of the physician and the coach is an excellent solution to an emerging problem.

RESPONSE

Pascal Scemama de Gialluly

When I read about the use of the use of health coaches in the treatment of chronic illnesses, I was intrigued. I already had the opportunity to be exposed to the use of coaching and its benefits in the performing arts, business and personal development. In addition, as a pre-medical student, the doctor-patient relationship was of strong interest to me because it is where the scientific and human sides of medicine meet. The management of chronic illnesses constitutes a major challenge to our health care system, not only because of its costs but also because it often requires patients to make some substantial behavior and lifestyle changes. Initially, the coaching approach seemed well-suited to address these challenges. But as I looked deeper into the implementation of coaching and into the issues surrounding the doctor-patient relationship, I realized that the approach used by health insurers had some major risks. The use of coaches as a complement to the doctor-patient interaction could further exacerbate the rapid dehumanization of the doctor-patient relationships by institutionalizing a doctor-patient interaction solely focused on medical issues. Furthermore, the use of coaching outside the doctor-patient relationship also presents risk for patients. Managing a chronic illness involves having to make complex decisions involving not only medical but also personal and ethical elements. Physicians seem to be the best positioned to integrate these various elements, to help patients make the best decision possible and manifest the required behavior changes.

It then became clear to me that doctors should embrace the coaching approach in dealing with patients suffering from chronic illnesses. Placing the coaching approach at the center of the doctor-patient relationship would also get the relationship out of a non-productive duality. On one hand, patients of today reject the passivity of yesterday's

patients even though, as Anderson points out, many need to be trained to become more assertive. On the other hand, there is a tendency nowadays to view the doctor-patient interaction as simply a transaction between a consumer and a provider. In the end, patients seem to want both autonomy and comfort from their doctors. As Anderson rightly suggests, the physician as coach can resolve the conflict between these contradictory patient's needs by encouraging participation and responsibility while providing support and advice.

What struck me in my research is that many physicians seem to be aware of the potential benefits of a new approach with patients but are not taking any leadership to create a new direction. There are obviously many structural obstacles to redefining the doctor-patient interaction, for example, the way doctors are compensated. Ironically, health insurers have no problem disbursing additional monies to health coaches. Why not pay physicians to also be coaches? Anderson mentions the issue of sincerity when physicians appear to act according to the way they are remunerated and not according to the patient's well-being. Unfortunately, the issue of what boundaries doctors put around their role has become far more complex than a simple choice between what is right for the patient and what is right for the physician. In fact, articulating the issue as such a choice is consistent with the increasing transactional construct of the doctor-patient relationship because, in a transaction, there is usually someone better off and someone worse off. What is needed is a vision of the doctor-patient relationship solidly grounded in a win-win relationship where what is right for the patient is also what is right for the physician. This is the potential promise of physicians also acting as health coaches.

Incorporating coaching into the doctor-patient relationship seems to challenge something more fundamental about today's medicine: the fact that it is disease-centered and not patient-centered. Physicians, not health insurers, should take the lead in paving a new direction for their interaction with patients and for medicine as a whole.