The Elephant In The Exam Room

After writing about giving nutritional advice as a plump pediatrician—and experiencing the reactions—a doctor rethinks how public health and public relations are tied to giving advice.

BY PERRI KLASS

For years I’d considered writing an essay about giving advice on nutrition and diet in the medical exam room. I knew exactly what I wanted to say: How can I, as a pediatrician, give advice about losing weight when I’m not thin? Why should a young patient—or a parent—listen to my counsel about limiting portion sizes and avoiding junk food and increasing exercise when that patient—or that parent—can probably guess by looking at me what the number-one item is on my own New Year’s resolutions list?

So I’d wanted to write that essay, but I hadn’t done it. I’d written about some other pediatric advice-giving conundrums—I’d been happy to reveal in print that I can’t do time-outs or that my children didn’t have bedtimes. But if I wrote an essay about my weight, then I’d no longer be hiding my physical imperfections behind the sheltering page. I’d be admitting that they were the imperfections that made me most self-conscious in the medical exam room. After all, people can’t tell by looking at me that I’m an inconsistent disciplinarian, or that no one in my family (including me) gets enough sleep, but they can probably tell that I wish I could lose some weight.

What I was really wondering about, of course, is the larger issue of how to give advice so that it’s truly helpful to the person being advised. Advice ought to be all about the patient, and that means, I know, that I shouldn’t withhold good advice even in situations where I haven’t been able to follow it myself. My patients are entitled to my knowledge and understanding rather than my backslidings—to my strengths, shall we say, rather than my weaknesses.

A problem with giving good advice, and with measuring its effect, might be that although we measure effects across a population, giving and receiving advice remains a highly individualized transaction. Let’s say that you’re my primary care doctor, then, and you’re suggesting that I lose a little weight: Whether your words get through to me might depend on our relationship, on what I really think of you, on your tone, on my own mood, and so on and on. It’s possible that I’ll leave your exam room suffused with good resolutions about changing my life; it’s also possible that I’ll leave your exam room feeling irritated and overwhelmed. And let me confess here and now that either emotional state could easily lead me toward some highly caloric snack (either because I’m planning to start a diet tomorrow or else because you’ve been bothering me about dieting and I need comforting).

As we’ve come to hear more and more about the “childhood obesity epidemic,” I’ve thought more and more about the whole conundrum of advice giving. How do you give advice, how do you make it useful, how do you tailor it to the patient, does it ever do any good? Does it, in fact, matter if it’s advice you find difficult to follow yourself—especially in a case like this, where there’s physical evidence on display for the patient to evaluate? But even in other cases, where only you know you’re saying do as I say, not as I do, is there a way
to think about using your own struggles to improve your understanding and your capacity to help?

And finally I decided to write that essay. I’d thought of calling it “The Elephant in the Exam Room,” by which I meant, of course, myself. It ended up running with a somewhat more sober title, and I find myself returning to the subject now because this public “disclosure” provoked a variety of reactions, which have kept me thinking about those elephants, and how they affect our ability to give advice.

What I Wrote
The essay I’d long wanted to write ran in summer 2009 in the New York Times, where I write a monthly column on pediatrics. To tell you the truth, it was fun to research and write. It was primarily a reported piece, and it turned out that every childhood obesity expert I interviewed had thought about these questions and searched for ways to connect personal experience with professional practice. One physician, who had herself lost fifty pounds during the past year, talked with humor and honesty about the dynamics of giving advice that your own experience is somewhat helpful; I know when I’ve been scolded about my weight by skinny doctors I’ve thought ‘what can she possibly know about this?’ Alternatively I’m just rationalizing the situation.”

As often happens with Internet comments, many people wrote in to bemoan—or to boast of—their own combinations of professional expertise and personal practice: “I am a size 16 psychologist specializing in weight management. I practice what I preach, and have no personal/professional conflicts. I eat mostly healthy foods, respond appropriately to hunger and satiation, love to dance, and cope effectively with life.”

And then, of course, there were the angry and ungrammatical: “I think it is a disgrace that we allow fat doctors because it goes against everything the field is meant to advocate, and makes them very uncredible as to health issues, and I think drugs should be available without a docs ok, this would neuter the medical fields outrageus revenue stream.”

For myself, I have to say, I found the whole experience peculiarly liberating. I felt, in some tiny way, as if I’d come out of the closet. A number of health care providers thanked me—privately and passionately—for being willing to talk about this, let alone to joke about it. I got a guilty little jolt of pleasure when I encountered someone who’d read the column but never met me in person before. I could see she was surprised and disappointed that I wasn’t fatter than I am. She’d clearly imagined me as morbidly obese, as someone who would need a seatbelt extender, and here I was, merely dumpy.

I suppose that was also part of what I’d wanted to say in the essay. I’d like to lose thirty pounds—or forty pounds—but that doesn’t mean I actually ignore all of my own good advice. In fact, I don’t eat junk food, don’t eat in front of the television, drink no sweetened beverages, don’t own a car, and do walk all the time. I follow lots of the important advice I give patients, but I weigh more than I want to—and that’s another reason that this is a hard subject to tackle, in advice and in real life.

Then Came The Media Calls
By writing about the subject, I had, of course, moved my weight out of the realm of real life and moved the whole elephant aspect into the realm of public discourse and publicity. So perhaps I shouldn’t have been surprised when the phone rang. It was a producer from CBS. “Interesting piece in the Times,” she said. She had a question: Was it inspired by the controversy raging on the Internet?

Since I’m a journalist as well as a physician, and since I pride myself on having a finger both literally and figuratively on the pulse, I was slightly abashed to have to ask: What controversy raging on the Internet? She directed me to some stories about Surgeon General and a furor about President Obama’s recent nominee for surgeon general and a furor about a program on Fox News that had accused her of being too heavy. That’s a joke, I said, or words to that effect. I’ve read about this woman, she’s totally qualified, she’s even heroic. It’s a totally ridiculous made-up issue and, no, my column had nothing to do with it. I was trying to write personally about the exam room dynamic between doctor and patient.

A little later that day, ABC checked in. Then NPR called. Everyone wanted to
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Revisiting The Dynamics Of Advice Giving

The experiences of that essay, and its aftermath, have made me think even more about the dynamics of giving advice, whether one on one, in the medical exam room, or in the public health forum. The truth is, we don’t know how to give advice effectively, especially when weight is concerned. For all the fuss and furor about childhood obesity, there are few interventions that produce large and lasting effects.

So is it easier—or more effective—to hear “lifestyle advice” from someone who feels your pain? If you pass your internist sneaking a smoke in the park?
advice, and this is true in the exam room or in the public arena: The people who are already following the advice, the people who have no difficulty following the advice, are never your targets. Here’s another hard thing about giving advice (and I should certainly serve as an object lesson here): Knowing the information isn’t necessarily enough to change behavior. And here’s one more tough nut: Follow some of my good advice (don’t eat junk food, don’t drink sweet drinks, take the stairs, walk more), and it won’t necessarily make you any thinner than it’s made me.

We have to distinguish between appearance and reality, between public relations and public health. Modifying the environment so that people walk more, or take the stairs, or have better access to fresh vegetables is public health. Using doctors as role models (positive, negative, or in between) might or might not be useful (at least for some patients), but it veers much closer to public relations. But public health and public relations can usefully intersect when advice is given in a way that’s actually helpful to someone who’s struggling. So my job in the exam room is to harness the elephant to the plough, so to speak. The only goal is to do the job effectively, and to communicate well, and to use who you are and what you’ve learned and how you’ve lived in ways that will get the job done. There are a lot of us, every single day, struggling to figure out how best to do this.

There’s certainly a place for public officials to inspire—or model—or challenge us on so-called lifestyle issues, and I suppose that a surgeon general might choose to personalize any particular issue (let’s all quit smoking together, let’s all decrease our salt intake, let’s all make sure our neighbors have access to good primary care). But none of these can be usefully reduced to questions of individual virtue and morality (I never put any added salt in my food so I’m better than you are!). If the only people who can stomach the good advice, so to speak, are those who are already following it, then you’re giving bad advice—or giving advice badly—no matter how sound and evidence-based your recommendations. A certain self-consciousness, about our individual selves, and also about our collective behavior, might keep us from discounting or devaluing the struggles we haven’t experienced, or with which we can’t identify.

The elephant’s job, perhaps, is to remind us all, doctors and patients, that we are all only human.

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