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A FOCUSED REVIEW

GOAL-DIRECTED HEALTH CARE AND THE CHRONIC PAIN PATIENT: A NEW VISION OF THE HEALING ENCOUNTER

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We introduce a new way to engage the patient with chronic pain, Goal-Directed Health Care (G-DHC). Identifying the patient's major life goals during the medical interview is the key element of this approach along with connecting these life goals to specific health-related goals. The implementation of G-DHC is a shift in process from the usual focus on disease-related goals such as relief of pain, titrating narcotic refills, and working on condition management to broader, long-term, personal goals. It emphasizes the importance of identifying the global life goals of patients and the *reasons they wish to be well for* and *what they would do with improved health* once they had it. Utilizing these life goals as a point of reference, discussion, and motivation makes clearer what specified health goals mean, whether or not the patient is ready to work on them, and most significantly, what the underlying motivation is to participate in their own care. We anticipate such a model of patient-centered care will shift the dynamic of the medical encounter with the patient with chronic pain to one that is ultimately more productive and satisfying for both patient and physician. Illustrations of cases, questions to ask patients, and a detail of the process may allow the reader to adopt this method into their practice.

Key words: Goals, goal-directed health care, patient-centered care, integral medicine, integrative medicine

The chronic pain patient is one of the hardest challenges facing any physician. Axiomatically, this patient is the focus of the pain physicians' practice, and thus it is vital that the pain physician be able to recognize and respond to the special issues, demands and difficulties inherent to treating the person in pain. Often distraught and uncomfortable, with lives sometimes reduced to near-inactivity, pain patients frequently approach the physician literally begging for relief from pain. But (not unlike most people who have been reduced to begging) they are also frequently overtly or covertly angry, and disgusted with the limitations of medicine (as either science or art!). They desperately need help but may distrust or suspect the physician of not actually knowing and/or caring about them. They frequently seek narcotics, because that is the only relief they have known, and often in much higher doses than physicians are comfortable prescribing. They commonly say that they will "…*do anything*" to get past the pain, but the only thing that seems likely to happen is that they will take the medications offered. Other approaches (e.g.- physical therapy, mind-body techniques, acupuncture, massage, and lifestyle changes) may be deemed impossible because of the pain, or simply not happen for a variety of economic or circumstantial reasons. Physicians often respond with a variable mix of concern, disbelief, or negative emotions, and often the patients' cycle of anxiety and distrust begins anew.

Both the pain physician and chronic pain patient are in a dilemma: both want the pain to be managed as effectively as possible, with improved quality of life – and yet physician and patient often have vastly different ideas of how to achieve these ends. The patient's wish is a medical intervention that will make him/her feel better (i.e.- completely alleviating the pain, and often the resolution of the life-effects that pain has incurred) quickly and hopefully permanently. The physician knows that such a wish can be both unlikely and potentially dangerous. If we can "*take the pain away*" it is often at the cost of incurring considerable burdens and risks: danger of addiction, loss of clarity and effectiveness, potential for ever-rising needs for medications, etc. Thus, while it appears to the patient that he/she is asking for what seems to be a simple intervention; the physician recognizes its complexity and problematic potential.

How might we change the discourse from that of a supplicant asking an expert to make their life better to two people with different stakes facing a dilemma together given that 1) patients often feel as if physicians do not understand or care about the depth and extent of their pain and 2) physicians often feel that patients have no awareness of the complexities represented by the escalating use of narcotics for pain relief? We believe that a new paradigm is needed that facilitates active physician-patient

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relating, that establishes the physician-patient dyad as team, in which each individual brings relative expertise and different insights to the same problem.

The current paradigm of acute health care situates patients and physicians within a superficial scheme of seeking symptom reduction or relief. This paradigm establishes an isolated, "do-something-now approach" that de-contextualizes the pain and puts the physician in the position of either doing something that is immediately helpful or not. "I am coming to you with a serious issue – it's your job to make me feel better" is the unwritten implication within this encounter, and this explicitly assumes the tenor of an overt contractual relationship that is built upon a unrealistic premise, and foils the intentions and abilities of both physician and patient. For even when pain is appropriately redefined and treated as a chronic illness, it is common for the pain patient to regard it as an acute issue requiring an immediate solution, and re-instigate the un-realistic demands upon the physician, and the clinical relationship.

GOAL-DIRECTED HEALTH CARE (G-DHC)

We propose a new approach, Goal-Directed Health Care (G-DHC), for the care of the chronic pain patient (as well as the care of other chronic illness). G-DHC alters the physician-patient relationship in several dimensions: 1) greater equality between physician and patient through 2) more shared responsibility; 3) development and maintenance of a larger, longer term context to care rather than the 'make me feel better now' and 'turnstile' mentalities of patients and physicians, respectively; and 4) a shared understanding of the patient's fundamental life goals as a major basis for medical decision-making. The incentive for G-DHC is relatively straightforward: help the patient articulate his/her primary life goals (inclusive of, and beyond the pain/illness experience) as a basis for evolving pain control strategies that serve those goals.

G-DHC moves away from the idea of the physician simply "taking care of" the patient, and moves toward a shared decision-making process based on the physician's teaching about what will (or might) make the most difference to the patient. It replaces symptom reduction - the unstated but actual goal of most medical encounters - with progress toward larger goals that embody patient values. It implies that the physician expects less overt control, assuming instead the role of knowledgeable consultant and supporter while the patient is more empowered to make informed decisions. Those decisions may or may not appear to be sensible – at least at face value- to the physician, or be the ones that the physician wishes the patient would make. But ultimately, such decisions reflect patients' wishes and choices, and also rest upon the patient assuming some active level of responsibility for the consequences of (informed) choices that are made.

G-DHC: A BACKGROUND

A search for previously published literature on G-DHC using Ovid, MedLine, CINAHL, and PsychINFO databases (with query terms of goal-directed medicine, goal-oriented medicine, patient-oriented medicine, chronic pain, quality of life, physician-patient relations) yielded no specific references related to G-DHC as we present here. While much has been written about specific disease-oriented goals for pain management, the risks of analgesic abuse as well as of under-treatment and other patient-centered care issues (1-3), there is not a substantial medical literature that addresses the higher order life goals that comprise G-DHC. Instead, the stage-setting for such an approach is found in the human performance and psychological literature. The flavor of this has been established by Earl Nightingale's definition of success as "…the progressive realization of goals that are worthwhile to an individual" (4). For the patient in pain, it would seem that getting rid of, or controlling pain is one of the highest priority goals, and that any other goals are subsumed by this. Yet, this leaves the patient and physician in a quandary: if we adopt Maslow's hierarchy (5), for example, the pain patient is "stuck" at one level until that need (i.e.-freedom from pain) is satisfied. Approaching the problem non-hierarchically, but rather heuristically allows the vector of change to move to transcendence. This is necessary for the patient to move beyond a sole focus on the biological, social, psychological, and even spiritual dimensions of the seemingly overwhelming pain experience. This kind of change in referent is what psychiatrist Viktor Frankl observed and detailed in his book, *Man's Search for Meaning.* While imprisoned in a Nazi concentration camp, Frankl noted that those fellow concentration camp inmates who survived did so because they seemed to have had a purpose and meaning beyond the focus on the horrific, day-to-day experiences of the camp (6).

Many pain patients surely see themselves, at times, as likewise imprisoned by the constraints imposed by pain upon their body and activities. To survive and thrive in spite of this requires a transcendent or transformational process. Such a dynamic of change and change agency is well described in the works of Wilber (7, 8), Quinn (9), and Beck (10) which purport that value derives from increased self-awareness, enlargement of consciousness, and the choice to grow and transform not only in the face of pain and suffering but because of it. However, depending on the psychological readiness of the pain patient, the kinds of transcendent goals and the steps to reach them might be very different. A person afflicted with pain who sees it as a "punishment" may be willing to endure it until a spiritual solution is found while one who is frustrated by his/her pain from achieving career goals might be best motivated by an alternative career path that can be managed despite the painful state. Recognition of these goal domains, as well as the patient's pre-contemplative-, contemplative-, and action-readiness to change is essential (11). This approach requires "motivational interviewing" techniques as well. A key to motivational interviewing is "…allowing patients to explore their own ambivalence for change"(11).

Patients' attitudes are shaped by their own words, not by those of the practitioner. This allows for internal examination that can be a powerful trigger for change (12); providing a familiar, though incompletely expressed context for the G-DHC interview and subsequent process. Discussions of cultural psychiatry, anthropology, ethnic, and cross-cultural issues in the medical context address the challenges to the provision of care and overall goal-setting when languaging, traumatic experiences, and values of the care provider and the patient or family differ substantially (13-15).

Confounding the problem of communication about patients' life goals is the pluralism of contemporary society that has altered (to some degree) the fundamental, moral concordances between physicians and patients. The medical ethics community has struggled with this issue as it directly impacts the question of moral agency (16) as germane to the proper role of the physician in the therapeutic relationship. Reconstruction of the relationship between physician and patient is currently called for as possible and necessary (17-19), and this call may be addressed to some extent by the model of G-DHC that we are proposing.

Finally, it is crucial that clinicians provide continuous, positive support for even the most unexplainable symptoms that a patient may be experiencing, for failure to do so could incur far-reaching negative effects upon both the clinical encounter, and the subsequent physician-patient relationship, as a whole. It was recently shown that patients' coping skills and abilities are enhanced when physicians overtly express direct interest in providing ongoing health-related support (20). Interestingly, while 62% of patients saw clinician support as vital, only 2% of clinicians saw it as instrumental to patient-centered clinical interaction. In fact, substantial clinician dissatisfaction is centered upon the failure of the 'expert knowledge' model of care when there is persistent inability to resolve unexplained symptoms, including pain. G-DHC can foster better communication about expectations for patient coping, clinician support, and functional improvement, by helping align therapeutic goals and anticipations with the broad and powerful traction of life goals. Indeed, these may often transcend purely biological goals (21) and enter into realms of patient values that are experiential (and may have significance for patients on a more spiritual level) (22). Thus, the clinician must have or develop resources and /or expertise to refer to clergy, chaplains, or others trained and skilled to address patient life goals and needs at this level.

HEALTH GOALS AND LIFE GOALS

As described, G-DHC reframes the sickness encounter into one of hope and possibility. The patient is led through a brief process of reviewing and exploring his/her most important life goals, beyond the sick role, and for which he/she wants to regain health and wellness. Health goals are always separated from life goals and the rule of thumb is that all health goals must serve one or more life goals, or there will be little or no change-energy behind them. Further, health goals can, and often will change from encounter to encounter, while the life goals of patient may not change to any significant extent.

For the pain patient, this focus changes the conversation from the goal of "*being free of pain*," or "*getting a refill on my narcotics,*" to those that are more existential and essential regarding what matters in his/her life. What the patient would actually do with life if medical needs were met becomes the central issue. For what end does he/she want to be well? What really matters to and in his/her life?

Questions that attempt to identify life goals are important, are not trivial, and include: "*What do you care most about in your life, and why?*"; "*What is the most valuable and enjoyable part of your life?*"; "*What is most worth living for?*"; "*What, if you could not have it, would make life less (or not) worth living?*"; "*What do you want to be able to do that you can't do now?*"; "*What do you worry about not being able to do in 2-5 years that is important to you?*"; "*How long do you imagine you will live?,*" and "*How important is it to you to live long?*"

These kinds of questions reframe and recontextualize the experience of pain and help to reveal and/or illustrate different horizons of possibility. The goal is to get the patient beyond immediate symptom relief so that he/she can make intelligent, informed choices based on the most fundamental individual desires. (See Table 1)

Table 1. *Sample questions for Goal-Directed Health Care.*

What do you care most about in your life, and why?
What is the most valuable and enjoyable part of your life?
What is most worth living for?
What, if you could not have it, would make life less (not) worth living?
What do you want to be able to do that you can't do now?
What do you worry about not being able to do in 5 years that is important to you?
How long do you imagine you will live?
How important is it to you to live long?
What is your greatest dream, what you still wish to accomplish in your life?
If you had 6 months to live, how would that change what you are doing now?
In response to any answer to above questions: Why? Repeat as needed to make clear the difference between health goals and life goals. (e.g., why would you want to have no pain – what would you do once pain-free?)

The treatment of patients' pain represents one of the most effective uses of G-DHC. Pain patients become focused upon symptom (pain) removal at almost any cost. Having lost their enjoyment of life to the pain, they become narrowly perseverant upon the outcome of "not hurting," without any particular awareness of what such freedom would allow. As a result, the freedom from pain becomes an end in itself, and any method toward this end will suffice. The goal of "no pain" or "less pain" is an abstract, impersonal goal that may never be fully achieved. As well, it is a poor goal, because even if it is reached, it is continuously self-monitored for how long it will last, and invariably it will not last long enough. In contrast, functional goals (e.g.- "I want to work in my garden," "… we want to be able to visit the kids…") are healthier, more positive, and more attainable.

In addition to an intense desire for the physician to passively remove or alleviate pain, patients often develop the fantasy that the physician can take the pain away, if only she *would*. The patients' imagined role in this scenario is that they need do nothing except to be available for treatment. The result is that patients have neither a healthy goal in mind, nor a healthy process to achieve more realistic goals (i.e.-what choices must be enacted to achieve goals by working together with the pain physician). The blind pursuit of an effective (viz.-magic) cure becomes an entire undertaking. However, with G-DHC, the process has a much broader focus, recognizes and acknowledges a healing versus solely curative model of healthcare, and the question changes from "*will the physician cure/save me?*" to "*Can I/will I do the things that will make a difference in my life?*"

Pain patients often epitomize the person who turns him/herself over to the prospect of passive, curative intervention that is often impossible to provide. The underlying message is, "… *make me feel better,*" yet, the underlying reality is that the means to fully achieve such an end are sometimes, if not frequently not within the control of the physician. By sheer circumstances of time, it becomes obvious that the patient is 95% responsible for what happens beyond the boundaries of the clinical encounter. Yet the physician is often the one motivated to try another test, a louder urging for cooperation or admonition against certain behaviors, and a search for new or better treatments - all with the concomitant feeling of failure when these results cannot be realized.

This paradigm reflects a fundamental misallocation of responsibility. The idea of the patient doing something different or better often becomes a vain wish for the physician, and therefore becomes something of an idealized expectation that can generate frustration for both patient and physician alike.

CHANGING THE DIALOGUE

However, such expectations persist; not least because far too often the physician is rendered professionally impotent without the explicit cooperation of the patient. Yet physicians frequently do not know how – or often even if it is acceptable – to ask the patient for improved cooperation in order to become a reciprocal partner in the process of long-term care. When and where it feels acceptable, the physician is often reduced to challenging, and/or pleading the case – things that simply do not work well (11).

How then can we evoke change so as to allow for a better cooperation, shared responsibility and more effective patient involvement in pain care? It is in this light that G-DHC was specifically developed as a way to change the discourse with chronically ill patients. The new discourse basically begins by determining what the patient values (in life), and what specific, objective life goals arise from these values, and are explicitly desired. This moves the physician to a role of understanding the patient's values and goals, and informing and recommending those ways that these could be best achieved, and helping the patient to sift through various choices and options. But ultimately, the patient must be responsible for their choices, and the execution of the acts toward such choices. In other words, it communicates to the patient that: "*You must recognize and choose what your goals are, what to do, and whether or not you will do it. I cannot be responsible for that, and I cannot do things for you.*" (See Table 2)

Table 2. ***Differences in the Narrative Between Problem-Oriented Health Care and Goal-Directed Health Care***

Narrative in Problem-Oriented Health Care	**Narrative in Goal-Directed Health Care**
Eliminate pain	Find what important thing(s) pain prevents
Pathography (story of illness)	Future biography
Problem-focused and immediate symptom-focused	Goal-focused
Emphasizes problem solving and symptom reduction	Emphasizes creativity and establishment of important, life-giving realities
History; repetitive patterns of dysfunction	Future; possible scenarios of vital activity
Regrets, fears, doubts	Hope, aspirations, possibilities
Push toward health by physician often responded to with patient resistance	Pull to health by patient as part of a team

In teaching patients about this process, the metaphor of a mountain-climbing guide is often used. The guide (i.e.- the physician) is responsible for knowing the routes and equipment and schedules for getting to the top, but he/she cannot carry anyone up. Instead, he/she can help the climber (i.e.- the patient) judge how high to scale, what is needed to make the climb, and what will favor a good probability of (relative and self-relevant) success. As well, the guide can relate what has happened to others who have succeeded or failed at the ascent, but in the end, each climber must do the work to make it to the goal (which, incidentally, need not be the summit). This represents a fundamental shift of responsibility in choice that we feel is both long-overdue, and which the contemporary medical system has not taught physicians how to negotiate.

A New Vision Of The Healing Encounter

Reformulating the physician-patient relationship along these lines is difficult. It challenges expectations of both the patient and the physician (or other health care provider). Although this approach regards the "readiness to change model" (1), it also critically relies upon the willingness to redefine the topography of the healing relationship. While patient-centered, it moves the expectations from the "fix me" perspective, to a more holistic, shared and integrated approach to patient-focal goals, over and above simple passive, symptomatic control. For the physician (or other healer), it reverses the polarity from "push" or "pull," in which the physician and patient are in tension about what is important, to a new, shared, inter-subjective dynamic. The new dynamic states: "*…tell me what really matters to you, and I will give you the information and viable tools that help you to decide what is worth doing and commit to a path to get it done.*" This means that the patient is clearly a principal agent in the change process. The exhausting urging, prompting, and lecturing by the physician are no longer expected to be the catalysts for change. The physician's role becomes one of clarifying choices and how they relate to the patient's avowed life goals, and providing the medical (i.e.- intellectual and technical) and relational support required for the patient in his/her difficult task.

The patient's new role is to redefine the question of what he/she cares about, wants, and will work for. Because the focus is on desired positive outcomes, not merely on symptoms and problems, the patient's autonomy and self-responsibility are enhanced rather than undermined. We are working in the patient's area of expertise (e.g.- what he/she cares about, and what he/she will do to achieve such goals) and utilizing our own expertise as well (e.g.-what is wrong with them and what can we do about it.) Instead of being in constant tension with the physician, patients are reminded again of the goals that they have defined as important, and are guided so as to remain focused on what they most wish to attain, in specifically functional terms. Esoteric or obtuse goals, such as "…I want to have a happy life" would not be helpful; instead, it is more important to help the patient understand what makes for a happy life (e.g.-family, work, hobbies, achievements) and how objective goals within these domains might best be realistically achieved, via a process of patient and physician reciprocally sharing tasks and responsibilities within the respective domains of expertise and competence. The following cases provide examples of how G-DHC can be utilized to foster such a process.

Case 1

Patient was a 62-year-old, female chronic pain patient who was in a protracted battle with her physician for more narcotics to manage her "unbearable pain". When the referring physician, Dr. X asked for a G-DHC consult, after explaining to her the concept of G-DHC, the conversation proceeded as follows:

PHYS: So what do you really care about? What would you do if you didn't have the pain?

PT: I just want to get rid of the pain. I can't stand it anymore.

PHYS: Of course you do. What I am interested in is what you would do if you didn't have the pain. What matters to you so much that you would be willing to work towards it?

PT: I am not sure what you mean, Doctor. I really care about getting rid of this pain and getting on with my life.

PHYS: And what would be the most important things to you if you could get on with your life?

PT: My kids and grandkids are the most important things in the world to me. I would like to care for my grandkids so I have more time with them and so their parents can work and make some money instead of paying for day care.

PHYS: So you'd really want to step in and take an active role with the younger generations? Really make a difference in their lives?

PT: Exactly. And it would be better for me. But I can't do it with this pain.

PHYS: But you'd have to be pretty clear-headed and on top of things, yes?

PT: You bet. Four kids under 10, and two of 'em not in school yet. It's a lot.

PHYS: So if the medication made you foggy, you couldn't even do it! That would be a waste.

PT: That's true. But I can't do it with all this pain either.

PHYS: Right. I get that. So we need to find a way to ease your pain that lets you do what you care about doing – that lets you feel good enough to do it, but doesn't make you so foggy you're not responsible.

PT: Well, couldn't the Oxycontin do that?

PHYS: Not from what I hear from your doctor about the kind of dose you're on. No one - neither you, your kids, nor Dr. X. – would feel good about you tending the grandkids on that much medicine.

PT: Whew! They didn't tell me that. Dr. X. never mentioned that. That's not good.

PHYS: That's because you and Dr. X never talked about why you wanted to get over the pain, you just worried about the meds and the dose and all. We are trying to get better about putting that together with the why, so we're aiming people towards what matters to them.

PT: So what do I do? I'm in a box here. I didn't realize…

PHYS: It's not for me to say. I do know this: there are a lot of things you can do for pain that have no bad side effects of that kind. What Dr. X and you and I need to do together is to figure out what you can do for the pain that makes your goal more possible…

The case progressed with Dr. X. presenting the patient with a variety of possible approaches that could help with her pain and her mobility. These included joining a mind-body group working on symptom reduction through increased mindfulness, deep breathing, and imagery. She also enrolled in a water aerobics physical therapy program for 12 weeks. Throughout the process, there was dialog about her choices and her desired outcomes, about ways her children and grandchildren could be part of her recovery, and her larger pain treatment (taking walks together, throwing a medicine ball with her, etc.). The biggest change was in the process between the patient and Dr. X., where the constant struggle for more and more narcotics changed substantially, and the patient started to take more interest in managing the pain by using the lowest effective dose, as recommended and needed.

Case 2

The patient was a 50-year-old female who came to the physician taking 600-700 mg of long acting morphine daily for severe arm pain. The pain resulted from a brachial plexus injury during lymph node dissection for breast cancer. She had been under the care of the pain clinic which kept her on maintenance doses such as this, but she wished to find alternatives to being on such high doses. Specifically, she was interested in acupuncture, or other less pharmacologically-based means of pain control. In reviewing her case, the physician recognized that the pain had a well documented anatomical cause, and also came to believe that the patient was sincerely interested in reducing her pain medication or even eliminating it. She was unemployed because of the pain, and felt that there was little she could do because the pain medication made her unable to concentrate.

PHYS: So, what is it that you really see as the best outcome in this situation?

PT: I just want someone to believe all the pain I am in. The folks in the pain clinic look at me as if I am a junkie, and I don't like that.

PHYS: Well you are on rather high doses of medication.

PT: I know and I'd really like to cut back. That's why I have an interest in acupuncture.

PHYS: So what is your goal if we reduce your pain and your medications? How would you like your life to be?

PT: I want to start my own tax consulting business. I was working as an accountant before my surgery, you know. Also, I'd like to be able to take better care of my mother, as she is well over 80 now and I feel like I can't help her much because of my problems.

PHYS: Alright, so you want to be free enough from pain and the effects of medications that you can be clear enough to return to your profession and to help your mom remain independent.

PT: Yes, that's it.

PHYS: I respect and honor that and believe we can work together. Let's schedule an appointment for acupuncture and talk about a gradual decrease in your morphine dosage.

PT: You will give me my medications won't you?

PHYS: Yes, but only as much as you need to control your symptoms and at the same time be able to function towards your life goals. Is that fair?

PT: Yes, thank you. You don't make me feel ashamed of myself for being on medication.

PHYS: But that's because *you told me* what you really want, and it's my job to help you achieve that. Let's schedule your next appointment and let me fill out my triplicate for a dose that is 10-25% less than what you are on now. You must stop getting prescriptions from the pain clinic or elsewhere while we work on adjusting your dosage.

PT: Will the acupuncture help me to do that?

PHYS: We will give it a try. The main thing is that we are going to try some new things to help you move closer to what really matters to you.

Within 3 months, the patient had reduced and maintained her daily usage of MS Contin® from over 600 mg to 180 mg. She was spending more quality time with her mother and had enrolled in evening classes at the community college to expand her knowledge of tax law. While she couldn't afford regular acupuncture after the first few helpful sessions, she has maintained a more consistent, active way of managing her pain and her life.

Conclusions

As these cases illustrate, G-DHC can involve aspects of both patient-centered care and relationship-centered care. Even a physician who has known a patient for many years can learn entirely new dimensions and aspects of a patient's reality and worldview by asking questions about, and then sincerely listening to the answers regarding patients' life goals. This type of interaction and the dialogue it produces vastly enriches the patient's opportunity to view him/

herself as being made "whole" as consequential to the healing process, and as having played an important role in that re-integration. It provides an opportunity for the physician to enter enhanced levels of empathy, compassion, and understanding. It re-centers the relationship in the precise question of what values, goals and choices are important to the patient, and what must the patient do – by working together with the physician - to achieve these goals.

We hope to replace the scenario of frustrated physicians and patients involved in an unproductive and non-healing relationship. In G-DHC, physicians act as change agents to allow the patient to commit him/herself to healthier behaviors by choice. It is clearly the patient's goals that matter. However, in this model, physicians are no longer merely "taking care of" patients, but rather are helping patients to take responsibility for being a partner in their care, as they move toward realizing important life goals. Or not; for if patients choose not to acknowledge this role and accept responsibilities for cooperation and change, then physicians must acknowledge that this is both the patients' choice and their responsibility. But will the dynamic of "*fix me*," "*refill my medications,*" and "*take away my pain*" start anew at this point? Perhaps not; if the topography of the therapeutic relationship has sufficiently changed, the patient now better understands that the physician is acting from a beneficent imperative, and not a position of antagonism, hostility, or mistrust. It becomes clear(er) that the physician really desires that the patient move to his/her realistically addressed and recognized personal goals, beyond the imposition of pain and the issues it manifests. This is a new level of relationship-centered care for both patient and physician.

What is different about G-DHC is that if the patient chooses not to pursue healthy choices, it is seen as a distinct choice, with consequences, and the physician is not expected to assume sole responsibility for "making the patient better". By helping the patient to identify his/her most important life goals, physicians can work to relate and realize the connection(s) between patients' life goals and health goals. This allows physicians to enhance the quality of their patients' lives, and may lead to enhancing the quality of the healing encounter, and ultimately to the satisfaction of both the patient and the physician. Wellness- in the most literal sense- becomes the goal instead of avoidance of pain or the problems of illness-associated morbidity, and pain medicine becomes better able to embrace a healing role for those patients in whom pain may not be able to be cured.

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REFERENCES .

1. Verbeek J, Sengers M, Rikemens L, Haafkens J. Patient expectations of treatment for back pain: a systematic review of qualitative and quantitative studies. *Spine* 2004;29:2309-2318.
2. Wagner EH, Bennett Sm, Austin BTG, Breene SM Schaefer JK, Vonkorff M. Finding common ground: patient-centeredness and evidence-based chronic illness care. Third American Samueli Symposium, Developing Healing Relationships, April 21-22, 2005. *Journal of Alternative and Complementary Medicine* 2005;11(Supplement 1): S7-15.
3. Tresolini CP and the Pew-Fetzer Task-Force. *Health Professions Education and Relationship-Centered Care.* San Francisco: Pew Health Professions, Commission, 1994.
4. Nightingale E. *Lead the Field* audiotape series, Chicago: Nightingale-Conant, 1973.
5. Maslow A. *Motivation and Personality.* New York: Harper & Row, 1970(2nd ed).
6. Frankl VE. *Man's Search for Meaning.* New York: Simon and Schuster, 1984 .
7. Wilber K. *Integral Psychology.* Boston: Shambhala, 2000.
8. Wilber K. *The Integral Operating System,* Version 1.0. Boulder: Sounds True, 2005.
9. Quinn RE. *Change the World: How ordinary people can accomplish extraordinary results.* San Francisco: Jossey-Bass, 2000.
10. Beck DE, Cowan CC. *Spiral Dynamics: mastering values, leadership, and change.* Malden, MA: Blackwell, 1996.
11. Rollins S, Mason P, Butler C. *Health Behavior Change.* A Guide for Practitioners. Edinburgh: Churchill Livingstone, 1999.
12. Rakel D. Motivational Interviewing Techniques in Rakel D (Ed.) *Integrative Medicine.* Philadelphia: Saunders, 2003, p.732.
13. Lewis-Fernandez R, Kleinman A. Cultural psychiatry. Theoretical, clinical, and research issues. *Psychiatric Clinics of North America.* 1995;18:433-448. .
14. Fadiman, A. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures.* New York, NY: Farrar, Straus, and Giroux, 1997.
15. Buck T, Baldwin CM, Schwartz GE. Influence of worldview on health care choices among persons with chronic pain. J *Alt Compl Med* 2005;11:561-568.
16. Giordano J. Moral agency in pain medicine: philosophy, practice and virtue. *Pain Physician* 2006;9;41-46.

17. Pellegrino ED. Toward a reconstruction of medical morality. *Am J Bioeth* 2006;6:72-75.
18. Veatch, RM,. Doctor does not know best: why in the new century physicians must stop trying to benefit patients. *J Med Philos* 2000;25:701-721.
19. Veatch RM. The place of care in ethical theory. *J Med Philos* 1998;23: 210-224.
20. Nordin TA, Hartz AJ, Noyes R, et al. Empirically identified goals for the management of unexplained symptoms. *Fam Med* 2006;38(7):476-482.
21. Gallagher RM. Biopsychosocial pain medicine and mind-brain-body science. *Phys Med Rehabil Clin North Am* 2004;15:855-882.
22. Giordano J, Engebretson J. Neural and cognitive basis of spiritual experience: biopsychosocial and ethical implications for clinical medicine. *Explore* 2006;2:216-225.