



Book Reviews

Health Behavior Change: A Guide for Practitioners

STEPHEN ROLLNICK, PIP MASON & CHRIS BUTLER

Churchill Livingstone, Edinburgh (1999)

225 pp., ISBN 0443058504, US\$19.00

This is an excellent book. It deals with one of the most challenging and frustrating aspects of the helping professions—assisting patients in their efforts to adopt health-promoting behaviors. The result of a collaboration between a clinical psychologist, a nurse clinician, and a physician; this book is relevant to a wide range of health care professionals. A masterful blend of theory and application, there is something for everyone in this concise, easy to read volume. The principles it covers are relevant to any form of behavior change, whether it be smoking cessation, the adoption of an exercise program, or adhering to a medication regimen.

The authors provide a succinct and accessible overview of the theoretical foundations of health behavior change and motivational interviewing. But the main strength of this work is in the way it breaks the process down into discrete “microskills and strategies.” These strategies include suggestions for accomplishing the various tasks that go into helping another person identify behaviors that might be changed; assessing the patient’s readiness for change; developing patient-generated tactics for accomplishing change; and dealing with resistance and relapse. Throughout, the authors provide ample illustrations and examples that should enable the reader to operationalize the abstractions of the stages of change model that are presented.

The book also offers numerous, and clearly labeled, examples of “how not to do it” at various stages of the process. I suspect many well-intentioned clinicians will recognize themselves in these examples. Most of the errors made by practitioners in their efforts to help patients adopt health-enhancing behaviors grow out of faulty or untested assumptions that are all too commonly held by health care professionals. A careful read of this book will help clinicians spot these assumptions in their own practices and recognize just how unhelpful interventions based on these assumptions can be. One of the beauties of the way this book is organized is that a practitioner having difficulties with a particular client should be able to quickly identify specific portions of the book that will aid in diagnosing the problem and suggesting strategies for dealing with the current challenge. The one topic that was not dealt with is that of time. Many of the steps required in implementing the methods described in this book could be time-consuming. I suspect that physicians will be particularly sensitive to this issue. In subsequent editions, and I hope there are many, I urge the authors to deal with this potential source of resistance to the behavioral changes they are hoping professionals will make.

In short, this is a useful book and one that I think should be on the bookshelf of every practitioner. But don’t let it set there gathering dust. Read it, refer to it, and

recommend it to colleagues who are frustrated with patients who “won’t do what they need to do.”

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The Scalpel and the Silver Bear

LORI ARVISO ALVORD & ELIZABETH COHEN VAN PELT

Bantam Books, New York (1999)

204 pp., ISBN 0553378007, US\$23.95

Dr. Lori Arviso Alvord is the first Navajo woman to become a surgeon. Currently she is the Associate Dean of Student Affairs and Minority Affairs at Dartmouth College Medical School. As an assistant professor of surgery, she cares for patients and teaches medical students and residents.

In *The Scalpel and the Silver Bear* Dr. Alvord tells two stories. The first is about how a girl from a remote Native American community in the United States traveled across “cultural, class and educational borders” to become a surgeon in “a medical world whose doors have been closed to minority people for most of its existence.” The second story is about “how ancient tribal ways and philosophies can help a floundering medical system find its way back to its original mission: healing.”

The stories are universal, so they can be enlightening for health professions educators and professionals throughout the world. This book should be particularly helpful to educators who work with students and/or with patients who are from different cultural backgrounds.

Lori grew up in a family that had little money, power, or influence. Very few Indian people were physicians. Although her parents did not have college degrees, they encouraged Lori and her two sisters to get an education. At age 16 Lori was one of only six students in her high school class of 58 who went to college.

At Dartmouth College, there were about 50 other native students. Even so, Lori experienced culture shock: “I thought people talked too much, laughed too loud, asked too many personal questions, and had no respect for privacy. They seemed overly competitive and put a higher value on material wealth than I was used to.” Lori missed traditional clothing, ceremonies, and her favorite foods. However, she and the other Native American students created a group that nurtured and supported each other.

After graduation, Lori’s fascination with the human body led her to Stanford Medical School where she was one of only three Native Americans. Once again she was lonely and found it difficult to be competitive and to draw attention to herself. She was accused of being remote and disinterested. Yet it was hard for her to behave any other way. “Silence is a normal part of Navajo communication; words are used sparingly and weighed carefully. It took me a long time to be comfortable with the non-Navajo style of learning.”

During medical school Lori had to deal with Navajo taboos. Dissecting a cadaver meant breaking the taboo against touching the dead. Examining and operating on patients

required breaking the taboo against touching another person, especially a person one does not know. Asking patients sensitive and probing questions required breaking the taboo against asking personal questions.

Lori knew that she wanted to be a surgeon and that she wanted to help her people. Doing so meant not only continually violating taboos but also facing other obstacles. At that time only about 4% of practicing surgeons were women. Further, there were only a few Native American surgeons in the world, none of whom were women.

In dealing with these formidable obstacles, Lori had the help of an Indian physician who shepherded her through rotations at a hospital near the Navajo reservation and became her mentor, friend, and later, her colleague. With his guidance, she was accepted into the very competitive surgical residency program at Stanford.

After completing her residency, Dr. Alvord joined the Indian Health Service and worked at a medical center, 50 miles from her hometown. She thought that she could fit easily back into the Navajo community, but discovered that because of the ways in which her education had changed her, coming back was as difficult as leaving. "Although I was a good surgeon, I was not always a good healer. I went back to the healers of my tribe to learn what a surgical residency could not teach me."

Alvord was reminded of the concept of "Walking in Beauty," which means caring for your mind, body, and spirit and having the right relationships with your family, your community, the animal world, the environment, the planet and the universe. People, she decided, want and need health care that "connects rather than isolates." Alvord discovered that patients who went through traditional ceremonies prior to surgery were calmer and had better outcomes. Alvord also learned, "The scalpel is my tool, as are all the newer technologies of laparoscopy, but my 'Silver Bear,' my Navajo beliefs and culture, are what guide me."

During her medical education, Alvord was not drawn to join academic medicine because so many of the academics she met were competitive and "not fun to be around." Then she was invited to apply for the position of Associate Dean of Student Affairs at Dartmouth Medical School. After going through a very competitive process, Alvord was offered the job.

Alvord knew it would be very difficult to leave her people and the beauty of southwestern United States. Then she considered the benefits: "For Navajo people, I would be breaking another glass ceiling, which might make it easier for others to follow a medical path in the future." Alvord could also influence prospective physicians and teach Native ways of thinking about the healing process.

Now, admissions is one of five programs under Alvord's supervision. In a telephone interview, she challenged the conventional approach of selecting medical students largely on the basis of their prior academic performance. This approach she said can result in the admission to medical school of "competitive, even cut-throat" students. If we want our future physicians to be empathic and altruistic, this approach, she says, is "upside down." Other cultures, such as Native cultures, select healers who have demonstrated an ability to think and live like a healer, people who are role models and communicate well with others.

Most of Dr. Alvord's patients are not Indian. However, she still uses Native approaches without labeling them as such. She listens carefully to patients, builds trust, and encourages patients to be active participants in their healing. Before surgery, Dr. Alvord works to ensure that patients are well informed, relaxed and in balance in their life and their world.

When Dr. Alvord teaches these approaches to her students, some students wonder how they can do this when they and most physicians are being forced to see more and more patients per hour. Dr. Alvord replies: "I do not know the answer. But what works for me, whether I have 5 or 55 minutes, is to give myself completely to my patient for that time. I listen to them and let them know that my attention is completely focused on them and that this is their time. It isn't the entire answer, but it helps."

Hospitals and clinics with square walls, harsh lighting, and cold chrome are not Dr. Alvord's idea of good places for people to heal. "I would love to see Native leaders in health care begin to design models of health care that include our culture, our way of thinking, our spirituality, our ways of interacting." Medicine men should be involved. The physical structure should reflect "the ways that we see beauty, the art that we create." Perhaps it would have adobe walls and natural smells such as roasted green chili and fresh corn. It would be "light-filled and warm, with generous and comfortable seating for relatives." There would be porches and gardens. "In addition to state-of-the-art operating rooms and equipment, there would be a ceremonial space, for use by any who felt the need for it." Even the grounds on which the hospitals and clinics are built should "honor the relationship that we have to the earth and to animals." For example the grounds might be farmland with horses and sheep. In short, Alvord, this Navajo woman who walks competently in both the traditional world and the high-tech world says, "We need to reclaim our healing."

Reading Alvord's fascinating book we are introduced to a woman who is likely to play a role not only in helping indigenous people reclaim their healing but also in helping the troubled western medical system find its way back to its original mission of healing. For now Alvord will do this work from her base at Dartmouth. However, during her last 10 years of practice, she plans to be back home on the Navajo reservation working directly with her people again.

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