Cowboys and Horse Whisperers: Changing Paradigms of Diabetes Education and Care

Barbara J. Anderson, PhD

Editor's note: *This article is adapted from the address Dr. Anderson delivered as the recipient of the American Diabetes Association Outstanding Educator in Diabetes Award for 2003. She delivered the address in June 2003 at the Association's 63rd Annual Meeting and Scientific Sessions in New Orleans, La.*

I grew up in Texas, so I learned that a cowboy's job was to break horses, that is to use tactics such as fear and domination to control or "break" a horse so that the horse would submit to a saddle, bridle, and rider. Later on, as an adult, I discovered horse whisperers, who used tactics such as observing and learning a horse's natural language and understanding and respecting the innate nature of the horse as a flight animal. In this way, a horse whisperer could "join up" with a horse, rather than "break" the horse, in order to saddle, bridle, and ride it.

These two strikingly different strategies for achieving the same goal of horse compliance to human authority hold lessons for us all as clinicians dedicated to the education and care of people living with diabetes. In this article, I will trace the story of how the cowboy paradigm of diabetes education and care has, over the decades, gradually transformed into more of a horse whisperer's paradigm. And because this article grew from a celebration of outstanding education, I will also discuss my two primary clinical mentors about the patient-provider relationship: Dr. Julio V. Santiago and Dr. Sarah A. Anderson.

A Mentor in the Art of Listening

I owe my fundamental education about diabetes to Dr. Santiago, who recruited me into diabetes care 25 years ago, when he saw a resume I had submitted in 1977 at St. Louis Children's Hospital in St. Louis, Mo. Dr. Santiago asked if I would be interested in working with him at the Diabetes Research and Training Center at Washington University. I told him that I knew nothing about diabetes, that I didn't know the pancreas from the pituitary gland. And he said, "I can teach you about diabetes. We need you to teach us what you know as a psychologist about normal development and family interactions."

What a superb mentor Dr. Santiago was! His intuitive respect and understanding for his patients was a solid foundation for me as I also learned about the intricacies of managing diabetes in "the dinosaur age," before the era of blood glucose monitoring. Among his tools, Dr. Santiago did not have the routine use of the hemoglobin A_{1c} assay. There were no insulin analogs, mixed insulins, or insulin pens. Small, user-friendly blood glucose meters had yet to be developed. Dr. Santiago's most valuable tool was his talent of listening to and respecting his patients.

Dr. Santiago died unexpectedly in August of 1997, and the diabetes community prematurely lost a premiere educator, researcher, and clinician.

The Cowboy Paradigm

Looking further back at the *real* dinosaur age of diabetes management, we remember the story of Elizabeth Hughes, which was recently related in the remarkable book *The Discovery of Insulin*, by Michael Bliss.[1] Elizabeth had diabetes and received one of the first insulin injections in the United States. Her story is remarkable because her negative experiences with diabetes education and treatment in the pre-insulin era in many ways continued even after the discovery of insulin.

In 1919, after seeking the best available medical opinions, Elizabeth's parents hospitalized her in the Physiatric Institute run by Dr. Frederick Allen, who had perfected the starvation of people with diabetes in order to prolong their lives by a few months. Allen's strategy involved complete domination of his patients' lives. As medical writer Austin Bunn has noted, "Dr. Frederick Allen's remedies blurred the line between treatment and torture."[2]

When Elizabeth entered Dr. Allen's hospital program, she was 11 years old and weighed 75 lb. Under Dr. Allen's direction, she fasted for 1 week and was then put on an extremely low-calorie diet, which included one day of fasting each week. Her weight plummeted to 45 lb.

Like all of his patients with diabetes, Elizabeth was assigned a personal attendant who scrutinized, weighed, and measured every bite she took and punished her for deviations from Dr. Allen's protocol. Elizabeth was a very compliant patient and rarely had sugar in her urine.

Dr. Allen's treatment strategy included obsessive scrutiny of his patients' food intake and severe punishment when any child or adult managed to find other things to eat, such as toothpaste or birdseed from a canary cage in the hospital. His treatment approach was a campaign to master the disease of his patients through domination and punishment. Without insulin, there was no other

choice in 1919—or was there?

Elizabeth was brought back to life by the discovery of insulin. As she and others slowly regained their strength and spirit, Dr. Allen, owner of the expensive starvation clinic whose patients no longer needed his treatment, went out of business.

We know from Dr. Bliss' book that Elizabeth Hughes went on to attend Barnard College, marry, and raise three children and that she kept her diabetes a secret for most of the adult years of her 74-year life. Why did this survivor keep diabetes a secret?

There is a certain irony in the fact that this most-written-about recipient of early insulin injections kept her diabetes under cover. It reminds me of an experience at the Joslin Diabetes Center, when my colleague Dr. Lori Laffel and I met with Katherine Astrove Adler, a wonderful, generous supporter of the center's pediatric programs. Mrs. Adler had lived a full life with diabetes and was dying of ovarian cancer when we met. I learned then that she had graduated from Mt. Holyoke College and that, like Elizabeth Hughes, she had kept her diabetes a secret for many years. Mrs. Adler told about giving injections in the closet of her dorm room out of sight of her roommates. This was a magnificently bold woman who lived with diabetes courageously for more than half a century and yet kept her diabetes a secret for the first 25 years.

In reading and reflecting on the diabetes treatment and education paradigm that prevailed in the pre-insulin era, I wonder if the seeds were planted then for a kind of cowboy paradigm of diabetes education and treatment that continued for more than half a century after the discovery of insulin. In this model, dominating patients was the standard.

Elizabeth Hughes died in 1981, and I suggest that the consequences of the paradigm of diabetes education and care she received both before and after the discovery of insulin involved unrealistically rigid rules for living. This paradigm was laced with plenty of blame and punishment for deviations, and it led to a sense of shame, a distrust of medical providers, and a wounding of the human spirit that was not easily healed.

The Horse Whisperer Paradigm

In contrast to the cowboy practice of breaking horses through fear and domination is the legacy of Monty Roberts, whose amazing discovery of how to use the language of wild horses led to the cultural popularization of horse whisperers through the Robert Redford film, "The Horse Whisperer," and the Nicholas Evans novel of the same name on which the film was based.[3] What many people don't know is that both the novel and the film were based on Mr. Roberts' 1996 autobiography, *The Man Who Listens to Horses*.[4]

Note that Mr. Roberts emphasized in the title of his autobiography not his role as a communicator or "whisperer," but rather his part as a listener to the natural language of horses. As he described in the book, "If you can use your skills as a trainer to open a door that a horse wants to go through, then you have a horse as a willing partner instead of your unwilling subject."[4]

How did Mr. Roberts learn to listen to horses? In his own words, "I watched my father breaking horses, and I was repelled by the violence involved in the traditional methods he and all the other ranchers used. I watched him tie up six horses at a time in a corral, the horses evenly spaced, and each one at his post. My father proceeded to tie up their hind legs so they could not move, and then he would deliberately frighten them by throwing a weighted sack at their hindquarters. Of course, they would resist. In my father's view, when the horses were totally submissive and showed no defiance, no matter what he did, then he had broken them. And 'broken' was the right word. These horses were traumatized and worked only out of fear. This was tyranny."[4]

Instead, he wrote, he sought "a nonviolent way of communicating my intent while respecting this horse's rights. It was up to me to listen, to read the signals, and to show that I understood the [horse's] language by the speed and accuracy of my response."[4]

Mr. Roberts rejects the term "horse whisperer" as too mystical. He believes that common sense and keen observation lead to first a conversation and then a contract between himself and the horse that he is "joining up with."

This concept that one need not frighten or dominate a horse in order to earn its cooperation or compliance strikes me as a remarkable parallel to our shifting paradigm of diabetes patient education and care in the 21st century.

A Mentor in Patient-Clinician Relationships

In addition to Dr. Santiago, my other primary mentor about patient-clinician communication was my younger sister, Dr. Sarah A. Anderson, a psychologically-minded physician who died unexpectedly a year and a half ago. My sister, whom our family called Sally, was remarkably attuned to issue of "counter-transference," the psychoanalytic term to describe how a provider's identification with a patient helps to shape the clinician-patient relationship.

My sister understood that patients whom providers viewed as less worthy or bad patients often got less timely and less adequate medical care. This realization led her to a career dedicated to providing quality health care to the homeless and disenfranchised. She served for a time as medical director for the Commonwealth of Massachusetts prison system. She was also a tireless advocate for quality health care for homeless people at the Shattuck Hospital Shelter in Boston.

From my dear younger sister, I learned about gardening, about butterflies and birds, and about how our training as clinicians or educators often does not prepare us for the psychological issues that arise when one in power "helps" one without power. I also learned from my sister about the remarkable book, *Who Has Seen a Blood Sugar? Reflections on Medical Education,* by Dr. Frank Davidoff.[5] In this wonderful poetic and philosophical book on medical education, Dr. Davidoff describes three essential elements that clinicians need for effective communication with patients:

1. getting at the patient's real chief complaint(s)
2. entering the patient's world and perspective without losing sight of the medical issues, and
3. monitoring ongoing interactions

with patients while at the same time remaining connected with the patient.[5]

I see a remarkable parallel between Dr. Davidoff's three elements and the philosophy of Mr. Roberts, the man who listens to horses.

Horse Whispering for Humans

Mr. Roberts changed not only the way we communicate with horses, but also the way we communicate with each other. Recently, hundreds of corporate officers from companies such as Disney, Xerox, General Motors, and AT&T have traveled to hear this horseman speak at his farm in California. What works with horses, he says, also works with humans; the name of the game is listening.

Recall Mr. Robert's rule: observe, understand, respect, and then converse. In other words, there is no "good communicator," no "best bedside manner." It's all about listening first and then individualizing from what you hear.

So why are corporate CEOs going to Monty Roberts, the man who listens to horses? They are going to learn the secret and the value of observing and listening, whether as prelude to having a conversation with a horse or with a human. Also, it could be they are hearing from this expert that it takes less time to listen and then converse than to dominate and intimidate and impose your agenda. And to these busy executives, as to many in today's health care environment, time is money.

Those who go to Mr. Roberts are learning that there are some truths that cut across species. They learn, for example, that "A horse . . . feels security in numbers. Isolate him and he will want to 'join up' with another creature, even a human—if the trust is there."[6]

In his second book, *Shy Boy: The Horse That Came in From the Wild*,[7] Mr. Roberts eloquently wrote that "The wild horse had decided that I was no threat. It was as though I were one of his family members scratching the top of his neck. I slipped a loose rope around his neck and schooled him to 'lead,' so he would follow alongside my saddle horse. He was not particularly resentful of that; as far as he was concerned we were both on the same team, of the same family."

Mr. Roberts was talking here about trust, the most fundamental foundation of all relationships.

Horse Whispering for Diabetes Educators

In the past decade, we have witnessed a dramatic transition in paradigms of diabetes education and care that have at their core listening just as Mr. Roberts recommends. First came the patient empowerment model based on the pioneering work of Dr. Bob Anderson and Martha Funnell at the University of Michigan.[8] At the heart of the patient empowerment model is the concept of providers listening to, and collaborating with, patients. As Ms. Funnell and Dr. Anderson recently wrote, "Within this model, our role is not to change our patients' behaviors, but to inspire, inform, support, and facilitate their efforts to identify and attain their own goals . . ."[9]

The second component of the recent evolution in diabetes education and care is the concept of "diabetes burn-out," which was first introduced by Joan Hoover, an astute listener and effective advocate for people with diabetes,[10] and has become practically a household word as a result of the work of Dr. Bill Polonsky, who listens so well to his patients.[11]

Throughout the evolution of our models of diabetes education and care, we have seen new signs of providers listening to and observing patients. One example is the stages of change model applied to diabetes by Dr. Laurie Ruggiero and Dr. Russ Glasgow. This model acknowledges the importance of observing individual differences in patients' readiness to make behavioral changes.[12,13]

One more reflection of the value of providers listening to and observing patients is seen in the diabetes coping skills model taught by Dr. Richard Rubin and Dr. Mark Peyrot.[14] Their method involves *1*) recognizing that patients are in control, *2*) starting with patients' agendas, *3*) helping patients specify their problems, and *4*) focusing on patients' successes.

There is no hint in any of these clinicians' methods of domination or its cousins, punishment, fear, shame, and blame. Their models do not suggest that there is a one-size-fits-all communication technique. Thankfully, our practices have shifted away from the cowboy paradigm of "breaking" patients to the horse whisperer paradigm of "joining up" with our patients in a mutual and collaborative way.

Most recently, diabetes clinicians have been encouraged by Dr. Paul Ciechanowski and his colleagues in Seattle, Wash., to pay attention to their own and their patients' "personal attachment styles." The term "attachment style" refers to a person's interpersonal style, which is based on their individual history of trusting relationships beginning in early childhood, in the family. According to Dr. Ciechanowski, " . . .patients with diabetes are more likely to adhere to treatment if they perceive that their providers understand their perspective and feelings and that their providers offer choices in treatment. A key component of such a patient-centered approach may be the provider's flexibility in attuning to a patient's unique interpersonal style—based on interpersonal needs, perceptions, and behaviors—rather than relying solely on generic 'bedside manner.'"[15]

We have come a long way since Dr. Allen's starvation protocols. As we move forward with the valuable and innovative technological and pharmaceutical tools we now have in diabetes treatment, I hope that we continue to move away from the cowboy tactics of domination and intimidation that ruled supreme both before and well after the discovery of insulin.

Today, in 2003, we have learned that it is by listening to and respecting our patients' agendas and by being open to our patients' language that we can come to adjust our most fundamental tools—our words, minds, and our hearts—to create a more meaningful "joining up" with our patients.

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Barbara J. Anderson, PhD, is an associate professor of pediatric endocrinology and metabolism at Baylor College of Medicine in Houston, Texas.