Patient-centred information and interventions: tools for lifestyle change? Consequences for medical education

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Life style related risk factors have negative consequences for many health outcomes. Although preventive actions undertaken on a population level are effective, these actions do not reach the individuals who could benefit most. Family doctors could reach many of these individuals when they consult them for other reasons. Unfortunately time constraints and competing demands as well as the fact that many practising physicians have not been trained in patient-centred communication and life-style interventions interferes with optimal prevention in primary care. Patient centred approaches can be helpful in prevention. Placing the subject on the agenda of a consultation, followed by a discussion of risks and symptoms that is adjusted to the patients’ context are a start. Information building on the patients’ existing knowledge is more effective than information in general. Patients can be motivated towards change through discussions, and empowered to make necessary changes. Of the available effective patient centred approaches this article discusses the ‘Stages of Change (Trans Theoretical) Model, motivational interviewing, problem solving and action planning, and demonstrates a combined approach using a family practice patient with a number of risk factors. Fortunately modern medical education does pay attention to patient centred communication in general. In order to have a positive impact on the health of populations, additional options for training in patient-centred techniques should become available in residency programmes, and in continuous medical education for those practicing physicians who are not yet trained in patient centred approaches.

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Mr. Swift is a 56-year-old divorced lorry driver. He works long hours. His 17-year-old daughter lives with him half of the time. They both smoke. Since his divorce he has gained 20 pounds. He is not aware of having a potential problem.

Introduction

Lifestyle-related risk factors contribute negatively to outcomes of many chronic illnesses and avoidable deaths in many countries in Europe and the rest of the world. To confront them, preventive actions are undertaken worldwide. These actions are mainly carried out on a population level, and although they are effective, they often do not reach the individuals who could benefit most. Many individuals, with one or multiple risk factors or with symptoms already, are not aware of the risks they are taking with their unhealthy habits and the (long-term) consequences. Generally speaking, many are not concerned about their own health; they are often not pre-occupied with health at all.

But almost everyone comes into contact with health care at a certain point, mostly for other reasons than risk factors or lifestyle, for instance when consulting a (primary care) physician for common (minor) health problems. In such cases, physicians are under the obligation to discuss not only the presenting health problem but also other conspicuous patient features, such as obesity, trying to raise awareness about the risks this person is taking with the overweight. Ideally, this
should be followed by a discussion about necessary changes in lifestyle, and support should be offered in making them.

Unfortunately many physicians do not have the time to engage in discussions about lifestyle matters during regular, busy everyday practice consultations with many competing demands and they do not feel confident to bring these matters up. After all, many practicing physicians have not been trained in patient-centred communication, and even less in carrying out effective patient-centred lifestyle interventions.

What makes it even more difficult is that changes in behaviour in general are difficult to achieve, even more so when these changes concern treatments in health care and lifestyle matters. Overall compliance/adherence with treatment is low. Effectiveness of advice giving in lifestyle changes is as low as 5–10%. Physicians tend to be very doctor centred when they are giving information and advice, using persuasion and not meant to scare the patient out of his wits. Even if the physician is an expert in these matters, he or she is not a salesperson, and persuasion and giving strong advice alone does not work.

Evidence shows that in all kinds of consultations, better outcomes are achieved with patient-centred approaches and involving patients more in consultations. In patient-centred consultations, there is more emphasis on a dialogue with the patient than in doctor-centred consultations where the doctor does most of the talking. There is also more attention for the patients’ context and not just a discussion of risks and symptoms. For instance when information is given in a patient-centred approach, this information builds on the patients existing knowledge, whether this knowledge is correct or not, and therefore techniques should be used to elicit the patient’s views first. Then incorrect existing knowledge can be modified and added upon. In lifestyle advice, a patient can be motivated towards change through discussions and empowered to be able to make necessary changes.

Physicians often not realize that placing the subject on the agenda of the consultation is a first and difficult task. This will only succeed if patient and physician share the decision that time will be spent discussing these matters, and not when it is something the doctor alone has decided that is necessary for his or her patient.

If both patient and physician have agreed on a discussion about lifestyle matters, the next steps can follow. When giving information, information about risks of certain behaviour should be realistic but clear and not meant to scare the patient out of his wits. Even if the physician is an expert in these matters, he or she is not a salesperson, and persuasion and giving strong advice alone does not work.

In lifestyle matters, information giving is not enough but it is also necessary to analyse the problems the individual might encounter if he or she wants to change lifestyle before deciding on actions. The biopsychosocial model is helpful here because this demands looking at concrete behaviours, risks as well as the context of the patient and discussing solutions for difficulties together.

Even more important is using the patient’s solutions rather than the doctors’, empowering the patient and ensuring more commitment and effectiveness. Shared decision and agreement about changes and how to achieve them is one of the keys for success.

Effective patient-centred approaches

Many theories for Health Behaviour Change have been described, underpinning effective lifestyle interventions. The ‘Stages of Change (Trans-Theoretical) Model’ is one of the theories used in many lifestyle interventions and offers helpful practical support. In this model, five stages are identified. Moving too quickly and trying to persuade a patient to change behaviour when he is not interested to do so yet, impedes actual change. The model offers practical support for physicians to know when ‘trying to persuade’ a patient is counterproductive and unnecessary. The stages are pre-contemplation, when a patient has no intention of any changes (yet); the stage of contemplation, when a patient is aware of risks or problem behaviours and considers changes in the future; the preparation stage when he or she is committed to change behaviour; the action stage when the change is carried out short term (under 6 months) and the stage of maintenance when the changes are maintained for over 6 months.

Mr. Swift

In the precontemplation stage he never thinks about health and in terms of risk factors, so he does not consider doing anything about them. The physician on the other hand does. When Mr. Swift consults him for what happens to be just a common cold, the doctor sees his overweight and takes his blood pressure, which is much too high. When evaluating Mr Swift’s cardio-vascular risk he also discovers that his blood glucose levels are higher than normal. He decides that even though he has no additional risk factors, it is time to discuss various matters with Mr. Swift, among which is his lifestyle, and brings the subject up. Mr. Swift, apart from his cold, feels good and does not see any reason but agrees to discuss these matters ‘not now but a next time’.

A little later than his physician had hoped, he does show up again. His blood pressure is still too high and he agrees on a discussion about the risks. His physician tells him about some of the risks of his high blood pressure and about diabetes, trying to engage him in a dialogue, following, even though this is difficult, Mr. Swift’s slow pace in this matter.
Because according to the Dutch Guidelines it is justified to start with other strategies before deciding on medications for his blood pressure and diabetes, he is patient, even more because Mr Swift made it clear that he is not keen on taking pills. During one of the follow-up visits they discuss the risks of his overweight and lifestyle. Initially he is rather reluctant to do anything about it but his physician does not press him and takes his time on these matters over a number of visits, giving bits of information and some information leaflets as support. Slowly Mr. Swift is moving into contemplation and starts thinking about changes in the future.

Moving through the stages can be facilitated keeping in mind that patient and physician cognitions differ during the stages of change as demonstrated in Mr. Swift. An effective intervention to help individuals move through the stages is motivational interviewing. This technique was described by Miller and developed further by Miller and Rollnick into a directive, client-centred counselling style. It has been used and studied for many health behaviours when provided by various health care professionals including psychologists, nurses and physicians.\textsuperscript{11–15}

Motivational interviewing is a particular way of helping individuals recognize and do something about their current or potential problems, based on the theory that motivation is a state of readiness for change, which fluctuates over time. Behaviour change in patients who are ambivalent about this change is facilitated by helping them explore and resolve their ambivalence, focusing on what they want, think and feel. The patient is the one doing the talking although the physician is directive in these consultations.

When a patient is motivated to make a change, intentions can be converted into actions. Here again it is important that this is done in a patient-centred way because actions planned by physicians are not so successful as actions planned by patients themselves.

Action planning is a collaborative process, in which the patient chooses the goals. The clinician and patient negotiate a specific plan, looking at the patients’ level of confidence to accomplish that plan. Research on action planning demonstrates that it is not always necessary to move through all stages of change with a patient and with this intervention some patients can achieve changes more quickly and actually convert directly from the pre-contemplative to the action stage.\textsuperscript{16}

Solution-focused and problem-solving strategies can also be used.\textsuperscript{17,19} Problem solving is used not only in primary care with success as brief psychological treatment but also in various management programmes for chronic illnesses, for instance in diabetes care.\textsuperscript{19–21} It was originally derived from cognitive behavioural treatment to use with patients with emotional problems, teaching patients a strategy to solve practical problems in everyday life in a structured way. Key point is showing a patient that he or she can exert control over these problems and increase confidence about his or her own ability to solve problems. In this respect, an unhealthy behaviour can be seen as a problem, which needs to be solved and the structure of problem solving can be used to establish achievable goals and find solutions to achieve them. The physician guides the patient through the process but it is the patient who actually finds the solutions and solves the problem. In this technique, the emphasis is on setting achievable goals, formulated by patients themselves and reaching long-term goals through one or more short-term goals.

A sequence of the above-mentioned techniques is practical and it seems worthwhile to learn and use these techniques in everyday practice.

Mr. Swift

After about 4 months Mr Swift decides he wants to try and do something about his weight but is unsure what and how. His physician helps him by discussing what his goals could be, encouraging him to come up with achievable goals himself. The physician keeps in mind how he can support Mr. Swift, and if his goals are achievable and feasible. They discuss diet changes, losing some weight and planning physical activities. They discuss the fact that even small changes in weight will reduce his risks, and that losing 20 pounds might not be so achievable, in any case not short-term, but smaller changes are. At the end of their discussions short-term goals are set and Mr. Swift is ready for action. He is aware of his problem behaviour and the risks for his health and has decided he is going to do something about it: to start with, keeping his weight at the current level for the next 2 weeks he will plan a physical activity for 2 days a week. He is confident he can do it, even though it can be difficult at times.

They also discuss his possible solutions and he comes up with lots of suggestions. After weighing pro’s and con’s he decides that going for a walk with his daughter once a week and taking the stairs to his apartment in stead of the elevator every time is feasible. They discuss the plan to make sure there will be no unforeseen obstacles and the first step is made.

Consequences for medical education

Fortunately in modern medical education, teaching of patient-centred communication is an important and
integrated part of many core curricula of medical schools and universities. If the additional patient-centred techniques as described above are also taught to medical students and consolidated in residency programmes for general practice and for relevant specialties as well as in continuous medical education programmes on a large scale, the impact on the health of populations can be influenced in a positive direction. It is therefore important that prevention and research programmes both link up with medical education to ensure that more effective interventions find their way into medical education more quickly and from there into everyday practice.

Declaration

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References