Consultations about changing behaviour

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Persuading patients to change behaviour that is damaging their health can be difficult. Changing the style of consultation could improve the experience for doctors and patients.

Health threatening behaviours are the commonest cause of premature illness and death in the developed world, affecting the sustainability of our health services and society. Almost every healthcare worker interacting with almost every patient has an important opportunity to change health behaviour. Examples include a general practitioner talking to a patient about smoking or exercise, a health visitor engaging a mother about her child’s diet, an accident and emergency house officer talking to an injured patient about alcohol, a renal nurse discussing fluid intake, and a dental hygienist discussing flossing. These consultations can be difficult to navigate, however, and practitioners often make a cursory attempt to satisfy external guidelines or end up avoiding the subject altogether. Here, we consider how the flexible use of a guiding style could make health promotion more satisfying and effective.

Skillfulness makes a difference

The challenges of changing health behaviour have parallels in everyday life. For example, the more we raise the stakes in telling a child to do something, the more likely conflict will follow. “Please get into the bath, now!” is often followed by, “But I am not dirty!” In the more polite confines of the consulting room, weariness is a common reaction. Doctors feel pressure to do more to prevent the effects of health compromising behaviours on their patients. Yet, doctors say they are not social engineers, cannot dictate the lives of their patients, and were trained primarily for diagnosing and treating medical conditions not monitoring and modifying their patients’ behaviour. When they raise health behaviour, clinicians usually default to a directing style of interacting with their patients. It is not difficult to distinguish discussions that go well from those that go badly. When the discussion goes well, the patient is actively engaged in talking about the why and the how of change and seems to accept responsibility for change. When the discussion goes badly, the patient is passive, overtly resistant, or gives the impression of superficially agreeing with the practitioner. These reactions are measurable, predict outcome, and are influenced by the behaviour of the practitioner; confrontational interviewing, for example, predicts high levels of patient resistance.

Therefore, practitioners might have greater potential to raise or lower patient resistance than many assume. If this is true, skilful consultation about behaviour change, like the skilful and compassionate breaking of bad news, is worthy of every effort to give patients the best quality of care possible.

The process of changing behaviour

Just telling people they are at risk of developing a disease is rarely sufficient to change behaviour. People change if they come to believe that it is both of value and achievable. Maintaining change is not easy, and successful change often requires multiple attempts. Decisions about change can be finely balanced and linked to other behaviours, as with the smoker who gets irritable and puts on weight each time she quits. Information about risk is but one of several influences on this process. We can help patients weigh up the value of change and set realistic targets, but ultimately the patient must decide whether to change and how.

This rather obvious conclusion probably accounts for the enthusiasm with which motivational interviewing has been adapted from psychotherapy into health-care settings. Since patients often feel ambivalent about change, they are sensitive to well intentioned efforts to persuade them one way or the other. Resistance and denial are common reactions, but these can be overcome, and outcomes improved, if the practitioner elicits the case for change from the patient rather than imposes it.

Directing or guiding?

So, how might everyday healthcare practice be improved? It is useful to contrast at least two styles of consulting about behaviour change. When practitioners use a directing style, most of the consultation is taken up with informing patients about what the practitioner thinks they should do and why they should do it. When practitioners use a guiding style, they step aside from persuasion and instead encourage patients to explore their motivations and aspirations. The guiding style is more suited to consultations about changing behaviour because it harnesses the internal
Use of listening, asking, and informing in directing and guiding styles

**Directing style**

**Clinician:** Your test result shows that the levels of glucose in your blood are raised today. This means that you really need to watch your diet (informing). Have you thought about adjusting this (asking followed by listening)?

**Patient:** Well, it’s not that easy. I have tried, but you know what it’s like. I mean, it’s not so easy with my job, driving around in a rush and you know you just have to grab some food at lunch and keep going.

**Clinician:** You could bring your own lunch with you (informing).

**Patient:** I could do that, but it’s so busy in the morning, just getting us all out of the house, and then I stop in a cafe anyway at lunch, so I would then have to avoid the easy option of just getting a roll and feeling full and ready for action.

**Clinician:** Well, my advice to you is to treat this as your top priority (informing).

**Guiding style**

**Clinician:** Your test result is high today (informing) and I wonder what sense you make of this (asking followed by listening)?

**Patient:** I don’t know. I am not surprised because it’s hard enough getting by day to day without worrying about this as well.

**Clinician:** Everyday life can’t stop because you have diabetes (listening).

**Patient:** Yes, exactly, but I know I do need to be careful.

**Clinician:** In what way?

**Patient:** I need to watch my diet and get more exercise. I know that, but it’s not so easy.

**Clinician:** What might be manageable for you right now?

**Patient:** It’s got to be exercise, but please don’t expect great things from me.

**Clinician:** Well, a change in diet or exercise will be a great help (informing).

**Guiding and behaviour change**

The three core skills are also used in the guiding style, but here asking often involves eliciting from patients why or how they might change and listening is used to convey understanding of their experiences and to encourage further exploration. Even the use of informing is different. Informing is combined with asking to encourage choice and promote autonomy rather than to tell the patient what to do (see box). Challenges for the practitioner include being restrained, conveying the conviction that solutions lie within the patient, and handing over responsibility about decisions to the patient while retaining control over the time and overall direction of the consultation.13

The style being used can be reflected in small things like the phrasing of a question, the offering of an invitation to consider change, or the seating arrangement. Everyday life provides other examples. Parents commonly use both styles. Directing seems essential and appropriate in some situations but quickly generates resistance if clumsy or wrongly timed. To avoid resistance, parents and teachers use scaffolding or guided participation, adjusting the level of support according to the needs of the individual. This occurs consistently across cultures and predicts later success for the learner.14 15

**Core skills**

Asking, informing, and listening can be thought of as core tools or skills used by practitioners in different combinations and in the service of either directing or guiding. Asking involves the use of questions. Paying careful attention to choice of words, timing, tone of voice, and the ambiguities and contradictions often elicited in replies will engage patients more actively. Informing involves providing information, advice, feedback, or a demonstration. Focusing attention on clarity, evidence, purpose, and congruence with patients’ needs is likely to achieve efficient use of time and reduce the likelihood of resistance. Listening involves hearing what patients say and ensuring that their meaning is understood. Responding appropriately, sometimes by conveying understanding through empathic or reflective listening, engages patients constructively. The box shows the use of these three core skills in the service of either directing or guiding.

**Directing and behaviour change**

In the directing style, informing is usually the dominant mode. This is appropriate in many circumstances—for example, when a patient has acute appendicitis. However, to be effective in changing health behaviour this style requires a particularly well timed and personally relevant quality. More often, the directing style manifests in a rigid routine in which, for example, the first question to a smoker, “How much do you smoke?” is followed by a series of closed questions before the delivery of advice to quit. Informing then becomes telling patients what they already know (or have considered, tried, and rejected) and presenting them with a single, apparently simple solution. Resistance is a common reaction, and this dysfunctional interaction can leave practitioners blaming the patient for lacking motivation or being in denial.

Perceived lack of time is a common explanation for the almost reflex use of a directing style when trying to change behaviour. Contractual obligations to discuss certain subjects may lead to a raw, number crunching approach that loses sight of individual needs. Similarly, guidelines may also unwittingly reinforce an oversimplified approach by encouraging practitioners to advise patients about lifestyle change in an unhelpful manner.

Patients themselves are probably the best teachers when it comes to learning how and when to use the
moving forward

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The guiding style can also be used to change practitioner behaviour, avoiding the didactic approach assumed in evidence based guidelines and incentivised targets. The goal is to enable practitioners to adjust their routine approach to talking about behaviour change and engage the patient more in decision making. Despite the subtlety of processes, it seems possible to measure skillfulness and to identify improvements associated with training and to identify ways of maintaining changes in practitioner behaviour. While motivational interviewing itself might take time to learn, the guiding style on which it is based is well within the reach of busy healthcare practitioners.

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