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1 – When Education and Advice Don't Work: Motivate Behaviour Change

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I have a patient C. A. B., 50 years, an alcoholic who was hospitalized for necrotizing pancreatitis for 20 days in ICU.He is a retired judge, very intelligent, and used alcoholic drinks in his social environment. Two years after his hospitalization, during a routine consultation he asked to return to social drinking. He doesn't feel he is living without parties and without his friends. The psychiatrist oriented him to change his friends – As if someone can make new friends at the age of 50, he asked me. And he also got the advice "do not celebrate Christmas, New Year, birthdays "… "I survived a serious fact, but I am not living," he said to me.

The question in my mind is: what does he expect of me? How can I help him? And I asked him this question: How can I help you? "Let's stipulate some rules, doctor, negotiate with me ... I m already returned to take some beers, and I don't want to lie." He will drink only during festivities, never during weekdays, he won't drink spirits and always drink in the presence of his wife ... and if not, he would tell me ... "How else can I help you ..." The last question: "You think I'm going to fail?" "An alcoholic person becoming a social drinker is a very risky business. I'm not sure that you're going to succeed , but the important thing is that I will -continue to take care of you…"

What do you do with patients who do not change their behaviour in response to our education and advice?

When we use only a hammer (provide advice), we treat patients' unhealthy behaviours as nails. Most patients and their behaviours, however, are more like nuts and bolts rusted together. Hammering away can damage the threads of the bolt, so the nut never comes off. With advice only, patients may become more resistant and less likely to consider change. (1)

The information and advice we convey to our patients is often ineffective. Knowledge of risk factors alone seldom dissuades people from smoking, excessive alcohol consumption, overeating, high-risk sexual behaviour or substance abuse.

Why is it so difficult to apply our knowledge? The guidelines are available and quite straightforward. If results can be obtained in the tightly controlled world of the randomized trial, why can they not also be obtained in the world outside?

It is tempting to blame primary care physicians, their patients or both. But let us at least consider that the way medicine is being practised and taught is part of the problem. We practise a medicine based on the metaphor of the body as machine. Our

logic is of linear, unidirectional causal chains, and our notion of therapy is a technology of control. The mechanistic approach to medicine extends not only to treatment but also to behaviour modification based on control, reinforcement, conditioning and social engineering—an approach that overlooks human decision-making and autonomy. Not surprisingly, this approach has significant limitations when it comes to promoting healthy behaviour and the self-care of chronic disease. (2)

Patients have to be engaged where they live. It is not easy to change oneself: there have to be good reasons, and the motivation to change has to come from the heart as well as the head. We are all — practitioners and patients — very good at self-deception, at finding reasons (rationalizations) for avoiding change.

We need to learn from our clinical experiences about how to work with patients in alternative ways.

Furthermore, rational interventions do not work for the majority of patients because they are simply not ready to take action. Evidence-based tobacco cessation guidelines tell us what works, but they don't tell us how to work with people when proven interventions fail. Something is missing in the conduct of RCTs in terms of dealing with the full spectrum of patients. RCTs rarely address the internal process of why change did or did not occur. They do not tell us the whole story about change, either from the practitioner's or the patient's perspective. Instead, they provide a very limited view for understanding human experience and behaviour change.

For the practitioner educated in the "fixit" role, going though behaviour change ourselves can help us to empathize with patients facing similar changes. The patient centred method is designed to deal with he complexity "understanding and responded to the patient's feeling's and knowledge of the crucial importance of the emotions". "Listen to the patients story " - "seek common ground" (3)

I had a fat patient. The greatest traumas is the balance… I learned with Blasco PD in his class (4), - "Today I will see your weight, and you aren't to come back here for the numbers. These day your weight is our secret (every fat patient knows your weight)" but it's a way to take care with kindness and motivate the patient to be prepared to see the pounds in next consultation

With unhealthy behaviours, emotions often supersede reason. Patients frequently decide that the short-term emotional benefits (e.g., smoking to relax) are more important than the long-term quantifiable benefits (e.g., live longer). They make so-called "irrational" decisions. Recommendations from RCTs provide no guidance on how to deal with human emotions, perceptions and values. Scientific rationality lacks sophistication in dealing with human irrationality and otherwise knowledgeable patients who lack the critical factor: motivation.

Working with and providing continuity of care to our patients, we have many opportunities to adopt a motivational approach and deliver individualized interventions that meet their changing needs over several years. Effective training methods can help us move beyond standard question-and-answer clinical interviews to engage patients in "change dialogues" so they not only adopt healthy behaviours but maintain these changes. (5)

Carl Rogers, a seminal thinker about human psychology, captures essential ingredients for motivating change—listening: We think we listen, but very rarely we do listen with real understanding, true empathy. Yet listening, of this very special kind, is one of the most potent forces for change that I know of. (1)

A mixed methods study by Greene et al uses aggregated quantitative patient activation data in a large sample of patients to compare the approaches of physicians with high vs. low levels of improvement in their patients' level of activation. The exemplar physicians are more likely to use 5 strategies to support patient behaviour change: emphasizing patient ownership, partnering with patients, identifying small steps, frequent follow-up visits to share success and/or problem solving, and showing caring and concern for patients

We must move beyond the idea of control, that is, beyond trying to control our patients or having patients control themselves, to the idea of autonomy. Patients are more likely to adopt healthy behaviours if they want to rather than if

they ought to or have to change. Over time, patients are more likely to behave in healthy ways if we openly acknowledge their choice to engage in an unhealthy behaviour rather than trying to make them change. Autonomy-supportive approaches (offering choices) are more effective in helping patients change than are coercive measures. (1)

Taking class in an ambulatory clinic of chronic disease, one student asked me why "you talk and listen to your patient, but only sometimes you insist in changing behaviour… The student said that we need to use this opportunity to let the patient feel fear"… He said to this diabetes patient: "do you want to die?" Asked "if he was prepared to go blind? To be referred to haemodialysis …" My answer is that fear doesn't change behaviour… most patients may not yet be ready for action or are willing to explore change, but we need to spend our time in consultation for their trust, continue to promote their change. Most medical students and other doctors believe that they have the power to make the patient fearsome, and erroneously think that this is a way to help this patient…

"Grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference" (Reinhold Niebuhr)

Take Home Message

- Never try to direct to change in the first consultation, respect the time for the patient… Know your patient, listen to his story.
- Create no fear—motivate your patient with empathy
- The advice is not "standard"…. Individual advice, for individual patient
- Use patient centred medicine model to take care of this patient. It's the only way to take care of change behaviour
- If he cannot change, and most will not, continue being their physician

Original Abstract

http://www.woncaeurope.org/content/abstract-no-1147-workshop-when-education-and-advice-dont-work-motivate-behaviour-change

References

1. Beyond Advice: 1. Becoming a Motivational Practitioner and 2. Developing Motivational Skills.
2. Botelho RJ, University of Rochester School of Medicine and Dentistry Rochester, New York 14620 USA 2002 Printed in the United States of America
3. McWhinney IR. A textbook of Family Medicine. 1997. Oxford University Press.
4. Patient Centered Model. Blasco PG. O médico de família, hoje; 1997.
5. Greene J Hibbard JH Alvarez