Scandinavian Journal of Primary Health Care, 2011; 29: 99–103

informa
healthcare

ORIGINAL ARTICLE

Patients' experiences with lifestyle counselling in general practice: A qualitative study

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Abstract

Objective. (1) To elucidate the relevance of Habermas's theory as a practical deliberation procedure in lifestyle counselling in general practice, using a patient perspective. (2) To search for topics which patients consider of significance in such consultations. *Design.* Qualitative observation and interview study. *Setting.* General practice. *Subjects.* A total of 12 patients were interviewed after lifestyle consultations with their GPs. *Main outcome measures.* How the patients perceived the counselling, how it affected them, and what they wanted from their GP in follow-up consultations. *Results.* The GP should be a source of medical knowledge and a caretaker, but also actively discuss contextual reasons for lifestyle choices, and be a reflective partner exploring values and norms. The patients wanted their GP to acknowledge emotions and to direct the dialogue towards common ground where advice was adjusted to the concrete life situation. A good, personal doctor–patient relationship created motivation and obligation to change, and allowed counselling to be interpreted as care. *Conclusion.* The findings underscore the necessity of a patient-centred approach in lifestyle counselling and support the relevance of Habermas's theory as practical guidance for deliberation. *Implications.* The findings suggest that GPs should trust the long-term effects of investing in a good relationship and personalized care in lifestyle consultations. The study should incite the GP to act as an encouraging informer, an explorer of everyday life and reasons for behaviour, a reflective partner, and a caretaker, adjusting medical advice to patients' identity, context, and values.

Key Words: *Communication, doctor–patient relationship, family practice, Habermas, health behaviour, lifestyle counselling, patient preferences, primary health care*

The challenges of lifestyle counselling in general practice are reflected in research showing general practitioners (GPs) perceiving counselling as difficult [1], patients characterizing counselling as insensitive and rushed [2,3], and low patient compliance [4,5]. There is sparse evidence concerning how GP counselling ought to be conducted in practice [6], despite knowledge that patient compliance is influenced by behavioural and psychological strategies, a good doctor–patient relationship, value-focusing, and patient-centred medicine (PCM) [4,5,7–11]. Shared decision-making (SDM), an integrated aspect of PCM, increases the patients' expectations as to their own compliance [12]. In SDM, patients appreciate being involved in *the process* towards decision [13]. Deliberation is an essential part of SDM [14]. Habermas offers a detailed description of a deliberative procedure in his theory of communicative action [15]. He emphasizes a respectful dialogue seeking mutual understanding through well-reasoned arguments from subjective, objective, and social parts of life. Clarifying reasons for action reveals patients' values and norms, and increases the likelihood of getting in touch with what is perceived as good and right, allowing decisions to be rooted in patients' experiential worlds and tacit value systems [15]. In a time of individualized values and norms, it is important to consciously reflect upon these issues [16], central to the establishment of inner motivation [11]. A deliberative model allows an expanded autonomy where the patient may reach a deeper understanding [17], from which reasonable goals and a perception of challenges as manageable may arise [15,18]. In previous articles we have, through

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(Received 23 April 2010; accepted 21 December 2010)

ISSN 0281-3432 print/ISSN 1502-7724 online
DOI: 10.3109/02813432.2011.553995

GPs find lifestyle consultations hard; patients are often dissatisfied and experience lifestyle changes as difficult to carry out.

- A good doctor–patient relationship may create motivation and commitment to change.
- To produce adjusted advice, GPs should explore patients' everyday life, share knowledge, offer care, and engage in reflections upon reasons for decisions and actions.

theoretical considerations and consultation analyses, shown Habermas's theory to be potentially relevant for lifestyle counselling in general practice [19,20]. The pre-understanding of the present study is that the patient perspective will confirm this, and probably establish additional conditions for medical use of Habermas's theory. Hence, the aim of this study is twofold: (1) To elucidate the relevance of Habermas's theory as a practical deliberation procedure in lifestyle counselling in general practice, using a patient perspective, and (2) To openly search for topics which patients consider of significance in such consultations.

Material and methods

In southern Norway, we asked nine GP group practices (33 GPs) to preselect consultations where the GP and the patient had agreed on an agenda of lifestyle counselling. Eight GPs accepted. The first author, introduced as a researcher and an experienced GP, audio-taped and in a discrete way observed 12 consultations, subsequently interviewing separately the GPs in their offices and the patients in the conference room (Table I), locations chosen for practical reasons. To further explore their experiences, eight patients were interviewed after three months (following patients' preferences: five were interviewed in their GPs' conference room, one in the patient's home, and two in the researcher's home). One declined the second interview, three did not respond to notification. The researcher asked open questions (Table II), and, to favour conditions for eliciting patient views, responded to questions and offered empathy [21]. Performing parallel analysis, recruitment was stopped when no essential new information was obtained. This article presents the analysis from all the patient interviews; analysis of the consultations is presented elsewhere [20]. The audio-taped interviews were transcribed verbatim by the first author, and analysed by all authors by systematic text condensation [22]. The preconception concerning the benefits of Habermas's theory was bracketed throughout the analysis. The following steps were conducted: Reading the material for a general impression, categorizing meaning-endowing answers to interview questions utilizing the computer program NVivo 8 [23], condensing each category, and summarizing the condensates into new concepts. The results were validated by re-reading, ensuring that the patient's voices were reflected. The study was approved by The Regional Committee for Medical and Health Research Ethics.

Results

Patient's communication advice

The patients wanted the dialogue to help doctor and patient to establish a common understanding of the medical situation and of patients' everyday life. They perceived this as a help to adjust the advice to their particular situation. They even offered guidance for how GPs can do this: They wanted their GP to share medical knowledge, explore how things work in everyday life, to search for the reasons why things do not work as planned, and to contribute in reflections

Table I. Overview of the patients and their GP.

Patient	Characteristics	GP
1	Male in his 30s, overweight, hypercholesterolemia	Experienced, male
2	Female in her 20s, overweight	Experienced, female
3	Male in his 40s, overweight, hypertension	Inexperienced male substitute for regular GP
4	Male in his 50s, overweight, hypertension	Experienced, male
5	Male in his 40s, overweight, hypertension, hypercholesterolemia, diabetes	Inexperienced, male, substitute for regular GP
6	Female in her 30s, overweight, smoker	Experienced, male
7	Male in his 60s, overweight, hypertension, hypercholesterolemia, diabetes	Experienced, male
8	Male in his 50s, abdominal fat, cerebral apoplexia	Experienced, male
9	Female in her 50s, overweight, hypercholesterolemia, fibromyalgia	Experienced, male
10	Male in his 50's, overweight, hypercholesterolemia, lumbago	Experienced, male
11	Female teenage, overweight	Experienced, female
12	Female in her 30s, overweight, fibromyalgia	Experienced, female

Table II. Interview guide.

1. How did you perceive it when your GP performed lifestyle counselling in the present consultation?
2. What does it mean to you that the counselling is performed by your GP?
3. When you are going to change lifestyle, what do you need from your GP in the follow-up consultations?

towards adjustment of the advice, as illustrated by Patient 2:

> *You have to look for solutions…. How do we manage this?… What's happening?… Find out what triggers what, true? Because, when you find those little triggers, then you can take them away, or at least improve things.*

Themes they considered important were: food, physical activities, emotions, relationships, and practical circumstances such as a job and the daily schedule. To make their problem concrete and to highlight its seriousness, they wanted numerical information on cholesterol, glucose, blood pressure etc. This kind of dialogue was perceived by patients as a help to dig deeper into the foundations of everyday life, to gain an overview of the situation, and ownership of the tasks, as stated by Patient 3:

> *I want it to sink deeper inside of me, I really have to get ownership of it…. I think it's important for me, the way we do now, to sit down and talk about it.*

Without this dialogue, things tended to become a mess; it was difficult to see what functioned, what did not, and why.

The patients considered lifestyle change to be hard work, and acknowledged the need for care. They wanted the GP to express appreciation when things went well, and understanding, consolation, and encouragement when results were less successful, as expressed by Patient 9:

> *When I fail, I need some comfort and encouragement to start over. You need some praise to manage at all. Sometimes you get really fed up with being so strong all the time, you want to be weak and be given something. To sort of crawl up on a lap and be like a child again.*

Time

The patients emphasized the need for time and repeated consultations. They stated that a tight time schedule creates superficial general advice of no use, here illustrated by Patient 2:

> *You have fifteen minutes with your doctor, they are often very stressed … and even if my doctor actually is super fantastic … she has only time to say "Yes Patient 2, you have to remember…", then I: "Yes, yes, yes". And, well, it results in nothing.*

They also emphasized that tight time schedule is a barrier to talking about themes touching upon vulnerable spots in their lives.

Motivation, obligation, and care

In the counselling situation, patients valued the fact that the GP knew them and their situation, and acted in an open, honest, friendly, direct, and humorous manner. They pointed out that in a relationship with such characteristics, the GP is perceived as a medical expert and a caring person at the same time. They perceived counselling from a person with this dual role as more deeply motivating than general public information and advice from relatives and friends. It helped them realize the relevance and seriousness on a more concrete, individual level. When the GP, holding this dual role, showed concern and took time to listen and counsel, the patients felt an obligation to heed the advice, as illustrated by Patient 3:

> *The GP spoke directly and clearly, and wanted to help, so then I felt, when he in a way met me, that I too have to take this seriously and do my job.*

They referred the obligation to three aspects: the personal responsibility for an agreement, the commitment to a professional who involves her/himself, and respect for authorities. Patient 9 put it this way:

> *I feel maybe that if the GP has said so, then I do it…. If I only say it to myself, then I can change my mind. "Yeah, I can wait until tomorrow … until next month", true?*

A good doctor–patient relationship created a situation where the patients tolerated counselling better, as illustrated by Patient 4:

> *It's on the personal level. When you have a doctor you feel some connection with, it's easier to talk about lifestyle changes.*

Despite touching upon vulnerable themes they perceived the counselling as conveying care and respect. Patient 10 says:

> *My GP is fine, he follows me closely. He really seems to care…. If he didn't respect me, he'd let me slip away.*

Discussion

This study shows that patients want physicians to spend time in dialogue, so that common ground can be established on a detailed level. Reasons for behaviour should be explored, advice adjusted to everyday life, and emotions acknowledged. Patients assign their GP the roles of informer, explorer, reflective partner, and caretaker. A doctor–patient relationship perceived as good creates a foundation where lifestyle counselling is apprehended as care and respect, and contributes to motivation and commitment to agreements.

Methodological considerations

The recruitment process opens up to selection bias; the GPs willing to participate may share certain characteristics, such as a special interest in lifestyle, and may select patients they have good relationships with, or patients with certain personalities. This bias is perhaps reflected in the fact that patients describe few negative qualities in their GPs. Interviewing the patients in their physicians' conference rooms may influence what they share about their GP, although the impression of the interviewer was that they spoke freely. The interviewer applied interview strategies facilitating a good relationship with the patient-informants, increasing the likelihood of obtaining valid knowledge [21]. The informants varied in age, gender, diseases (patients), and experience (GPs), strengthening the findings. The presence of the researcher in the consultations may have influenced the counselling process. The researchers being experienced GPs this may contribute to realistic interpretations, but may also represent the blindness of habit. The theoretical preconception of the project increased our sensitivity to elements considered important in dialogues directed towards good decisions, but may have weakened our ability to appreciate unexpected phenomena. This bias was counteracted by the use of open questions and conscious bracketing. The internal validity is considered good, and findings are judged to be relevant in many GP settings.

Contribution to existing knowledge

The patients' communication preferences documented in this study accord with PCM and Habermas's theory, emphasizing the need for sharing and exploring of relevant biopsychosocial issues to reach common ground [15,24]. Through exploring reasons for acting in one way or another, values and norms are clarified. This paves the way for a reflection where lifestyle adjustments may be aligned with other preferences and commitments. Patients want GPs to take the lead in contributing to a well-reasoned argumentation, supporting previous studies on the use of Habermas's theory in medicine [19,20]. The communication techniques used by GPs in lifestyle counselling are not always optimal [25], underscoring the need for practical guidelines and supervised training opportunities.

A good relationship with the GP is associated with better treatment adherence and better outcome of consultations [9,10,26–28]. However, the nature of interactions within this relationship is complex and not fully understood [9,10,29]. In the present study, patients claim that a good relationship makes counselling comfortable, possibly counteracting shame and vulnerability associated with exposing an unhealthy lifestyle [2,30]. The study also suggests that counselling by a person with the dual role of expert and caring fellow human heightens patients' insight and realization of what is at stake, a decisive ingredient in motivation [31]. The establishment of a feeling of commitment reverberates with interpersonal obligation theories: (1) commitment through linguistic agreement [15], (2) an obligation to "pay back" [32], and (3) respect for authorities when motives are trusted [33].

The need for care stated by the patients is well recognized in PCM, and has been demonstrated in general to be a core element in efficient talking therapy [24,34]. The patients' emphasis on laboratory tests points to important challenges. Numbers are difficult to interpret [35], may create unnecessary anxiety, and must be carefully integrated in reflections to avoid decisions detached from the patient's context [16].

The demand for more time is challenging, but logical. Hasty advice of a general nature represents wishful thinking about how people change, and is doomed to fail.

Conclusion and implications

Our study expands the understanding of lifestyle counselling in general practice. The findings underscore the significance of a patient-centred approach, add new facets to core elements of PCM, and underpin the relevance of Habermas's communication theory in lifestyle counselling as practical guidance to carry out deliberation. The results suggest that GPs should trust the long-term effects of investing in good relationships and personalized care based on exploration of patients' life-world concerns. The GP should serve as an informer, an explorer of biopsychosocial conditions and reasons for behaviour, a reflective partner, and a caretaker who adjusts advice to the patient's identity, context, and values. GP education should target the relevant competences.

In our opinion, this perspective on lifestyle counselling is promising, and should incite further exploration of the nature and effects of GP–patient interaction. Quantitative studies are needed to establish the long-term effects of these suggestions to improved lifestyle counselling in general practice.

Acknowledgements

Thanks are offered to the Norwegian General Practice Research Fund which funded the project, and to the patients and doctors who participated.

Conflict of interests

None.

References

[1] Mann KV, Putnam RW. Physicians' perceptions of their role in cardiovascular risk reduction. Prev Med 1989;18:45–58.
[2] Malterud K, Ulriksen K. Obesity in general practice: A focus group study on patient experiences. Scand J Prim Health Care 2010;28:205–10.
[3] Brown I, Thompson J, Tod A, Jones G. Primary care support for tackling obesity: A qualitative study of the perceptions of obese patients. Br J Gen Pract 2006;56:666–72.
[4] Oldridge NB, Stoedefalke KG. Compliance and motivation in cardiac exercise programs. Clin Sports Med 1984;3: 443–54.
[5] Graves KD, Miller PM. Behavioural medicine in the prevention and treatment of cardiovascular disease. Behav Modif 2003;27:3–25.
[6] Newell SA, Bowman JA, Cockburn JD. Can compliance with nonpharmacologic treatments for cardiovascular disease be improved? Am J Prev Med 2000;18:253–61.
[7] Campbell MK, Carr C, Devellis B, Switzer B, Biddle A, Amamoo MA, et al. A randomized trial of tailoring and motivational interviewing to promote fruit and vegetable consumption for cancer prevention and control. Ann Behav Med 2009;38:71–85.
[8] Lai DT, Cahill K, Qin Y, Tang JL. Motivational interviewing for smoking cessation. Cochrane Database Syst Rev 2010(1): CD006936.
[9] Kokanovic R, Manderson L. Exploring doctor–patient communication in immigrant Australians with type 2 diabetes: A qualitative study. J Gen Intern Med 2007;22:459–63.
[10] Cable TA, Meland E, Soberg T, Slagsvold S. Lessons from the Oslo Study Diet and Anti-smoking Trial: a qualitative study of long-term behaviour change. Scand J Public Health 1999;27:206–12.
[11] Rollnick S, Miller WR, Butler C. Motivational interviewing in health care: Helping patients change behaviour. New York: Guilford Press; 2008.
[12] Edwards A, Elwyn G, Hood K, Atwell C, Robling M, Houston H, et al. Patient-based outcome results from a cluster randomized trial of shared decision making skill development and use of risk communication aids in general practice. Fam Pract 2004;21:347–54.
[13] Edwards A, Elwyn G. Inside the black box of shared decision making: Distinguishing between the process of involvement and who makes the decision. Health Expect 2006;9: 307–20.
[14] Murray E, Charles C, Gafni A. Shared decision-making in primary care: Tailoring the Charles et al. model to fit the context of general practice. Patient Educ Couns 2006;62: 205–11.
[15] Habermas J. The theory of communicative action. London: Heinemann; 1984.
[16] Komesaroff P. Troubled Bodies. Critical perspectives on postmodernism, medical ethics, and the body. Durham and London: Duke University Press; 1995.
[17] Emanuel EJ, Emanuel LL. Four models of the physician–patient relationship. JAMA 1992;267:2221–6.
[18] Antonovsky A. Health, stress and coping. San Fransisco: Jossey Bass; 1979.
[19] Walseth LT, Schei E. Effecting change through dialogue: Habermas' theory of communicative action as a tool in medical lifestyle interventions. Med Health Care Philos 2010; 14:81–90.
[20] Walseth LT, Abildsnes E, Schei E. Lifestyle, health and the ethics of good living: Health behaviour counselling in general practice. Patient Educ Couns 2010;June 19 [Epub ahead of print].
[21] Kvale S, Brinkmann S. InterViews: Learning the craft of qualitative research interviewing. 2nd ed. Los Angeles: Sage Publications; 2009.
[22] Malterud K. Shared understanding of the qualitative research process. Guidelines for the medical researcher. Fam Pract 1993;10:201–6.
[23] QSR. http://www.qsrinternational.com/.
[24] Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, T.F. Patient-centred medicine: Transforming the clinical method. 2nd ed. Oxford: Radcliffe Medical Press; 2003.
[25] Abildsnes E, Walseth LT, Flottorp SA, Stensland PS. Lifestyle consultation in general practice – the doctor's toolbox: A qualitative focus group study. Fam Pract 2010; November 10 [Epub ahead of print].
[26] Bendapudi NM, Berry LL, Frey KA, Parish JT, Rayburn WL. Patients' perspectives on ideal physician behaviours. Mayo Clin Proc 2006;81:338–44.
[27] Merenstein B, Merenstein J. Patient reflections: Saying goodbye to a retiring family doctor. J Am Board Fam Med 2008; 21:461–5.
[28] Di Blasi Z, Harkness E, Ernst E, Georgiou A, Kleijnen J. Influence of context effects on health outcomes: A systematic review. Lancet 2001;357:757–62.
[29] Vermeire E, Hearnshaw H, Van Royen P, Denekens J. Patient adherence to treatment: Three decades of research. A comprehensive review. J Clin Pharm Ther 2001;26:331–42.
[30] Malterud K, Tonstad S. Preventing obesity: Challenges and pitfalls for health promotion. Patient Educ Couns 2009;76: 254–9.
[31] Kieffer C, editor. Studies of empowerment: A developmental perspective. New York: Howarth Press; 1984.
[32] Korsgaard MA, Meglino BM, Lester SW, Jeong SS. Paying you back or paying me forward: Understanding rewarded and unrewarded organizational citizenship behaviour. J Appl Psychol 2010;95:277–90.
[33] Murphy K. The role of trust in nurturing compliance: A study of accused tax avoiders. Law Hum Behav 2004;28: 187–209.
[34] Davidsen A. Experiences of carrying out talking therapy in general practice: A qualitative interview study. Patient Educ Couns 2008;72:268–75.
[35] Halvorsen PA, Kristiansen IS. Decisions on drug therapies by numbers needed to treat: A randomized trial. Arch Intern Med 2005;165:1140–6.