

Out of Hours

Coaching for health:

holding the curtains so patients can change

BACKGROUND

Over 30 years ago Stott and Davis¹ described four types of activities in the general practice consultation, in which opportunistic health promotion has a key place (and is still the backbone of the QOF). Five years later, Pendleton² described a time-sequenced, task-based model of the consultation in which emphasised the importance of exploring patients' ideas, concerns, and expectations. Neighbour, in 1987,³ saw the process of consultation as climbing a mountain, describing five stages in the ascent. He identified the need for safety-netting, ensuring that future risks to the patient and other diagnoses are considered, and housekeeping, where, after the consultation, the doctor deals with their own feelings. Middleton's⁴ process model is not time sequenced, but describes something of what Neighbour called connecting with the patient, and is also a helpful way to look at Pendleton's ideas, concerns, and expectations in more depth. Middleton acknowledges that both patients and doctors have agendas and that by clarifying both, at least in the mind of the doctor, it is possible to gain a better understanding of the consultation.

Silverman *et al*⁵ produced a list of 54 skills to deploy in the consultation, with a consultation framework to put them in. Along with the teaching model developed to train doctors, these skills have dominated thinking on the consultation for 15 years. Chaos theory⁶ has taught us something about how to deal with complex consultations when the number of uncertainties is high, but there is still a core of consultations that don't seem to work. How do we make patients change their unhealthy behaviours? What can we do with consultations that repeatedly seem stuck on the same issues: the depressed patient who doesn't get better, the diabetic whose control remains poor for example? Coaching for health is a skill set and consultation model that suggests a different way of approaching these challenges.

The usual models of consulting we use rely heavily on the doctor as the expert knowing what to do. Middleton at least acknowledges the patient has an agenda, and Silverman talks of negotiating skills, but deciding the 'healthy' thing to do, even in motivational interviewing, remains for the doctor to bring up. This is often very appropriate as, for

example, the doctor knows the epidemiology that for most sore throats antibiotics will cause more harm than good, but sometimes the doctor is in no position to know what is appropriate in a person's life, and a much more patient-centred approach is needed. Is it appropriate, for example, for the man with tension headache to take long-term medication, or change his work, or seek relationship counselling?

COACHING FOR HEALTH

Coaching for health is based on three principles that distinguish it from other consultations models. First, it is truly patient centred. In coaching, patients decide what they want to talk about and what goals they want to set. This would not work for a patient with central crushing chest pain, but for the person with tension headache the patient can decide on what they may do to improve their situation, as they see it. Second, coaching recognises that patients have a remarkable potential to help themselves. Even the most insightful maker of poor choices has the potential to make their life different, often with only minimal intervention from outside. The third key principle is that patients are responsible for their own lives and actions. If the patient chooses not to stop smoking it is not a failure of professional intervention, it is a choice made by the patient, however unhealthy we may think that is.

This means that the twin tasks of coaching for health are raising patients' awareness of the issues they face, and allowing them the responsibility to make choices. The task of the professional is to help the patient see what they are doing, reflect on what could be, and allow them the space to work out how they could change. Two coaching skills will help to illustrate this.

ABC BEHAVIOURAL HEALTH COACHING

In the Antecedents, Behaviour, Consequences (ABC) skill,⁷ the health professional (coach) first uses reflective questions to help the patient build up a detailed picture of what is happening with them. For example, what happens before (antecedents) and after (consequences) a headache comes on; what thoughts, emotions, bodily feelings, and behaviours surround it, and in what situations or interpersonal contexts. This provides information and raises the patients'

awareness of their situation. It may then be obvious to the professional what is happening and we are tempted to tell the patient what the diagnosis and treatment. However, in coaching, having raised the patients' awareness, the professional will simply say 'So what do you think is going on then?' It is up to the patient to make the connections and see possible ways forward. For example, it may not be a change in medication they need, but rather a way of stopping the children screaming all evening that will make the difference. The doctor could not have known that, and now the patient has made the connection rather than just being told, they will be motivated to explore changes they can make. The ABC skill then focuses on the goal a patient would like to set for addressing their health issue, and encourages the health practitioner to discuss resources and strengths to support the goal before supporting the patient to set a plan of action:

1. Antecedents: ask the patient to describe what occurs or exists immediately before the behaviour occurs.
2. Define the behaviour: in clear observable terms (frequency, intensity, and duration).
3. Consequences: ask the patient to describe what they are aware of both immediately after, and/or in relation to longer term effects of the behaviour.
4. Elicit meaning: ask the patient for their interpretation of the health issue based on the ABC above.
5. Elicit goals: ask the patient what they would like to do or achieve with their health issue.
6. Elicit resources: explore previous successes or strengths that the patient can draw on.
7. Way forward: negotiate actions based on the patient's perception of the best way forward — keeping responsibility with the patient where possible.

TGROW

Another useful coaching skill is the TGROW or IGROW model,⁸ in which the patient identifies the topic of discussion and is supported to set specific goals they would like to achieve. They may decide for example to deal with their diabetes by exercising rather than controlling their diet more

tightly. The health practitioner can help by asking the patient what they are doing now (their current reality) and then exploring a range of alternatives they could choose to do (their options). It is then up to the patient to decide what they will actually do and set timescales, and the role of the health practitioner is to support their plan of action:

1. Topic: clarification and exploration of the topic.
2. Goal: setting of specific goals; long/medium/short term.
3. Reality: understanding where the coachee is now in relation to their goals?
4. Options: exploring options for moving forward.
5. Will/way forward: identifying and agreeing specific action.

It will not always be appropriate to use a coaching approach, but we can think of the coaching process as a consultation in which the professional uses reflective skills to allow the patient to become aware of their situation, to reflect on possible ways forward, and allow a truly patient-centred, indeed patient-generated, action plan to emerge.

THE USE OF COACHING IN THE CONSULTATION

Consultations where this approach seems particularly relevant include those where some sort of behaviour change is required in the patient's life, in long-term conditions where patients benefit from being more in control, in complex and chaotic situations where the doctor can't get a full picture of the patient's life, or with those patients who seem emotionally stuck and unable to move on for themselves.

It is important to stress that the aim of this approach is not to deny the diagnostic ability or knowledge of clinicians, but rather to combine clinical skills with behaviour change skills. It aims to raise awareness and responsibility in the patient, achieved through a transformation in the clinician-patient relationship. We propose that the approach can offer a more effective way of eliciting patients' inner resources, and this can activate greater behaviour change than the traditional medical model of education and directive advice from health professionals.

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Coaching presents a model of consulting that can be fresh and different from more traditional models of GP consulting that can be liberating for patients where other approaches have not been effective. It is as if we are holding the curtains while someone gets changed, and this metaphor does seem to capture its facilitative patient-centred approach.

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Further information on coaching and training events can be found at:
<http://mentoring.londondeanery.ac.uk/>

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MISS POLLY HAD A DOLLY WHO WAS SICK, SICK, SICK ...

*Miss Polly had a dolly who was sick, sick, sick,
sick,
So she called for the doctor to be quick,
quick, quick,
The doctor said, 'I'm sorry Miss Polly but
you see
We've commissioned our home visits to a
private company –
They'll be with you in a jiffy, they'll help you
in a tick,
To access their service takes just one click
On www.virtualcare.org
They'll turn your dolly's room into a virtual
ward.
Spot diagnoses are their real forte
(But only over Skype, else you'll have to
pay).'
Miss Polly said, 'But doctor, she seems
very ill,
I've tried to give her Calpol but she won't
keep still.
The internet's for shopping not for primary
care,
Now please come out and visit or
complaints I'll prepare.'
'Complaints? Oh, Miss Polly, don't go down
that route,
Here, have the number of our conciliatory
group;
It's just been set up by the new LMC
To help maintain relations 'tween the likes
of you and me.'
Miss Polly hung up. And with dolly on her
knee,
She joined the endless queues at her local
A + E.*

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