

# Lifestyle consultation in general practice—the doctor’s toolbox: a qualitative focus group study

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**Background.** GPs consider individual lifestyle counselling as part of their obligation. There is a lack of knowledge about how such counselling is done.

**Objective.** To investigate what tools GPs utilize in individual consultations concerning lifestyle change.

**Methods.** Qualitative analysis of six focus groups with 50 GPs sharing and commenting each other’s case stories.

**Results.** To enhance change of lifestyle, GPs adjusted the organization of their practice and utilized visualization tools. They established doctor–patient relationships based on shared decision making and trust, and gave their patients advice and tips to accomplish change, but also used paternalistic approaches and rhetoric manipulation.

**Conclusions.** GPs use a variety of tools in consultations about lifestyle change. A patient-centred approach is shown, but GPs also deliberately use distressing communication tools.

**Keywords.** Communication, family practice, focus groups, lifestyle, qualitative research.

## Introduction

An unhealthy lifestyle is associated with increased morbidity and mortality. Although the most powerful tools used to change risk factors related to unhealthy lifestyle in a population are political and public health ones, there is much focus on individual responsibility.<sup>1,2</sup> As part of their preventive health care work, GPs are expected to give advice about how lifestyle affects quality of life, risk of disease and premature death. GPs are also expected to advise and motivate patients to accomplish change of an unhealthy lifestyle. In Norway, nearly the entire population takes part in the semi-private list system for GPs. Seventy-one per cent of the inhabitants see their GP every year, and a referral from the GP is necessary to receive specialized health care. This gives the GP an opportunity to give individual advice on lifestyle to many of those who may benefit from such counselling. Increased focus on individual and opportunistic lifestyle counselling affects the doctor–patient relationship and the content of the assignment given GPs as lifestyle consultants by society.<sup>3–5</sup> Despite increasing workload, GPs are positive about health promotion and lifestyle counselling.<sup>6</sup> A study analysing Norwegian GPs’ clinical communication patterns found that

the frequency of communication exploring patients’ personal resources and positive coping strategies was very low.<sup>7</sup> This corresponds to findings in studies from other countries.<sup>8</sup> British research groups recommend a patient-centred style in communicative approaches on lifestyle counselling.<sup>9,10</sup> European guidelines on cardiovascular disease prevention in clinical practice advocate estimation of total risk and a patient-centred approach.<sup>11</sup> The aim of this study was to investigate what GPs do in consultations concerning change of an unhealthy lifestyle and to explore what kind of ‘tools’ they use in everyday practice.

## Methods

To elicit information about the variety in lifestyle counselling among GPs, we chose a qualitative study design utilizing focus groups.<sup>12,13</sup>

### Study setting

The focus groups were selected by purposeful sampling to provide information from GPs with different clinical background, education, experience and skills. Each group had met regularly, from 6 months to >5 years, as part of either postgraduate training or

continuing medical education. The groups were not homogenous. The first author, an experienced GP, invited seven groups located in the southern part of Norway to participate, by sending an email with information about the study. Six groups accepted the invitation and one group did not answer. He conducted the focus groups in the period September 2008 to February 2009. The first author has been involved in public health programmes to accomplish change of lifestyle.

#### *Participants and data collection*

Six groups with 50 GPs participated. Each group had five to twelve members. The groups included 20 female and 30 male GPs working in rural as well as urban districts. Seventeen had worked as GPs <1 year, 11 had worked between 1 and 5 years and 22 had worked >5 years (the last group referred to as experienced).

#### *Focus groups*

By collecting information in focus groups, we enabled colleagues to present and discuss case stories from their own practice. We used the critical incident technique to include significant cases.<sup>14</sup> Participants were invited to present stories of ‘success or disaster’, in which they acted as lifestyle consultants. The informants commented and reflected on each other’s stories and told about their own experiences in related situations. We did not use any interview guide. The first author got the group back on track when the discussion lost focus, for instance by asking for the next story. When the discussion concerning the case presented seemed to finish, he asked for stories concerning other kinds of unhealthy lifestyle. He asked silent members of the groups of their opinion on the task to secure information from all informants. He also asked questions to clarify statements and made field notes after each session. An observer, a sports scientist, was present in all groups. The observer made field notes during the group sessions and summarized his impressions to the group at the end of each group session, giving the group opportunity to correct misunderstandings. The sessions lasted from 73 to 91 minutes.

#### *Analysis*

The first author recorded each focus group session on audiotape and transcribed the information verbatim. We used systematic text condensation in the analysis.<sup>15</sup> We established themes according to an editing analysis style.<sup>16</sup> Bracketing preconceptions, we searched the text for meaningful units concerning communication tools. We coded these units, organized them in subgroups related to each theme and identified final categories during the process of preparing the article.

Example: Giving a patient advice about benefit of walking to work instead of driving was defined as

a meaningful unit. This unit was coded as information, ending up in a category called advice. In the final presentation it was presented under the subtitle “concrete proposals and advice”.

#### *Ethics*

We presented the study protocol to The Regional Committee for Ethics in Medical Research. As the study did not involve patients, and all cases were anonymously presented, the committee regarded the study outside their mandate. Every participant signed an informed consent before the focus group session started.

## Results

The informants regarded lifestyle counselling as an important, difficult and mandatory part of a GP’s obligation. Their case stories comprised counselling on smoking cessation, obesity, dietary advice, physical activity, alcohol abuse, doping and eating disorders. Many considered treatment goals defined in clinical guidelines as impossible to achieve.

The experienced GPs generally expressed lower ambitions about changing their patients’ lifestyle and showed a more pragmatic approach than those with less experience. The less experienced GP’s were enthusiastic and eager to facilitate change but seldom reflected on the difficulties of enhancing patients’ motivation. They were often disappointed when their efforts failed. There were no obvious differences between male and female informants with respect to the tools they used.

#### *Ways of organizing practice*

All the informants used electronic patient records. It was emphasized that a well-organized patient record might give the GPs important information about which patients they should introduce to lifestyle change. Basic information included family history, previous diseases, social history, education and work history, smoking habits, use of alcohol or drugs. They regarded such information as important to understand needs, resources, self-efficacy and motivation for change. Many blamed themselves for not taking the time and effort to record this regularly:

... I try to ask everyone—is there heart disease in your family, is there cancer in your family, and then you get it ... And smoking, do you smoke? ... But it takes time. And it requires extra effort. (inexperienced female GP)

The informants organized regular checkups for patients with chronic diseases related to unhealthy lifestyle like obesity, hypertension and diabetes type II.

In these consultations, they ritually repeated comments about adjustments and encouraged their patients to continue when a positive change of lifestyle had been adopted.

Patients with alcohol addiction, eating disorders and severe obesity were referred to hospital. Counselling on physical activity was performed by the GP, trained staff or by referral to other primary health care providers. Some practices employed specially trained staff to talk to patients about smoking cessation and diets and about treatment of diabetes or chronic obstructive pulmonary disease.

#### *Tools of visualization*

The informants utilized written information, risk calculators, brochures and printouts from computer-based programmes to estimate risk of diabetes or cardiovascular disease and to visualize how the risk might be reduced. Some felt that such tools disturbed the dialogue and the doctor–patient relationship. Others liked to use risk calculators. The informants expressed ambivalence towards using sponsored written information and visualization tools provided by the pharmaceutical industry. Many preferred to enclose neutral information.

Some informants asked their patients to record diet, exercise and smoking habits in diaries between consultations. This visualized the patients' habits in a way that facilitated further counselling:

... make them write down what they eat, decide with the patient three days that are normal days. Next time we make a list. And then many are surprised, it doesn't look like what they say. They use to say they don't eat much at all ... (experienced male GP)

#### *Paternalistic approaches and rhetoric manipulation*

Although some informants emphasized that use of fear and correction in a paternalistic way did not promote motivation for change, many deliberately utilized rhetoric manipulation, scaring and rectifying. The context of the consultation allowed physical examination and questions about private affairs. While doing lung auscultation on smokers, GPs told their patients that they could hear and smell that the patient smoked. One GP told a patient taking anabolic steroids that she looked for striae and other signs of skin disease that could be related to the drugs. Confronting the patient with the risk of continuing an unhealthy lifestyle in a direct manner, they stated that this might push the patient towards change:

I use to frighten mothers in the well-child clinic. Those who come with young children who are wheezing and obstructive. I am cruel with them. I say quite directly to them that it is your fault that

your child has got asthma. I had a 19 year old mother yesterday, she got very upset. She should go home and quit smoking at once. (inexperienced female GP)

Deliberately distressing visualization was reported. One GP told about a colleague who used to show his diabetic patients a white cane to encourage them to change their lifestyle, if not they could be blind due to diabetic complications. Another compared the risk of continuing smoking with that of experiencing a plane crash and asked the patient if he would continue flying if it was as risky as smoking. One GP told an obese patient who could not understand why she did not lose weight that there were no obese people among the prisoners in the concentration camps during Second World War:

... according to your thoughts, that some of them, if they only had a small piece of bread, would gain weight—and the others not. But it was not this way for any of them. (inexperienced male GP)

Blood tests and X-rays were used to confirm diagnosis and monitor treatment. However, several informants also used blood tests to verify suspicion about alcohol problems without informing the patient. Chest X-rays and spirometry were used to visualize the risk of respiratory disease for smokers, but also to scare, and to promote smoking cessation.

The GPs reflected upon the ethical dilemmas of utilizing tools that might be considered as rhetoric manipulation and misuse of power in an unequal relationship. Several stated that they did not believe such an approach would enhance change of lifestyle.

#### *Clinical communication patterns*

The informants considered patient-centredness, reflections about own communication style, improvement in consultation skills and time to build a doctor–patient relationship important:

When I was young and inexperienced, I saw solutions and should fix it on behalf of the patient. And especially when it comes to change of lifestyle this shows to be a bad solution. Maybe contraindicated, because the patient leans back, and yes, the doctor can fix it. And then we don't fix it at all ... (experienced male GP)

Some utilized open-ended questions as a strategic tool and tried to stimulate the patient to talk about change. They improvised and changed techniques during the consulting process. Some used personal experience and even private information about their own struggle with lifestyle to approach their patients. They also reflected with the patient and negotiated about the priority of planned efforts.

Many told about 'golden moments', situations when patients open up, and the GP had an intuitive feeling of connection and response. They experienced such moments at crossroads in the patient's life, like after a heart attack or when given a serious diagnosis. Even consultations with smokers having airway infections might have this character, when a patient's motivation suddenly changed and (s)he was ready to receive advice:

Then you are on the same planet, in a way. You meet, speak the same language in a way. You can disclose information, one is receptive and the other says what is right, in a way. (inexperienced female GP)

Humour was used to open up the conversation when the doctor knew the patient well; otherwise, the patient might misunderstand the GP's intention. Paradoxes could also open up a locked dialogue, introduce unexpected viewpoints or give new proposals. One GP told a patient that smoking-related diseases generated the doctor's income. An experienced male GP had an old tobacco sign on the wall in his office to start a dialogue about smoking cessation:

More doctors smoke Camel than any other brand.

#### *Concrete proposals and advice*

Most GPs informed patients by sharing their knowledge and giving advice as professionals. They expressed that patients expect the GP to give advice about lifestyle change, but they did not explore what kind of information the patient wished. They prescribed drugs to support smoking cessation and combined prescription with repeated counselling, often with success. Some used drugs in obesity treatment, but success was not often reported.

The informants gave tips about small adjustments in the patients' efforts to change. One GP advised a patient with peripheral vessel disease to bring with her a portable chair to encourage walking. Some creative proposals were reported:

I have a mentally retarded patient who used to be very obese. We did a practical change. Very little fork, very little plate ... When the plate is empty you start getting satisfied, right?

## Discussion

### *Strengths and weaknesses of the study*

What is presented by the informants is influenced by the context of the focus group. What the GPs tell they do is not necessarily what they actually do. Reporting real case stories may reduce this bias. The presence of their colleagues within the group, as well as the

researchers, may have affected what the informants chose to share with the group.<sup>17</sup> What is told between GPs is affected by their shared professional background as some knowledge is taken for granted.<sup>18</sup> The tradition of sharing case stories influenced the study. Some expressions were considered to be acceptable in the context of a meeting between colleagues but would not be presented to the public.<sup>19</sup> Several such expressions were presented in these focus groups. The fact that the informants also presented 'rough tools' may indicate that they hardly were influenced by the presence of researchers in the focus group and thus can be considered as an expression of the validity of the findings. The study adds information about what happens in consultations concerning change of lifestyle, but patient interviews and observational studies should be considered to ensure other perspectives and validate the findings.

### *Visualization*

Risk presented as numbers is difficult to grasp for doctor and patient.<sup>20,21</sup> Tools of visualization may transform numbers into meaningful pictures and may help to make the patient aware of the invisible in an abstract field of their lives.<sup>22</sup> Risk charts and risk calculators can identify those that may benefit most from lifestyle change.<sup>23</sup> Computer-based risk estimation programmes are based on allegedly 'objective' measures and emerge from a positivistic tradition. So does the traditional health information, representing extrinsic motivational factors in the process of change of lifestyle. In this study, the informants used tools representing both this tradition and the patient-centred tradition. It is the GP's challenge to tailor medical knowledge to each patient's life. The informants expressed ambivalence towards using sponsored written information, computer-based risk calculators and visualization tools. Neutral tools should be easily accessible.

### *Clinical communication patterns*

Guidelines advocate patient-centred care in lifestyle counselling.<sup>11</sup> Current Norwegian guidelines on primary prevention of cardiovascular disease recommend patient-centred care and motivational interviewing as communicative tools.<sup>24</sup> These guidelines consider it unethical to utilize approaches that intend to intimidate or offend the patient, even if they are effective.

GPs do not politely follow guidelines and may even regard them as a square peg to fit in the round hole of the patient's life.<sup>25</sup> Emanuel and Emanuel describe four patterns of a doctor-patient relationship: paternalistic, informative, interpretive and deliberative. Considering ethics, patient autonomy and exploiting the doctor's skills, they recommend the last in most situations—including preventive health work.<sup>26</sup> In this study, all these models were represented. Many utterances

represented a directing rather than a guiding consultation style, the latter known to facilitate change best.<sup>10</sup> Shared decision making and patient-centred care does not include rhetoric manipulation and paternalism.

On one hand, the GPs in this study acknowledge clinical guidelines and patient-centred care. On the other hand, they acknowledge that they do not always follow these ideals in a complex clinical encounter. Training health care providers in patient-centred approaches are challenging but possible and positively affects patient satisfaction with care.<sup>27</sup> Effect on patients' health behaviour is more difficult to prove, but this approach is incorporated in clinical guidelines.<sup>11,28</sup>

#### *The mandate's borders—primum non-nocere*

Power is necessary in clinical settings, often benign but may offend.<sup>29</sup> Due to the professional role and context of the consultation, GPs are allowed to ask questions and perform investigations of extreme intimacy. Trust can be used to explore the patient's life and in this way enhance change of an unhealthy lifestyle. However, the patient is the vulnerable part in an asymmetrical relationship in the consultation. Transferring distressing information about risk in individual consultations may humiliate vulnerable patients. It is the professionals' challenge to explore patients' vulnerability when utilizing power. The intention of health care should be to improve the patient's health-related quality of life.<sup>30</sup> This intention should be kept in mind when utilizing distressing presentation of risk, prognosis and suggestion of efforts unfamiliar to the patients, who not necessarily define themselves as sick or at risk.

## Conclusions

GPs consider lifestyle counselling as an important part of their work. Motivating patients to change of lifestyle is often a process that takes time and involves different approaches. Communication in clinical settings is a challenging task, and a continuous focus on communication skills is necessary. The toolbox contains a variety of tools; some may cause humiliation and feelings of guilt and shame. GPs who continue to use distressing tools may be aware of these effects and the ethical dilemmas they pose. It would be of interest for further research to understand more about when, how and why they continue to use distressing communication tools and to explore patients' expectations, experiences and preferences concerning GPs' lifestyle counselling.

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## Declaration

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