UNIVERSITY OF BRISTOL
MEDICAL SCHOOL

Academic Unit of Primary Health Care

Health Related Behaviour Change

Summer Education Day for GP Teachers

Engineers House Clifton
27th June 2008

Report by David Memel and Chris Johnstone

Introduction

This year's Summer Education Day, attended by over sixty GPs, concentrated on how we as GPs, can help our patients to achieve better health, or better control of chronic diseases, by changing their behaviour. We can then pass on these important skills to medical students learning in our practices. A Masterclass was run by Dr Chris Johnstone, a leading specialist in behavioural medicine. Previously a GP, he's worked for over fifteen years in the addictions field and is much involved in training health-professionals. He co-ordinates the behaviour change teaching for medical students at Bristol University, trains GP's in motivational interviewing, and works within organisations to promote positive working environments. His book *Find Your Power* offers a self-help guide to behaviour change

Other talks on the day were

- Update on Primary Care Teaching
- Final Year SSC Audit Projects
- GMC visit to Bristol Medical School

Plus… a lunchtime guided walk to Clifton Suspension Bridge!

Update on Primary Care Teaching at the University of Bristol
Chris Salisbury

This academic year, Prof Chris Salisbury has taken over from Debbie Sharp as Head of Teaching in Primary Care. Chris started his talk by acknowledging the great contribution that Debbie had made in developing the contribution that Primary Care made to teaching in the Medical School in Bristol, since her arrival in Bristol fourteen years ago.

Chris then outlined the different courses and opportunities for GPs to contribute to teaching medical students. These are summarised in Appendix 1, at the end of this report.

He felt that his priorities for the near future were:

- Keep doing what we do so well- Primary Care teaching both at the University and in General Practices is acknowledged within the medical school as being of high quality
- Make management of the teaching more of a shared responsibility. A Teaching Senior Management Team has been established and will be the main decision making forum.
- Review each one of our courses in rotation at the termly teaching meetings- what is going well, what needs to be improved?
- Try to ensure that all relevant research staff are involved with teaching so that students benefit from contact with some of the leading experts in their field
- Encourage more research on teaching
- Build closer ties with the Severn Deanery and post-grad GP education

- More clarity and consistency over payments to GP practices
- Streamline our administration. Build a teaching database and make almost all communication with practices via email and the web, with less paper.
- Quality improvement - Teaching across multiple practices risks isolation for teachers and variable quality. So:
    - Continue to support teachers with workshops
    - Encourage process of self-appraisal as the basis for review and discussion with Academy GP leads
    - Have a clear mechanism for accrediting teachers as Honorary University Teachers, based on self-assessment, student feedback, training and regular commitment to teaching
    - Demonstrate consistently high quality through the above processes and student feedback

Promoting Health Related Behaviour Change

Chris Johnstone

"Health threatening behaviours are the commonest cause of premature illness and death in the developed world"
Rollnick et al[1], BMJ 2005;331;961-963

A key variable influencing the outcome of many medical conditions is patient behaviour. Exercise and dietary change can lead to clinical improvement in patients with diabetes, depression, arthritis and hypertension. Tackling smoking may be the single most important intervention in patients with respiratory conditions like chronic obstructive airways disease or asthma. Yet our health-promoting advice doesn't always fall on willing ears – and when it is resisted, consultations addressing health-related behaviour can be frustrating for both doctors and 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."
Rollnick et al[1], BMJ 2005;331;961-963

The purpose of today's theme is to look at what might help behaviour change consultations go well. We'll also explore some of the factors that can get in the way of this. We'll be drawing on research into the psychology of change and describing an approach shown by controlled studies to be more effective than simply giving advice. Finally, we'll be looking at how we can teach evidence-based insights and interventions to the next generation of doctors, so that they'll be in a stronger position to tackle the health challenges of chronic illness, obesity, depression and addictive behaviours.

It used to be thought that motivation was something some patients had, others didn't and that there wasn't much we could do to change this. However, research[2] suggests motivation fluctuates: some types of conversation can draw it out, whilst other, more

confrontational, exchanges can increase the expression of resistance. The approach of motivational interviewing develops this insight into a set of skills and strategies, and many of these are suitable for use in GP consultations. Drawing on Motivational Interviewing principles, I'd like to focus on seven suggestions for making behaviour change consultations more satisfying and effective. These are:

1) Recognise our ability to influence resistance

2) Aim for progress rather than perfection

3) View resistance as a signal

4) Use empathy as a tool

5) Support patients to make their own arguments for change

6) Use teachable moments

7) Explore a menu of options and ask them to choose

1) Recognise our ability to influence resistance

Can you remember times when someone pressured you to do something in a way that got your back up and made you more resistant? Avoiding things that can provoke resistance, like arguments, is a good starting point for conversations designed to draw out its opposites of enthusiasm and motivation.

2) Aim for progress rather than perfection

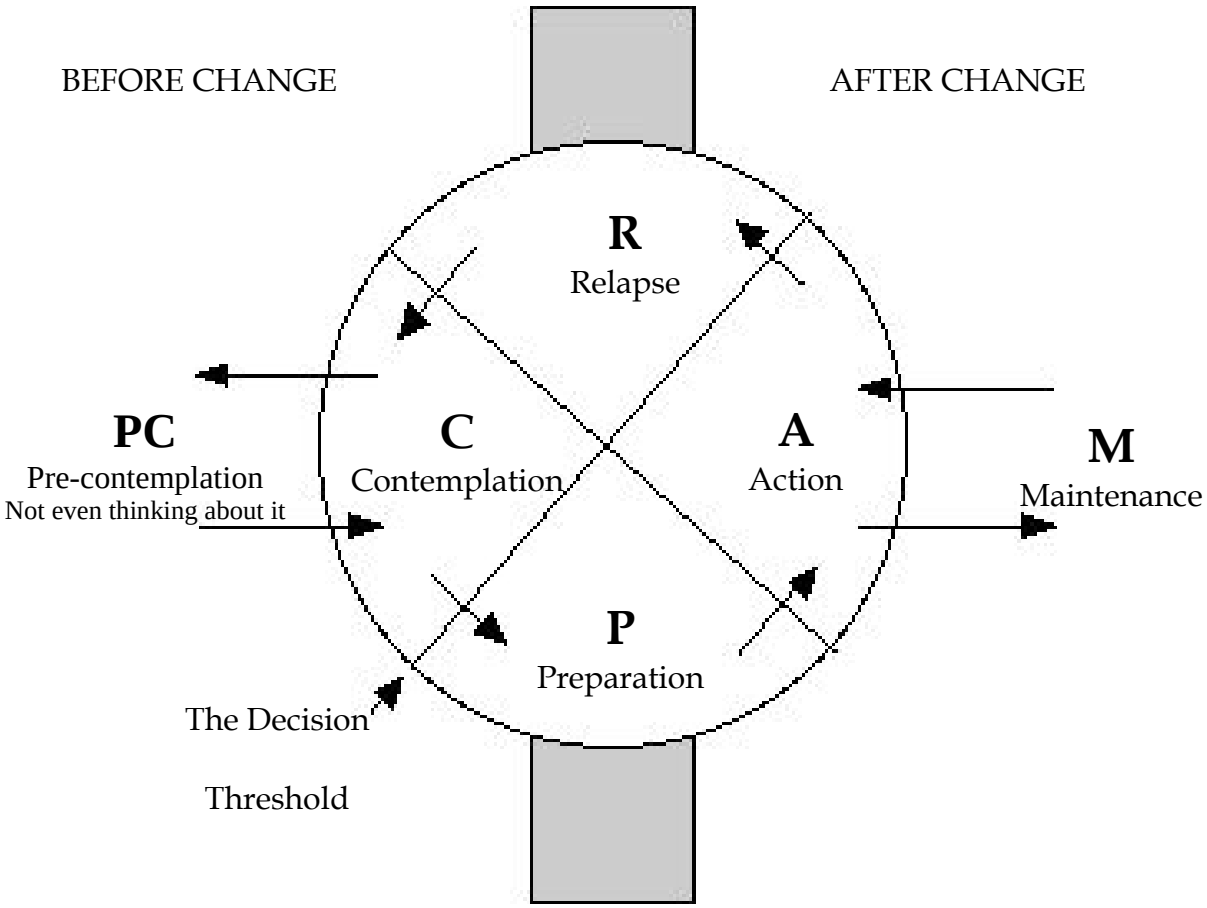
I find the 'stages of change' model enormously helpful here. Rather than feeling that we're failing if our patient isn't in the action stage of behaviour change, a motivational nudge that helps someone move in this direction is seen is as a success. The diagram below presents the journey of moving through these stages as similar to passing through a revolving door. If someone isn't even thinking about change (the Pre-contemplation stage), then raising awareness in a way that starts them thinking is a positive step.

People can get stuck at any of these stages, or stuck in a loop of going round the door (see Fig.1 below). It helps to have an understanding of common blocks and also to have ways of helping people through these. Skilfulness in behaviour change consultations is based on being able to recognise where the patient is at, and aiming for a step of progress from that point.

3) View resistance as a signal

Patient resistance can be evidence that the Doctor has moved too far ahead of the patient in their change process (see stages of change diagram on previous page). If a person is ambivalent about a particular change and still in the contemplation stage, for example, while the doctor has jumped ahead to talk about how the person can take action to accomplish that change, the doctor may find themselves in a "yes but" scenario. Here the doctor works hard at finding potential solutions and the patient responds with reasons why the solutions are unworkable for them. Using resistance as a signal can help you move back to where the patient is and work from there.

Fig 1: The stages of change model of Prochaska and Diclemente



4) Use empathy as a tool

Research identifies empathy as a key ingredient in successful behaviour change consultations[2]. An empathic intervention is where the doctor aims to understand the patient by first giving them room to express their view, and then accurately reflecting back or summarising what they've heard. A useful prompt for this is "Nudge, listen, summarise". A good question can invite or nudge the patient into describing their view, making space through active listening can draw this out, and by summarising you show you've listened, can check you've understood the patient's view correctly, and also help the consultation move on.

Motivations are usually mixed and resistance can be thought of as 'counter-motivation', where the patient is motivated, but in the opposite direction. Making room for people to explore mixed feelings can help them become clearer about what they want. Double-sided reflections (reflecting back both the attractive and not so attractive aspects they've described of their behaviour) can help the patient work through ambivalence.

Questions I ask myself, to help me understand a patient's perspective, are:

- "What are they a customer for?" (ie what's the change that's most important to them. This may not be the change you've identified as important).
- "What's the want behind the should?" To find their motivation, they need to associate the behaviour change with a gain that is attractive to them. What would this be?

5) Support patients to make their own arguments for change

Rather than persuading them, be interested and curious in why they might want to change. When we listen to patients describing their reasons like this, they may talk themselves into the change they want to make. Motivational Interviewing is an approach based on this, and one of its core interventions is to 'elicit self-motivating statements'.

When I hear a patient express interest (even slightly) in a change, I might use questions and reflective listening to draw this out more. Here's an example:

P: *"I'm not much good at sticking at diets, but I suppose I will have do something about my weight at some point"*
D*: "Aha, what makes you say that?"*
P*: "Well I can see it isn't going to do me any good"*
D*: "You have some concerns about what might happen if you didn't tackle this" (reflection, then silence and an interested look, which invites the patient to elaborate).*

6) Use teachable moments

The more the patient links the behaviour in question with symptoms they're concerned about, the more they are likely to be motivated to change. You can ask the patient whether they see any link. The link can be strengthened at 'teachable moments', i.e. times when a patient is particularly open to considering change (e.g. they are feeling ill due to a particular behaviour or someone close is suffering due to their similar behaviours).

A useful question to draw out links to lifestyle is "Why do you think this (ie current condition) is happening now?" If a patient doesn't seem aware of a link, a question that can open up a discussion about this is: "would you be interested in finding out more about what sort of things make a condition like this more likely to happen?"

7) Explore a menu of options and ask them to choose

It is their life and their choice; responsibility lies with the patient. But listing options can be a way of adding suggestions, and then leaving it to the patient to decide which of these to move forward with.

Closing quote:

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 motivations of the patient. This was the starting point of motivational interviewing which can be viewed as a refined form of a guiding style.
Rollnick et al[1], BMJ 2005;331;961-963

References

1. Rollnick et al (2005)[1], Consultations about changing behaviour, *BMJ;331;961-963*
2. Miller WR, Benefield RG and Tonigan JS (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology,* 61(3), 455-461.

Recommend Reading

1) We have developed an on-line teaching resource on Blackboard with key articles about behaviour change. To get onto the Blackboard site, type www.ole.bris.ac.uk . Then use the Guest login "med021". The password is "primcare". Under 'My Courses' on right, click **Community Orientated Medical Practice 2** Then on the Behaviour Change Resources. The Core Reading section is particularly recommended.
2) Stephen Rollnick, Pip Mason and Chris Butler (1999), Health Behaviour Change – a guide for practitioners, Churchill Livingstone. This is the key text in this field.
3) Chris Johnstone (2006), Find Your Power – boost your inner strengths, break through blocks and achieve inspired action, Nicholas Brealey Publishing. A self-help guide to behaviour change drawing on motivational interviewing and other approaches.

For more information on Dr Chris Johnstone's courses, see www.chrisjohnstone.info

Student Selected Components – Year 5 Audit Projects

David Memel

Student Selected Components (SSCs) are those parts of the curriculum that allow students some choice in what they want to study, and according to the GMC, should constitute25-33% of the curriculum.

Internal SSCs are integral to a core course, such as the Case Study in COMP2 in Year 4, based on interviewing a patient, carer, and health professional. GPs may be asked to find a suitable case for students attached to their practice.

External SSCs offer students Opportunity to study independently or pursue a course on a special interest. In their final (5^{th}) year they have a one month block, and many are interested in spending more time in General practice, doing an audit project.

Advantages for GPs are

- You can examine an area of care that you are interested in, but do not usually find the time.
- You share your ideas with the student, supervise them and they do the work
- You can use the audit for your GP Appraisal
- The practice gets paid £420

The role involves

- Meeting student beforehand to arrange project and sign registration form
- Set them on their way with Audit Administrator and be available for queries
- Mark the project within three weeks
- Arrange for student to present their project at a practice meeting

This scheme is usually only practicable for practices with easy access from the University (Bristol and surroundings), although some students arrange to go back to one of their COMP2 practices in their Academy, having made the arrangement the previous year.

Further details are available on the website
http://www.bristol.ac.uk/primaryhealthcare/ssc.htm
Contact Melanie.Stodell@bristol.ac.uk

GMC Visit to Bristol Medical School

Trevor Thompson

In the coming academic year the School of Medicine is undergoing a (routine) inspection by the General Medical Council known as QABME (Quality Assurance in Basic Medical Education). As part of this, the QABME team will wish to assess the way in which the School teaches medicine in Primary Care. This will involve visits to general practices. As the formal guidance on this is very brief, I picked up the phone and called the GMC and was surprised to end up a 30 minute conversation with programme manager, Ms Kirsty White. Below are my gleanings from this conversation which she has subsequently confirmed.

- The GMC is not visiting GPs to assess them but to judge the medical school and curriculum for which they are teaching. There are therefore no direct consequences for a practice (excepting exceptional circumstances).
- They like to visit a range of practices: those that do a lot of teaching in several years and those that do only limited amounts (say one year only). They also like to visit practices close to Bristol and those far distant.
- They typically visit 3-4 practices at each medical school, whilst students are present. Each visit lasts around 2 hours.
- All visits involve a meeting between the QABME team (typically two persons) and the GP educator and, separately, with the medical student(s). Interviews begin with open questions before addressing any specifics.
- Sometimes, though not always, they like to observe teaching in consultations. Typically they would do this with two assessors.
- Interviews are not confidential in that problems encountered may be fed back to the medical school but, crucially, as evidence of systemic issues not as opportunities for criticising individual practices.
- Participation is voluntary but seen as very important to the GMC as it provides a professional view outside the formal structure of the medical school
- The warning time before a visit may only be weeks. The process is designed so that GPs do not need to do any preparation, as they prefer to see normal teaching sessions.

Lunchtime Walk to Clifton Suspension Bridge

Mike Rowland

During the lunch break, there was a windswept guided walk by Mike Rowland of the Clifton Suspension Bridge Trust. This was a wonderful example of Good Teaching, including audience participation and the use of humour.

The Clifton Suspension Bridge, spanning the beautiful Avon Gorge, is the symbol of the city of Bristol. For almost 150 years this Grade I listed structure has attracted visitors from all over the world. Its story began in 1754 with the dream of a Bristol wine merchant who left a legacy to build a bridge over the Gorge.

The first competition in 1829 was judged by Thomas Telford, the leading civil engineer of the day. Telford rejected all the designs and submitted his own but the decision to declare him the winner was unpopular and a second competition was held in 1830. 24 year old Isambard Kingdom Brunel was eventually declared the winner and appointed project engineer – his first major commission.

The foundation stone was laid in 1831 but the project was dogged with political and financial difficulties and by 1843, with only the towers completed, the project was abandoned. Brunel died prematurely aged 53 yrs in 1859 but the Bridge was completed as his memorial and finally opened in 1864. Designed in the early 19th century for light horse drawn traffic it still meets the demands of 21st century commuter traffic with 11-12,000 motor vehicles crossing it every day.

There was a medical aspect to Mike's talk, when he described the long history of the suspension bridge as a site for attempted suicides. This included Sarah Ann Henley from Bristol, who in 1885 following an argument with a boyfriend, threw herself from the Bridge. Beneath her billowing dress she was wearing crinoline petticoats which slowed and cushioned her fall. She was injured but was pulled from the mud, eventually recovered, and died in 1948 at the grand old age of 84.

One of our course participants Carole Buckley, GP in Fishponds, Bristol, reminded us that her husband Mike Nowers a psychiatrist, has done important research on this topic, including a recent paper demonstrating the effectiveness of the barriers on the sides of the bridge in reducing the number of suicides.

References:

Effect of barriers on the Clifton suspension bridge, England, on local patterns of suicide: implications for prevention
Bennewith O, Nowers M, Gunnell D. *Brit J Psychiatry* 2007; 190: 266-267.

Suicide from the Clifton Suspension Bridge in England
Nowers M, Gunnell D. *J Epidemiol and Commun Health* 1996; 50:30-32.

Appendix1: Overview of General Practice based teaching organised by Primary Care

For more information visit: http://www.bristol.ac.uk/primaryhealthcare/teaching.htm

Year	No of students	Teaching task	Sessions	When
1	groups of 3, 4 or 6	**Human Basis of Medicine Course** **Aims and objectives of the Primary Care Attachment** To raise awareness of the scope and nature of primary health care through observing health care professionals and meeting and interviewing patients • Visited patients at home in pairs to develop interviewing and listening skills to elicit patients' perspectives on their health, illness and the health care that they have received. • Observed the GP consult with a variety of patients and begin to understand the skills that contribute to good verbal and non-verbal communication. • Applied theoretical information from sociology lectures and the first year handbook to clinical practice and evaluated the relevance to doctors and patients. Academic support: Louise.Younie@bristol.ac.uk Admin. Support: Jacqui.Dalley@bristol.ac.uk	8 consecutive sessions	Oct. – Dec.
2	groups of 4 or 5	**Basic Clinical Skills element** **Aims and objectives of the Primary Care Attachment** To develop students' clinical skills and knowledge in history taking, physical examination and communication. • Taken, recorded and presented a relevant history from a patient with symptoms relating to cardiovascular, respiratory, gastrointestinal, renal and neurological systems, using a range of communication skills. • Examined a patient and elicited, demonstrated and interpreted common physical signs in these systems. • Gained a holistic understanding of the causation and effects of diseases through practicing and reflecting on the integration of physical, social and psychological factors Academic support: Barbara.Laue@bristol.ac.uk Admin. Support: Jacqui.Dalley@bristol.ac.uk	2 groups of students, each group for 4 sessions a total of 8 sessions in academic year	Sessions are spread throughout the year

3	groups of 3-5	**GP teaching in Medicine and Surgery** **Aims and objectives of the Primary Care Attachment** To develop and consolidate students' clinical skills and to foster professional attitudes towards patients and other team members. • To practice and consolidate clinical skills (consultation skills, history taking, examination and formulation of diagnoses and management plans) through being observed consulting with patients with common clinical problems in a small group setting in general practice. • To reflect on and appreciate the differences between diagnosis and management strategies in primary and secondary care. • To evaluate their clinical experience by drawing on the teaching in the vertical themes of whole person medicine, ethics and communication skills. Academic support: Barbara.Laue@bristol.ac.uk Admin. Support: Melanie.Stodell@bristol.ac.uk	2 groups of students, each group for 4 sessions a total of 8 sessions in each academic year	During each unit of the 4 units which make up this year
4	1	**Community Orientated Medical Practice 2** **Aims and objectives of the Primary Care Attachment** To develop the students' skills in the management of common and chronic problems encountered in primary health care, dermatology and care of the elderly. COMP 2 explores and provides experience in the following vertical themes: - Communication Skills - Whole Person Care - Disability **Objectives** (specific to Primary Care) By the end of the unit each student should be able to: • Describe the role of the GP and the other members of the primary health care team and appraise the different systems providing open access health care in the UK. • Know differential diagnoses for each of the common symptoms presented in the Primary Care syllabus and understand the concepts of disability and illness.	Two 2 week placements or One 4 week placement on a residential or non-residential basis. 15 sessions for each 2 week placement	Sessions are spread throughout the year

		• Demonstrate in a simulated consultation how to manage each of the clinical problems listed in the Primary Care syllabus, including complex medico-psycho-social presentations. • Demonstrate in a simulated consultation appropriate communication skills including how to manage uncertainty (diagnosis and management), how to help patients change their behaviour and how to communicate risk. • Evaluate evidence and guidelines when offering treatment options to patients. Academic support: Andrew.Blythe@bristol.ac.uk Admin. Support: Melanie.Stodell@bristol.ac.uk		

Undergraduate teaching opportunities at the University, outside your practice, contact Melanie.Stodell@bristol.ac.uk

Year 1 Small group facilitator for one session following the introductory lecture for year 1 students
Year 2 teaching communication/consultation skills in small group setting with actors
Year 3 Single communication/consultation skills session with actors
Year 4 Single communication/consultation skills session with actors
Year 5 Interface session
Acting as examiner for primary care OSCE (Objective Structured Clinical Examination) stations in year 3 and 4 and finals