大阪公立大学 Osaka Metropolitan University 学術情報リポジトリ

Patient Education : Recognizing and Overcoming Barriers to Change

メタデータ	言語: English
	出版者:
	公開日: 2009-08-25
	キーワード (Ja):
	キーワード (En):
	作成者: Miers, Anne G.
	メールアドレス:
	所属:
URL	https://doi.org/10.24729/00005624

Journal, Sch. of Nurs. Osaka Pref. Univ. Vol.12 No.1
大阪府立大学看護学部紀要　12巻1号，2006

資　料

Patient Education: Recognizing and Overcoming Barriers to Change

Anne G. Miers, MSN, RN, CNRN, APRN-C
Neuroscience Clinical Nurse Specialist
Mayo Clinic, Saint Marys Hospital
Rochester, MN

Introduction

Over the years, health care providers have developed many kinds of written and video materials to give to patients for education on disease and health management. Research is showing the healthcare community, however, that information alone may not be enough to bring about changes in patient behavior to result in changes in self-care.

In the United States (US), some have argued that health care systems have not adapted well to working with chronic conditions. The medical model still largely supports the belief that it is the health care professional's role to diagnosis and prescribe, and the role of the patient to comply. This philosophy may work very well in managing acute conditions such as appendicitis or bacterial infection, but it is not as effective in managing chronic conditions that can change over time. There is a growing belief that effective care can only occur through patient and provider partnership.

In the US and in some other countries, the physician-patient relationship has shifted from a physician-directed model to one that encourages greater patient participation (Balint & Sheldon, 1996). This model stresses patient empowerment, increased access to information and options and shared decision-making.

Glasgow and Anderson (1999), in an article in *Diabetes Care*, stated the following: "Patients are in control. No matter what we as health professionals do or say, patients are in control of these important self-management decisions. When patients leave the clinic or office, they can and do veto recommendations a health professional makes."

This "patient centered" model of providing care and education to patients has health care professionals in the roles of consultant, interpreter of symptoms, resource person and one who offers treatment options. Patients are responsible to monitor symptoms, report them accurately and manage their disease from day to day.

Lorig and Holman (2003) and other authors (Clark et al., 1997) note that patient self-management strategies basically include three tasks. The first is medical management of their condition. This includes tasks such as recognizing and acting on symptoms; using medications correctly; and managing emergencies.

The second task is maintaining, changing and creating new meaningful behaviors. This has the patient maintaining nutrition and diet; maintaining adequate exercise; using stress reduction techniques; not smoking and interacting effectively with health care providers.

The third task requires one to deal with the emotional sequelae of having a chronic condition which alters ones view of the future. These tasks might include using community resources; adapting to work; managing relations with significant others; and managing psychological responses to illness

Of these tasks, it is felt that tasks number two and three may be the most challenging self-management behaviors to change. Patients are more likely to take medications than to change their lifestyle. However, promoting health behavior change among those with chronic disease is felt to be critical to helping reduce further morbidity (Wing & Goldstein, 2001).

In a 2003 interview with Dr. Robert Bazell on the NBC's Today television program, Elias Zerhouni, then the director of the National Institute for Health in the US, emphasized the importance of behavioral research for the future of medicine. He stated. "Fifty percent of the burden of disease in the United States is due to behaviors such as smoking, overeating, not exercising and so on which we could, with behavioral interventions, change." Zerhouni also said that researching ways to change behavior could be more daunting than decoding the human genome.

Changing behaviors

Why is it so hard to change behavior? In the US, consumers are bombarded by advertising in magazines and on TV that give false promises about products and the change the product can have on a person's life. Consumers are promised a product can help them loose many kilos of weight in "just weeks". Or they are promised a product will help them quit smoking forever. One product advertisement states that quitting smoking is "like child's play". Nurses and health care educators know from working with people that helping them to change is never this easy.

There has been research done looking at how people learn and the stages they go through before making a change (Prochaska & Diclemente, 1983). This model suggests that there is a period of contemplation, (people need to think about it), preparation, (getting things ready for the change), an action stage (finally doing it), and then there is a time of maintenance and often a period of relapse. The reality of changing behavior through education is that it is a process, it can take time, it requires maintenance and it is rarely quick and easy.

What are studies of human behavior teaching us about the counseling done by physicians, nurses and other health educators (Bondenheimer et al., 2002, Clark & Vickers, 2004, Warsi et al., 2004)? First of all, we are learning that counseling is effective in modifying patient behavior (Clark & Vickers, 2004). Research shows that physicians and nurses consider patient education valuable, however the results of the education may have limited effects for changing the patient behavior in chronic illness (Warsi et al., 2004). The studies also show that in order for patient self-management to work, the patient must be empowered (O'Hara et al., 2004). There has to be a good patient-clinician relationship. We are also learning that the education provided must be patient-centered and the use of motivation-enhancing and patient-centered counseling strategies will bring about health behavior change (Lorig et al., 1999, Warsi et al., 2004).

One might say, well that sounds good, but where do we start? We must start with ourselves. We need to examine barriers in our own behaviors that impact our abilities to conduct health behavior and self-management counseling.

Clinician Barriers

It would be interesting to identify if the barriers that clinicians in the US state are similar to those caregivers in Japan might list. When asked why we don't do the education and counseling we know we should do, many reasons are listed by US clinicians. The following list of reasons is complied from many sources (Cabana et al., 1999, Coleman et al., 2000, Kushner, 1995, Mcllvain et al., 2002, Stafford et al., 2000):

- Time--we say we don't have enough time to do this kind of education
- We have a perceived lack of counseling skills (I couldn't do that...)
- There is some pessimism about change (This patient has been overweight since childhood, he will never loose weight)
- There is a lack of reimbursement--in US there is no payment schedule for the time spent teaching a patient
- We have an inadequate system for delivery, tracking and follow-up for these types of services
- Intrapersonal variables (If I smoke or if I am over weight, or if I don't control my diabetes, how can I encourage a patient to change behaviors?)

It is important for clinicians to examine this list and address those barriers that can be overcome.

Work by Beck et al. (2002), shows that relationships with patients are very important as a positive relationship can bring about change. A positive clinician/patient relationship can lead to

- Increased patient **satisfaction**
- Increased patient **trust** in clinician
- Increased **understanding and adherence** to instructions
- Decreased litigation for malpractice
- Improved patient health status

While this research comes from medical literature, it can easily apply to anyone providing education to a patient. Physicians, nurses and health educators can improve patient outcomes by doing some of the following interventions with patients (Beck et al., 2002):

- Express empathy to the patient
- Make statements that show reassurance and support
- Be friendly and courteous
- Use patient-centered questioning techniques
- Increase the clinical encounter with more time spent on health education
- Express positive reinforcement in response to patient
- Address patient's feelings, emotions, and social relations
- Share medical data with patient
- Listen to patient questions and statements
- Summarize information from patient

In contrast, in this study (Beck et al., 2002) shows us that there are clinician behaviors that negatively impact patient outcomes. These include:

- Demonstrating irritation, anger, or nervousness
- Frequently interrupting patient
- Information collection without feedback to patient
- Antagonistic behavior
- Exerting dominance
- Using a strictly biomedical questioning style
- Demonstrating body orientation away from patient

Confrontation often increases resistance to change or denial that a change has to be made. It also impacts disclosure and rapport with the patient. In summary, clinician behavior impacts patient outcomes both positively and negatively.

Patient Barriers

Having examined the barriers to clinicians providing education, what are the barriers patients have to changing their behaviors?

As noted, patients may find it hard to make change when they realize they have a chronic condition versus an acute condition that would heal quickly. This can lead to pessimism. Patients may feel overwhelmed and may experience a fear of failure. They can experience "All or None" thinking. For example they may ask themselves, why should I be happy that I lost 5 kilos when I have 30 more to loose?

There can also be societal/environmental influences that are perceived as barriers to making the change. Stress plays a part in the resistance. One must ask, what are these patients experiencing outside of their disease experience? How convenient is making the change?

Hathaway et al. (2004) have done a study of patients with advanced-stage cancer to see what were perceived as barriers to performing physical activity. It not uncommon for us to tell patients they should remain physically active or to exercise. This is what these patients listed as the reasons they didn't do what they were advised to do:

- They experienced fatigue, decreased stamina and low energy
- They had physical problems, pain and side effects of treatment
- There was a lack of motivation
- Lack of time
- Lack of exercise partner
- Weather/environment was a barrier
- Lack of instructions/knowledge of what physical activity is safe or recommended
- Family and child care responsibilities got in the way of doing their exercise.

Would these be reasons your patients might list too? Despite identifying barriers to physical activity, 50% of participants in this study indicated that they were seriously planning to increase their physical activity within the next 6 months (Hathaway et al., 2004). In addition, 47% reported being "probably" or "definitely" interested in receiving professional support to help increase or maintain physical activity levels (Hathaway et al., 2004).

Motivational Interviewing

A technique for working with patients that has growing popularity in the US is called Motivational Interviewing. It is defined as "A directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence (Miller & Rollnick, 2002)." Again, the key principles, based on the research in this area (Emmons & Rollnick, 2001, McVambridge, 2004, Miller & Rollnick, 2002), would be to

- Express empathy.
- Develop discrepancy between patient goals and current problem behavior.
- Avoid arguing (patient responsible for decision to change).
- Roll with resistance (avoid confrontation).
- Support self-efficacy and optimism for change
- Avoid assumptions.

In reviewing what was perceived to be a barrier by the provider, it was noted previously that "time" is an issue in providing counseling and education. What can one do if you only have a few minutes with the patient?

One can begin by building rapport and expressing empathy which we probably do already in our encounters. In my opinion, however, where we need to improve, is in the assessment and discussion with the patient about readiness to change.

Here are some examples of questions or comments that might elicit a response when discussing change. One would choose a question/comment that best fits the context of the situation.

- How would you rate your motivation/confidence to make a change?
- What would you choose as a first step?
- What could work?
- How else could you do it?
- What other strategies have you thought of?
- I can see how that would concern you, what might help that?
- Yes, there are many reasons why change can be difficult, what could work?
- I'm impressed that you were able to...
- I've noticed that you really care about...
- The fact that you were able to...makes me optimistic.
- Despite all of that, it seems like you have really thought about making a change.

If you have a few more minutes with the patient, you could initiate discussion regarding the pros and cons of the change. You can begin to assist the patient to select an initial goal that is realistic, short term, one that they rate confidence that they might achieve and modify it if it doesn't look like it will work.

Practical Example

Here is a very specific example of what motivational interviewing might look like in the clinical setting. The example goes through a scenario on how to do a brief tobacco use intervention. It could be adapted to any chronic health issue requiring change.

Conclusion

Obviously, much more research needs to be completed on the best methods to get humans to change behaviors, but some beginning research gives health care providers beginning tools to attempt and methods to test. It is important that healthcare consumers have access to interventions based on proven strategies for health risk reduction. Providing resources for people that can effectively empower health behavior change and reduce health risk behavior can impact important outcomes such as health care cost and health-related quality of life (Vickers, 2005).

**I wish to thank Kristen S. Vickers, PhD, Clinical Psychologist, Department of Psychiatry and Psychology, Mayo Clinic, Rochester, MN for her assistance in the preparation of this presentation and manuscript.

Table 1. Application of Motivational Interviewing: A Brief Tobacco Use Intervention

Introduce Topic and Assess Readiness for Change		
Goal	Strategy	Example
Introduce topic	Use an open-ended, nonjudgmental question or comment to invite the individual to discuss smoking.	*I'd like to understand what it is like for you to be a smoker—please tell me about it.*
Assess motivation	Ask the individual to rate motivation to quit smoking.	*Please rate for me, on a scale from 0 to 10, your current motivation to quit smoking. If 0 is not at all motivated to quit smoking and 10 is completely ready to quit smoking, what number are you right now?*
Assess confidence	Ask individual to rate confidence to quit smoking.	*Again on a scale from 0 to 10, how confident are you that you could be successful at quitting smoking if you decided you wanted to quit right now?*
Address Motivation and Confidence		
Goal	Strategy	Example
Discuss motivation	Elicit individual's self-statements about change by having them explain their motivation rating.	*Why are you a ___ and not a zero?* *What would it take for you to move from a ___ to a (higher number)?* [Note that anchoring the question in the other direction (why are you a ___ and not a 10) is unhelpful because it encourages the individual to argue against change.]
Weigh pros and cons	Explore both the benefits of change and barriers to change with the individual.	*What do you like about smoking?* *What concerns you about smoking?* *What are the roadblocks to quitting?* *What would you like about being a nonsmoker?* Summarize both the pros and the cons, then ask: *Where does that leave you now?*
Provide personal risk information	Share nonjudgmental information about risk and discuss the information (avoid advice-giving or attempting to shock/frighten the individual into change).	*What do you make of these results?* *Would information about the risks of smoking be helpful to you now?*
Discuss confidence	Elicit self-statements about confidence to quit smoking	*Why are you a ___ and not a zero?* *What would help you move from a ___ to a (higher number)?* *What can I do to support you in moving up to a (higher number)?*
Offer Support and Make Individualized Plan		
• Work together to create an individualized plan that matches the person's readiness to quit. • Encourage individual to consider what could work, rather than focus on what could not. • Provide options (referral, nicotine replacement, patient education materials), but not direct advice. • Ask the individual to select the next step. • Reinforce any movement toward making a change. • Follow-up on subsequent visits.		

Vickers, K.S adapted from:
Rollnick S, Butler C, & Stott N (1997). Helping smokers make decisions: The enhancement of brief intervention for general medical practice. *Patient Education and Counseling*, 31, 191-203.
Miller W, Rollnick S (2002). *Motivational Interviewing: Preparing People for Change*. New York: Guilford Press.

References

Balint, J., & Shelton, W. (1996). Regaining the initiative; forging a new model of the patient-physician relationship. *JAMA, 275 (11)*, 887-891.

Beck, R., Daughtridge, R., & Sloane, P. (2002). Physician-patient communication in the primary care office: a systematic review. *Journal of the American Board of Family Practice, 15*, 25-38.

Bodenheimer, T., Lorig, K., Holman, H., et al. (2002). Patient self-management of chronic disease in primary care. *JAMA, 288 (19)*, 2469-75.

Cabana, M. D., Rand, C.S., Powe, N.R., et al. (1999). Why don't physicians follow clinical practice guidelines? A framework for improvement [see comment]. *JAMA, 282 (12)*, 1458-1465.

Clark, M. M., & Vickers, K. S. (2004). Counseling for health behavior change. In R. Lang, & D. D. Hensrud (Eds.), *Clinical Preventive Medicine 2nd Edition* (p.59-67). Chicago: American Medical Association.

Clark, N., Janz, N., Dodge, J., et al. (1997). Self-management of heart disease by older adults. *Research on Aging, 19*, 362-382.

Coleman, T., Murphy, E., & Cheater, F. (2000). Factors influencing discussion of smoking between general practitioners and patients who smoke; a qualitative study. *British Journal of General Practice, 40 (452)*, 207-210.

Emmons, K., & Rollnick, S. (2001). Motivational interviewing in health care settings. *Am J Prev Med, 20*, 68-74.

Glasgow, R. E., & Anderson, R. M. (1999). In diabetic care, moving from compliance to adherence is not enough. Something entirely different is needed. *Diabetes Care, 22 (12)*, 2090-2092.

Hathaway, J., Vickers, K.S. & Smith, M. (2004). Benefits and barriers of physical activity among advanced-stage cancer patients [published abstract. *Annals of Behavioral Medicine*, 27 Supplement, S022.

Kushner, R.F. (1995). Barriers to providing nutrition counseling by physicians; a survey of primary care practitioners. *Prev Med, 24 (6)*, 546-552.

Lorig, K. R., & Holman, H. R. (2003). Self-management education: history, definition, outcomes and mechanisms. *Annals of Behavioral Medicine, 26 (1)*, 1-7.

Lorig, K. R., Sobel, D. S., Stewart, A. L., et al. (1999). Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization. *Med Care, 37*, 5-14.

McCambridge, J. (2004). Motivational interviewing is equivalent to more intensive treatment, superior to placebo and will be tested more widely. *Evid Based Ment Health, 7 (2)*, 52.

McIlvain, H. E., Backer, E. L., Crabtree, B. R., et al. (2002). Physician attitudes and the use of office-based activities for tobacco control. *Family Medicine, 34 (2)*, 114-119.

Miller, W., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press.

O'Hara, E. L., Boudreaux, E. D., Jeffries, S. K., et al. (2004). Stage of change movement across three health behaviors; the role of self-efficacy. *Am J Health Promot, 19 (2)*, 94-102.

Prochaska, J. O., & Diclemente, C. C. (1983). Stages and processes of self-change of smoking: toward an integrative model of change. *J Consult Clin Psychol, 51 (3)*, 390-5.

Rollnick, S., Butler, C., & Stott, N. (1997). Helping smokers make decisions; the enhancement of brief intervention for general medical practice. *Patient Education and Counseling, 31*, 191-203.

Stafford, R.S., Farhat, J.H., Misra, B., et al. (2000). National patterns of physician activities related to obesity management. *Arch Fam Med, 9 (7)*, 631-638.

Vickers, K. S (2005). Empowering behavior change. *Health and Productivity Management* (Special edition) 2 (1), 9-13.

Warsi, A., Wang, P. S., Lavalley, M. P., et al. (2004). Self-management education programs in chronic disease: a systematic review and methodological critique of the literature. *Arch Intern Med, 164 (15)*, 1641-9.

Wing, R. R., & Goldstein, M. E. (2001). Behavioral science research in diabetes; lifestyle changes related to obesity, eating behavior and physical activity. *Diabetes Care, 24 (1)*, 117-123.