

A qualitative study of lifestyle counselling in general practice in Ireland

Barry Lambe^a and Claire Collins^b

^aDepartment of Health, Sport and Exercise Science, Waterford Institute of Technology, Cork Road, Waterford and ^bIrish College of General Practitioners, 4/5 Lincoln Place, Dublin 2, Ireland.

Correspondence to Barry Lambe, Department of Health, Sport and Exercise Science, Waterford Institute of Technology, Cork Road, Waterford, Ireland; E-mail: blambe@wit.ie

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Background. There is limited information in Ireland on the attitudes of GPs and practice nurses to lifestyle counselling and the strategies or approaches they use. Furthermore, there is no national framework or resources to support the systematic and uniform provision of lifestyle counselling.

Objectives. To explore the views of Irish primary health care practitioners about behavioural risk factor management in particular to the provision of lifestyle counselling. To identify barriers to behavioural risk factor management and to inform the development of a risk factor management toolkit for general practice.

Methods. The research design is a qualitative study consisting of six focus groups with primary health care practitioners in urban and rural locations in the Republic of Ireland. Two focus groups were conducted with GPs, two with practice nurses, one with a mixed group of GPs and practice nurses and one with a Primary Care Team. In total, 56 participants, aged 30–64 years, attended the focus groups. Descriptive analysis was performed.

Results. GPs and practice nurses experienced considerable barriers to lifestyle counselling. These include insufficient time, patient resistance, lack of funding for prevention and lack of training. Participants were aware of the value of patient-centred lifestyle counselling; however, the provision of simple lifestyle information and advice was the predominant strategy used.

Conclusions. GPs and practice nurses regularly conduct lifestyle counselling despite considerable barriers. It is essential that they are supported to carry out lifestyle counselling as part of a systematic 'whole practice approach' to prevention in general practice.

Keywords. Chronic disease, counselling, health promotion, lifestyle, prevention, public health.

Introduction

Despite the apparent advantages of promoting positive health in general practice, the transition from its traditional predominant focus on curative care has been slow. The complexities of lifestyle behaviour change require health professionals to move away from simple advice giving to a more counselling-based approach. Lifestyle counselling includes a broad range of behaviour change strategies (e.g. decisional balance, self-monitoring, goal setting and relapse prevention) used by general practice staff when working collaboratively with patients. This change in approach is made more difficult due to the predominantly private provision of GP services in Ireland. Indeed, it also raises the question of whether it is the responsibility of the GP to provide lifestyle counselling.

Although the majority of primary care health professionals believe that they should be providing

preventive services, in practice, they are less likely to do so.¹ Internationally, rates of lifestyle counselling are low, with studies suggesting rates as low as 1–5% for common lifestyle behaviours such as alcohol consumption, physical activity, stress, diet, weight and smoking.^{2,3} The most commonly cited barriers to lifestyle counselling in general practice include lack of time due to a heavy workload,^{1,4–7} no reimbursement^{1,7} and lack of training and knowledge.^{4–10} Although lack of time is consistently cited in studies, findings contrary to this were reported in a large randomized control trial of lifestyle counselling among US clinicians, where 63% of clinicians reported that counselling caused little or no increase in the length of a routine visit.¹¹ There is also a large body of evidence to suggest that both GPs and practice nurses believe that their advice will be ineffective and unlikely to be followed by patients due to a perceived lack of interest.^{1,4,12}

The European guidelines on cardiovascular disease prevention in clinical practice¹³ recommend that practitioners follow eight strategic steps to enhance the effectiveness of lifestyle counselling. Despite having such clear recommendations and evidence-based guidelines, there are no support structures, guidelines or resources to support lifestyle counselling in Irish general practice.

The objectives of the study were as follows:

1. To identify the barriers to behavioural risk factor management in general practice in Ireland.
2. To identify the current strategies used by Irish GPs and practice nurses when promoting healthy lifestyle choices with patients.
3. To inform the development of a pilot behavioural risk factor management project in Irish general practice.

Methods

Setting and participants

Six focus groups were carried out between May and June 2007 to inform the development of a behavioural risk factor management toolkit for general practice. Two focus groups were conducted with GPs, two with practice nurses, one with a mixed group of GPs and practice nurses and one with a Primary Care Team (PCT). The PCT was a multidisciplinary group consisting of four GPs, two practice nurses, four public health nurses, one social worker, one physiotherapist and one occupational therapist.

Sampling was purposeful and aimed to include primary care participants from both urban and rural locations in the Republic of Ireland. The sampling frame was responders to an information letter on the development of a behavioural risk factor management project in Ireland. The six focus group locations were chosen based on the greatest number of responders in a particular geographical area. Each focus group consisted of participants representing several different practices. Participants received a sample behavioural risk factor management toolkit prior to attending the focus group. The project was approved by the Irish College of General Practitioners (ICGP) Research Ethics committee.

Focus groups

Each focus group was conducted in a hotel conference facility with the exception of the PCT interview, which took place in the PCT meeting room. They were facilitated by a research assistant employed by the ICGP. Each interview lasted ~75 minutes with the exception of the PCT session. This interview was facilitated as part of the teams' weekly clinical meeting and therefore only lasted ~40 minutes. Consequently, an

abridged version of the topic guide was used with the PCT. The topic guide was developed from a review of the literature and included questions related to the perceived importance of lifestyle counselling, the strategies they used, their priorities for prevention, their vision for a national programme and their views on the sample toolkit. The PCT were only asked to discuss the latter two issues.

Immediately prior to the interview, the researcher explained the purpose of the focus group and asked participants to base their discussions on five risk factors. These were smoking, nutrition, alcohol, physical activity and weight. These were listed on a flip chart for the duration of the session. The sample toolkit was also explained by the researcher (~5 to 10 minutes) during the focus group before participants were asked to discuss its appropriateness in an Irish context.

Data analysis

All interviews were recorded and subsequently transcribed verbatim. Descriptive analysis using Kruger's framework analysis approach¹⁴ was carried out. A copy of the first draught report was distributed to each participant to validate the accuracy of its content.

Results

In total, 56 participants attended the focus groups. Participants were aged between 30 and 64 years. Twelve PCT members participated in the PCT focus group.

Attitudes to lifestyle counselling

General practice does not have a long history of providing preventive services to patients. Nonetheless, many GPs and practice nurses said that they regularly give simple lifestyle information and advice to patients despite considerable barriers to the practice. Many participants considered this to be the normal care of the patient:

[prevention is] part of what we do. It's not all about medications (practice nurse)

They described general practice as an ideal setting to deal with lifestyle behaviours due to the influence of the GP and the ability to reinforce health messages with patients:

I think the GP is still held in high esteem with most people. You're quite influential even though you probably don't realise it all the time (GP)

Barriers to lifestyle counselling

The main barriers to lifestyle counselling experienced by participants include the predominant focus on treatment in general practice, limited time and patient

resistance. These systematic barriers to lifestyle counselling in general practice are the most extensive of all barriers and were predominantly highlighted by GPs. Both practice nurses and GPs displayed a very good understanding of behaviour change concepts recognizing that it is a complex process. In contrast to practice nurses, GPs particularly emphasized the influence of the wider determinants of health on lifestyle behaviours. That is, participating in unhealthy lifestyle behaviours is often secondary to the root cause of a patient's problem. To deliver lifestyle counselling, according to participants, would require a considerable reorganization of the general practice setting because currently '... the whole system is set up to write prescriptions' (GP).

Some GPs also expressed their concern that the current public contract for services does not include preventive activities in general practice. Lifestyle counselling was viewed as time consuming and something that is tagged on to the end of a consultation and has the potential to 'open a can of worms' (GP). Therefore, lifestyle counselling can impact on the profitability of the practice. This was seen as important for a small number of GPs who felt that business-minded practices would only consider engaging in activities that would generate an income for the practice. This view was also reiterated by some practice nurses who noted that:

Health promotion is not actually why we're employed in the practice, I mean it's a business, so it's what's going to generate money for the practice.

GPs also cited the difficulty associated with finding a suitable time to broach the subject of lifestyle behaviour change. This may be related to patient resistance. GPs reported that many patients get offended if they raise the subject of lifestyle behaviours with them. Patients may not realize that their lifestyle behaviours are related to their condition and so 'can get very shirty and think that we're being judgemental'. One GP, in particular, suggested that she would be very conscious of not offending patients for fear of losing them to another practice:

I've come back from working in a practice in England where people can't doctor shop as much and I'm more conscious of it now starting off in a new practice, not wanting to antagonise people but being very conscious of the importance of it [lifestyle counselling].

Both GPs and practice nurses repeatedly highlighted a deficiency in their lifestyle counselling skills. Further training needs related to the barriers expressed by participants include knowledge of the evidence for lifestyle counselling for each risk factor,

how to provide lifestyle counselling regardless of the practitioner's personal lifestyle choices, intensive training in addictive behaviours and initiating a lifestyle consultation (for GPs).

Approaches to lifestyle counselling

Neither GPs nor practice nurses felt that they were very effective at lifestyle counselling despite using a wide range of strategies. The most commonly used strategy by all participants was the provision of simple lifestyle information and advice to patients. Some participants recognized how ineffective unsolicited advice and information provision was. However, the use of fear appeals was also a very common approach used and more evident from discussions with practice nurses than GPs.

I've a chart that shows what's in a cigarette and I'd come down heavy on them, telling them there's arsenic and rocket fuel in it. They'd be horrified (practice nurse)

A large number of the strategies described by group members were underpinned by using these fear appeals to increase the importance of change with the patient. Most participants, though not all, displayed a good level of understanding of the potential pitfalls of using fear appeals.

A national programme

Many participants were dissatisfied with the current inequity of access associated with programmes in general practice. Therefore, a national initiative would have to accommodate both public and private patients equally. Both GPs and practice nurses shared similar visions of how it would be structured. The GP would initiate the lifestyle discussion and the practice nurse would then lead the programme, facilitating patient follow up. The programme would also be supported by professional referral services, but more importantly it would compliment community activities in their local area. This would empower practitioners to broach behaviour change knowing that the patient would be supported in the community. Lastly, it was also reported that the programme should not be established as a stand-alone project but rather as an aid to support existing programmes in general practice.

Discussion

Summary of main findings

The majority of participants regularly engage in lifestyle counselling and perceive it to be an important component of service provision. While GPs and practice nurses remain positive about lifestyle counselling, they do so with considerable barriers to the practice.

These include insufficient time, patient resistance, lack of funding for prevention and lack of training. There was ample evidence of patient-centred rhetoric in relation to lifestyle counselling throughout the focus group discussions. Despite this, the provision of simple lifestyle information and advice was the predominant strategy used by both GPs and practice nurses. While this is an important task in lifestyle counselling, it is associated with increased patient resistance if unsolicited. Fear appeals were another very common approach used by participants. Both GPs and practice nurses shared a similar vision of how a national programme for lifestyle behaviour change in general practice might operate.

Strengths and limitations of the study

The purposive sampling method may have led to ‘enthusiasts’ of lifestyle counselling attending the focus groups. This may have led to an overestimation of the frequency and quality of lifestyle counselling. However, this was also a strength in that participants were extremely knowledgeable about the barriers to lifestyle counselling and the possibilities for developing the concept.

Comparison with existing literature

The barriers to lifestyle counselling cited in this study are largely in agreement with previous studies. The most commonly cited barriers to lifestyle counselling in general practice include lack of time due to a heavy workload,^{1,4-7} no reimbursement^{1,7} and lack of training and knowledge.⁴⁻¹⁰ Despite this, the suggestion that lifestyle counselling creates a greater workload has been contested in the literature. One study indicated that the majority of GPs reported little or no increase in time demands.¹¹ This is of particular importance whereby GPs attempt to quantify the time demands of providing lifestyle counselling to public patients.

Patient resistance also emerged as a major barrier for participants. This may be related to insufficient training in health communication skills. It is also possible that patients are generally not resistant but rather, the practitioner creates resistance in patients by their actions.¹⁵ There was limited evidence in the present research to suggest that an empowering, client-centred and collaborative approach to lifestyle counselling is commonplace. In agreement with previous research,¹⁶ the provision of information and advice was frequently highlighted without reference to patient participation or collaborative working. The use of ‘shock tactics’ or ‘fear appeals’ by some participants is worrying. Although fear appeals are a frequently used tool for mass media health messages, their misuse can be damaging to an individual. Strong fear appeal and low self-efficacy messages are likely to produce maladaptive fear control actions such as defensive avoidance.¹⁷

Indeed, both health professionals and patients themselves in general practice have indicated a preference for a more client-centred approach.¹⁸ However, changing from the medical model of health education is not an easy task. Allowing patients the freedom to make their own decisions about their health behaviours can be a difficult task for practitioners. This is in agreement with previous research where the provision of client-centred training to practice nurses did not result in long-term changes in their approach to lifestyle counselling.¹⁶ This is an example of how strong the ‘righting reflex’¹⁹ can be, where practitioners feel a professional responsibility to accurately advise the patient rather than allow the patient to exercise personal choice. This expert and prescriptive approach has been shown to be less effective than when a patient makes a decision for themselves.²⁰

Implications for future research and clinical practice

In conclusion, this research suggests that although the rhetoric of patient-centred lifestyle counselling is evident in general practice, the traditional health education approach predominates. GPs and practice nurses, however, regularly counsel patients about multiple lifestyle behaviours despite considerable barriers and without support structures. Therefore, it is essential that they are supported to carry out lifestyle counselling as part of a systematic ‘whole practice approach’ to prevention in general practice. The proposed national behavioural risk factor management pilot project should have flexible implementation options based on good practice internationally. The implementation plans should facilitate practitioners to provide lifestyle counselling in a targeted manner but also opportunistically during a related consultation. Lifestyle counselling training should be made available to all GPs and practice nurses. The training should focus on brief intervention skills (tailored to general practice), the evidence for lifestyle counselling, reducing patient resistance, the addictive behaviours and the determinants of health. Further research should focus on the characteristics of successful lifestyle counselling interventions and systems employed within general practice to manage behavioural risk factors.

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Declarations

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Conflict of interest: None.

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