“DOCTOR”

In Latin (*docere*) means ‘to teach’

Owen Phillips, MD

Disclosure

- Nothing to disclose

Objectives

- Using teaching skills for patient encounters
  - Motivational interviewing
  - Difficult conversations

The Gross Clinic

- Dr. Samuel Gross:
- Invented a life-saving treatment for osteomyelitis

- Thomas Eakins (1875) submitted this to the Philadelphia Art Fair

Philadelphia Museum of Art

As “professors” in academic health science centers….

We teach:

- Medical students
- Other professional students
- Residents
- Nurses

TEACHING:
One of the 5 ACGME core competencies

- Medical knowledge, patient care, professionalism, practice-based improvement, problem-based learning

- And TEACHING

- Residents are expected to teach and are evaluated on it as a resident

We are all teachers

Every day:

- Instruct patients on how to take contraceptive pills
- Give patients options for abnormal uterine bleeding (by teaching)
- Instruct patients on what to expect after a Cesarean Delivery

(exception to teaching: depositions)

We may do it by sitting down with our patients

We may use tools: handouts, videos

But, how effective are we?

Challenges

Time

Patient's Health literacy

Patient/Physician interaction

- Patient ambivalence to the message or recommendations
- Non-adherence
- Resistance

What we want

Engaging in patient-centered conversation

Patients who adhere to our evidence-based recommendations

More typical

Younger patients (but older ones too)

Disengaged

Resistant

Relying on friends or social media or Google to help make healthcare decisions

Physician

Directs the discussion

Identifies a problem

Prescribes solutions

Motivational interviewing

A patient encounter tool kit

Originally, a behavioral health model to address an unhealthy behavior

How to get a teenager to stop smoking

How to get an adult to cut back on alcohol use

Our interest: (e.g.) getting a sexually-active 17-year-old to consider a LARC

Motivational interviewing

- First described in 1983 as a method to get people to change behaviors
- As of 2022, more than 1900 controlled clinical trials involving MI across a broad range of issues
- More than 200 published meta-analyses and systematic reviews (including many on contraception, safe-sex practices)
- MI is now commonly found on lists of ‘evidence-based treatments’

Motivational interviewing

- Steps

Engaging

Focusing

Evoking

Planning

Most Important

A. ENGAGING

1. Ask permission to discuss topic

Is it OK if we spend a few minutes talking about birth control?

Is it OK if I share recommendations about vaccines during pregnancy?

Is it OK if we talk about the importance of breast feeding?

MI steps (not a script- but a conversation)

A. ENGAGING

1. Ask permission to discuss topic

Is it OK if we spend a few minutes talking about birth control?

2. Explore thoughts and feelings

Tell me about your concerns about using birth control

3. Listen and affirm

It sounds like your friends have had some unfortunate experiences with the depo provera shot

MI

B. FOCUSING

4. Provide Information: TEACH

“Birth control pills don’t cause cancer. In fact, research shows that they prevent several forms of cancer”

5. Express concern about the possible health consequences

“I’m concerned if we can’t find a birth control option, you will get pregnant

C. EVOKING

6.Elicit patient response: “What do you think?”

7. Listen

D. Planning

a. ‘I understand you’re not ready to get started on something today.’
   Advise: ‘I’m here to help.’

b. ‘It seems you wish to get on something, but you are not sure what’
   Encourage: ‘Where does this leave you now?’ ‘Is there anything you’d like to do between now and our next visit? Reading information, websites?’

c. ‘It seems like you want to try Depo-provera’
   Strengthen commitment: ‘Why does that seem like the best choice for you’

Motivational interviewing

- Steps: Should be fluid. Not meant to be a rigid script. But one method that may help in some cases. And, a patient-centered, respectful way to care and educate our patients

Engaging- ask permission

Focusing- teach

Evoking- what do you think

Planning- next step

- Should not take (much) additional time: little data

Better than

- Cajoling
- Threatening
- Getting frustrated
- And, in the end not getting the patient to accept a medical recommendation from you

Evidence that MI works

Tomlin, et al: Motivational Interviewing to Promote Long-Acting Reversible Contraception in Postpartum Teenagers. (2017) JPAG

MI

“When would you like to have another baby”

“I am hearing you say that you wish to finish high school and probably go to college”

“Do you think having another baby in the next year would interfere with that?”

“Is it ok if we talk a bit about birth control options?”

Tomlin, et al

Postpartum Birth Control Method	NHTC (n = 159)	Standard Care (n = 150)	*P*
LARC methods			
IUD	44 (27.7)	19 (12.7)	<.01
Implant	21 (13.2)	4 (2.5)	<.01
Total	65 (4.9)	23 (15.3)	<.01*
Non-LARC method			
DMPA	57 (35.8)	76 (5.7)	<.01
OCP	17 (1.7)	29 (19.3)	.03
Condom	6 (3.8)	7 (4.7)	.70
Other	1 (.6)	2 (1.3)	.61
Total	81 (5.9)	127 (76.0)	
No Method	13 (8.2)	13 (8.7)	.88

Tomlin, et al
Limitations

MI patients were from one teen pregnancy clinic; controls were teens from a standard care OB clinic at same institution (acknowledged in paper)

But, other research has found that just being in an adolescent-only clinic did not increase use of contraception

Did not have longer term outcomes

No mention about time commitment and comparison

Whitaker, et al: Motivational Interviewing-Based Counseling Intervention to Increase Postabortion Uptake of Contraception. (2017) Patient Educ Couns

Randomized control trial

MI plan: similar to previous study

Ask permission

Educational component: pictorial guide from WHO

Also had a feasibility component

Outcome	Intervention	Control	p-value[a]	RR (95% CI)
Uptake within four weeks of abortion[b]				
	N=29	N=31		
LARC method	19 (65.5)	10 (32.3)	0.01	2.03 (1.14 – 3.61)
Any effective method	25 (86.2)	23 (74.2)	0.34	1.16 (0.90 – 1.50)
Use one month after abortion[c]				
	N=26	N=29		
LARC method	15 (57.7)	10 (34.5)	0.08	1.67 (0.92 – 3.05)
Any effective method	21 (80.8)	20 (69.0)	0.37	1.17 (0.86 – 1.59)
Use three months after abortion[c]				
	N=25	N=26		
LARC method	15 (60.0)	8 (30.8)	0.05	1.95 (1.01 – 3.77)
Any effective method	21 (84.0)	16 (61.5)	0.12	1.37 (0.96 – 1.93)

Whitaker, et al: Other findings

At the three-month contact, women in the intervention arm were also significantly more likely to report satisfaction with their contraception counseling than women in the control arm (92.0% vs. 65.4%, p=0.04)

The MI-based intervention lasted a median of 24 minutes (range 14-39 minutes).

“Any disruption to clinic flow caused by the intervention was well-tolerated by clinic staff.”

Future research: processes that can shorten the length of counseling and be less likely interfere with clinic flow.

Cochrane database (2016)

Summary on studies on contraception using MI versus handouts

4 trials: The MI group more often reported effective contraception use at nine months (OR 2.04, 95% CI 1.47 to 2.83).

2 trials: The MI group was less likely to report using ineffective contraception at three months (OR 0.31, 95% CI 0.12 to 0.77) and four months (OR 0.56, 95% CI 0.31 to 0.98)

1 trial: The MI group was more likely to initiate long-acting reversible contraception (LARC) by one month (OR 3.99, 95% CI 1.36 to 11.68) and to report using LARC at three months (OR 3.38, 95% CI 1.06 to 10.71).

Petersen, et al. Pregnancy and STD Prevention Counseling Using An Adaptation of Motivational Interviewing: A Randomized Controlled Trial. (2007) Perspectives on Sexual and Reproductive Health.

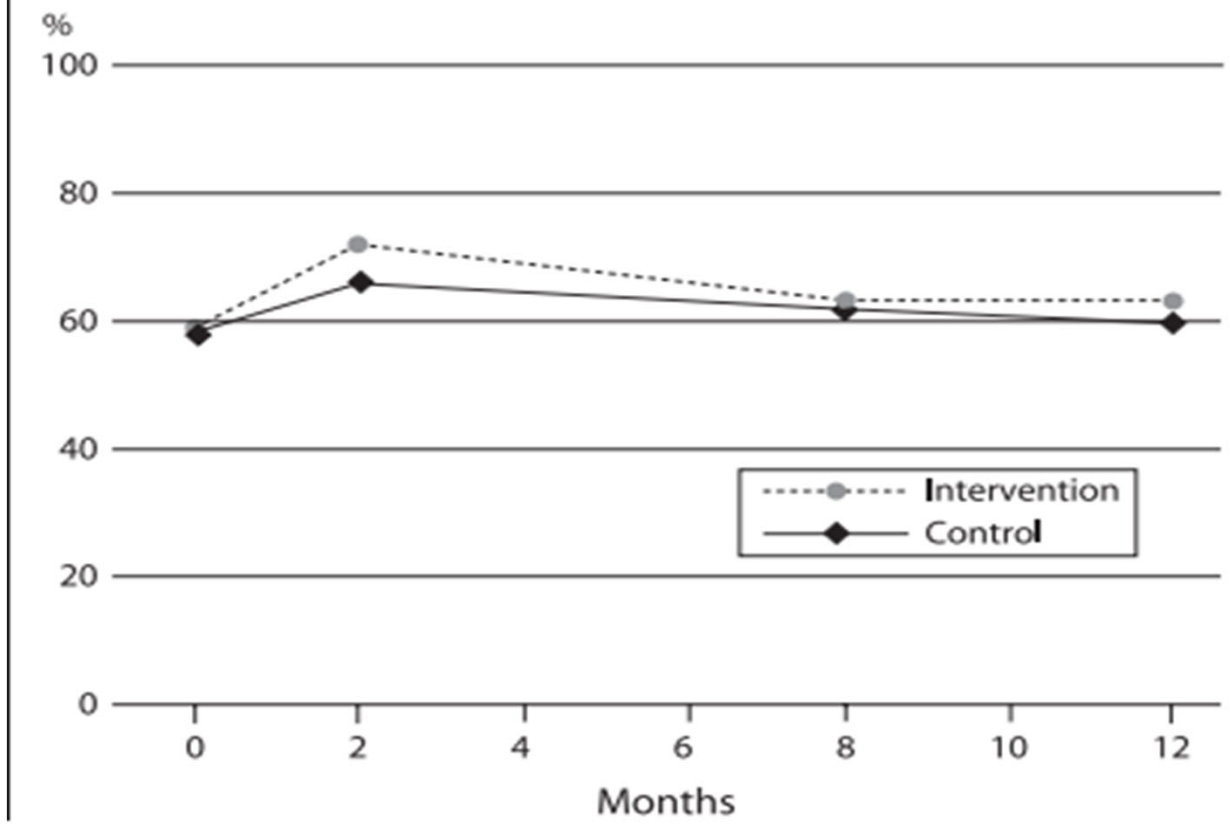
Randomized 764 women aged 16-44. MI v Routine care

Goal: Encourage women to adopt consistent, effective contraceptive use, and condom use for the prevention of STD

The primary outcome was change in the level of women's contraceptive use. (from none/low to high efficacy methods)

Followed up at 2 months, 8 months, one year in person

FIGURE 1. Percentage of women maintaining a high level or improving their level of contraceptive use from baseline to 12-month follow-up, by study group



Thoughts by authors

The control group also had an increase at 2 months

No difference by 8 and 12 months

We want to get through to her

- And have an engaging encounter
- And, not to get frustrated
- And, not spend your time arguing, cajoling, judging
- And, not spend a lot of time doing it

MI checks some of these boxes

- Asking permission- what if she says no.
- If yes, you are a collaborator
- By asking about concerns and motivation, you are getting to know her
- Then, a chance to give your education pearls
- And, more likely to come away with an ‘OK’ (according to evidence)

Meeting resistance

Can be expected with certain patients

MI gives you tools

- ‘roll with resistance’
- Not a personal or professional attack
- Instead, acknowledge patient’s concerns without arguing
- Listen to concerns, validate feelings
  - “It sounds like you still have concerns. What is on your mind? Maybe I can answer questions that you might have”

Roll with resistance

If she will not commit, then OK

Offer a return visit, written information, handouts, websites

And then, “Let it go”

Other Difficult Conversations

Vaccines

Sex

Interpartner violence

Breast feeding

Introducing Difficult Conversations:

Consider using an abbreviated MI tool

1. Ask permission
2. Start with educating

Goal: comfortable for provider and patients.

1. Ask permission

Is it OK if we talk about the recommended vaccines during pregnancy?

Is it OK if I ask some questions about you and partner’s relationship?

Can we talk about the importance of breast feeding?

2. Begin with education

Sex: Many women want to ask questions about their sex lives with their doctor.

Or: Research shows women have an orgasm with <50% of sexual encounters

Vaccines: Your baby's pediatrician and I recommend you have a TDAP vaccine during pregnancy and here's why.

IPV: Because violence is so prevalent, it is recommended that we as health care providers should ask all women about this

3. Listen

Ospina, Phillips, and Montori. J Gen Int Med. 2018

- Recorded 112 patient interviews
- 36% elicited patient's agenda 'how can I help you today'

- Clinician interrupted patient after a median of 11 seconds

- Most patients were able to articulate their complaints in a median of 6 seconds

Sir Francis Peabody: ‘The Care of the Patient’ JAMA; 1927

“The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine—or, to put it more bluntly, they are too "scientific" and do not know how to take care of patients.”

Peabody

"the secret of the care of the patient is in caring for the patient"

Phillips' paraphrase:

> "In order to care for the patient, you must care about the patient"

The Gross Clinic

What we really want

Engaging in patient-centered conversation

Identifying motivators for behavioral change

Helping patient work through discrepancies by educating

We also want

- To do it in a time-efficient manner
- But, if we haven't created a relationship, moved the patient to a healthful plan that she will adhere to, etc., we truly are wasting time.
- Thank you