

Adapting an Effective Counseling Model from Patient-centered Care to Improve Motivation in Clinical Training Programs

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Abstract: The value of establishing a patient-centered relationship within the context of the clinical encounter is well documented. The learner-centered method of medical education parallels the patient-centered clinical method; therefore, it should be explored as a method for teaching in the context of the learning encounter. In Japan and other Asian countries, rotations through services not related to the learner's chosen medical specialty are mandatory parts of the medical internship. Participation and effort in these rotations are often met with resistance from learners and are a common problem for medical educators. We adapted the counseling method for patients based on patient-centered methods such as motivational interviewing and solution-focused therapy to address this common problem.

We show one case of a medical resident who lost his motivation to learn during his training. A resident has many kinds of mental and physical stress. One such problem arises from the gap between what they want to do and what they have to do. Strategies from motivational interviewing and solution-focused therapy were adapted to successfully resolve a common teaching problem in Japan. A physician teacher (preceptor) helped this resident solve the issue for himself instead of arguing in favor of change. The positive aspects of the counseling method were based on patient-centered medicine and proved useful and effective in counseling for medical residents. We may take the lessons learned from using patient-centered counseling methods to further develop a clear and systematic process of counseling methods for residents to conduct learner-centered medical education.

Keywords: learner-centered, patient-centered, motivational interview, solution-focused therapy, resident counseling

The motivation of trainees is a very important aspect of teaching and learning theory in adult education.¹⁻³ Residents encounter many types of stressors during their training. Identifying and developing possible motivators is key to promoting individual goals in medical residency training. As medical residents are adult learners, they like to help set their own learning objectives and goals.²⁻⁵ However, many learners at this stage have difficulty recognizing what they do not know.⁶⁻⁸ This may be one of the biggest problems in mandatory programs of residency training.

One such problem arises from the gap between what residents want to do and what they have to do. Individual goals are sometimes different from the goals set by the institution and physician teachers.² This situation for residents is very similar to that of patients who require health behavior changes. However, just as physician encour-

agement and "change talk" helps patients move closer to their desired health goals, so too can preceptors help residents move closer to their desired learning goals. The goal of this paper is to demonstrate a counseling method that can be used by physician teachers to encourage behavioral change in residents who have lost their motivation for learning. This counseling process is built on the theories of motivational interviewing⁹⁻¹⁴ and solution-focused therapy¹⁵⁻¹⁸ based on a behavior change model.^{11,12} The process is illustrated by a case study.

Motivational Interviewing

The concept of Motivational Interviewing (MI) is based on principles drawn from these stages of change and from motivational psychology.⁹⁻¹¹ The stages of change model is an attempt to describe readiness and how people move towards making decisions and behavior change.¹²

The Behavior Change Model suggests that people often move in and out of different stages when they are in the process of thinking about change: precontemplation, contemplation, preparation, action, and maintenance.^{11,12} Precontemplation suggests that someone is not actively thinking about change, while contemplation suggests that the individual is actively thinking about change. Individuals in the subsequent stages of preparation, action, and maintenance are, as these words imply, in the process of preparing for change, taking action toward changing and maintaining the change. Based on research, the stages of the change model suggests that people will think and feel quite differently depending on the stage they are in; therefore, the counselor/physician's approach should vary depending on the stage and needs of the individual.

Motivational Interviewing (MI) is a brief psychotherapeutic intervention for helping patients change addictive behaviors.¹¹⁻¹³ William Miller and his colleagues reported the motivational interview with problem drinkers in 1983.¹¹ MI has been applied successfully to many kinds of addictive behaviors such as smoking, anorexia nervosa, bulimia, personality disorders, and depression.^{13,14}

MI suggests that most people who are thinking about making a change are ambivalent. For example, they want to change, but they also want to stay the same. One of the goals of MI is to help patients/clients resolve this ambivalence.¹³ In the case of the medical residents, they may want to successfully pass their rotation, but they may prefer learning elsewhere. There are four general principles underlying the process of motivational interviewing which may be helpful in resolving students' learning ambivalence: express empathy, develop discrepancy, roll with resistance, and support self-efficacy.^{11,13,14}

The first basic step is to 'listen empathetically'. In other words, do not assume you understand what a resident may be thinking or feeling. One important technique is to give patients or the medical residents who have lost the motivation to be part of the rotation at least two minutes to speak after asking an open ended question that invites them to share how they feel about the particular change. The second is to encourage patients/residents to explore both the reasons for staying the same and for changing. By vocalizing their own reasons for change, patients/residents begin to talk themselves into moving forward with the change. When residents are allowed to explore the reasons for productively learning in the rotation, preceptors can help change the resident's perception of the experience without the resident feeling pressured or coerced. Rolling with resistance means not arguing with patients about all the reasons they should make a change.

Patients/residents may have many good reasons for not making the change right now. Pressuring or arguing for change often pushes people in the opposite direction of the desired change. In the case of the resident ambivalent about committing to learning in the rotation, argumentatively presenting reasons why the resident needs to embrace their current learning experience may only create greater resistance. Finally, the patient's or resident's sense of self-efficacy, or belief that they can succeed with a task is critical. Residents need to feel they are capable of successfully completing the rotation. Give residents hope, express optimism, provide whatever available tools are needed to help the resident succeed, knowing that it is the resident who is responsible for making the change, not the preceptor.

Solution – Focused Therapy

Solution-focused therapy (SFT) emerged in the United States in the late 1970's from family therapists who developed a model of counseling that clearly departed from the psychoanalytical theory and practice of the day.¹⁵⁻¹⁸ SFT's concentration on collaborative identification and amplification of patient strengths is the foundation upon which solutions to an array of problems are built. Many texts, articles and books about SFT have been published over the years, providing useful examples of building solutions with clients that are relevant in the clinical practice.¹⁵⁻¹⁸ Although the literature on SFT is abundant, the MECSTAT process conceived by Giolando and Schilling¹⁶ is a clear, succinct and sequential technique of SFT and will be used as the model for adapting a solution-focused approach with unmotivated learners in medical education. An outline of the MECSTAT has been included in Table 1.¹⁶ Educators combine the steps in MECSTAT depending on the time available, the problem, the residents' readiness to change, and their own skills. By asking these questions, educators remind learners of many things: goals that are important to and defined by learners (miracle questions), exceptions to problems exist (exception questions), helping learners to cope (coping questions), making vague learner perceptions concrete and definable (scaling questions), reflecting on conversations they have just concluded (time out), encouraging learners to think about personal accomplishments (accolades) and thinking about what learners are doing to prevent the situation from worsening (task).

Case Illustration: Using MI and SFT

"T.K." is a 24-year old male Japanese first-year post-graduate resident. In Japan, a new mandatory broad-based two-year residency training model started in 2004. Although T.K. wants to be an ophthalmologist, he can take

Table 1: Solution-Focused Therapy using MECSTAT⁵

M	Miracle questions	“Imagine that, while you are sleeping tonight, a miracle happens. You wake up tomorrow, and you sense that you are on track toward making a decision. What will you be doing differently that will tell you that you are on track?” “Pretend the problem is solved. What are you doing differently?”
E	Expectation questions	“Are there now times that a little piece of the miracle happens? Tell me about these times. How do you get that to happen?” “What will you do to make that happen again?”
C	Coping questions	“How did you manage to get yourself up this morning?” “That sounds nearly overwhelming. How do you manage to cope?”
S	Scaling questions	“On a scale of 1 to 10, where 10 is the problem solved and 1 is the worst it has ever been, where is the problem today?”
T	Time-out	Timeout allows both clients and counselors to reflect on conversations they have just conceded. “I ‘d like to pull together...so we can see where we are.”
A	Accolades	Using accolades is a simple strategy that packs a powerful punch. “I think it’s great that...”
T	Task	Clients who are willing to change are given ‘doing’ tasks.

ophthalmology training for only six of the 24 months. He thinks the other 18 months are a waste of time for him. Although he understands the new Japanese training system has focused on primary care, he is not interested in general training of other specialties and has no motivation to learn them.

The physician who is the assigned supervisor of this resident conducts a regular semester meeting with him. The following conversation uses elements from both motivational interviewing and solution focused therapy to demonstrate how strategies from these two methods can be used to help the resident become free and move toward change.

Physician(P): Tell me about your work at your current rotation.

(Open-ended question encourages the student to do most of talking while the preceptor empathetically listens).

Resident(R): I am working at the department of gynecology. Sometimes I am very excited and sometimes very bored. I am okay. Although gynecology is not interesting for me, I only have to put up with it for one month. Oh...but definitely the next three or four months are not good. I have a Gynecology rotation and then Psychiatry and then Community Medicine!

P: (Nods).

(Express empathy; seek to understand client’s feeling and perspectives.)

(The resident is encouraged to continue talking about his concerns regarding the rotations.)

P: So you feel that your experience in gynecology is not relevant to your desire to be an ophthalmologist?

(Simple reflection; a way of checking out that you understand what was meant)

R: Yes, I know it’s supposed to be important for my training, but I can’t see what is important for me in this rotation.

P: You understand that you are supposed to complete a rotation in gynecology because it is important for your training, but you can’t see how gynecology can possibly relate to your goal of being an ophthalmologist?

(Amplified reflection: to demonstrate understanding that the student is frustrated with having to complete a rotation in gynecology)

R: That’s right. I don’t mind working hard, but I just wish the time would pass more quickly and I could enjoy my work more.

P: On one hand, you don’t mind working hard to achieve your goal of being an ophthalmologist,

but you just wish the time would pass quicker in the other rotations and that you could enjoy your work there more.

(Rolling with resistance using a double-side reflection)

R: That's right. I have all this time to put in with rotations I don't want to be in.

P: Where does that leave you?

(Avoiding confrontation and rolling with resistance by emphasizing: personal choice and control)

R: Well, I guess if I have no choice in completing these rotations I need to find ways where I can enjoy myself.

P: So if you could find ways to feel like you are working hard and challenging yourself in preparation to becoming an ophthalmologist you wouldn't mind completing the rotations?

(Reframing the resident's words to possibly suggest a solution)

R: That's right.

P: Well, I'm more than happy to help you work on that goal. Maybe we should make a list of how you could achieve that.

(Helping the resident find solutions while ensuring the responsibility for change remains with the resident)

R: Sounds good.

P: Let's begin by imagining the gynecology rotation is now over and you both worked hard and enjoyed yourself. What will be different in your work that will tell you that you learned something that contributed toward your goal of becoming an ophthalmologist?

(miracle question)

The resident provides examples of a few learning goals he has achieved.

P: That's great. Let me ask you something else. On a scale of 1 to 10 where 1 means you absolutely hate your gynecology rotation and 10 means you absolutely loved it, where would you place yourself on the scale today?

(Using a Scaling question to better understand how the student feels about the clinic and to look for exceptions)

R: I guess I would be a 3.

P: A three? As high as that? I'm surprised based on what you were saying I thought you might be

a 1. Why so high?

R: Well, there is this supervisor on the ward who is really good with patients and I am learning a lot from him.

P: Anything else?

R: Yes, I had a patient who came into the clinic because of gestational diabetes. The patient was actually experiencing some vision problems so I got to accompany her to the ophthalmology clinic for the workup. I learned a lot.

P: It sounds like you are achieving some learning goals on this rotation. Our time is up for today. I really appreciate you taking the time to talk to me about this. Your learning is obviously very important to you. I wonder if between now and our next session you could think about what it would take for you to move from a 3 to a 5 on the same scale? That will help us focus our next session on setting some specific goals around making this rotation a meaningful learning experience for you.

(Accolades and Task)

R: Thank you very much.

Discussion

The key to counseling for residents is the same as that of patients in motivational interviews. Motivation, according to the therapeutic theory of motivational interview, is not a personality trait but the likelihood that a patient or resident will do what is needed to get better or be healthy.^{13, 14} Therefore, motivation is a probability factor. Furthermore it is the product of a partnership between patients or, in our case, residents and physician-teachers. Traditionally, as many physicians have believed that motivation is up to the patients,¹³ teachers have thought motivation to learn is up to the residents. They have thus lacked any strategy of counseling residents to improve their motivation.

The goal of motivational interviewing for residents is to explore their conflicts and encourage residents to express their own reasons and readiness for change.^{11, 13, 14} Preceptors can help residents solve issues for themselves instead of arguing in favor of a particular change. At the first stage, 'Precontemplation', physicians must listen empathetically to residents and have residents voice their own reasons for change and reluctance to change.^{13, 14} Physicians can anticipate successful change when patients think it's important to make a change, think they can do it, and their level of readiness is approximately 70%.¹³ Sometimes achieving change can be a slow process over a number of years.¹² However, in the case of

residents, if they are equally motivated, physician-teachers may actually have more readiness available because most residents want to achieve benefits quickly within the limited time period of their training rotation.

If residents have resistance to change, teachers should not put themselves in a position of arguing or of trying to persuade residents to take a different position. Ideally residents should be asking for advice. Preceptors need to analyze the causes of resistance. When the resistance to change is not caused by internal stressors but by systemic problems, preceptors may need to consult with other staff such as program directors and colleagues and make conditions better for residents to learn and work. Preceptors can help by providing whatever support and resources are needed to help residents explore their ambivalence. Providing hope and optimism is critical for change.

The key to counseling residents is whether busy physicians can make the time for residents and listen to residents' concerns. The medical literature supports solution-focused therapy as a collaborative counseling model that fits within a busy patient-centered family practice.¹⁶ SFT's focus on the patient's strengths, abilities, and resources creates a counseling atmosphere flavored with hope and optimism.¹⁶ Many of the strategies used in SFT are amenable to practice with residents because they quickly help focus conversations on solutions rather than getting overwhelmed by the problem.

Conclusion

Many of the principles underlying motivational interviewing and solution-focused therapy translate well to working with clinical trainees. It is important to help residents find their own solutions to problems. Adapting these methods for work with students is a useful and effective way for preceptors to conduct learner-centered medical education. The learner-centered method of education parallels the patient-centered clinical method¹⁹ where the student is no longer being led by the preceptor. Although it remains the student's ultimate responsibility for change, the relationship is more equal with both preceptor and resident playing active roles in identifying goals and finding solutions.

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