

Provider Perspectives

Current challenges of behavior change talk for medical professionals and trainees

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ARTICLE INFO

Article history:

Received 13 July 2011

Received in revised form 28 November 2011

Accepted 3 December 2011

Keywords:

Behavior change

Qualitative

UK

ABSTRACT

Objective: To explore medical professionals' and trainees' experiences and views of behavior change talk in various health care settings to develop current understanding of the challenges that underlie this phenomenon.

Methods: Qualitative, semi-structured interviews were conducted with medical professionals and trainees ($n = 29$). Grounded theory principles informed sampling, data collection and analysis. To achieve maximum variance, participants with different levels of experience were purposively sampled from a range of primary and secondary care settings. Analysis was iterative, involving a constant comparative approach allowing emergent ideas to be tested in subsequent interviews until thematic saturation was reached.

Results: Three emergent themes described reasons for not engaging in behavior change talk with patients: (1) 'personal challenges'; (2) 'somebody else's responsibility' and (3) 'prioritizing the doctor–patient relationship'.

Conclusion: Despite increasingly being recognized as a core aspect of medical practice and education, medical professionals and trainees remain unprepared to discuss health-related behavior change with patients and unclear of their roles within contemporary health care.

Practice implications: Formal training in theory-based behavior change techniques is likely to help empower doctors and mitigate many of the barriers found, particularly in relation to socially and emotionally uncomfortable topics that are perceived to threaten the doctor–patient relationship.

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1. Introduction

Non-communicable diseases (NCDs) are viewed as largely preventable due to their close associations with health-related behaviors and yet are now estimated to be responsible for 60% of the world's annual mortality [1]. It is suggested that as much as 80% of heart disease, stroke, type II diabetes and one third of cancer could be avoided with the appropriate changes in lifestyle such as stopping smoking, decreasing alcohol use, increasing exercise, and improving diet [1]. Unhealthy behaviors are also costly to health care systems. Obesity treatments for example cost NHS England £0.5 billion annually [2] and takes up one sixth of the US health budget [3]. Worryingly NCDs are also now causing concern within developing countries [4]. The World Health Organization (WHO) [1] estimates that the greatest rise in NCD deaths over the next decade will occur in the African and East Mediterranean regions

(27% and 25%, respectively). In response to this growing global challenge, health care system reforms are increasingly focusing upon health promotion and preventative approaches to patient care [1,5–7]. Thus medical professionals are now recognized to have a key role to play in terms of contributing to resolving the burden of lifestyle-related diseases [8].

Primary health care professionals are thought to be particularly well placed to counsel and motivate patients about health-related behavior change due to their frequent contact with individuals who would benefit from changes to aspects of their lifestyle [9]. Evidence also suggests that physician counseling can lead to positive outcomes in patient weight loss [10,11], smoking and alcohol consumption [7]. However, beyond the parameters of intervention research, opportunities to discuss behavior change with patients in medical practice are often missed [12–14]. Thus, although health care policy makers and research have highlighted the responsibility and potentially efficacious role doctors have in tackling patients' unhealthy behaviors, evidence suggests that this is not being fulfilled.

One possible explanation is the lack of health-related behavior change education available to medical trainees and professionals [15]. A substantial evidence base exists within the psychological

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literature for theoretically derived effective behavior change techniques for a wide range of health-related behavior such as smoking, diet and exercise [see 16]. Many specific techniques (e.g., goal setting and motivational interviewing) have been found to be useful in facilitating change in time-restricted medical encounters [16–19]. Moreover, these techniques are based upon a range of theories which describe determinants of health-related behavior and the relationships between these, behavioral intentions and outcomes [20]. Given that these models of behavior provide identifiable, testable and targetable factors underlying health-related behaviors, it is unsurprising that evidence suggests theory-based interventions are more effective compared to those that are atheoretical [21].

However, within the context of medical education, behavioral and social science theory are often perceived as ‘nice to know’ rather than ‘need to know’; formal assessment of them is rare; and it can be difficult to find appropriately qualified teaching staff [22]. It therefore seems unlikely that this knowledge about effective behavior change communication has been transferred to medical practice. Taken together, this evidence illustrates the discordance between health care objectives to prioritize health-related behavior change, available evidence regarding effective strategies, and current medical practice and training. Understanding the challenges to engaging in behavior change discussions with patients is therefore likely to help inform intervention research and education in this area. Thus the present study set out to ask: (1) what are medical professionals’ and trainees’ perceptions of health-related behaviors and (2) what barriers to effective behavior change communication exist?

2. Methods

2.1. Methodological approach

Ethical approval was obtained by the relevant ethics committee (Project no. 282/07P). Since this study sought to inductively explore a range of views and beliefs held by medical professionals and trainees regarding health-related behavior change, a flexible data collection method that allowed for novel and unexpected data to surface was required.

2.2. Recruitment

Guided by a grounded theory approach [23], purposive sampling was used to recruit individuals with maximum variation in relation to age, ethnicity, sex, specialty and career stage. In line with key qualitative methodological principles, this sampling method aimed to seek out the widest range of views available relating to the research questions rather than to generate a representative dataset that removes more atypical cases [24]. Medical professionals and trainees working within a large urban conurbation in the North West of England were identified through university directories of students and staff and then snowball sampling in which participants provided contact details of other relevant individuals. All individuals were initially approached via email explaining the purpose of the study and invited to take part in a one-to-one interview. Response rate to recruitment emails was 76% with nine individuals not replying. The remaining 29 individuals expressing interest completed an interview.

2.3. Interview procedure

Interviews were conducted with one of two of the authors trained in semi-structured interviewing techniques (AC, VL) at times and locations convenient to participants. All participants gave written consent before interviews commenced. Interview

questions explored a number of areas relating to participants’ experiences and views about how health-related behavior change is managed within their health care setting. Broad topics initially included what participants viewed to be involved in health-related behavior change within their health care field, how often and how feasible it was to engage in behavior change talk with patients, as well as how confident or comfortable participants felt discussing behavior change topics with patients. Although interviewers prompted discussion around these topics, they were also reactive to participant responses so that the direction of each interview was flexible. The interviewers combined open questions to elicit free responses with focused questions for probing and prompting. In line with grounded theory principles [23] the topic guide was amended throughout the study to allow interviewers to explore emerging themes and ideas with participants in subsequent interviews. All interviews were digitally audiotaped and transcribed verbatim. Interviews ranged from 10 to 72 min (*mean* 38 min) in length.

2.4. Analysis

The inductive analysis proceeded in parallel with the interviews, taking an interpretative stance [24,25]. Coding was iterative and informed by the accumulating data and continuing analysis. Thematic categories were identified in the initial interviews, recorded electronically (word processing document) and then explored in subsequent interviews which sought disconfirmatory evidence [23]. This process involved altering the topic guide following each iteration of analysis, thus cases that may have initially seemed deviant (i.e., unsupported by the rest of the dataset) could be tested out in interviews with new participants. If these seemingly isolated data points remained unsupported by subsequent data collected they were ultimately labeled as deviant cases; whereas in instances where new data went onto support such a data point, they could be built upon as an emerging theme or sub-theme in the analysis document. In this way thematic categories were allowed to develop through comparing data and analysis until no new information arose from the data indicating that sampling, data collection and analysis should cease [23].

3. Results

Table 1 lists the specialties of participants included in the sample, and Table 2 provides demographic information and details of participants’ stage of training.

The analysis firstly presents a description of participants’ current experiences of and perceptions about behavior change talk. Secondly three inter-linked sets of reasons why doctors do not engage in behavior change talk are presented. These are: (1) ‘personal challenges’; (2) ‘somebody else’s responsibility’ and (3) ‘prioritizing the doctor–patient relationship’. Each theme contains sub-categories represented by a substantial proportion of views in the sample; however descriptions will highlight when data derive from a small minority of participants and contrasts with other data

Table 1
Specialisms of doctors and medical trainees represented in interview sample.

Anesthesiology	Junior doctor (foundation & specialty trainees)
Chemical pathology	Pediatrics
Clinical genetics	Palliative care
Diabetes endocrinology	Psychiatry
Emergency medicine	Obstetrics
General practice	Oncology
Geriatrics	Respiratory medicine
Gynecology	Medical student (years 1–5 of medical school)
Intensive care	

Table 2
Participant demographics.

	Medical students (n=5)	Junior doctors (n=6)	Doctors (n=18)	Total (n=29)
Age				
Mean	22	24	46	39
Range	18–23	27–32	32–61	18–61
Sex				
Male	1	2	10	13
Female	4	4	8	16
Ethnicity				
British	4	5	16	25
Chinese	1	0	0	1
Indian	0	0	1	1
Irish	0	1	1	2
Work setting				
Primary care	–	2	7	9
Secondary care	–	4	11	15

within a given sub-category. The analysis is supported by illustrative quotes and participant identification codes are provided in parentheses indicating the career stage and then speciality of the participant. The term junior doctor refers to either foundation year (FY) or specialty training (ST) trainees and thus some identification codes also indicate the specialism in which a junior doctor is training in.

3.1. Current experiences of and perceptions about behavior change talk

Participants reported that health-related behavior change was highly important to their work and relevant to their patients' health conditions but despite this, it was a subject that was rarely discussed. In addition to these issues, analysis revealed three further themes that involved more complex constructs relevant to this issue.

3.2. Reasons for avoiding behavior change talk

Three sets of reasons underlay doctors' reluctance to engage in behavior change talk with patients and a schematic model of these interlinked themes is presented within Fig. 1.

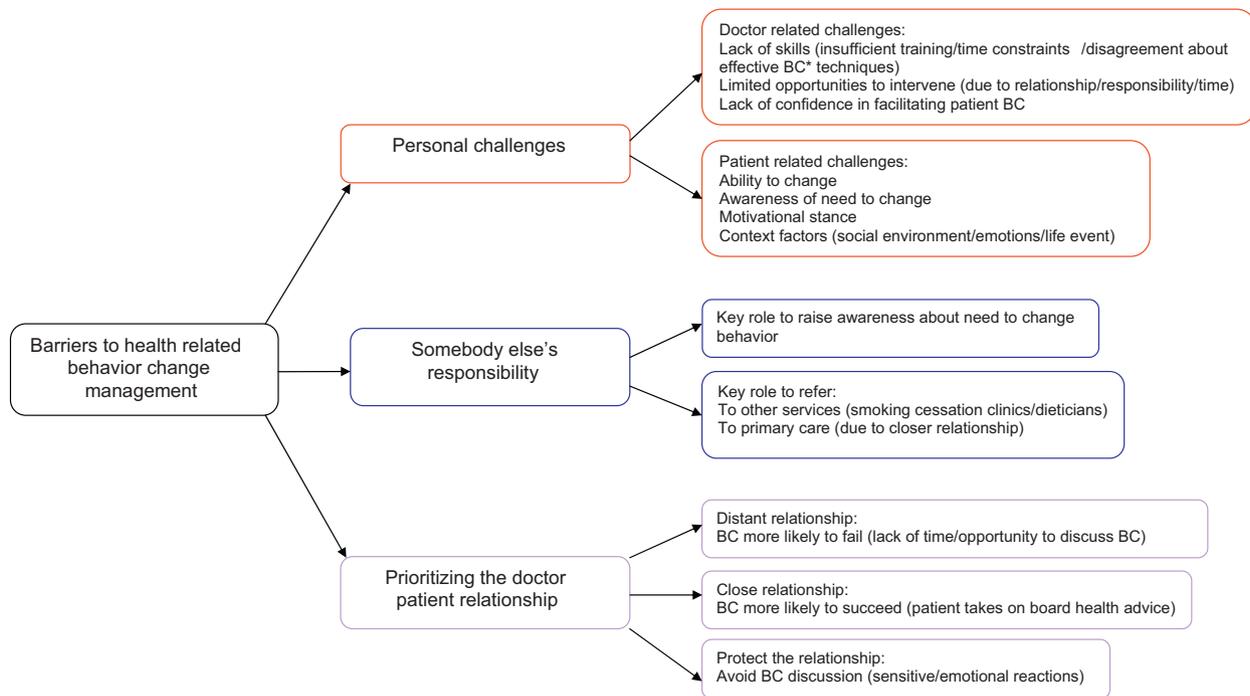
3.2.1. 'Personal challenges'

Participants highlighted challenges that separately affected the individuals involved in behavior change discussions (i.e., the doctor and the patient). Both sets of perceptions about individual level factors served as barriers to engaging in behavior change talk with patients. Beliefs about specific challenges to doctors were influenced by perceptions of their own skills and whether they believed that behavior change was an achievable goal. Insufficient training was reported as preventing participants from effectively managing these conversations with patients and as such participants were uncertain of how to approach consultations of this kind.

"I find it quite difficult if we are talking about obese ladies...we have never received any training on how to do those consultations very well...I feel at a loss to, I don't know how I can get, I don't know, I am not sure what to do" (29, junior doctor, obstetrics)

Time constraints added to the problem and even though doctors recognized that behavior change had the potential to reduce disease and hence save time in the longer term, they also felt there was often limited time to address the issues, arguing that it was too demanding a task to simply 'tack on' at the end of a consultation. Similarly, participants reported conflicting perceptions in that a lack of confidence in the efficacy of behavior change interventions co-existed with feeling obligated to address such issues with patients.

"Although I do it and I feel I have to do it, and I feel I must do it, I don't really feel like it's going to work" (20, doctor, respiratory medicine)



*Behavior Change (BC)

Fig. 1. Emergent themes and sub-themes derived from qualitative analysis of interviews.

Table 3

Behavior change techniques spontaneously raised by participants and perceptions of their efficacy.

Behavior change technique	Perceived as effective	Perceived as ineffective
Directive communication style	✓	✓
Emphasize importance of change	✓	
Goal setting	✓	
Information giving	✓	✓
Instilling confidence	✓	✓
Motivational interviewing	✓	
Scare/shock tactics	✓	✓

A further consequence of being unskilled and lacking in confidence to discuss behavior change with patients was that participants reported having developed a range of different techniques acquired through trial and error or by observing other doctors' behavior change talk. Thus behavior change techniques were often selected arbitrarily, without having any clear understanding of why the techniques used with patients may be effective in eliciting change.

“Sort of giving it a go and seeing, and seeing and watching people's responses to things that you have tried before, you know what raises somebody's hackles and what seems to keep them engaged” (22, doctor, gynecology)

It was therefore unsurprising that participants reported inconsistent perceptions of which strategies they perceived to be effective in facilitating patient behavior change (see Table 3). Techniques that were considered to be effective by one participant (for example using scare tactics to elicit behavior change) were dismissed as ineffective by another.

Alternatively, participants cited a number of patient-related factors that made behavior change discussions particularly challenging. One key factor centered upon patients' ability to change: regardless of whether the doctor was skilled in techniques that were effective, there was a view that patients still might not be able to implement changes. Further, patients' awareness regarding the importance of behavior change was thought to influence whether they would attempt to discuss these issues. For example, one participant (25, doctor, pediatrics) highlighted that with overweight children, it can seem futile to attempt to discuss behavior change if the patient (and/or patients' parents) were unaware that changes to behavior were required. Patients' motivation was also thought to be integral to achieving behavior change and this was something over which the patient rather than the doctor ultimately had control.

“Now I realize that you can't change anything unless the patient wants to change it” (12, doctor, general practice)

Participants also took into account the wider context of patients including issues such as current social or emotional situations (e.g., bereavement) that could prevent successful behavior change and hence be a reason for the doctor to not engage in behavior change talk. Thus participants reported a number of specific beliefs about doctor- and patient-related challenges to behavior change. Although the sample represents doctors from various specialties and at different stages of training, it was noted that more experienced doctors described feeling 'jaded', 'demoralized', 'burnout' which suggested experience had led to learned helplessness at not being able to effect change.

“There is a real risk that you get completely demoralized with behavior change because, if you are using strategies that don't

work, then you don't use any strategies at all you just sort of let it go by” (3, doctor, general practice)

3.2.2. 'Somebody else's responsibility'

Another core reason for avoiding behavior change talk was when doctors perceived their main responsibilities were to raise awareness about the issue of behavior change to the patient and refer them to the appropriate resources rather than facilitate changes in patients' behavior themselves. This was despite recognizing that it was important for the patient's health and even for the specific condition they were treating.

“I know I am not the person who will be carrying it out, but you know I might flag up smoking cessation services or talk about different weight loss plans or refer to the weight loss clinic here” (22, doctor, gynecology)

Interestingly this was raised by doctors across secondary care specialties who perceived that behavior change talk was within the remit of the GPs' expertise and role, based on assumptions that GPs have closer and more continuous relationships with their patients, more time and opportunities to discuss lifestyle issues, and therefore would be more successful in their attempts to facilitate behavior change. However GPs disagreed, also perceiving that their key responsibilities were not to effect change but to raise the issue and refer onto those perceived to have more time and expertise such as dietitians, practice or specialist nurses. Hence it was found that doctors, regardless of their specialty, tended to see behavior change talk as being the responsibility of another party.

In contrast, for a small minority, the responsibility for behavior change was thought to lie outside the healthcare service, with lifestyle being seen as the patient's personal choice which doctors have no moral right to redress. Others felt the issue was one that society should engage with and that the responsibility lay with the government.

“That's not a health issue, that's a societal issue, it needs sorting out at societal level by politicians, we can't sort that out, you and I can't sort that out” (11, doctor, general practice)

3.2.3. 'Prioritizing the doctor–patient relationship'

The final set of reasons why doctors avoided behavior change talk with their patients, concerned the quality of the relationship they have with them. Participants described a range of relationships with patients. These grouped into close relationships, usually involving long term contact in which they worked to build a positive rapport with the patient, and more distant relationships, in which patients were seen infrequently and doctors were less familiar with the individual and their broader circumstances. Unsurprisingly, the more distant relationships were associated with specialties that did not involve follow-ups (e.g., A&E).

Having a continuing relationship with a patient was viewed by participants as a prerequisite for considering behavior change talk as it provided doctors with more opportunities (hence time was less of a barrier) and it enabled them to see the issue through to success. Furthermore, it was felt that having an established trusting relationship would make behavior change talk more likely to be successful.

“The formation of the relationship is initially important if you're going to be effective... deliver a consistent message, personal message” (2, doctor, general practice)

However, paradoxically, having a better relationship with a patient also served as a barrier to engaging in behavior change talk. This was because talk about lifestyle, and hence changing lifestyle,

was viewed as a highly sensitive topic with potential to offend. This was particularly the case for behavior change relating to obesity.

“Telling somebody they are fat effectively, no matter how nicely you wrap that up, is hurtful. . .obesity is a very sensitive issue” (18, doctor, anesthesiology)

Doctors were acutely aware that these sensitive social interactions had the potential to evoke emotional reactions in patients. However participants also commented upon their own emotions within such consultations and how these discouraged them from engaging in behavior change talk.

“I think [talking about weight] makes it awkward and even if it's not awkward I feel it's going to be awkward so I don't really go there” (20, doctor, respiratory medicine)

An interaction with a patient with whom a relationship was established made doctors feel that they were countering the work they had previously done to build the relationship and potentially risked damaging this. Participants contrasted the health benefits with the risks of damaging the doctor–patient relationship that they valued and many reported that they chose to prioritize maintaining this relationship, thereby avoiding behavior change discussions.

“You can turn them off completely, you know, and perhaps whatever advice you have just given them will be completely wasted by you addressing their weight issue and them being offended by it. . .and do harm to the relationship you have established, the rapport that you have established” (14, medical student)

4. Discussion and conclusion

4.1. Discussion

This study sought to identify factors underlying whether medical professionals discuss health-related behavior change with patients because although being well positioned to impart relevant knowledge and advice [9], they often struggle to facilitate these changes with patients [13,26]. The present findings indicate reasons why this is so challenging, despite increasing calls for training to prepare medical professionals and trainees in facilitating behavior change with patients [27,28]. Partly explaining this was that participants were unsure about which strategies were effective, relying upon individual experiences rather than formal evidence-based training and reporting low confidence in successfully addressing these issues with patients. Past research has also demonstrated that primary care professionals are unconfident in facilitating behavior change with patients, find it time consuming, difficult to raise with patients, and professionally unrewarding [18,29–32]. The present study has replicated this within UK primary care settings and has also demonstrated that secondary care doctors and trainees much earlier in their careers experience similar barriers.

Participants also explicitly debated who was responsible for discussing behavior change with patients and explained how different doctor–patient relationships might affect this (for example closer relationships were associated with more responsibility and more success). Interestingly, participants highly valued the doctor–patient relationship and described not wanting to risk damaging it by raising sensitive topics related to patients' lifestyles. In line with this, past research has highlighted potential negative consequences of the modern doctor–patient relationship [see 33]. Findings from qualitative research with chronic disease patients suggest that GPs may feel unable to challenge or motivate

patients to manage their conditions due to increasing emphasis placed on valuing patient agendas and therefore collude with patients and their symptoms in order to maintain a positive relationship with them [34]. The data in this regard suggest that it is the nature of the social interaction between doctors and patients that prevents successful behavior change management. That is, sensitive topics (e.g., obesity) elicit emotional responses which can lead doctors to avoid behavior change talk in order to reduce the risk of discomfort and maintain a positive doctor–patient relationship. It remains an empirical question whether the quality of the relationship does impact on the success of behavior change if doctors were to raise the issues.

Resolving such issues has been recognized as integral to successful medical care and initiatives such as the US-based Patient Centered Medical Home have devised principles specifically to promote constructive and ongoing doctor–patient relationships, and define physicians' roles and responsibilities within collaborative health care teams [35]. However, the current findings suggest that these remain problematic within current UK consultations involving behavior change talk and thus similar initiatives focused upon tackling these specific barriers may be required.

Including primary and secondary care settings within the present sample allowed for a diverse range of perspectives to be elicited, contributing a novel exploration of how behavior change is managed across the health care system. This adds to previous research which has illustrated findings that support the present study but usually concentrate upon individual areas of health care or health behaviors [36,37]. Also novel to the present sampling approach was the inclusion of medical trainees alongside qualified professionals. This provided an opportunity to capture issues that arise in early career stages as well as later on in professional practice thus indicating specific gaps in current medical education.

The recruitment of patients by convenience sampling from one geographical area however, limits the results in terms of accurately representing the target population. It is also possible that the high response rate (76%) was due to the snowballing method used throughout recruitment. Thus medical professionals/trainees who are less enthusiastic about the importance of behavior change research may not have been reached and the findings may have captured a more optimistic view than that of the target population. It is also important to note that obtaining participants' accounts of issues relating to behavior change is not an objective measure and therefore conclusions cannot be drawn regarding how behavior change is actually managed within health care although findings do indicate areas that could be addressed by future research.

4.2. Conclusion

In conclusion we found that current medical professionals and trainees encounter common and interlinked barriers to discussing health behavior change with patients that permeate across health care settings. Primary and secondary care professionals felt that their roles involved raising and referring but not discussing behavior change, despite established recommendations to train medical professionals to be proficient in these skills. Findings also reveal that pre-existing barriers such as lack of confidence and skills in behavior change facilitation persist for practicing clinicians as well as those currently in training. Additional issues may also arise due to evolving approaches to the doctor–patient relationship, especially in relation to managing the competing demands of simultaneously addressing patients' and doctors' agendas.

4.3. Practice implications

The findings suggest that participants were largely unfamiliar with the theory and evidence-based behavior change techniques

that exist within the literature [16]. Understanding which techniques are likely to promote or inhibit behavior change is essential if we expect medical professionals to give patients the best possible chance at achieving substantial changes in their behaviors [38]. Findings therefore indicate that successful medical education in this area may be lacking and that better implementation of current clinical practice policies is required. Research should also consider where future interventions are best placed (within medical education or continuing professional development). As participants in our study highlighted that this topic is relevant across different specialisms, and that medical trainees encountered the same challenges as professionals it can be argued that it may be most beneficial to deliver this training prior to specialization; a view consistent with latest recommendations for students to leave medical school with competence in discussing the psychological and sociological aspects of behavior change with patients [27]. Finally, although many of the barriers identified in this study could benefit from structural modifications to health care systems (e.g., to address time pressures), or policy level interventions (e.g., to clarify parameters of doctors' roles), they may also be tackled through providing skills training which empowers doctors and demonstrates how to operationalize their roles as behavior change facilitators within care settings.

Contributions

AC, SP and JH conceived of and designed the project. AC and VL conducted the interviews. AC led the analysis, supported by SP and JH. AC, SP and AC drafted the manuscript, to which all authors contributed.

Conflict of interest

We declare that we have no conflict of interest.

Acknowledgement

All the participants took time to take part in an interview for this research.

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