# The Chiropractic Report

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## Professional Notes

**LBP – Success Adding Chiropractic to Standard Medical Care**

It is always a good day when Spine, the most prominent medical journal in the specialty of spine care, publishes a randomized controlled trial (RCT) reporting the benefits of chiropractic care. A new trial from Christine Goertz DC, PhD, Cynthia Long PhD and other senior researchers from Palmer College is particularly noteworthy because:

- It reports that adding chiropractic manipulative therapy (CMT) to standard medical care (SMC) produces statistically and clinically significant improvement in terms of both pain reduction and improved function – and produces much higher patient satisfaction rates;
- In a real-world group of patients with acute low-back pain (4 weeks or less) which has not been much studied – active duty male and female soldiers aged 18-35 from a diverse racial and ethnic background.

Summary points are:

a. The primary purpose of "this pragmatic, patient-centered comparative effec-

*continued on page 4*

# Motivational Interviewing in Health Care

*"Motivational interviewing works by activating patients' own motivation for change and adherence to treatment."*

*"If your consultation time is limited, you are better off asking patients why they would want to make a change and how they might do it rather than telling them that they should."*

Rollnick, Miller and Butler 2008

## A. Introduction

AS CHIROPRACTORS AND OTHer health professionals adapt to the pressures of modern practice – lack of time, standardized and computerized patient intake and assessment forms for efficiency and to measure results and to meet the demands of third party payers and others – patients are increasingly faced with a barrage of questions.

On one hand patients are forced to devote much time to filling in forms or answering a sequence of standard questions from health professionals. On the other hand they often get no time to tell their story. This is deeply alienating and can promote a dysfunctional relationship and dissatisfaction from the first consultation.

Further, health care is increasingly about changes in lifestyle and long-term condition management. It is therefore about health behavior change – those things patients can do to improve their health.

As a chiropractor you will have many conversations about behavior change every day – about exercise, diet, posture, and compliance with treatment. How should you approach this? How do you approach this? Do you:

- Explain what patients could do differently in the interest of their health?
- Advise and persuade them to change their behavior?
- Warn them what will happen if they don't change their ways?
- Take time to counsel them about how to change their behavior?

How much do you give advice and direct the patient, acting as the expert and authority? How much do you listen and guide, treating the patient as your partner? What blend of these roles works best in patient interviews and why?

Expert answers to these questions come from prominent British and American clinical psychologists in *Motivational Interviewing in Health Care: Helping Patients Change Behavior*[1] by Rollnick, Miller, and Butler.

Motivational interviewing (MI) is a collaborative style of interviewing and communication which pays particular attention to the patient's language of change. It strengthens personal motivation for and commitment to change by exploring the patient's own reasons for change and adherence to treatment.

As Rollnick et al. explain in their introduction, it is a myth that there are problem patients unmotivated to change diet or exercise, quit smoking, or otherwise change behavior. MI will find their personal motivations and "the way in which you talk with patients about their health can substantially influence their personal motivation for behavior change."

MI was originally developed as an intervention for problem drinking, where patient motivation is a common obstacle. Clinical trials demonstrating success with MI have now been published across a broad range of behavior change problems. Patients exposed to MI vs. treatment as usual have been

found more likely to stay in and complete treatment; to participate in follow-up visits; to increase exercise and fruit and vegetable intake; to reduce stress and sodium intake; to keep food diaries; to reduce unprotected sex and needle sharing; to decrease alcohol and illicit drug use; to quit smoking; etc. See a bibliography of trials in the book and at www.motivationalinterview.org.

This issue of the Report now summarizes the background, principles and use of MI.

## B. The Origin, Spirit and Principles of MI

2. The clinical method of motivational interviewing (MI) was first developed and described in 1983 by William Miller PhD, Professor of Psychology, and Psychiatry at the University of New Mexico.

Miller also served as Co-director of the University's Center on Alcoholism, Substance Abuse, and Addictions, and MI was first developed as a counseling approach for the treatment of addictions. Miller, who has published 35 books and more than 400 articles and chapters, is named by the Institute for Scientific Information as one of the world's most cited scientists.

The co-founder of MI and co-author of the core text *Motivational Interviewing: Preparing People for Change* (Miller and Rollnick, 1991, 2001, 2012) is Stephen Rollnick PhD, clinical psychologist and Professor of Health Care Communication at Cardiff University in Wales. Rollnick (*pictured on opposite page*) has a special interest in challenging consultations in health and social care, and is primary author of the 2008 text *Motivational Interviewing in Health Care: Helping Patients Change Behavior* by Rollnick, Miller, and Butler already mentioned. Rollnick practiced in a primary care setting for 16 years before becoming a full-time teacher and researcher on the subject of communication.

Christopher Butler MD is Professor of Primary Care Medicine and Head, Department of Primary Care and Public Health, at Cardiff University. He has a general medical practice. For his doctoral work, directed by Rollnick, he focused on behavior change counseling and completed qualitative research into patients' perceptions of advice against smoking from clinicians. He has published more than 70 papers.

3. **Spirit of MI.** The spirit is one of *guiding* the patient, more than *directing*, listening as much as telling, and is:

a) *Collaborative.* Instead of an uneven power relationship in which the expert clinician directs the passive patient in what to do, there is an active collaborative conversation and joint decision-making process. This is particularly vital in health behavior change, say Rollnick et al., "because ultimately it is only the patient who can enact such change."

b) *Evocative.* Often health care seems to involve giving patients what they lack, be it medication, knowledge, insight, or skills. MI instead seeks to evoke from patients that which they already have, to activate their own motivation and resources for change.

A patient may not be motivated to do what you want him or her to do, but each person has personal goals, values, aspirations, and dreams. Part of the art of MI is connecting health behavior change with what your patients care about, with their own values and concerns. This can be done only by understanding patients' own perspectives, by *evoking* their own good reasons and arguments for change.

c) *Honors Patient Autonomy.* Clinicians may inform, advise, even warn, but ultimately it is the patient who decides what to do. To recognize and honor this autonomy is also a key element in facilitating health behavior change.

"There is something in human nature that resists being coerced and told what to do. Ironically, it is acknowledging the other's right and freedom not to change that sometimes makes change possible."

These three characteristics describe the underlying "spirit" of MI, the mindset for conversations with patients about behavior change.

4. **Guiding Principles of MI.** These, remembered by the acronym RULE (resist, understand, listen and empower) are:

a) *Resist the righting reflex.* The urge to give advice, and to direct patients, is natural. But so is "a natural human tendency to resist persuasion." Linked to this is "another well-documented basic principle of human nature: We tend to believe what we hear ourselves say. The more patients verbalize the disadvantages of change, the more committed they become to sustaining the status quo."

If you are arguing for change and your patient is resisting and arguing against it, you're in the wrong role. It is the *patient* who should be voicing the arguments for change. "MI is about evoking those arguments from the patient, and that means first suppressing what may seem like the right thing to do - the righting reflex."

On most issues of health behavior change patients are ambivalent. They see need and good reasons – then hit the "but" as in:

PRACTIONER: Well, if you did decide to exercise more, that would not only help your knee but also help you lose weight and improve your mood, you know. Exercise makes people slimmer, fitter, and feel better.

PATIENT: Yes, I know all that. *But* I can't help thinking that if I exercise while my

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knee hurts, even with gentle things like swimming, that I am doing more damage to it, despite what you say about those studies you read…"

b) *Understand Your Patient's Motivations.* Because it is the patient's own reasons for change, not yours, that will most likely trigger behavior change, be interested in and understand the patient's own concerns, values and motivations.

"This may sound like a prolonged process, but it need not be. If your consultation time is limited, you are better off asking patients why they would want to make a change and how they might do it rather than telling them that they should."

c) *Listen to Your Patient.* Good listening "is actually a complex clinical skill" and requires much more than asking questions and hearing replies. Quality listening, which is a large part of MI, "involves an empathic interest in making sure you understand, (*and involves*) making guesses about meaning." Rollnick et al. discuss this skill at length in Chapter 5. (See paragraph 8 below.)

d) *Empower Your Patient.* This is the final guiding principle of MI, helping patients explore how they can make a change and difference to their health. You know that regular exercise is important, but it is your patients who know best how they could successfully build it into their daily lives. "Patients in essence become your consultants on their own lives and on how best to accomplish behavior change."

"A patient who is active in the consultation, thinking aloud about the why and how of change, is more likely to do something about this afterward."

This summary of the spirit and principles of MI gives the rationale for using MI when talking to patients about behavior change. Rollnick et al. observe:

"One of the most striking features of MI is a feeling that you get in the consultation, almost tangible, that your stance in relation to the patient is easy and less conflict-ridden. As a colleague once remarked, "It's like dancing rather than wrestling." This experience is not just a reflection of the patient's attitude and behavior but of yours as well… Shift your style, and the consultation feels different."

## C. Communication Styles

5. Rollnick et al. explain that there are three legitimate and important commu-

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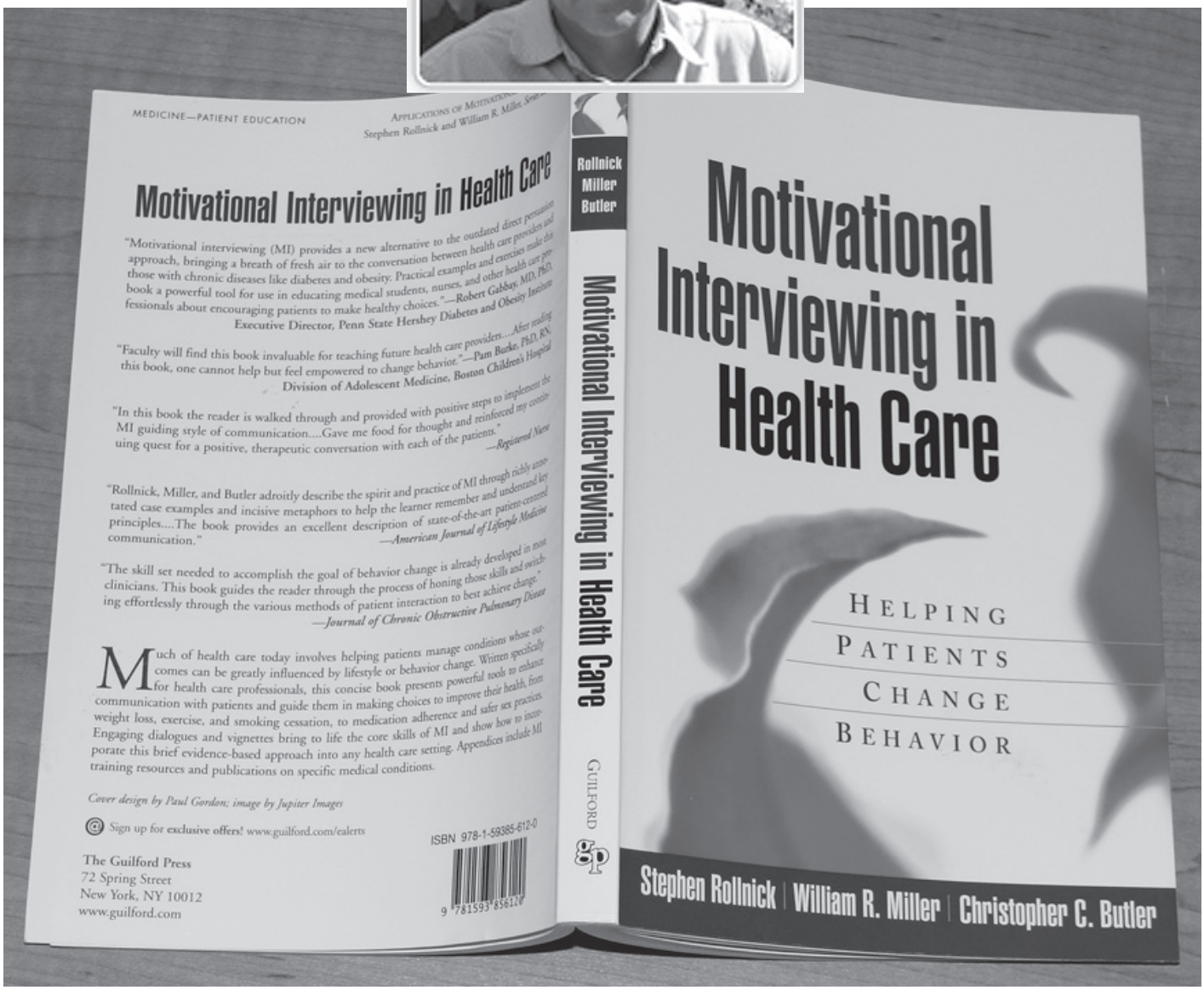

**LBP – Success Adding Chiropractic to Standard Medical Care**

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tiveness study", which took place in 2008-2009 at the William Beaumont Army Medical Center, Fort Bliss, El Paso, Texas, was "to assess whether the addition of CMT to SMC reduces pain and increases physical functioning compared with only SMC for the treatment of acute LBP."

b. After exclusions 91 subjects were randomly assigned to 1 of 2 groups:

• Standard Medical Care (SMC) - this included "any or all of the following: a focused history and physical examination, diagnostic imaging as indicated, education about self-management including maintaining activity levels as tolerated, pharmacological management with the use of analgesics and anti-inflammatory agents, and physical therapy and modalities such as heat/ice and referral to a pain clinic.

• SMC plus chiropractic manipulative therapy (SMC plus CMT) – up to 2 visits weekly for 4 weeks. HVLA manipulation was the primary approach for all subjects, but with ancillary treatments at the chiropractor's discretion as described in the paper. The median number of CMT treatments given was 7 (range 2-8).

c. The primary outcome measures were the numerical rating scale (NRS) for pain and the Roland Morris Disability Questionnaire (RMQ) and the back-pain functional scale for function. Secondary outcome measures were global improvement and patient satisfaction.

d. Results were:

• **Pain**. Both groups improved, as one would expect in this LPB population, but the SMC plus CMT group had significantly greater pain reduction at both 2 and 4 weeks, which were the 2 times for follow-up and assessment in this study.

• **Function**. Again, both groups improved but on both the RMQ and the back-pain functional scale the SMC plus CMT group had significantly better results. For example on the RMQ, where a minimal clinically important difference is a reduction of 2.5 points out of 24, the SMC plus CMT subjects had a clinically important advantage over the SMC subjects of 3.9 at 2 weeks and 4.0 after 4 weeks.

• **Global improvement**. 73% of subjects in the SMC plus CMT group rated their global improvement as pain completely gone, much better, or moderately better, compared with 17% in the SMC group.

• **Satisfaction.** Importantly, on a scale of 0 to 10 where 10 is completely satisfied, average satisfaction for care in the SMC plus CMT group was 8.9 at both weeks 2 and 4, whereas average satisfaction for the SMC group was 4.5 and 5.4 respectively.

• **Adverse events**. As in all previous controlled trials of spinal manipulation "there were no serious adverse events."

Limitations with this study are discussed by Goertz et al. It was only single blind (those analyzing the results were blinded but not the subjects or treating clinician), and although subjects in both groups had a similar number of medical visits those in the SMC plus CMT group had greater clinician contact.

(Goertz C, Long C, et al. (2013) *Adding Chiropractic Manipulative Therapy to Standard Medical Care for Patients With Acute Low Back Pain* Spine 38, 627-634)

## Other Research

1. **Canada – SMT: How does it work?**

There is growing evidence supporting spinal manipulative therapy (SMT) for the treatment of a range of neuromusculoskeletal disorders, including the very common chronic myofascial pain syndrome (MPS). The supposed basis is pain-relieving (antinociceptive) effects and restoration of normal joint mechanics. However two key things are still poorly understood:

• The underlying physiological mechanisms of SMT.

• The pathophysiology of MPS – although research indicates that myofascial trigger points (MTPs) play an integral role.

Unresolved is whether SMT acts through regional (segmental) or general (non-segmental) neurophysiological mechanisms or both. In a new trial Canadian chiropractic researchers Srbely, Vernon et al. from the University of Guelph and the Canadian Memorial Chiropractic College investigated:

• Whether SMT can evoke immediate pain-relieving effects in myofascial tissues by increasing pressure pain thresholds (PPTs) over myofascial trigger points in young adults – the result was yes.

• If so, whether these effects are regional or general – the result was "robust regional mechanisms."

Thirty-six subjects with identifiable MTPs in the infraspinatus and gluteus medius muscles were randomly allocated to two groups. One received chiropractic SMT at the C5-C6 spinal segment, regionally related to the infraspinatus but not the gluteus medius, and the other received validated manual sham SMT.

PPT was measured throughout a 15 minute post-treatment period. There was a statistically significant increase in PPT (i.e. decreased pain sensitivity – peaking at 36% decrease) in the infraspinatus muscle in the treatment group, but not in the gluteus medius, and not in either of the muscles in the sham SMT group.

Srbely, Vernon et al. review other existing literature showing that SMT produces regional inhibitory mechanisms in myofascial tissues. Recent research suggests, they say, that the primary physiological effect of SMT may be neurophysiological rather than changed joint mechanics. Their study serves as an important base for future research.

(Srbely J, Vernon H, Lee D et al. (2013) *Immediate Effects of Spinal Manipulative Therapy on Regional Antinociceptive Effects in Myofascial Tissues in Healthy Young Adults* (J Manipulative Physiol Ther In press doi:10.1016)

2. **Australia – Upper Extremities and TMJ**

JMPT is soon to publish a comprehensive 59-page systematic review of the research supporting manual and manipulative therapy (MMT) for upper extremity disorders including TMJ disorders. An international chiropractic research team led by James Brantingham DC, PhD from the School of Chiropractic and Sports Science, Murdoch University, Perth, Australia has prepared this

review with funding from the Council on Chiropractic Guidelines and Practice Parameters (CCGPP), the organization established by the US chiropractic profession to generate clinical guidelines.

This important review has 254 references, and covers all relevant good quality studies to March 2012. It builds on earlier systematic reviews in 2008 (chiropractic treatment for upper extremity disorders) and 2011 (MMT for shoulder pain). It has recommendations for treatment and key conclusions are:

• MMT with exercise and/or multimodal therapy is effective in the treatment of common upper extremity NMS disorders, including tennis elbow, carpal tunnel syndrome and TMJ disorders.

• The level of evidence is Fair, rather than Strong.

• The evidence of effectiveness is comparable, however, with that for other conservative or standard care (e.g. steroid injection) with exercise and/or multimodal therapy.

(Brantingham J, Cassa T, Bonnefin D, Pribicevic M, Robb A, Pollard H, Tong V, Korporaal C (2013) *Manipulative and Multimodal Therapy for Upper Extremity and Temporomandibular Disorders: A Systematic Review.* J Manipulative Physiol Ther 2013. In press.)

3. **UK – GP Referrals for SMT Increase**

The May issue of this report reviewed a Canadian survey showing orthopedic surgeons willing to partner with chiropractors in the collaborative management of spine pain patients referred by family physicians for surgical consults.

In the UK clinical guidelines encourage general medical practitioners (GPs) to refer back pain patients for spinal manipulation. Kier et al. from the Welsh Institute of Chiropractic at the University of Glamorgan (after a recent merger now the University of South Wales) surveyed 182 or approximately 20% of GPs in Wales in 2007 with a response rate of 50.8% to get information in two unexplored areas – first "the proportion of GPs who either do refer, or would consider referring, patients to SMT practitioners, in compliance with the low-back pain guidelines"; and secondly GPs' preference towards a specific provider of SMT both with respect to referrals and personal use. Points are:

a) A high proportion of the GPs responding to this questionnaire did or would refer patients for SMT, very different from former research findings. 85% had either referred patients to SMT (72% - 131) or would consider referring (13%).

b) Of the 127 GPs who expressed a preference 58% chose a physiotherapist and 42% "either osteopath, chiropractor or both." The survey does not give reasons, but Kier et al. note from conversations and anecdotal evidence that the general availability of physiotherapy on the National Health Service (NHS) seems to be an important factor.

c) Asked to name the type of clinician that GPs had personally sought or would consider seeking SMT treatment from for their own healthcare, the results were physiotherapist 22%/osteopath 16%/chiropractor 13%. An additional 23% responded that they had no preference and would seek help from any of the three professions.

Fundamental messages from this survey seem to be:

1. In spine care, family physicians/GPs are increasingly aware and accepting of the SMT skills of chiropractors, osteopaths and physiotherapists. Their perspective is that these professionals are all well-trained and largely interchangeable for their needs.

2. They will use those that they can work with most easily – in terms of a common language and approach, availability, integration of services and patient preferences. A major factor in patient preference is cost – reimbursed services under public or private insurances will be the first chosen preference of most patients – and therefore their referring physicians.

(Kier A, George M et al. (2013) Survey Based Investigation Into General Practitioner Referral Patterns for Spinal Manipulative Therapy. Chiropractic and Manual Therapies 21:16.)

4. **Switzerland – Spinal Surgery: Patient and Surgeon Expectations Differ Widely**

Lattig, Fekete et al. from Switzerland, after a survey of 227 consecutive patients aged 15-90 undergoing spinal surgery in an orthopedic hospital in Zurich, a survey also completed by their 7 surgeons (4 orthopedic, 3 neurosurgeons), report that there are "wide discrepancies between the patient and the surgeon regarding the expected result of surgery."

All patients had visited their surgeons at least once before surgery. During a final 20-30 minute preoperative informed consent consultation there was detailed information given to patients about their spinal disorders and treatment options as described in the paper – including help from imaging and a model of the spine, a discussion of potential complications orally and in writing, review of the planned rehabilitation program etc., with opportunity to ask questions during the consultation.

At the end of the preoperative consultation patients were also given the study questionnaire which asked them for their "realistic expectations regarding their status 3 months after surgery in relation to pain, pain medication usage, sensory and motor function and the ability to work, do household activities and participate in sports." The surgeons completed the same questionnaire.

Compared with the surgeons, patients "had much more optimistic expectations about their likely pain and activity level at 3 month post-operative." For example:

• 78.9% of patients thought that they would have no (23.9%) or little (55%) back pain which compared with 58.7% for surgeons (9.8% and 48.9% respectively).

• 1 in 2 of patients expected to have no leg pain (53.1%) which compared with 1 in 3 for surgeons (32.8%).

• 56.4% of patients expected to be taking no pain medication, compared with 29.5% for surgeons.

• For those with sensory disturbances, 99 or 58.6% expected them to be completely resolved, which compared with 27.4% for surgeons.

• Many more patients thought that they would have full ability to return to work (27.2%), housework/gardening (40.4%) and sports (22.5%) than surgeons (7.1%, 13.3% and 4.9% respectively).

(Lattig F, Fekete T, O'Riordan D et al. (2013) A Comparison of Patient and Surgeon Preoperative Expectations of Spinal Surgery. Spine 38:12 1040-1048.)

**Main Article** *continued from page 3*

nication styles used in health care practice, as in everyday life also. These are:

a) *Following.* Listening predominates. There is no agenda beyond understanding the other person's position. At the start of a consultation a brief period of following helps you to understand patients' symptoms and the impact of these on their lives and health. With regard to behavior change, this style communicates "I won't change or push you. I trust your wisdom about yourself, and I will let you work this out in your own time and at your own pace."

b) *Directing.* With this style you take charge for the time being. There is an uneven relationship with regard to authority, expertise and power. With respect to behavior change, the directing style communicates "I know how you can solve this problem. I know what you should do."

c) *Guiding.* A guide helps you find your way. It is not within the guide's authority to determine what you want to see or do. You decide where to go, and you hire a knowledgeable guide or travel agent to help you get there.

A good guide knows what is possible and can offer you alternatives from which to choose. With regard to behavior change the guiding style communicates "I can help you to solve this for yourself."

These three styles of communication are suited to different circumstances and relationships. All are needed. The problem is when they are mismatched.

"A skilful practitioner is someone able to shift flexibly among these styles as appropriate to the patient and situation." What is described as "an old-fashioned, good bed-side manner" is probably a reflection of much more than a friendly chiropractor, doctor or nurse. "It is someone with the skill to switch among communication styles and the wisdom to seek and understand what style the patient needs."

**Table 1. Six Kinds of Change Talk**

| | |
|---|---|
| • *Desire:* | Statements about preference for change.<br>"I *want* to …"<br>"I would *like* to …"<br>"I *wish* …" |
| • *Ability:* | Statements about capability.<br>"I *could* …"<br>"I *can* …"<br>"I *might be able* to …" |
| • *Reasons:* | Specific arguments for change.<br>"I would probably feel better if I …"<br>"I need to have more energy to play with my kids." |
| • *Needs:* | Statements about feeling obliged to change.<br>"I *ought* to …"<br>"I really *should* …" |
| • *Commitment:* | Statements about the likelihood of change.<br>"I am *going* to …"<br>"I *will* …"<br>"I *intend* to …" |
| • *Taking steps:* | Statements about action taken.<br>"I actually went out and …"<br>"This week I started …" |

## D. Change Talk

6. Most of the book deals with the core skills of MI – asking, listening, informing - and practicing these skills with examples. There is informed and helpful analysis of concepts that many experienced clinicians use intuitively, but they can be used more skilfully if better understood.

One example of this is change talk. Most patients, as with most people, are ambivalent about change as in these statements:

"I need to lose some weight, but I hate exercising."

"I want to get up, but it hurts."

"I should quit smoking, but I just can't seem to do it."

The tell-tale sign of ambivalence is the *but* in the middle. People become stuck. "It is as if the arguments on either side of the *but* cancel each other out, and so nothing changes."

When you take a directing style with an ambivalent person you are taking the pro-change side, adopting the righting reflex already mentioned, and positioning patients to talk themselves away from change rather than into change.

However your role is to promote change talk, not resistance. You must recognize change talk and understand its level of commitment and its link to the individual patient's personal motivations for change.

Rollnick et al. present the six kinds of change talk as seen in Table 1. The first four – Desire, Ability, Reasons and Need – can be remembered by the acronym DARN. They are precommitment forms of change talk but are valuable in that they indicate motivations for change which you the health professional can build on.

Take cessation of smoking as an example. Clinicians, instead of giving their reasons why a patient should quit, can use questions such as those that follow to encourage DARN statements from a patient.

"Why would you want to quit smoking (desire)?"

"How would you do it, if you decided to (ability)?"

"What for you are the three best reasons for quitting (reasons)?"

"How important is it for you to quit (need)?"

When you hear DARN language in their replies you are discovering what your patients hope for, what matters.

These are the motivations that will lead to the final two kinds of change talk seen in Table 1 – commitment and taking steps – and to actual behavior change. How do you know if you are getting more skilful in guiding patients to behavior change, at motivational interviewing? In the words of Rollnick et al.:

"Although we can give you some guidelines for using MI in practice, your real teachers are your patients. Whenever you try the guiding style, you get immediate feedback. If you hear more change talk, you know you're doing it right. When you seem to be eliciting arguments against change, your patient is telling you to try a different approach."

## E. Asking, Listening and Informing

7. **Asking.** Asking open questions that give patients room to respond (e.g. how are you feeling today; how can I help you; what are you most worried about; tell me about your headache), rather than closed questions seeking specific information (e.g. where does it hurt; does the pain seem worse in the morning or evening):

- Invites relationship and gives the patient more active involvement.
- Often produces more useful information.
- Is perceived by the patient as showing personal interest and caring, transforms the quality of the consultation, and leaves patients more satisfied.
- Can be just as time efficient yet leaves patients feeling they were given more time.
- Gives you an opportunity to pause, look and listen.

Rollnick et al. advise that "the social etiquette of open questions is to make eye contact when asking them (rather than, for example, reading or writing in a chart) and to listen carefully to what the person has to say." Questions should be short and simple. "It feels to the patient as if it's a normal conversation connected to her *(or his)* experience."

Most consultations involve both open and closed questions. "A common approach is to build the exchange around initial key open questions, with closed questions being used only to funnel down and elicit specific information as necessary."

Rollnick et al. give examples of key open questions that cover many purposes such as:

a) "*What's worrying you most today about your problem?"* This puts the patient at the centre of the consultation and provides a good platform for topics on your agenda.

b) *"What exactly happens when you get that pain?"* The word *exactly* signals an intention to get to the bottom of the patient's concern. The patient is invited to tell a story which will likely answer many other questions and expose motivations.

c) *"What did you first notice about your child's condition?"* Rollnick et al. explain that the word *notice* can be very useful. People respond well because it invites them to be the expert commentator about their experience of events and behavior. Information often comes flooding out, they feel heard.

Rollnick et al.'s chapter on asking is full of other practical advice and examples, including:

- Routine closed questions set you up as the authority figure following your own agenda "and tend to evoke defensiveness, often leading to answers that are half-truths as a means of protecting self-esteem."
- Good open questions are those that promote change talk – see the earlier discussion of the DARN acronym.
- Questions using a weighting scale can elicit change talk and tell you about the patient's level of motivation at the same time – e.g. "How strongly do you feel about wanting to get more exercise? On a scale from 1 to 10, where 1 is 'not at all,' and 10 is 'very much,' where would you place yourself now?"

8. **Listening.** Rollnick et al. commence a long chapter on "listening within a guiding style, a skill that lies at the heart of MI", with this observation:

"There is something about being heard and understood, about being the focus of full compassionate attention, that is in itself healing. Such listening is, we believe, one reason why patients so frequently seek out and appreciate the services of alternative healers and those health care practitioners who listen well."

They then make this case for the importance of practitioner's developing their listening skills:

- You gather important information you might otherwise miss.
- As little as 1-2 minutes of quality listening can greatly promote your relationship with a patient. Long after the specifics have faded, patients often remember that chiropractor, doctor or nurse who really listened to them.
- Patients are not only more satisfied with their care but are also more likely to be open and honest "and, we believe, more likely to adhere to advice."
- Perhaps most importantly, good listening is a large component of the non-specific, placebo aspect of healing.
- "Listening can save you time, because you develop an ability to quite quickly grasp the essence of the patient's concerns. This allows you to move on to another topic more easily."

Key situations for use of listening include:

a) The first part of a consultation. One of the most common patient criticisms of consultations is not being allowed to tell their story. Interrupt this activity and the seeds of dysfunction and the sense of not being heard are sewn.

b) Brief episodes throughout the consultation. Patients will signal the need for this when they seem confused, disengaged or annoyed.

c) After you ask an open question.

9. Listening skills discussed include:

a) Giving full attention, including silencing outward talk or roadblocks to listening (e.g. agreeing, disagreeing, questioning) and "inner chatter" (thinking about questions, next steps, other matters).

b) Use by the practitioner of facilitative responses (e.g. "I see"; "say some more about that") used by the practitioner to break pure silence.

c) Short summary reflections on what is being said. "Proof positive that you are listening, hearing, and understanding is to reflect back to the person a short summary of how you understand what he or she said. Parrots cannot do this – it involves more than repeating."

d) Offering reflections as statements rather than as questions. The practitioner's voice inflection "turns down at the end of a good reflection, not up as when asking a question."

e) Focusing your reflections on elements of change talk in what the patient has said. Rollnick et al. give excellent dialogue examples of this.

f) Effective ways of bringing listening to a close because of time constraints – something that health professionals worry about but "that is actually quite manageable." Effective ways include:

- Summarize what you have understood and suggest a change in direction.
- Be honest about your time limitations.

• Acknowledge the value of what you have heard.

Rollnick et al. give this example on the last two points: "Thank you for sharing this with me. What you have told me today has really helped me get a much better understanding of the situation. I wish I could listen longer, but I have to see someone else now, and I don't like to keep people waiting. Let's talk more about this the next time I see you."

10. **Informing.** Opening their discussion of giving information within the framework of MI, Rollnick et al. reiterate that MI is based on a guiding style. A competent guide provides information in a particular way. Features of this are:

a) *Asking permission*. If the patient asks for information you automatically have permission to inform. Otherwise ask first – e.g. "may I make a suggestion?"; "would it be alright if I tell you one concern I have about your situation/plan?"

Asking for permission, say Rollnick et al., has several good effects. "It directly honors and reinforces patients' autonomy and active involvement in their own health care. It emphasizes the collaborative nature of your relationship. It also lowers resistance."

b) *Offer choices* – more than one at the same time so that you are informing and guiding rather than directing. For example:

"It's a common fear that exercise might cause additional injury. If you do this appropriately there is no evidence at all that it is harmful. It's a question of what will suit you. Some of our patients walk or swim longer distances each day, some use exercise equipment at home, others come down to our gym to use our equipment with guidance. It's your choice. I wonder what would make sense to you right now."



c) *Talk about what other patients do*. As in the above example.

d) *Information exchange*. See informing as information exchange – a two-way process and partnership in which the patient remains active. Instead of using the directive approach of chunk-check-chunk (you provide a chunk of information, check patient understanding, then provide another chunk) use the elicit-provide-elicit (EPE approach).

Two forms of open question with which you can begin the information exchange are:

• "What would you most like to know about_____?" You are inviting the patient to tell you what seems most important from his or her own perspective.

• "What do you already know about _____?" Advantages of this form of question are that it can save time, prevent you from lecturing patients about what they already know, allow you to discover and correct misconceptions, and it can produce answers with change talk and an implicit understanding of the need for health behaviour change.

## F. Conclusion

In many studies, including the new one from Palmer College discussed in the Professional Notes in this Report, chiropractors score very highly in terms of patient satisfaction. As Coulter concludes on a review of the evidence:

"Chiropractors are very effective at communicating… the studies have identified the doctor – patient communication as the key component (in the high rates of patient satisfaction)."[2]

But after this discussion of MI, on a scale of 1-10 how good is your communication in patient interviews? How can it be improved?

To conclude with a memorable example of the power of an open question exploring patient motivation, visit this link to an ABC Nightline television news story on October 17 last year: http://abcnews.go.com/Nightline/video/chiropractic-neurology-miracle-method-placebo-17032877.

Stacey Hubbard, a hands-on mother of two, has been referred by her neurologist to chiropractic neurologist Dr Ted Carrick. She has spent 10 weeks in bed with a neurological disorder and cannot walk a few steps without stumbling.

*Question – Dr Carrick:* If you could pick one thing, what's the worst thing you would like me to fix for you?

*Answer:* I want to be able to hug my children home from school.

This news video then documents Stacey's recovery and shows her hugging her children home from school. Clinical success with a second patient is also shown. Not mentioned is the fact that ABC waited six months before running this story – which was conditional upon the patients maintaining their improvement for that period. TCR

## References


1 Rollnick, Miller, Butler (2008) *Motivational Interviewing in Health Care: Helping Patients Change Behavior* The Guilford Press, New York and London.

2 Coulter ID (2005) *Communication in the Chiropractic Health Encounter,* Chapter 5 in *Principles and Practice of Chiropractic,* ed. Haldeman SH, 3rd edition, McGraw Hill, New York.