MIH-CP

Motivational Interviewing for the Community Paramedic

06/02/2016

Issue: July 2016 (/magazine/ems/issue/2016/jul)

Dan Swayze, DrPH, MBA, MEMS (/contact/19740/dan-swayze-drph-mba-mems)

The initial assessment was uneventful. The patient had recently been discharged for CHF, and the community paramedic was visiting as part of a program to reduce the likelihood of a readmission. The visit revealed the patient was taking medications for acid reflux and gout in addition to the meds on his hospital discharge list, but was otherwise unremarkable. The challenge came when the CP called the patient back with a message from the patient's cardiologist.

The doctor said the patient could continue taking his stomach medication, but that he should stop taking the medication for the gout, as it could cause fluid retention. The patient became irate when he heard the order. He explained that his gout caused severe pain and limited his mobility. He adamantly refused to stop taking the medication. He would rather risk having another CHF attack, he said, than face a life of chronic debilitating pain. The CP tried to explain the man could die if he had another attack of CHF and even offered to talk to the patient's doctor to find a replacement. The patient refused and abruptly ended the call, telling the CP there was no reason for her to return.

We use this case to introduce one of the most challenging aspects of community paramedicine: understanding that the patient has the right to decide their priorities in life, even when those choices could severely limit the quality or quantity of that life. Many healthcare providers assume if they provide education on a disease or describe the risks involved in the patient's behaviors, the patient will make a rational choice and change their ways. If that were true, however, the prevalence of smoking, obesity and sedentary lifestyles in EMS providers would be close to zero. A quick look at your EMS colleagues shows that is not the case. Many of our colleagues know the long-term consequences of their behaviors but choose unhealthy habits regardless. CPs who believe their job is to simply lecture their patients on the errors of their ways will likely find their patients disengaged from the program or frustrating in their lack of progress.

While education alone may not be sufficient to motivate a change, there are ways we can influence the patient's choices. This article will introduce motivational interviewing (MI), an evidenced-based therapeutic communication style that can influence the decisions our patients make. Mastering these techniques can be challenging for CPs, who must learn to transition from being a quick-thinking problem solver to interacting with patients in a completely different role.

The Essence of MI: *PACE* Yourself

By far the hardest part of using MI is trying not to solve the patient's problems. In your traditional EMS role, problem solving was a critically important skill. You needed to be able to quickly assess and prioritize the patient's problems and stabilize those you could treat. While

you will still assess the patient's problems in the CP role, trying to rush your assessment or prioritize their problems could lead you astray. And unlike your role in traditional EMS as the expert problem-solver, the patient is the only expert on what solutions will work for them. To help understand the essence of MI, William Miller (the father of MI) describes four characteristics that help put our new role into perspective. They can be described using the mnemonic *PACE.*

Partnership—In our traditional EMS roles, the patient has a problem, and we offer the solution. However, MI is built on a more equal partnership. Our role is not only to assess patients' problems but to elicit their priorities. We can introduce them to new resources but may be surprised when they turn down options we think would help. The practice of MI is built on the understanding that the patient is the only expert on their life. They are the only ones who can decide whether their quality of life (e.g., being free from gout pain) is more important than its potential quantity (e.g., avoiding premature death from a CHF exacerbation). They are the only ones who can choose which healthy behaviors to adopt or ignore. Our role is not to encourage them to do what we think is best but to help them make the best decision given their priorities in life.

Acceptance—Accepting that partnership, and the patient's right to choose their own priorities, means we have to respect the person's autonomy. In fact, Miller describes our new role as requiring a "radical acceptance recognizing that ultimately whether change happens is each person's own choice, an autonomy that cannot be taken away no matter how much one might wish to at times."

Patience will be tested when the patient has a different value system that results in decisions that are illogical to us. CPs will be frustrated when their patient's behaviors lead directly to their poor health, but they refuse to change. When the patient engages in behaviors we consider immoral, unethical or illegal, we will wrestle with our own ethics and moral compasses. CPs have to understand that although we are trying to help these patients out of a tough spot, they may not choose the same destination we would. It is, however, their inalienable right to choose.

Compassion—The Dalai Lama defined compassion as the wish to see others free from suffering. If we accept that definition, then community paramedicine is compassion in action. A healthy amount of compassion for our patients is critical to the success of our CP interventions and the practice of MI. If we approach the patient with the same clinical detachment taught to our colleagues in medicine, we will likely have a hard time engaging them in the change process. Without empathy and compassion, our desire to judge our patients will be stronger than our desire to continue to try to help.

Evocation—Whether it appears as parental nagging or our boss's micromanagement, offering unsolicited advice seems to be an incredibly common but unwelcome behavior when it is directed at you and me. Despite the fact that we largely ignore those who offer us advice, giving advice under the guise of "patient education" is our default intervention when we try to help our patients as a CP. Patient education is an important component of CP programs, but one whose value is overestimated. MI is based on the premise that the ideas most likely to succeed are those generated by the patient. Eliciting ideas from the patient is a different skill and role for EMS providers who are used to being problem solvers. Nonetheless, the practice of MI recognizes that the patient is most likely to try and maintain solutions they generate themselves.

Understanding these four guiding principles will help us approach the patient differently than we have in our traditional EMS roles. To put these guidelines into practice, however, requires that we learn new communication skills.

The Application of MI: Core Skills

Not only does MI involve a different way of thinking about how to help patients, it requires us to practice conversational techniques that are vastly different from those we've used in our traditional roles. Not unlike learning to perform a clinical intervention, CPs must learn and repeatedly practice the techniques described below to become more effective at helping their patients. The following four conversational skills are the foundation for MI interventions.

Ask open questions—The time-sensitive nature of traditional EMS work means we have to sift through lots of information in a very short time frame. We don't have time to listen to the patient explain all the major events in their life they believe led up to the call to 9-1-1; we just want to know what prompted them to call today. When the patient starts going off on a tangent, we redirect them using closed questions to which there is little opportunity for elaboration.

In community paramedicine we benefit from hearing the rest of the story. Understanding adverse childhood experiences, a history of physical or emotional traumas and family support systems (or lack thereof) is critical for CPs. These stories help us understand not only why a patient is in their current predicament but what resources may be available to help them. This information is more likely to be obtained through an open question such as "Tell me about yourself," rather than a closed question such as "Were you ever abused as a child?"

Provide affirmations—An affirmation is an expression of a sincere appreciation for some trait or behavior of the client. Sharing these observations with the patient can be a powerful tool in building a rapport and confidence in their ability to change behaviors. Miller describes an affirmation as finding what is right with the patient rather than constantly focusing on what's

wrong. However, finding these positive attributes can sometimes be challenging. We may not agree with the patient's lifestyle choices, values or behaviors. At times providing an affirmation to the patient means we have to reframe our view of the patient's situation. Given the multiple challenges (self-imposed or otherwise) many patients face, it may be helpful to appreciate that your patient has not given up. In most cases even the most troubled patient can be considered a survivor.

Use reflection, not questions—If there is one skill that is critical to master to conduct MI successfully, it would be the use of reflections. Rather than interrogating the patient with a series of questions to obtain the information we need, MI relies on the skillful use of reflective statements to gather the information. Reflective statements essentially repeat what the patient said as a way of allowing the patient to elaborate. The statements reassure the patient you're listening while allowing you to confirm you understand what the patient is trying to say. Reflections come in two general categories, simple and complex. A simple reflection simply repeats verbatim or rephrases what the patient just said. Complex reflections are attempts to check the meanings or emotions behind the words.

Table 1 provides examples of how a single statement can be reflected back to the patient as an opportunity to explore what the patient really meant. While it seems counterintuitive at first blush, using reflective statements can often elicit better information faster than direct questioning. More important, reflections allow the patient to tell their story without the feelings of judgment or interrogation questions can often elicit.

Use summary statements—The final skill for practicing MI is the use of summary statements. CP visits tend to be longer than traditional EMS patient encounters, and it can be useful for the patient and the CP to occasionally review what has been discussed. For example, you might start a summary statement with, "Mr. Smith, you've mentioned several concerns about your medications, and I want to be sure I'm capturing all the important ones." Then list the individual concerns the patient has mentioned and conclude with, "Tell me what other concerns you might have."

Summary statements can be helpful to ensure the CP is capturing all the important information that has been shared. Summaries can also be helpful in redirecting the patient when they go off on an unproductive tangent to areas that are more relevant to the current discussion.

Getting Engaged: Foundation of the MI Processes

Mastering the conversational skills listed above will help the CP be better prepared to help patients help themselves. However, an all too common frustration is those patients who refuse to follow through. These patients may allow the CP to visit but refuse to take any

actions between visits to accomplish what they have agreed to do. The result is that the patient fails to make any progress and the CP becomes frustrated with the patient for their apparent unwillingness to help themselves. Using MI techniques may help correct or even avoid these types of impasses.

Miller describes successful MI interventions as a four-step process that includes *engaging* the patient in the partnership; *focusing* their time on the steps necessary to make progress; *evoking* ideas from the patient on how to change their behaviors; and *planning* to implement the changes once a direction has been determined. However, if the patient disengages from the CP or program, the rest of the steps in the process will not be successful.

To stay engaged in CP programs, patients must trust and respect their CPs. Overlooked, however, may be the fact that the CP must have the same feelings toward the patient to remain interested in helping. When the patient demonstrates feelings of entitlement, displays manipulative behaviors or expresses a profound sense of hopelessness, the community paramedic may not trust the patient to have their own self-interest at heart. Observing those feelings and behaviors makes it difficult to want to continue to help and can lead to the CP disengaging from the patient. Conversely, patients who believe the CP's visit is yet another futile interaction with the healthcare system, or who question the CP's motives, or who don't believe the CP is really listening, will also find it difficult to engage in the process. Mutual engagement in the relationship is essential for the visits to be therapeutic.

Just as there as several ways for either party to become disengaged, there are several things that can be done to help keep the interactions on course. The first is to manage the patient's expectations. An explicit discussion about the types of services you can help with and defining their responsibilities in the process can help the patient understand how this may differ from their previous healthcare encounters.

Similarly helpful is to do a periodic reassessment of the patient's priorities. Patients who appear withdrawn or who have not followed through on an agreed-upon action may be distracted by the emergence of a new challenge that takes priority. Rather than assuming the patient has lost interest in your help, periodically make sure you are still working on the priority issues.

Last, maintaining a sincere positive and hope-filled attitude despite the patient's current emotional state can help lift the patient's spirits. While it may seem like a waste of time, spending a few moments during the visit to socialize can help recharge the patient's mood and remind them of how enjoyable life can be despite their current frustrations.

Table 1: Examples of the Types and Intent of Using Reflective Statements

The patient says...

TABLE 1: EXAMPLES OF THE TYPES AND INTENT OF USING REFLECTIVE STATEMENTS
The patient says...
"I don't like taking that medication!"
Types of reflection
Simple reflection—repeat: "You don't like taking that medication."
Simple reflection—rephrase: "You don't enjoy taking that particular drug."
Complex reflection—explore the statement's meaning: "You don't like the side effects that medication causes."
Complex reflection—explore the meaning and emotions behind the statement: "It's frustrating to deal with the side effects of your prescriptions."

"I don't like taking that medication!"

Types of reflection

Simple reflection—repeat: "You don't like taking that medication."

Simple reflection—rephrase: "You don't enjoy taking that particular drug."

Complex reflection—explore the statement's meaning: "You don't like the side effects that medication causes."

Complex reflection—explore the meaning and emotions behind the statement: "It's frustrating to deal with the side effects of your prescriptions."

Summary

Motivational interviewing is both a philosophy and a set of communication skills that can help CPs better understand and help their patients. Recognizing that patients have the right to choose their own direction in life and are the best source of ideas for how to change will help the CP avoid trying to solve problems outside of their control. Using open-ended questions, affirmations, reflections and summary statements can facilitate those discussions and make it less likely that any patient ever tells a CP there is no reason to return.

Dan Swayze, DrPH, MBA, MEMS, is the vice president for the Center for Emergency Medicine in Pittsburgh, PA.