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Review: Experiences and preferences of counselling about living habits in healthcare – a systematic review of studies on the patient perspective

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Abstract

Background Recent policy in Sweden states that patients in every part of health care are to be presented with health counselling concerning living habits: tobacco, alcohol, an inactive lifestyle and eating habits. This review aims to investigate experiences and preferences of counselling about living habits from the patient's perspective.

Method A literature review of six major databases using a wide approach to detect studies of different methodologies, patient categories, health care settings and intervention types. Inclusion criteria were studies in any setting/category concerning patients' experience of discussing living habits with a health care practitioner (HCP). Results came to merit synthesis and quality appraisal using only instruments for qualitative studies.

Results 21 studies are presented. With one exception all originate from primary care. Themes are presented under headlines: encouragement, empowerment & support; doctor-patient relationship; individualization & involvement; stigma; time and ongoing support; empathy; and attitudes not favoured by patients. Most studies are of good quality with the most common remark of not having discussed chosen methodology or not having discussed the researcher's role in outcome.

Results are discussed in relation to Motivational Interviewing, Self-Determination Theory and Social Cognitive Theory. A review of qualitative studies had to take special emphasis to search strategy, quality appraisal and synthesis.

Conclusion/implication This review provides an overview of published studies in the field of patient experience. Further study is needed to widen the scope beyond Primary care and to secure findings in more controlled settings.

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Introduction

According to a recent investigation and policy document from the Swedish National Board of Health and Welfare every person in contact with Swedish healthcare should be provided with health counselling about living habits such ass tobacco, alcohol, an inactive lifestyle and unhealthy eating habits (1). The foundations of such a policy is hardly disputed with an estimated one third of the total burden of disease in the industrialised countries derive from tobacco, alcohol, blood-pressure, cholesterol and obesity according to the World Health Organisation (WHO) (2). Growing attention is being directed towards lower income countries with an increase of lifestyle related disease making lifestyle related disease a global dilemma, and even in these countries more persons die from lifestyle-related illnesses than infections (3). In Sweden, tobacco, excessive use of alcohol, insufficient physical activity and unhealthy eating habits together constitutes the greatest contribution among living habits to the total burden of disease (4).

Health promotion (HP) was conceptualised in the Ottawa charter from 1986 as "the process of enabling people to increase control over, and to improve, their health" and is since then seen as a process of empowerment towards health (5). This concept of health dates back to the original WHO definition from 1948 where health was seen as "a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity" (6). Since 2000 the WHO has focused on securing HP on an evidenced based platform, hence the WHO general secretary statement: "Health promotion should be based on evidence rather than ideology", and evidence based HP is recently acknowledged and conceptualised

in a WHO document emphasising the importance of empowerment concerning lifestyle, behaviour and readiness for change as an entrance to lifestyle intervention programs (7).

From a theoretical perspective patient centred medicine is a topic receiving a lot of attention in the field of doctor-patient relationships today (8). Although multiple theories and frameworks coexist, Mead and Bower provide five dimensions of patient centred care: a bio-psychosocial approach, understanding the meaning of health from the patient's personal perspective, using shared decision making and sensitivity for patient preference, creating a therapeutic alliance and understanding the meaning of personal quality and preference in the practice as a doctor (9). One way of increasing patient centeredness is by conducting a Motivational Interviewing (MI) approach to the health encounter as proposed by Miller & Rollnick (10).This includes the four major techniques: showing empathy, developing discrepancy, avoiding resistance and increasing autonomy. Another way, Self-Determination theory by Deci and Ryan (11), is based on autonomy, competence and relatedness, and yet another stems from the concept of self-efficacy of social cognitive theory by Bandura (12), both of which link to the influence of behaviour.

To fully carry out evidence based medicine one must acknowledge evidence, competence within staff and the preference of patient, where the patient's perspective is to be just as acknowledged as evidence and skill (13) and should be used to educate policy makers (14). It is known that patients accept questions and advice from healthcare practitioners (HCP). This has been recognised in the first studies of the subject (15) as well as in a recent Scandinavian context by Johansson et al. where advice about exercise was the most common and advice about alcohol the least common (16). They also found that patients receiving advice were more satisfied with their visit than patients who did not receive advice. Nilsen investigated feelings toward brief alcohol advice finding that conversations rarely generated unease and that conversations were more likely to result in changed living habits if they lasted ten instead of five minutes (17). These studies mainly use questionnaires to investigate the views of the public and it, with the words of Stott and Pill, "with its reliance on self -administered postal questionnaire and forced choice format answers, inevitably means that little is known about those who reject or have reservations about the concept of lifestyle counselling or why they hold such views" (18). Whether or not the public opinion is in line with healthcare causal relationships between living habits and disease is to some part questioned though (19). This merits the use of qualitative studies as well as quantitative. Furthermore, many qualitative studies have been performed on patient preferences, but only recently international consensus has been gathered for the methods of reviewing qualitative research (20).

The aim of this review was thus to gather the experiences and preferences of patients in relation to receiving health counselling concerning the four major lifestyle habits responsible for most disease, hence answering the following research question: What are the experiences and preferences of patients having undertaken various ways of health counselling directed towards living habits?

Methods

Search methods

In the period March 6 to April 4 2012, Medline, Embase, CINAHL, Web of Science, The Cochrane Library and PsycInfo were searched for scientific publications using the search strategy given in appendix 1, supplemented by manual search. Although changes were made to comply with respective database index system, such as the Medline MeSH, the basic concepts of each search strategy were similar to the one provided.

Inclusion/ exclusion

Studies included in this review investigated patients' experiences and preferences about health, personal behaviour and treatment during health promoting interviews. Studies were accepted for review independently of qualitative or quantitative methodology. Included studies concerned adult patients of any kind, who had undergone health counselling of health promotive, preventive and rehabilitative nature. Living habits included by this review concerned the four major ones: tobacco, alcohol, insufficient physical activity and eating habits as related to recent guidelines (1). The studies should evaluate the experiences of HP counselling that had taken place and if possible also the preferences, but not for example only evaluate the effect, compliance, satisfaction and frequency of HP counselling, or deal with wishes, barriers, visions, facilitators and expectations without having undertaken the HP counselling. Most importantly it should explicitly be mentioned in the aim of the studies to measure patient preference and expectation of the review topic.

Exclusion criteria were studies of children, partners or families as well as studies of health professionals alone or together with patients. In addition other health talks and specific health concerns were not included. There were no exclusion criteria for publication year, language or gender.

Design

Although we had no preconception of certain methodological preferences such as RCT studies, qualitative studies or studies using survey methodology, we acknowledged that patient preference could often be investigated using qualitative methodology such as individual interview or focus group interview. Although this acknowledgment did not affect our search strategy, the studies retrieved by the search warranted synthesis of qualitative material and quality appraisal related to qualitative research. For such a synthesis we have chosen the thematic analysis as described by Dixon-Woods (21), and the criteria for good and poor quality was chosen from the Cochrane Collaboration (20). According to this a quality assessment tool should comprise of the following four core themes: credibility, transferability, dependability and confirmability corresponding to quantitative terminology: internal validity, generalisability, reliability and objectivity. For the critical appraisal of studies in this review we use the Critical Appraisal Skills Programme (22) as it is recommended for first time users by the Cochrane collaboration. The results of this evaluation are found as table 1 in this review.

According to thematic analysis we have read manuscripts repeatedly to look for common themes and patterns. Although no attempt has been made to alter or conjoin themes they are presented under common headlines for clarity.

Results

Search outcome

The search strategy resulted in 30,274 articles. These were sorted according to relevancy of title, which rendered 4,849 articles of relevant topic. After controlling for duplicates these amounted 4,175 (see figure 1). Inclusion procedures included reading abstracts, examining inclusion criteria and performing a team conference after which a total of 21 qualitative studies were accepted for review (18;23-42) (see appendix 2 for details of the studies).

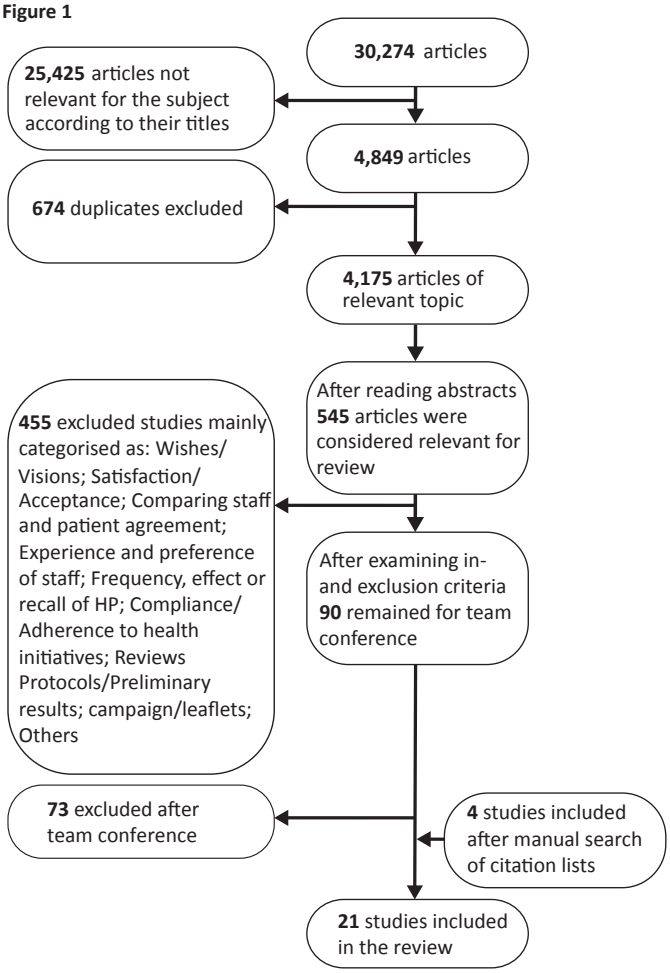
Settings

The presented studies used the primary care setting only or in part but Arborelius et al. (ante-natal clinic) (40). Other settings included a hospital setting (23;24), a diabetes learning centre (27) and an ante-natal clinic (41) in addition to primary care.

Health determinants

Seven studies focused on tobacco specifically (18;24;38-42). Stott & Pill and Lock put particular emphasis on alcohol (18;36). Insufficient physical activity was considered in five studies (18;25;28;30;32). Only Hardcastle et al. and Cable et al. investigated diet expressly (25;38) and weight reduction was considered by Malterud et al., Brown et al. and Stott & Pill (18;26;34). Five studies explored lifestyle counselling within DM-2 treatment (27;31;33;35;37). Dellasega et al. and Walseth et al. had no certain living habit in focus but general lifestyle counselling (23;29).

Figure 1



Themes elicited

Major themes from thematic analysis of chosen studies are presented in detail in table 1 and are described under the following headlines: encouragement empowerment & support; doctor-patient relationship; individualisation & involvement; stigma; time and ongoing support; empathy and attitudes not favoured by patients.

Encouragement, empowerment and support

Participants in 13 studies stressed the importance of receiving encouragement, being empowered or getting support from their HCP during discussion of living habits (23-25;28-31;34-36;38;40;42). Studies by Dellasega

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Table 1 Critical Appraisal Skills Programme

Article	Was there a clear statement of aims?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the study?	Was the recruitment strategy appropriate to the aims of the research?	Were the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis suficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Score:
Dellasega, 2011 (23)	+	+	-	+	+	-	+	+	+	-	7/10
Hansen, 2011 (24)	+	+	-	+	+	-	-	+	+	+	7/10
Hardcastle, 2011 (25)	+	+	-	+	+	+	-	+	+	+	8/10
Malterud, 2010 (26)	+	+	-	+	-	-	+	+	+	+	7/10
Oftedal, 2010 (27)	+	+	-	+	+	-	+	+	+	+	8/10
O'sullivan, 2010 (28)	+	+	-	+	-	-	+	+	+	+	7/10
Walseth, 2010 (29)	+	+	-	-	+	+	-	+	+	+	7/10
Horne, 2009 (30)	+	+	-	-	+	-	+	-	+	+	6/10
Adolfsson, 2008 (31)	+	+	-	+	+	-	+	+	+	+	8/10
Elley, 2007 (32)	+	+	-	+	-	-	+	-	+	+	6/10
Kokanovic, 2007 (33)	+	+	-	+	-	-	+	+	+	+	7/10
Brown, 2006 (34)	+	+	-	+	+	-	+	+	+	+	8/10
Hornsten, 2005 (35)	+	+	-	+	+	-	+	+	+	+	8/10
Lock, 2004 (36)	+	+	-	+	+	-	+	+	+	+	8/10
Pooley, 2001 (37)	+	+	-	+	-	-	-	+	+	+	6/10
Cable, 1999 (38)	+	+	+	+	+	-	-	+	+	+	8/10
Butler, 1998 (39)	+	+	-	+	+	+	+	+	+	+	9/10
Arborelius, 1997 (40)	+	+	-	+	+	+	+	+	+	+	9/10
Haugland, 1996 (41)	+	+	-	+	+	-	-	+	-	+	6/10
Willms, 1991 (42)	+	+	+	+	+	-	-	+	+	+	8/10
Stott, 1990 (18)	+	+	+	+	+	-	-	-	+	+	7/10

et al., O'sullivan et al. and Hornsten et al. put emphasis on autonomy supportive consultation styles (23;28;35). In the study by Hardcastle & Hagger to provide physical exercise and diabetic counselling support and encouragement was considered more important than advice and information (25).

O'sullivan et al. report a strong satisfaction from participants in being supported with aspect to autonomy and letting the patient be in control of the decision making process and simultaneously in conveying a sense of responsibility into these decisions (28). Participants do not like being told what to do but to acknowledge what is needed together with their counsellor and thereby feeling responsible. Autonomy is delivered from having an ability to choose among different alternatives and getting to set the agenda for exercise for themselves. (28).

The Doctor-Patient relationship

Twelve out of 21 studies emphasised the importance of a good doctor-patient relationship (18;23-25;29;31;33;35-38;42). According to Hansen et al. and Walseth et al. this facilitated a good reception and tolerance of advice within the patient and impeded feelings of aversion or submission. Patients, who empathised with their practitioner, accepted and welcomed advice (18;24;27-30;34;36;39). Apart from increased tolerance, a good relationship could create a sense of responsibility towards the healthcare practitioner (23;25;26;29;31;42) and could determine whether advice were acted upon or not (18). A successful relationship was described more as a partnership and contrasted with images of a more paternalistic approach (23;35). Adolfsson and colleagues described, in their setting of an empowerment group, relationships of horizontal nature where changing and learning came through active involvement rather than by receiving knowledge and complying (31). A more hierarchical relationship could in turn make patients lie to HCPs (24) or withhold information and questions (33;37). Patients across the sample of studies appreciated when the HCPs were familiar with their personal circumstances and when patients were regarded as experts of their life (29;33). In the study by Dellasega et al. the patients reported enjoying talking to MI trained nurses instead of standard condition doctors because of "being heard and responded to as a person" (23).

Individualisation & involvement

Six studies stressed the need for patient involvement during consultation (23;26;27;31;35;42). The Dellasega et al. participants reported agreement with a partnership in planning and goal setting together with MI-trained nurses. Nurses way of informing patients, letting them decide among alternatives, acted as empowerment to make own decisions using nurses as a resource. A tailored approach, fit to the unique patient, was centred by nine out of the 21 studies reviewed (27-29;32;33;37;39-41). According to Dellasega et al. one way of facilitating the relationship to patients was by using patient centred communication (23) which was described by Butler et al. as respectful, responsive and understanding. Being heard and listened to in an interested way as a way of performing a patient centred approach were emphasised by several studies (18;23;25;35;37;40).

Stigma

Seven studies concerned the topic of stigma within the patient and concerned mostly smoking or weight related living habits (24;26;30;34-36;39). In the Hansen et al. study perceptions of stigma was a prevalent finding. This included the feeling of smoking being the only thing on the doctor's mind and, to the patients, an unrealistic causality with smoking being blamed by health professionals for every sign of disease. Strategies to avoid this included lying to doctors about smoking status.

Time and ongoing interventions

To participate in lifestyle discussion the patients wanted sufficient time during the consultation (29;33;34;37;41), and ongoing support (25;27;28;32). Oftedal pointed out the importance of receiving supportive feedback from HCPs to motivate ongoing life style remodelling and in the same time emphasising its constant presence (27). Ongoing guidance and support were further acknowledged by O'sullivan et al., with participants emphasising the meaning of ongoing support from a physical activity counsellor in addition to physical activity counselling from their ordinary HCP.

Empathy

Participants from four studies included empathy (23;27;29;33). Dellasega et al., Oftedal et al. and Kokanovic et al. all emphasised the need to receive empathy during consultations (23;27;33). Oftedal et al., in their study of support and education to self-manage DM-2, underscored the importance and breadth of empathy in consultations, reporting empathy as the main ingredient in support. Empathy, being defined by participants as "an understanding, listening and holistic approach", impede participants to be honest to their practitioners, being willing to engage in conversations, whereas lack of empathy gave the most opposite effect. Participants underscore the listening aspect of empathy, waving of text book solutions to lifestyle and making it more about the patient where empathy is seen as a way to gain a holistic approach to the individual's needs. Another kind of empathy was wished for by participants in the Walseth et al. study (29). They see empathy as a way of support, such

as appreciation when things go well, but also seek for encouragement, consolation and support when things don't. This also emphasises that patients in the Walseth condition see the practice of lifestyle intervention as an ongoing process in partnership with HCP.

Attitudes not favoured by patients

In addition, eight studies described attitudes that were not favoured by patients. Six studies rejected attitudes described as vertical, paternalistic or preaching (23;24;31;33;35;40). Although, some of the participants in the Hansen condition did not reject to a lecturing consultation style about smoking (24). Two articles mention lack of interest for discussion among staff (35;41). Patients strongly strived for non-judgmental treatment from HCPs (23;26;34).

Quality of studies

On a scale from zero to ten the assessment of the study quality ranged from six to nine with a median value of seven (see table 1) with regard to the CASP assessment tool. Most commonly studies did not discuss choice of design within the qualitative field (such as why a focus group is chosen instead of individual interview etc). Another common shortage was a discussion of the researchers' own role in formulating research questions or possible part in the outcome narratives.

Discussion

This review included twenty-one qualitative studies involving 760 (498 women/ 262 men) patients participating in HP counselling. The main experiences and preferences of patients undergoing HP counselling showed in the doctor-patient relationship; individualisation & involvement; encouragement, empowerment & support; and stigma. Further, but less frequent themes, were time & ongoing interventions; empathy; and attitudes not favoured by patients.

The doctor-patient relationship was further examined in a review by Di Blasi et al. (44), which showed that friendly appearance supports the patient's health outcome, but also that studies in this field are methodologically complex to conduct. This is further supported in a study by Moller Hansen et al. (45). In their work-shop based study about patient education, one major theme from participants was ensuring 'Entirety' in the meeting with the doctor. Entirety is about connecting what has happened in the past with what is present today, which put special focus on the doctor-patient relationship. Entirety is also about taking a patient centred viewpoint, to see the person instead of the disease. This is an aspect of individualisation which therefore could be seen as an outcome of a good doctor-patient relationship and as the ability to provide individualised care.

Another recurrent theme is that of support, which in terms of Bandura's social cognitive theory is about increasing clients concept of self-efficacy through encouragement and being positive (12). Supporting self-efficacy strengthens the individual's confidence about capability to perform certain activities, possibly lifestyle modification. To support self-efficacy is also to consider lasting behaviour change, and is associated with positive feedback, which was also mentioned as desirable, by several of the studies. Hardcastle interprets this as to use individualised feedback and to set personalised goals (25). A way of increasing autonomy, competence, as well as self-efficacy is by using an MI approach. This was done in the study by Dellasega et al. (23). Although here used in a longer term intervention, the essence of the approach can be used in every day consultations by using open-ended questions, affirm and support patients' self-confidence by using reflective listening and by summarising discussion (23).

Also mentioned, the presence of stigma put forth by several studies pose special consideration by HCPs, and patients in these studies wish for a sensitive approach (24;26;30;34-36;39). The opinions of the overweight or obese have furthermore been investigated by Gray et al. who found a wide spread of opinions, but propose avoiding terms as 'Fat', while 'obese' although also negative to patients were considered effective within the frame of health discussions (46). Equally important is the subjectivity of experience mentioned by Malterud et al. (26). This is important in the case of perceived paternalistic, hierarchal or preaching communication styles perceived from the aspect of patients where, as Malterud et al. puts it "exploring encounters between doctor and patient from the perspective of one of them – the patient – will not provide access to the motives or attitudes of the other" (p 208). That is to say, what have been perceived as stigmatising or humiliating may have been with the best of intentions.

The hierarchical communication patterns were among the most prevalent of unfavoured behaviours in this review (23;31;33;35;40). Although, the results of Hornsten also provide an alternative possible conclusion that unfavoured behaviours were the mere failures of delivering the wanted ones such as empathy, autonomy or equality (35).

The need for time in form of constant or prolonged surveillance and control was apparent in many of the studies. This is in line with the second and less successful

means of behaviour motivation postulated by Deci and Ryan in Self-determination theory. This theory suggests that motivation can either be autonomous or controlled, where autonomous means of motivation is strived for as this extends behaviour change beyond intervention time frames (11). This theory suggest three psychological needs for behavioural activation; autonomy, competence and relatedness. All three are suggested by independent studies in this review, where a lack of choice produce resistance and acknowledgment of feelings, and perspectives produces incentives to change. MI has previously been associated with all three concepts of psychological need for behaviour change postulated by self-determination theory. Although MI in the studies reviewed was used more as a controlled intervention it is, as postulated by Hardcastle, also possible to use this as an approach in regular counselling and conversation. Another of the main ingredients to MI-inspired communication is empathy, which is emphasised as important in four of the reviewed studies (23;27;29;33). Pollak et al. provide further support to the importance of empathy, which, as delivered by doctors during weight-loss discussions can increase patients' attempts to lose weight by providing empathy in the consultation (47).

The present review shows that primary care and diabetes constitute the load of attention from researchers. Eggleston et al. show that GPs and practice nurses are the most appropriate professional category to deliver professional advice according to patients (48), and most studies concerned in this review focused GPs and practice nurses. Although, since the health promotive paradigm is to be spread everywhere in healthcare (1), more research is necessary to investigate the roles of professionals other than the GP and Nurse Practitioner, and to healthcare settings other than primary care. Also the perceptions of hospitalised patients and special populations merit more focus since none of the studies rendered by this review mention these.

This review has several strengths and limitations. The comprehensiveness and the broad searching for literature are strengths. However, still many papers may have been overlooked according to the tradition of grey literature in qualitative studies. Other publication bias would be similar to those known from quantitative studies, i.e. positive or unique results and English language skills (49).

Although this review did not search for qualitative material only, it was expected from the start that the majority of material would be of such type. Several authors have emphasised the limitations of carrying out a systematic literature search of qualitative studies (50-52). Evans et al. described the difficulties of using title searches for qualitative studies, which in qualitative standards are more descriptive than informative. Further, abstracts of qualitative studies have been under less evaluation and may lack the type of structure and standard known to RCTs (51). Both Evans et al. and Mays et al. suggest differences and deficiencies in indexing of qualitative material in scientific databases (51;52). This might be because of less interest in qualitative studies during early development of evidence based medicine. In all, difficulties as such may make the search process less efficient in finding everything written on a subject and authors may expect a lot more material from the hand search not covered by the systematic literature search (50;52), for example as much as half of included studies in a study by Casteel et al. (53). For the reviewer this might mean, as for Harden et al. who report difficulties finding qualitative material for their review, a need to use a wider scope returning a large number of citations to include relevant qualitative material (50).

The concept of quality is another limitation of debate concerning qualitative studies as for how much emphasis, and in what way, quality is to be measured (54). For quality selection and criteria this review acknowledged the need for a quality assessment, but in agreement with Dixon-Woods et al. (54) faced the difficulties in choosing such criteria for such a diverse field as qualitative research and that quality does not necessarily have much to say about individual narratives in an otherwise flawed study as concluded by Hannes (20). Thus, in agreement with Harden et al. (50), quality assessment was not used as an exclusion criteria but instead to inform the reader, to make sure studies do in fact assess intervention and outcome in the subject of review (20) and as a way of the exploration and interpretation process (55). It is, as according to Hannes, about detecting methodological flaw, yet maintaining the importance of the narrative (20).

In congruence with Dixon-Woods et al. (21) there are numerous ways to conduct a meta approach to qualitative research. Two main categories of synthesis can be identified; the integrative and the interpretive. Integrative synthesis will allow for causal generalisations but demand secure parameters and well defined concepts. The interpretive will avoid specifications beforehand and aim to develop these along analysis. Although theories of meta-analysis seldom consist exclusively of one or the other, proportions of these two main directions exist within every technique. For this review we chose the thematic analysis as described by Dixon-Woods et al. (21) similar to the narrative review (56), because of its suitability with reoccurring themes. According to Dixon-Woods et al. the thematic analysis "involves the

identification of prominent and recurrent themes in the literature and summarising findings of different studies under thematic headings" (p 47) (21). As most studies in this review used a thematic approach conceptualising participants' narratives into common themes, the narrative approach was fitting since strategies like thematic analysis and narrative reviews "seeks to identify and bring together the main, recurrent or most important issues or themes arising from a body of literature" (p 12) (52). Such an approach demands that data and themes are well defined such to avoid forming new themes or concepts (21).

From a clinical perspective it is important to realise that patients have important experiences and clear preferences to use for future HP counselling. However, it is unknown to which degree the results of this qualitative review will have an effect, if they are generalised and implemented, or if the value lies in the further generation of new hypotheses or qualification of existing hypotheses to become evaluated in for instance a randomised design to create evidence at a higher level. In case of direct implementation it would be relevant to carefully monitor the results and outcomes. It is also important to evaluate the possibilities of generalisibility of the results beyond those specific settings and realities of the individual studies (57).

From a research point of view, this review has given a collated overview of the existing papers, their quality and results. Interestingly the quality of the studies included was relatively good. The review process has shown the need for better structured abstracts and articles.

To our knowledge this was the first review to gather and present what is known on the patient's perspective of lifestyle counselling within healthcare. In conclusion this review identified the importance of encouragement, empowerment & support, a good doctor-patient relationship; individualisation & involvement; the significance of stigma, distributing sufficient time for discussion and the advantages of showing empathy while discussing healthy lifestyle change with patients.

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Research and Best Practice

Appendix 1 Search strategy, Medline

1	MH "primary health care+"
2	MH "general practice+"
3	MH "inpatients+"
4	MH "outpatient clinics, hospital+"
5	MH "pregnant women+"
6	MH "alcoholics+"
7	MH "alcohol drinking+"
8	MH "drug users+"
9	MH "mental disorders+"
10	MH "psychiatric nursing+"
11	MH "smoking+"
12	MH "diabetes mellitus+"
13	MH "cardiovascular diseases+"
14	MH "lung diseases+"
15	MH "vulnerable populations+"
16	MH "overweight+"
17	MH "sedentary lifestyle+"
18	(TI maternal N2 care) OR (AB maternal N2 care)
19	(TI maternal N2 care) OR (AB maternal N2 care)
20	(TI maternal N2 "health care") OR (AB maternal N2 "health care")
21	(TI maternal N2 "health care") OR (AB maternal N2 "health care")
22	(TI "maternal health" N2 service*) OR (AB "maternal health" N2 service*)
23	(TI alcohol N2 use*) OR (AB alcohol N2 use*)
24	(TI drug N2 use*) OR (AB drug N2 use*)
25	(TI psychiatric N2 patient*) OR (AB psychiatric N2 patient*)
26	(TI diabetes) OR (AB diabetes)
27	(TI surgical N2 patient*) OR (AB surgical N2 patient*)
28	(TI special N2 population*) OR (AB special N2 population*)
29	(TI inactive N2 lifestyle*) OR (AB inactive N2 lifestyle*)
30	(TI obes*) OR (AB obes*)
31	(TI sedentary) OR (AB sedentary)
32	(TI smoker*) OR (AB smoker*)
33	(TI hospitalized N2 patient*) OR (AB hospitalized N2 patient*)
34	OR/1-33
35	MH "data collection+"
36	MH "questionnaires+"
37	MH "qualitative research+"
38	MH "focus groups+"
39	(TI qualitative) OR (AB qualitative)
40	(TI survey*) OR (AB survey*)
41	OR/35-40
42	MH "health promotion+"
43	MH "patient education as topic+"
44	MH "counseling+"
45	MH "health education+"
46	MH "early intervention+"
47	MH "early intervention+"
48	MM "Early Intervention (Education)"
49	TI counsel#ing) OR (AB counsel#ing
50	(TI health N2 advice*) OR (AB health N2 advice*)
51	(TI lifestyle N2 advice*) OR (AB lifestyle N2 advice*)
52	(TI health N2 counsel#ing) OR (AB health N2 counsel#ing)
53	(TI health N2 education) OR (AB health N2 education)
54	(TI simple N2 advice*) OR (AB simple N2 advice*)
55	(TI advice*) OR (AB advice*)
56	(TI minimal N2 intervention*) OR (AB minimal N2 intervention*)
57	(TI brief N2 intervention*) OR (AB brief N2 intervention*)
58	(TI motivational N2 enhancement*) OR (AB motivational N2 enhancement*)
59	(TI motivational N2 interviewing) OR (AB motivational N2 interviewing)
60	(TI behavio#ral N2 counsel#ing) OR (AB behavio#ral N2 counsel#ing)
61	(TI extended N2 intervention*) OR (AB extended N2 intervention*)
62	(TI stage* N2 change) OR (AB stage* N2 change)
63	(TI goal N2 setting*) OR (AB goal N2 setting*)
64	(TI negotiation N2 method*) OR (AB negotiation N2 method*)
65	(TI self N2 efficacy) OR (AB self N2 efficacy)
66	(TI reasoned N2 action*) OR (AB reasoned N2 action*)
67	(TI social N3 learning N3 theor*) OR (AB social N3 learning N3 theor*)
68	(TI patient N3 cent#red N3 counsel#ing) OR (AB patient N3 cent#red N3 counsel#ing)
69	(TI planned N2 behavio#r*) OR (AB planned N2 behavio#r*)
70	(TI health N4 action N4 process N4 approach) OR (AB health N4 action N4 process N4 approach)
71	(TI FRAMES) OR (AB FRAMES)
72	(TI 5A) OR (AB 5A)
73	OR/42-72
74	MH "patient satisfaction+"
75	MH "patient preference+"
76	MH "attitude to health+"
77	MH "professional-patient relations+"
78	MH "patient acceptance of health care+"
79	(TI patient N2 opinion*) OR (AB patient N2 opinion*)
80	(TI patient N2 perspective*) OR (AB patient N2 perspective*)
81	(TI patient N2 perspective*) OR (AB patient N2 perspective*)
82	OR/74-81
83	34 AND 41 AND 73 AND 82

Appendix 2 *(1/4)*

Study	Patients and setting	Incl. criteria	Counselling staff	Aim	Method	Intervention	HDS	Analysis	Frame of reference	Outcomes	Conclusion/ implication	Quality of study
Dellasega 2011	19 (9w/10m) DM-2I from an RCTII (intervention group). Gen med clinics and primary care.	Adult, > 1 yr in RCT study, diverse sample, underserved neigh-bourhood.	Nurses with 4 months MI[III]-training.	Patients' preferences after MI.	Focus group, exp facilitator, PhD.	Min. 4 MI sessions over 1 yr.	"All areas of lifestyle change".	Interpretative Pheno-meno-logical analysis (IPA).	MI, patient centred communication.	5 themes: Non-judgmental account-ability, being heard and listened to as a person, encourage¬ment and empower¬ment through em¬pathy, collaborative action planning and goal setting and coaching rather than critique.	DM-2 patients receptive to MI counselling technique. The MI approach applicable to everyday consultation.	7/10
Hansen 2011	32 (9w/23m), Smokers at time of first time ACSIV. Public hospital and primary care.	Adult (40-74). Ongoing smokers + abstainers, minimum 1 yr.	Doctors, primarily General practioners (GPVs).	Patient's view of doctor's role in smoking cessation talks.	Semi-structured interviews by research assistant.	Smoking cessation counselling by doctors of different speciality.	Smoking.	Grounded theory and Constant Comparison Method.	None specified.	Major themes: Advice, stigma and support. Unsolicited advice unwanted, personal experience of doctors preferred, GPs positively viewed and were less likely to lecture. Feeling stigmatized by doctors.	Doctors should avoid lecturing, engage in dialogue and inform patients of cessation possibilities.	7/10
Hardcastle 2011	14 (9w/5m) overweight from an RCT (intervention group). Primary care.	18-65 yrs. > 1 CHD[VI] RF[VII] Both un- + successful participants.	PA specialists + dieticians trained in MI.	Patients' perceptions + experiences of counselling.	Semi-structured interviews performed by nurse.	5 MI-sessions over 6 m.	PA[VIII], Diet CHD RF.	Inductive thematic content analysis.	MI self determination theory, self-efficacy theory.	4 themes: Monitoring and support; Listening support; Motivation and selfregulation; Barriers.	Extended contact and support were deemed necessary for these patients.	8/10
Malterud 2010	13 (8w/5m), obese patients. Primary care.	Adult (30-55). BMI[IX] > 40 or > 35 + additional related problem.	GPs.	Patients' experiences with weight management by GP.	Gender separate focus group by first author. Introduced with an openended question.	Lifestyle consultation towards weight reduction and referral.	Weight management.	Systematic text condensation.	Stigma.	Patients want their GP to discuss weight problems non-judgmentally, although not loosing focus other aspects of the consultation. Patients want information of choices available.	Doctors are to discuss weight in an individual-ized/ EBM[X] -manner, while preserving patient dignity.	7/10
Oftedal 2010	19 (7w/12m) DM-2. Diabetes coping and learning centre, primary care, diabetes association.	Adult (30-65). ≥ 1 yr from Diagnosis.	GPs in primary care condition.	Patient's descriptions of support by HCP[XI].	Semi-structured Focus group × 2, by first author.	Structured educational diabetes programme, or standard GP care.	DM-2 self management.	Qualitative content analysis.	The expectancy-value model of achievement motivation and social support theory.	Five main themes of support from health care practitioners: An empathetic approach, practical advice and information, involvement in decision-making, accurate and individualized information and ongoing group based support.	Empathic, individualized, practical and ongoing support can be used to empower DM-2 patients to self manage disease.	8/10
O'sullivan 2010	15 (11w/4m) from PA-Coun-seling RCT (intervention group). Primary care.	Adult (32-65). Diverse sample, intensive counselling arm of intervention.	Not specified for learning centre condition.	Patients' perceptions + patient attributions of successful intervention.	Semi-structured interviews × 3 by exp qualitative researchers.	Brief PA counselling + 6 sessions (3 mths) in congruence with SDT[XI].	PA.	"Variant of Grounded theory".	SDT [XII].	9 themes: Satisfaction with intervention, intensive counselling, the tailored approach, autonomy support, competence through encouragement, information and strategies, relatedness, further recommendations.	Satisfaction and feasibility of PA-counsellor in primary health team. A tailored approach and autonomy-supportive counselling.	7/10

Appendix 2, *continued (2/4)*

Study	Patients and setting	Incl. criteria	Counselling staff	Aim	Method	Intervention	HDS	Analysis	Frame of reference	Outcomes	Conclusion/ implication	Quality of study
Walseth 2010	12 (5w/7m), life style related disease. Primary care.	Adult, 1 teenager, Pt's provided by GPs as suitable. Ag-enda to dis-cuss lifestyle.	Experienced GPs.	Habermas' communication theory + important topics to pt in lifestyle con-sultation.	Observation, semi-structured interviews × 2 (3 months apart) by experienced GP.	1 session, standard lifestyle consultation in primary care.	General life style consultation. Not specified.	Systematic text condensation.	Patient-centred medicine (PCM), shared decision-making and Haberma´s communication theory.	A good doctor-patient relationship and Patient-Centred Medicine creates common ground and facilitates responsibility, motivation and facilitates responsiveness to advice. Support/encouragement.	Pt's want time for dialogue. Long term effects of good relations and personalized care.	7/10
Horne 2009	127 (81w/46m), regularly activesedentary older adults. Primary care.	Adult (60-70). Diverse sample regarding, ethnicity, health, PA-experience.	Primary health care practitioners (PHCP).	Patient's experiences + pre-ferences of talking to PHCPs about PA.	Etnographic approach, semi-structured focus group or interview by author. Real-timetranslation when needed.	PHCP PA-counselling.	PA.	Frame-work approach.	None specified.	Use of encouraging and positive information, avoidance of ageist remarks.	PHCP advice is welcome as primary pre-ventive measure rather than secondary prevention.	6/10
Adolfsson 2008	28 (14w/14m), DM-2, from RCT, (intervention + control group). Primary care.	Adult. Usual diabetes care (individual) or and also empowerment group (control).	GPs and Diabetes specialist nurses.	Patients experiences of empowerment group or individual counselling.	Semi-structured interviews.	DM-2 education, 2 approaches.	DM-2 self management.	Qualitative content analysis.	None specified.	Horizontal communication appeared in empowerment group making learning participatory. Vertical, one-way communicative in counselling, making learning compliant reducing sense of responsibility.	Individual counselling need to involve patients actively and use horizontal relationships.	8/10
Elley 2007	15 (9w/6m), sedentary adults from RCT (intervention group). Primary care.	Adult (43-78). Both un - + successful participants.	GPs or Practice Nurses.	Patients' attitudes and experiences of RCT intervention.	Semi-structured telephone interviews.	Tailored physical activity + written advice on PA-prescription + telephone support 3m.	PA.	Content analysis.	Transtheoretical model of change.	Four themes: Tailored advice (personalised, advise characterised as physically, psychologically and socially acceptable), Barriers, Internal motivators and Significant others.	Continuous support may be expensive to incorporate but effective. HCPs need to address themes put fourth by patients.	6/10
Kokanovic 2007	30(15w/15m), DM-2 Primary care.	Adult (mean 66.43). DM-2 diagnose > 5 yr, oral medication or insulin, no complications Immigrants.	GPs.	Perceptions of interaction with GP about DM-2.	Semi-structured interviews by author or interpreter.	DM-2 consultation by GP.	DM-2 self management.	May's and Pope's framework of qualitative research.	Shared decision making.	Patients appreciated additional time, understanding of personal circumstance and empathy. Success is put in partner¬ship terms, though relationships most often considered hierarchical.	Communication and relationships are crucial to patients chronic disease or preventive care.	7/10
Brown 2006	28 (18w/10m), obese. Primary care.	Adult (19-77). BMI > 30 + aware of diagnosis and suitable for interview.	GPs.	Patients' perceptions and experiences of support in primary care.	Semi-structured interviews.	Lifestyle consultation towards weight reduction.	Weight management.	Grounded theory.	Stigma.	Elements of longer intervention and non-judgmental practical support as well as longer term support groups being non-judgmental, sensitive and clear gained most approval.	Clear, non-judgmental communication with recognition of stigma associated with obesity.	8/10

Appendix 2, *continued (3/4)*

Study	Patients and setting	Incl. criteria	Counselling staff	Aim	Method	Intervention	HDS	Analysis	Frame of reference	Outcomes	Conclusion/ implication	Quality of study
Hornsten 2005	28 (18w/10m), obese. Primary care.	Adult (19-77). BMI > 30 + aware of diagnosis and suitable for interview.	GPs.	Patients' perceptions and experiences of support in primary care.	Semi-structured interviews.	Lifestyle consultation towards weight reduction.	Weight management.	Grounded theory.	PCM.	Agreement/disagreement about goals, autonomy and equal/ adaptation and submission, worthy/ worthless, attended and welcomed/ignored, safe and confident/unsafe and lacking confidence.	What satisfies patients simulate PCM. Focusing on what's good and what's less good can improve consultations.	8/10
Lock 2004	44 (21w/23m), DM-2. Primary care.	Adult (40-80). DM-2 > 2 yr, from 4 Health care centres.	PHCP.	Reflections and experiences on clinical encounters.	Interviews with set initial question.	DM-2 consultation in primary care.	DM-2 self management.	Qualitative content analysis.	None specified.	Positive to advice in an appropriate context. Unwarranted advice instead of acknowledgment gave humiliation. Doctor-patient relationship facilitated permitting climate.	PHCP should indulge in positive lasting relationships to create a positive climate for lifestyle discussion.	8/10
Pooley 2001	47 (gender not specified), DM-2. Primary care.	Adult (50-76). DM-2, > 50 yr of age, living at home.	Primary care diabetes teams. Mainly GP setting, but significant spread in care regimes.	Central issues in diabetes management with emphasis on doctor-patient relationship.	Semi-structured interviews.	By diabetes team.	DM-2 self management.	None specified.	PCM.	Five themes: Time, continuity, questioning, listening, individuality.	For efficient diabetes care there is an increased need of staff and time to make sufficient relational investment.	6/10
Cable 1999	25 (0w/25m), patients with increased risk of CHD, from OSDAT study 1972-1980 (intervention group of 1975). Primary care.	Adult (62-71). s-cholesterol ≥ 6.9 mmol/l syst. BP < 150mm Hg. Both un- + successful participants. 80 % smokers.	GP and dietician.	Patient perceived factors of long term, behavioural change.	Semi-structured focus groups by fourth author.	Smoking cessation advice and dietary education.	Diet and smoking.	Method according to "long interview" by Crabtree and Miller(43).	Locus of control theory, transtheoretical model, health belief model, social learning theory.	Five themes identified: Doctor-patient relationship, significant others, motivators, barriers and empowerment.	Great importance of doctor-patient relationship supporting long term behaviour change. Should be emphasized in medical.	8/10
Butler 1998	42 (24w/18m), smokers, from RCT (intervention group). Primary care.	Adult. Opportunistic recruitment. Quitters + ongoing smokers.	GPs.	Patient' experiences of oppor-tunistic anti-smoking intervention.	Semi-structured interviews by social scientist and general practitioner.	Opportunistic smoking intervention talk.	Smoking.	None specified.	None specified.	Patient centred approach (respectful, sensitive, understanding, not preaching). Patients sceptical about persuasiveness of doctors and some found it irritating.	Doctors should engage in a caring and respectful way but not all may benefit from repeated advice.	9/10
Arborelius 1997	13 (13w/0m), birth giving mothers. Antenatal clinic.	Adult (20-38). Birth givers + smokers during antenatal visits.	Midwives.	Perceptions + experiences of smoking in pregnancy.	Structured inter-views by midwives during home visits.	Smoking related information or advice by midwives.	Smoking.	None specified.	PCM.	Most women agree, authoritarian advice or lecturing style is inefficient counter productive. Friendly, positive and asking attitude preferred.	Midwives should act in a patientcentred way and support mothers self image.	9/10

Appendix 2, *continued (4/4)*

Study	Patients and setting	Incl. criteria	Counselling staff	Aim	Method	Intervention	HDS	Analysis	Frame of reference	Outcomes	Conclusion/ implication	Quality of study
Haugland 1996	33 (33w/0m), Pregnant smokers. Ante-natal clinic + primary care	Adult (>20). Pregnant, daily smokers pre con¬caption + on¬going at first ultrasound.	GPs and midwives.	Patients' experience of info at antenatal clinic + smoking cessation assistance	In depth, semi-structured interview, by first author in week 27-35 of pregnancy.	Smoking cessation counselling from midwives and GPs.	Smoking.	Hermeneutic, phenomenological. Case analysis and Cross case analysis.	Self efficacy.	Patients experienced lack of interest and supporting smoking conversations. Often the topic wasn't mentioned or to discrete. Patients wanted repeated updating.	Midwives and GPs are responsible to raise smoking subject.	6/10
Willms 1991	43 (23w/20m), from a clinical trial, smokers. Primary care.	Adult. Patients offered participation in trial during regular office visit.	GPs.	Patients perspectives of efficient "personalistic" components of intervention.	Ethnographic method, open-ended questions, "relatively unstructured". Several interviews/ patient, spanning over one year.	Highly structured smoking cessation intervention.	Smoking.	Etnographic analysis.	None specified	Degree and nature of support mostly valued by participants. Patients value "positive imagry", good doctor-patient relations generating sense responsibility. Less of actual intervention.	More should be done to create clinically based support groups.	8/10
Stott 1990	130 (130w/0m), Mothers, Primary care.	Adult (25-40). Participants of earlier study, General practice population + "Mothers of lower social class".	GPs.	Contrast quantitative survey material on perception of HP in primary care to qualitative follow up.	Survey material and semi-structured interview by second author and research assistant.	Lifestyle advice by GP.	Weight problem, smoking problem, drinking problem and/or fitness problem.	None specified.	PCM.	Respondent accepted advice but expected them to be relevant to their situation. Responsibility of the individual emphasized. Doctor-patient relationship determines how advice is perceived and acted upon.	Qualitative methods explain and strengthen quantitative data. Doctors should precede advice by investigating beliefs, investing in the relationship.	7/10

Abbreviations
I = Diabetes Mellitus Type 2, II = Randomized Control Trial, III = Motivational Interviewing, IV = Acute Coronary Syndrome, V = General Practitioner, VI = Coronary Heart Disease, VII = Risk Factor, VIII = Physical Activity, IX = Body Mass Index, X = Evidence Based Medicine, XI = Health Care Practitioner, XII = Determination Theory.

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