A gender specific use of fear appeals in general practice

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Abstract

Lifestyle counselling is a collaborative method aiming to encourage poor lifestyle behaviour changes. Fear appeals are high threat messages which carry a negative association in terms of their overall use. It is understood that men respond more positively toward behaviour change in the event of a major life event (e.g. heart attack). Therefore fear appeals may have some role to play especially when considering the male patient. To date there has been no gender specific research carried out in this topic area. The purpose of this study was to identify the acceptability and practice of using fear appeals in a gender specific context.

This was a qualitative study design, using non probability convenience sampling. It consisted of two focus groups and two semi structured interview. Focus groups were divided by gender, male focus group (n=5), female focus group (n=8). Semi-structured interviews involved a general practitioner (n=1) and nurse practitioner (n=1).

The main results showed that lifestyle counselling may need to consider a gender specific approach. Both genders showed contrast opinions of the preferred type of consultation with males preferring a practitioner-centred approach and females a patient-centred approach. In practice males appeared to have better overall relationships with their GPs, while females were rarely satisfied by consultations. Although the male focus group favoured the use of fear appeals practitioners avoided their use due to the associated pit falls thought to damage the practitioner-patient relationship. Health practitioners should consider gender specific approaches coupled with the use of fear appeals and a variety of additional resources when offering lifestyle counselling.

To conclude fear appeals may not be an entirely inappropriate method of lifestyle counselling. There is a need for more gender specific training and research in lifestyle counselling.

Chapter 1.
Introduction

1. Introduction

Premature mortality in Ireland is currently caused by the following health complications; cancers, circulatory problems and respiratory issues (the Department of Health and Children, 2011). There is a strong association between the aforementioned health complications and modifiable risk factors such as hypertension, smoking, sedentary lifestyles and obesity (WHO, 2009). The discovery of these modifiable risk factors ultimately meant that these major health complications could indeed be prevented through lifestyle changes (Hardman & Stensel, 2003). In Ireland recent research suggested that targeting lifestyle change in general practice involves moving from simple advice to counselling type sessions (Lambe & Collins, 2009). A proposed method in order to achieve this is known as lifestyle counselling (LC). LC if instigated properly has been shown to positively affect lifestyle behaviours (Elford et al., 1994).

Lifestyle counselling (LC) is a collaborative method involving decision making, goal setting and relapse prevention (Lambe & Collins, 2009). It is believed that general practitioners (GPs) and nurse practitioners (NPs) are some of the best people to offer LC (Clark et al., 2010; Heijens et al., 2012). This is due to the opportunities of reaching the wider society in addition to people listening and acting on their advice (Clark et al, 2010; Heijens et al., 2012). It has been noted that of the two practitioners, NPs, once in receipt of adequate training, were most likely to provide patients with LC (Pfister-Minogue & Salveson, 2010). The need for additional training to carry out LC has been shown to be one of several barriers to its overall success (Noordman, 2013; Lambe & Collins, 2009; Booth & Nowson, 2010; Sluijs et al., 2004). Therefore other methods encouraging lifestyle change exist, namely fear appeals.

Fear appeals have grown in popularity in health promotion as fear is seen as a motivator in lifestyle change (Ogden, 2012). The overall intention of a fear appeal is to raise an individual's awareness of a negative outcome/threat as a result of a chosen behaviour (e.g. smoking) (Vance et al., 2012). Recent literature has found fear appeals to be successful in increasing interest and persuasion (Williams, 2011). A reason for this was seen in advertising campaigns whereby individuals were most likely to remember those portraying warnings through fear as opposed to positive and emotionally vacant warnings (Williams, 2011). Witte

and Allen (2000) stated that fear appeals have addressed multiple health issues. These include; smoking, alcohol and drug abuse, driving behaviours and exercise promotion to name but a few. Therefore as reported by Lambe and Collins (2009) NPs may use such tactics in general practice. However in this study NPs were not aware of the associated pitfalls (e.g. avoidance). They were fundamentally being used to amplify the importance of change thus limiting their overall success. Despite the apparent advantages of offering lifestyle advice in general practice there are many obstacles. There is an over-reliance on the use of fear appeals and the use of a one-size fits all approach for both men and women. Fear appeals tend to be used in a very practitioner-centred manner and as a result their use is not commonly recommended. This conclusion may not be warranted however. There are currently no gender specific guidelines for lifestyle counselling. The purpose of this study is to explore the attitudes of male and female patients towards the use of fear appeals during lifestyle counselling in general practice.

Chapter 2.

Lit-Review

2.0 Literature review

2.1 Approaches to health behaviour change in General Practice

According to Lock et al. (2010) GPs are more inclined to use preventative medicine (i.e. lifestyle counselling) than in previous years. LC is considered an important part of a GPs work but appears to be offered only when patients suffer an existing health complication (Geense et al., 2013; Glasgow et al., 2001; Wee et al., 1999). In the absence of an existing health complication patients may need to become the initiator in order to receive lifestyle advice from GPs (Lancaster et al., 2000). Although LC is seen to be important less than half of 2500 European GPs surveyed would implement its use (Brotons et al., 2005). This was seen more closely in Germany where 54% of 676 GPs admitted their use. However in this study it was found that in one years practice, 10 or fewer patients were approached by the 54% of GPs (Twardle & Brenner, 2005). The previous mentioned studies and Ulbricht et al. (2006) stated that GPs offered so few lifestyle counselling sessions due to lack of materials, inadequate training and time. Another barrier is that LC is perceived to be different between GPs and patients. One study showed how both GPs and patients of the same consultations had contrast opinions in terms of LC (Tulloch, Fortier & Hogg, 2006). This study found that 20% of patients and 80% of GPs believed that LC was offered within the same consultation. Therefore approaching LC is not enough if the patient doesn't realise it has taken place.

Rubak et al. (2005) stated that practitioner-centred and patient-centred consultations are two approaches to LC which exist in general practice. A practitioner-centred approach is defined as the "traditional" approach, whereby GPs assess a patient and advise them accordingly without considering the patient's views (Rubak et al., 2005). In Elwyn et al.'s (2000) study practitioner-centred approaches were a preferred choice taken by practitioners when conditions were known and treatable. Blakeman et al. (2006) also stated that most GPs feel a level of professional responsibility when treating patients. This lends itself to increased caution limiting the control offered to patients in decision making. A more extreme reason for this preference is that GPs deemed their patients too ignorant to make health conscious

decisions for themselves (Kabaa & Sooriakumaranb, 2007). Regardless of the reason practitioner-centred approaches are taken, Butler, Rollnick and Stott (1996) stated this type of approach encounters compliance issues with patients and overall lifestyle behaviour change.

Therefore as recent literature has shown LC must move away from "traditional" approaches and focus more on patient-centred approaches (Kabaa and Sooriakumaranb, 2007; Sonntag et al., 2012; Little et al., 2001; To, 2003). Rubak et al. (2005) explains that patient-centred approaches are collaboration between both practitioners and patients. Whereby patients are largely involved, working with practitioners throughout consultations in order to identify a realistic and effective solution. Recent literature stated that GPs appear to have adopted such an approach offering consultations with empathy for the patient's along with follow ups (Kay, Mitchell & Clavarlino, 2010; McKenna and Vernon 2002). A patient centred approach with increasing success in general practice is motivational interviewing. Britt, Hudson and Blampied (2004) continued to say that motivational interviewing is a method which allows patients time to explore and resolve their own behaviour. This is done through a skilled interviewing process where there is a goal to change a said behaviour. Motivational interviewing was considered feasible in general practice and a useful tool once adequate training was provided (Eijk-Hustings et al., 2011). LC is predominantly a patient centred approach. Therefore understanding the efficacy of patient-centred LC on poor lifestyle behaviours is warranted.

2.2 Efficacy of Patient-Centred Lifestyle Counselling:

In relation to changing lifestyle behaviours such as a poor diet, smoking, low physical activity and alcohol consumption, multiple studies cite a positive relationship with patient-centred consultations (Hutchinson et al., 2002; Jonas et al., 2012; USPSTF, 2002; Butler et al., 1999; Verbiest et al., 2013). Smoking is one of the most common lifestyle behaviours targeted by health practitioners (USPSTF, 2002). Lancaster et al. (2000) found that smokers may not quit due to medical advice alone. (Lancaster et al., 2000). It has been found that patients in receipt of patient centred approaches (e.g. motivational interviewing) and follow up/referrals had greater reductions and smoking cessation than those without (Butler et al.,

1999; Verbiest et al., 2013). According to Zwar et al. (2010) a critical element in the success of the previous studies is the patient follow up/referral. A successful intervention by Zwar et al. (2010) involved both of these elements, consisting of GPs referring patients in need of lifestyle change to NPs. It was found that those who attended four or more meetings with NPs hereafter were more inclined to quit smoking. These studies show that successes can be made with patient centred approaches. More importantly smokers may benefit more from an integrated system between GPs and NPs.

In relation to follow-up techniques or multiple consultations Thompson et al. (2011) and Hardcastle et al. (2008) found similar results in relation to diet and physical activity. These studies consisted of information sessions and motivational interviewing relating to diet and physical activity behaviour. It was found that those who attended more sessions succeeded further in reducing factors linked with CHD (weight, cholesterol and blood pressure), showing greater levels of physical activity than those who attended fewer sessions. Orrow et al.'s (2012) systematic review of sedentary adults receiving physical activity advice in primary care, found that PA levels significantly improved up to and beyond 12 months. Similarly, Lindstrom et al.'s (2006) cohort study, of diabetic patients found lifestyle counselling to cause significant improvements in physical activity and diabetes.

Although patient-centred consultations are indeed beneficial, its overall success is varied (Mead & Bower, 2002). This variance may be caused as some patients still prefer "traditional"/practitioner-centred approaches (Ogden et al., 2002). As well as this Ogden et al. (2002) and Noordman (2013) noted that such practices were not implemented by GPs and placed greater responsibility on NPs to perform LC. NPs however noted that LC would only be used in some instances, not all. Therefore although the literature supports the effectiveness of LC, there appears to be barriers impeding its overall success.

2.3 Practitioner barriers to lifestyle counselling

Jonas et al.'s (2012) systematic review found the most effective LC sessions to be within 10-15 minutes. This being said recent literature cite time as a commonly reported barrier to its overall use, together with lack of financial incentives, patient resistance, lack of training, lack of understanding in health promotion and patient honesty (Casey, 2007; Noordman, 2013; Lambe & Collins, 2009; Booth & Nowson, 2010; Sluijs et al., 2004). Aside from the previously named barriers, recent literature acknowledges that the NPs primary role of disease management may prove to be a barrier in and of its self (Wilhelmsson & Lindberg, 2009). Moreover multiple studies also cite the lack of structure to support and implement LC into general practice along with unsupportive supervisors (Johansson et al., 2010; Wilhelmsson & Lindberg, 2009; Lambe & Collins, 2009). Therefore NPs are less likely to act on their own free will and initiative, reducing the likelihood of engaging in LC (Lambe & Collins, 2009; Johansson et al., 2010; Phillip, Wood & Kinnersly, 2014).

In Jansink et al.'s (2010) qualitative study on Dutch NPs, patients themselves were perceived to have inadequate knowledge or the self discipline to manage their own lifestyles (Jansink et al., 2010). Therefore in terms of LC NPs appeared to opt for a more practitioner-centred approach (Jansink et al., 2010; Casey, 2007). Regardless of the approach taken, Cockburn and Pit (1997) reported that health practitioners ultimately treat the patient with their own beliefs regardless of the patient's views. Edmondson (2004) stated that this narrow mindedness in practice is a major barrier to the success of LC. This study found that treating the conditions presenting themselves or looking for the "quick-fix" is detrimental. Therefore practitioners are encouraged to delve deeper with patients, understanding their issues and ultimately identifying intrinsic motivation for long-term lifestyle change (Edmondson, 2004; McKenna & Vernon, 2004).

The sole responsibility placed on either GPs or NPs in general practice appears to be an issue in itself. Ockene et al. (1999) found that an integrated medical system was effective in reducing poor alcohol behaviours in over 500 patients. This system involved brief interviews carried out by GPs and NPs with support from an array of in house professionals such as, dieticians, exercise professionals and counsellors. However without such support these barriers are more widespread resulting in missed opportunities to offer patients lifestyle advice. According to Sargeant et al. (2008) GPs are aware of these missed opportunities and

are willing to change and adopt new strategies to overcome this. Currently however, these missed opportunities may lead to over use of fear appeals and little or no acknowledgement of the need for gender specific advice.

2.4 The use of fear appeals in general practice

Fear appeals are high threat messages most commonly used in smoking and road safety campaigns (Leshner, Vultee, Bolls & Moore, 2010). Williams (2012) stated that fear appeals apply a message whereby if a particular behaviour is not adopted there will be dire consequences (e.g. death, cancer, heart attack). Although the overall aim of a fear appeal is to promote positive lifestyle changes, pitfalls have been associated with their use (e.g avoidance, messages having little worth and depression) (Cho, 2000). Interestingly it has been found that females tend to respond negatively to fear appeals emotionally, questioning whether their overall use is in fact ethically sound (Jones & Owen, 2006; Williams, 2011) For this reason fear appeals may be identified as counterproductive and ineffective (Maloney, Limpiski & Witte, 2011; O'Neill & Nicholson-Cole, 2009; Johnson & Warkenten, 2010). This may ultimately lead to "GP-Shopping" meaning the patient will source multiple GPs if they feel like a poor practitioner-patient relationship exists and/or they are in receipt of inadequate advice (Sansone & Sansone, 2012).

Therefore GPs must use fear appeals with caution understanding there is a fine line between scaring individuals and encouraging them (Thomas et al, 2010; Hansson, Rasmussen & Ahlstrom, 2011). Fear appeals were seen to be a motivating factor in some cases and further success was seen if the individual's needs were addressed (Williams, 2011; Hansson, Rasmussen & Ahlstrom, 2011). The best fear appeals should consist of emotional, negative and stimulating messages best described using the Extended Parallel Process Model (EPPM) (Elliot, 2003; Williams, 2011). The EPPM according to Witte (2000) is when a threat is high but an individuals self efficacy to overcome such a threat is higher. Therefore understanding the intended population is crucial to their success (Benet et al., 1994; Witte and Allen, 2000; Lewis et al., 2007).

In an attempt to understand a patient the trans-theoretical model and stages of behaviour change work hand in hand with fear appeals (Cho & Salmon, 2006). The Trans-Theoretical Model consists of six stages; pre-contemplation, contemplation, preparation, action, maintenance and relapse (Prochaska & DiClemente, 1982). Cho and Salmon (2006) recommended fear appeals consider these stages when encouraging behaviour change. Unfortunately Cho and Salmon (2006) report that those who are most in need of behaviour change may not be affected by such fear appeals. It has been found that fears experienced through an individual's own experiences may force an individual to change more so than fabricated warnings (Begley et al., 2007). In addition to this fear was seen to drive people to cling to their core values. Therefore using methods such as motivational interviewing to identify an individuals personal experience along with their core values may prove significant when encouraging lifestyle change (Begley et al., 2007; Rollnick et al., 2010). As benefits can be seen from the use of fear appeals it is still unclear how lifestyle behaviour change differs among the genders.

2.5 Gender differences in lifestyle behaviour change strategies

According to Eschenbeck et al. (2007) and Mahoney (2010) males and females have different coping strategies with females opting for more social support. Maciejewski et al. (2001) stated that females opt for more social support than males as they experience greater depression during a major life event (life-threatening illness or injury). It is perceived that females attempt to adopt behaviour change more often than their male counterparts. Perhaps this is due to females attending GPs more often from an early age due to pregnancies, contraception and menstruation (O'Brien, Hunt & Hart, 2005). Therefore the opportunity to discuss behaviour change may arise more often. During such consultations it is of note that females tend to respond greater to emotional content such as seeing adverts associated with those affected by an incident (Lennon, Rentfro & O' Leary, 2010). In support of this finding mothers smoking habits were significantly reduced when specific counselling highlighted the negative effect smoking has on their children (Hovell et al., 2000)

Males on the other hand may not attend or seek support from their GPs as often due to, Hegemonic masculinity/typical male role (O'Brien, Hunt & Hart, 2005). If and when they do Richardson and Carroll (2009) identified that males prefer confidential, brief and hassle free consultations. Seymore-Smith, Wetherell and Phoenix (2002) stated that men who stepped outside the typical male role were left isolated and marked as abnormal. These findings however are also said to be relative to the individual, for example, more males with "masculine" jobs such as firemen were seen to converse frequently about health in order to maintain their job roles (Seymore-Smith & Phoenix, 2002). Therefore similar to their female counterparts once core values are identified a more health conscious approach may be adopted. Unfortunately as men underuse the healthcare system fewer opportunities may arise to do so. Therefore until a major life event (e.g. heart attack/major health scare) occurs opportunities to challenge poor health choices may not arise. This being said in an attempt to avoid a similar occurrence Schwarzer and Schulz (2002) stated that men are more self-reliant and independent following a major life event than their female counterparts.

Other gender differences were present when considering specific lifestyle behaviours such as smoking, physical activity and diet. Croghan et al.'s (2009) retrospective review on 2139 ambulatory and 1259 hospitalized smokers receiving tobacco dependence treatment, found that gender played no role in failure to refrain from smoking. However relapse rates appeared be more severe when considering the female patient (Huskey et al., 2008). It was found in the previous study that the greater need for nicotine by the female patient was the overall reason for this. Therefore when considering the female patient a combination of social support and pharmacological interventions may be required to ensure long-term abstinence (Piper et al., 2009) This understanding may prove essential in future success. In terms of physical activity uptake, there is an early emphasis in a male's life on competitive sport and not so much on recreational physical activity for health. This is a determinant to why men's PA levels decline as they age (Richardson & Carroll, 2009). This again is an example of how health is not at the forefront for physically active males from an early age. This being said in behaviour change, men respond more so to physical activity advice than other behaviours such as diet. Al-Sinani et al. (2010) supported this in a study involving LC on nutrition and dietary advice. In this females showed a more significant response than males to improving their lifestyles using nutritional advice sessions.

In practice Noordman (2013) identified that males were targeted more than their female counterparts in relation to smoking, physical activity and alcohol use. These differences in approaches by GPs were evident even with the majority of studies consisting of 70% females and 30% males. This shows that males are targeted more by GPs than their female counterparts in relation to LC. It is also of note that when dealing with the male patient, effective treatments should involve figures/numbers, gadgets and tangible equipment (Richardson & Carroll, 2009; Lennon, Renfro & O'Leary, 2010). In terms of fear appeals and LC there is no research showing whether males or females respond differently (Elliot, 2003). Therefore greater exploration is needed in terms of gender specific approaches to lifestyle counselling and the use of fear appeals.

2.6 Patient's assessment of effective lifestyle counselling

In terms of lifestyle counselling it is important to look at the research that shows what the patients consider the best practices. Understanding how patients respond to different approaches may be worth considering and to also identify if these responses are in any way related to gender differences.

The opportunity to explore and psychologically enhance their own behaviour was endearing to most patients (Resnicow et al., 2006). This study also showed that patients were still very much inclined to favour informative sessions with their GP, these sessions were described as direct and educational. There was no descriptive statistics separating gender within this study. Ogden et al. (2002) found that patient-centred approaches were welcomed by both GPs and patients with GP receptiveness and empathy decisive factors. This study involved mostly female participants (71%) and although gender differences were not mentioned, these findings are predominantly formed from female opinion. Similarly, Vick and Scott (1998) generalised that patients prefer more advice from their GP in relation to their treatment. Vick and Scott (1998) also found that it was preferred that GPs listened to the patients throughout

the entire consultation. This study again involved both genders with females making up 73% of the study population.

Wensing et al. (1998) carried out a systematic literature review on patient priorities in general practice care. On average, 65% of the participants in all studies reviewed were female. The results of this study match previous literature discussed in terms of; informative sessions, empathy, patient involvement in decision making and patient centeredness. Ease of access, time for care and access to special services were also said to be key in terms of positive experiences when visiting GPs. Bowling et al.'s (2012) study found that males, responded best to short sessions and practitioner led consultations. Females opted for longer sessions, to be listened to and involvement in decision making. These findings coincide with much of the literature already discussed. However, Bowling et al. (2012) found helpfulness, respectful understanding GPs, knowledgeable GPs, informative (about illnesses and management of health) and being given the opportunity to discuss their problems as the main expectations. These findings tended to match more female expectations, thus gender differences were not cited in the results even though they were evident.

This biased generalisation is seen in other studies. The Department of Health and Children (2003) reported patient satisfaction is made up of cognitive and emotional factors. These factors are said to relate to previous experiences and social networks. As already seen in the literature females appear to respond to both emotional and social aspects of health care more than their male counterparts. Therefore the recommendations may only consider females when considering patient satisfaction. Of course the greater number of females attending GPs may influence any advice offered in terms of patient satisfaction. The Department of Health and Children (2003) acknowledged that there is very little literature relating to gender tailored consultations. This being said a patient satisfaction handbook for GPs was published by the Department of Health and Children (2003) based predominantly on female opinion.

2.7 Rationale

The determinants of lifestyle behaviour change are different for men and women. While the use of fear appeals is generally not advocated, the majority of studies examining this issue have not reported gender-specific results. It is not well understood whether men and women respond differently to such tactics. Indeed Richardson and Carroll (2010) suggest that major life events such as getting a health scare can be a necessary trigger for health behaviour change in men. Therefore the purpose of this study is to examine gender differences in patient responses to fear appeals in GP. Elliot (2003) stated that only one study considered gender as a variable in terms of fear appeals, with none relating to lifestyle counselling.

2.8 Research Questions:

1. How do men and women respond to fear appeals during lifestyle counselling in general practice?
2. How does gender influence the lifestyle counselling approach adopted by practitioners in general practice?
3. What role do fear appeals play in the provision of lifestyle counselling in general practice?
4. To identify gender specific good practice for lifestyle counselling in general practice.

Chapter 3.
Methodology

3.0 Methodology

3.1 Rationale for Research Design:

The use of qualitative research is advocated when the research demands answers that are complex in nature and involve in-depth assessment of participant attitudes (Bowling, 2009). Qualitative research has been chosen as it was stated by Raynor et al. (2007) to be a useful tool to receive information that had not been anticipated by researchers especially in medical settings. Zwar et al. (2011) carried out semi-structured interviews with GPs and NPs in another study in order to develop a deeper understanding into methods used in smoking cessation. It is hoped to use this similar approach and interview GPs and NPs in order to understand their views and opinions in relation to lifestyle counselling.

3.2 Research Design

This was a qualitative study consisting of two semi-structured interviews and two focus groups. The semi-structured interviews consisted of one with a GP and the other with a NP. Two focus groups were carried out; one with male patients (n=5) and another with female patients (n=8).

3.3 Study Population and Sampling

The study population making up both focus groups consisted of both males and females (females n=8 and males n=5), who attended their GP within the last 6 months, ranging from 30 – 60 years of age. It also consisted of one GP and one NP, which took part in the two semi-structured interviews. Non-probability convenience sampling was used to recruit all participants for this study. The patients were recruited with the help of a general practice manager who notified GPs in the centre of the study. GPs then informed willing patients who then came forward to participate. A GP and NP were then requested to participate, again with the help of the general practice manager.

3.4 Variables and Concepts

This study measured five main concepts;

Focus groups measured the following concepts:

1. The attitudes of patients (males and females) to receiving fear appeals during lifestyle counselling
2. The response of patients (Males and Females) in relation to fear appeals and lifestyle change

Semi-structured interviews measured the following concepts:

3. The attitudes of practitioners (NPs & GPs) to the use of fear appeals during lifestyle counselling
4. Practitioner perceptions of the role of fear appeals in lifestyle counselling
5. Gender differences in the strategies adopted by practitioners when providing lifestyle counselling

3.5 Data Collection Methods

The tools that were used in order to carry out this study were two focus groups and two semi-structured interviews. In order to answer the research questions, a topic guide for the semi-structured interviews (See Appendix A) and focus groups (See Appendix B) were used. Both topic guides were created based on an extensive literature review, which was carried out in September 2013.

3.6 Procedures

Focus Groups

Two videos were used in both focus groups, video 1 “the good GP” and video 2 “the bad GP”. These videos involved a hypothetical lifestyle counselling consultation between a GP and his patient. The “good GP” was very patient centred and focussed on changing a chosen health behaviour decided by the patient. The “bad GP” was practitioner centred, involving harsh fear appeals and focussed on changing multiple behaviours without considering the

patients views. Both focus groups were divided into two parts; participants watched video 1 with a discussion that followed (part 1). This process was carried out again with participants then watching video 2 and a discussion followed (part 2). Both videos were part of the resources developed for the National men's health training program "Engage".

1. The focus groups took place in a community centre. The information about the location and time was issued via email and text message to all participants, 7 days prior to the meeting and on the day of the meeting.
2. Refreshments were made available for both focus groups
3. Prior to both the focus groups and semi-structured interviews, a reminder of the purpose of the study was explained by the researcher. At this point each participant filled out informed consent forms (See appendix C). Any questions relating to these forms and the study were answered by the researcher.
4. Questions (Appendix B) were distributed before the first video was seen and participants were asked to base their discussion on these areas.
5. The focus groups were recorded using the "QuickVoice Application" on the I-Phone 4s
6. Video 1 "the Good GP" was played (9 minutes 30 seconds) using "Real-Player" software. The video was projected by a NEC projector NP 210G, for the audience stemming from a HP Pavillon G6 laptop. The participants were blinded to the type of video (i.e. good or bad)
7. Discussion based on questions distributed prior to the video commenced
8. Once this finished the video 2 "the Bad GP" (7 minutes 40 seconds) was played, following the same procedures as the first.
9. Using the same set of questions in point 4, a discussion took place related to the second video.
10. Minimal involvement took place from the researcher during both focus groups. This involved maximal facilitation skills, whereby, the participants were encouraged to discuss the area as a group as opposed to engaging the researcher.
11. During each focus group the initials of each participant were noted as they spoke in order to match what was said by the individual later in data analysis.

Semi-Structured interviews:

1. The semi-structured interviews were carried out within the GPs surgery.
2. Prior to both semi-structured interviews, a reminder of the purpose of the study was explained by the researcher. At this point each participant was asked to fill out informed consent forms (See appendix C). Any questions relating to these forms and the study were answered by the researcher to avoid any confusion.
3. The questions for the interviews was based loosely on those outlined in Appendix B.
4. As with the focus groups, semi-structured interviews were recorded using the "QuickVoice Application" on the I-Phone 4s

3.7 Data Analysis

The following section has been adapted from Taylor and Gibbs (2010) description of qualitative data analysis. Qualitative data analysis consists of interpreting, understanding and explaining the information gathered in the focus groups and semi-structured interviews. This was carried out by coding the information into themes, interpretation, organising and computer based analysis.

Once the data was collected, each focus group and semi-structured interview was transcribed verbatim using Microsoft Word 2003. These transcripts were stored in a secure folder on HP Pavillon G6 laptop. Memo writing occurred after each focus group and semi-structured interview. This allowed anything noticed throughout to be taken into account during analysis (e.g. body language, facial expressions, contradicting statements to name but a few) (Charmaz, 2006). Organisation is critical throughout this process as the transcripts, memo's and analysis is known to be quite a lengthy process. Therefore the use of Microsoft Word 2003 was used for both transcribing and coding making organisation easier and more efficient related to coding and themes. This consisted of generating new documents for each theme with text or information (i.e. quotes from each transcript) being copied and pasted under the relevant theme.

Coding the information into themes:

Coding involved applying labels to specific passages or text from transcripts which have been identified by the researcher as part of a thematic idea. This type of analysis allows information to be gathered under one theme, allowing the researcher to examine and compare all information relating to that specific theme. The generation of codes involved emerging codes. The use of the grounded theory (Charmaz, 2006), was used to create new codes through emerging trends. This involved identifying and interpreting what had been said and forming new areas of interest which could then be analysed as part of this study. This is part of the noticing, collecting, thinking model by Seidl (1998) which is a cyclical process. It is believed the more one thinks about existing codes more themes/codes are noticed. Seidl (1998) offered the analogy of a jigsaw for this model, whereby pieces are pulled together helping to create the final picture or results.

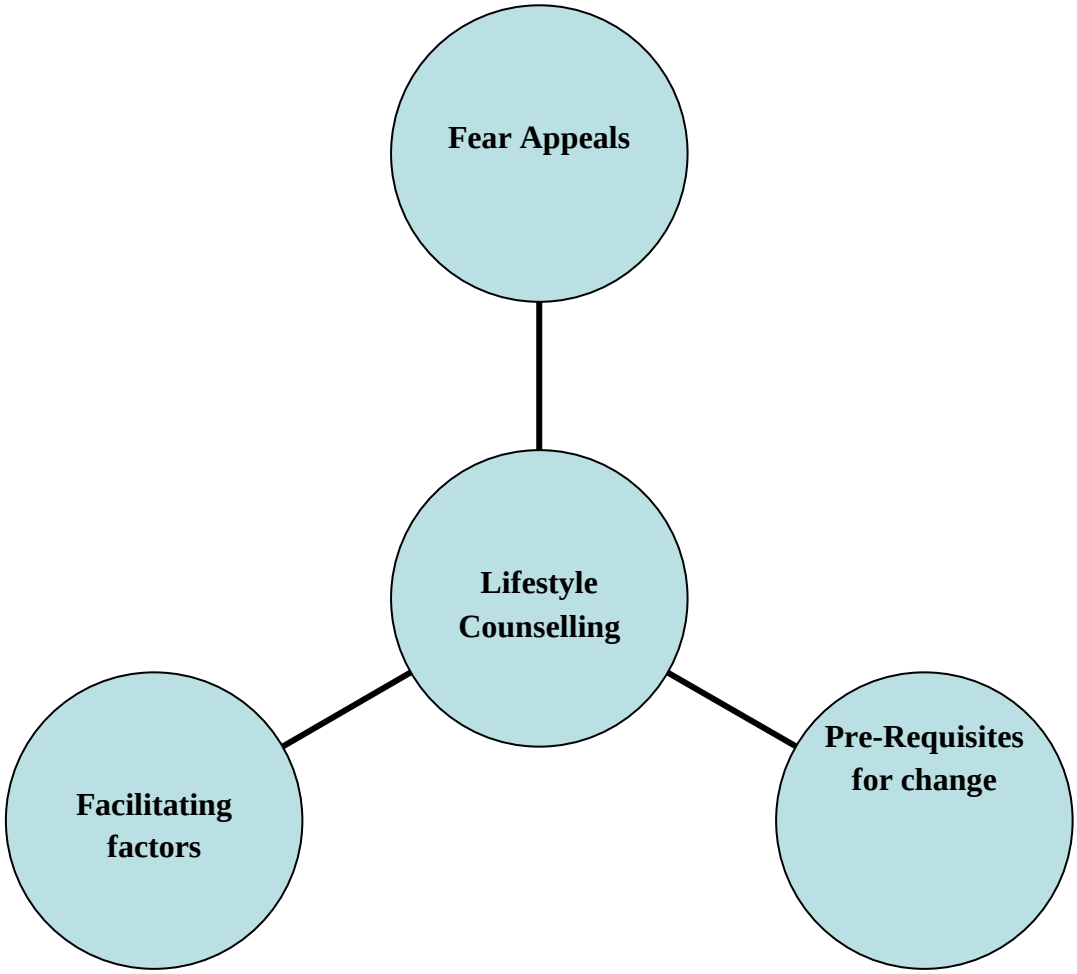
Once all the data had been sorted into relevant codes, the most important or dominant ones were promoted to central themes. A hierarchical structure was also applied to the codes whereby similar codes were grouped together under a new central theme. Once all the key themes were identified a summary of each one was written supported by key quotes.

3.8 Ethical Considerations

Anonymity was addressed using pseudonyms for participants in both focus groups in transcripts and results chapter. All data collected was kept in both secure folders and under lock and key. Locations were kept anonymous in order to ensure that GPs surgeries are not the focal point of any scrutiny, thus eliminating any fears GPs may have. As there can be a negative association with the use of fear appeals GP and NP honesty may be an issue (i.e. GP/NP may deny their use). A rapport was built with local GP and NP prior to the interviews. This removed initial doubts they may have had in terms of the purpose of the study and hopefully allowed for truer reflection. A similar worry was present in terms of the focus groups. It was felt that biased opinions would emerge if the participants were aware of the content in each video. Therefore blinding the participants to the purpose of each video was found to be the best solution (e.g. fear appeals/patient centred).

Chapter 4

Results


Fear Appeals
Lifestyle Counselling
Facilitating factors
Pre-Requisites for change

4.1 Lifestyle counselling

4.1.1 Approaches to lifestyle counselling:

The GP and Nurse had differing opinions on ways to approach lifestyle counselling. Patients were said to get in contact with the nurse, whereas the GP took opportunities within consultations to speak about lifestyle behaviours. It was evident that both professions took steps in approaching lifestyle counselling, as stated by the nurse "*You're promoting a healthy lifestyle for patients […] so you would have to reinforce that*".

The nurse described the approach to lifestyle counselling as very open, with the use of open ended questions, identifying realistic solutions and allowing the patient to identify their own barriers and solutions. A description which appeared to be patient centred with similarities to the principles of motivational interviewing. The GP claimed to be patient centred however this was less evident in practice. The GP explains that, "*My constraints would be time, […] unfortunately and I'm ashamed to say it there are times when you do not perhaps approach people on lifestyle changes".*

The patient's preferred approach was formed using two videos, a "good" consultation and a "bad" consultation. A clear difference between the preferred approach by males and females was evident. Males appeared to favour the "bad" consultation which was more direct involving broad terminology, fear appeals, multiple health concerns and very little interaction from the patient themselves. Eddie in the male FG stated "*you're going into the doctor for advice, you're getting advice aren't you?*" The same video was described as "*a waste of time […] that man was going to go out and he wasn't going to change one bloody thing*" by Karen in the female FG. The female FG favoured the approach shown by the "good" GP. This choice was due to the patient centred approach (i.e. being listened to and central to the discussion). Although this approach was favoured, Karen in the female FG explained, "*it wasn't realistic as a doctor, like as you said (Joan) and I'd agree with you it was more like a*

counsellor than a doctor […] putting the questions to him and kind of letting him tease it out himself".

4.1.2 Initiation of lifestyle counselling:

The initiation of lifestyle counselling was predominantly the responsibility of the health professionals. The GP suggested that a family doctor "*would have incredible opportunities to broach the subject (lifestyle counselling)"*. This was further encouraged when in partnership with another professional such as a counsellor or dietician. The nurse was clear that her daily role involved giving advice to patients and encouraging them to make more positive health choices. The role of the practitioner to initiate lifestyle counselling is essential. The added worry of damaging practitioner-patient relationships appeared to hinder its initiation. It was noted by both practitioners that the fear of patients becoming defensive, aggressive and/or offended was a barrier to their use. Both focus groups were clear that they would not initiate lifestyle counselling due to feelings of discomfort, embarrassment and overall fear of being judged by the health practitioner. Caution is required when initiating lifestyle counselling as patients responded unfavourably to the "bad" consultation where the GP offered advice to the patient based on the smell of smoke. Both focus groups found this to be an unusual and unfavoured means of initiating lifestyle counselling. In practice the GP explains, "*as a doctor you […] you can't just suggest what you think sometimes, ah, otherwise that in itself might affect the entire, ah, relationship with the individual*".

4.1.3 ***Outcomes and effectiveness of lifestyle counselling:***

All parties within the study suggested that the outcome and effectiveness of lifestyle counselling is entirely up to the patient. The GP and Nurse differed on how responsive the genders were to lifestyle counselling. The GP stated that females were more open to change, with the nurse suggesting males show more self determination and drive. There was a difference in opinions shown in terms of the overall success of lifestyle counselling. The GP stated that *"lifestyle counselling is pretty dismal in terms of its overall success in Ireland.*

Again I don't see how, in talking with my colleagues that family doctors simply have the time or the resources to make it a success". The nurse felt that part of her job is to continue to show patients any change is positive and that things will get better with minor lifestyle changes. The nurse and both focus groups stated that focussing on one disease such as cancer can have a numbing effect on patients. The nurse explained that "*your still not guaranteed that you're not going to develop cancer if you give up smoking".* Therefore focussing on the effect of smoking on activities of daily living through a plethora of illnesses can improve the outcome of lifestyle counselling, as suggested by the Nurse.

Both focus groups suggested the success of lifestyle counselling was similar to their preference in its approach. Therefore females and males would be more likely to positively change their behaviour if consultations were similar to the "good" GP and "bad" GP respectively. It was also suggested by the male FG that GPs should put more pressure on an individual to change. Robert explains that "*he (the GP) didn't appear to set out any programs […] he should be giving him a bit of paper this is what I want you to do and I want to see you in two weeks time and see how you're getting on."*

4.2 Pre-Requisites for change

4.2.1 Understanding the patient:

Patients from both focus groups explained that understanding the patient is an important factor when considering lifestyle counselling. The GP understands how patients like Mary "*lie to the doctor"*. The GP explains one method to overcome dishonesty, "*I often ask in relation to alcohol dependence, 'how many pints do you drink in a day, 30?' and they often would say 'no, no 15 or 20'. I learned perhaps if you put a figure, a high figure, they tend to, well, they tend to think, "if he thinks 30 is an okay amount then.*" In terms of using fear appeals it is important to understand that females may not consider change unless the effect is imminent, at which point as Karen stated it may be too late. Understanding the approach to using fear appeals is important as the stark difference in how males and females respond is obvious. Males agreed that during a major scare, major lifestyle changes took place such as

smoking cessation, increased physical activity and an improved diet. The female group on the other hand showed that during times of extreme pressure, health behaviours worsened. Both the Nurse and the GP understand this difference amongst the genders. The GP gives a clearer understanding stating, "*I have seen men just stop smoking instantly following a heart attack. Completely cut them out now […] I would have to say that women could even potentially become more dependant or fall deeper into poor health choices.*"

Other gender differences were evident in relation to the time of a consultation. Females were more concerned about feeling rushed and that visits nowadays are just in and out with GPs lecturing the patient. The "good" GP was a favoured approach and although it was a mere 2 minutes longer than the "bad" GP, it was concluded that "*a GP would not spend that much time on you anyway*" (Joan, Female FG). Therefore the approach appears to be an important factor in how long a consultation is perceived. Males on the other hand understood how busy GP surgeries are but noted that if their condition was serious enough, the GP would give them deserved time. The difference that not every consultation is of equal importance and understanding that females believe they are is important.

Both FGs suggested that removing the social side of poor health behaviours may be more detrimental to an individual's health. The female group were more vocal that there was a concern over what is going to replace it? The Nurse is of the opinion that replacing poor health behaviours are likely to lead to developing more bad habits. In some cases the poor health behaviour is the only opportunity they may have to meet with friends or as Robert stated "*to get out of the house".* Understanding that social health is of importance to both genders is critical. This was not suggested by any practitioner, with the majority of concern focussing on physical health concerns.

The GP appeared to show good understanding of dealing with many scenarios both genders mentioned. There are obvious gender and patient/practitioner differences when approaching lifestyle change. Understanding these is more important than the individual scenario's and when the GP was asked whether some methods were more effective/ineffective on either gender he replied "*that I don't know, that I don't know"*. The nurse on the other hand

understood how the patient's personality is significant if behaviour change is to be adopted. As motivational interviewing allows practitioners to control individual's intentions, it is a method overlooked by GPs as another professionals concern.

4.2.2 *Relationships:*

Within this study male participants actually showed to have greater relationships with their GP than females. The female FG appeared to put more emphasis on how a GP greets the patient. When the "good" GP shakes the patient's hand Karen stated, "*there was a respect there, now even when he came in and shook his hand, there was a nice, dynamic*". In "bad" GP was more associated with actual practice, where the GPs office is described as less welcoming. In relation to this aspect, females only commented on the salutation of a GP and of its importance, no other subject mentioned this.

The female FG noted that the choice of GPs nowadays makes it difficult to form any relationship as they are all completely different and too busy to see the same GP on a regular basis. This was not an issue for the male FG as Barry explains "*I'd find it very difficult to go to a different doctor, I'm going to the same doctor since he started practicing in [towns name] so I'd feel easier talking to him and I'd be more honest with him than with a stranger*".

The practitioners noted benefits to sustained relationship with their patient in terms of lifestyle counselling. Regular meetings with the same patients allowed the GP to visually examine if poor lifestyle behaviours are maintained. The Nurse also proclaimed in order to put patients on the right path she would go the extra mile for those who visit regularly. It was also explained by the GP, "*these relationships tend to allow, I suppose, allow greater exploration or perhaps a better understanding of their behaviours. For me to approach some patients more so than others is very much down to the relationships formed over time.*"

4.3 Fear appeals

4.3.1 Views on fear appeals:

The Nurse had a negative opinion on fear appeals proclaiming that they never work and she would never try to use them in practice. This was not entirely true as the Nurse suggested that males respond better to fear appeals. The term fear appeal is a barrier to their use in practice. The Nurse believed that informing patients of the negative impact of certain health behaviours on their health is not the same thing. The Nurse explains, "*I wouldn't call it a scare tactic, what I'd call it is giving people information about their own health […] they have to take ownership […] Put it back on the patient*".

The GP noted that fear appeals could motivate certain individuals to adopt lifestyle changes. However as fear appeals may not cause a complete change this is overlooked. The GP explains that "*I'm certain it doesn't work because fear is only a small part of whether an individual changes their behaviour."*

In terms of the focus groups a stark contrast was evident in relation to views on fear appeals. Eddie in the male FG stated that "*some people need a good fright to actually change lifestyle".* The biggest fear pointed out by the male FG was a lack of knowledge. In response to the "bad" GP males showed positive and encouraging signs from such a consultation, in fact the only criticism at one point was that there was not enough pressure to evoke a change. Fear is important for men especially when using multiple complications, Barry explained that, ""*if someone was trying to make you paranoid and focussed in on the one thing you'd say well 'feck him*'". The female FG had a very negative view which matched both practitioners' views. Mary stated "*fear tactics are not working, I mean forget it*" after witnessing an amputee smoking a cigarette outside the hospital entrance.

4.3.2 *Approaches when using fear appeals:*

Both the nurse and the GP have used some form of fear appeals, whether admittedly or not. Interestingly both professionals can have success in using them, more evident when dealing with male patients. The GP within this study stated that as a male himself he compares himself to others in a competitive manner. This was supported by the male FG with a preference of using norms, exact numbers comparing cholesterol and BMI giving them a target to work with.

Robert explains his preference, "*your BMI is x and if it's x plus 1 in two weeks time your, you know you'd be looking for an undertaker to help you out […]he didn't put him under severe pressure, he put him under some pressure but not under sever pressure, he wasn't giving him any targets*"

Although within the present study little evidence shows fear appeals are favoured in any way by the female participants. Fear may change female behaviour, Bernie states that "*you realise it that bit more when it happens someone close to you".* The female FG stated that fear appeals may not be an effective method if approached in the perceived stereotypical and aggressive manner. However it was noted that at some point the GP should inform them of the damage certain behaviours cause.

4.3.3 *Reactions to fear appeals:*

The use of fear appeals on males appears to positively influence lifestyle change. Both practitioners are aware of this relationship but are mindful of their overall use. Too much fear placed on individuals is said to be detrimental for overall change. Contrary to the need for more pressure by the male FG, this belief is another barrier to their overall use.

The GP explains the expected reaction from patients experiencing too much fear, "*It can cause a person to leave the centre and to simply not come back […] even though the best interests of the patients at heart, it can certainly be quite damaging to place too much fear onto someone."*

This reaction was evident in the female FG after watching the "bad" consultation, where some females suggested they would never return to a similar setting. Males on the other hand were more open to such an approach, stating they would rather know the effect of certain behaviours. Males stated that they would prefer GPs to speak direct and in some instances aggressively towards certain issues. Unfortunately Barry's experience with his GP left him thinking that being overweight was not cause for concern, "*I went about it to my doctor years ago and he said, because your healthy I'm not going to get onto you about it*". Although the GP may have indirectly suggested he is overweight, such indirect routes are wasted, especially on Barry in this instance.

4.4 Facilitating factors

4.4.1 Technology and modern resources:

The use of stereotypical fear appeals is a major issue in their overall use. The GP admitted to effectively using computer software in order to demonstrate to male patients the effect of their lifestyle behaviours on their overall health. This was welcomed by the male FG, although it was not experienced in actual practice. Disappointment fell over the male group when one male did not receive adequate information on his cholesterol level. The group continued to state that the enforcement of physical activity programs, computer based technology to track their goals and dieticians to encourage dietary changes should be encouraged.

Stephen in the male FG explains how modern resources may be more welcomed by male patients, *"like they [dieticians] do the analysis and that kind of stuff […] and they do all this, the BMI stuff, the fat index, the glycerol fat all that kind of stuff.*"

In contrast computer based technology may not be welcomed by females. It was stated that in recent years the computer is the worst item to be put into a GPs office. Karen in the female FG stated that it adds to losing contact with the patient as the GPs focus is elsewhere. Using other modern resources or health professionals was not mentioned by the female FG. One method suggested by the Nurse is to give "*them information they can assimilate".* This method which was not technology based may be suitable for use in both genders.

4.4.2 *Children:*

All participants in the study identified that children were seen to play a major factor in behaviour change. Having biological children was not a deciding factor as it was identified by both FGs simply having a close relationship with a child is as important. The Nurse felt that children become the most important factor in a person's life. Therefore lifestyle changes were adopted in some of her patients in order to witness various stages of a child's life.

In practice the GP stated, "*I find Dad's and their daughters to be a major factor. A young daughter who asks their Dad to quit smoking […] certainly tends to either cause change or at least get […] the process going."* The GP was unaware whether the same relationship could cause a change in female patients. Bernie in the female FG stated "*if he (son) asked me to stop smoking in the morning I'd stop […] definitely".* This appeared to be the most definitive and sincere reason for her to quit. Therefore as suggested by the GP females and their sons appear to have a similar effect as that of the father and daughter. Although practitioners were aware of such relationships effecting lifestyle change it was not apparent that this was used as a method to impose change.

4.4.3 *Follow ups and referrals:*

The GP explained how an in house counsellor for a short time eliminated many barriers to approach lifestyle changes. This included in house referrals eliminating missed opportunities and time constraints. Referring an individual to another professional allowed the momentum of change to continue in a positive and supportive manner. The GP explains the effect of an in house counsellor on encouraging behaviour change, *"referring them elsewhere now has poorer outcomes. […] The initial thought [and] momentum has indeed been lost and so ah you could say that process may see many missed opportunities."* Such poorer outcomes were evident when speaking with the Nurse. It was stated that patients were often referred to smoking cessation officers in other venues. However it was not known if such programs were utilised by these patients. The Nurse stated that following somebody who went elsewhere is not feasible as Ireland's present health care structure simply does not support such practice.

The overall success of lifestyle counselling is enhanced when using referrals and follow ups. A member of the male FG spoke about seeing a dietician involving regular meetings every two weeks. This was met with great enthusiasm in the group as it was felt such regularity keeps goals at the forefront. In practice, patients presenting with high cholesterol are not seen for a further six months. Eddie explained the importance of regular visits as he will attempt lifestyle changes for a few weeks before they are inevitably forgotten. This consistent regular support was a requirement for both FGs, as noted by Mary in relation to the "good" consultation, "*like he said how confident he was in changing and he said 2/3 and that's a long way a way from [change]*". The female FG pointed out that one or two consultations are not sufficient if lifestyle change was to be adopted.

4.4.4 *Quality of life:*

An individual's quality of life was mentioned by all parties as a deciding factor in behaviour change with varying discrepancies. Males were seen to completely turn their lives around

when areas such as work and daily living were affected. The mere alteration of taking a tablet for a sustained period of life is enough to encourage change according to Eddie, "*I'd have to change […] I don't think anyone would like to be taking medication for the rest of their life".* This too was seen to effect members of the female FG when one member was encouraged to change their behaviour due to the need for steroids to overcome respiratory illnesses. Another ex smoker of the group was reminded that any time they were sick a chest infection was inevitable. Although associated illnesses were ultimately the reason for change, it was the effect these illnesses were having on daily living. In relation to emphysema Karen in the female FG stated the biggest reason for change is "*the quality of life that they won't have if they keep smoking."*

Neither practitioner mentioned the importance of holistic health when attempting to encourage behaviour change. The nurse explains, "*bring in the other diseases, you know the pulmonary, airway obstruction, peripheral neuropathy […] you have to focus on all of that, not just Cancer".* Although overall health is the nurses reasoning for this, patients may need to be reminded what they can lose in their lives not just the plethora of illnesses which may arise due to a particular behaviour.

4.5 Summary:

In summary it is evident that there is a need for a gender specific approach to lifestyle counselling. Males tend to respond best to direct consultations inundated with fear appeals. Females on the other hand do not respond well to fear appeals with the added pressure compounding existing lifestyle issues. In practice, both practitioners perceive fear appeals to be aggressive and forceful. This stereotypical view of fear appeals prevents their overall use failing to accommodate the needs of the male patients within this study. Fear appeals may be more useful to motivate patients rather than solely change a person's lifestyle. Lifestyle counselling is currently unsuccessful in general practice which may be due to its one size fits all approach. Both practitioners fail to adapt their consultations to each patient along with focussing too much on physical implications. The present study suggests gender specific

resources which may benefit its overall success including technology, children, follow ups and referrals and an individual's holistic health.

Chapter 5
Discussion

Discussion 5.0

It was the intention of the researcher to investigate the following four areas;

1. Do men and women respond differently to fear appeals in general practice?
2. Does gender play a role in the approach taken when offering lifestyle counselling?
3. What role fear appeals play in the provision of lifestyle counselling in general practice?
4. To identify gender specific good practice for lifestyle counselling in general practice.

The present study found that a gender difference may be evident in relation to fear appeals. The male FG appeared to respond positively towards their use, preferring such methods to enforce a lifestyle change. Unfortunately fear appeals are under used in general practice, partly due to the approach taken by practitioners. Although fear appeals can be delivered in a variety ways (e.g. patient-centred/practitioner-centred), practitioners believe that they can only be offered one way, in a stereotypical aggressive manner. In line with this, practitioners do not appear to alter their approach to consultations depending on the gender of the patient. It appeared that consultations were practitioner centred for the GP and patient centred for the Nurse. This was predominantly decided by the practitioner's preference rather than assessing the patient's. The present study also found that the current methods used in LC alone may prove ineffective. There may be a need for multiple resources to enhance its overall success, including; technology, follow ups, referrals to specialists or other professionals, identifying intrinsic motivation and core values (e.g. children). The findings of this study will be further discussed under three headings; the efficacy of lifestyle counselling, facilitating factors and fear appeals.

5.1 Efficacy of Lifestyle counselling:

Although preventive medicine is more prevalent now than in previous years (Lock et al., 2010), it appears to be of little priority in Ireland's general practice. The GP acknowledges that he has many opportunities to initiate lifestyle counselling. However, time, a common

barrier prevented such practice (Lambe & Collins, 2009; Noordman, 2013). In order to improve the overall efficacy of LC in general practice the approach may need to be tailored with the patient's gender taken into account.

As shown in previous studies, lifestyle counselling itself may be avoided by practitioners (Phillips, Wood & Kinnersly, 2014; Noordman, 2013). This is partly due the fear of damaging the overall practitioner-patient relationship. Findings in the present study showed that these fears may be warranted, especially when considering female patients. LC is often initiated as a response to the presence of a health complication (e.g. respiratory problems) (Noordman, 2013; Geense et al., 2013; Glasgow et al., 2001; Wee et al., 1999). However findings in the present study showed that such methods have been used extensively and ultimately exhausted by GPs. The female FG found that such methods were used far too frequently and encouraged patients to become dishonest and ultimately dissatisfied with the overall practitioner-patient relationship. In order to overcome a relationship breakdown Lancaster et al. (2000) proposed a method which allows the patient to become the initiator. However in an Irish context this may again prove to be ineffective as it was found that all parties believe this to be the practitioner's role. Therefore the overall approach to LC must be altered.

Recent research has shown that some of the most successful approaches to lifestyle counselling are patient centred (Hutchinson et al., 2002; Jonas et al., 2012; Lock et al., 2010; Butler et al., 1999; Verbiest et al., 2013; Orrow et al., 2012). Findings in the present study showed that a patient-centred approach was favoured more so by the female FG with males preferring practitioner-centred approaches. Within the present study the female FG identified the "bad" consultation corroborated their actual experiences. Therefore patient centred approaches are not commonly used in general practice. Similar to the findings of Tulloch, Fortier & Hogg (2006) the GP interviewed in the present study, considered his approach to be patient centred with little evidence from his descriptions showing this to be the case. This highlights a major issue in the efficacy of LC; what the GP believes is being offered is often not what the patient perceives (Tulloch, Fortier & Hogg, 2006). Males on the other hand reported an overall good relationship with their GPs and preferred the approach taken by the

"bad" GP. Thus the evidence suggests that GP's approach patients in a similar manner regardless of their gender, with males responding best to such an approach.

Ogden (2002) and Vick and Scott (1998) found that study groups where over two-thirds of the participants were female, preferred a patient-centred approach. The present study is in agreement with this finding that females prefer a patient-centred approach. Adopting a patient-centred approach for female patients may also lessen or remove a commonly reported barrier i.e. time (Noordman, 2013; Lambe & Collins, 2009; Booth & Nowson, 2010; Sluijs et al., 2004). The female FG identified the time offered by the "good" GP as unrealistic. Although the "good" and "bad" consultations were of similar duration, the different approaches taken by the GP's allowed the female FG to think and interact differently. Both consultations were within ten minutes, a time identified in Jonas et al.'s (2012) systematic review as the most effective for LC. This being said it was noted that if the approach taken was not patient centred, females were generally not satisfied. In contrast to their female counterparts males were more understanding of shorter, direct and informative consultations (Resincow, 2006; Bowling, 2012).This being said, in the presence of a health concern, males found a longer consultation helpful. This finding shows that while all consultations may need to be lengthy for overall female satisfaction, males require only longer consultations in order to gain a greater understanding of serious health issues.

In an attempt to prevent serious health issues smoking appeared to be the most common health behaviour discussed (USPSTF, 2002). Interestingly findings in this study appeared to be similar to Huskey et al. (2008) whereby females reported relapsing more often. Huskey et al. (2008) reported that females relapsed more often due to a greater need for nicotine. Findings in the present study show that females appear to be concerned primarily on replacing their health behaviour with another "distraction" or coping mechanism. Piper et al. (2009) had similar findings where females more successful in refraining from smoking sought social support and pharmacological intervention. Therefore without such supports relapse may be inevitable. The present study showed the nurse to understand the need for social support for females but again it was not enforced by either practitioner. Men too reported that a key factor influencing the adoption of poor lifestyle behaviours was social connections. However it is interesting to note that these same social connections were not

perceived to be an issue for males if and when they decided to quit. Here again evidence is seen that gender specific approaches to LC are required in order to ensure its success.

Findings from the present study show that females are unsatisfied with the service they receive in general practice. Interestingly this is in direct contradiction to the research which states that current LC practices best cater for the female population. Based on the findings in the present study the department of health and children's (2003) handbook on patient satisfaction appear to reflect only the female point of view. Therefore it must be noted that a large body of evidence based on LC is not dealt with in a gender specific manner. Worse still although males appear satisfied with their GP, the guidelines for delivering effective LC have been developed primarily to deal with females. Such recommendations if adopted may see further missed opportunities, especially in the male population.

5.2 Fear appeals:

Findings within the present study identified a need for a gender-specific approach when using fear appeals. All parties understood that fear appeals involved illustrating the dire consequences which may come to pass as a result of poor health choices (e.g smoking and cancer) (Williams, 2012). However practitioners seem unaware that successful fear appeals need to be used with caution and offered alongside reasonable coping strategies (Witte & Allen, 2000). Such strategies include the extended parallel process model and the transtheoretical model (Williams, 2011; Hansson, Rasmussen & Ahlstrom, 2011; Elliot, 2003). Thompson et al. (2010) further highlighted this point stressing that the ultimate goal of fear appeal use is to encourage lifestyle change by informing patients of their choices rather than scaring them. The Nurse appeared to approach the use of fear appeals in this manner. However the nurse did not actually consciously recognise that she was in fact using this alternate fear appeal approach. Believing instead that informing her patients was an entirely different approach. This finding may explain why both practitioners, as in previous literature, concluded that fear appeals are ineffective and counter productive (Maloney, Limpski & Witte, 2011); O'Neil & Nicholson-Coyle, 2002). It is thus imperative to note that using fear

appeals in this manner, without developing suitable coping strategies may place the individual under unnecessary additional pressure/stress.

Similar to Schwarzer and Schulz (2002) females in the present study highlighted the fact that poor lifestyle behaviours worsen in the event of extreme pressure/stress. This does not seem to be evident when working with the male patient. Males find fear to be a lack of knowledge and in order to change fear is needed. As in previous studies, males responded positively in the event of a major threat, preferring the use of fear appeals and in general seemed to prefer heightened levels of pressure when compared to their female counterparts (Maciejewski et al., 2001; Schwarzer & Schulz, 2002; Richardson & Carroll, 2010). Both practitioners acknowledged the success of fear appeals when working with male patients. In the present study the GP stated that fear appeals can indeed be a motivating tool, with males in particular viewing a threat/fear appeal as a catalyst for change (Witte & Allen, 2000). Regardless of this understanding practitioners within the present study would still avoid their usage due to the fear of associated pitfalls (Johnston & Warkenten, 2010).

Cho (2000) identified some of these pitfalls as avoidance, depression, aggressive response and ultimately relationship breakdown. Findings in the present study identified that females were more likely to experience some if not all of these consequences. From this it can be implied that while fear appeals do indeed involve risk, the risks may be far greater for female patients. This finding is similar to the findings of Jones and Owen (2006) where it was also stated that females simply do not like fear appeals. The present study also found that females were more likely to seek multiple GPs in a search for satisfaction, similar to the findings outlined by (Sansone & Sansone, 2012) in which unsatisfied patients turn into GP shoppers.

However the aforementioned pitfalls were only evident when fear appeals were used their harshest manner. Both genders acknowledged that if there was a personal threat (e.g. if a loved one developed cancer) then a positive lifestyle change may be adopted (Begley, 2007). Therefore practitioners must strive to help the patient to identify a personal or core reason for change. Generalised fear appeals are simply not effective in practice as seen in Cho and Salmon's (2006) study. The importance of identifying intrinsic motivation in order to

encourage change through fear appeals is critical (Edmondson, 2004; McKenna & Vernon, 2004). The previous studies clearly illustrate that the "quick-fix" mentality of practitioners is detrimental to overall lifestyle change. This was particularly evident in the present study particularly when considering the threat of Cancer. Most smokers in the present study had received the threat of Cancer, however cancer is not explicit to smoking alone and so its threat level was seen to be diminished in the minds of the participants. This was confirmed by the nurse who mentioned that an overall "numbing" effect has occurred to such threats. It was also seen that the female FG stated that threats concerning their physical health may come too late. This raises an interesting point regarding the timing of fear appeals. On this point Benet (1994) also found that fear appeals must have age related outcomes in order to be effective. Here again it is highlighted that the successful use of fear appeals must target individuals on a personal level, connecting with their core values and identifying personalised threats to their health. In both focus groups the use of fear appeals was seen to be more successful if the fear appeals were personalised to the patient, similar to Begley (2007).

5.3 Facilitating Factors:

There are many factors external to LC which both directly and indirectly affects both its implementation and overall success. As already discussed one important factor is an over reliance on the flawed "quick-fix" approach. Also identified in the present study and in numerous previous studies were major barriers affecting LC including initiation, time, financial incentives, structure and lack of training. However some additional important factors affecting LC appear to be over looked entirely by practitioners, these include the use of technology, children/loved one, follow ups, referrals and holistic health (Quality of Life). It is felt that the addition of gender specific approaches to LC coupled with a consideration of the aforementioned factors can further enhance the delivery of effective LC and help to remove many perceived barriers to its success.

Initiating LC is difficult, and is made even more challenging since at present LC approaches do not take gender into account. A possible solution to some of these problems is Australia's "lifescripts". The "lifescripts" program involves patients identifying any health behaviours

they would consider changing and willing to discuss with their GP. This is done while in the waiting room. Therefore the patient identifies if an issue is present and highlights they are open to discussion on the matter. However gender may again be an issue with this approach, with female patient's being more open to discussing their issues and also attending their GPs more frequently (Woolf et al., 2006; O'Brien, Hunt & Hart, 2005). We know that a males hegemonic role in society can indeed be a barrier to the overall use of general practice (Seymore-Smith, Wetherell and Phoenix, 2002; O'Brien, Hunt and Hart, 2005). Therefore a program such as "lifescripts" may be ignored or go unnoticed by male patients.

Woolf et al. (2006) proposed an interesting possible solution which suggests that a practice based website may prove more effective when considering the male patient. The website included lifestyle questionnaires for individuals along with advice to help overcome particular issues. GPs used the website as a point of reference for patients in the hope of initiating LC (Woolf et al.'s (2006). In the present study males appeared to respond well to this model and indeed to the use of computer based programs in general. They felt a well rounded consultation should involve the GP offering advice accompanied by tangible materials, goals/targets and an understanding of the norms (Richardson & Carroll, 2010). The present study identified that female patients were not in support of computers in the GPs office which may prove to be an issue in the effective use of a practice based website. Thus efforts and considerations must be made to ensure that any practice based website is seen as inclusive to both genders. At present neither "lifescripts" nor practice websites are used in an Irish general practice considering such approaches may prove essential for the future success of LC.

Once LC has been initiated, a fundamental flaw is that there is no follow-up process in place. In the present study, other than the GP who believed he saw his patients too frequently for their need, follow ups were identified as major priority. The female FG identified that the GPs favoured method was ineffective. They noted that if LC was offered at all it was a once off occurrence and had not experienced further help from that point on. Thus it can be seen that it is not correct for the GP in this study to suggested regular encounters with his patients is enough to satisfy a LC role. Multiple studies Lancaster et al. (2000), Zwar, Thompson et al. (2011) and Hardcastle (2008) found that follow ups are vital and very effective. In the present

study the nurse outlines that the structures which would allow her to carry out follow up LC support simply do not exist. Therefore referring patients to other external professionals may assist this burden. The GP noted that unless referrals were in-house, the process would see many missed opportunities since external professionals would not have the same intimate knowledge of the patient. Therefore as Ward (2009) proposed an integrated health system may be more successful.

The present study found that the male FG would prefer to be referred to other health professionals specific to the cause. In fact another finding shows that males source help from other professionals (e.g. dietician) more so than their female counterparts. Referrals and other professionals appeared to be more associated with the male FG, this is not to say it would not be welcomed by the female FG especially since they are more likely to "GP shop" if they were not in receipt of what they perceive to be helpful advice. Although no significant gender differences were evident in the approach to follow ups or referral it is important to acknowledge the findings in the present study in relation to the preferred approaches to consultation. All professionals need to be aware of such approaches, otherwise follow-ups/referrals may prove to be insignificant and ultimately ineffective.

Intrinsic motivation must also be identified and developed within the patient. The present study found children and quality of life to be two areas of some importance. Worryingly both of these are misunderstood and underused by practitioners in order to encourage lifestyle behaviour change. Although overall quality of life was spoken about more by the female FG. Males appeared more willing to ensure quality of life is restored. Unfortunately males appeared to consider quality of life only after it was negatively affected (e.g. heart attack). Therefore implementing lifestyle changes may be more effective in the female FG prior to the onset of poor health. Both FG's identified that getting out of the house and staying/becoming active in some instances was more important than changing their lifestyle behaviour (e.g. drinks with friends). Therefore social health for both genders is of major importance, understanding this is a necessity in order to offer adequate support in changing one's behaviour. Unfortunately in the present study both practitioners major concern was physical health (i.e. ensuring the absence of disease). The social health/wellbeing of the patient was not recognised at any point.

Children on the other hand are recognised by all parties in this study as a primary reason for behaviour change. The GP highlighted that males responded best when persuaded by their daughters. Both focus groups acknowledged that a child in general would have a major influence. Hovell et al.'s (2000) study on different counselling approaches found that lifestyle counselling for behavioural change, accompanied by counselling outlining the effect of passive smoking on children was significant in its reductions when sustained for 12 months. Therefore specific LC targeting core values such as children and family may prove to be successful (Witte & Allen, 2000; Benet et al. 1994; Rollnick et al., 2010). As the adoption of LC by practitioners is unlikely, the present study highlights methods for all health professionals. This is in the hope that an integrated health system will be adopted in order to support individuals adequately during lifestyle changes.

5.4 Limitations:

The following limitations of the present study have been identified by the researcher:

- Understanding the success or failure of fear appeals in general practice may be difficult. Fear appeals are not seen to be politically correct therefore the honesty of both practitioners in their overall use may prove an issue.
- The presence of the researcher during the semi-structured interviews and focus groups may affect how participants responded. This process may also cause the researcher to unintentionally lead the study down a biased path.
- Generalising the results of the study will prove difficult as the population sample was somewhat small.
- As it is a qualitative research there are also no definitive results. Findings within the present study merely raise a flag that this is area requires further investigation with larger study populations.
- Fear appeals can be offered in a variety of ways. However, the present study only presented one type to the patients. Therefore the views of either gender is based on only one type of fear appeal and does not suggest that the response may be different when using other fear appeals.

5.5 Recommendations:

Although the present study has identified that both genders respond differently in the use of fear appeals it is not clear that fear appeals however are effective when working with males. This is similar to Wakefield (2010) as perceived effectiveness is identified, thus meaning although males see fear appeals as a good method, this may not translate into effective practice. Therefore it is proposed that further research is required to identify if this equates to an effective approach over longer durations and actual practice. In order to determine the gender specific findings high quality research is required research should include a variety of fear appeals to establish if none or any is explicit to either gender. It is proposed that randomized control trials should be considered in order to gain the best quality evidence to support the overall use of fear appeals in general practice. Until such a time that randomised control trials can be achieved literature from previous lifestyle counselling research should be re-analyzed with the intention of identifying gender differences.

The present study has highlighted a number of areas which should be considered in practice. The researcher feels that there is a need for policy and structure changes within the health care system. With preventative medicine likely to save the economy substantially, funding is needed to support practitioners in the adoption of practices such as lifestyle counselling. Funding is needed to ensure a more suitable, integrated health care system is put into practice. This type of approach will offer practitioners the needed support to increase the overall efficacy of lifestyle counselling as well as eliminating many commonly reported barriers (e.g. time, training, knowledge). With the proposed integrated health care system, all health professionals involved require additional gender specific training. Other methods which have been shown to be a success elsewhere include “lifesctipts” and practice websites. These approaches should be considered coupled with the use of mobile phone applications and SMS messaging used as prompts, reminders and support for patients attempting lifestyle changes.

5.6 Conclusion:

As it was the intention of the author to ultimately identify a gender based opinion on approaches to lifestyle counselling, its preference and fear appeal use. Findings have shown that a gender difference may exist. As the present study was conducted with a relatively small study sample, findings are suggested with caution in the hope of further research. Unfortunately fear appeals carry a stigma associated with their use in general practice. The present study offered the use of fear appeals in its harshest manner to two focus groups divided by gender. The male focus group preferred this type of approach as it may encourage a lifestyle change more so than a patient-centred consultation. This was in contrast to the females opinions, who responded unfavourably to such an approach. Practitioners are aware of this type of reaction believing the risks of fear appeals greatly outweigh the benefits and in turn deem them ineffective avoiding their use. Although fear appeals can be offered with various degrees of severity, participants in this study were not aware of this. Therefore the harshest method portrayed in this study is in fact the common perception of a fear appal. As a result the use of fear appeals are avoided and unfavoured based on only one type of fear appeal. This further compounds the one size fits all approach to lifestyle counselling which currently exists in general practice.

Findings in this study suggest that patients appear to commonly receive practitioner-centred consultations, an approach which is unfavoured by the female focus group. In line with this a large body of evidence suggested that lifestyle counselling should adopt a more patient-centred approach, moving away from “traditional” practitioner-centred approaches. If such recommendations are adopted, findings in this study have shown that this would mean general practices would no longer cater for the male patient. As practitioners fail to alter their approaches based on the patient’s gender, they also fail to identify the core values of their patients. Like other studies practitioners appeared to opt for the “quick-fix” approach. This may be due to the perceived barriers practitioners face such as time, financial support and a poor health care structure. Therefore without a major structural change in general practice coupled with gender specific approaches lifestyle counselling will likely continue to fail. Therefore encouraging patient follow-ups, an integrated health system involving multiple health professionals, using multiple resources (e.g. websites, SMS messaging, lifescripts) and

identifying a patient's intrinsic motivation is critical. These gender and patient specific changes along with structural changes may enhance the efficacy of lifestyle counselling. As well as that fear appeals may not be an entirely inappropriate method in lifestyle counselling.

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Appendices

Appendix A

Interview should last approximately 30 – 40 minutes

A brief introduction to lifestyle counselling and fear appeals:

Lifestyle counselling is a collaborative method whereby patients and GPs/NPs work together in order to adopt behaviour change in areas such as smoking cessation, alcohol use, physical activity and diet. Fear appeals are high threat messages which may be used to scare an individual into adopting/changing a particular behaviour, for the purpose of this study these behaviours will include the above mentioned.

Questions:

What approaches do you use to change clients health behaviours? Where did this approach come from (e.g. training, experience)

Examples if needed (Practitioner centred, patient centred)

How would your differ in your approach depending on whether the client was male or female?

How receptive are males or females to lifestyle counselling? More or less receptive to different lifestyle behaviour topics?

What is your experience of how effective it is with both men and women

What do you perceive as the barriers to changing lifestyle behaviour of men or women in GP?

What is your opinion on using fear appeals when trying to change someone's behaviour?

What is your experience of using them?

How effective are they? Under what circumstances? i.e. how should they be best used?

Appendix B

Questions for participant in focus groups will be given prior to watching two 10 minute videos.

- How would the patient react/feel after?
- How likely is the patient to change?
- How effective was the consultation? Why?
- List the things the GP did that made it effective or ineffective
- Relationships between GP & Patient?

Appendix C

Informed Consent: (This form was adjusted courtesy of WHO, 2013)

General Information:

The following informed consent form was designed for members of the Clonmel area that were invited to participate in focus groups and/or semi-structured interviews to aid with research in the area of gender differences in lifestyle counseling and scare appeals.

This study will be carried out by Derek Daly, a 4th year student in Exercise and Health Studies from Waterford Institute of Technology. The study will involve a small group (10 people) and although your opinion and point of views are important to this study at no point should you feel forced to talk or part-take. If there is anything throughout this study and/or prior to the study which you do not understand or feel uncomfortable about please do not hesitate to get advice from anyone you wish or myself. If there is anything that I can do to help with your questions I am more than happy to help.

Purpose of the research

Physical activity, alcohol consumption and smoking are forms of lifestyle behaviours. The purpose of this research is to understand if you have received any advice in relation to changing these behaviours from your doctor or nurse. It is also to help understand how you feel about receiving advice in relation to such lifestyle behaviours and if you were to speak about or change such behaviours how would you prefer to speak or what is an effective method to help with change.

Voluntary Participation

You have chosen to participate in this study entirely voluntary. As already stated you're not under any obligation to speak or give your opinion however it would be greatly appreciated. If at any

stage throughout this interview that you feel you no longer want to participate you are free to leave. I would appreciate if you decide to no longer participate 24 hours prior to the focus group that you could contact me in order to allow suitable time to find a replacement.

Procedures

.

For the purpose of this study the focus group and interviews will have to be recorded. This information will be entirely confidential as well as any personal details which you may have provided. These details will only be seen by me and my project supervisor. At no stage throughout this study will your names be used on tape and they will not be in any written document (The final study and the transcripts of the focus group/interviews).

Duration

The duration of the focus group is about 1 hour and the interviews will be at least 30 minutes. This will be a once off interview and focus group and therefore your time commitments are for the times mentioned and no more.

Informed Consent

I have read and understand what is expected of me in relation to this study. I have been given a clear understanding to what this study is about and I have also had time and opportunity to ask any questions. I am satisfied that I have received enough information and I consent voluntarily to be a participant in this study

Print Name of Participant_____

Signature of Participant _____

Date _____

Day/month/year

GP Transcript

Bold Font = Doctor

Normal Font = Interviewer

Ok, so from what I read lifestyle counselling is when you discuss with participants or patients in a collaborative way where they are open to the floor and you can discuss, say changes to smoking, drinking or lifestyle activity or physical activity. What in your opinion is lifestyle counselling?

Well I suppose in my experience as a GP it's mainly done on a one to one opportunistic type of way, ah, in my job, ah where I see an opportunity to, ah actually come up with some advice on lifestyle changes.

Ok

That would be my, my

Would those opportunities arise often?

To me as a family doctor I would have incredible opportunities [mmhm] **to ah, broach the subject. My constraint, constraints would be time, the availability of time. That's a huge issue now because ah if you have a waiting room full of patients you have to be careful and you have to and unfortunately and I'm ashamed to say it there are times when you do not perhaps approach people on lifestyle changes.**

Yeah, of course.

You know it is going to end in delays or back logs

Oh of course, yeah, I understand your point. I have read multiple studies, that in Ireland, that time with doctors and nurses too have, ah, a difficulty with time. Do you find that there is anyway of overcoming that?

Certainly for a short time, ah, we had, we were able to direct people to a counsellor, an in house counsellor and the fact that the counsellor was within your premises the patients didn't feel as threatened by it. There is a barrier when you ask someone to go

somewhere else and then they are visiting unfamiliar ground really. But from that point of view and the reason is that allowed us as a GP to initiate the counselling or the advice really on lifestyle changes, now you could maybe direct them. Like for instance on the weight issues, people would respond or in fact be offended if you broach that topic and so it can be quite difficult to target some individuals who are unwilling to discuss an obvious issue.

I understand, and ah, just going back you said ye had a counsellor, is that gone or why is it no longer in practice?

Well actually ah with the changes and the, am, cuts I suppose, the counsellor left on maternity and was never replaced.

Right, I see and

Now there was quite, she was quite a popular choice for many of our patients and so it is a pity I suppose. As I said referring them elsewhere now has poorer outcomes. Ah, by the, ah, time a counsellor is sourced and the individual has been referred. The initial thought, or the chance ah…

The momentum

Yes, yes exactly the momentum has indeed been lost and so ah you could say that process may see many missed opportunities. We also had an in house dietician for some time, which would work with many different patients, ah but you would direct those with weight issues to ah consult with them, but again, denial is a big thing.

Okay so you find the individual must be, like, open to the process

Absolutely, absolutely.

Are you familiar with patient centred and GP centred consultations?

Ah I suppose, ah, I wouldn't really be, no, no I wouldn't

Well, like, from what I read patient centred approaches are centred solely around the patient, ah, there opinions and they would be more involved in the consultation. Ah, GP centred is, people or doctors in your position dictating or controlling the consultation with little involvement from the patients. Ah, do you see yourself fitting into any of these?

Ah, well, from those definitions, ah, I would like to consider myself as, well as a more patient centred GP.

Right, right and would this be the same regardless of whether it was lifestyle counselling or a normal visit?

Ah, no I don't think I change my approach, ah whether it is for, it's very much a personality thing you see. I tend to be patient centred and I would like to think that I am consistent whether that is lifestyle counselling or not.

Yeah, I understand and so, ah on that what approaches do you take? Say when dealing with changing behaviours such as smoking, alcohol use, physical activity? Like have you heard of Motivational Interviewing?

I have, yes, ah it came to my attention with a package, a leaflet with a smoking cessation program.

Ah, right

I wouldn't have ever used it now, again time would be an issue and I just feel, I felt, ah

Perhaps another profession?

Yes, yes it would probably be good for someone else to have but again I would have had little use for that here.

And so what kind of strategies would you have used?

Well, I suppose it depends really a lot on the individual. In saying that however I was in Aiseiri [Drug and Alcohol Clinic] a while back and I remember asking how the hell, how do you get them to open up. And, ah, one counsellor said to me I often ask, ah, in relation to alcohol dependence, I often as "how many pints do you drink in a day, 30?" and they often would say "no, no 15 or 20". So, ah, I learned perhaps if you put a figure, a high figure, they tend to, well, they tend to think, "if he thinks 30 is an okay amount then"

So over exaggerating, ah,

Yes, it does work in that instance, from my own experience and from speaking with others.

So would your experiences play a big role in how you approach, ah, lifestyle counselling?

Ah, I would have to say yes, the University of Life has thought me many things. I feel how I deal with patients, ah, has largely changed. You can probably see it, I am, ah, in the, ah, latter stages of my professional career. And, ah, so earlier on I would have been eager to change people and be more, I suppose GP centred but now I, well I tend to approach things very differently.

Ok, in what way?

Ah, well as I said its more a case of if I see an opportunity, ah, I suppose I will try advise an individual on lifestyle behaviours.

Does the opportunity have to arise or does it come from either the patient or the doctor?

Ultimately, it must come from the patient, yeah.

And so would lifestyle counselling be offered if you felt it was necessary, like what I'm saying is if the patient didn't directly seek advice.

Ah, well, it comes down to knowing your patients too. Ah, I feel over my professional career I have built relationships with my patients, ah, and these relationships tend to allow, I suppose, allow greater exploration or perhaps a better understanding of their behaviours. For me to approach some patients more so than others is very much down to the relationships formed over, ah, time.

Right, that is interesting. Ah, just in terms of gender differences. There has been many studies which highlight, am, men wanting a more direct, short snappy visit. Like they want to just sit down and be out the door as quickly as possible. Women were said to be opposite to that, wanting longer visits, to be listened to, be more involved in the visit. Does this match what you experience? Or, well what you see on a daily basis?

Ah, it would be to an extent a fair snap shot, ah, I guess. Actually I have noticed more recently that men, some of, ah, my male patients are beginning to chat for a bit longer. Now, in saying that it appears to be more general chatter.

How do you mean?

Ah, what I'm saying is, they might speak about the match last night or other events but nothing, ah, specific to themselves.

Right.

However as you have said, females tend to be more involved and want to perhaps understand their own conditions, ah, I suppose a little better.

Interesting, am, like from what I have read that tends to be common

Oh, does it yeah?

Yeah, and am, just in terms of lifestyle counselling, do you, ah, would you change your approaches, like if the patient was male or female?

Ah well I suppose, no, no, I wouldn't say I do. Like I do believe personality is a major thing, and ah, I deal with people in quite a similar manner. I can't say, ah, for sure that I would have a different approach because of that no.

Okay so your own individual personality plays a major role.

Yes, yes I think that is the case for many of us [Doctors]

Would you experience males or females being more receptive to lifestyle counselling?

Ah, I suppose, that's a good question. I suppose, females tend to be a little more open to change, I guess from my experience but again they have to want to change. They can be a little more committed too, like if they want to change, ah, they do broach many avenues to help ensure that change can, ah, well can happen.

Okay so women tend to be more committed to a change

Well, they do but again perhaps I'm a little biased in that aspect, it's just how I feel on the matter.

And, like do you find that differs with different behaviours, like smoking, drinking, and physical activity?

Ah, how do you mean?

Sorry, ah, like, am, do you thing men or women are more receptive in terms of say, smoking, drinking and physical activity. Like is there a difference or no difference at all.

So are they more inclined to accept advice in one of the areas than the others, is that what you mean?

Mmhmm, yeah

Ah, I suppose it comes back to the individual again, certainly I encounter more smokers who seek advice. However overall, ah, I would have to say that there would be very little difference in terms of receptiveness to any and ah, again they really have to want to make certain changes for it to have benefits

Right, so, like you have mentioned that multiple times, is a pointless to approach behaviour change without this.

Ah, perhaps not pointless but ah, certainly to see change they must want it, yes.

Okay, am, how effective is lifestyle counselling be with both men and women and like would you see a difference if any in its effect? Or have I already asked this?

Ah, I would have to say, that ah, lifestyle counselling, ah, its effectiveness would be pretty poor. Ah, I think that is mainly due to again the time constraints in offering it.

Would that be an issue just in your centre?

Ah, well, no, no I would have to say that lifestyle counselling is pretty dismal in terms of its overall success in Ireland, ah, in general practice. Again I don't see how, in talking with my colleagues that family doctors simply have the time or the resources to make it a success.

And obviously that is your opinion to both genders.

Well, yes, ah, I don't think it can be effective more to either gender. Ah, again I feel its overall effectiveness is poor.

I have read in some studies that follow up on patients seems to be quite beneficial. Like would that be something you have done?

Ah, no, I have often thought about it alright but I, well my patients would visit quite regular and so carrying out follow ups would not prove worthwhile for my own patients.

Okay, and like would you think you would see how effective lifestyle counselling is, am, like just by. Am do you think these visits allow you to see if it is effective?

Well I think you can see clearly with, ah, patients you have seen frequently, ah, or have known for quite sometime. For instance, you can see clearly if an individual maintains alcohol abuse. You can also smell the smoke and things like that

Right so you using your own senses and know how you can tell

Ah, yes that would be an approach I suppose that I would use. Poor lifestyle behaviours tend to be quite easy to spot, ah, in the case of gambling, I believe this would be one that I would not really be able to just know by talking to a patient if whether a, ah, ah, major change has happened.

Right so like you can tell if an individual has changed without following up?

In most cases, yes, you can see by their general health and again some obvious signs if, ah, ah change has taken place, yes.

Okay, am, is there any barriers to changing lifestyle behaviours. Am, I know you have already mentioned time but is there anything else that am you might feel is a barrier?

Ah, I suppose the patient's integrity or honesty to themselves would be a big factor. Ah, for instance as I said earlier, ah, in terms of weight management, denial can effect majorly how that goes. The patient can get offended, aggressive and ah, that of course is a major obstacle. Also, in a different, ah, circumstance, ah, a patient who is a heavy drinker or smoker would under estimate their usage. So these would be areas, ah, I suppose I would encounter when trying to discuss behaviour change with my patients.

Okay so their honesty to the situation and am, their own views on how they look or feel is a major factor.

Yes absolutely, along with my own time constraints I would have to feel these are, ah, certainly areas which may, ah, stand in the way of, ah, generating an appropriate overview of particular behaviours. Ah, I know it's not particularly relevant but gambling in itself is a barrier to lifestyle behaviour change, ah, because unless you identify money issues and ah, the source of where the money has gone, it is very difficult to see or assume that this is, ah, well

A poor health behaviour

Yes but also if as a doctor you cannot see a particular behaviour in an individuals life, you, ah, you must be careful to or you must not

Like judge them in the wrong sort of thing is it?

Exactly, you can't just suggest what you think sometimes, ah, otherwise that in itself might affect the entire, ah, relationship with the individual.

And so just taking that point, like do you find these opportunities arise more often with either men or women?

Well I suppose you can get a feel for female's lifestyle behaviours a little better, ah as they tend to chat with you a little bit more.

Right, and you said earlier that ah, men are talking now but am, just a little about general life and so

Well yes but you can get a feel for their behaviours on that but it's only recently men are starting to chat with me a little longer than, ah, well than what I have previously experienced.

Oh, okay, okay I get what you mean. So you haven't actually like gotten this from men before and it's only a recent thing you have noticed.

Yes, yeah.

Is there any particular reason why this may be happening?

Ah, well I don't know really, I'm not too sure I could pin-point why this is the case or why it has been happening. If I listed things like lonlieness or perhaps ah being friendly, but again I would ah, I would be speculating in relation to this.

No worries, that's fine. Am, just in terms of fear appeals then.

Ah yes, am I suppose they, ah, ah, they certainly serve a purpose. Ah in terms of their use I think. Using them on younger patients though, ah, I think can be a little wasted. Ah like we all tell someone in their 20's that you know by the time you get to 40 you will have throat cancer. And ah, I feel, I suppose it can be a little like, like water off a, a, like water of a duck.

So the outcome must be felt soon

Yes, I certainly feel that the fear must be almost, ah, instantaneous for it to become effective. I have used posters from time to time with, ah, horrific images for, ah, many behaviours, smoking, ah sexual behaviour and so on, like for safe sexual activities I have done this quite a bit especially ah, when dealing with younger patients. But again, I'm certain it doesn't work, ah, because fear is only a small part of ah, whether an individual changes their behaviour.

I have read that it can be a motivator, am would you agree with that?

I suppose it would motivate some people, possibly more than others.

Would that be seen more so in men or women?

No, I would again think it's more an age related matter. Ah, I feel young people will not worry about illnesses or, ah, which may be 20 years down the line. I do feel however that as they age perhaps values change a little.

Oh okay so, am, so I have also read in numerous studies that am, men tend to respond better to, to tangible or, fears which may affect them directly and that women more so to emotional aspects. Do you think that is a fair reflection?

Ah, I suppose, in terms of emotional aspects I don't feel that there is that gender divide no. I know people close to others that have developed throat cancer and because of that all their friends have stopped smoking. Ah

Is that seen in both genders, yeah?

Well, ah, perhaps I'm being biased here but that would be related very much to male patients. Ah, amazingly in my years practicing, ah, ah, I have never had a female patient who suffered from throat cancer. So, ah, I would have to say that those patients who have developed it [Throat Cancer] would have caused many close friends to quit, ah, quit smoking.

That is interesting and like those friends would be male

Yes, yes ah, they would be predominantly male yes.

Is there any other reason that you may see am, like, a behaviour change in men or women?

I ah, also find that children play a major factor in behaviour change. I find Dad's and their daughters to be a major factor. A young daughter who, ah, who ah, asks their Dad to quit smoking or ah, "Dad, Dad, why don't you stop smoking so much?" that certainly, ah tends to either cause change or at least get ah, ah, ah

Get them to think about it

Ah yes, it for the want of a better word gets the process going.

Is this the same type of relationship between mothers and son's or does this matter?

Ah, that I don't know, that I don't know, it's not something I have seen but I definitely have noticed that bond or ah, ah, relationship on male patients having a greater effect on behaviour change.

I have read that am men tend to change their behaviours more, easier when or if they suffer a heart attack for example

That is absolutely true, absolutely true. I have seen men just stop smoking instantly following a heart attack. Completely cut them out now. And I'm thinking to myself, ah, why could you not have done that beforehand. It's quite amazing that you should bring that up, ah, because it certainly is the case. And I have seen people completely turn their

lives around. Ah, and it's not always the one's you would expect either, if you know what I mean, ah it can effect and ah change individuals that you would least expect in these instances.

Okay, okay and could the same be said for women, like does a heart attack cause women to change.

Ah no, actually no, ah I would have to say that women could even potentially become more dependant or fall deeper into poor health choices.

That is interesting because I had read that women tend to relapse more so than men

Right am I can't say for sure that they relapse more, but I certainly have noticed that during hard times or ah, after a heart attack, their behaviour becomes quite more dependant on, ah, say cigarettes or alcohol use.

What is your opinion on using fear appeals when trying to change someone's behaviour?

Ah I have found that personality does play a major role again, ah, I think you need a certain type of personality to, to target an individual and be very direct with them about their health choices. Ah, I don't feel that I commonly use, ah, I suppose a stereotypical way of scaring someone into a change. What I have done, ah quite recently is I have used a chart for one of my patients blood cholesterol. And, ah, I have pulled up the chart on my, on my computer screen and I have said you are here and you should be here. And I have found that, ah, it's quite amazing in fact how effective a little number can be.

Right

Like for them to see and compare themselves to others it really got him to sit up and start taking it in, taking in what I was trying to say

So this patient was male then

Yes, ah, ah, like I do spin classes myself and it's quite funny but you tend to watch the man beside you, you watch his clock on the, on the front of his bike and you begin

comparing your numbers. Now I can't compete with some of these lads, but I feel that is present in a lot of us.

You find that competitiveness amongst men to be important and am, you think that like effects ah, behaviour change.

Ah, yes, yes the competitiveness, exactly. Ah, I think when you put the fear into them that they are so far beyond the normal ranges in comparison to others then, ah, they certainly tend to sit up a little bit more and listen.

Do you notice any changes in behaviour?

Ah, I suppose it really gets the ball rolling more so than seeing an immediate, ah, change.

Okay, now you have already, am talked about your experience and you mentioned your personality, can you explain that more?

Ah, I suppose their can be a slight bit of boldness required to use fear as a motivator, and I know one Doctor, a friend of mine. And he told me that one time he got up on his, onto to his, ah, desk. I believe this really happened now, he got up onto his desk and started to jump up and down. His patient was sitting, possibly where you are now looking up at this, and he said, he looked and he said you think I'm mad don't you? And his patient said that he did, and he said well I think your mad for smoking as much as you do. And I feel it's that type of, of,

Madness??

Yes, that type of carefree madness to tackle an individual and to, ah, cause them to sit up and think hard about their choices. I don't think I have that aggressive, direct approach. I do believe though that the young graduates, who are beginning their careers, have a good hold on this edgy personality and ah, again to have this type of personality will certainly help ah with regards scaring a change into some of their patients.

You mentioned being direct, am, do you feel there is no other way in using fear appeals. Like do you think beating around the bush is not an option.

No, I believe you must be direct in their use, if you ah, are going to use, or scare a patient there is no point approaching it indirectly. You have to meet that head on.

I have also read that the outcome must be within a persons grasp when using fear, like, I mean they must see a realistic, achievable outcome and not just leave scared. Do you think that is the case?

I do, I absolutely do, I think fear can be the beginning of a change, but not just fear. Ah, I think that in terms of any behaviour change the person must see a solution that suits them. The person must either find where they are going with ease or, ah, they must at least break down the path into achievable realistic sections.

Okay, I have read similar opinions from various studies so that is good. Just, am, do you think that there are any negative effects or pitfalls when using fear appeals? Like do you think there is any really negative aspects of them?

Ah, yes, ah, I think too much fear can be detrimental. Ah I feel that with too much fear, it can cause a patient to stick their head in the sand and simply ignore the entire issue.

You feel they can become overwhelmed

Overwhelmed, absolutely, overwhelmed by the entire situation can easily become evident when ah, when they are met by too much fear. It can cause a person to leave the centre and to simply not come back. Ah, they might even approach other doctors and ah when they don't receive the same treatment they become satisfied. Now their behaviours may not be addressed immediately, and so they become more comfortable, ah, even though the best interests of the patients are, are, ah at heart, it can certainly be quite damaging to place too much fear onto someone.

Well, I feel you have given me enough of your time and that you have answered all the questions I need you to. Am, thank you very much for the opportunity and for participating in this. I appreciate your time. Thank you.

It's been no issue at all and you are more than welcome. Thank you too and the best of luck with everything.

Thank you

NP Transcript

Bold Font = Nurse

Normal Font = Interviewer

So ah, what's your ah opinion of lifestyle counselling? Or what is it?

Am, lifestyle counselling would be, to me, means somebody who gets in contact with somebody if your not happy where your at in your own life and you want guidance on, we say, your health, well being, its just a holistic approach to moving forward in your life. Yeah. **Basically.**

And would you come across say much with health behaviours, say like, smoking, drinking, weight management. **Am.** In relation to lifestyle counselling?

Would I come across it? Yeah. **No.**

Not at all. **Not really, no, no, in my job is it?** Yeah, Yeah. **Ah well yes I would in my job, yeah, sorry, wait now sorry, sorry, I misunderstood you there.** Yeah, no problem. **You would in the job because obviously your, your, your promoting a healthy lifestyle for patients** [yeah, yeah] **and that kind of thing, so you would have to reinforce that.**

You were saying you come in contact with them or someone comes looking for help like, would many people come looking to you or would they be referred to you?

Ah well mostly, you'd counsel them we'd say, to stop them smoking for example, because that interferes with healing [yeah] **you know wound management and all that kind of thing** [okay] **and just to try and alter their lifestyle from that point of view** [perfect] **right.**

Yeah, am, and just say ah, do you kind of give them an open floor, like, to decide whether they can give up or would you kind of dictate..

Oh Jeez no, no. No sure you have to leave it, at the end of the day it's up to the person themselves [yeah] **you can only give that advice. You can give the advice, tell them the pros and cons and try and push them into a positive** [mmhmm] **you know, frame of mind but its up to them at the end of the day to take the next step.**

And is there any methods you use to push them into that positive frame of mind?

Ah, well, you, well definitely, ah, definitely we'll say open ended questions [yeah] **that kind of thing getting their feedback about where they are in their life, what they are doing, why their doing a certain thing and then trying to put up suggestions in a very open way** [yeah, yeah] **and nothing specific about how they could change that** [very good] **but leave that, them, come up with the, the, the, am solutions rather than you telling them the solutions.**

I was looking at a couple of studies and they were saying that doctors kind of feel there's an ethical side, [**mmhmm]** like where if they give the patient too much room that they can end up causing more harm than good [**right]** would you, would you agree with that like?

If they give the patient too much information?

No, if they leave the patient decide too much for themselves that they might take a, ah, negative approach.

Ah, at the end of the day the way I'd feel about that is, ah, you know, ah, the patient or the patient or the client whatever you would like to call them needs to decide for themselves [mmhmm] **because if you don't take ownership of your own illness, be that what it may, you'll never move forward.**

Yeah

So if you tell somebody you have to give up smoking, or you have to walk 15 minutes a day, they won't do it. [yeah] **But if you give, tell them, if you don't walk 15 minutes a day or if you do continue smoking, this is going to be what'll happen. Then your more inclined, so I think information is a good thing to give people.**

Kind of trying to scare people, would that be an idea, no?

Am, not really, not really [yeah] **because that generally doesn't work. I don't think because even yourself if somebody turned around and said ah feck it so what's the point, where as giving them, giving them an alternative,** [yeah, yeah exactly] **you know what I mean and they can even meet you half way** [yeah, yeah] **is better than, you know.**

Yeah because I actually done focus groups as I said earlier, and well the females were saying that you kind of have to fill your bad behaviour with something else like **[mmhmm]** say you'd have to take up another **[yes]** another habit like **[yes]** whether that's a good habit or a bad habit, would that be kind of what your saying?

Ah, you'd, I wouldn't necessarily agree with that because I think say from somebody who's given up smoking [mmhmm] **right, ah I didn't fill it with anything else but what I needed to realise from my point of view was what I was doing to myself and then get into the right head space** [yeah] **say fine enough of this. But if you start filling it with something else, your, your, ah, I think you run the risk of developing more bad habits, or, oh I'll treat myself to a bar of chocolate, [**yeah, yeah, yeah] **or you know that kind of thing.**

At some point your going to end up going backwards.

Exactly, exactly, so it's about, about, getting your head around what your doing and where your going.

Yeah and your saying, you're a smoker or an ex-smoker [**ex-smoker]** would you use a lot of your, kind of, your approach to dealing with people from your own experience.

About smoking? [mmmmm] **Am, I tend to, I certainly don't push it down peoples throats that I, [**yeah] **ever smoked or I ever gave them up because being an ex-smoker I know that's the last thing you want to hear** [yeah, yeah, yeah] **So if somebody turned around and are like "well I gave them up!!"** [right right] **Do you know what I mean? [**yeah, yeah] **That's not what they want to hear** [exactly] **and until your in the right frame of mind you won't anyway but it's to get somebody into that frame of mind is where you would be pushing [**yeah, yeah]

And as you said that's kind of from giving them open ended questions [**Exactly, absolutely yeah]** Am, would you find that's different between the genders now, **[yes]** would you say men respond differently to women?

Without a doubt, I think men are more, more, ah, how would you say, there, they, actually, men respond more to scare tactics, and to telling them facts, saying if you don't give up smoking this is what's going to happen. We'll say from the point of view of wound management, if you keep smoking 20 a day your wound is not going to heal, right [yeah] **then it's oh right, where as women don't.**

Right, right, [**okay]** and would you say that it may be because it might effect their day to day life, say like as you said with wound healing, that it might have a direct influence on their own life [**oh yeah]** or whatever it might be

Absolutely and I think men are just more black and white, simple as, in my opinion.

Very good, am, would you actually use that different approach then, with a man or a woman, would you try and scare a man versus a woman?

Ah, I'd never try and scare either of them.

You'd never at all, [**no, no]** even though it might work.

Ah, I would by scare like, I would say, by talking to a man you do know that if you don't reduce or give up your smoking that you have a lesser chance of this wound healing or this bone healing. That's how I would put it.

Right

As opposed to you have to give up smoking, you know

Yeah, that's interesting because one of the doctors I was speaking to, he said, am, you have to be so aggressive when your using scare tactics, **[yeah],** but is that an opinion in, ah, ah, in your industry like? Like would it have to be so, like scare tactics has this bad, negative kind of

Yeah, yeah you see I wouldn't use it, your interpretation of what probably scare tactics wouldn't be mine [yeah, yeah] **because I'm nursing, what 30 something years, you'd probably interpret my am ah, [**approach] **approach, as being scare tactics. [**yeah] **whereas I wouldn't [**yeah] **do you know what I mean, like, to me I'm informing them, if you don't do this, this is what's going to happen**

Yeah, yeah, like so as I said, do you think that's a problem in your area like, that scare tactics, has this really negative view, that you have to be really really direct and aggressive, whereas

by simply informing them of a negative outcome, is still kind of a scare tactic when you think about it.

Well, ah, I wouldn't call it a scare tactic, what I'd call it is giving people information about their own health, their own path, if you like and then they have to take ownership it's up to them then to move forward or not but don't expect the magic wand if your going to keep smoking we'll say, and your wounds, your bones, other issues are going to go away. Like you have to take ownership and realise that. [Yeah yeah] **there is no magic wand, do you know what I'm saying** [yeah]. **Put it back on the patient**

There has to be a relationship found to give up

Exactly yeah and there has to be ownership of their own health

That's actually fairly common, with anything I assume, like, once the patient decides themselves to give up, that's when it happens.

That's when it happens, it's the same if their a diabetic, any any of the chronic conditions, once you take ownership of it you can move forward and live a healthy happy life. If you don't you will end up in hospital on numerous occasions do you know what I mean [yeah] **because your not following advice**

And would you find that men, say respond to, say if they have a heart attack **[yeah]** they'll change their life, very very abruptly

Ah, they, yes, yes, yes [they'd stop a lot of bad habits things like that] **exactly yeah.**

And, I was speaking to a doctor, but I'd like your own opinion on this, what would you think the females response to a bad time in their life would be like.

Ah it can vary on a scale of zero to ten, you've got both ends, you know you can get somebody like, for example, and i'll give you and example, I'm working with a girl who had breast cancer, she's only 41, she had it 6 years ago so she was very young, 35, she has 3 young kids, she has turned her life around and she is so positive and so like she is just a fantastic person to be around because she is so positive [yeah] **now I have met women, because I did breast care a few years ago and I have met women who have just**

gone under [right] **so you get both, like I think personally it's a personality thing, it's personality based, and possibly to the same extent to men as well.**

It's not as black and white **[its not as black and white]**

Yeah, men are perceived to do more probably for themselves but then that's a huge area because they usually have the backing of a wife, [okay] **behind them, do you know what I mean** [yeah] **I think that kind of thing has to come into play as well, whereas women by their nature, look after the house you know even if they are out working or whatever, so they probably don't have the same support [**right, right] **do you know what I mean, emotionally.**

Would you think that support is really important like

Oh yeah hugely, hugely.

And a lot of studies there said, as you've said, that men tend to do it on their own but their probably not when you think about what you've said **[exactly]** but women tend to go for a more social, kind of meeting the girls **[support groups]** yeah, **[exactly yeah]** like that's probably what your saying there, they aren't getting that same support from their husbands or

It's just a different kind of support, it's not that their not [not getting it, yeah yeah] **support, but it's just different**

And that's emotional support, **[exactly]** and like that plays into a lot of things like, say as men respond better, like you were saying to me before we started recording that men respond more to the tangible side of things **[yeah]** things like charts, numbers, figures, **[yeah]** like is that emotional side of women there as well in changing their behaviours,

Yes without a doubt like the head has to be in the right frame of mind for any change to take place.

And say on other peoples experiences, would you say women respond to just anybody suffering, like would they tend to take it on board and say, you know I might change my life or does it have to be a direct family member?

Ah I would think that you have to be emotionally connected to somebody, now that doesn't mean that it has to be, a direct family member but even a friend or whatever [yeah] **but I think for anyone, you actually have to know a person** [yeah exactly, yeah, there has to be something there] **yeah because like if you turn on the TV your looking at, you know, death and destruction, and illness the whole time and if that was the case everyone would change** [exactly yeah]

And would you actually think that's a big thing like the fact that we're surrounded by such negativity, that we just don't pay it any thought any more

Yeah I think, well I think, we're all numb to it at this stage do you know what I mean

That is, that is fairly interesting. Just on men and women then, do you think the relationships they have in their lives you said their wives are very important or their girlfriends **[exactly]** but would you say kids play a big role in either of the genders or both?

As in?

As in changing their life, their behaviours

Oh yeah, yeah, yeah. Sure you know yourself after having a child your outlook on life completely changes doesn't it?

Oh it does yeah, absolutely [**do you know what I mean]** absolutely like 100%

They become like the most important thing in your life and your looking at your own health and saying well I want to get them to this stage and that stage or whatever, so you start thinking about the choices your making then.

Do you think that change comes to men more when they have a child, because females tend to be more health conscious **[possibly]** all their life **[possibly, possibly yeah]**

Okay, so overall how effective do you think lifestyle counselling is?

From my point of view, talking with people I think it is, I think you need to, you know, your negligent number one if you don't point out these things as a health care professional your negligent if you don't and it's also I mean I think that's why we're all in the job is to help people. So like, yes, yes I do and I think it's important to keep focussing on positives for people [yeah, yeah] **and you know things can get better and will get better if you change and it doesn't have to be a huge big change just a small change do you know what I mean?**

Yeah, and your saying your focussing on the positives there like, does that include highlighting the really bad things, or is it just say for example smoking, your goanna develop cancer, that's obviously not a positive outlook **[yeah]** what way would be a positive outlook that your not going to develop cancer?

No to say to somebody like that if they do give up smoking for example, that okay, your still not guaranteed that your not going to develop cancer if you give up smoking, right, but we'll say bring in the other diseases, you know the pulmonary, airway obstruction, all that kind of stuff the peripheral neuropathy, you know going around with a fecking oxygen tank you know going around with ya. So you have to focus on all of that, not just, people tend to focus just on the cancer, but I think you have to emphasise that you will have a healthier life, lifestyle [right so overall life] **exactly do you know what I mean like there is a whole plethora of things** [that can go wrong just from] **and can start to go right** [exactly] **from giving up a poor health behaviour.**

And do you think men or women tend to respond to like say, four or five different things to go wrong, or to change or to see a massive improvement in. Like do they respond better to a multiple option?

Ah, I think, I think probably men and I'm not basing that on anything only assumption right [no yeah] **am I think probably yes with men more so than women.**

I was actually am, I actually done the groups and the men actually did say that they'd rather discuss four or five different things and the women said that they'd much rather talk about the specific, the specific things. So that's interesting

Right, oh very good, that is interesting there yeah.

Just so you know in research, fear appeals are said to be a motivator to get people going

What have?

Scare tactics **[oh scare tactics oh yeah sorry]** they kind of motivate people to stop. You've said that it doesn't really play into them and you don't like using them, and in your work is that a common perception?

Yeah, not, not to the aggressive way that like if you don't give up smoking, this is going to be what happens or whatever, because it doesn't work. It just doesn't work. Whereas informing people about what will happen if you do give up smoking and get them thinking about it. That's a much better approach for patients I think.

Yeah and would you kind of have to follow up much, say to make sure a person is giving up, like if they came to you for advice or you gave them advice **[mmhmm]** would you say there is a necessity to follow up with patients?

There is, in the ideal world it would be wonderful to do that [yeah] **but in the health system we have at the moment that is not possible. There are say, smoking cessation officers that are, that you can refer people to out in the hospital but am from a personal point of view, I couldn't follow somebody up.**

Right and would you know, like as you said, I don't know, like would you know if that person took the option of going to see the smoking cessation officer?

No, no [there's nothing there] **no.**

And like say just in practice, would you say if that person was in house that there is a higher chance of someone coming straight from you and down to speak to that person about smoking rather than if they had to go, I suppose, five, ten minutes out of their way **[oh yeah, yeah, definitely]**

That's really important, would you say that's important?

Mmhmm, yeah

I heard it's a missed opportunity if you have to refer them further a field.

Oh yeah, once they go back out the front door, it's forgotten about whereas if you could pinpoint them there and then, do you know what I mean like and give them the advice and get them motivated and whatever, yeah.

And like, I was talking to a couple of people as well on diets, and they were saying that when they go to a dietician that there's a two week plan, there's a two week follow-up, there's a two week everything and they found that really effective like **[yeah]** and like do you think that like and I know your saying it's not there, and it's not financially there and it's just not present but would it ever be there and would it be a necessity?

Well I think that that's a, like if the HSE were to look a lot broader they would see, that they would save millions, if not billions in the health service if they had all these structures in place because I mean, as your well aware from your course the amount of people who are obese and morbidly obese. Like I mean if they were caught at a younger age do you know what I mean. Like your looking at the diabetes, heart attacks, strokes, bla, bla, bla, bla, bla. So if they were all caught earlier [yeah exactly yeah] **do you know what I mean? It would save millions, millions.**

And like who initiates that kind of, like, do you know is it the patient or the nurses or the doctors who say right well I want to give up or like you know your saying the patients who need to change or will change will do it for themselves. They'll come in and talk about it. But like if you really felt the need would you say, this needs to be done and like how often would that happen?

You can, like you can ask somebody like do they want to or do they even feel like they want to talk about it, I'm not asking you to give up anything here or whatever but then you can get somebody in to talk to them [right] **so it is up to the patient then after that.**

So you open the door but they still take it?

Yeah exactly

And do you think that's different amongst the genders, like do you think women tend to take that step more so or visa versa?

I think it's 50/50 [really yeah] **yeah I do yeah, I think that's personality [**mmhmm] **you know?**

Yeah it's on the person themselves like [**yeah]** and just on fear appeals or scare tactics like is there any pitfalls, like as you said, scaring someone, as you said, like if we got scared we'd probably just go out the door and say ah sure **[yeah]** is that the major problem with scare tactics?

Yeah and it's also, your also treating the patient like a child [yeah, yeah] **do you know what I mean [**yeah] **your not treating them as an equal, you know whereas giving them information they can assimilate it and then work off that but scaring somebody I mean it just doesn't work, end of.** [yeah] **you know [**yeah].

I was in with a GP and he was saying that am, men tend to respond better if they are compared to their peers, or the normal ranges etc like do you think that's necessary like that men kind of have this competitive nature, [**yeah, definitely, definitely, yeah]**

And they do, men do even have more get up and go we'll say as far as even exercise or ah you know I do, it's just in their nature [just in their nature]

So do you just think it's because of their nature or is there any other particular reason?

Not really no I think that's just the way their wired you know

Yeah, yeah and you don't think scare tactics are one bit effective?

No [that's the way it is] **that's just the way it is, from my years nursing, no. it just doesn't work. You actually make people more I think aggressive and more, they just get their backs up.**

Yeah and that obviously effects the relationship between you and the patient

Exactly exactly

Nobody wants a bad relationship there, [**exactly, exactly]** you'll do more good for the person if the relationship is stronger

Yeah absolutely

And would you develop any bond with patients to do that?

Ah you would with the odd few who are regular patients and you kind of go that extra mile with them [yeah, yeah] **you know what I mean to try and get them on the right path.**

I suppose that's kind of similar to following someone up that your with them more often **[yeah, yeah]** would you see differences in that relationship?

You would and you wouldn't you see you kind of like there is ah, like a kind of a partition there if you like, when your in at work and they are patients do you know what I mean [yeah] **and it's only so far you can go** [yeah exactly] **do you know what I mean, you can't take them home like [**no, no, no]

And like would the family ever get involved?

Families do, yeah, yeah, some families, and like that that's very individual as well because some families want to dump people as well [right, right] **you know, and some families are absolutely brilliant who will do everything they can [**yeah, yeah, yeah]

I don't really have much more to ask you,

That's grand, not a bother

Thanks very much now

Male Focus group transcript

Interviewer: Okay so we're ready to go

Eddie: Awh shit 'tis PG

Group: Laughs

(Video 1: the good doctor played, lasting 9minutes 30 seconds)

Paddy: Was he a doctor?

Interviewer: He was yeah

Paddy: Some empty press beside

Group: Laughs

Eddie: I'd say your man beside him had a cushion shoved up underneath

Group: Laughs

Interviewer: He did, he did have one of them

Eddie: 'Twas a bit too square wasn't it?

Group: Laughs

Barry: Here's the real thing here (shaking his stomach)

Eddie: At least its round, he'll need to round his off

Group: Laughs

Interviewer: Oh God, so ah, so is that a realistic experience in the doctors with ye?

Barry: No

Interviewer: Why?

Barry: Why? Well the doctor's concentrating on one area he's not concentrating on everything around it

Interviewer: he's just concentrating..

Barry: He zoned in on drink

Interviewer: mmhmm

Barry: Right

Eddie: Totally he did, he did, yeah, yeah, yeah, he didn't say anything about fries or anything like that

Barry: whereas, they said he was on medication for blood pressure [yeah] **it's proven that one to two units a day preferably one unit of a spirit is good for a start, so that's good for blood pressure unless he had low blood pressure** [mmhmm] **which in that case he can't touch beer or anything at all** [mmhmm] **ah, I've had those conversations and that there, that's completely unrealistic**

Interviewer: What would your own experience be like?

Barry: If you're suffering from stress your blood pressure goes up [mmhmm] **they want to talk more about what's causing that or how to alleviate that rather than hone in on one place because generally anyone suffering from it, it's a collection or a collaboration of things**

Interviewer: So you'd rather talk about four or five things that's causing it

Barry: Well, generally they do [your saying they] **they'll go in around four or five things and try narrow it down to the biggest issue** [mmhmm] **where there was no discussion there it was just straight into drink**

Interviewer: Why'd he do that though?

Barry: what?

Interviewer: He gave him the option to talk about drink, so that's the only reason

Barry: but he only gave him one option

Interviewer: he didn't give him the option, he asked your man to choose a behaviour to change and he took alcohol and he went down that road, that's the only reason.

Barry: Yes, but there's a phrase gently, gently catches the monkey [mmhmm] **he wanted to turn him 180 degrees** [that's true] **in the first go, which is not realistic**

Interviewer: Exactly, exactly it's not realistic and you are right like

Eddie: was he trying to frighten him?

Interviewer: what's your own opinion on fear? Would ye be frightened into changing your behaviour for any reason?

Barry: Fear is only a lack of knowledge

Interviewer: Keep going, what do you mean?

Barry: Huh?

Interviewer: how do you mean?

Barry: fear is, fear of anything is only a lack of knowledge, if you don't understand it your afraid of

Interviewer: mmhmm, so say if you had your smoking, your drinking or whatever and someone turns around and says your gonna get cancer in five years no effect

Barry: well, if you have knowledge of it your going to correct it [mmhmm]

Paddy: well, you'll, you can take steps to probably correct it anyway, yeah

Barry: well, if, if, if you read all the surveys like, your gonna get cancer from tea, your gonna get cancer from coffee or you can get it above in [name of housing estate] from radon, you know

Eddie: It's very hard to give up something that you enjoy as well, isn't it

Interviewer: Yeah, yeah

Eddie: you know he was saying he always goes out for a few drinks, well he says a few drinks

Barry: what would have ha, what would have had a bigger effect on that persons life, particularly his blood pressure was losing the whole side of his social life

Interviewer: yeah, so is that really important

Barry: It's really important, he lost his job, he lost his job they said that in it [mmhmm] **when you lose your job, there's nothing worse than doing nothing and that brings depression in itself. Getting out meeting new people cuts down on depression**

Eddie: 'tis but, I..

Barry: A person who stays at home they retreat into themselves

Eddie: Yeah but I know a lot of people that give up the drink and they still go down to the pub

Barry: Yeah, well I'm normally the designated driver

Eddie: Yeah, yeah maybe so but you can still enjoy yourself when your off it [yeah] **just chatting and different things or whatever**

Interviewer: and say with the doctor there, you know, real nice approach like, would you think your man would feel good, bad, indifferent after that, would he give up, stay going or how would you think?

Eddie: well he said he wouldn't give it up, he said he wouldn't give it up fully

Interviewer: but would he make the steps towards it after something like that now?

Eddie: well, especially when he's son kinda, mentioned it to him

Interviewer: So kids, kids are real important like

Eddie: I'd imagine so yeah

Interviewer: would ye all agree with that, in general

Paddy: Yeah, I think I would yeah

Barry: I wouldn't particularly like the doctors..

Eddie: his attitude, his approach to it?

Barry: no no just to focus in on one thing, because often to deal with people, to get to the heart of the problem or deal with one issue, you need to

Eddie: yeah but

Barry: you need to go around it rather than just

Eddie: but it's a different story if the doctor knew that person, and he wasn't a complete stranger

Interviewer: yeah, yeah

Eddie: I'd say

Barry: Rather than

Eddie: Clears throat

Barry: rather than asking him to cut down, he was asking him to cut out

Eddie: well he gave him a kind of a gauge from naught to ten, a kind of a

Barry: the gauge was only a possibility of him doing it

Interviewer: you were saying..

Eddie: show that video again

Group: Laughs

Interviewer: we'll start the whole thing again now (laughs)

Barry: but do you know what I'm saying

Eddie: yeah, yeah, yeah

Barry: it's like a diabetic and sugar, ah, if you can get him to start cutting it down you can get him off it, but if you tell him today you can't have anymore

Eddie: yeah but what you said, if you do it in stages, you might come off it eventually, but it's hard to go from a ten to a nil or a one

Interviewer: Yeah, yeah you were saying there about his attitude, what do you think of his attitude? Did you like it or hate, ah, it's for everyone now

Eddie: yeah, ah, I didn't mind the doctors attitude, I'd rather he be straight out than to be bating around the bush

Interviewer: mmmm, mmmm, do you think he bet around the bush or was he straight out in that?

Eddie: I thought he was straight out with your man, I thought so anyway, yeah

Stephen: A lot of people wouldn't be able to handle that if they were just that direct about it as well though

Eddie: maybe, maybe

Stephen: that's the only thing

Eddie: maybe, but sure we're all different really

Stephen: true, well, I'd prefer it if it was just direct as well like

Eddie: awh, I think so as well yeah

Stephen: but ah, there was a few other things too if it was just about reducing the BMI he could have actually got into the actual diet side of it as well instead of, rather than just the alcohol as you were saying

Eddie: yeah

Stephen: there is other factors as well, that may be easier to influence like [yeah] **so**

Interviewer: So would ye actually rather talk about more than one or two things, yourselves like? Not based on the video, like if you went into the doctor would you rather pay your 50 euro and talk about everything that's going on and get out the door or

Eddie: Well, I went into the doctor the other day paid him 50 euro and he didn't fucking mention half that

Group: Laughs

Eddie: I felt I was fucking robbed, yeah, oh Jesus sorry (points at the recorder)

Interviewer: No, no that's fine, curse away it's grand

Eddie: Yeah, yeah, yeah

Robert: Well, there maybe something there that we don't know Derek, ah, was, was the interview solely related to the guys problem with drink, his health problems, his social problems, his economic problems [yeah, yeah] **if that's what it was all about, then I think the doctor was going in the right direction** [yeah exactly] **he was trying to point out things like you know, his family, his wife** [mmhmm] **his children, the fact that he was missing games with the children, missing social time with his children all because of the drink you know** [yeah] **without putting too much emphasis on that medical…the badness of that drinking and the medical side, I think the doctor was doing him a fair deal, you know he was letting the guy make up his own mind** [yeah, yeah] **on what the right road was to take, it wasn't the doctor was recommending it, it was he was given his own choice and letting him think about it. Like ten being the worst case scenario and one being the best case scenario or visa versa and he was really making the guy think**

Interviewer: yeah, is that important though like, to have your own personal, your own personal thought like? Do you know, if you were left thinking for yourself, making your own personal choice, is that important to change your behaviour like?

Robert: At the end of the day, you've got to make up your own mind

Eddie: Ya 'tis his life

Paddy: like if he decided there that he just wasn't going to change his attitude

Robert: An alcoholic is never going to stop up drinking, stop drinking if he doesn't want to stop

Interviewer: exactly yeah, that's a hundred percent

Robert: a smoker is not going to stop, if they don't want to stop smoking, so

Interviewer: exactly

Barry: it's like even any detox centre, most detox centres won't even take you unless you want to give up yourself because it's pointless

Group: mmmm

Interviewer: Oh yeah, it's true yeah you have to want to change the behaviour. That's what I'm trying to say at the start, he wants to change, he want's to approach alcohol, he saw that as his biggest factor like, so do you think going through four or five different behaviours before actually hitting the one he can and wants to change is important?

Barry: I think it's the one he wants to change, but ah, to hit it, to keep focussing in the whole time ah

Eddie: but he knew that was the one that was doing the damage

Barry: Yes but ah, different people need to be approached different ways, where you could see him lying back and he kept harping on about the social side and he wasn't working. He didn't want to lose the social side, if he was told to go down to the pub an hour later to start with

Stephen: that would have probably been a better idea to start with that, yeah

Barry: then because once you plant a seed in his own mind it's up to him whether he does it or not [mmmm] **alls you can do is try and plant the seed and encourage him**

Interviewer: What about follow ups then after that like, how often does the doctor need to be

Barry: oh, two to three weeks

Interviewer: Constant checking up or

Barry: well for the first two or three weeks time, bring him in see how he's going

Interviewer: mmmm, has anyone ever experienced that though, has anyone ever been called back by their doctor to see how your getting on

Paddy: No

Barry: I have,

Paddy: have you yeah?

Barry: I have yeah, I had a blood infection one time, so I had to, they put me on this strict diet thing

Interviewer: is that from a, a health behaviour like?

Barry: no, no just

Interviewer: but that's from a different

Barry: they had to monitor it

Interviewer: yeah, but say has anyone turned around to you and said, say, you have to give up fatty foods and then call back, say, two weeks time and we see if your going down the right road?

Eddie: No, six months time, cholesterol like [yeah], **yeah, yeah, that would be**

Interviewer: that's mandatory, kinda

Eddie: yeah

Stephen: I started going to a dietician a few months back and that's every two weeks your back in again, like they do the analysis and that kind of stuff again and so that's every fortnight

Interviewer: did you go off your own back to that like?

Stephen: Yeah, yeah, I did yeah, and they do all this, the BMI stuff, the fat index, the glycerol fat all that kind of stuff. Every two weeks is better because it kind of keeps it in your mind as well

Interviewer: yeah yeah exactly yeah

Stephen: it's good like you know

Robert: Progress reports as well

Stephen: yeah exactly yeah, you can see it in the graphs and all that kind of stuff as well

Robert: keep an eye on how your going, yeah, very good

Stephen: yeah exactly

Interviewer: and has the GP ever recommended to any of ye to see someone like that, another specialist like, like a dietician, has that ever happened to anyone/

Barry: the time I had a blood infection

Interviewer: you got recommended on? Did you take it like? Did you take that opportunity?

Barry: I had no option (laughs)

Eddie: yeah but you could have ignored it, but you went down that road did you?

Barry: I went myself to see the specialist

Eddie: yeah, yeah but you could have said, ah, to hell with that I'm going to die anyway

Barry: well, when your time's up your times up

Eddie: yeah, yeah, yeah

Interviewer: it's true yeah, and what made you do that? You just wanted to

Barry: I was just married (laughs) I was sent for (laughs)

Group: laughs

Stephen: Out of fear so

Paddy: the other fear factor

Interviewer: and do you think that relationship between the doctor is realistic? Would ye have a relationship like that with ye're own doctors?

Robert: yeah I would (sniffs) [Yeah] **yeah I think so.**

Interviewer: and is that fairly normal?

Robert: I think it would be yeah, like I went there, if I was called there and I had a particular problem, I think I could discuss it in very very similar to that one

Interviewer: yeah, yeah, and that long? Or a long consultation like that or would it be quick?

Robert: well he's (man in video) obviously got a medical card so time is not important to him (laughs)

Group: laughs

Robert: it probably was longer than we think it was, do you know [yeah, yeah] **but yeah I think if the doctor is very sincere about what he wants to speak to you about, he'll give you that time, do you know. Then again if you have 5,6,7,8 waiting out in the waiting room all with appointments. But ah, it might be a bit more there than we can imagine, there might a more in depth problem and the doctor is trying to get through to your man**

Interviewer: and do you think if the doctor knew you personally and like he knew there was problems there and he really needed to spend the time with you, he'd give you that time?

Robert: I think so, I would hope so

Interviewer: Everyone

Paddy: I'd say so yeah

Interviewer: Okay, cool, sure we'll watch the second video. Ah, can you hear that alright

Eddie: is it the same doctor?

Interviewer: it could be, all answers shall be revealed

Group: laughs

(Second video: the bad doctor played, lasting 7 minutes 40 seconds)

Interviewer: can you hear that alright there?

Eddie: yeah, I can yeah, yeah

Eddie: the poor bastard is in for it again

Group: laughs

Robert: he's in trouble

Eddie: yeah, yeah two weeks later

Stephen: looks a bit nervous alright

(after video)

Eddie: that cursed drink again

Group: laughs

Robert: drinking ten pints a night?

Eddie: yeah, yeah

Robert: how much is a pint now?

Paddy: we were just sayin' that

Barry: we were just saying that, about four euro's

Eddie: four fifty or four euros yeah

Robert: forty euro's a night and he's not workin'

Paddy: and the chipper on the way home (laughs)

Eddie: for an auld treat

Robert: ah the auld treat was for her

Group: laughs

Interviewer: he's thoughtful though give him credit, give him credit

Eddie: but he was after cutting down on the fags though (sarcasm) (laughs)

Interviewer: saving up for the pints

Eddie: yeah (laughs)

Paddy: I thought the doctors approach there though was an awful lot better than the first video

Interviewer: really yeah?

Eddie: is it because we've gotten used to

Group: chatter

Robert: he got the message through though, your man wasn't wearing it really

Barry: but he covered a lot more ground, he came at it from a lot of different

Eddie: I don't think that your man was as savvy enough to think he was doing anything wrong

Barry: well he thought he was making the attempt, which he wasn't

Eddie: He wasn't making any attempt I'd say, your man

Barry: the doctor contradicted himself as well, in the fact that he asked him to cut down on high fatty foods and then later said everything had to be cut out

Interviewer: so which one is better? That one or the first one?

Barry: I think that one

Paddy: I thought the second one as well

Interviewer: yeah, what makes that better?

Group: huh?

Interviewer: what makes it better?

Stephen: more direct

Eddie: the doctors approach to it

Interviewer: just pure direct

Eddie: he was, yeah, yeah

Paddy: he was direct, yeah he covered a bigger area whereas the first one just isolated one, one hundred percent on drink, where as this one brought, drink, cigarettes, food, exercise brought everything into it

Eddie: yeah

Interviewer: and do you think that's more value for the money or more value for the patient

Eddie: Bit of both I suppose

Paddy: bit of both, yeah

Interviewer: that's important obviously.

Eddie: yeah

Interviewer: and how do you think he'd react after that? Would he go off and change something? From your own experience like? Would you go and change something more after the second video or after the first video?

Eddie: Well if the doctors were to give you that information, I think, I'd be inclined to change

Barry: I think the likelihood of a doctor taking that kind of approach, he would call you back within a week, two weeks to monitor, if there wasn't some sort of a change by then it would get a little more drastic or give up on ya

Interviewer: mmmhmmm

Barry: but definitely the second one is more of an approach that I would like

Robert: perhaps, what may have been missing for me is that the doctor said he was concerned, you know, and…he didn't appear to set out any programs for your man, you know, he should be saying, giving him a bit of paper this is what I want you to do and I want to see you in two weeks time and see how your getting on. I'll check your BMI now and see how it is in two weeks, or you know, your cholesterol and so on. Although he did mention the cholesterol as my own is being controlled by medication, you know [yeah] **but ah, he was assertive, and yet he was a little bit lacking there by was he going to put your man under enough pressure, by making him, making him perform you know**

Barry: but you don't see him leave, you don't know if that's going to happen afterwards

Robert: no but

Interviewer: we're basing it on the video though, yeah

Barry: he raised a lot more issues in the one time

Robert: yeah he did yeah

Barry: which I think, certainly if it was me, it would put me thinking more than

Eddie: than the first video, yeah, yeah

Barry: if someone was trying to make you paranoid and focussed in on the one thing you'd say well "feck him"

Group: yeah

Barry: whereas if they give you the full picture the whole way round [yeah] **it would put you thinking yourself**

Interviewer: you were saying there [Robert] about having something on a sheet

Robert: yeah, he didn't say to your man, your BMI is x and if it's x plus 1 in two weeks time your, you know you'd be looking for an undertaker to help you out

Group: laughs

Robert: you know that type of thing, he didn't put him under severe pressure, he put him under some pressure but not under sever pressure, he wasn't giving him any targets nevertheless I think the message was getting through I think, but ah your man was a difficult enough subject too wasn't he, he wasn't wearing a lot of it [no, no] **he's going to have a few treats "for her" going home I'd imagine**

Group: laughs

Interviewer: yeah, yeah only for her though only for her. And ah, do you think like if you saw your score against the normal scores you'd be more likely to change

Robert: I think, ah, I think it would make a bit of sense

Interviewer: and does that make sense to ye?

Group: it does yeah

Interviewer: ah, would you say there's a good relationship or a bad relationship there?

Robert: between doctor and patient?

Interviewer: doctor and patient yeah

Robert: too good actually

Interviewer: yeah, nobody has that here, you were saying you had a good relationship in the first one (directed at Robert)

Robert: I have a good relationship with my doctor

Interviewer: and would you prefer that relationship or the first relationship

Robert: ah, well I, well it's hard to judge with there relationship because it's on a set

Interviewer: yeah, well yeah it's an imitation

Robert: On the one occasion my doctor rang me and said we got to do something about this, I sat up and we did something about it

Interviewer: yeah, yeah, exactly yeah

Eddie: yeah, but some people may not,

Robert: well that's

Eddie: some people may not

Robert: that's the impression that guy gives me, maybe because it's on a set up ya know

Eddie: mmmhhmm

Robert: he doesn't seem to be worried about it, does he?

Interviewer: What would actually cause you to worry about your health like? What would be the big stand out thing like?

Robert: results of an examination for example, you know blood tests, you have no idea, like he has no idea what his cholesterol was, and he has no idea what his blood pressure was, we've no idea what his BMI was you know

Eddie: but he did say at the beginning of the last one that everything was high so it was up above standard I suppose

Robert: but given the numbers it's an awful different thing to being told it was high, do you know, like if you were told it was 7.2

Eddie: yeah

Robert: you know whereas it should be 5.2 it's a different scenario you know

Interviewer: yeah, yeah I know what you mean yeah

Eddie: I was told today I was 6

Interviewer: and how did that make you feel?

Robert: well, you'd want to do something about it

Eddie: 6 isn't bad is it?

Robert: well, it depends on whether it's good cholesterol or bad cholesterol

Eddie: oh right, yeah

Interviewer: and did he not tell you that no?

Robert: did the doctor not tell you whether it was bad or good

Barry: mine is 4.3

Eddie: 4.3, Jesus but they'd actually rather someone of your stature go in (obese) because at least they can say cut down on something, they feel that you know

Barry: mmmm, it kills them when the cholesterol is low

Group: laughs

Barry: everything else is gone but the cholesterol is low (laughs)

Interviewer: and what do they do then?

Eddie: well in my case its kind of fries (fatty breakfast), fries and that you know greasy foods

Interviewer: yeah, yeah and would they help you out, like do they try and help you out, say, change your diet change your life

Eddie: no, they just tell you kind of try and cut back on certain things

Interviewer: and that's all, out the door

Eddie: that's

Robert: no program?

Eddie: no, no, no

Robert: no dietician to speak to?

Eddie: no, no, just one on one, just tell you out straight, try and cut down on this and hopefully we see you in six months time

Interviewer: and would that, would you go home and try that then like?

Eddie: oh I would, I would, yeah I'd try it for a few weeks and then say

Group: laughs

Interviewer: but yeah, that's it though isn't it, you'll try for a few weeks and that's the end of it

Eddie: yeah, yeah

Stephen: the dietician that I'm seeing at the moment, what they do is you see, it's a full program and you get all your meals for the day, they set it out and your, your not, your eating normal foods as well it's just the portions

Eddie: your eating good food

Stephen: yeah yeah exactly yeah

Eddie: good food yeah

Stephen: and I mean you wouldn't be hungry after it or anything, it's grand like, you go down there every fortnight you get your, you do your analysis, what you get, you get your graphs so you can visualise where you are

Eddie: at least you can see whether your up or your down

Stephen: exactly yeah

Eddie: yeah you see some people think once you leave the table hungry that it's not a meal at all

Stephen: exactly

Barry: I'll tell you a funny thing, the real reason I'm heavy is that I don't eat regular

Interviewer: your metabolism is slowing down is it?

Eddie: do you eat late at night then?

Barry: No, just if I'm busy, I don't think of eating

Eddie: seriously?

Barry: Yeah

Eddie: yeah but tis your

Barry: so when I do eat my body stores it up

Eddie: yeah

Barry: because it thinks jesus I mightn't get any til tomorrow

Group: laughs

Barry: but it's a serious problem, you'd be better off, like what did they say years ago "little and often" you'd be better off having five meals a day

Eddie: yeah, the same as feeding a pup they say, little but often yeah

Interviewer: but say you know that's a problem and it's obvious

Barry: oh I know it's a problem

Interviewer: yeah, but why don't you change it like?

Eddie: but some things you can't, you can't just eat kind of regularly if your job or your lifestyle doesn't allow you to do that

Barry: your lifestyle dictates

Interviewer: your lifestyle dictates, in what way

Barry: in what way, I worked shift for 16 years and your body tells you, you shouldn't be up and everyone else is in bed and your whole system is thrown out

Eddie: shift work would be a major one alright

Barry: Yeah, it took me about a year and a half to get back into a sleeping pattern

Stephen: I did that as well, there was 3 cycle shift in Guidant at the time, now it wasn't major but your still thrown. But at the moment the way we started going like where I am, I'm on the road a lot and work long hours your grabbing takeaways and all that kinda stuff

Eddie: it's easy food yeah

Stephen: exactly yeah, but we're given kind of a lunch box thing and you get your breakfast, lunch, dinner, couple of snacks along the way and that's it your good to go, it's ideal actually

Paddy: but with your cholesterol today and your man told you just to cut down on fries, would you, do you think you'd be just happy with that like? Or do you think he should have given you more of a, of a

Eddie: yeah, well I'm off biscuits and that, I'm off all that shite, so

Barry: and do you know these little cholesterol yogurts you get

Eddie: yeah I eat those

Barry: said to reduce it

Eddie: yeah

Barry: how many of those would you have to eat, to reduce it by one point?

Eddie: oh I, I wouldn't have an idea

Paddy: what are they?

Eddie: kind of a yogurt, a little yogurt, yogurt thingy

Paddy: right

Barry: there ah, there to improve your cholesterol

Eddie: yeah they help you kind of break down the cholesterol

Paddy: oh right

Barry: yeah I think it's about 10,000 of them (laughs)

Eddie: is it?

Interviewer: a fair bit of eating

Eddie: it's a bit of a farce then is it

Barry: no, no they actually work in conjunction with everything else but I think if you were to solely rely on them alone

Eddie: oh right, yeah, yeah. But that's one thing I hate is being on tablets, I actually hate taking tablets

Interviewer: oh go way, so if the doctor actually said to you, you have to go on tablets you'd change your life straight away, beforehand like

Eddie: well if I changed and it didn't help it, if I didn't change enough I, I'd have to take a tablet, I'd have to take it

Interviewer: but say, if he frightened you with the chance of you'll be taking tablets in two or three weeks if you don't change, would you change?

Eddie: oh I'd have to change, yeah, yeah

Interviewer: would everyone be the same

Group: oh yeah

Eddie: yeah I don't think anyone would like to be taking medication for the rest of their life

Interviewer: your on them (Robert) but were you ever given the option or were you ever frightened into changing?

Robert: ah, definitely yeah, I got two stents put in, overnight, four years ago you know [yeah yeah] **so I had to change a lot of things**

Interviewer: and did you do that because of the stents

Robert: no warning whatsoever

Eddie: yeah, some people need a good fright, yeah, to actually change lifestyle

Group: yeah

Robert: I had no warning though, in my view I was perfectly healthy, I was actually out walking when it happened, walking from my house, walking for my health. And still, even at 69 I still go to the gym

Eddie: 69, Jesus you don't look it

Robert: do you want to see my birth cert

Group: laughs

Eddie: says you, you'd want to be inside looking out

Group: laughs

Eddie: 69

Robert: but yeah, yeah, I maintain my weight now probably around 14 stone, whereas I was nearly 15 stone at that time and I was still out walking

Eddie: yeah well, exercise is great

Robert: but no warning, and sometimes that's all you need is a warning. Whereas I gave up smoking because I wanted to, I didn't need to do it, as I said earlier it's because I wanted to do it, mentally

Eddie: you have to have willpower some people give in too easy though

Interviewer: yeah, yeah

Stephen: I was the same with them myself, I'm off them 5 years now

Interviewer: and what made you change like

Stephen: I just wanted to give them up

Interviewer: you just wanted to give them up

Eddie: enough is enough

Stephen: I'm out in Saudi and you can buy 200 for the price of 10, I was buying them by the pack of 200 and I said to myself this is going down the wrong road (laughs)

Group: laughs

Robert: I was working an hour and halfs drive from home a few years back, and I'd smoke 5 fags on my way in every morning, and spit out dirty black shit out the window and so I thought this is it

Eddie: right yeah, a lot of that now is habit,

Robert: what?

Eddie: a lot of that was habit

Robert: well of course it was

Eddie: well do you know what I mean, you'd see a sign and without thinking, you'd pass something and say it's time for a fag, you know you had it timed as in the 5 fags you knew where you were smoking I bet

Stephen: after dinner when I was driving is when I used to smoke the most all the time, that was the worst actually when I gave them up, after dinner yeah and every time I got into the car I'd still be reaching for the packets for no reason

Eddie: yeah, yeah, a brother or ours now gave up the cigarettes and he'd have a box of 20 in the glove compartment. Now he was like an anti-christ but when he knew they weren't there he'd want them more

Interviewer: so just on that then, you know the way your saying if there gone you want them more, so if the doctor tells you to just cut them out completely do you think you'd want them even more and more

Eddie: yeah as you said earlier on [Paddy] cut down rather than nip it, I'd say (non-smoker)

Robert: that's very difficult to do

Eddie: is it? See I'm not a smoker you see I don't know

Robert: cutting down on cigarettes, no, no I don't think so

Eddie: either cut out or keep smoking

Robert: put a date on it and keep working up to that date and that's it bang gone

Eddie: yeah

Stephen: I didn't cut down either I just stopped

Paddy: you just stopped

Stephen: yeah

Eddie: and had you withdrawal symptoms?

Stephen: ah it was tough enough for a couple of weeks but after that it was grand

Eddie: yeah

Interviewer: Do you know when you gave up smoking, did you have to fill that with anything else, did you have to fill that void with anything else

Stephen: no

Barry: just chewing gum

Group: laughs

Eddie: some people go back to eating

Stephen: but even now I know people who are trying to give them up and their on these new E cigarettes but I don't know I think if your gonna give them up and that's about it you know

Eddie: yeah, as [Robert] says it's very hard to cut down, you either give up or keep at it

Stephen: yeah, yeah, it'll creep in you see, you'll have an extra one along the line and before you know it your back to normal in few weeks time

Barry: sister in law gave them up after 40years and she said the biggest problem after giving them up was that everything tasted of oxygen

Group: laughs

Barry: now she's still off them a year and a half now but she'd kill just to stand beside someone who smokes

Eddie: yeah, now I never smoked now but I loved the smell of the pipe, you know years ago, people with the pipes I used to love that, I don't know what it was

Others: Jesus yeah the pipe yeah

Interviewer: just on lifestyle counselling, say going in there, would ye as patients ever bring it up, would ye ever say, I want to give up smoking, I want to go down this road

Eddie: I think people that smoke, maybe try to hide it a bit, they don't mention it unless it's actually being mentioned

Interviewer: ye as smokers would ye ever go into the doctor and bring it up or would ye avoid it at all costs

Stephen: sometimes you go into the doctor and they ask you are you a smoker

Eddie: no but you, you wouldn't bring it up

Stephen: no

Eddie: no, you wouldn't

Stephen: not unless it was something to do with smoking, like coughing up a lung or something

Robert: only if it's in a medical questionnaire or something

Eddie: yeah but you wouldn't mention it if the doctor didn't mention it

Paddy: that was one thing in the video, the doctor didn't actually ask him if he smoked, he just assumed he did, he said "I get a smell" that was very strange, I've never seen that, I've often been asked by a doctor

Robert: but then your man said he was cutting them down

Group: laughs

Barry: but then the amount of people that go in and drink two pints a week and say nothing

Eddie: two pints a night

Barry: no a week

Robert: ten pints a night

Eddie: ah, I know Jesus that was a bit

Robert: it reminds me of poor auld Johnny horselips, when we started a medical program in [company name] and Johnny went in to see Dr. [name] and Johnny said, now this doctor hated drink and hated anybody drinking or smoking and he said, ah, how many pints would you drink. About ten he said, you know Johnny said. That be in a week the doctor said. No he said, in a fucking night (laughs)

Group: laughs

Barry: now the same doctor over at [company name] Christmas do was panned on the floor with sick all over him, after guzzling brandy, because it was free you see

Eddie: twas free, yeah, yeah.

Interviewer: and you were saying there that doctor hated drink did he

Paddy: who [doctor's name]

Robert: hated everything else too

Group: laughs

Barry: if you drank 2 pints a night, you were a roaring alcoholic

Interviewer: and how would you feel about that doctor now, just coming down hard on it, just a pure hatred for drinking, smoking, whatever it is

Eddie: I'd say the majority of doctors are against it

Interviewer: but he obviously did, because ye all

Barry: well I don't know about [company name] but in [company name] he was known as Jake the fake, because if he told you, you were ill, you needn't worry, but if he told you, you were healthy, 'twas a serious time for concern. You know you couldn't eat red meat because you were going to eat a heart attack. And someone asked him one day, because he was always on about the Chinese eating fish and chicken, someone asked him well what's the main cause of death in China, he could tell what the main cause of death that was here and that you should be eating fish and chicken like China but he couldn't tell what the main cause of death was there. But it actually turned out it was cancer in the colon, because it turned out that they didn't actually have enough red meat in the diet like. Everything is a balance

Interviewer: everything is a balance like

Eddie: moderation yeah

Barry: but certainly if somebody told me I was seriously sick, I'd be looking for a second opinion. Doctors differ, patients die

Interviewer: so you don't, you think if someone told you you were going to die, you'd go and find someone else for their opinion

Eddie: a second opinion like

Interviewer: yeah, everyone here like

Barry: if you were told that there's a serious noise coming out of your engine and your told the back axle is falling off, wouldn't you like to ask a second mechanic

Stephen; tis true yeah

Barry: and actually most doctors, if it's a good doctor they'll refer you on anyway [yeah] **Because they want to get a second opinion to confirm. It's like the stents, shipped on straight away**

Eddie: I actually changed doctor the other day, there in the same building but I just asked to see someone else [yeah] **just to get a second opinion**

Interviewer: and how did that go

Eddie: fine, fine

Interviewer: did they confirm or

Eddie: no, the same shite they told me

Group: laughs

Eddie: the very same

Interview: and you didn't care just once it was the same

Eddie; well I was happy, in my own mind I was happy because I thought the first fella knew me so well, that he saw me coming through the door and didn't examine it and he though ah here I'll put you on or I'll keep you on [yeah, yeah, yeah] **I just as I said to you I don't like taking tablets, so I tried to come off them, but seemingly I can't.**

Interviewer: I was talking to a doctor and say he was saying that if he frightened the life out of someone and they went off and got a second opinion and they didn't frighten the life out of them, they'd be happy out. Like so would you rather get the exact same opinion off the second doctor and

Robert: as long as it wasn't fatal

Eddie: yeah, yeah exactly. But if it was at least you'd know

Robert: but yeah, obviously if you go to the doctor and he say's you have a very serious problem

Eddie: but that's why you go to the doctor

Robert: and the next fella doesn't your obviously gonna love the second fella aren't you

Stephen: need a third opinion after that

Group: laughs

Interviewer: exactly yeah, yeah. Now if you were inside in the surgery and he said you need to lose serious weight, point blank how would you feel about that?

Eddie: your going into the doctor for advice, [yeah], **and your getting advice aren't you.**

Interviewer: so that direct, boom, is good

Eddie: yeah I think so, I'd prefer that yeah

Interviewer: Everyone yeah

Group: Agreed

Interviewer: and say on time now, would you rather spend much time in there now?

Barry: because I have weight oppose to the rest of ye, I went about it to my doctor years ago and he said, because your healthy I'm not going to get onto you about it but if you lost a pound or two it wouldn't do you any harm, gently, gently. But he said the day it

does become an issue get ready for a long one. So I know once I'm going in there once a week or once a fortnight I'm in for some going. But generally if your going to the doctor, now I'd find it very difficult to go to a different doctor, I'm going to the same doctor since he started practicing in [towns name] so I'd feel easier talking to him and I'd be more honest with him than with a stranger [yeah, yeah, yeah] **but having said that if I felt there was something wrong or I have no hearing in this ear (points to right ear) and once that started I was referred to a specialist, and I'd prefer that kind of thing, if you have a heart issue or a lung issue you should go to someone who just deals with that**

Eddie: a specialist yeah

Barry: because a GP is a general practitioner, he's not a specialist [yeah] **so if he's worth his salt, he's not gonna fix ya, he's gonna help you**

Interviewer: I was in with a doctor and he said he had a counsellor on site for this kinda stuff lifestyle counselling, and she went on maternity, and was never replaced. He said if patients left the building their probably goanna forget about it and just get on with their day like normal. Would that be common practice for you guys? Would ye walk out of the building after getting advice and ye need to see a counsellor but is in, say, another town, would ye bother?

Eddie: I suppose if you needed to I would, I would

Stephen: it depends on how serious it would be like if it wasn't too bad you might take your chances but if it was serious you probably would like

Interviewer yeah exactly yeah

Eddie: yeah

Interviewer: Anyway guys I think that's pretty much it, thanks and I appreciate your time

Female Focus Group Transcript

(Laughter)

All right so lads we'll make a start. (Video 1: the good doctor played, lasting 9minutes 30 seconds)

Interviewer: Ye can wake up now. **Laughs.** Right, ah, just on the first topic there how would you think the patient would feel or react after that? You can base that on your own experience or his experience in the video.

Susan: Well you'd freak out I suppose if you found out you were gonna have diabetes or something wouldn't ya?

Interviewer: you'd freak out?

Susan: Yeah, especially getting a needle in everyday and shit like that

Interviewer: yeah, yeah

Alice: Well it could have been all show as well, like, looking all concerned in front of the doctor, like normal most people do "oh yeah, yeah, I take that on board" (Laughter) and then go out the door and be like "he knows nothing."

Mary: I think he was very respectful in how he did it.

Alice: He took over the whole role of like psychiatrist

Joan: I thought he was more of a counsellor than a doctor

Group: Yeah

Joan: and I don't think a doctor would spend that much time on you anyway

Group: no, no

Joan: that's two things I felt about it anyway

Mary: like I thought the way he approached it rather than saying your drinking too much and if you keep drinking your going to die or it'll kill you. Like who's going to hear that anyway, it's the same thing with the cigarettes, "stop smoking, they're bad for you"

Joan: then when the poor fella went in he was all happy and then he said this, this and then your man's voice went like, what the hell

Alice: You'd be back in the week after for depression tablets

Group: laughs

Joan: But you would like.

Mary: the fact that he drank only 10/11 pints

Group: Laughs, yeah yeah

Alice: I go out there most nights but I'm not a heavy drinker

Karen: But it wasn't realistic as a doctor, like as you said (Joan) and I'd agree with you it was more like a counsellor than a doctor. Because he was putting the questions to him and kind of letting him tease it out himself, he wasn't am, telling him. Now it is probably the best way to do it now but as you said, do you know, you don't want to be sitting there and be talked to like you're a four year old. He knows himself, he's sitting there and is like yeah I'd have more money I'm drinking too much, I go home at 8 o' clock, like he knew it all himself like, it's whether he chooses to do anything about it or

Mary: But at least there was, like if you think a doctor were to approach it that way

Group: Yeah

Mary: it would be more successful

Interviewer: do you think you have never experienced that from a doctor, ever?

Group: no

Interviewer: Nobody?

Group: no, no

Alice: I have done a couple of times now, I'd have to say now, the doctor I've been to now and she was lovely like she really spent time talking to me and I was like "ah, okay". Now to be fair when I did come out I was still like, she was talking shit to me about that one but maybe she made sense with this bit but that one no, no she couldn't have a clue about that

Karen: you see sometimes I have kind of met the ones that would be like, "awh you poor auld crater, tis an awful addiction" like you know when I was smoking. And they weren't saying to me give them up they were just saying you poor crater give them up, I know it's very hard. And then you met the other ones, that when you walked in. I remember going to the doctor once and at the time I was on the pill and she wouldn't give it to me because I smoked…

Alice: I had one of them too..

Karen: and she was like treating me like I had lepersy

Group: Laughs

Karen like she was so, it was just awful, like I felt ashamed I was so embarrassed now the first thing I did when I left…was lit up a cigarette

Group: Laughs

Mary: But like, we all lie to the doctor, like when I used to smoke, now I don't anymore, but when I used "Awh, I'm only smoking 5/10 a day" You'd always half it wouldn't you?

Group: Yeah, you would yeah

Bernie: That's why they all look at me like I'm lying, because that is how much I smoke so it's because of people like you

(Laughter)

Mary: No!! you would because you know whatever they say to you, you know, well smoking is bad for you and do you know what your doing to your body

Alice: but what I do in the doctors now and I really confuse them a few times, because I knew they were going to put it all down to smoking, well I don't smoke anymore, "Oh" you can see the confusion in their face "what are we going to blame now?"

Joan: Yeah, that's happened to me a few times, they'd say "that's a bad cough there, are you alright, how many fags are you smoking?" I'd say I'm not smoking fags, I'm off them five years and they're like "Oh right, are ya?"

Karen: I don't know, lately now in the papers there was a study and I was really surprised by it, because for years it's been telling us it adds to your life if you give up cigarettes, all of us know, you know you get an extra year or an extra five or ten years depending on your age and they had that it makes no difference at all and I don't know how helpful that is to people because if you were there and your thinking, I'll give them up and I'll add to my life and then they're saying in this research

Joan: it makes no difference at all

Interviewer: but say like ah,

Alice: but what happens if you get hit by a bus? You go and you add a year to your life, like should you have got hit by that bus a year beforehand?

(laughs)

Mary: Yeah but it's your quality of life is improving when you don't smoke anymore

Joan: but they have nothing to blame it on

Mary: you don't get sick as often

Bernie: Your smell and taste

Mary: you don't get sick as much, especially when you get older, the longer you smoke the more damage it's doing to your body I found anytime I got sick, it went straight to my chest, I got a chest infection so the fact that I don't smoke anymore, touch wood, I don't be in the doctor from one end of the year to the next

Joan: yeah but

Interviewer: So like, just based on the video first

(laughs)

Interviewer: How likely is the patient to change?

(laughs)

Mary: for me if that was to happen yes I think yes you would have a better chance to change than giving out to them, like your drinking too much or you have a problem go to AA (laughs) do you know it's not going to work

Jenny: It's a better approach

Group: yeah

Bernie: I think it's 50/50 like because it's making him realise how much he's spending and how much he could save. But, it also made him realise how good he feels after it to, so it could go either way.

Interviewer: Do you think, the fact that he started we say, like, finding out how much he saves, sorry finishing with how much he saves, and the benefits of giving up would make any difference?

Bernie: Sure they'd know that at the start anyway. Like, going out to the pub with money and coming back with nothing

Alice: yeah

Mary: but he did say how much or likely he is to change, he said to or three, he didn't say I'll go straight out and change. He told him the truth. He got more out of the patient by his approach, he kind of got good information out of him, he did make him think but your right (Bernie) he good go home and have a bad day and…but he might consider drinking a little less, I think.

Interviewer: Do you think that was effective so yeah?

Group: yeah

Bernie: Yeah well he did tell him he was obese, so I think that kind of effected him

Group: Laughs, just get rid of his cushion

Interviewer: Laughs, yeah it was a pretty obvious fake bump

Mary: it was

Interviewer: Laughs, so anyway what are the things the gp did that made it effective?

Bernie: made him talk about it

Alice: he talked to him like an adult and not like some piece of shit that was on his shoe, basically.

Lucy: I think he had the patients to talk to him as well though, like it wasn't just an in and out visit

Group: yeah, yeah, the time, yeah he had the time

Karen: which is not realistic in my opinion

Jenny: Jesus no not at all they want you in and out the door

Karen: that's why sometimes I think they do just lecture us, I think they don't have the time and they just throw it out there, you'd want to do something

Joan: and they're only half listening to you when you get in there 'cause they just want to get into the next patient, they're like "oh right, yeah, yeah" and then they're giving you all the wrong stuff nearly.

Karen: the whole lot that was really effective is the fact that he let him come to everything in his own time and let him see it from himself, he didn't tell him, he knew everything that he was asking him so I think that was the most effective thing to let him find out for himself.

Interviewer: Anything else there

Group: no,

Interviewer: Anything on relationships between them, would you think it was good/bad

Bernie: he was like a mentor to him

Interviewer: kind of looked up to the doctor, yeah

Group, yeah

Karen: there was a respect there, now even when he came in and shook his hand, there was a nice, dynamic

Alice: and the way the doctor didn't stand up and be kind of like, you know he stayed sitting down and kept it informal

Interviewer: kept it casual, yeah. And has anyone ever experienced that casual relationship with there doctor

Alice: yeah, I'm telling you I have a good doctor

Karen: my doctor just looks at the laptop

Interviewer: really yeah?

Karen: yeah that's the honest to God truth

Joan: my one just stays sitting there, "how ya? What are you here for today" no

Mary: but you often find that the doctors that are good, you can never get in to see them

Interviewer: yeah, yeah

Bernie: or you forget their name

Group: laughs

Mary: but you know their often the ones that are busy, and you can never get into see them, but I do think that it would be the best way for the doctor/patient relationship to be

Bernie: it doesn't seem like their rushing you

Karen: what was good too, is he didn't show any disapproval, like when he said to him about drinking eleven pints a night, like most people again when it comes to drinking, lie.

Interviewer: yeah

Karen: like I might have one/two, like he was very honest about his drinking, you know

Mary: but I think he was honest because of the way he was

Group: yeah

Karen: he didn't disapprove, you know it's like when you smoke and you say four or five and they go "ooohhh" like as if it was twenty. It's the same for drink, like we'll say if you have one glass a night, like if you said you had the bottle what would they do like?

Joan: Yeah like a lot of doctors are very judgemental aren't they?

Karen: very judgemental

Mary: and yet they all drink and smoke

Joan: they do, every one of them

Mary: well not all of them, but they do drink and smoke

Interviewer: do you think they're realistic though the way they talk to ye like?

Bernie: not, no, no it sounds like they're reading from a book half the time

Karen: if you're going by this (video) it's how it should be but the majority of them don't. like what is a recommendation for them anyway, like both of them are bad for you anyway.

Bernie: a glass of red wine everyday

Group: laughs

Bernie: apparently it's good for you

Interviewer: apparently it is, yeah!

Mary: but what's good for you today, mightn't be good for you next year! It does vary

Karen: the goal posts keep changing

Interviewer: and do you think it's changed over time, like say with the doctors, have they changed their goal posts or is it always the same hammering home

Bernie: it all depends what the doctor is like, if they're more traditional in their ways or

Joan: I don't know, I thought they were friendlier years ago

Karen: I think some doctors, with smoking, they really hate it and

Bernie: they've no tolerance for it

Karen: you walk in and it's like a cloud of smoke has come in with you

Group: laughs

Mary: they've no tolerance for it

Interviewer: they just want you out the door

Mary: the reality is, they've gotten into that profession and your, their patient comes in and they, they shouldn't be judging. That's no good to anyone

Interviewer: yeah, yeah, yeah

Susan: your made feel very uncomfortable then

Interviewer: do you think you feel uncomfortable the whole time

Bernie: I think a lot of them judge ya

Susan: yeah

Joan: they do yeah, I think so as well

Mary: I smoked when I was pregnant, and I felt like you might as well crucify me, I might as well have been the worst mother ever and I mean, it's great if you can stop smoking if your pregnant but I didn't but I felt very judged.

Bernie: I was the exact same but I was 18 so I felt like, they made me feel so insecure because your like a young mother

Interviewer: and do you think you wanted to give up more because of them judging you or did you want to smoke more

Mary: sure what do you do when you're under pressure you smoke. You smoke more under pressure

Alice: but sure I smoked on both my two and the doctor gave out to me, and he said " you really need to give up them fags" and I said "it's like this I said, if I give up them fags, I'm going to get stressed, stress is as bad for the baby, now am I to give them up?" he said "okay you got me there" I was like "okay, grand leave me be" and then they were all saying then that "this will have an effect, and this will have an effect" the two of my babies are perfect, there's not one bit of asthma in them, they were massive babies, they were huge, and their fine.

Mary: but I mean at the same time, you wouldn't say to someone if they were pregnant now tomorrow, smoke on the pregnancy because it's good

Alice: well it would be up to her, doctors seem to think because they have half the alphabet behind their name (referring to credentials) that they have a right to tell you how to live your life

Karen: you see sometimes not being bad, but I had difficulties with smoking when I was pregnant, not being funny,

Alice: yeah

Karen: like when my first was born, the after birth had disappeared and that's one of the effects of smoking

Joan: but if you weren't smoking what would they blame

Karen: well no, no that is one of the main things that can happen as a smoker

Mary: if your smoking and you know anyway that you shouldn't really be smoking when your pregnant, now if you could have given them up, wouldn't you be doing it?

Karen: yeah you would

Mary: your not going to say, like for me to go in to someone and say and I know myself I really shouldn't be smoking, I feel bad about smoking anyway. To go in to someone then and they telling me how bad I am to be smoking, it doesn't help, it really doesn't

Karen: most people have you know, the intelligence to know

Interviewer: there's enough out there now

Karen: yeah like, but if you got a new baby and gave him a fag like, what would it look like?

Interviewer: yeah

Group: laughs

Karen: yeah, but you know that but you do it, when your addicted you addicted and when your under pressure you'll smoke

Joan: you will, you need a walking stick to get through life, whether you use the fags or the drink you just need something

Interviewer: and what would cause you to give it up like? What would be the main thing,

Bernie: oh it's always something that happens in your family, like, you wouldn't think of anything about cancer until somebody in your family gets it. I think it's true now and I don't mean it in a bad, I think you realise it that bit more when it happens someone close to you

Joan: there's willpower though as well there

Karen: it's really a personal choice, like for me, giving up cigarettes, it was sitting down and saying do I want to keep doing this, spending seventy quid a week on this..

Joan: yeah, but you had willpower then didn't you?

Karen: you know, but I saw all the negatives of it I didn't see any, anything good about it anymore and that's why I gave them up

Mary: it's all about changing your thinking and for me that's what worked, I saw that I didn't, I made a decision, I saw and in my head I didn't want to smoke anymore, I wrote down all the reasons why I didn't want to smoke (clears throat) and it was the hardest, it's very hard, when you want to smoke it's so hard

Alice: then with this whole doctor thing we're after watching, with the way the doctor was saying it to your man, he might come to that realisation where he's going to write them down

Mary: yes

Alice: he mightn't give it all up completely so I reckon that was kind of the effects of how the whole consultation was like the way we're all putting it in to our own perspectives or whatever it's called, it could turn out that way for your man

Mary: it could send him home and actually think about it, he actually talked, he probably never actually talked, so now he was actually thinking about why he was actually going out

Alice: he probably never even spoke out loud about it either, never mind think about it

Interviewer: would you say he'd need more help after that then like?

Alice & Group: oh he would yeah, oh God yeah.

Interviewer: like your not going to just drop it after one or two chats with your doctor

Group: oh no, no, no

Mary: he's only 2/3, you know, like he said how confident he was in changing and he said 2/3 and that's a long way a way from

Joan: it is

Alice: like he's not bad enough to go to an AA meeting but he's not bad enough to or or

Interviewer: good enough

Alice: good enough to get off it that fast

Mary: but what's he going to replace it with? He had nothing else? That was his only outlet

Alice: that would be him then trying to, right, go back playing golf or becoming the designated driver and you could still have the craic, whether your drinking or not

Mary: he needs to replace it with something else would be the first thing

Joan: he does yeah, he needs to find another way to meet his friends doesn't he?

Interviewer: do ye all feel that? That ye need to fill your void with something else

Bernie: oh God yeah, I gave up fags and took on food

(Laughs)

Mary: it must be a positive thing though, like I hate that when people say what are you going to give up for the new year, instead of what, what are you going to take up?

Interviewer: yeah

Mary: rather than actually giving up something this is an opportunity to take up something new, so he might decide,

Bernie: for him it has to be something in the evenings, that's when he get's his cravings the most

Joan: yeah, that's when he needs it yeah

Mary: he needs to, he needs to meet people he's very isolated, he's locked in his world and

Bernie: he needs to get out of the house anyway

Alice: he needs to, like he's drinking 10/11 pints and even if he cuts that down to 6 he's still going to miss that amount of alcohol, like that's what knocks him out in the night time. So he's going to be even more messed up with the lack of sleep because, it'll be normal sleep and not drink sleep. So he is going to need an awful lot of help, so if that does happen, the doctor he better be good and not just for the video but he needs to help him out afterwards.

Karen: you see this is it, like where is that kind of help going to come, like is it, like were saying that the most effective way for somebody to give up and addiction like say drinkers, to support, talk and where do you get that? He's not an alcoholic per se he just needs support

Joan: yeah

Karen: where would you get that kind of support?

Joan: where would you get it yeah?

Karen: and the doctor can't give it

Bernie: by taking up a hobby I suppose, going out and doing a sport I suppose, anything.

Interviewer: I was with a doctor last week and he was saying, that am, that they had kind of a counsellor in house like and then she went on maternity leaf and they never replaced her because of the budget and things like that

Karen: Yeah

Interviewer: and do you think that person in house is really important?

Group: oh God yeah!

Mary: and then you know how many people can afford to go and see a counsellor? €30/40 a visit like, how many people can afford to do that?

Interviewer: mmmm

Joan: most people would say that I might as well stay on the drink rather than do that

Mary: yeah!

Joan: like at least I know where my €40 is gone

Bernie: 50 euro a week sure I'd spend that on drink

(laughs)

Mary: he could have got 3 or 4 nights out for it couldn't he?

Interviewer: you kind of have to want to give it up though, like obviously, if your thinking of spending money on drink rather than a counsellor your not gonna give it up anyway, so

Group: yeah

Mary: I do feel though that if that was the approach it would be more effective that, just giving out to people.

Interviewer: okay. Sure look we'll watch the other video so and see what ye think of that one.

(Second video: the bad doctor lasting 7 minutes 40 seconds)

Mary: oh, I don't like him anymore.

Interviewer: there's a few Oscars in this

Group: laughs

Joan: he just assumed he wasn't eating healthy and he assumed this and he assumed that, he judged him there and then

Alice: he was kind of condescending, he was, so the patient felt after that consultation

Joan: that he wanted a fag anyway

Alice: that he wanted to puck him in the jaw

Bernie: like I have to say, he blamed his wife for everything like

Joan: he did ya

Bernie: it's her fault they were getting a treat

(laughs)

Mary: he's on the defensive, did you see him on the chair (leans back)

Interviewer: Do you think he went like that because of the doctor?

Bernie: oh God yeah, yeah, he just gave him no chance to speak at all, no praise for anything

Joan: but he just assumed that he wasn't doing anything, didn't he?

Interviewer: Okay, so yeah is that more realistic or

Bernie: Oh God yeah, it's from a book completely

Joan: that's definitely a doctors office

Interviewer: your not being one bit harsh, that's exactly what's there?

Joan: that's exactly what's there

Karen: he didn't listen to him at all

Group: no, no

Alice: he was actually thinking there, right the specials this week in the chipper are

(laughs)

Alice: I have about ten euro in my pocket, I reckon I could get two pints and maybe a lucozade and bring it home to the wife

(laughs)

Alice: the exercise he was putting down as well was that I walk to the pub and sure I walk home again

Group: yeah

Alice: now if a doctor is speaking to him like that, he is going to be, I get my exercise, it is 30 minutes, 15 each way, I'm sitting down, I walk to the toilet, sit on it. We all know, no matter what age you are, if someone speaks to you like that you're going to go how dare you

Jenny: you get defensive, yeah

Karen: and it's not realistic, he's saying to him give up everything

Joan: everything

Karen: give up your drink, give up your food, give up you know all the things that

Joan: he never said give up the wife though

Mary: ah she's sick, your hard on the wife she's sick

Joan: she's draining his pocket though

Group: Chatter

Joan: anyway any doctor would tell you to go off the rails for a day or two anyway

Alice: what doctor do you go to?

Interviewer: Do they? Do they really?

Joan: well do you know in terms of your diet, your entitled to do one bad day, you are yeah, every doctor will tell you that

Bernie: one bad day though

Interviewer: one bad day, yeah, but like let's say it's a problem like, it's a proper problem not just one bad day

Joan: he does it once of twice a week

Interviewer: Every week

Background: every week

Joan: you're a good boy for 4 days and well

Jenny: it depends how bad you are

Bernie: but he's not explaining anything to him, he didn't understand anything,

Alice: yeah he went waffling on about the cardiovascular

Susan: yeah using all the big words like

Alice: yeah, heart disease, I'm talking about heart disease

Joan: and he kinda saluted him at the start of it the way my one would salute me, "how ya, what's wrong with ya"

Bernie: that's like my doctor as well, don't even look at you in the face just read from the book

Interviewer: you're saying that a lot, do you think the doctors just constantly look at the books

Bernie: A lot of them do and there is some good ones out there (mumbles, mainly women) but

Mary: I think the worst thing in recent times in the doctors office is putting in the computer, the computer is the worst thing that ever happened the doctors

Joan: yeah there losing contact with the patient

Mary: and they're so busy looking up your records

Joan: and writing stuff

Bernie: half the time they don't even look up your records, I remember I was 4 months pregnant and I walked in there and they were like "what's wrong with you" and I'm like "I'm pregnant"

(laughs)

Karen: that consultation was a waste of time though really, that man was going to go out and he wasn't going to change one bloody thing

Bernie: he probably wouldn't even go back to him

Karen: so it was really a waste of time, the doctors time and the patients time

Joan: I couldn't see him going back to that doctor again, he'd say can I see a new doctor, that's what I'd be saying

Karen: you see I don't know, I would have went to doctors that gave out to me about cigarettes and I would have went back to them when I needed to. I'd just go in for the anti biotic

Joan: I wouldn't go back to that now

Mary: I rarely see my doctor from one end of the year to the other touch wood

Bernie: I'm in there nearly every week

Interviewer: yeah, but ye've said that that is the same as any doctor ye've ever been to and yet ye always go back like, so is it really true to say you're not going to go back like

Group: mmmm, yeah

Bernie: there's so many doctors to choose from now

Alice: you go back you see because you can't get in to see any other doctor

Joan: That's exactly it yeah

Karen: well it's not even that too, there's part of me thinks that anyone I go to is going to be the same anyway and I only, touch wood have to go once or twice a year anyway so

Bernie: I don't know, I think they're all completely different. Now I'm not saying anything about men and women but my doctor is male and I will only go to a female doctor because I feel they listen more

Karen: Do you yeah

Bernie: oh absolutely, the male doctors are really abrupt

Joan: my one is female and she might as well be male if that's the case

Alice: all doctors are completely different

Bernie: completely different yeah

Alice: one could go the old school way, one who's straight out of college and actually reads out of a book and then you have the ones there that are comfortable, there not old school and there not new

Bernie: they're there for the money

Alice: no, they speak to you and actually look at you like a human being other than a walking disease

Mary: it's just so many doctors are just so busy and sometimes you only go to the doctor when they are busy, like you only go when, like people only go when they're sick but yeah, I'd say there in the minority though, doctors that you can talk to.

Interviewer; yeah

Mary: I would think they're a minority

Interviewer: and would you, you just hit on it there, would you ever consider just going to the doctor because you want to give up any habit, like drinking, smoking or you want to give up

Group: no

Interviewer: nobody would ever consider that

Alice: I did, I did and they gave me out them patches, and the patches didn't work and there was no like checking up to see how I got on, later I went to the doctor because I was sick that time, and there was no oh and how are you going with the..it was just like that time you were giving up the fags and after that it's just like a phase

Interviewer: so they never went back to you,

Alice: no, they never got back to see how are you getting on with them, are you still of them, do you need any more help. It was like just and episode of eastenders, off the fags the today, next a runny nose and then dum dum dum dum…what's next on

Group: laughs

Mary: you could write Eastenders

Karen: I'm not watching it now I'm telling you it sounds boring

(laughs)

Interviewer: her story or the actual one? (laughs) Oh my God…..Anyway how do ye feel about scare tactics? Like do ye respond to that at all?

Alice: you see the way the first, well I know it's the same doctor, but the first one they way he went about it, he done it in such a way that it was nice, it was a nice scary. But the second part, he just came across like an obnoxious prick who drives a BMW

Bernie: I think to a certain extent though he should let someone know the damage it's causing

Alice: but he didn't need to be so condescending

Joan: he just assumed that everything he was doing was wrong

Bernie: yeah and he just didn't ask him anything and just talked

Joan: but just assumed everything is wrong, I would feel very bad if someone was like to me well you Jesus you have to give up everything really.

Interviewer: and what would, what would frighten you to change?

Mary: I seen a fella with, am, diabetes and he lost a leg and he was going outside the hospital for a fag. I'm not being mean. But fear tactics are not working, I mean forget it, fear tactics were not working there

Interviewer: but for you guys, like, you as a group what would make you scared into stopping

Mary: I stopped smoking for my health

Joan: I gave them up because I didn't like the taste of them anymore

Karen: for my health I did because I was going on steroids every time I got a chest infection and you do you sit there when your on steroids and you know its from the fags

Joan: I just didn't like the taste of them anymore, nah, just don't like them and started looking at all the things I didn't like about them.

Mary: the reason I gave them up is because I went out for dinner and you weren't aloud to smoke anymore in the restaurants and I was trying to get a cigarette in between the starter and the main meal and between the main meal and the desert and it struck me I said, Jesus eating is interfering with my smoking (laughs) I couldn't enjoy the fag I'd only have it lit, and they brought down the main meal and I thought could they not wait until I finished the cigarette

Group: laughs

Mary: I hated that feeling of that I couldn't actually sit down and even enjoy a meal without having a cigarette, cigarettes were even controlling how I eat when I eat. But you know, nowadays I think there's no excuse for anyone, I if they smoke, they know the damage they do I mean there on the packets of cigarettes. I mean you can see the pictures that are on them

Joan: but most people now that are smoking, right, are inside working and there thinking right I need 5 minutes this is driving me crazy, the first thing they'll say is right I'm going for a fag. They're not going to go right I'm going to go for a walk around and get a bit of fresh air

Mary: but when you stop smoking that's what you do, you will go out for a walk and fresh air

Joan: no you wouldn't, I wouldn't, there's no way if I was stressed that I would go out and go for a walk

Mary: why?

Joan: if I was smoking I'd be gone out 20 times

Mary: where I work now, I'd go up to the staff room for a drink of water just for a few minutes and get away from it all. I'd get a glass of water and just take that few minutes to chill and if I was under pressure and needed to get away even the walk from my class to the staff room gives you time to chill out

Karen: But I think where this is effective is, do you know that man who had lung cancer and it reappeared, I think those kind of stories do, for me, I had met a friend who developed emphysema and is it COPD on the lung

Jenny: COPD yeah,

Karen: but because she was 6 years older than me I was giving up and

Joan: but isn't it too late to give them up then

Karen: well it's not they can still have, a quality of life that they won't have if they keep smoking. One had emphysema in one lung and the other was clear and he said if she stopped smoking it would stop there and she would have a better quality of life but she kept smoking and I think for me especially if you someone you know says, I got this diagnosis and oh God here I am

Lucy: then again I don't know, like my sister in law died before Christmas of cancer and she never drank or smoked in her life

Group: yeah

Joan: and what do they blame it on

Karen: but you see emphysema is from smoking

Lucy: ya but Cancer is a big one that always gets thrown in and I know people who smoke all their lives and are fine and people who've never smoked develop cancer

Mary: yeah like we all know people who have died from cancer who never drank or smoked and another guy I knew lived until he was 95 and he was smoking 20 cigarettes a day and lived to that but they are the exceptions, that's the reality. People who smoke and I smoked myself, you always think well I'm different it won't effect me. But as you get older and you smoke as you get into your 40's and your 50's

Bernie: you can't walk up stairs any more

Lucy: but the damage is done at that stage

Joan: that's what I'm saying

Lucy: like my next door neighbour was smoking for over 20 years and she gave up the fags and one year later she died and she got every illness under the sun because obviously the smoking was actually protecting her in the end because it was clouding everything and the minute she gave them up everything came on top of her

Joan: that's what happened my father then as well, went to the doctor they told him give up the fags, he came out quenched the fags end of story and then he got sick and died.

Mary: but that could have happened anyway, people stay smoking and they die as well

Joan: but the damage was already done, why ask him to give up if its that late in life

Mary: I suppose it's more the fact that life is missing something but the reality is I don't feel like I miss out by not smoking anymore.

Lucy: and how long did it take you to get to that stage

Mary: (Clears throat) it took me about a year

Alice: and did you get help from a doctor or was it all from you

Mary: I tried a load of times but you really have to be thinking

Alice: but that's your whole experience do you think your man there will go and

Mary: he's on the right track in that he's looking at his drinking, why he's drinking, costs, so he knows now why he's drinking the way he is, he knows the impact it's having on life. Even the fact that his son, 17 years of age said it to him, that really upset him and he didn't want that

Joan: how do you know that's going to effect him into giving them up

Mary: I'm not saying it's going to but it's a good start

Alice: yeah in the first video he got into his head but in the second he just

Background: he definitely would have been drove to drink in the second

Mary: he was depressed after it, it actually made the situation worse

Karen: I think it's the talking that makes the difference, like all the scare tactics that may be used and the lungs, the rotten lungs on a packet of cigarettes, I never, I mean they never effected me when I was smoking, the same with drink it never effected me. For me it's real people, like that man dying of cancer, like it's too late and it is that's too late. But again as you said it is luck too, there's people who've smoked for 40 years and never developed cancer or any kind of cancer

Interviewer: yeah

Lucy: it's your genes, I think an awful lot is to do with your genes

Karen: but it doesn't help

Mary: there's a lot more chemicals in them nowadays

Group: oh God yeah

Bernie: a chemical that helps quench it on it's own, like what's that doing

Susan: yeah to your body

Mary: they knew what they were doing adding in chemicals to make them addictive, like that's negligence. But even now, despite all the fears with smoking, there is still a subliminal message about smoking being cool, because still how many young teenage girls are still smoking

Joan: there not as many as they used to I don't think

Mary: but a lot of young girls smoke because they want to keep their weight down

Bernie: I was handed my first fag when I was 8 by a 12 year old

Group: oh my God

Bernie: now if I seen someone doing that to my own child I'd break their legs, wouldn't you

Background: you would

Bernie: I'd clatter them, drag them up to their parents and make sure they clattered them as well

Karen: would you like to see your child smoking?

Bernie: God no, if he asked me to stop smoking in the morning I'd stop

Interviewer: if your child asked you to stop smoking you'd stop?

Bernie: I would definitely

Joan: and why not give them up now before he asks?

Bernie: I've tried

Mary: my young one said "Mammy don't smoke in the car" and I'd smoke in the car and it's one thing that stopped my smoking, she got caught smoking and buying cigarettes and I swore I'd never give her a cigarette and I never gave her one and she smokes now, she's 23 but I'd never give out to her over it because it's her decision

Bernie: I bet ya she'll give them up in her own time

Mary: nothing to do with me I can't make her, but I think if you grow up in a house where there's smokers

Bernie: yeah if you grow up around it

Mary: then if you say don't smoke

Joan: I don't know now

Karen: I don't know either, my daughter was reared around fags and she hates them

Bernie: yeah I used to hate getting into my friends car and the smell

Alice: my parents never smoked around me and I became the black sheep smoking, drinking, you name it, hanging on street corners

Group: laughs

Interviewer: so just to finish up then, if a GP was to suggest that you needed to lose weight, give up smoking etc. how would/should they approach that?

Alice: they'd have to stick by ya

Interviewer: but if they just were to come point blank out and tell you, you need to lose weight

Bernie: they need to give you options and ways, like everyone is not the same

Alice: yeah but if they turned around and asked you

Bernie: but that's the way he was in the last video, like, I have the exact way you need to go but that doesn't work for everyone you need different options

Lucy: but he's asking something that's impossible, lose weight, give up the fags, give up the drink

Joan: there's two ways of looking at this, if your down on yourself at all and the doctor says you need to give up this, lose weight and your going to feel worse than you already are, whereas if your confident at all and he says this is this and this is this, then your gonna say okay

Bernie: yeah but then when your having a bad day, your thinking about the weekend, comfort food and fags

Susan: and when your drinking anyway you need a fag, you smoke more when your drinking

Bernie: and the food afterwards is just the cherry on top

Joan: but the doctor didn't know if there was anything behind it,

Bernie: exactly it could have been stress, anxiety or anything behind that

Lucy: and then when he said there was a smell of smoke off him, like he didn't know if he was off the fags a week or two weeks

Bernie: or if somebody was smoking around him

Lucy: he could have been in the car with someone who was smoking, like you know if you go out and someone, your friend smokes, and you smell of smoke. So he was obviously judging him before he knew anything else

Interviewer: yeah yeah exactly yeah

Joan: I found him very judgemental and if he was anyway unstable at all he would have driven that man worse

Interviewer: Okay guys, we'll leave it at that, thank you for your time.