

Interaction Opportunities in the Health Sector – Developing Professionals’ Counselling Methods

Linda Dalbom^{1,2}, Nella Hiivola¹, Sara Niemelä¹, Harry Köhler^{1,3} & Päivi Rautava^{1,2}

¹ Public Health, University of Turku, Finland

² The Wellbeing Services County of Southwest Finland/Research Services, Finland

³ Organisational Communication, University of Helsinki, Finland

Correspondence Linda Dalbom, doctoral researcher, Public Health, University of Turku, Finland. E-mail: linda.dalbom@utu.fi

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Abstract

Promoting the customer’s change in lifestyle is considered important in health care, but professionals often feel that their methods are insufficient for effective lifestyle counselling. The study describes what kinds of interaction methods are used by health sector professionals in lifestyle counselling. The study aims to find out whether health sector professionals had adopted the method from the further training course on interaction as part of their own practices for customer encounters. The data consists of audio recordings, collected in 2018–2019, of discussions between diabetes specialist nurses who had participated in the interaction training (n 6) and customers (n 23). The method of analysis used was theory-based content analysis. The customer-centred interaction methods used in the appointment discussions were listening to the customer, giving space, open questions, challenging the customer and having a meaningfulness discussion. A general observation was that the methods were not used sufficiently, and they were not used throughout the appointment. The majority of professionals did not include the new way of operating as part of the appointment. Professionals need to have the skill to recognise the customer’s individual capabilities to reflect on their own health and to support these capabilities. These professional skills should be strengthened and their adoption should be supported.

Keywords: interaction, counselling, further training, professional development, implementation

1. Introduction

This study examines the lifestyle counselling carried out in health care customer work, counselling as a professional’s tool, and strengthening counselling skills through further training.

Promoting changes in the customer’s lifestyle is considered important in health care, but Jallinoja et al. 2007, for example, observed in their study on professionals’ views on lifestyle counselling that a large number of professionals felt that their methods were insufficient for effective lifestyle counselling. Salmela (2012) defines lifestyle counselling as an interactive process which aims to promote the customer’s health and well-being by supporting the customer’s own capabilities for a lifestyle change (Salmela, 2012). Counselling is its own professional skill, and counselling practices play a central role in the support of adults’ life questions and change processes (Vehviläinen, 2021). For this reason, it is important to develop professionals’ counselling capabilities through further training and support professional development with the help of interaction skills, in order to make it easier for professionals to learn and change their ways of operating.

1.1 Customer-Centred Counselling

In customer-centred care and patient counselling, the essential thing is the customer’s perspective and the interaction taking place in the patient care relationship. (Suhonen & Stolt, 2013). In customer-centred lifestyle counselling, change and counselling are based on what the customer values and needs, and as well as their own desire to participate in their care. (Kosklin, 2013.) The customer and their needs, opinions, values and traits are at the core of customer-centred care (Poochikian-Sarkissian et al., 2010).

The theoretical roots of counselling are seen to be in psychology and pedagogical, andragogical, sociological and philosophical sciences. (Vehviläinen, 2021).

Vehviläinen has examined the interpretations and status of counselling in society for a period of 25 years. In this, she identifies three kinds of basic assumptions. In the first interpretation, counselling is seen to help people cope with the challenges set by a changing society. This interpretation can be considered pedagogical or psychological, and it displays a trust in the opportunities of counselling to find sensible solutions to meaningful questions in one's life. According to the second interpretation, counselling is a mechanism that highlights the individual's responsibility, which pigeonholes and controls people and maintains inequality. The critique within this interpretation is particularly targeted at the self-control. The emphasis on personal development and self-improvement is evident in the increasing demand for individual exercise and self-shaping. In the third interpretation, counselling is seen as falling between the abovementioned interpretations, where the approach of counselling is hope-seeking and aims to build a better shared life, that is, the so-called caring perspective. It recognises the opportunities of counselling operators to act actively as a critical force. In this study, counselling is seen to fall in this third interpretation of a middle ground: counselling attempts to support the customer in considering a lifestyle change as important due to the things they feel are important and meaningful in their own life (view of counselling as a method of coping), and attempts to inspire the customer to reflect on their own health and impact opportunities in the promotion of their health (view of individual responsibility).

1.2 Self-Direction in Learning

The modern view on learning has in many cases abandoned the idea that learning arises from receiving information, considering it to be too one-sided. (Rauste von Wright & Wright 2003). Already Hersey and Blanchard (1980) and Grow (1991, 1996) observe that the learning of an individual acting in an organisation is the increasing or strengthening of self-direction. As the learner reaches higher levels of learning, their self-direction increases. They are able to evaluate their own habits in relation to what they have learned and reach their own conclusions or even intuitive, subconscious solutions. Grow presents four levels of self-direction: dependent, interested, involved, and self-directed.

Oikarinen (2002) defines the levels of self-directed learning as modification and innovation. Modification means the controlled refinement of what has been learned in accordance with the requirements of the environment and situation. Innovation also includes searching for new ways of operating to reach objectives. The individual then cannot objectively reflect on their actions in relation to the new objectives. Oikarinen (2002) describes that kind of learning as imitation by its nature, the repetition of a given model and acting in accordance with the model.

In teaching, the learner's attitude toward their own competence and need for learning is vital. If the learner recognises the need for development and learning, they have the prerequisites for evaluating their own competence in relation to new objectives. Absorbing new things includes continuous questioning and re-evaluation. The learner has the prerequisites to renew their competence and operating model. Learning is, by nature, problem-solving and adapting. (Argyris, 2004; Oikarinen, 2002.)

Learning a new way of operating is a multilevel phenomenon. Learning which leads to adopting and applying a new practice requires sufficiently in-depth effects on the learner's information, attitudes and operational capabilities (Köhler, 2019). It is important to recognise and understand those factors which increase the effectiveness of training interventions and the adoption of evidence-based good practices in the work of health professionals based on internal and external stimuli of the learner.

Argyris (2004) states the key challenge of learning is the learner overestimating their own level of competence. Argyris believes that the individual has the tendency to cling to the current state and current model of thinking, and their ability to tolerate uncertainty is limited. If the learner does not feel the need to question their own competence, they are not able to unlearn their old operating model. Old habits guide their activity and they act in accordance with them subconsciously, without any questioning. They have learned that, in acting this way, they will reach their objectives. The individual then cannot objectively reflect on their actions in relation to the new objectives.

1.3 Interaction as Part of a Health Sector Professional's Competence

In a successful interaction, the customer gains information and understanding with which they can, if needed, change their view on their health and condition, and become more ready to start a lifestyle change (Cloninger, 2013). From the customer's perspective, these impacts caused by the interaction can be seen as a learning process. Changes in information, attitudes and actions can be examined as a learning process (Falvo, 2011; Köhler, 2019).

The interaction situation in customer-centred counselling highlights the equality of the discussion's participants (Oksanen, 2014). In interaction which progresses change, the professional recognises what the change means in the customer's daily life and what opportunities the customer has for change. In that case, the professional is able to support the change in the correct way. Objectives are set in such a way that the customer is able to commit to

them and can start working towards them on their own initiative (Köhler, 2019).

In a customer-centred counselling situation, the professional must know how to give the customer space and responsibility for decision-making (Lindahl et al., 2019). Open questions can be used to support the customer in talking about their feelings, thoughts and experiences with their own health and the factors which affect it. By giving the customer time to answer and think things over, the professional signals their desire to listen and the customer has the opportunity to also ask questions (Järvinen, 2017). Questions which can be seen as non-customer-centred are those which often seem to contain the questioner's presumptions and thus lead to giving short answers, either with a negative or positive (Oksanen, 2014).

Speech taking place in the lifeworld, on the other hand, rests on the customer's subjective experience of the course of their own life and their everyday. It consists of the things the customer feels are meaningful (for change, either positive or negative), which can be connected to, for example, work, hobbies, social relationships or beliefs and values. Taking the lifeworld into account supports the customer in considering the aspects that hold significance in their daily life. It helps them become aware of and reflect on their existing assumptions regarding both old and new information.

In a meaningfulness discussion, the customer is supported in internalising why a lifestyle change would be important to them specifically due to the things they personally find meaningful. In a realisation discussion, the customer can be challenged to ponder their health and opportunities to affect it. The aim of meaningfulness and realisation discussions is to support the customer in thinking about and reflecting on their change objectives and in adopting the lifestyle change (Köhler, 2019).

Professionals are familiar with counselling interaction methods, but often fail to make use of them. They feel the methods are laborious and learning them is difficult (Mauksch, 2008; Absetz, 2019; Liira & Hietanen, 2019; Downey et al., 2021.) New evidence-based data on the benefits and effects of the methods in customer work are required.

2. Purpose, Research Questions and Objective of the Study

The study describes the interaction methods used by health sector professionals in lifestyle counselling. The purpose is to find out whether health sector professionals had adopted the method from the further training course on interaction.

This study examines as a criteria of learning whether the nurses applied customer-centred interaction practices in accordance with the situation as a tool of treatment. Effectiveness is examined on two levels. We take into account the effects of teaching on the nurses' way of guiding discussions with customers, as well as the effects that the learned manner of speech has on customers. Both of these levels of effectiveness are necessary when the aim is to increase the effectiveness of the care discussion through teaching.

The customer-centred practices examined are the meaningfulness discussion, which promotes customer reflection, challenging the customer, which encourages realisations, and open questions and providing space.

The non-customer-centred methods examined are the skipping of the meaningfulness discussion, leading questions and an advisory and instructive style.

We pay attention to the nurses' ability to question and renew their skills and produce new ways of operating by observing:

- a) whether an old practice can be observed from the nurse's manner of speech (=health talk, open questions without follow-up questions and discussion) or if they try to apply the new way of operating (=recognise and take into account the customer's needs in their own lifeworld, using open questions to start a conversation).
- b) whether the nurse seems to repeat open questions in accordance with the model or whether they adapt in accordance with the situation and to help the situation.

2.1 The Research Question Is:

How did the diabetes specialist nurses who completed the interaction training incorporate the new way of operating as part of their own customer encounter practices?

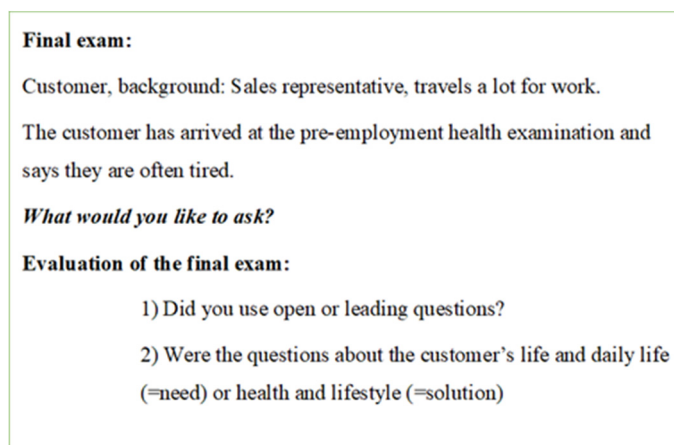
The aim of the study is to gain an understanding of how training can be used to put a new way of operating into practice.

3. Materials and Method

3.1 Target Group and Data Collection

The Southwest Finland health care district area took part in the Effective lifestyle counselling for social and health care cross-functionally (initials in Finnish VESOTE) key project funded by the Ministry of Social Affairs and Health in 2017–2018, where the aim was to develop the effective and goal-oriented lifestyle counselling of social and health sector professionals, as well as related good practices, operating models and competence. As one measure of the project, the “Becoming a lifestyle counselling professional further training course was implemented for social and health care professionals. The training strengthened competence in nutrition, exercise and sleep lifestyle counselling, as well as effective patient communication.

The aim of the effective patient communication course was to teach professionals a practical customer-centred method for interaction. Teaching included four approximately 45-minute lectures. In connection with the lectures, participants completed reflection and practice assignments in small groups, with the aim of pondering on and internalising the reasons, effects and application of what was taught. Between lectures, the students tested the taught methods and reported on them to the shared discussion platform. At the end of the training, the students completed a written final exam, which tested their knowledge of the taught customer-centred interaction methods in a practice situation. Before returning the exam, the students got to evaluate their own answers with the provided evaluation instructions. The aim was to strengthen self-direction by learning to reflect on the reasons and effects of the method they were taught. There was no evaluation of the final exam; self-evaluation was used instead, which was more important in terms of learning than feedback received from a teacher. The assignment and self-evaluation instructions for the final exam are presented in Figure 1.



Final exam:

Customer, background: Sales representative, travels a lot for work.

The customer has arrived at the pre-employment health examination and says they are often tired.

What would you like to ask?

Evaluation of the final exam:

- 1) Did you use open or leading questions?
- 2) Were the questions about the customer's life and daily life (=need) or health and lifestyle (=solution)

Figure 1. Final exam assignment and self-evaluation instructions

The data consisted of audio recordings collected in 2018–2019 of interactions between six diabetes specialist nurses and their customers (n 23) during appointments in five municipalities in Southwest Finland. The duration of the appointments ranged from 20 minutes to 90 minutes. The data collection was part of the Southwest Finland health care district's project's evaluation, and a university of applied sciences' nursing thesis was also written using the data.

The target group of the present study was six diabetes specialist nurses who had completed the “Becoming a lifestyle counselling professional” further training course and 23 of their customers, who happened to have appointments during the study. There were 14 women and nine (9) men. The average age of the female customers was 68 years old (range 49–84 years) and average age of the male customers was 64 years old (range 52–75 years). The unifying factor was type 2 diabetes and the need for lifestyle counselling. All diabetes specialist nurses who took part in the study were women.

The producers of the recordings acted as bystanders and the appointment situation was conducted as normal.

3.2 Analysis of the Material

3.2.1 Analysis of the Appointments

The total duration of the audio recordings was approximately 22 hours. When transcribed, the text totals the equivalent of 203 A4-sized pages. The transcription focused on speech related to the customer’s reason for coming and ailment, as well the need for lifestyle counselling and guidance. Parts which were irrelevant to the study were left out (e.g. speech relating to medicine dosages and booking future appointments). The discussion was recorded in audio format only, meaning that the study material did not offer the opportunity to analyse expressions and gestures. The study sought to identify the customer-centred and non-customer-centred interaction methods described in the framework in the appointment discussions. In the customer interviews after the appointments, the appointment experiences and intentions for change were evaluated.

There were two phases in the analysis of the material: first, the appointment recordings were analysed for the kinds of customer-centred interaction methods the health sector professionals used.

Second, the study looked into which different stages the learning self-direction seemed to be in.

For the question of what kinds of customer-centred interaction methods the professionals used, the answers gained were grouped into five subcategories: open questions, meaningfulness discussion, challenging the customer, leading questions, and skipping the meaningfulness discussion. These subcategories are the customer-centred and non-customer-centred methods described in the theory section. An example of the summarised analysis frame is described in Table 1.

Table 1. An example of the summarised analysis frame, containing the interaction methods used by health sector professionals. (Rautava & Niemelä, 2019)

Original expression	Subcategory	Supercategory	Main category
H6: “What is your exercise like now?”	Open questions	Customer-centred interaction methods	Interaction methods used by health professionals
H3: “Can you tell me a bit about what your eating habits are like?”			
H2: “...but then I’m thinking about what your resources are right now to change [your lifestyle], we need to think about that. What do you think, is there something that’s possible for you to change there?”	Guiding to meaningfulness discussion	Customer-centred interaction methods	Interaction methods used by health professionals
A20: “Yes!”			
H1: “So, how is your health?”	Challenging to reflect on their own health	Non-customer-centred interaction methods	Interaction methods used by health professionals
A4: “I don’t know, things ache... I can manage with a painkiller, though.”			
H1: “Yeah. Have you thought about what it might be related to, the aching? What situations, does it happen after something?”			
H1: “What do you think about [smoking]?”	Challenging to reflect on their own health	Non-customer-centred interaction methods	Interaction methods used by health professionals
H2: “What do you think, is it possible for you to change something?”			
H2: “Have you been feeling well?”	Leading questions	Non-customer-centred interaction methods	Interaction methods used by health professionals
H1: “You’ve exercised?”			

A20: "...Yeah, I'm more tired than usual, but work and home, both are kind of stressful. I've been thinking that's why I'm tired." Skipping the meaningfulness discussion

H2: "Yeah, sure, those blood sugars, the level is a little high..."

3.2.2 Learning Analysis

For the analysis, a division was made for identifying the learning stage: does the nurse repeat what has been taught and act according to the model, or do they think about and adapt what they have learned to the situation and objective. The pair of options are acting according to the model and acting according to the situation.

The most important subject of observation was the open questions used by the nurse. For example, if the nurse used open questions which were aimed at the customer's life, daily life and values, they were implementing the taught model. Learning the way of operating is, by its nature, imitation and represents a low amount of self-direction (Argyris 2004, Oikarinen 2002, Grow 1991, 1996). If it seems like the nurse is consciously using open questions to try and shift the focus of the discussion from the world of health care to the patient's lifeworld, it can be considered as adapting. In this, it is possible to recognise the learner's ability to evaluate the learned way of operating in relation to previous ways and their own problem-solving in applying the way of operating to the specific situation at hand (Argyris 2004, Oikarinen 2002, Grow 1991, 1996). A characteristic of adapting was seen in particular when the discussion continued after the open question, such as through a further follow-up question which activated the customer and gave the customer space to think over their own values and expectations.

In examining learning, the division proposed by Oikarinen (2002) was applied: imitation, modification, innovation, combined with Grow's (1991, 1996) definitions of self-direction. We apply it in such a way that the level of imitation does not contain its own evaluation, and the interested and involved levels contain their own evaluation and attitude. On the self-directed level, the learner produces new practices on their own initiative. (Table 2). In this division, imitation does not include the learner's self-direction, while modification and innovation do. The learned operating model is implemented in accordance with the model, not the situation or the learner's own solution. The change in operating to be achieved happens through copying, without adapting. Modification manifests as problem-solving and adapting the way of operating to the situation, such as by reacting to the customer's answers with follow-up questions directed at the customer's lifeworld. In addition to the above, innovation includes multilevel, rational and intuitive consideration of cause-effect relations, new solutions, renewing ways of operating, and the ideation and innovation of new good practices.

In this examination, our main focus is on whether learning and self-direction above the level of imitation can be observed in the nurses' activities.

Table 2. Learning in the different stages of self-direction

	Imitation	Modification	Innovation
Self-direction	Dependent	Interested, involved	Self-directed
Aim of action	Repetition of learned operating models	Controlled refinement of learned operating models according to the situation	Searching for new ways of operating according to internal and external stimuli
Learning style	Remembering and understanding	Reflection on causes and effects	Multilevel, rational and intuitive reflection
Learning objective	Changing action	Problem-solving and adapting	ideation and innovation

The material was evaluated according to the above division. Attention was paid to the questions asked by the nurses, the attitude towards the customer's meaningfulness talk and the guiding of the discussion between the world of health care and the customer's lifeworld (Table 3).

Table 3. Division for the examination of the material

	Imitation	Modification	Innovation
Questions	Open question	Open + follow-up question	Deepening the discussion in the customer's lifeworld
Attitude toward the customer's meaningfulness talk (=joys, worries, how they are doing, etc.)	Skipped, return to health talk (e.g. health, exercise, nutrition, sleep, etc.)	Taken into account and followed up on (e.g. "you said that... what do you think about it...")	searching for new solutions creatively (e.g. "how have you tried to take care of..." or "you said that... so you should...")
Lifeworld vs. health care world	primarily health care world	Includes discussion of the lifeworld	Deepening and searching for solutions through the lifeworld

4. Results – Incorporating the New Way of Operating as Part of Customer Encounters

In the material (Rautava & Niemelä, 2019), professionals were found to use the following customer-centred methods: open questions, encouragement, highlighting positives, listening and giving the customer space.

In their interactions, the professionals used open questions the most. With the open questions, the professionals mapped out the customer's lifestyle and asked about their overall condition. The professionals used open questions especially when they transitioned to a new topic in the discussion.

The professionals often also used encouragement and the highlighting of positives.

4.1 Non-Self-Directed Implementation/Imitation

At the start of the appointment, the professional used an open question to give the customer the space to express their feelings on matters relating to their daily life and the course of their life which they wished to discuss. However, the professional often did not have the time or patience to wait for the answer, and instead immediately asked a new question, to which the only possible answers were yes or no. (Rautava & Niemelä 2019.)

At appointments where the professional listened and gave the customer space, the discussion did not much relate to lifestyle or diabetes treatment. The discussion ended only once the customer themselves changed the subject. The professional was empathetic and listened, but the customer was not guided towards deeper reflection. (Rautava & Niemelä 2019.)

4.2 Self-Directed Implementation/Modification

Self-direction could be seen in situations (Rautava & Niemelä 2019) where the professional challenged the customer to think about their own condition and wellbeing, as well as their own opportunities to affect them. For some customers, this led to reflecting on the significance of their own lifestyle in their health.

H2: "Have you thought about how you could get more [exercise]? What would be meaningful?"

A7: "Of course, I could walk..."

The challenging question set by the professional led to a meaningfulness and realisation discussion. It could be observed that guidance to a meaningfulness discussion inspired the customer to consider, for example, meaningful activity for themselves.

H2: "...but then I'm thinking about what your resources are right now to change [your lifestyle], we need to think about that. What do you think, is there something that's possible for you to change there?"

A20: "Yes! And I know somewhere deep down that this is not a good way. I hope that I can use this as an excuse to get a grip on things and make changes. Exercise is one, since I sit at work... Let's say everyday exercise... I really like working in the yard... So I think one thing that would help would be having a regular rhythm. And if I go a long time without eating, it's really easy to overeat."

In another case, it was observed that guiding to a meaningfulness discussion helped the customer realise the impact of exercise on their aches and to think about different suitable forms of exercise. The professional gave the customer space. Instead of direct answers, they challenged the customer to think for themselves. Thus, the professional succeeded in supporting the customer's own realisation.

H1: "So, how is your health?"

A4: "I don't know, things ache... I can manage with a painkiller, though."

H1: "Yeah. Have you thought about what it might be related to, the aching? What situations, does it happen after something?"

4.3 Self-Directed Implementation/Innovation

The use of customer-centred interaction methods fulfilling the characteristics of innovation were not identified in the material (Rautava & Niemelä 2019).

There were few fully customer-centred appointments, as well as few fully non-customer-centred ones. Generally, the professionals used a mix of both customer-centred and non-customer-centred interaction methods.

The professionals who took part in the study clearly sought to use customer-centred interaction methods, but these were not completely established as counselling methods. Self-direction could be seen in situations where the professional started to challenge the customer based on the issues the customer brought up. The majority of the professionals who completed the training had not internalised the new way of operating as part of their own customer encounter practices.

5. Discussion

5.1 Reviewing the Results

In a systematic review covering ten articles, Melender et al. (2016) make note of care sector teachers' excessively optimistic understandings of students' capabilities to adopt and apply new information in care work. The authors call for further research on the effectiveness of teaching of the care sector's evidence-based practices.

In their work, Grimshaw & Eccles (2012) found that the adoption of a new operating model through training had a low success rate, or at best a moderate one. In addition to training, active and purposeful management support for the change is required. Establishing a new way of operating as part of the work of health care professionals is a multistage, time-consuming event, where simply providing information is not sufficient (Wiik 2016). Successful management communication requires a lot of interaction and inclusion of the community (Åberg 2006).

The results of this study are similar in that further training alone cannot make a new method part of everyday operation.

Health sector professionals have, in previous studies, brought up the point that the interaction methods they use in lifestyle counselling are insufficient for achieving good treatment results (Jallinoja et al. 2007). The material in this study shows that professionals have many different kinds of customer-centred interaction methods at their disposal. The challenge has been shown to be more that the use of customer-centred methods stopped short and did not continue as the appointment progressed.

In their literature review examining customer-centredness, Yun and Choi (2019) reached similar results. Although customer-centredness is supported in care work that promotes change, it has not become established as part of professionals' way of working (Downey et al. 2021). This observation gives reason to consider what kinds of objectives health care professionals set for customer encounters and their manners of speech within them. For example, is the motive behind customer-centred manners of speech the aim to increase effectiveness, or maintaining a good atmosphere and conversational connection?

Poskiparta et al. (2006) propose that not enough time is dedicated to interaction which promotes a lifestyle change in the customer encounters of health sector professionals. Köhler (2019) states that, even in a short period of time, the customer's attitudes and empowerment can be affected when the lifeworld and its meaning to the customer are paid attention to.

6. Reliability of the Results and Ethics

In evaluating the reliability of the qualitative study, the criteria of credibility, confirmability, transferability and reflexivity are used (Kylmä & Juvakka, 2012, Vaismoradi et al., 2013). The researchers analysed the research material independently of one another (Rautava & Niemelä, 2019) and the observations and interpretations obtained in this way were compared to each other. The aim of the comparison and detailed description of the research process was to increase confirmability (Kylmä & Juvakka, 2012). The original expressions used in the presentation of the research results enabled the evaluation of the results' quality and interpretations' correspondence (Kvale, 1996). We also sought to increase the study's confirmability by comparing the results to the results of earlier studies. Transferability was increased by describing the background information of the professionals and the customers who participated in the study, as well as describing the phases of the data collection and analysis. As is characteristic of a qualitative study, the research results of this study cannot be

generalised, but they increase understanding of the phenomenon being studied (Malterud, 2001). The study can be repeated. However, a similar study with a different group of participants may obtain different results. This study found similar results compared to previous research results. The reliability of the study suffers due to its small data set, which further asserts the fact that the results may only be treated as indicative.

The results of this study are in line with the findings of previous studies that concluded that outputs will not be implemented into practice without systematic measures. Therefore, the results of this study can be considered transferable when it comes to promoting successful implementation despite the limited data set.

Research permits for the study were applied for and obtained in those municipalities where the study was carried out. The diabetes specialist nurses and their customers were presented with information and consent forms. Everyone was informed of the study's progress and it was made clear that participation in the study was voluntary. All participants were informed of their right to stop the study at any time without it affecting the care they receive. (Pelkonen & Louhiala, 2002, Kylmä & Juvakka, 2012, Leino-Kilpi & Välimäki, 2014.) Consent was also requested in writing. The study did not require processing by an ethics review committee, as it did not interfere in the integrity of the person. After collecting the data, the names and identifiable information of the participants were replaced with anonymous letter-number combinations. In the original expressions presented in the results section, no information which can be linked to the participants is shown. (Leino-Kilpi & Välimäki, 2014.) The researchers did not interfere in the course of the appointment or in the counselling received by the customer in any way. The presence of an outside researcher may affect the kind of interaction used by the professional at the appointment. In this study, it seemed that the customers and nurses rather quickly forgot about the researcher sitting in a chair.

7. Conclusions

As the health care system is overhauled, it is important to find new approaches and ways of thinking to prevent the system becoming strained. One approach is to support the awakening of the customer's internal motivation to promote a lifestyle change. Health sector professionals have several different kinds of customer-centred interaction methods at their disposal. A potential deficiency may be that the methods are not used sufficiently, and they are not used throughout the appointment.

Health care students and professionals who have already graduated should be offered effective interaction training courses, which pay attention to the connection between different manners of speech and the effectiveness of treatment. Melender et al. (2016) recommend self-directed learning combined, if needed, with a teacher's/instructor's consultation opportunity, as well as the use of various learning tools in professionals' further training. For its part, this study shows that one training course is not enough to enact change in a way of operating, rather, adopting new ways of operating requires reinforcement and practice in practical work, as well as competent, purposeful management.

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Informed Consent

Obtained.

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Data Availability Statement

The data that support the findings of this study are available on request.

Competing Interests Statement

The authors declare that there are no competing or potential conflicts of interest.

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