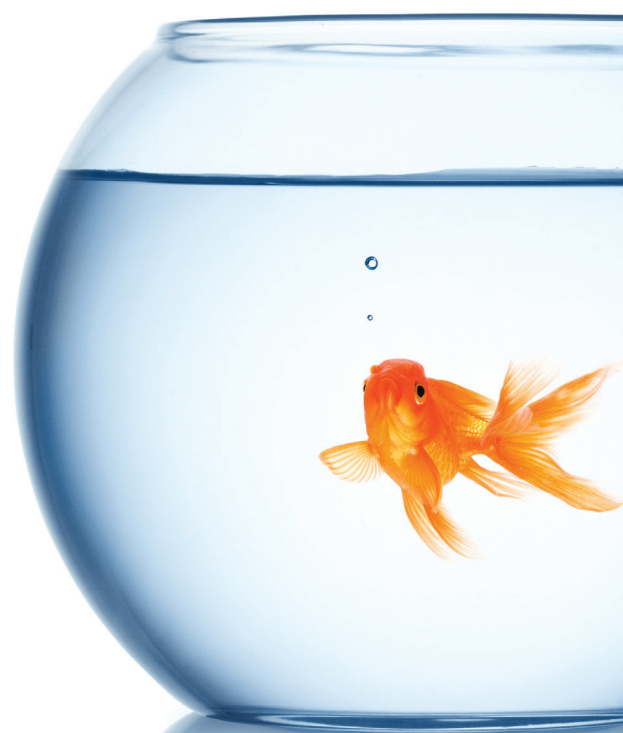




3 - MINUTE EMPOWERMENT



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Internal Medicine



3

- MINUTE

EMPOWERMENT

Lifestyle changes are the cornerstone of comprehensive chronic disease management. Healthcare professionals generally use a directive approach, which is relatively confrontational, to “inform,” “convince” and “prescribe” actions leading to change.

The material for this workshop provides professionals with a **UNIVERSAL** intervention tool (a single technique that applies to all behaviours) which is part of a short three-minute empowerment process. The goal of this intervention is to accelerate and reinforce the natural process involved in the stages of behaviour change.

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THIS IS A

TWO-STEP TOOL:

1) EVALUATION:

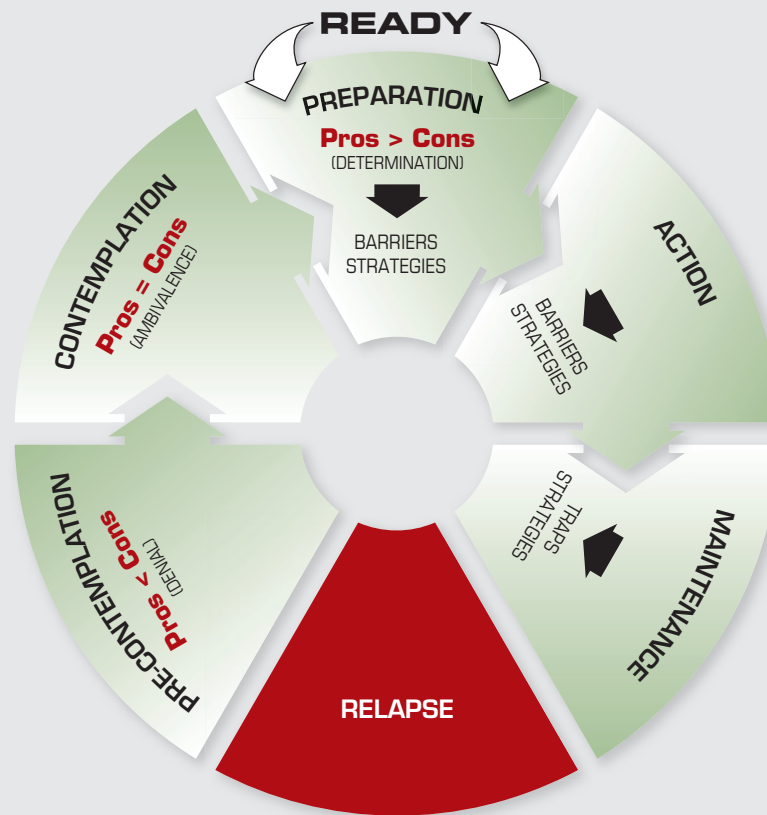
- A) Intervention goal: stages of change (Prochaska)
- B) Intervention target: conviction and confidence (Miller and Rollnick)

2) INTERVENTION TECHNIQUE:

Motivational interviewing

1A) EVALUATION – STAGE OF CHANGE

The decision to make a lifestyle change is the result of a NATURAL process that takes place in STAGES over a certain period of time. Each stage is the foundation for the next stage. The role of the health professional, alone or as part of a team, is basically to recognize, reinforce and accelerate the natural process throughout these stages.



PROCHASKA'S STAGES

This model shows Prochaska's six stages of change:

1) PRE-CONTEMPLATION:

Denial of the problem behaviour. The person does not see the benefits of changing the behaviour (pro < con).

2) CONTEMPLATION:

Ambivalence based on the perception that the behaviour change has as many advantages as disadvantages (pro = con).

3) PREPARATION:

Conviction that the advantages related to the change outweigh the drawbacks (pro > con). The person tries to define the obstacles and find strategies that would help him/her take action.

4) ACTION:

Behaviour change.

5) MAINTENANCE:

Behaviour change sustained for six months after taking action.

6) RELAPSE

This is not a failure, but rather an integral part of the process. The professional should use the relapse as a learning opportunity to be able to implement protective measures (anticipation of obstacles and protective measures) so that the next time action is taken, it will be final and conclusive.

Stages are evaluated by using open-ended questions:

**“What would you think about... Quitting smoking?
Getting more exercise? Changing your eating habits?
Changing the way you take your medication?”**

It happens that the answer will resemble an APPARENT stage that is not the real stage since the patient may tell us that he intends to change only to please us or by fear of a confrontation (memory of a previous confrontational experience with a health professional). The health professional will have to confirm or determine the REAL stage by a match with the conviction level (refer to section: “Merging the two concepts”).

By systematically determining the starting point, or stage, of each behaviour, you can set a realistic goal for each intervention (one intervention = one stage). You can then measure the patient's progress (or lack thereof) by seeing if the patient has changed stage when he comes in for his next appointment. If there has not been any change in stage, a different strategy may be required.

The impact is even greater in an organizational situation that involves multiple professionals working as a team (doctors, pharmacists, nurses, nutritionists, kinesiologists). This allows a professional to determine the optimal time for consulting another professional in the team by getting the patient to the preparation stage. There is no point requesting a consultation with a nutritionist to help a patient lose weight if this patient is still at the pre-contemplation stage!

The professionals in the team will therefore redefine their method of intervention. They can start each interview by determining the patient's stage and conviction-confidence level in relation to the target behaviour. The initial intervention is to get the patient to the preparation stage (early stages [pre-contemplation, contemplation and preparation]) and from there, to discuss specific techniques leading to action (late stages [preparation, action and maintenance]).

1B) EVALUATION – INTERVENTION TARGET:

Conviction or confidence

CONVICTION : PERCEIVING the benefits that would result from a behaviour change.

CONFIDENCE: FEELING capable of changing a behaviour.

Open-ended questions should be used to evaluate conviction and confidence, just as they are used to evaluate the patient's stage:

CONVICTION: "If you decided to... how would that benefit you? »

CONFIDENCE: "If you decided to... do you think you could do it?"

Conviction can be...

1) LOW (1 to 3/10)

Patient sees either no advantages, or abstract advantages, by adding "maybe..."

2) MODERATE (4 to 6/10)

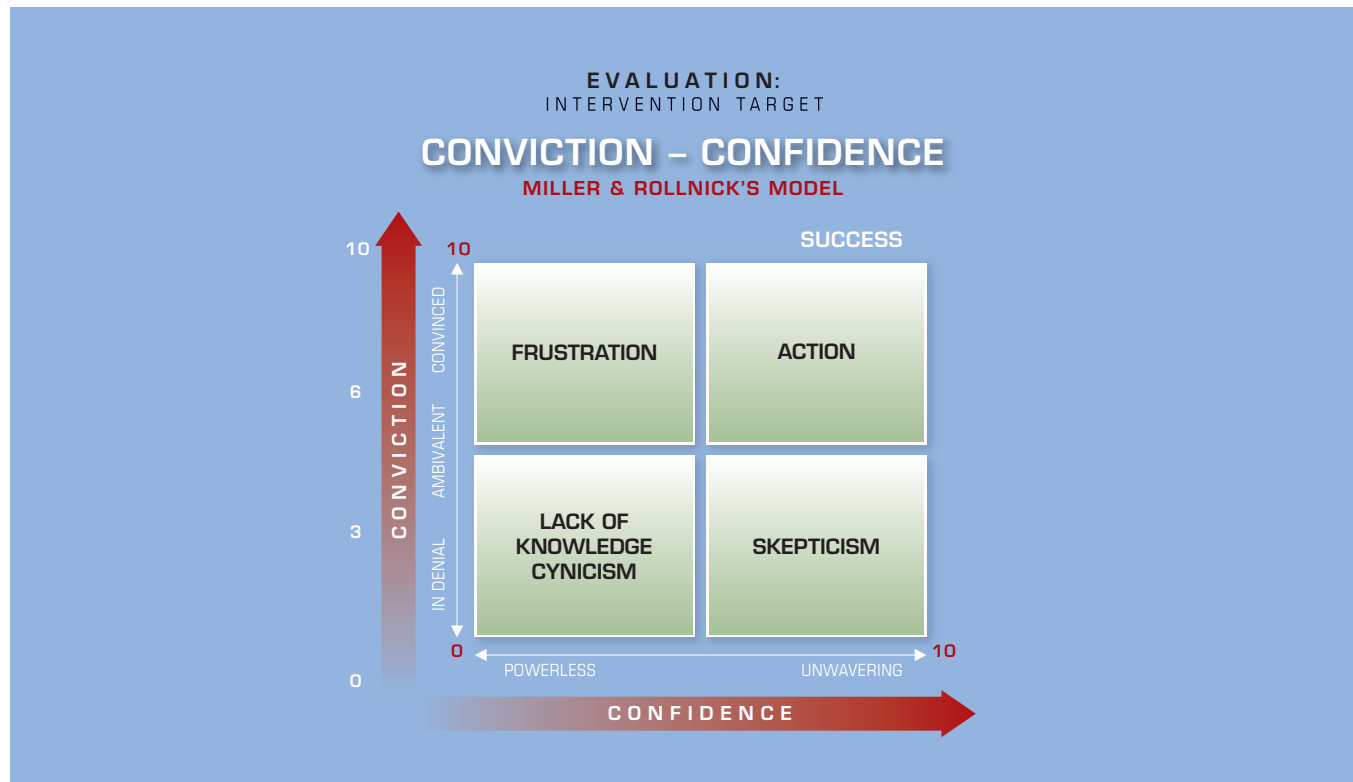
Patient has learned of the abstract or theoretical advantages through readings, Net browsing or the information provided by a health professional. ("My health would improve."; "My cholesterol would be lower."; "It would make it easier to control my blood sugar level." "My risk of having a heart attack would be reduced.")

3) HIGH (7 to 10/10)

Patient sees advantages not only at a cognitive level (abstract advantages), but also at a personal, highly emotional level. ("If I stop smoking, I won't be so out of breath. I'll enjoy my life and be able to play with my grandchildren. I'll have a wonderful life!")

Similarly, confidence can be low (feeling powerless) or high (overwhelming confidence).

Conviction and **confidence** can be measured on a scale of 1 to 10 and can be illustrated as follows:



The graphic above shows four boxes corresponding to the patient's characteristics:

- > **skeptical** (low conviction – high confidence)
- > **frustrated** (high conviction – low confidence)
- > **cynical** or **ignorant** (low conviction AND low confidence)

The purpose of a “**targeted intervention**” is to increase **conviction first** and then to boost confidence, to get the patient to take **ACTION** when **both** are high.

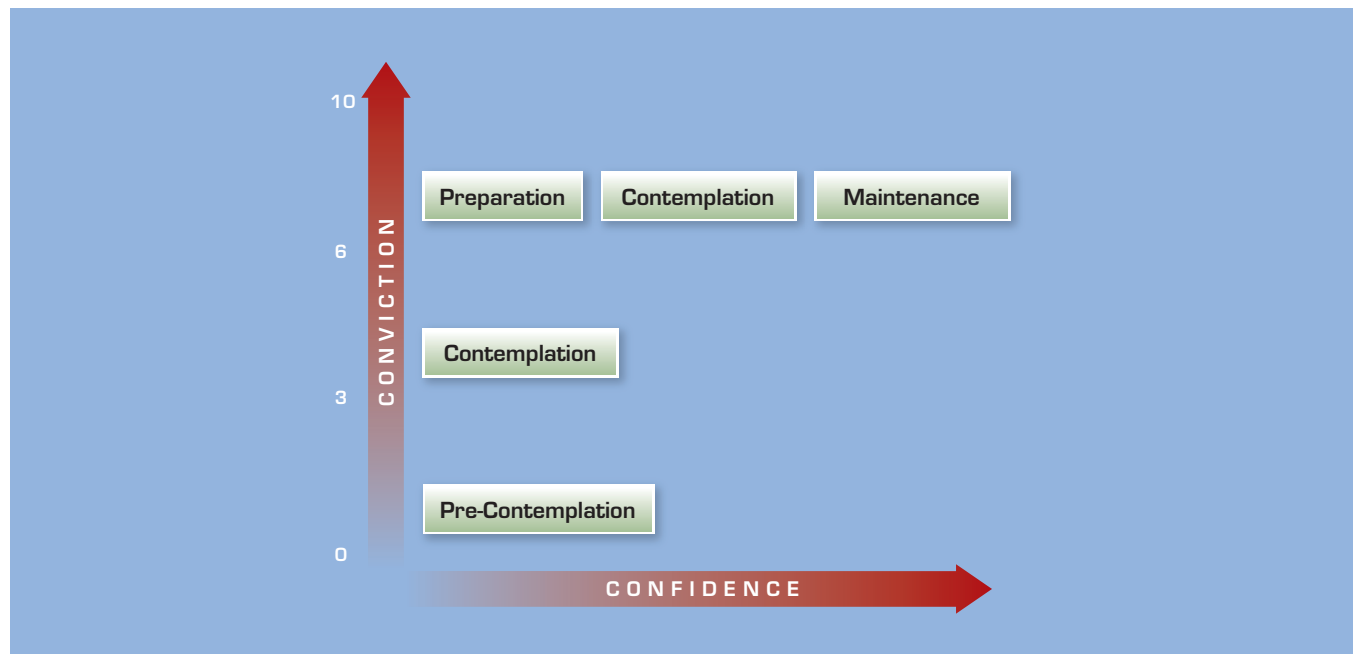
In a patient who is **skeptical** (low conviction – high confidence), the intervention aims mainly to increase conviction, basically by improving the patient's perception of the **ADVANTAGES** (on a personal level, with strong emotional content), while correcting the patient's knowledge and underlying values (using empathy).

In a patient who is **frustrated** (high conviction – low confidence), the intervention should aim to increase confidence, while encouraging the patient to define obstacles and solutions (strategies) leading to action.

In a patient who is **cynical** or **ignorant** (low conviction AND low confidence), the priority of the intervention is to boost conviction, so that the patient is motivated and willing to change. Only then do you tackle confidence.

Merging the two concepts

The **conviction** scale (Miller and Rollnick model) is basically the **mirror image** of the first **three stages of change** (Prochaska): pre-contemplation, contemplation, preparation.



Low conviction (0 to 3/10): Pre-Contemplation

Either no advantages or abstract advantages indicated by “maybe...” denote a patient in the pre-contemplative stage (denial: pro < con).

Moderate conviction (4 to 6/10): Contemplation

A patient who grasps the abstract or theoretical advantages is at the contemplation stage (ambivalence: pro = con).

High conviction (7 to 10/10): Preparation

A patient who perceives both theoretical advantages AND positive advantages with very high emotional and personal content is at the preparation stage (determination: pro > con).

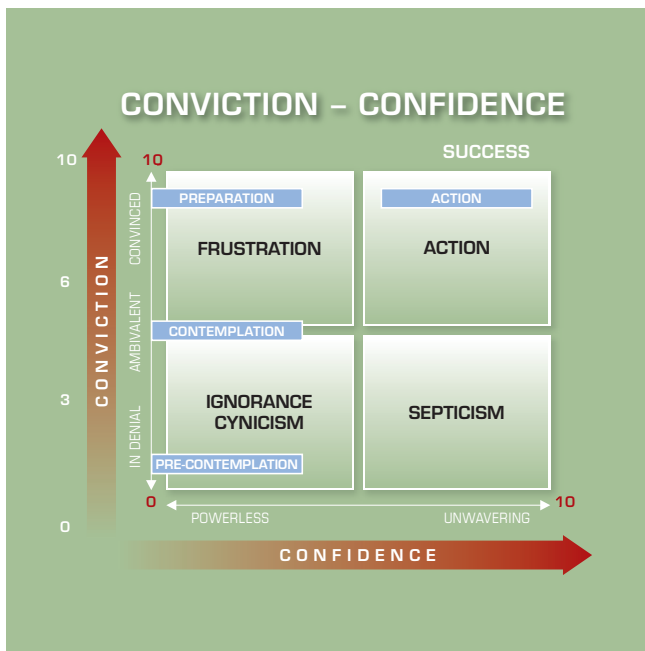
By determining the conviction level one can always determine the “real” stage of change which the patient cannot hide.

A patient who is **READY** for change is at the **PREPARATION STAGE**, and **MOTIVATED** to take action.

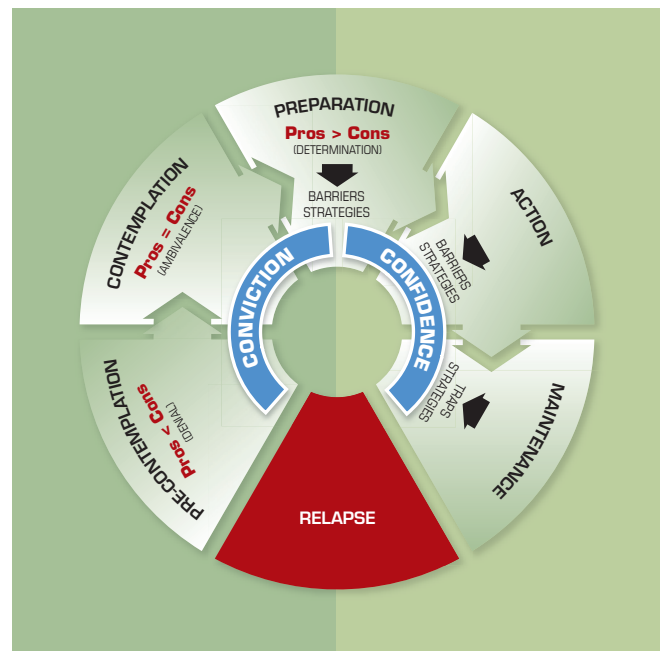
A **MOTIVATED** patient has a very high conviction level (7 to 10/10), and perceives personal advantages with very high emotional content.

We can see therefore, that any intervention that aims to increase conviction level moves the patient within the first three stages, the last of which is preparation. Confidence level is then addressed and the patient is encouraged to move onto action and maintenance.

The following illustration integrates Prochaska's model into the Miller and Rollnick model



The following illustration integrates Miller and Rollnick's model into the Prochaska model



This finding (merging the two concepts) provides us with a new tool that enables us to validate the patient's **REAL stage** and alter our intervention accordingly.

For instance, a patient who says that he intends to quit smoking (which would indicate that he is at the preparation stage), but who doesn't see any benefit to quitting (low conviction) is actually at an earlier stage (pre-contemplation).

Your strategy as a professional should therefore be adjusted accordingly (based on the **conviction scale** to determine the **real stage**) and the intervention target should be redefined. In this case, you redefine your intervention **target** to increase conviction (target required when a patient is at the pre-contemplation stage) not confidence (which you would have done if the patient had actually been at the preparation stage).

2) INTERVENTION

Motivational interviewing

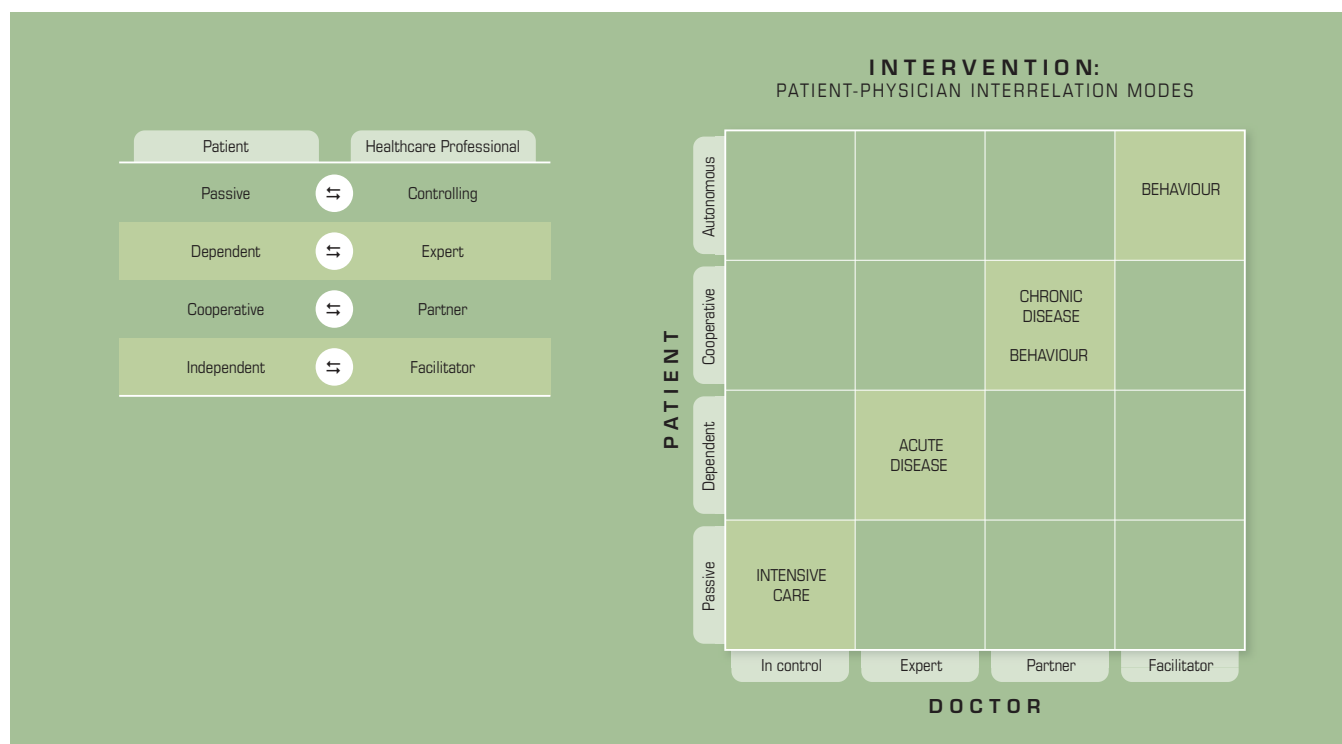
The traditional directive approach, which consists of informing the patient, trying to convince him and giving him instructions about what he should or shouldn't do, is often directive, confrontational and worse, ineffective.

The patient's response to this is often, "Yes, but..." (this response is an unfortunate indication of a directive intervention mode). The "Yes, but..." syndrome caused by the directive intervention mode is a disaster. As long as he has arguments to support his answer of "Yes, but...", the patient is convincing himself of the opposite of what we wanted him to understand. The directive approach that resulted in a **"Yes but" is therefore a step backward, not forward.**

On the other hand, the negotiated approach (a feature of the motivational interview) uses the power of **OPEN-ENDED QUESTIONS** to raise his awareness about the benefits (increased conviction) in the early stages of change (pre-contemplation, contemplation, preparation), and then evaluate obstacles and solutions in the advanced stages (preparation, action, maintenance).

The effectiveness of the intervention is based on the fact that the change comes **from** the patient and is implemented **by** the patient (not externally imposed).

There are four levels of control and responsibility for patients and healthcare professionals, defining four modes of communication:



Each mode of communication can be appropriate, depending on the clinical situation.

For instance, the passive–controlling (healthcare professional-centered) mode would be appropriate for a patient in intensive care who is unconscious or unable to communicate.

In the dependent–expert (disease-centered) mode, the patient temporarily gives up some of his autonomy and accepts the professional's expertise in treating an acute disease. In this case, the characteristic action is the prescription.

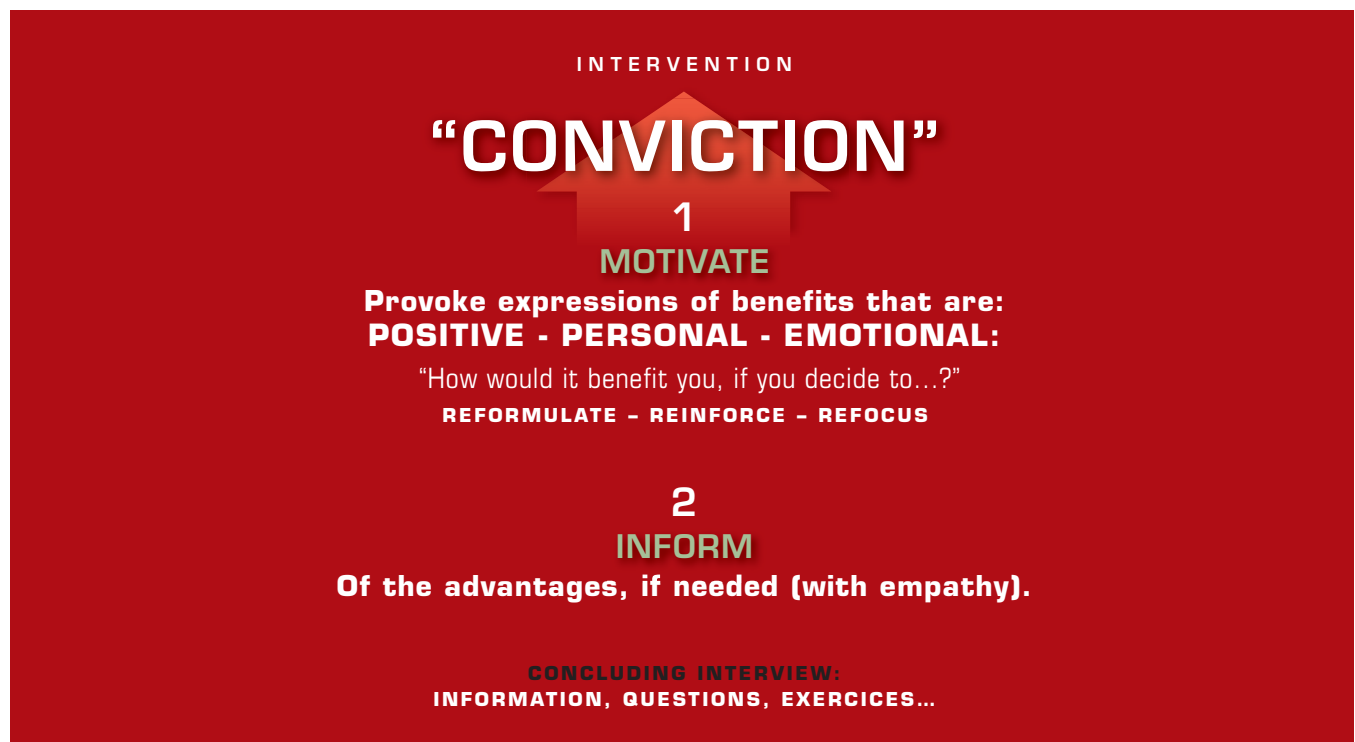
The treatment of a chronic problem (high blood pressure, high cholesterol, diabetes) as well as an intention to provoke a behaviour change involves a level of communication in which the patient plays a predominantly active role in deciding to initiate or pursue a treatment. The cooperative–partner (patient-centered) mode is therefore effective in this situation. The characteristic action is negotiation leading to action, not a prescription.

When the goal is a lifestyle change, the communication model is cooperative – partner during the first stages and then independent–facilitator for the more advanced stages (maintenance).

Knowing how to shift from one means of communication to another, according to the clinical situation, is a characteristic of a clinician who is an expert in four of the six* overlapping roles of the CanMED program (professional, communicator, collaborator, health advocate).

Increasing conviction

The goal of the intervention is to increase conviction in the first three stages (pre-contemplation, contemplation, preparation).



The **CONTENT** of an intervention should both motivate and inform (as needed).

The only **OBJECTIVE** of each intervention is to progress from one stage to the next.

The **BENCHMARK** to measure whether an intervention has succeeded or failed is one stage of progress per intervention (100% success).

The TOOL used is to ask OPEN QUESTIONS that can provoke progress rather than imposing it.

The intervention technique to improve Conviction can be personalized according to one of two possible scenarios:

- 1) Intervention intended to aid progress from Pre-Contemplation to Contemplation.
- 2) Intervention intended to aid progress from Contemplation to Preparation.

There are therefore two possible **CONCLUSIONS** to the interview, specific to each of these scenarios.

INTERVENTION INTENDED TO AID PROGRESS FROM PRE-CONTEMPLATION to CONTEMPLATION (50% of cases)

The objective here is to move from weak conviction (0–3/10: corresponds to Pre-Contemplation) to moderate conviction (4–6/10 “abstract advantages”: corresponds to Contemplation stage).

The intervention technique (motivational interview) consists of re-framing, reinforcing and rephrasing the open question to encourage the patient to express him or herself regarding perceived advantages and, in so doing, convince him or herself gradually to the point that he or she is expressing the advantages.

In the rare cases where a patient isn't aware of any advantages, the professional can return to the traditional intervention method and deliver information (with empathy) to lead the patient to the Contemplation stage with some knowledge of abstract advantages.

How can one reorient a patient in Pre-Contemplation who has established inflexible barriers and refuses to express any sense of advantages?

This situation may arise particularly among patients in the Pre-Contemplation stage who have experienced trauma due to earlier experiences in which they felt aggression from a professional using confrontational, directive interventions.

The technique consists of rephrasing the question, but using the conditional form. For example, using “What would be the advantages of...?” and “What could be the advantages of...?”, if the answer to the first question, “What are the advantages of...?”, is negative (with nonverbal signs of total closure). The conditional form offers far less threatening phrasing when the patient dreads confrontation.

In the hypothetical case of total inflexibility, a “BYPASS” is necessary – something that depersonalizes the question. “I understand that you wouldn't gain any advantages, but theoretically for SOMEBODY ELSE, what might the advantages be if...?”. When the patient starts to come up with some advantages, we rephrase and continue to ask questions about the advantages, removing this “somebody else”. We thereby come back to the advantages for the patient. When this technique is used, most patients are capable of starting their journey from the Pre-Contemplation stage.

INTERVIEW CONCLUSION once Contemplation is reached

To consolidate this new stage, information tools can be provided (reading material, Internet links, pamphlets, etc.) for later consultation, if needed. A patient action must also be negotiated so that the patient will continue to ask him- or herself questions until the next session (“How would it benefit me to...?”).

This process, which extends far beyond the short interview, results in the patient continuing to increasingly convince him- or herself of the benefits of change, thereby consolidating the Contemplation stage and even spontaneously moving towards the next stage – Preparation.

INTERVENTION INTENDED TO CAUSE PROGRESS FROM CONTEMPLATION to PREPARATION (20–30% of cases)

Here, the objective is to move from moderate conviction (4–6/10: corresponding to Contemplation) to high conviction (7–10/10: personal, emotional and positive conviction consistent with Preparation).

When the patient knows a number of abstract advantages (such as “my cholesterol will be lower, my health will be better,” etc.) (Cognitive Conviction = Contemplation Stage), the Conviction level will never pass the moderate level (6/10). We can continue to provide information until the patient becomes an EXPERT in the subject, which still may not motivate a change. To be motivated, MORE than abstract advantages must be felt – there must be personal, positive benefits with very high emotional content.

In response to the question “What are the advantages of...?” that starts the intervention, the patient expresses one or more advantages (such as “What are the advantages of quitting smoking?” Reply: “My health will be better and I’ll save money!”). The therapist then chooses some benefits that seem to have potential to lead the patient to express positive, emotional and personal advantages, then REPHRASES the question specifically to express these advantages for him (“You say your health would improve – what would better health mean to you?” Reply: “If I quit smoking, I’d run out of breath less, and cough less.”) A first stage has been breached: the patient is now expressing personal advantages (coughing less, being less winded) BUT without any emotional load.

The therapist then chooses an expressed advantage and rephrases the question to add a positive and emotional dimension to the advantages; the goal is to motivate the patient and make the patient desire change. (“You said that you would be less easily winded. What good would it do you to not run out of breath so easily?” How would your life be improved... be more fun...? Reply: “The other day, I was trying to play with my grandchildren and I had to stop after two minutes because I was winded. If I was less lively to run out of breath, I’d be able to play with them, go outside with them...”) The crucial step has been taken: the patient has expressed very positive benefits (spending time with grandchildren) that are extremely emotional (grandchildren).

At this moment, the therapist has made the association “quit smoking – grandchildren” and asks a question so that the patient will continue to convince and motivate him- or herself to change. (“You just said that quitting smoking would help you be closer to your grandchildren – what do you enjoy doing with your grandchildren?”) The more the patient describes things they do with their grandchildren, the more they’ll be motivated to modify their negative behaviour.

The more they talk, the more convinced they’ll become, moving on to the Preparation stage (high emotional conviction, 10/10).

See Appendix 1 (Mr. Martin)

This technique is the opposite of the traditional technique, in which the therapist tries to convince the patient of the advantages the therapist sees (with information and instructions), that results in the creation of “Yes, but...!” responses by the patient, who then convinces him- or herself to reverse and backslide in their progress.

This example is only an illustration of a general principle that is the same regardless of the type of intervention or behaviour. Increases in conviction are always achieved through the use and rephrasing of open questions in a way that always leads the

patient to create a perception of positive, emotional and personal advantages and avoids having the therapist provide their own perspective.

CONCLUSION OF THE INTERVIEW once Preparation is reached:

There are two possible interview conclusions when the patient arrives at the Preparation stage:

- 1) Leave the patient with open questions (as in the preceding intervention that moves from Pre-Contemplation to Contemplation) on the advantages of change, to reinforce this new stage.
- 2) Or start a new intervention, working on Confidence (barriers and strategies) to move to Action (strike while the iron is hot, if conviction is at 10/10 with a high emotional charge).

INCREASING CONFIDENCE

Any intervention aiming to boost the patient's confidence can only start ONCE THE PATIENT IS CONVINCED and motivated, i.e. has reached the key PREPARATION stage.

The intervention technique always uses open-ended questions (three questions in a row) to encourage the patient to express how he sees his own obstacles and solutions (as opposed to the directive approach, in which the professional outlines the patient's obstacles and solutions as he or she sees them).

Once the patient has expressed his perceived obstacles and solutions, the interview concludes with an agreement on steps to be taken (actions) before the next appointment.



This action is realistic because it is based on solutions put forward by the patient. Even if it is only partially successful, it can be a first step toward building the patient's confidence and serving as a foundation for the next stage.

See Appendix 2 (Mrs. Richards)

During the action and maintenance stages, the professional remains actively involved by reinforcing the patient's conviction, identifying pitfalls and helping to implement protective mechanisms to avoid a relapse.

What if a patient needs to change more than one behaviour?

Addressing more than one behaviour simultaneously, notably diet and smoking, or alcohol and smoking, more often than not leads to a total failure of the intervention.

Therefore, particularly if there is limited time available, you should choose to focus on a particular behaviour and put off dealing with other behaviours until later.

After evaluating the stage and conviction-confidence level of each behaviour, the first intervention should focus on the behaviour that is at the most advanced stage (preparation, then contemplation, and finally pre-contemplation); usually, this corresponds to the behaviour the patient would like to change first.

For instance, a smoker who is overweight, sedentary, and has poor eating habits may be at the preparation stage for physical activity, contemplation for diet, and pre-contemplation for smoking. In this case, the first interview should focus primarily on physical activity (the most advanced stage of behaviour, i.e. preparation) which has the greatest chance of quick success (taking action). Building on this first success will have the effect of boosting confidence. You can then change your strategy and target the second behaviour, i.e. diet. The patient will then move from contemplation to preparation, and then to action, etc.

Physical activity, however, remains the exception to the "addressing one behaviour at a time rule" as it constitutes a behaviour which catalyzes other behaviours. Active individuals generally tend to eat better, smoke less and be leaner. Addressing physical activity combined with another behaviour within the same intervention (for instance, physical activity and diet, or physical activity and smoking) often proves more successful.

SUMMARY

For each behaviour that needs to be changed, the professional starts by determining the starting point (stage) and the goal of the intervention (to move on to the next stage).

Use open-ended questions after determining the TARGET (conviction or confidence). If the patient is at one of the first three stages (pre-contemplation, contemplation, and preparation), the focus should be on improving conviction. If the patient is motivated and has reached the key preparation stage, the focus should be on boosting confidence (defining obstacles and strategies).

Since, as a professional, you have already intuitively developed your own intervention habits, you will have to invest some time and effort into systematically basing your approach on the three questions discussed previously.

The most difficult challenge will be to replace the standard DIRECTIVE approach with the motivational interviewing technique. You have to become accustomed to PROVOKING change to happen versus DIRECTING it.

The reward for this effort will be an instant change in the type of relationship you have with your patients. As a professional, you can become a real partner or even collaborator (there is no more confrontation since there is no more directive intervention).

You simply have to get used to asking these three key questions:

- 1) “What do you think about the idea of...?” (stage)
- 2) “If you decided to..., how would this benefit you?” (conviction)
- 3) “If you decided to..., do you think you could do it?” (confidence)

You would then be equipped with an objective, effective, quick, systematic tool that would help you recognize, reinforce and accelerate the process leading to change. The more targeted the intervention, the quicker and more effective it will be. The systematic use of this tool will make it possible to accurately determine the target of the intervention (conviction or confidence) and easily measure over time (at a future visit) the impact of the previous intervention (moving the patient to a more advanced stage or not). If the patient has not progressed, or has regressed, a different strategy should be necessary.

Lastly, the tool will greatly facilitate the work of the various professionals within the same team (family practice group, lipid clinic, hypertension clinic, heart failure clinic, etc.). If all group members use this tool, their interventions will be much more effective (accelerating the process leading to action) since each member will become a link in the same chain and everyone will be pulling in the same direction.

This is just the beginning of a step in the right direction!

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Internal Medicine

APPENDIX 1 – INCREASING CONVICTION

Mr. Martin

Myocardial infarction, dyslipidemia, COPD

Medication: enteric-coated ASA 81 mg, atenolol 50 mg, atorvastatin 40 mg, ipratropium bromide/salbutamol sulfate (Combivent® inhalation) PRN

Clinically stable

Has smoked since age 12 and has never tried to quit

Quit drinking 4 years ago

Goal: Quit smoking

1) EVALUATION

STAGE

Professional: "Have you ever thought about doing something about your smoking habit?"

Patient: "I'll probably quit someday, but I'm not ready now." (Contemplation)

CONVICTION

Professional: "How do you think quitting smoking would benefit you?"

Patient: "I think I'd be healthier." (Moderate conviction)

CONFIDENCE

Professional: "If you decided to quit smoking, do you think you could do it?"

Patient: "If I decided to quit, I wouldn't have any problem. I quit drinking four years ago and I've never fallen off the wagon." (High confidence)

Mr. Martin is at the contemplation stage with moderate conviction and high confidence. The goal for this intervention should be to increase his conviction level, to get him to the preparation stage.

2) INTERVENTION

Ask **open-ended** questions that encourage the **patient** to express himself about the benefits of changing his behaviour (don't try to answer for the patient). You can rephrase and reformulate questions depending on the patient's answers, leading the patient to talk about personal advantages with a high emotional content (the basis of **motivation** to change).

Professional: "If you decided to quit smoking, how would this benefit you?"

Patient: "My health would improve." (abstract benefit: low conviction)

Rephrase the question based on the patient's answer

Professional: "How would it improve?"

Patient: "I wouldn't cough as much and I wouldn't be so short of breath."

(Benefits are more personal. Pain and discomfort are not abstract concepts: moderate conviction)

Rephrase the question based on the patient's answer

Professional: "If you weren't so short of breath, what else could you do?" How much more fun would your life be...?

Patient: "My quality of life would be much better. For instance, just the other day I tried to play with my grandchildren. I had to stop after 30 seconds because I was just too short of breath. I could be much closer to my grandchildren. I could do more things with them, maybe take them on trips."

(The benefits are now very personal and highly emotionally charged. "Play with grandchildren": high conviction)

Reinforcement

Professional: "Yes, it would be great if you weren't so short of breath. You could really enjoy life more and be closer to your grandchildren."

Once the patient has reached the preparation stage (high conviction), this is the time to boost the patient's confidence. Ask open-ended questions that encourage the patient to identify obstacles and strategies with the idea of passing to action.

APPENDIX 2 – INCREASING CONFIDENCE

Mrs. Richards

Mrs. Richards, a 31-year-old customer service representative who works full-time at a bank, comes to see you to discuss her weight problem. She has been unable to lose the 18 kg gained over the course of her two pregnancies. She now weighs 79.5 kg. Her height is 1.65 m and her BMI is 29 kg/m². Mrs. Richards tries to eat healthy foods. She was an avid athlete prior to marriage, but now claims she has no time for regular exercise.

The goal of this intervention is to help the patient lose weight by resuming her physical activities.

1) EVALUATION

STAGE

Professional: "What do you think about increasing your level of physical activity?"

Patient: "I'd love to be more active and hopefully I will be in a few months when I have found someone to help out with the housework." (Preparation)

CONVICTION

Professional: "What benefits do you see in becoming physically active?"

Patient: "I used to be really active and I'd like to get back into shape. I wouldn't feel exhausted at the end of the day. I could finally lose this weight, get in shape and have more energy. Life would be wonderful... I'd be able to enjoy every minute of it!" (High conviction)

CONFIDENCE

Professional: "Do you think you could do it?"

Patient: "Right now I get up early with the kids, work all day and collapse after I get them into bed. I don't see how I could do it right now." (Very low confidence)

Mrs. Richards is at the preparation stage with high conviction and low confidence. The target of the intervention should be to increase her confidence.

2) INTERVENTION

This intervention procedure also uses open-ended questions so that the patient can express how she sees her own obstacles ("What is keeping you from ...?") and her own solutions ("How do you think you can overcome this obstacle?").

The meeting concludes with some negotiation, urging the patient to take concrete steps before her next appointment. This is the beginning of her taking action.

Identification of obstacles

Professional: "If you really decided to get more exercise, do you think you could?"

Patient: "I guess so, but it would be pretty tough."

Professional: "What would prevent you from getting more exercise?"

Patient: "Time and energy."

The obstacles are time and energy.

Identification of solutions

Professional: "How do you think you could work around this?"

Patient: "I guess I could start by taking the kids for a walk after work."

Professional: "From a practical point of view, do you know how you could start doing this?"

Patient: "Yes, I could walk for 30 minutes three times a week."

Conclusion: negotiating concrete action

Professional: "Could you decide today to walk 30 minutes three times a week? We can talk about it again at your next appointment."

Patient: "OK, I agree. I'll start tomorrow. Let's see how it goes!"

This is how the process begins. This realistic strategy (small step: 30 minutes of physical activity three times a week) has every chance of succeeding. Encouraged by this partial success and improved well-being, the patient will be more inclined to take the next step, i.e., to increase the duration and intensity of her daily workout.



Dr Jacques Bédard

Dr. Jacques Bédard has been a specialist in internal medicine since 1976.

A member of both the Canadian Royal College of Physicians and American College of Physicians, he serves as Internal Medicine consultant at Sherbrooke University Hospital (Québec).

He is a Full Professor of Internal Medicine at Sherbrooke University since 2002.

As the principal investigator at the London Clinical Research Centre, Dr. Bédard has participated in more than 50 multi-centre international clinical trials, including CARE, PRISM PLUS, CHARM, ACTION, SPORTIF V, VALUE, VALIANT, SWORD, PROFILE, RESOLVD, CHARISMA, ARISE, ADONIS, OVERTURE, and ILLUMINATE....ect

He has been a guest speaker at more than 1200 CME-related conferences, on a comprehensive range of topics within the cardiovascular field: diabetes, high blood pressure, dyslipidemia, stable and unstable coronary syndromes, heart failure, atrial fibrillation, peripheral vascular disease, dizziness and syncope, and mentoring through effective lifestyle modification.

Dr. Bédard received the CSIM (Canadian Society of Internal Medicine) Osler Award in 2002 in recognition of his work in CME activities, both nationally and internationally.

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