

Chinese General Practice Research Methodology Series

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Abstract

The transformation of “medical advice” into “health behavior” is a core challenge in primary care chronic disease management, while traditional one-way communication is often insufficient to address patients’ difficulties in maintaining behaviors in real-life contexts. Motivational interviewing (MI) offers an important approach to this issue; however, existing MI is mostly implemented in research settings with relatively sufficient time, which is somewhat disconnected from the realities of primary care outpatient services in China, where consultation time is short and workloads are heavy. Accordingly, this paper adopts a narrative literature review and theoretical integration approach, combined with examples of primary care doctor-patient communication, to concretely elucidate the technical system of MI, including change talk and sustain talk, four core foundational skills, the four stages of the interview, the “relationship-technique” dual-path mechanism model, and the four spirits of MI. Further, based on an analysis of typical service scenarios and in light of the continuity characteristics of primary care services, three types of adaptation strategies are proposed: capturing “MI moments” in routine outpatient consultations and embedding “lightweight MI”; establishing a “micro-MI” closed loop in family doctor contract follow-up; and promoting the transformation of health education from a “one-way instruction” model to a “group motivation-evoking” model, with the aim of providing a reference for the practical implementation of MI in primary care chronic disease management. Future research may focus on advancing the development of localized lightweight and micro-MI techniques, developing a stratified and categorized systematic training system, and improving institutional safeguards and localized fidelity assessment tools to support the routine implementation of MI.

Full Text

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Application of Motivational Interviewing in Healthcare Provider-Patient Communication for Chronic Disease Management in Primary Care: From Principles to Practice

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【Abstract】 The transformation of “medical advice” into “health behaviors” is a core challenge in primary care chronic disease management. Traditional one-way communication often fails to adequately address the difficulties patients face in maintaining behaviors in real life. Motivational interviewing (MI) provides an important approach to solving this problem; however, existing MI is mostly implemented in research settings with relatively sufficient time, which is to some extent disconnected from the real circumstances of short consultation times and heavy workloads in Chinese primary care clinics. Based on this, this paper adopts narrative literature review and theoretical integration analysis methods, combined with examples of primary care healthcare provider-patient communication, to concretely explain the technical system of MI, including change talk and sustain talk, the four core foundational skills, the four stages of conversation, the mechanism model of the “relational-technical” dual pathway, and the four spirits of MI. Furthermore, based on service-typology scenario analysis and combined with the continuity characteristics of primary care services, three types of adaptation strategies are proposed: capturing “MI moments” in routine outpatient consultations and embedding “lightweight MI”; setting up “micro-MI” closed loops in contracted family-doctor follow-up visits; and promoting the transformation of health education from a “one-way didactic model” to a “group motivational elicitation model.” The aim is to provide a reference for implementing MI in primary care chronic disease management. Future research may focus on advancing the construction of localized lightweight and micro-MI techniques, developing stratified and classified systematic training systems, and improving institutional safeguards supporting routine MI implementation as well as localized fidelity-evaluation tools.

【Keywords】 Motivational interviewing; primary healthcare services; chronic disease management; healthcare provider-patient communication; health behavior change

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[Abstract] The transformation of “medical advice” into “health behaviors” is a core challenge in primary care chronic disease management, as traditional one-way communication often fails to adequately address the difficulties patients face in maintaining behavioral changes in real life. Motivational Interviewing (MI) provides a significant framework for addressing this issue; however, existing MI practices are mostly implemented in research settings with relatively ample time, which creates a disconnect from the reality of Chinese primary care clinics characterized by short consultation times and heavy workloads. Based on this, this paper employs narrative literature review and theoretical integration analysis, combined with examples of primary care doctor-patient communication, to concretely explain the technical system of MI. This includes change talk and sustain talk, the four core foundational skills, the four stages of a session, the “relational-technical” dual-path mechanism model, and the four

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pillars of the MI spirit. Furthermore, based on an analysis of typical service

scenarios and the longitudinal nature of primary care services, three adaptation strategies are proposed: capturing “MI moments” in daily outpatient clinics to embed “light-weight MI” ; establishing “mini-MI” closed-loops during family doctor contract follow-ups; and promoting the shift of health education from “one-way preaching” to “group motivation stimulation,” aiming to provide a reference for the practical implementation of MI in primary care chronic disease management. Future research should focus on advancing the construction of localized lightweight and mini-MI techniques, developing stratified and categorized MI training systems, and improving institutional supports and localized fidelity assessment tools to support the routine implementation of MI.

[Key words] Motivational interviewing; Primary healthcare services; Chronic disease management; Healthcare provider-patient communication; Health behavior change

Primary healthcare institutions are the main arena for chronic disease diagnosis, treatment, and health management. Chronic disease control depends heavily on patients’ long-term adherence to health-related behaviors such as regular medication use, a reasonable diet, sustained exercise, smoking cessation and alcohol restriction, and health monitoring^[1]. However, chronic disease patients’ long-term adherence is generally suboptimal^[2], and the effects of lifestyle interventions often diminish over time^[3-5], making the transformation of “medical advice” into “health action” a core challenge in primary chronic disease management^[6].

Provider-patient communication is a key link connecting professional medical guidance with patients’ everyday health practice^[7]. Chronic disease-related behaviors are deeply embedded in patients’ work rhythms, family responsibilities, economic conditions, social support, and emotional states^[8]. Because short-term benefits are not obvious, patients often repeatedly weigh health goals against real-life demands, and may even interrupt health behaviors^[9-10], often wavering in the early or preparatory stages of change^[11]. Although health education and risk notification are indispensable, for patients who are not yet prepared for change or who have experienced setbacks, one-way instruction and direct planning often have difficulty responding to their complex circumstances and ambivalent psychology, and may even trigger defensiveness or strain relationships^[12]; they are also significantly associated with increased non-adherence risk^[13]. Therefore, provider-patient communication should not remain merely at the level of knowledge transmission. It also needs to understand patients’ real-life circumstances, help them handle ambivalence, cope with experiences of failure, and, through building understanding and trust, managing emotions, forming a therapeutic alliance, stimulating patient agency, and improving the quality of medical decision-making, thereby improve patients’ adherence behaviors and clinical outcomes^[7]. As chronic disease management shifts toward an integrated care model, there is an urgent need to develop communication approaches that combine provider-patient alliance, empowerment, and behavioral support functions, so as to solve the problem of translating

“medical advice” into “health action” [14-16].

Motivational interviewing (MI) provides an important approach to addressing the above needs. As a collaborative, patient-centered communication method focused on behavior change, MI aims to strengthen patients’ own intrinsic motivation for change[17]. Its core mechanism is: through empathy and acceptance, to build a therapeutic alliance and emotional management space; to evoke patients’ intrinsic values and stimulate patient agency; and to achieve patient empowerment through collaborative partnership, thereby reaching shared understanding and high-quality medical decision-making. Empirical studies show that MI has positive effects in fields such as hypertension, diabetes, and chronic obstructive pulmonary disease[18-24]; it can also improve healthcare providers’ communication self-efficacy and job satisfaction, and reduce occupational burnout[25-26]. These characteristics of MI complement the deficiencies of traditional communication models and are highly consistent with the requirements of provider-patient communication in primary chronic disease management[15-16].

Domestic studies have confirmed the cross-cultural applicability and positive intervention effects of MI[27-29]. However, MI is mostly implemented in standardized and controllable research settings by specially trained personnel, with sufficient time and relatively fixed intervention procedures. This differs markedly from real primary care settings (short consultation time, heavy workload, and fragmented communication), and medical staff find it difficult to reproduce standardized MI conversations under a “research environment.” There is still insufficient discussion on “how to identify MI opportunities within limited time and in what form to embed MI into daily consultation, follow-up, and health education processes.” Based on this practical gap, it is necessary to propose MI application strategies suited to real primary care contexts, promoting the transformation of MI from a structured intervention into an identifiable, embeddable, and sustainable everyday communication approach.

Based on this, the present article is positioned as an applied narrative review. It adopts methods of narrative literature review[30] and theoretical integrative analysis to organize the literature on MI theory, mechanisms, primary care application evidence, and brief behavior change counseling; combines this with examples of provider-patient communication in primary care to systematically explain the MI theoretical and technical system; and finally, based on typical primary care service scenarios in China, proposes MI application strategies suited to real communication contexts, in the hope of providing a reference for the promotion and application of MI in primary care.

1 The Theoretical Foundations and Technical System of MI: An Integrative Analysis Based on Dialogue Examples in Primary Chronic Disease Management

MI was proposed by Miller and Rollnick in the 1980s and was initially mainly applied to addiction intervention[31]. As the theory evolved, by the fourth edition the definition of MI had been updated to “a particular way of talking with people about change and growth,” aiming to strengthen their internal motivation and commitment to change[17] (to fit the provider–patient communication context, the term “the person” is hereafter uniformly referred to as “the patient”). As a systematic communication method, MI contains a complete theoretical and technical system. To present the communication style and operational logic of MI more intuitively and clearly, this article will combine typical provider–patient communication examples in primary chronic disease management to systematically explain the relevant theories and technical system of MI.

Table 1 uses a family doctor outpatient scenario as an example, presenting two communication modes used by a physician during a face-to-face visit with a 45-year-old male patient with diabetes regarding lifestyle adjustment and adherence promotion. The following text will begin with the characteristics of the patient’s language, and, combining this dialogue example with MI theory, systematically explain MI’s conversation strategies, process framework, and deeper mechanisms.

1.1 Viewing Behavior Change Through Patients’ Language Expression: Change Talk and Sustain Talk

In provider–patient communication in chronic disease contexts, patients who are in an ambivalent state...

Table 1 Sample dialogues: traditional communication vs motivational interviewing in primary care chronic disease management

Communication round	Traditional “education—advice—persuasion” communication style	Motivational interviewing communication style
Opening	Doctor: Your blood glucose is still poorly controlled. Today’s fasting level is 9.8, too high. Patient: Recently I’ve been eating a bit randomly and can’t control it well.....	Doctor: Today your fasting blood glucose is 9.8. What do you think of this result? (open-ended question) Patient: Recently I’ve been eating a bit randomly and can’t control it well..... (sustain talk)

Communication round	Traditional “education—advice—persuasion” communication style	Motivational interviewing communication style
Responding to difficulties	Doctor: If you keep going like this, problems are sure to occur. Diabetes is not something to be taken lightly; it can damage the eyes and kidneys, and may even lead to amputation. Patient: Hmm……I know……	Doctor: It sounds as if you have noticed that eating is somewhat difficult. Have you tried any methods before that made it easier to control your diet? (reflection + open-ended question) Patient: For a while I changed the rice I ate at dinner to multigrain rice, and my blood glucose did come down a bit. But later I got lazy again……(change talk + sustain talk)
Responding to ambivalence	Doctor: You are simply paying too little attention! I told you last time that diet must be controlled, you must exercise, and you must take your medicine on time. Patient: I am taking the medicine; I just sometimes forget.	Doctor: When you adjusted your staple food, your blood glucose improved. That shows you do have methods. When you say you “got lazy,” perhaps it is also related to being tired from work and lacking energy? (affirmation + complex reflection) Patient: Yes, when I get home from work I am too lazy to move and don’ t want to deal with eating. (sustain talk)

Communication round	Traditional “education—advice—persuasion” communication style	Motivational interviewing communication style
Establishing focus	Doctor: You must not forget to take your medicine. Your blood glucose is unstable because of this! Have you insisted on walking every day? You do not exercise, and you do not take your medicine reliably, so how can your blood glucose be controlled? Patient: Sometimes when I get off work too late, I simply don’ t move……	Doctor: You usually work very hard, and in the evening you also want to keep healthy; it is already not easy. Which part do you most want to begin adjusting now—diet, exercise, or medication? (affirmation + focusing) Patient: Taking medicine should not be difficult; I just sometimes forget…… (ability-type change talk)
Evoking motivation	Doctor: You can’ t use forgetting as an excuse. If you don’ t move, how will your blood glucose go down? Next time if it is still like this, I can only consider increasing your medicine. Patient: Sigh……	Doctor: You accept taking medicine; you just need a little reminder. (reflective listening + reframing) Patient: Yes, I am thinking whether I can set a phone reminder. (mobilizing CT)

Communication round	Traditional “education—advice—persuasion” communication style	Motivational interviewing communication style
Forming a plan	Doctor: Starting now, you must get moving strictly. First, walk briskly for 30 minutes every day; second, eat less rice and noodles and more vegetables; third, you must take your medicine on time. Have you remembered these points? Patient:Okay, I’ ll try.	Doctor: Good idea; it is very practical and can help you manage your blood glucose more steadily. You have already thought through the first step. If later you want to discuss diet or exercise, you can bring it up anytime. You can decide the pace yourself. (summary + respect for autonomy) Patient: I can start with taking medicine first; as for exercise, I will talk about it after I have adjusted my condition. (mobilizing change talk + desire-type change talk) Doctor: Very good. Starting from what you already feel confident about—this arrangement is very mature. (affirmation)

Patients often intersperse expressions of wanting to change and not wanting to change in their speech^[17]. The MI communication framework defines any patient language oriented toward change as change talk, and defines language that provides reasons, wishes, or experiences of failure for maintaining the status quo as sustain talk. Taking the patient in the example: “Recently I’ ve been eating a bit randomly and can’ t control it well” expresses real-life barriers and belongs to sustain talk; whereas “For a while I changed the rice I ate at dinner to multigrain rice, and my blood glucose did come down a bit” reflects a successful experience and belongs to change talk. Sometimes the two kinds of talk appear at the same time, as in “I just sometimes forget to take it,” which both contains acceptance of taking medication on time (change talk) and retains an implementation barrier (sustain talk), showing a typical ambivalent state of change.

MI makes a fine distinction between these two kinds of talk. Its theoretical basis is self-perception theory^[32] and commitment-consistency theory^[33]: when individuals verbally express reasons or commitments for a certain behavior, they will subsequently create self-cognitions and motivational states consistent with that expression. Based on this, MI holds that a person's motivation to change is not a static "have or have not," but is in dynamic fluctuation. Thus, the core logic chain of MI operation is formed: doctor-patient interaction guides patient language (eliciting change talk or sustain talk) → the patient's verbal expression reshapes internal motivation → the strength of internal motivation ultimately determines the probability of behavior change. Therefore, the fundamental goal of MI is: through specific communication strategies, to elicit and reinforce change talk, soften and reduce sustain talk, and tilt the balance of intrinsic motivation toward behavior change.

1.2 From traditional responses to MI response strategies: four core foundational skills

When facing patients' change talk and sustain talk, the way health-care professionals respond directly affects the subsequent direction of patients' language. In traditional "education—advice—persuasion" communication, health-care professionals tend to point out problems and behavioral requirements directly. For example, when a patient expresses "eating randomly, can't control it well" (sustain talk), the traditional response is often "If you keep going like this, problems are sure to occur" (risk intimidation); when a patient says "sometimes I forget," the traditional response is "You can't use forgetting as an excuse……medicine must be taken on time" (denying difficulties and applying pressure). This type of response ignores the patient's living context and only causes the patient to repeatedly reinforce difficulties, continuously utter sustain talk, and consolidate a stance of "not changing."

In contrast, MI advocates adopting differentiated response strategies according to the different directions of the patient's language: for change talk, the emphasis is on evoking and reinforcing; for sustain talk, the emphasis is on understanding, accepting, and appropriately softening. The basic tools for implementing these strategies are the four core skills of MI^[34], namely open questions, affirmations, reflective listening, and summaries, abbreviated as OARS from their initial letters.

In the example, when the patient says "got lazy again," the doctor responds, "Perhaps it is also related to being tired from work and lacking energy," which is a deep reflection of sustain talk, understanding the difficulties behind it and creating a safe atmosphere; when the patient says "I just sometimes forget," the doctor responds, "You just need a little reminder," thereby transforming the barrier into a gentle solution through reframing. To evoke and reinforce change talk, OARS skills are used in combination. The doctor uses an open-ended question to evoke the patient's internal resources ("Have you tried any methods before?"); when the patient describes a successful experience, affirmation is used

for reinforcement (“That shows you do have methods”); as the conversation proceeds, summary is used to integrate key points and consolidate motivation (“Good idea, very practical……You have already thought through the first step”).

1.3 Advancing the conversation directionally: four stages of guiding, focusing, evoking, and planning

The use of OARS skills is not random; rather, it is embedded within the four clearly directional process stages of MI¹⁷. (1) Guiding: with the patient…

establish a collaboratively trusting partnership, create a safe atmosphere, and support the patient in openly expressing ambivalence; this process runs throughout the entire encounter. For example, the doctor asks, “How do you view this result?”, thereby inviting the patient and establishing cooperation. (2) Focusing: jointly negotiate with the patient to determine the priority topic for the consultation and avoid dispersion of content. For example, the doctor asks: “Among diet, exercise, and medication, where would you most like to start making adjustments now?” , which both respects autonomy and determines the direction of the consultation. (3) Evoking: this is the most characteristic core stage of MI. By cultivating change talk and softening sustain talk, it guides the patient to perceive intrinsic motivation. At this stage, healthcare professionals use OARS techniques to stimulate patients to state reasons and commitments for change, so that the consultation naturally moves toward change. For example, the doctor elicits through reflection: “You have accepted the fact that you need to take medication; you just need a little reminder,” prompting the patient to move from “taking medicine shouldn’ t be difficult” to proactively proposing “setting a phone reminder.” (4) Planning: when the patient’ s intrinsic motivation is mature, assist the patient in forming a concrete, executable action plan, and discuss possible barriers and coping approaches. For example, the doctor summarizes and affirms the patient’ s proposal of “setting a phone reminder,” while leaving space for the patient’ s autonomous decision-making.

It should be noted that actual consultations need to move flexibly back and forth among the four stages. If interruptions, digressions, silence, or family interference occur during the consultation, this may mean that the physician-patient relationship is disharmonious or that the patient is resistant; at this point, healthcare professionals need to observe sensitively and immediately return to the “engaging” stage to re-establish the relationship.

1.4 Why MI Is Effective: The “Relationship-Technique”Dual-Pathway Synergistic Model

The OARS skills and four-stage process described above have been systematically interpreted for their effectiveness in the “relationship-technique” dual-pathway synergistic model proposed by Miller et al.¹ The relational pathway

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constitutes the cornerstone of intervention. Through empathy, acceptance, and autonomy support, healthcare professionals create a safe atmosphere and avoid evoking defensiveness through eagerness to correct. For example, when facing a patient's self-denying statement such as "I am just lazy," the doctor does not judge, but understands the patient's fatigue, so that the patient does not need to initiate self-defense. The technical pathway provides direction and momentum for change. Healthcare professionals use MI techniques to purposefully evoke and reinforce change talk and soften sustain talk. For example, after identifying "taking medication shouldn't be difficult," the doctor reflects it as "the key is how to remind yourself," thereby promoting the patient to propose a concrete plan. Empirical studies have confirmed² that the effectiveness of MI arises precisely from the synergy of the dual pathways: the safe space created by the relational pathway enables patients to dare to face ambivalence, while the technical pathway precisely pushes patients' verbal orientation to move toward behavioral change. Neither can be absent; together they ultimately facilitate substantive behavioral transformation³.

1.5 The Foundation of All Skills and Techniques: The Four Spirits of Cooperation, Acceptance, Compassion, and Empowerment

If one further asks why the dual-pathway model can work, the answer is deeply rooted in the four spirits of MI. Miller et al.⁴ have consistently emphasized that spirit is the deep foundation that distinguishes MI from traditional didactic persuasion, and is also the root of all skills and techniques.

- (1) Cooperation: view the patient as an expert on their own lived experience, and form an equal partnership with the patient. For example, the physician does not open the consultation with one-way evaluation, but asks the patient "how do you view the result" and "where would you like to start," allowing the patient to participate in selecting the topic.
- (2) Acceptance: undertake to acknowledge the patient's current ambivalence with empathy and nonjudgment. For example, if the physician does not attribute "I can't control my mouth" to a lack of self-discipline, but instead responds, "It sounds like you have some difficulty with diet," the patient's defensiveness is reduced.
- (3) Compassion: always place the patient's welfare first. For example, the physician does not require the patient to change diet, exercise, and medication all at once, but permits the patient to start with the comparatively manageable "taking medicine on time," protecting the patient's confidence.
- (4) Empowerment: support the patient's autonomy and enhance their self-efficacy. For example, by affirming that "there is a way," reframing the problem as "needing a reminder," and evoking the patient's own action plan.

Only when the OARS skills and the four-stage process are rooted in the four spir-

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its will MI not be reduced to a tool for manipulating patients, but truly become a clinical communication method that respects patients, stimulates motivation, and promotes lasting healthy behavior change.

2 Strategies and Considerations for Implementing MI in Primary Healthcare Service Scenarios

2.1 Practical Constraints and Adaptation Pathways for Implementing MI in China' s Primary Healthcare Context

Traditional complete MI consultations require relatively sufficient time, whereas primary care outpatient time is clearly limited. A systematic review showed that primary care consultation times in the United States and the United Kingdom were 21.1 min and 9.2 min, respectively⁵; the situation in China is even more severe. A survey by this research team showed that 89.9% of physicians had more than 40 patient visits per consultation session, with an average consultation time of only 5.4 min⁶, close to the 5.9 min reported by Sun Gang⁷, fully reflecting the extreme limitation of physician-patient communication time in China' s primary care. For short medical encounters, Rollnick et al.⁸ and Beck et al.⁹ developed behavior change counselling (BCC), a consultation technique focusing on change in a single behavior, which has been promoted and used. Lane et al.¹⁰ subsequently developed a matched fidelity measurement tool. This “development-implementation-evaluation” closed loop provides a methodological reference for establishing localized brief MI techniques in China. However, this technique still requires an approximately 10 min structured counselling window. Given that single consultation times in China are generally less than 6 min and highly fragmented, wholesale transplantation of this technique remains difficult.

Therefore, adaptation of MI in China' s primary care requires another pathway. Miller et al.¹¹ proposed that MI is not an “all-or-none” intervention; in implementation, it may present a continuum from none to full. A systematic review by Rubak et al.¹² also confirmed that brief MI consultations can produce positive effects, and multiple consultations are more conducive to cumulative effectiveness. In combination with the advantage of “time continuity” afforded by China' s basic public health services and family doctor contract services, this suggests that even if only trace MI elements are used in a single encounter, cumulative benefits can still be obtained through long-term follow-up. In summary, MI cannot be designed as a lengthy consultation in primary chronic disease management, nor is it easy to transplant the full set of BCC tech-

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niques; instead, “short-duration, repeated, embedded” communication methods should be explored to adapt to primary care settings.

2.2 Embedding MI in Routine Outpatient Diagnostic and Treatment Processes: Identifying “MI Moments” and Embedding “Lightweight MI”

In routine primary care consultations for chronic diseases, the time for a single visit is only 5–6 min. Healthcare professionals often observe signals such as poor disease control, declining adherence, silence in response to recommendations, and resistance, indicating that the patient is falling into behavioral ambivalence; these are also “MI moments” that healthcare professionals should sensitively identify. For such extremely brief situations, “lightweight MI” strategies can be embedded:

It does not pursue the completeness of a conversation, but instead targets the patient’s immediate ambivalent state and intersperses a single MI technique for a 1–2 min intervention.

For example, when a patient remains silent after hearing that they should exercise more, healthcare personnel may use “reflective listening + open-ended questioning”: “When exercise is mentioned, I see that you paused for a moment. Perhaps this makes you feel somewhat difficult. Would you be willing to say what is hardest for you?” This communication approach enables the patient to quickly feel “heard” and rapidly clarifies the behavioral “sticking point.” For another example, when a patient with a chronic disease feels discouraged, the “affirmation” technique may be used: “Although your blood glucose is not well controlled, I see that you insist on measuring it every day. This precisely shows that you care a great deal about your health; persisting every day is not easy.” In this way, a connection is quickly established. If a patient is strongly resistant to dietary adjustment, the technique of “emphasizing autonomy” may be used: “Whether or not to adjust your diet is entirely up to you. I only want to understand your current concerns.” On the surface this is a “step back,” but in fact it lowers the patient’s psychological defenses. The goal of “lightweight MI” is not to reach a behavioral contract, but to “break the ice” with respect to the patient’s resistance and to leave “space” for future change. This strategy takes very little time and is also applicable to telephone follow-up and home visits for chronic diseases^[47]; its effectiveness depends highly on the precise application of a single technique and its reasonable matching with the target behavior.

2.3 Integrating MI into Contracted Follow-up by Family Doctors: Establishing a 5–10 min Closed Loop of “Micro-MI”

Contracted family-doctor services establish a stable and continuous follow-up relationship between physicians and patients^[48], and a single follow-up consultation may last 15–20 min, providing practical opportunities for implementing relatively complete “micro-MI”^[45]. After completing routine medical con-

sultation, assessment, prescription, and test arrangements in the earlier part of the visit, healthcare personnel may try to set the final 5–10 min as a fixed “micro-MI” period, devoted to addressing one chronic-disease behavioral issue of shared concern to both physician and patient.

A single session of “micro-MI” still includes four extremely concise steps: engaging, focusing, evoking, and planning. Taking follow-up for a patient with hypertension under a contracted service as an example, after blood-pressure measurement and prescription adjustment are completed, the physician conducts a micro-MI intervention targeting the patient’s tendency to “forget the medication once busy.” (1) Engaging and focusing: the physician first responds with empathy, “It sounds like you take high blood pressure seriously, but when many things come up it is easy for it to be crowded out.” The focus then becomes, “Today let’s discuss how to reduce missed doses—would that be all right?” (2) Evoking: by asking, “If you missed fewer doses, what benefit would be most important to you?” When the patient answers, “My blood pressure would be more stable; otherwise, if I had a stroke I would be unable to work or accompany my child,” the physician reflects at a deeper level: “You want to keep your blood pressure stable and support this family.” (3) Planning: guide the patient to propose a solution independently (“put the antihypertensive medicine next to the breakfast table; take it at breakfast and then tick it off in a notebook”), and agree on a small action. Thus, within 5–10 min, a brief but complete MI closed loop is formed.

2.4 Promoting the Transformation of Primary-Level Health Education from “One-Way Didactic” to “Group Motivation-Evoking”

In primary-level health lectures aimed at behavior change, “how to say it” is as important as “what to say” [49]. Traditional one-way didactic teaching often neglects the audience’s internal ambivalence and real-life barriers, making it difficult to stimulate actual action. The key to integrating MI into health education is not to reduce information delivery, but to change the way information enters the audience’s experiential world: transforming “one-way didactic lectures” into “group motivation-evoking health education.” The advantage of group MI lies in leveraging interaction among group members, peer experience, and a shared situation, transforming the audience from “passive listeners” into “experiential explorers and sharers,” jointly identifying obstacles and expressing reasons for change[50].

Taking a lecture on chronic-disease screening as an example: after explaining disease risks and the benefits of screening, the educator does not immediately shift to instruction, but uses open-ended questions to elicit real concerns: “When screening is mentioned, what worries everyone most?” When participants express their concerns, the educator uses group reflection to accept them: “It sounds like everyone is not ignoring this; rather, you have concerns about the examination process and results.” After reducing defensiveness, the educator then guides members to share experiences of benefiting from early screening, or

asks questions such as, “If screening could give you and your family peace of mind, what would that mean to you?” so that reasons for change are evoked and reinforced through peer interaction. Finally, menu-style choices are used to encourage participation and identify the smallest feasible steps. In this way, the lecture uses group motivation to transform screening from “a required task” into “a health action based on choice.”

2.5 Implementation Actors and Team Configuration: Full-Participation Model and Specialist-Backbone Model

Considering the current status of primary-level human resources, the implementation of MI may consider two types of pathways. First is the full-team participation model, in which general practitioners, nurses, public-health personnel, and others in the family-doctor team undertake brief MI tasks at different stages, such as lightweight MI when nurses measure blood pressure and during physician consultation, so that patients receive continuous and consistent supportive communication throughout the whole process^[46]. Second is the specialist-backbone model. When resources are limited, a small number of MI backbone personnel are trained to undertake in-depth counseling for cases with prominent ambivalence or repeated failures. This aligns with the concept of stepped care at the primary level, that is, behavioral counseling of different intensities is configured according to patients’ readiness for change^[51]. In primary healthcare abroad, specialized roles such as smoking-cessation counseling specialists and health coaches have already been developed^[52–53]. For example: “This patient is highly resistant; it is recommended to refer them to the MI backbone clinic for a dedicated behavioral conversation.”

2.6 Boundaries and Ethical Considerations in MI Implementation

Although MI emphasizes respect for autonomy and collaboration, its application has clear boundaries^[54]. (1) Clarify the complementary boundary with traditional health education. Health education and risk communication remain indispensable in primary-level chronic-disease management. For patients who already have relatively strong motivation for change, communication need not remain excessively in ambivalence exploration, but should more quickly shift to information provision, shared decision-making, and action planning to improve communication efficiency. (2) Clarify the boundary between medical safety and autonomy. In situations involving medical emergencies or requiring protective decisions (such as severe mental illness with lack of insight, severe cognitive impairment, etc.), MI cannot replace necessary medical coercive measures or supervisory decisions. Healthcare personnel must prioritize the duty of safety protection to balance the principles of beneficence and nonmaleficence. (3) Adhere to the ethics of confidentiality. Effective implementation of MI depends on a sense of safety and trust. When sensitive information involving health, family, and emotions is involved, confidentiality principles should be strictly observed, and the patient’s privacy and dignity must be protected.

3 Summary and Outlook

Crossing the gulf from “recommendation” to “action” is the core of primary-level chronic-disease management.

challenges. MI provides a highly valuable communication framework for this. Based on characteristics such as limited consultation time in primary care and continuous contact, and targeting typical scenarios such as outpatient visits and follow-up encounters, this article proposes an operational approach that is “brief, phased, and embedded.” It constructs a primary-care MI application strategy with identifying the “MI moment” as the entry point, embedded “lightweight/micro MI” as the core, and team-based collaborative configuration as the support. The above strategy still awaits practical verification. Future research may focus on in-depth exploration in three areas: first, building localized technical capacity, refining lightweight/micro MI models and local discourse systems adapted to typical scenarios; second, carrying out systematic training and development, constructing a tiered and classified training framework for primary-level medical care, and improving training content, teaching methods, cycle arrangements, and effectiveness evaluation; third, conducting long-term implementation evaluation, exploring institutional safeguards to support routine MI delivery, and developing localized fidelity measurement tools adapted to micro-interventions.

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