

WHEN GOOD ADVICE ISN'T ENOUGH

Brief motivational interviewing in the twelve-minute appointment—what it changes, what it costs, and what it cannot do

11.1%

Of Canadian primary-care patients with both diabetes and hypertension were highly adherent to all three prescribed therapies

A decision-maker's white paper

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Executive summary

Family physicians in Canada are being asked to manage more chronic disease with less time. Forty-six percent of Canadian adults live with at least one chronic condition. Diabetes or prediabetes now affects an estimated 11.9 million people—roughly 30% of the population—at a direct health-system cost of \$18.25 billion a year. Measured hypertension prevalence is 27.7%, and control fell thirteen percentage points between 2018–19 and 2022–24, from 55.7% to 42.7%.

Meanwhile, 5.9 million Canadian adults have no regular provider, only 27% of adults get a same- or next-day appointment when they need one, and in British Columbia that figure is 21%—the lowest in the country. Family physicians report spending ten to nineteen hours a week on administration; 46% report high burnout and 37% plan to reduce clinical hours within two years.

The constraint is not that clinicians are giving the wrong advice. It is that correct advice, repeated, does not resolve ambivalence—and repeating it consumes the only resource the system has none of.

The adherence data make the point sharply. In a Canadian primary-care cohort of 36,211 adults with both diabetes and hypertension, only 11.1% were highly adherent to all three of their antidiabetic, antihypertensive and statin therapies. High adherence to antidiabetic and statin therapy was each associated with roughly a third lower all-cause mortality risk.

Brief motivational interviewing is not a longer conversation. It is a different use of the same minutes: less time explaining, more time finding out what the person is actually deciding. The evidence supports modest, real improvements in physical activity, weight, blood pressure, alcohol use, adherence and glycaemic control. It does not support a claim of durable change from a single conversation, and it is weakest precisely where it is most often promised—smoking cessation.

The practical conclusion

- Repeated brief conversations, not one good conversation, carry the effect.
- The strongest recent evidence is in type 2 diabetes self-management; the weakest is smoking cessation.
- Use a structured brief derivative such as Brief Action Planning, which fits in three to five minutes.
- Budget for coaching. Skills decay measurably within six months without it.
- Expect effects over six to twelve months; the evidence does not support claims beyond a year.

The numbers at a glance

Indicator	Latest defensible figure	Meaning for leaders
46.1%	Canadian adults with one or more chronic diseases	The conversation in question is the most common one in primary care.
11.1%	High adherence to all three therapies (diabetes + hypertension)	Canadian primary-care cohort, n = 36,211.
42.7%	Hypertension control, 2022–24	Down from 55.7% in 2018–19.
21%	BC adults getting same- or next-day care	Lowest in Canada, tied with N.L.
10–19 hrs	Weekly physician administrative time	Any intervention that adds tasks will fail.
46%	Physicians reporting high burnout, 2025	Improved from 53% in 2021, still high.

1. The problem is not the quality of the advice

Family physicians are, by training and disposition, good at explaining. When a patient does not act on an explanation, the trained instinct is to explain better: more detail, more urgency, more evidence.

This is the correct response to one specific barrier—missing information—and the wrong response to almost every other one. Fear, competing priorities, cost, previous failure, low confidence, family disagreement, identity, and simple exhaustion are not addressed by additional explanation. They are made less visible by it, because the patient stops talking.

What the appointment actually contains

The clinician is answering	The patient is deciding
What is wrong and what should be done	Whether this matters more than everything else this week
Which medication is indicated	Whether they can afford it and tolerate it
What the guideline recommends	Whether they believe they can actually do it
What the risk is if nothing changes	Whether they have failed at this before
What the next step is	Whether they trust this will be different

These are different questions, and only one of them is usually asked out loud. An intermediate assessment in Ontario is self-reported at roughly 17.5 to 21.4 minutes. Whether those minutes are spent on the first column or the second largely determines what happens after the patient leaves.

2. Why this matters more now than five years ago

Three pressures have converged.

1. Rising chronic-disease burden

Diabetes or prediabetes is projected to reach 14.1 million Canadians by 2034. In British Columbia alone, 1.67 million people—about 30%—live with diabetes or prediabetes, at a provincial health-system cost of \$642 million a year, with diagnosed cases projected to grow 34% by 2034. Measured obesity rose from 25% to 33% between 2016–19 and 2022–24.

2. Falling disease control

Hypertension control fell thirteen percentage points in four years. That is not a communication failure alone—it reflects disrupted access and follow-up—but it means the conversations that do happen carry more weight.

3. Shrinking capacity per patient

Average panel size fell from 1,746 patients per family physician in 2013 to 1,351 in 2021. Canadian physicians report 10.4 hours a week on administration, and the CMA and CFIB estimate 18.5 million hours a year lost to unnecessary administrative tasks—the equivalent of 55.6 million patient visits. Seventy-five percent of physicians say unnecessary administration harms job satisfaction.

This last point sets a design constraint that most training programs ignore. An intervention that lengthens the appointment will not be adopted, however good the evidence behind it.

3. What brief MI actually changes

Motivational interviewing is a collaborative, goal-oriented communication method for strengthening a person's own motivation and commitment to change. In a primary-care context it does not replace advice. It changes the sequence: understand what the person is deciding, then place the advice where it will land.

Four moves that fit inside a short appointment

1. Ask permission before advising. “Would it be helpful if I shared what the evidence suggests here?”
2. Elicit first. Ask what the person already knows, has tried, and is concerned about before adding anything.
3. Test the yes. Use an importance or confidence question—“On a scale of one to ten, how confident are you? Why not lower?”
4. Close on a specific, owned step. Brief Action Planning ends with a plan the patient states, rates for confidence, and can describe.

Brief Action Planning, a structured self-management support technique grounded in MI, consists of three core questions and five skills. Experienced clinicians complete all steps in three to five minutes inside a standard twenty-minute visit. In its foundational evidence, 83% of patients created an action plan during the visit and 53% had completed it at three-week follow-up.

What changes in the encounter

Common pattern	MI-informed alternative
Open with the result and the recommendation	Open by asking what the person has noticed or is concerned about
Answer resistance with more evidence	Treat resistance as information about the conversation
Set the goal for the patient	Ask the patient to name a step they believe they can take
Ask “Does that make sense?”	Ask “What would get in the way of that this week?”
Repeat the same advice at the next visit	Ask what happened, and what would make it possible now

4. What the evidence supports—and what it does not

Supported conclusions

- Brief encounters work, and repeated brief encounters work better. In the foundational review of 72 randomized trials, 15-minute encounters produced an effect in 64% of studies; a single session produced an effect in 40% of studies, while five or more encounters did so in 87%.
- In medical care settings, MI produced a pooled odds ratio of 1.55 across 48 trials and 9,618 participants, with benefits for blood pressure, cholesterol, weight, physical activity, quality of life, alcohol and tobacco.
- The strongest recent finding is in type 2 diabetes: across 30 trials and 4,214 adults, HbA1c fell by 0.92 percentage points, rated high certainty—comparable in magnitude to adding a medication.
- For physical activity, a 2024 review of 97 trials and 27,811 participants found the equivalent of 1,323 additional steps a day, 95 more minutes of moderate-to-vigorous activity a week, and 51 fewer sedentary minutes a day.
- A recent blended eight-hour training for general practitioners produced patient-level improvements at six months: HbA1c down 0.50 percentage points and diastolic blood pressure down 5.96 mmHg versus control.

Claims the evidence does not justify

- That MI helps people stop smoking. A Cochrane review of 37 trials and more than 15,000 smokers found a relative risk of 0.84 against no treatment—not statistically significant—with low-certainty evidence throughout.
- That the effect is specific to MI. In the 2024 physical-activity review, when MI was compared with equally intensive interventions that simply lacked MI, evidence of a difference was lacking.
- That effects last. Beyond twelve months, the same review found no evidence of a difference from comparators. Another synthesis reports effect sizes falling from 0.77 at one month to 0.11 at twelve months and beyond.
- That MI beats other structured approaches. Effects are consistently larger against weak comparators than against active alternatives.
- That what is delivered in the room is MI. In the 2025 diabetes meta-analysis, only 8 of 30 trials reported any measure of MI fidelity.

The defensible claim is specific: repeated brief MI-consistent conversations, delivered by clinicians who receive ongoing coaching, produce small-to-moderate improvements over six to twelve months—strongest in diabetes self-management, weakest in smoking cessation.

5. Why one-day workshops do not work

This is the finding that should determine how a Division or Primary Care Network spends its education budget.

Across 21 training studies covering 987 practitioners, workshop training produced a substantial immediate skill gain of 0.76. Without post-workshop feedback and coaching, skills eroded over six months at an effect size of -0.30 —roughly 40% of the initial gain lost. Where coaching and feedback were provided, decay was effectively prevented, with a six-month effect size of 0.03. The sufficient dose was approximately three to four contacts totalling at least five hours over six months, and programs running 20 to 24 weeks retained better than shorter ones.

A systematic review of MI training for health care practitioners reached the same conclusion: MI competence “tends to decay quickly unless there is some systematic post-training support, supervision or training.”

What Canadian clinicians say about learning it

A Quebec participatory study followed 16 primary-care clinicians through seven meetings and nineteen hours of training with coaching, supervision, case discussion and video analysis over nearly a year. Clinicians moved through ambivalence, introspection, experimentation and mobilization. The dominant barriers were time and a perceived incompatibility with standard appointment lengths. The facilitators were protected time and funding, peer support, and manager endorsement that created a shared language across the team.

Clinicians described initial discomfort and a sense of incompetence. That is a normal and expected feature of learning this skill, and a program that does not plan for it loses people in the first month.

6. A model that fits a Division

British Columbia has 36 Divisions of Family Practice representing more than 230 communities, and 94 Primary Care Networks with approved funding. Divisions already convene accredited local education and

communities of practice. That infrastructure is a better fit for MI than a hospital in-service, because it can sustain the coaching tail the evidence requires.

Six-stage capability model

Phase	Purpose	Recommended activity
1. Define	Select one behaviour and one patient group	Baseline adherence, goal completion or follow-up attendance
2. Introduce	Build shared language and core skills	Interactive session using the group's own cases
3. Practise	Move from knowledge to usable behaviour	Brief Action Planning rehearsal under time pressure
4. Coach	Prevent drift	Small-group case review and observed or recorded samples
5. Embed	Make it normal work	MOA and team alignment; shared prompts; EMR-light supports
6. Evaluate	Test value	Compare goal completion and follow-up against baseline

Suggested 90-day pilot

Period	Actions	Evidence produced
Weeks 1–2	Recruit a small physician and team cohort; baseline one measurable behaviour	Baseline and real case scenarios
Weeks 3–4	Half-day introduction plus Brief Action Planning practice	Initial skill assessment and clinician confidence
Weeks 5–8	Apply in practice; two small-group coaching sessions	Fidelity samples and workflow barriers
Weeks 9–12	Reinforce; review early indicators	Pilot report and scale recommendation

7. Measuring it without overreaching

Stage	Measure	Timing
Reach	Clinicians and team members trained and participating	Immediately
Learning	Observed use of permission, elicitation and confidence testing	Pre/post and 30 days
Fidelity	Coded or observed consultation samples	30–90 days
Patient response	Documented patient-stated goals; goal completion at 3 weeks	30–90 days
Clinical	HbA1c, blood pressure, adherence proxy	90–180 days
Clinician	Confidence, appointment length, perceived burden	Throughout, including unintended effects

Track appointment length deliberately. The single most common objection is that MI takes longer. The evidence suggests it need not, but a pilot that cannot answer the question will not persuade the next group of physicians.

8. Risks and safeguards

Risk	What goes wrong	Safeguard
Workshop-only funding	Skills decay within six months	Fund three to four coaching contacts over six months
Appointment lengthening	Adoption collapses regardless of evidence	Train a structured brief derivative; measure visit length
Smoking oversold	The weakest evidence becomes the headline claim	Lead with diabetes self-management and physical activity
Fidelity assumed	What is delivered is warmth without technical skill	Observe practice; the technical element carries the effect
Durability oversold	Twelve-month claims are not supported	Report a six-to-twelve-month horizon and plan for repetition
Added administration	Any new documentation burden ends the pilot	Keep supports light; nothing that adds charting time

9. Recommendations for Division and network leaders

1. Name the behaviour, not the method. “Patients leave with a goal they set” beats “teach motivational interviewing.”
2. Start with diabetes and blood pressure, where the evidence is strongest and the data already exist.
3. Choose a format with a coaching tail before you choose a facilitator.
4. Train the practice team, not only the physician. Medical office assistants and nurses shape the same encounter.
5. Protect the time. In the Canadian implementation research, protected time and funding were the decisive facilitators.
6. Measure appointment length alongside outcomes, and publish the answer either way.
7. Expect discomfort in the first month and design supervision to hold people through it.

Conclusion

Primary care in Canada is being asked to do more chronic-disease work with less time per patient and fewer patients per physician than a decade ago. In that environment, the instinct to explain more is both understandable and expensive: it consumes the scarcest resource in the system and, when the barrier is ambivalence rather than ignorance, it does not work.

The alternative is not a longer appointment. It is a different distribution of the same minutes—fewer spent delivering information the patient may already have, more spent discovering what they are actually deciding and what would make the next step possible.

The evidence for this is real and it is modest. Presented as modest, it is persuasive. Presented as transformative, it will not survive the first physician who reads the Cochrane review on smoking.

For a Division of Family Practice or a Primary Care Network, the appropriate next step is small: one cohort, one behaviour, one baseline, a coaching tail long enough to matter, and an honest measurement of whether the appointment got longer. If it did not, and patients left with goals they set themselves, the Division has something worth scaling.

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Brittany Godin works with health and social-service organizations on the communication skills that determine whether good intentions become completed care. Through Compassion Campus she teaches and coaches motivational interviewing as an operational capability—built through practice, observation and feedback rather than delivered as a one-time workshop—and helps leaders design pilots that test whether better conversations actually change what happens next.