In this Issue On

LIFESTYLE & HEALTH, II: STRESS & TOBACCO USE

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July 2011

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- *The 'Links' and websites are extremely helpful to look further…as we encounter questions.*

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(Mis)Diagnosis Stress: A Personal & Professional Perspective

Page 5 of this issue reports a situation in which a patient's serious medical condition was initially misdiagnosed as being caused by anxiety. We also reported a similar occurrence in January 2002 with a Book Review noting the author's account of her own such experience.[1] In both cases, the primary complaint was that their doctors would not listen to them – would not consider another diagnosis. And there are many more patients, myself included, who have experienced similar difficulties.

In many cases, a diagnosis of stress is reached when symptoms are atypical and diagnostic tests are either negative or inconclusive. When that happens, it seems that some physicians are more inclined to believe test results which they know can be false, than they are to believe their patients who deny that stress is the problem. In other words, test results that may present false positives or negatives are often seen as more trustworthy than patients. Trust, then, is a major issue here – maybe even *the* major issue. It certainly was for me, as a patient.

I've since become aware that patients are reputed (perhaps deservedly so), to lie or, at least, to not be fully honest with their doctors about what they are, or are not, doing. To the extent that this is true, it's no wonder doctors tend to distrust their patients. Nevertheless, not all patients lie. So the questions I carried around as a professional have been: what would it take for doctors to trust their patients enough to explore, and not dismiss, their insights? And, how can doctors facilitate honesty?

Then, in June of 2010, while attending ENRICH – the annual 5-day course sponsored by the American Academy of Communication in Healthcare – an answer presented itself.[2] It was one that had been right under my nose – one I had been advocating all along: building relationships is key to building trust. While I have written and spoken on the importance of mutual trust, my focus had primarily been on steps clinicians can take to gain the trust of their patients. At ENRICH, I realized that by taking those steps, clinicians also make it easier for patients to be more open and forthcoming – more trustworthy. This, in turn, can help clinician and patient build the mutually respectful relationship that is so essential for effective healthcare. And this brings me to the source of my 'Aha!' moment – when RESPECT was introduced during a series of workshops at ENRICH.

RESPECT is an acronym for a model of interaction described as an "…action-oriented set of communication and relational behaviors designed to build trust across differences of race/ethnicity, culture and power."[3] Its designers see this model as useful for preceptors in medical training as well as for physician-patient interactions. Although discussions of this model focused largely on its value of encouraging medical trainees/patients feel comfortable with and trust their preceptors/physicians, its intention of also building trust in the reverse direction was clear. To illustrate, the following application of the model shows how each step can help doctors build mutually trusting relationships.[4]

Steps of RESPECT

Respect – A respectful approach helps reduce defensiveness.
"I appreciate how hard this has been for you…"

Explanatory Model – Seeking patients' explanations of their symptoms conveys an interest; presents a starting point for discussions (not dismissals); and can promote patients' forthrightness.
"What do you think is causing your symptoms? Why?"

Social Context – 'Chit chat' can promote comfort and provide insights into patients' well-being.
"How are you doing today?" "How's work?" "How is the family?"

Power – Resisting the impulse to take over and finding ways to share power can encourage patients to think of themselves as partners in care, not consumers guided by the motto: Buyer Beware!
"What would you like to do? Why?

Empathy – Responding to feelings heard 'between the lines' and not judging those feelings, shows that you're not only listening, but that you 'get it.'
"That sounds so difficult (frustrating, frightening, etc.)."

Concerns – Eliciting concerns can help patients start to process information and reach decisions.
"You seem reluctant to…" "Why?"

Trust – Acknowledging patients' sharing of info can encourage them to continue doing so.
"I really appreciate your sharing that with me."

[1] See **www.healthcp.org/pro/hcrps/v2n1PS-Wolf.pdf**
[2] Visit **www.aachonline.org**
[3] Visit **www.ncbi.nlm.nih.gov/pmc/articles/PMC2847117/pdf/11606_2010_Article_1274.pdf** for "Treating and Precepting with RESPECT: A Relational Model Addressing Race, Ethnicity, and Culture in Medical Training" by Carol Mostow, et al.
[4] See Note 3 for the designers' detailed description.

Helping Patients Quit Smoking

By Barbara Gallagher

We all know that smoking can lead to myriad diseases and chronic conditions. By intervening and helping patients quit smoking, doctors can improve the chances smokers have for affecting long-term change. Indeed, a review of 28 smoking cessation trials showed that physicians who gave brief advice or counseling to their patients to stop produced cessation rates of 5 to 10% and more intensive interventions resulted in 20 to 25% quit rates. Also, an analysis of National Cancer Institute-funded trials on smoking cessation showed that patients who receive interventions from their physicians have long-term quit rates that are two to six times higher. Recommendations also strongly support the value of referral to more intensive counseling. The question then becomes: How, exactly, should doctors intervene?

The National Cancer Institute offers one suggestion – use of the "5 As" Model, developed by the Agency for Health Care Policy and Research (AHCPR).[1] We would also propose that in using this, or any other specific approach, clinicians would do well to take into account the Stages of Change Model which was reported in the prior issue of this publication and which encompasses RESPECT.[2] To that end, what follows below is a brief description of the **5 As (ASK, ADVISE, ASSESS, ASSIST, ARRANGE)** along with their correlation to the **Stages of Change (SOC) Model**.

ASK and ADVISE. Clinicians are urged to **ASK** about smoking and quit history at every visit. Discuss pros and cons as well as benefits of smoking. **ADVISE** all tobacco users to quit. Advice should be clear, strong, and ideally targeted towards each patient's relevant personal health concerns and social situation. **SOC Model: Precontemplative Stage.** The goal here is to help patients (who may not be ready to change) to start thinking about doing so. Additionally, while giving information clinicians are urged to avoid scaring their patients.

ASSESS the patient's willingness to quit. If they are ready to try within the next 30 days, offer help with deciding on a treatment plan. If the patient is not ready, then try to identify factors guiding the decision and provide education as needed. **SOC Model: Contemplation Stage.** The goal is to help patients' decisionmaking process by helping them weigh the pros and cons; by acknowledging the difficulties; and by offering moral support as well as kudos for thinking about change.

ASSIST patients when they've decided to quit. Discuss intervention options and common misconceptions about quitting. Review nicotine withdrawal symptoms, identify environmental triggers, rehearse coping skills and advise them to set a quit date, within 2 weeks of the clinical encounter. **SOC Model: Preparation Stage.** The goal is to help patients plan small steps, the success of which can help them take more decisive steps later. Encourage them to address one barrier at a time and to keep you in the loop.

ARRANGE for follow-up contact with the patient, ideally within one week of the quit date and then monthly thereafter, to review treatment progress and determine any necessary adjustments. **SOC Model: Action and Maintenance Stages.** Reinforce patients' decisions; praise even small achievements; provide continuing support and encouragement; and ask what else they might need for continued success.

SOC MODEL: Relapse Stage. Perhaps a major distinction of this model is its recognition of the importance of continued support and encouragement, not only for help with maintenance but for making a renewed commitment should they relapse. Remind them that a lapse is normal and can be used as a learning experience. Review the circumstances that caused it. Discuss problems encountered (i.e., weight gain, depression, nicotine withdrawal, lack of support) and suggest alternative behaviors.

[1] See **http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.pdf** *Helping Smokers Quit: A Guide for Clinicians*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

[2] See Gretchen L. Zimmerman, PsyD. et al. "A 'Stages of Change' Approach to Helping Patients Change Behavior." *American Family Physician*. March 1, 2000 at **www.aafp.org/afp/20000301/1409.html**; and "Stages of Change and Physician Intervention at Each Stage" at **http://www2.medicine.wisc.edu/home/naa/stages of change**.

Resources

Guidelines

- **FREE Clinical practice guidelines**: **www.ahrq.gov/path/tobacco.htm**; and **www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.pdf**
- For more information on prescribing, precautions, and side effects: **www.ahrq.gov/path/tobacco.htm**.
- M.C. Fiore, et al. *Treating Tobacco Use and Dependence: 2008 Update*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

Educational Opportunities

Mayo Clinic's Nicotine Dependence Center (NDC) offers CE Distance Learning programs to help professionals learn and incorporate the nicotine dependence treatments that NDC has applied with great success. One-hour webcasts are $30 for Mayo Staff and $40 for others. For more information, visit **http://mayoresearch.mayo.edu/mayo/research/ndc_education**.