# GENERAL PRACTICE

COUNSELLING SKILLS

## GPs can help patients to stop smoking

Colin P Mendelsohn and Robyn Richmond

Smoking is a major health issue in general practice and continues to be the greatest single preventable cause of illness and death in the Australian community. Currently 30% of men and 27% of women in Australia are smokers.[1]

Family doctors have an important role in helping people to stop smoking. They have a high contact rate with the general public[2] and are accessible to over four million adult smokers in Australia annually.[3] They frequently find themselves in the "teachable moment" of an illness, when they can present objective evidence of organ damage at a time when the "captive" patient is most likely to be receptive to the "stop smoking" message.[4-7] Most smokers (80%–90%) would like to stop smoking,[8,9] and consider their doctor to be an appropriate person to help them to quit.[7]

Over the last decade, general practitioners have shown in clinical trials that they can be effective in helping smoking patients to quit. Studies have shown that very brief general practitioner advice generally yields smoking quit rates of 5%–12%,[10-15] such as the Sick of Smoking program from Adelaide, which had a one-year abstinence rate of 11.3%.[14] However, higher abstention rates of 20%–38% are achieved with a larger investment of the doctor's time and a greater intensity of counselling.[13,16-21] The original Smokescreen program, a smoking cessation program for general practitioners developed in the early 1980s in the School of Community Medicine at the University of New South Wales, Sydney, had a three-year biochemically validated success rate of 36%.[16]

With these reported success rates, it is therefore surprising to find that general practitioners identify only 56% of smokers within their patient populations and intervene with even fewer.[22] There are clearly a number of barriers which block effective intervention in smoking. The purpose of this article is to look at three of the problem areas confronted by general practitioners and to suggest some practical solutions. These are: (i) how to raise the subject of smoking; (ii) how to assess the patient's readiness to quit; (iii) how to motivate ambivalent smokers. The following guidelines form the basis of Smokescreen for the 1990s[23] — a recently revised and updated version of the original Smokescreen program.

### How to raise the subject of smoking

Doctors often express concerns about how to actually introduce the subject of smoking. Some patients become quite aggressive and hostile when challenged about their habit. Also, the doctor is often anxious about being unpopular or being seen as a "wowser" when confronting the patient about his/her last remaining pleasure! It is important, therefore, that the subject of smoking is raised in a non-confronting and non-

Smokescreen Unit, Prince of Wales Hospital, Randwick, NSW 2031.
Colin P Mendelsohn, MB BS(Hons), General Practitioner; Smokescreen workshop trainer for general practitioners.
Robyn Richmond, MA, PhD, Associate Professor, School of Community Medicine, University of New South Wales.
Correspondence and reprints: Dr Colin P Mendelsohn.

threatening way. A useful open-ended question, used in the revised Smokescreen for the 1990s, is: "How do you feel about your smoking?"

This method of raising the subject is non-judgemental and avoids implying the need for change, as is the case with a direct question like: "Don't you think you should stop smoking?" The neutral question allows the patient to respond in an honest way, without feeling under pressure from the doctor. The patient is more likely to answer truthfully, rather than give the answer he/she thinks the doctor wants to hear. This opening question often leads into a dialogue on the patient's concerns about his/her smoking and about quitting, which may then be addressed. It also begins the process of assessing the patient's readiness to change.

## How to assess the patient's readiness to quit

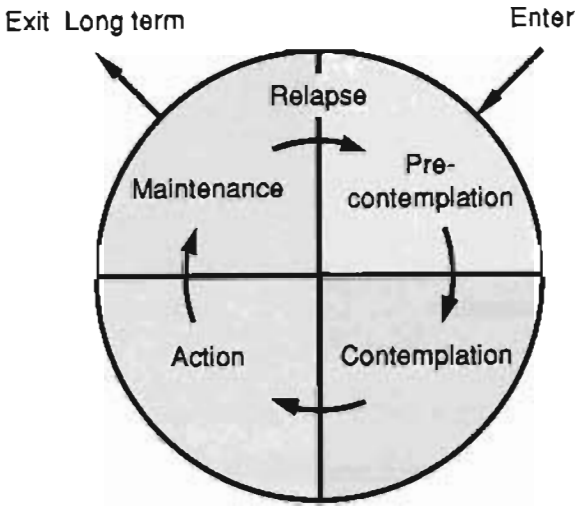
A key element in smoking cessation is identifying the readiness of the smoker to quit smoking. If a smoker is not ready to stop, lecturing, intimidation and scare tactics used by the doctor will be ineffective, and in most cases counterproductive. Many of the doctor's past failures have been from trying to help smokers who are not yet ready to quit, rather than the result of the doctor's poor counselling technique.

The resulting high failure rate for smoking cessation leaves the doctor feeling discouraged, frustrated and low in confidence.[24,25] Doctors need to see regular successes to maintain their motivation and interest in continuing to help patients to quit. The high success rates of many other medical treatments lead doctors to expect the same for smoking cessation. These expectations are often unrealistically high, causing further disappointment for the doctor.[15] A 100% cure rate for tonsillitis may seem reasonable, whereas in smoking cessation a success rate of 20%–30%[7,10,16,18] is very good.

A valuable model for assessing a person's readiness to stop smoking is the Stages of Change model which was developed by Prochaska and DiClemente (Figure).[26] This model recognises that, at any one time, smokers are either not ready (precontemplation stage), unsure (contemplation stage) or ready (action stage) to stop smoking. Clearly, smokers in each stage of readiness to change have different needs and require different interventions.

### *The "not ready" group*

Sixty per cent of smokers at any one time are not ready to quit.[27] These smokers are not thinking about quitting and may be resistant to any attempt to even discuss the subject. They generally see more positive aspects in smoking and do not like to acknowledge the disadvantages. Not ready smokers should be gently encouraged to think about their habit and advised that the doctor is




*A model of the change process in the addictive behaviours (adopted from Prochaska and DiClemente[26]). Reproduced from Richmond and Heather, with permission.[5]*

available to help should they wish to stop later. The intervention should be very brief, as these smokers are fairly resistant and change is unlikely at this stage.

### *The "unsure" group*

Thirty per cent of smokers are uncertain or ambivalent about their smoking.[27] They are thinking about the benefits of stopping smoking, but are also aware that there are disadvantages to quitting. Smokers in this stage are open to a discussion about smoking and about quitting. The aim with unsure patients is to assist them to examine their habit, to help them weigh up the pros and cons of their smoking, and decide whether continuing to smoke is worth it at the moment. A discussion of their particular concerns about smoking and about quitting will often uncover a barrier, such as worry about weight gain or concern about withdrawal symptoms, for which assistance may be offered.

### *The "ready" group*

Only 10% of smokers at any one time are actually ready to stop.[27] They have made a commitment to seriously attempt to stop smoking. For them the disadvantages of smoking outweigh the benefits. This group justifies a more active intervention by the doctor. Ready patients need specific brief advice to help them overcome withdrawal symptoms and triggers for smoking as well as a lot of support. It is interesting that, during the 1980s, all smokers were offered the same smoking cessation intervention regardless of their readiness to change. Such an approach was based on the assumption that, if identified and asked to stop, all smokers would in fact do so. The low cessation rates show that this blanket approach

is not appropriate for all.

### *The value of the model*

There are many benefits in categorising smokers according to their readiness to change. It maximises the use of the doctor's resources; little time is wasted on smokers who are not yet ready to deal with their habit, and more time is spent on patients who are most likely to benefit from it. The interventions are also more likely to be successful, as they are more appropriately targeted to each group's needs and concerns than is a rigid single approach for all patients. The doctor is therefore spared the frustration of repeated failures and maintains his/her enthusiasm to help the next smoker as a result of the positive reinforcement from successful brief intervention. Furthermore, there is also less risk of hostile responses from not ready smokers who would otherwise be advised to stop smoking by enthusiastic doctors.

The Stages of Change model is a dynamic continuum, in which smokers move from one stage of readiness to another, as a result of various personal, work and social circumstances. For example, a smoker will pass from being unsure to ready when he/she perceives that the disadvantages of smoking exceed the benefits. For some, the health issues will be the major concern. For others, workplace bans, social pressures, wanting to set a non-smoking example to children or cost may be the trigger. Success in intervening is redefined, not as simply assisting the patient to stop smoking, but rather as helping the patient move through the stages in order to achieve abstinence eventually. Therefore, all smokers can be helped, irrespective of their stage of readiness.

General practice is the ideal context in which to assist smokers, owing to the ongoing nature of the doctor-patient relationship. Over a period of time, the doctor will have many opportunities for intervening with the smoking patient who may present at various times in different stages of readiness to change. A patient who is not ready today may return in three months' time ready for help. An unsure smoker may require a number of interactions before making the final decision to quit or a ready smoker may require several attempts before stopping successfully.

This model also has valuable applications for intervening in a range of other lifestyle behaviours in general practice. It could be used to assess the readiness of a patient to lose weight, to reduce alcohol consumption, to begin an exercise program or to leave a partner. Once the stage of readiness to change has been assessed the most appropriate assistance can be offered.

## How to motivate ambivalent smokers

Motivational interviewing[28] is a style of counselling for patients who are ambivalent or unsure about a behaviour such as smoking, which can assist them to explore their habit and concerns about it. This may help them to move along the Stages of Change continuum towards becoming ready to quit.

**Weighing up the pros and cons of smoking***

1. "What do you like about smoking?"
2. "What are the things you don't like about smoking?"
3. Summarise your understanding of the patient's pros and cons.
4. "Where does this leave you now?"

*From Richmond et al.[27]

The four steps of motivational interviewing used in Smokescreen for the 1990s are listed in the Box. Important skills used in this process are open-ended questions and reflective listening. Firstly, the doctor elicits the patient's own thoughts about the good and bad aspects of his/her habit and selectively reflects them to the patient to encourage continued exploration and awareness of the problem. The doctor then summarises the position, first the good then the bad aspects, and encourages the patient to look at the balance. This allows the patient to decide whether to change his/her behaviour.

A key principle of motivational interviewing is that the patient takes responsibility for the problem. In most other medical interactions, the doctor tends to give advice or tells the patient what to do. However, patients are more likely to make a decision to change a behaviour if they have reached that decision by their own reasoning.

Confrontation and telling the patient what to do frequently create resistance and denial and should be avoided. Saying "Smoking is bad for you — you should really stop" often leads to a response of "Yes, but . . .". The patient responds by producing counterarguments to defend his/her position which further consolidates and entrenches the habit. The result is that the patient keeps on smoking.

This approach may be much easier for the doctor than traditional counselling techniques. The doctor does not carry the full weight of responsibility for solving the patient's problem, there is less arguing the case with a defensive patient, and the doctor does not have to have all the answers. Rather the doctor acts as a resource person or facilitator.

General practitioners spend much of their time trying to persuade people to change their behaviour. Motivational interviewing is a skill that is also applicable to other common general practice dilemmas, such as how to motivate patients to deal with obesity and other substance abuse, such as alcohol abuse.

## Conclusion

General practitioners can help their patients stop smoking by raising the subject in a non-confrontational

way, assessing the patients' readiness to stop smoking and using brief motivational interviewing skills to motivate ambivalent smokers to make a change. Success rates are likely to be higher and this will help maintain the doctor's interest and motivation over time.

### References


1. Hill DJ, White VM, Gray NJ. Australian patterns of tobacco smoking in 1989. *Med J Aust* 1991; 154: 797-801.
2. Bridges-Webb C. General practitioner services. *Aust Fam Physician* 1987; 16: 898.
3. Estimated resident population by sex and age, States and Territories of Australia. Canberra: Australian Bureau of Statistics, June 1988 and preliminary June 1989. (Catalogue No 3201-0.)
4. Mendelsohn C. Utilisation of the "Smokescreen" smoking-cessation programme [letter]. *Med J Aust* 1989; 151: 487.
5. Richmond R, Heather N. General practitioner interventions for smoking cessation: past results and future prospects. *Behaviour Change* 1990; 7(3): 110-119.
6. Baumgartner K. Smoking cessation: physician make a stand. *Can Med Assoc J* 1982; 126: 101-102.
7. Richmond RL, Webster IW. A smoking cessation programme for use in general practice. *Med J Aust* 1985; 142: 190-194.
8. Modern Medicine Smoking Survey. *Modern Medicine of Australia* 1964 Aug 7: 1-4.
9. Medical Practice Smoking Survey. You're setting the pace in the fitness stakes. *Medical Practice* 1983 Sept: 22-24.
10. Russell MAH, Wilson C, Taylor C, Baker CD. Effect of general practitioners' advice against smoking. *BMJ* 1979; 2: 231-235.
11. Russell MAH, Merriman R, Stapleton J, Taylor W. Effect of nicotine chewing gum as an adjunct to general practitioners' advice about smoking. *BMJ* 1983; 287: 1782-1785.
12. Russell MAH, Stapleton JA, Jackson PB, et al. District programme to reduce smoking: effect of clinic supported brief intervention by general practitioners. *BMJ* 1987; 295: 1240-1244.
13. Schwartz JL. Review and evaluation of smoking cessation methods, United States and Canada, 1978–1985. Bethesda, Maryland: National Institutes of Health, 1987. (NIH Publication No. 87-2940.)
14. Wilson DH, Wakefield MA, Steven ID, et al. Sick of Smoking: evaluation of a targeted minimal smoking cessation intervention in general practice. *Med J Aust* 1990; 152: 518-521.
15. Slama K, Redman S, Perkins J, et al. The effectiveness of two smoking cessation programmes for use in general practice: a randomised clinical trial. *BMJ* 1990; 300: 1707-1709.
16. Richmond RL, Austin A, Webster IW. Three year evaluation of a programme by general practitioners to help patients stop smoking. *BMJ* 1986; 292: 803-806.
17. Richmond RL, Kehoe L, Makinson RJ, et al. One year evaluation of three smoking cessation methods in general practice. *Addict Behav* 1993. In press.
18. Wilson D, Wood G, Johnston N, Sicurella J. Randomized clinical trial of supportive follow-up for cigarette smokers in family practice. *Can Med Assoc J* 1982; 126: 127-129.
19. Glynn TJ. Relative effectiveness of physician-initiated smoking cessation programs. *Cancer Bulletin* 1988; 40: 359-364.
20. Ockene JK. Smoking intervention: the expanding role of the physician. *Am J Public Health* 1987; 77: 782-783.
21. Kottke TE, Battista RN, DeFriese GH, Brekke ML. Attributes of successful smoking cessation interventions in medical practice: a meta-analysis of 39 controlled trials. *JAMA* 1988; 259: 2883-2889.
22. Dickinson JA, Wiggers J, Leeder SR, Sanson-Fisher RW. General practitioners' detection of patients' smoking status. *Med J Aust* 1989; 150: 420-426.
23. Richmond R, Webster I, Elkins L, et al. Smokescreen for the 1990s, the stop smoking programme for use by general practitioners. Sydney: School of Community Medicine and National Drug and Alcohol Research Centre, University of NSW, 1991.
24. Glynn T. Physicians and a smoke-free society. *Arch Intern Med* 1988; 148: 1013-1016.
25. Orleans CD, George LK, Houpt JL, Brodie KH. Health promotion in primary care: a survey of U S. family practitioners. *Prev Med* 1985; 14: 636-647.
26. Prochaska JO, DiClemente CO. Towards a comprehensive model of change. In: Miller WR, Heather N, editors. Treating addictive behaviours: processes of change. New York: Plenum, 1986: 3-27.
27. Prochaska JO. From recruitment to recovery: a stage analysis of smoking cessation. Presented at the conference — Brief Interventions for Smokers: An International Perspective, Sydney, April 1990.
28. Rollnick S, Bell A. Brief motivational interviewing for use by the non-specialist. In: Miller W, Rollnick S. Motivational interviewing: preparing people for change. New York: Guilford, 1991.


## SPECIAL PROBLEMS

# Anterior cruciate ligament injuries

## Clues for diagnosis

Mark M J Perko, Mervyn J Cross, Dean Ruske and Robyn Phillip

Interest and participation in sports are fostered at all levels in Australia. Commonwealth Government statistics indicate that 71% of people engage in some form of recreational activity, and of these 26% engage in organised sports.[1] With increasing numbers of participants there has been an increase in injuries; lower extremity injuries are commonest, and about one-third of these are to the knee and ankle. Of specifically ligamentous injuries to the knee, rupture of the anterior cruciate ligament (ACL) is the commonest and has the potential for causing the greatest disability; this has implications for longer-term consequences. Early diagnosis is important for prevention of further injury, institution of appropriate treatment and resumption of activity. ACL injuries have been recognised for decades yet they are

North Sydney Orthopaedic and Sports Medicine Centre, 286 Pacific Highway, Crows Nest, NSW 2065.
Mark M J Perko, MB BS, FRACS, Orthopaedic Surgeon.
Mervyn J Cross, MB BS, FRACS, Orthopaedic Surgeon.
Dean Ruske, Medical Student.
Robyn Phillip, BSc, Research Assistant.
Correspondence and reprints: Dr Mark M J Perko