Ask not what your doctor can do for you— Ask what you can do for your doctor

In our present system, without including clinical prevention, frontline physicians have too much to do and too little time in which to do it. To add to the primary care workload the clinical preventive measures that have been proven effective is to invite their non-performance. Professionals in other disciplines such as dentistry and pharmacy have trained co-workers who complement and support the work done by the senior professionals. Family physicians generally do not have such support. They work under a model that began in the 19th century. The time has come to introduce into primary medical care a staff person who would do for medical care what the dental hygienist has been doing preventively for dental care for the last 30 years. This new staff role would offer the components of prevention that don't require the physician's skills or relationship with the patient. That role could be called "preventive hygienist" or "medical hygienist."

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What we in the Society for Clinical Preventive Health Care (formerly the BC Doctors' Stop-Smoking Program) have learned in 15 years of helping doctors help their patients stop smoking is that clinical prevention needs to be simple, easy, effective, and rewarding for the doctor.

Let's consider clinical tobacco intervention. The great majority of smokers (85%) are not ready to stop smoking. Yet the following steps, done in about 1 minute, will double this group's rate of quitting from 3% to 6%: (a) identifying who smokes (either by chart-reminder or asking; 5 seconds), (b) asking their readiness to stop smoking (10 seconds), (c) giving clear advice to stop (10 seconds), (d) listening to how they feel about stopping smoking (32 seconds), and then (e) giving a succinct response to how they feel (10 seconds). The remaining 15% of smokers, those ready to quit, need more intensive care and follow-up. A practice that just delivers brief clinical tobacco intervention to its unready smokers will have a major effect on the prevalence of smoking.

If, in clinical practice, we go beyond smoking to systematically address physical activity, alcohol problems, depression, and other recommended preventive measures, practices will require significantly more resources. But how can we do this when frontline medical care is so overburdened?

Some health care decision-makers recognize the value of proven clinical prevention, which includes the substantial dollars to be saved in avoiding preventable medical costs. Those who want to implement clinical prevention should do so in ways that will enhance all of primary health care practice. This includes merging preventive strategies into routine care and facilitating medical practice's everyday work with the resources and personnel that are added for prevention.

Paraphrasing the words of John F. Kennedy's inaugural speech, I would say to such policy-makers, "Ask not what your doctor can do for you—Ask what you can do for your doctor."

Finding what might work in today's hectic practice of medical care will not be simple. A variety of models and strategies need to be explored, and this will take money, patience, and skill. Those preventive approaches that facilitate the overall delivery of frontline medical care will have the best chance to endure.

In Ottawa, on 17 September 2005, the first Clinical Prevention Implementation Network (CPIN) meeting will be held just before the Canadian Public Health Association's annual general meeting. It is sponsored by the Public Health Agency of Canada, the Canadian Public Health Association, and the Society for Clinical Preventive Health Care. The few practitioners and administrators who today are trying to implement clinical prevention in Canadian settings will share approaches and strategies and will determine whether their mutual support is worth continuing.

Even though you will read this article after September 17, your thoughts and suggestions on implementing clinical prevention will be most welcome and useful. Please send them to me at drfredbass@look.ca and copy Dr Bill Mackie, Chair of the BCMA Council on Health Promotion at bill_mackie@shaw.ca.

—Fred Bass, MD
Chair, Tobacco and Illness Committee