An apple a day is worth a pound of cure

Aphorisms, even about prevention, can be annoying. However, if we ignore the physician's role in prevention, we fail to maximize physicians' potential productivity. For example, since cigarette smoking accounted for 7% of medical care use and costs in recent times[1,2] and since a large part of the damage can be reversed by stopping smoking,[3,4] there would be considerable gain for our health care system if all practitioners systematically addressed smoking and just a few other modifiable major-risk factors, such as physical inactivity, problem drinking, and unhealthy diet.

All this is nice talk, but you may be pressed for time in your practice. If you're a physician, you don't get paid for prevention. You may not even be sure how some forms of prevention work. So what action do you take?

If you're a physician, you don't get paid for prevention. You may not even be sure how some forms of prevention work. So what action do you take?

During the past several years, the exemplary provincial Prevention Support Program adopted the strategy of identifying a short list of prevention problems and then offering interested physicians and their office staff brief training to work from a prevention flow sheet. It was well received by both patients and staff and the early evaluations showed positive trends. Unfortunately, it is no longer in operation.

We at the Society for Clinical Preventive Health Care urge you to do what many BC physicians have been doing since 1990: use the help of the BC Stop Smoking Program. We have provided provincial health professionals with clinical materials, patient materials, training, up-to-date information, and consultation. Two population surveys of BC smokers have shown that by taking a few seconds or minutes to do brief clinical tobacco intervention, physicians have helped their patients achieve extraordinarily high levels of smoking cessation (60% to 65% of smokers advised to stop by physicians have done so).[5] This is a highly cost-effective maneuver when it is spread over a large population.

The Stop Smoking Program aims to translate evidence-based recommendations for prevention into effective approaches suited to the brevity of the average patient visit. Changing the intervention paradigm from one of badgering the patient to stop smoking to one of planting motivational seeds, watching the preventive implant grow, and then finally delivering the full goods—counseling, medication, and follow-up when the patient is ready to stop—has worked well.

The society is expanding to help smokers who also have problems with drinking, depression, and physical inactivity. Specifically, we have modest funding from the federal tobacco control program to develop a role analogous to that of the dental hygienist—someone who is a clinical educator and coordinator of interventions who will help smokers by paying attention to these three risk factors. At this point, we refer to this role as "preventive hygienist." We invite you to contact us to discuss your thoughts about how this preventive hygienist model can work in the primary health care setting (contact details below).

Another project we are working on is the development of a national network of professionals involved in implementing clinical prevention practices called the Clinical Prevention Implementation Network. Clinical preventive programs can be quite isolated from each other and will benefit from sharing clinical strategies, materials, training, etc. We expect to soon have the resources to build a directory of programs, practitioners, researchers, and policymakers across Canada who are involved in delivering clinical prevention (as defined by the Canadian Task Force on Preventive Health Care).

The Society for Clinical Preventive Health Care invites any reader interested in clinical prevention to join us. The organization's mission is to promote the implementation of those clinical interventions that the Canadian Task Force on Preventive Health Care (www.ctfphc.org) has found to be effective and to discourage those proven to be ineffective. This is the first year that the Society for Clinical Preventive Health Care has asked health professionals to become members (see www.clinicalprevention.ca).

Dr Bill Mackie is the current president of the society, Dr Paul Wong is the treasurer, and I am the secretary. The remaining Board members include Drs Lorna Medd, Mark Fromberg, Ray Baker, and Alan Clews.

We are moving our office to 203–718 W. Broadway, Vancouver, BC V5Z 1G8, tel: 604 872-5573, fax: 604 872-5594, e-mail: info@clinicalprevention.ca.

Hail to your interest in prevention!

—Fred Bass, MD
Member, Addictions Committee

References

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How much does ICBC pay for the patient's clinical records?

Assuming you have a signed patient consent form, you may bill $77.90 to compile and review the records. Check with the adjuster if the volume of paperwork requested will require more than 15 minutes of your time. Photocopying records may also be charged according to BCMA code A00096.

If you have further questions related to fees or other concerns specific to ICBC cases, please contact me at martin.ray@icbc.com, by fax at 604 943-8344, or by phone at 604 943-6999. Let me know what areas you would like to see covered in upcoming articles so that I may report back on these topics. I look forward to hearing your feedback as I work with ICBC in the coming months.

—Martin Ray, MD

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cursor to change in physician behavior and to more appropriate evidence-based management of injured workers. Participants had varied attitudes about the learning method they preferred, which suggests that education providers should continue to pursue multiple methods of delivery.

For more detailed results of this study, see the original article in the *Journal of Occupational Rehabilitation*[1] (this abridged article is reproduced courtesy of Springer).

—Don Graham, MD, CCFP
WorkSafeBC Chief Medical Officer

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