Should physicians assess lifestyle risk factors routinely?

Carol P. Herbert, MD

See related article page 1830.

Physicians practise clinical health promotion when they attempt to identify risk factors in their patients' lifestyles and to assist them in making changes that will help them to improve or maintain health.[1] A physician's willingness and ability to practice health promotion in this way is governed not only by the evidence[2] but also by social factors, patient and physician characteristics and the nature of the physician's practice.[3]

Dr. Brigitte Maheux and colleagues[4] surveyed obstetrician-gynecologists and a stratified sample of general practitioners in Quebec about their practice of routine clinical health promotion; their findings are reported in this issue. The data are presented as the percentage of physicians who said that they assessed a given lifestyle risk factor in 90% or more of their patients. Although this seems a high standard even for a "routine" manoeuvre, self-reports of behaviour tend to overestimate performance; thus the reported rates may in fact be close to the "true" rates.

Among the general practitioners, routine assessment was reported by 82% for tobacco use, by 67% for alcohol consumption and by 34% for illicit drug use. Fewer obstetrician-gynecologists routinely assessed their patients' substance use (e.g., 56% v. 82% for tobacco use), but more routinely assessed condom use (47% v. 28%). Considering that their specialty concentrates on diseases of the reproductive system, it is not surprising that obstetrician-gynecologists asked about contraception and sexual risk factors more frequently than general practitioners. However, neither group inquired sufficiently about sexual orientation or sexual partners.

In spite of the lack of evidence of the effectiveness of such screening, the low rate of screening for family violence and sexual abuse is disturbing. When we consider the prevalence of family violence (at least 1 in 10 women in North America are affected) and of sexual abuse (which affects as many as 1 in 4 North American women), it is evident that Quebec doctors are missing the opportunity to identify and intervene in potentially deadly situations. As has been pointed out many times, lack of evidence of effectiveness is not synonymous with evidence of a lack of effectiveness.

What lifestyle risk factors *should* be assessed by physicians? The evidence does not take us very far: those preventive manoeuvres that have received an A or B rating from the Canadian Task Force on Preventive Health Care (formerly the Canadian Task Force on the Periodic Health Examination) include screening for smoking and alcohol abuse but not for family violence. Moreover, the playing-field of what constitutes evidence of effectiveness is changing. Newer analyses of cost-effectiveness, for example, account for the time spent by patients, family and friends and the use of nonmedical resources.[5] In this era of evidence-based medicine, is it fair to criticize physicians for failing to screen for lifestyle risk factors in the absence of good evidence that such screening will be effective?

In previous studies of self-reported adherence even to evidence-based guidelines for preventive care, compliance varied widely.[6] Over 90% of primary care physicians in British Columbia reported performing breast examinations, mammography, Papanicolaou testing and initial counselling against smoking in all or most cases. However, fewer than half performed 2 recommended manoeuvres for all or most patients who smoke: advice to follow a diet high in beta-carotene (10%) and scheduling of follow-up visits to reinforce antismoking counselling (46%). Most of the physicians in the BC study stated that they performed preventive manoeuvres, including lifestyle risk assessment, in the context of an annual general physical examination rather than integrating them into routine patient care. The 2 most frequently stated reasons for failing to schedule follow-up visits for antismoking counselling were that it was time consuming and that there was no provision in the fee schedule to bill for it.

However, before we castigate physicians for their failure to perform screening manoeuvres, we must also consider the possible negative effects of labelling patients, found long ago in relation to hypertension and more recently with respect to HIV status. Some physicians may actively avoid screening manoeuvres in patients with multiple problems to avoid "overloading" these patients. More likely barriers are lack of time, problems with office organization, insufficient training, and inadequate treatment resources. In the study by Maheux and colleagues, only 13% to 32% of respondents said that their training had been adequate. This is borne out by a World Health Organization study of opinions and practices of general practitioners with respect to early intervention for alcohol-related problems.[7] In that study, 96% of physicians in BC stated that they gave advice on lifestyle risks most or all of the time, and 97% placed high priority on screening for alcohol use. But only half

utilized routine office visits for lifestyle risk assessment or counselling.

One other thing to keep in mind is that even when a physician screens for a risk factor the patient will not necessarily acknowledge the risk factor or even remember having been asked about it. In a study of physicians' interventions with drinkers who may be at risk for alcohol dependence,[8] we found that both patients and physicians believed that physicians should help patients limit consumption, at least by asking about drinking behaviour and advising those deemed to be at risk to cut down. However, 58% of the patients surveyed did not recall ever being asked about their drinking behaviours and only 9% recalled having been advised to cut down. If 30% of adults have at some time had a drinking problem or been dependent on alcohol, these findings suggest either that the rate of assessment is low or that patient recall is faulty, or both.

What increases the likelihood that lifestyle risk assessment will occur? Predisposing, enabling and reinforcing factors have been described that have an impact on physicians' preventive behaviour.[1,9,10] Predisposing factors include the physician's degree of self-confidence and belief in the patient's willingness to change. Enabling factors include knowledge of strategies for behavioural change as well as organizational issues such as record-keeping, the use of computer prompts and the timing of appointments. Reinforcing factors include reimbursement for counselling, positive outcomes from previous attempts at intervention, peer support from colleagues and feedback from patients. One predisposing factor that may bear on Maheux and colleagues' study is the finding that female family physicians provide more counselling than their male counterparts.[11] In that regard, it is noteworthy that more women than men responded to the current study. There may also be regional differences, relating at least in part to peer support for lifestyle risk assessment. And, as in Maheux and colleagues' study, there may be differences between professional groups that reflect the relative prevalence of various conditions in the practices of those physicians. To encourage lifestyle risk factor assessment, physicians need clear guidelines for useful interventions that can be applied in the context of generalist practice where time is limited. To target their counselling more effectively, they need to be taught how to triage their patients with respect to readiness to change.[12] Perhaps most of all, physicians need consistent messages rather than the confusion of conflicting guidelines.

Should physicians be involved in clinical health promotion in the first place? I would argue that they should: they see patients at potentially "teachable" moments, as in an encounter with a pregnant woman who smokes. Whether physicians are the preferred professionals to practise clinical health promotion is a researchable question. Some would argue that nurses or health counsellors are more effective.[9]

As patients' expectations with regard to health promotion increase, physicians will need to determine where to put their emphasis to achieve the best result. Which issues, which patients, where and when to advise, how to mobilize family support and defuse family sabotage of behavioural change — all of these are important questions for future research.

Dr. Herbert is a Professor with the Department of Family Practice at the University of British Columbia, Vancouver, BC.

Competing interests: None declared.

References

1. Herbert CP. Clinical health promotion and family physicians: a Canadian perspective. *Patient Educ Couns* 1995;25:277-82.
2. Canadian Task Force on the Periodic Health Examination. *Periodic Health Examination Monograph: Report of the Task Force to the Conference of Deputy Ministers of Health*. Ottawa: Department of National Health and Welfare; 1980. Cat no H39–3/1980E.
3. Tudiver F, Herbert C, Goel V, for the Family Physician Study Group, Sociobehavioural Cancer Research Network, National Cancer Institute of Canada. Why don't family physicians follow clinical practice guidelines for cancer screening? *CMAJ* 1998;159(7):797-8.
4. Maheux B, Haley N, Rivard M, Gervais A. Do physicians assess lifestyle health risks during a general medical exam? *CMAJ* 1999;160(13):1830-4.
5. Russell LB. Prevention and Medicare costs. *N Engl J Med* 1998;339:1158-9.
6. Smith HE, Herbert CP. Preventive practice among primary care physicians in British Columbia: relation to recommendations of the Canadian Task Force on the Periodic Health Examination. *CMAJ* 1993;149:1795-800.
7. Baker R, Herbert CP, Miller J. Canada. In: Saunders JB, Wutzke S, editors. WHO phase III collaborative study on implementing and supporting early intervention strategies in primary health care. Report on Strand I: General practitioners' current practices and perceptions of preventive medicine and early intervention for hazardous alcohol use. A 16-country study. Copenhagen: World Health Organization Regional Office for Europe; 1998. p. 57-71.
8. Herbert CP, Bass F. Early at-risk alcohol intake: definitions and physicians' role in modifying behaviour. *Can Fam Phys* 1997;43:639-44.
9. Green LW, Kreuter MW. *Health promotion planning: an educational and ecological approach*, 3rd ed. Mountain View, CA: Mayfield Publishing; 1999.
10. Eriksen MP, Green LW, Fultz FG. Principles of changing health behaviour. *Cancer* 1998;62:1768-75.
11. Cohen M, Ferrier BM, Woodward CA, Goldsmith CH. Gender differences in practice patterns of Ontario family physicians (McMaster medical graduates). *J Am Med Womens Assoc* 1991;46(2):49-54.
12. Prochaska JO, Diclemente C. Stages and processes of self-change in smoking: towards an integrative model of change. *J Consult Clin Psychol* 1983;5:390-5.

Reprint requests to: *Dr. Carol P. Herbert, University of British Columbia, 5804 Fairview Cres., Vancouver BC V6T 1Z3*