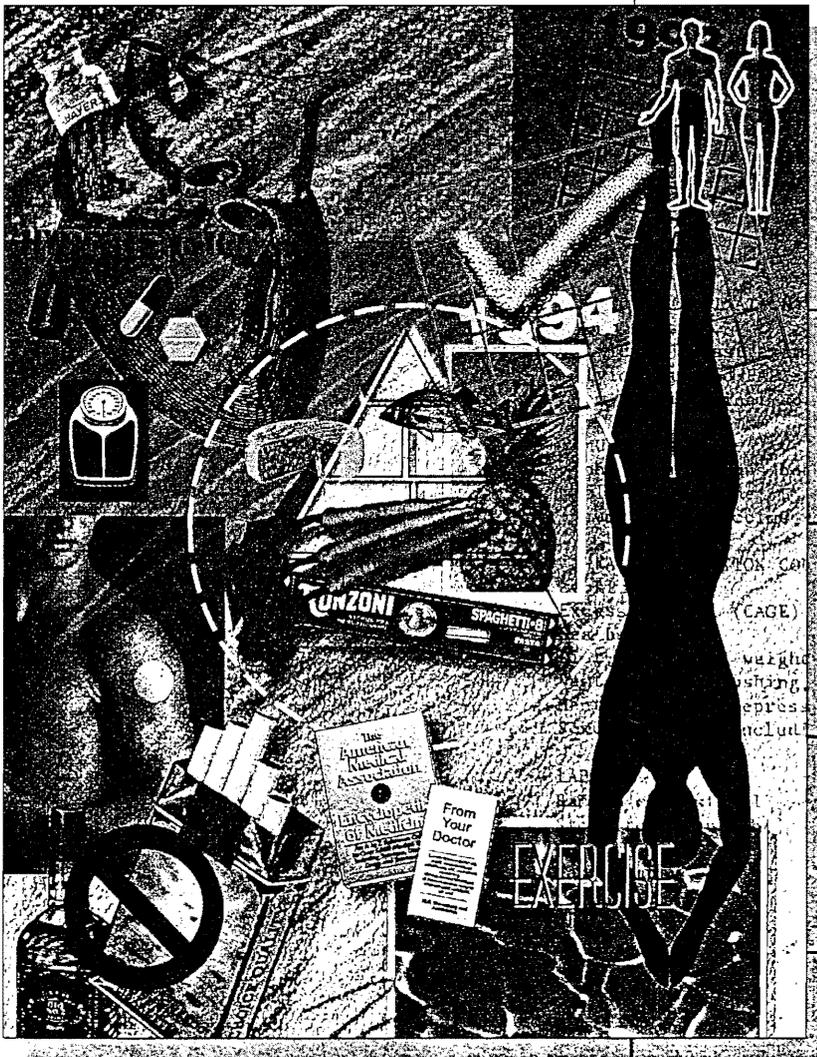


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SPECIAL ISSUE



PREVENTIVE MEDICINE in primary care

PART **1** OF 2

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Consumer advocacy: A crafty approach to counseling

Alan Blum, MD, who founded the international health promotion group DOC (Doctors Ought to Care) in 1977, here explains his approach to counseling patients who smoke. He positions himself as a consumer advocate and suggests that they reconsider their attitudes about smoking and self-image—and think about how much advertising affects those attitudes.

The power of the physician's words is the single most important factor in fighting the epidemic of cigarette-related disease, and all physicians need to be involved. It is important for us constantly to encourage individuals and society to pay more attention to the problem. This burden, however, should not rest entirely on physicians. We need a great deal of assistance—from the business community to provide smoke-free workplaces, from schools to educate young people, and above all from the political system to reflect an awareness of just how devastating an epidemic this is in terms of both public health and economics. An estimated 45-53 million people in this country smoke (approximately the same number as 30 years ago), and we obviously can't reach them all one at a time in our offices and clinics. For us to make appreciable progress there must be three areas of focus: the clinic, the classroom, and the community.

In our offices we can certainly remove or identify magazines that contain cigarette advertising (see Figure 1), display posters, and provide educational materials; but everything we do in the office to discourage smoking needs to be reinforced outside the office, to counteract the powerful effects of tobacco ad-

vertising. We have not yet been very successful in influencing the larger environment, but we need not accept that all we can do is tell patients to stop smoking and give them nicotine patches.

Tobacco advertising relies on consumers' perceptions of the underlying assumptions of the imagery used. We can begin to fight the lure of tobacco advertising by alerting people to these assumptions and the powerful use advertisements make of imagery.

The physician as consumer advocate

My immediate approach to the patient who smokes is to become a consumer advocate for him or her, by offering advice about the product instead of the behavior. This places me in a neutral position, allowing the patient to feel much less anxious and threatened than if I immediately focus on the reasons he should stop smoking. My initial objective is not to get the patient to stop smoking, but simply to give him a new way of thinking about the problem.

Because people are very conscious of the brand names and the social statements made by the brand they smoke, the first and most important question I ask a patient is, "What brand do you buy?" I always refer to *buying* cigarettes, rather than smoking—again, to shift the focus away from the smoker and onto the product. With this approach the person's defense mechanisms are less likely to come into play than if I bluntly ask if he smokes and how much.

I try to make the conversation humorous and engaging. For example, I'd ask a muscular young man if he smokes Virginia Slims Lights. As he realizes I'm teasing him, he may laugh self-consciously, and this facilitates a brief discussion about some of the assumptions made about different brands and one's self-image. If he says he smokes Marlboros,

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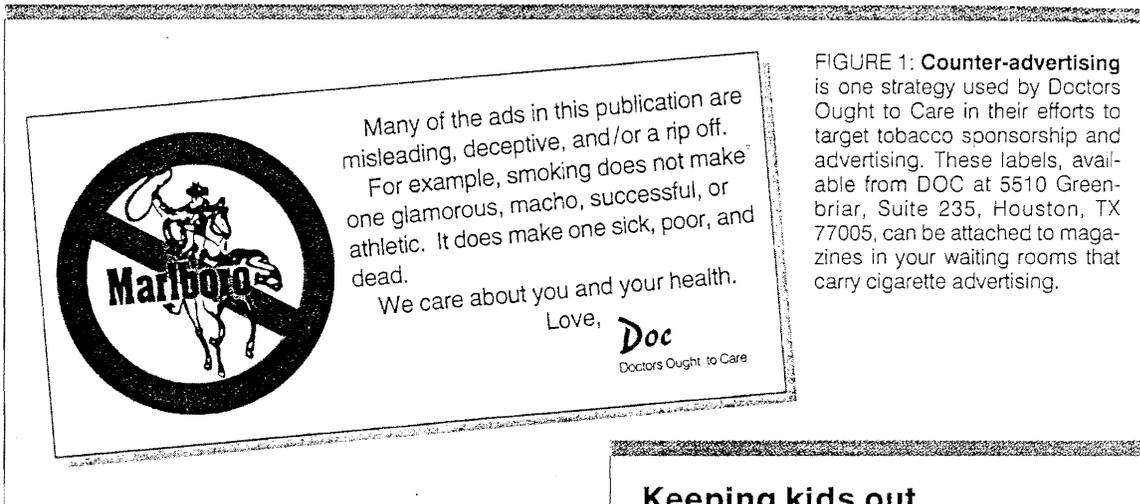


FIGURE 1: Counter-advertising is one strategy used by Doctors Ought to Care in their efforts to target tobacco sponsorship and advertising. These labels, available from DOC at 5510 Greenbriar, Suite 235, Houston, TX 77005, can be attached to magazines in your waiting rooms that carry cigarette advertising.

I ask whether he buys Marlboro Lights, Menthol Lights, Mediums, 100's, and box or soft-pack. (There are more than 15 different versions, which helps highlight the way cigarette companies create the illusion of choice and individuality.) And apart from the package design and advertising, do "men's" cigarettes really differ from "women's" cigarettes? I'm trying to help him realize he is buying the package and the underlying message of masculinity, not just cigarettes (for an approach to use with youngsters, see "Keeping kids out of Marlboro Country"). Many men are surprised to learn that Marlboros were originally marketed for women, using the slogans "Mild as May" and "Red tips to match your pretty lips." When the patient leaves the office, I want him to be aware of his manipulation by advertising and packaging techniques and to respond in part by not buying cigarettes—out of spite if nothing else.

During a first interview I also suggest that the person consider the annual cost of cigarettes, and he may be quite surprised and angry at just how much money he is spending. A pack-a-day cigarette buyer could save nearly \$1,000 a year if he were to put the money into a bank instead. No other product

Keeping kids out of Marlboro Country

Alan Blum, MD, the founder of DOC (Doctors Ought to Care), describes his approach to counseling teenagers about smoking.

It is particularly important to keep young people from ever starting to smoke, because if someone turns 18 without starting, there is only a 10% chance he or she ever will. Regardless of all our educational efforts, however, more than 3,000 young people in the United States start smoking every day. Almost three fourths of adolescents who smoke buy Marlboros, and I tell people that the number-one preventable cause of death in the United States is not heart disease, cancer, or drug abuse—it is Marlboro cigarettes.

One strategy I use with teenagers is to make fun of smoking. I have found that saying "You're 15 and still smoking? That's kid stuff!" is more effective than lecturing about what may happen to their health many years later. When counseling adolescents about smoking, the most important thing to be aware of is that the lure of tobacco is everywhere. And when it is associated with worthwhile activities such as sporting events, it acquires a legitimacy in youngsters' eyes. Last year in Houston alone we found more than 40 sporting events sponsored by tobacco companies. We have tried to do counter-advertising, such as sponsoring the Emphysema Slims tennis tournament, but the tobacco industry outspends us by about 300 to 1. Furthermore, most of our funding goes to smoking-cessation strategies rather than to primary prevention among young people, where it is needed most.

in the marketplace has the degree of profit tobacco does. A pack of cigarettes, which costs much less than 25 cents to manufacture, will sell for about \$2.50. The patient is simply paying for the brand name and the advertising.

The tar and filter frauds

Many people tell me they smoke Carltons or other low-tar cigarettes, but when questioned most do not actually know what tar is. I explain that cigarette smoke contains more than 4,000 separate

chemicals, more than 40 of which are known carcinogens, and that tar is a concentrated distillation of these poisons. They have bought into the convenient delusion that such cigarettes are safer. To counteract this notion, I tell them

that smoking low-tar cigarettes is equivalent to saying you would never jump off the 26th story of a building—only off the 20th. Low tar just means low poison; no daily exposure level is safe. Furthermore, smoking low-tar cigarettes may actually increase the person's risk for exposure to cyanide, carbon monoxide, and other gases likely to lead to emphysema. I also ask the person to take out and examine one of his cigarettes and ask if he knows what it is made of. When he replies paper and tobacco, I ask if he knows why cigarettes do not extinguish quickly in the ashtray as cigars do. This is because cigarettes have chemical additives that keep the paper burning—so the person will smoke more of them. Many people are surprised when I actually recommend that they switch to the highest-tar, highest-nicotine cigarette they can find, in the hope that they will smoke as few as possible.

Many patients will argue that an uncle lived to 85, smoked for 70 years, and never had lung cancer. They do not realize that the older cig-

arettes were probably less dangerous than the chemical-laden cigarettes being sold today. I don't dwell on a discussion of lung cancer; rather I keep the focus on the present, and the poison in cigarette smoke, such as cyanide, formaldehyde, and carbon monoxide. Patients are fascinated to learn that cigarette smoke contains ammonia, which leaves a urine-like odor on their breath.

By this point in our conversation the patient's guilt and anger are no longer directed at himself or at me, but rather toward cigarette manufacturers and promoters.

The addiction message

People who consider smoking cessation are being bombarded by messages about how difficult it is to stop, how ad-

dictive nicotine is, and how they'll need some magical (and expensive) cure in order to succeed. They may also have tried unsuccessfully to quit before. What is needed, I believe, is a shift in focus: We should de-emphasize the power of nicotine addiction and the need for pharmacologic interventions. The person who wants to stop smoking has already heard too many times how hard it is.

I try to stress the message that avoiding cigarettes may not be as difficult as the person believes and that pharmacologic intervention should be a last resort. The worst mistake a physician can make is to give a patient a nicotine patch on the first visit and let it go at that. During an initial visit, I discuss smoking, give the patient educational materials, and tell him to return in a week if he wants to use nicotine patches. I also suggest he keep a hefty supply of mints, lemon drops, or other hard candies, which many people find helpful.

During this first week, I ask him to try a technique I call Postpone/Inhale/Reconsider.

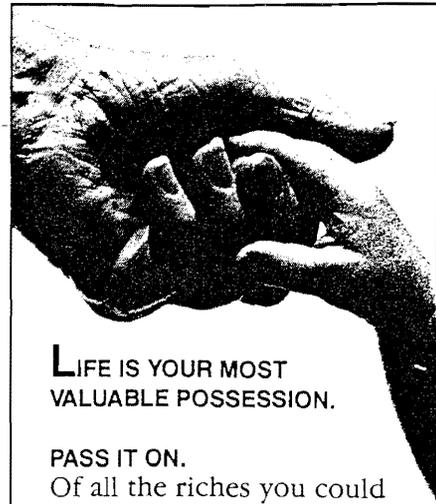
“Smokers have bought into the convenient delusion that low-tar cigarettes are safer—but low tar just means low poison. No daily exposure level is safe.”

With this technique, the patient takes a cigarette from the pack, but then replaces it and waits five minutes. During this period, he regularly places two fingers up to his mouth, just as if he were smoking, inhaling slowly. Five minutes of deep breathing can actually result in some physical effects similar to those produced by smoking a cigarette. At the end of five minutes, the person may take the cigarette out again, but this time he must reconsider: Do I really need this? Many people are able to cut their smoking by 50% in one week with this technique alone.

At the end of the week, if the patient returns and has followed through on the Postpone/Inhale/Reconsider technique, I assume that he is really serious about stopping. I would consider pharmacologic intervention if the patient requests it, although I would still be concerned with working out any underlying stresses. I consider nicotine replacement therapy a last resort because people have come to believe the patches are an instant cure and also because many people use them simply as a substitute for cigarettes. They will wear a patch to the office or chew nicotine gum during an airplane trip, just to get them through until they can resume smoking. That, of course, is not the purpose of these products and does nothing to eliminate the behavior. Anyone can stop smoking if he wants to enough, and that's where you and I can help—by helping the patient change his attitudes about smoking, self-image, and long-term well-being. □

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