ASPECTS OF PHYSICIAN – PATIENT COMMUNICATION IN THE PROGRAM OF SMOKING CESSATION

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ASPECTS OF PHYSICIAN – PATIENT COMMUNICATION IN THE PROGRAM OF SMOKING CESSATION (Abstract): The doctor-smoker patient communication is essential for smokers to realize the harmful effects of tobacco on health and the benefits of smoking cessation. Nicotine found in cigarettes is a powerful drug and a direct dependency generator, which makes smoking cessation difficult, the withdrawal syndrome being hard to overcome for many smokers. The doctor-smoker patient communication is a complex process of data, information and knowledge transmission, subjected to some semiotic rules. In the Counseling Center for Smoking Cessation (CCSC) from the Rehabilitation Clinical Hospital of Iasi the medical and psychological counseling and the pharmacologic therapy for smoking cessation is ensured by the qualified personnel. CCSC was founded in 2005, when the hospital was included in European Program: „European Network Smoke-Free Hospital“, and experienced an important development in 2007 with the initiation “Stop Smoking” National Program of Ministry of Health. The doctor-smoker patient communication in the CCSC was conducted during the smoker’s recruitment, therapeutic and post therapeutic period, a special place being occupied by the doctor-medical staff communication, including smoker medical students. The number of people who became nonsmokers after being counseled at our center was the evidence of the effectiveness of this communication. The obtained results determined us to join the global fight against smoking and to propose the introduction of the smoking cessation program in the curriculum of the medical education institutions. Keywords: DOCTOR - PATIENT COMMUNICATION, SMOKING, CESSATION.

ISRA Center Marketing Research conducted a study in 2007 for the Pfizer Romania Pharmaceutical Company which aimed to evaluate the incidence of tobacco use and the assessment of smoking behavior in Romania. This study showed that among the 3326 people aged over 18, 1550 were smokers, the incidence being higher for males. Of
these, 43.9% said that they thought to quit smoking. Geographically, in Muntenia the percentage of smokers was 51%, 49.7% in Moldova, 40.1% in Bucharest and 42.4% in Banat. Being asked: "Is it possible to have health problems due to smoking?", the majority answered: "Yes!" (1).

Because the incidence and prevalence of smoking increases from year to year, a worrying phenomenon also in Romania, as shown in the above study, in the same year-2007, the Ministry of Health initiated The National Program "Stop Smoking", which provides medical and psychological counseling and therapy for smoking cessation.

Smoking refers to the consumption of tobacco in form of cigarettes and it is a habit voluntarily acquired and which causes addiction. During the "Stop Smoking" program, there were established counseling and therapy centers for smoking cessation across the country, which were coordinated by pulmonologists with special training regarding the counseling of smokers, one of these being in Rehabilitation Clinical Hospital from Iasi (2).

Of the over 4,800 toxic substances existing in cigarette smoke, nicotine is the one that causes addiction, which is classified by The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) (3) and Fifth Edition (DSM-5) (4) as a disease. According to this authority, the criteria for this diagnosis include at least three of these phenomena during the last year to a smoker:
- Smoking more intense than normal;
- Strong desire to smoke, despite all efforts to reduce the number of cigarettes smoked per day;
- Tolerance to nicotine, manifested by the reduction of its effect and the need of increasing the number of cigarettes to achieve the same effect;
- Withdrawal symptoms after discontinuing smoking;
- Increase time spent smoking and acquiring cigarette, giving up the participation to different social or educational activities;
- Continue smoking despite the danger of ill health awareness.

The nicotinic withdrawal is also classified as a disease induced by nicotine consumption, according to DSM-IV-TR and DSM-5. It occurs in some people with major symptoms in the early days: very strong desire to smoke, difficulty concentrating, headache, nervousness, insomnia, irritability and even depression, increased appetite, reduced heart rate. These symptoms may disappear within a month.

Smoking is responsible worldwide for more than 85% of all deaths due to lung cancer, being the major cause of emphysema, bronchitis, Chronic Obstructive Pulmonary Disease (COPD) and cardiovascular diseases. Tobacco may also determine neoplasms located in the oral cavity, esophagus, pancreas, stomach, larynx, it can complicate surgery recovery, delay healing of wounds and fractures, decrease bone density, causing osteoporosis and it can affect the excretory and genital systems, skin and mucous membranes etc. (5, 6, 7, 8).

Counseling for smoking cessation has major and immediate health benefits, regardless the smoker's age. This medical counseling requires meetings and discussions where the physician explains to the patient the harmful effects of smoking on health and its negative economic consequences. Some smokers want to quit smoking but can not do it alone. In the "Stop Smoking" National Program of the Minis-
try of Health, after the counseling session conducted by the specialist doctor, patients who wanted to be included in the program have returned and attended medical and psychological counseling provided by the physician and psychologist and pharmacological therapy.

Drug treatment was made with Bupropion and Varenicline for 2-3 months. This treatment helps the smoker to overcome the withdrawal syndrome by the action of drugs on the central nervous system, inhibiting the wish to smoke. After the initial consultation, follows a period of 2 weeks of treatment then the patient went to the consultation to assess efficacy, followed by another period of treatment, until 2 or 3 months, depending on the drug used. After completing this treatment, the patient is monitored for another 6 months. The patient-medical specialist meetings involve direct communication.

The medical specialist-patient communication

In the entire world, the interpersonal communication is located to the top of communication hierarchy. It is a complex process of transmission of information, data and knowledge from one source to another, connecting individuals, communities, groups, companies, ensuring cooperation and collaboration between them.

The doctor-patient communication represents a social interaction which implies the existence of the two partners, one being the emitter (source message), and the other being the receiver (target message). Both partners have a common set of signs and they follow a common set of semiotic rules.

These semiotic rules are classified into three categories:

1. Syntactic - defines the formal properties of signs and symbols;
2. Pragmatic - concerns the relations between signs, expressions and their uses;
3. Semantic - reflects interactions between symbols and signs and their meanings (9).

Interpersonal communication is examined and analyzed according to several possible classifications. After the channel used, communication can be: auditory, olfactory, visual, tactile. Another classification is: verbal (words are vehicles for information) and non-verbal (physical methods are vehicles for information: signs and body language, paralanguage, eye contact, touching etc.).

Communication can be written (letters, recommendations, reports, statements etc.) or oral (discussion, exposure).

After the means used in the transmission of information, communication can be realised through: auditory media (radio, teleconferences), print media (newspapers), audiovisual media (television), and electronic media (e-mail, audio and video files).

Considering communication conditions, it can be: face to face (when all the four senses are involved) or remote communication (involving hearing, sight, or both) (10).

General aspects of the physician-patient relationship

The chronic respiratory pathology that dominates the daily hospital activity has brought us face to face with the consequences of smoking, due to the patients suffering from COPD, chronic bronchitis and pulmonary emphysema. The communication with these smoking patients is present in the daily activity, but even more within the anti-smoking program at the Rehabilitation Clinical Hospital from Iasi.
The communicational component is a process that needs abilities in the interpersonal relationships: listening, asking, speaking, analysis and evaluation. These partially native skills need to be shaped by a specific education and also on the basis of the personal experiences, as the ability of advising is acquired in time.

“Stop Smoking” the National Program cannot take place without the addressability of people, which has risen up from zero to a high number of smokers who have asked for help in giving up smoking. The first measure of the plan was to inform people in Iasi about the existence of this program, to present them the facilities of it and also to tell them about this Counseling Center for Smoking Cessation within the Rehabilitation Clinical Hospital. This Center was founded in 2005, when the hospital was included in European Program: „European Network Smoke-Free Hospital”, and experienced an important development in 2007 with the initiation “Stop Smoking” National Program of Ministry of Health. We used therefore all the available means of communication, ranging from inpatients, hospital staff and students, to written press, radio and television. The second main element was the message itself which was delivered to people in order to encourage them to contact the counseling center. Giving up smoking is possible, encouraging smokers and their entourage to take action, supplying all the details on how to apply for the services of the counseling center. In all of this, a balance was made between the positive and negative features of the message.

We tried to change the vision of smokers and non-smokers, convincing smokers to be more responsible towards their own health and of the people around them and the nonsmokers to convince the smokers to give up this habit. The main point of the message was that immediate action is urged because it is possible to give up smoking, being possible for the health status to be recovered. All the details were previously debated with the media representatives, all the aspects concerning the communication being paid attention, even to the apparently minor ones. When the message was delivered audio-visually, the aspects regarding the posture, voice, audio-visual amplification were carefully analyzed. During the radio and television broadcasts, the persons showing interest could interact with us live and that were advised to address to our center. Each time possible, the interaction with the audience was ensured, avoiding as much as possible the speeches. The message was insistently repeated using as much as possible present tense and imperative verbs.

The written press was used to underline the consequences on morbidity and mortality of the diseases caused by the active and passive smoking. These consequences equally affect both the men and women and depend on the number of cigarettes smoked per day, age and moment of start. The message was spread presenting advantages of giving up smoking on short and long periods, urging immediate action in giving up. Messages that underlined the negative aspects of smoking and the positive ones of giving up, confessions of the ex-smokers were used for the inpatients and the smokers in the hospital’s staff, emphasizing the possibility of direct addressing to the center. The inpatients with chronic addiction had two different attitudes after discussing with the physician. Some of them requested help in giving up smoking, some others had no reaction. For the smoking in patients who did not request out help, we initiated
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the minimal advice - three minutes intervention, which is the most efficacious prevention action. The chances to succeed are bigger if the patient attends the counseling center compared to trying to give up by them. We avoided mentioning percents and we used assertions such as: ‘A smoker dies each 5 minutes!’ or ‘Give up smoking gives years to the life and life to the years’. If the medical staff would give the three minutes intervention minimal advice to each smoker, 2200 years of life every 1 million people would be saved each year by preventing the occurrence of diseases caused by smoking (11). Psychologically, the nonsmoking staff is more credible than the smoking one. Mass-media gave us the chance to implement educational programs which advised the nonsmokers not to take up smoking and the smokers to give up by applying to the anti-smoking counseling center within the Rehabilitation Clinical Hospital from Iasi. It is important to mention that the smokers usually tend to ignore the danger in which they put people around them, who are passive smokers- having the same risks. The process of counseling is possible, useful and needs to take place gradually.

The physician-smoker patient communication during the therapeutic period

The therapeutic period starts at the moment when the patient comes to the counseling center for giving up smoking, admitting that he wants to give up, this representing the first step in the therapeutic success. At this moment, the communication between the physician and the patient has a special meaning, within the process of giving up smoking. The first step when communication is initiated is to explain to the patient the path that needs to be followed, were the nicotine withdrawal syndrome is very important. This syndrome is defined by the totality of symptoms which occur when cutting off the intake of nicotine after a prolonged period of use. It is given a special attention to it in order to realize that giving up is difficult and in order to recognize it and in this way to avoid panic. Therefore, the appointments in the first period are frequent, asking the smokers to contact us each time the fear occurs. At this moment, the communication with the smokers and their relatives takes place in all the four situations earlier mentioned:

- one emitter and one receptor: face to face communication with the patient during the session;
- one emitter and more receptors: the communication with the smoker and his relatives or a group of smokers, during the first session;
- more emitters and one receptor: medical counseling followed by the psychologically one, both given by a specialized person;
- more emitters and more receptors: the public presentations with supportive and educational role (8, 10, 11).

The style of communication is influenced by the personal sensitivity and the persuasion skills of the person who gives the message, each physician having a particular style of interaction with patients, shaped up by instruction, exercise and experience. The persuasion capacity of the physician is revealed by his ability to ask questions and make affirmations in the moment of interaction with the patient, while the personal sensitivity represents the degree of the control over expressing his emotions. Four personal communication styles are known to influence the quality of
physician-patient relationship: analytical, respectful, expressive, and directive. The difficult relationships may occur between the persons who belong to the analytical-expressive and respectful-directive styles. The verbal and nonverbal communication between the physician and the smoker has different percents, depending on the emitter and the receptor, the verbal component - 7-10%, the vocal one (clarity, inflexion, speaking speed and firmness) - 35-38% and the visual one (mimics and acts, visual contact) - 55%, being the most representative (10, 11).

Communication between transmitter and receiver can be disrupted by psychological, social, structural or environmental barriers that are technically called "noise". This can create a situation in which the transmitter and receiver do not see the same meaning of the message. To check the reception of the message by the patient, the medical provider uses different opened questions that let the liberty of several response options (example: What you did not understand?).

In the process of communication with the smokers I assured a persuasive communication, so that the smoker listens to the message, accepts it and implements it. Once the smoker knows how dangerous smoking is and tries to abandon tobacco, usually problems occur due to psychological dependence because smoking cessation causes numerous demotivating issues such as weight gain, withdrawal symptoms, sudden desire to smoke, depression, insomnia.

Therefore addiction requires medical treatment that consists of two essential components: the behavior intervention (education, information, advice) and the pharmacological support (treatment of the withdrawal syndrome), medical intervention increasing the success rate.

Stages of smoking cessation were formalized by British researchers in the 5 A:
- ASK (ask the subject if he is a smoker to force him to admit their status)
- ADVISE (advising to quit smoking)
- ASSESS (evaluation of the desire to give up smoking)
- ASSIST (help him to make an attempt to quit smoking)
- ARRANGE (maintaining constant contact for support)

For the smokers with compliance issues we can apply to the 5 R in persuasive form:
- RELEVANCE (personalized information)
- RISKS (both for the smokers and their entourage)
- REWARDS (smoking cessation benefits)
- ROADBLOCKS (obstacles that may arise)
- REPETITION (repeating information)

Non-pharmacological therapy is based on social support during and after treatment. Educational practice includes: educational models (social interaction, the processing of information, personal preferences, and behavioral system), educational strategies (direct, indirect and interactive training, personal documentation), educational methods and educational materials (texts, pictures, posters, multimedia interactions) (10, 11).

All problems encountered were analyzed and continuously improved over these 7 years of activity in this field.

Specifics of doctor-patient communication in the post-therapeutic period

In post-treatment period we should keep in touch and to ensure free addressability when the patient feels the need to discuss
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with us. Doctor-patient relationship is a key component of a good clinical practice in any situation, including the anti-tobacco treatment throughout its duration, but also in post-treatment period in order to consolidate the success and avoid relapse. The pre- and post-therapy counseling depends entirely on the doctor-patient relationship, the patient’s level of participation and the patient’s satisfaction.

Practical experience has put us in front of all situations regarding possible types of patient-physician relationship. There are 3 well-known views of the physician-patient relationship: as a consensual event – Person model (1951) (12), Szasz and Hollender model (1956) (13), Stewart and Roter model (1989) (14), as a conflict event - model Freidson (1971), or as a process of negotiation.

Because the patient goes to the counseling center on his own initiative or on the entourage’s initiative, we try to take control using the types of relationships based on the degree of control identified by Stewart and Roter (1989):

- Paternalistic (doctor-centered relationship; use of closed questions; model focused on defining illness and diagnosis).
- Consumerist (patient-centered relationship; he knows exactly what he wants).
- Absent (in this case focusing on patient fails; the doctor abandons the control of the patient, he is not willing to accept the doctor; the final result is a stalemate).
- Reciprocity (using open questions, encouraging the patient to talk about his suffering) (14).

These theoretical models concern the physician-patient relationship in terms of consensus, being static models, but in practice the relationship has a dynamic character due to problems occurring during the treatment and post-treatment. The situation is maintained even after exiting the program as any event can cause a relapse and long-term failure, if abandoning tobacco was not consolidated as a habit.

The dynamic nature of the doctor-patient relationship considered in the conflict and negotiation models, and the many reasons that can damage the communication, put us in the position to decide whether or not we continue the treatment, so that we can take a decision regarding the patient, approaching problems directly and identifying under what circumstances the partnership can continue.

Particularities regarding the communication doctor-medical staff, including medical students

Practical activity in the anti-smoking counseling center has made us confront with different issues regarding the medical staff of the hospital, various medical units and students from "Grigore T. Popa" University of Medicine and Pharmacy, Iasi (15).

The habit of smoking on healthcare professionals has an influence on their professional credibility and effectiveness in tobacco control activities. Studies shown that non-smoking male doctors advise patients more frequently to quit smoking, than the male doctors that smoke. The negative attitude of the latter affect the success of their therapeutic practices. For women doctors, differences are less significant between smokers and nonsmokers. Smoker healthcare professionals, as well as medical students, are a special target group because they can provide an assessment of the effectiveness of anti-smoking counseling program (16).

Based on the initiatives taken by the National Institute of Cancer of including
the anti-smoking education programs in the American medical education institutions (17), we considered healthcare professionals a very important target group and we proposed, along with other colleagues involved in “Stop Smoking” National Program, to also include in the Romanian medical education institutions, training classes about the harmful effects of smoking and smoking cessation treatment modalities.

REFERENCES