L e t t e r s  t o  t h e  E d i t o r

6  J a n u a r y  2 0 0 3  F a m ily  M e d i c i n e

train gender equally. These residents represented year of training and gender equally.

The ability to effectively and succinctly educate patients during an office visit has become more important than ever. One of the most studied methods used to meet this goal is called the transtheoretical model.1 Instead of viewing change as an all or nothing phenomenon, it delineates six stages that represent a spectrum of patient attitudes, from one who in no way considering a change in behavior to a person who no longer has to consciously choose to continue the new behavior—it has become intrinsic. Additionally, the model also describes the cognitive processes a person uses to transition from one stage to another. We performed a survey of family practice residents to determine how successful they felt in office encounters and also to quantify their knowledge of the transtheoretical model.

We mailed self-administered surveys to the 255 residents from the 12 family practice residencies in our state. The overall response rate was 58% but rose to 74% of 198 residents when excluding the three programs with minimal response rates. These residents represented year of training and gender equally.

Most of the residents (74%) said they had never heard of the model, and another 10% recognized it by name only. They feel that their patients are in denial about their poor health behaviors (57%) and make behavior changes lasting 1 week or less (46%). Even though residents know change is difficult for patients (46%), they believe that these people are willing to change (77%), even if unmotivated to do so initially (60%). Counseling (87%) and physician recommendations (90%) are important motivators. A patient’s internalized motivation (64%) or education can also increase compliance (88%). About two thirds of residents admit they “could use some suggestions” when it comes to effective patient education (65%). Although they feel inadequately reimbursed (74%) and short on time (54%) when “interrupting” their clinic for patient education, 96% agreed that an essential element of their job involves educating patients, not just treating them.

The transtheoretical model provides an explanation for both why and how people decide to change their behavior. It has been successfully applied to addictive and non-addictive behaviors and adverse health behaviors like tobacco and cocaine use, adolescent delinquency, and obesity, as well as positive health behaviors like initiation of exercise, condom and sunscreen use, and mammogram screening.2 Many evidence-based clinical trials of the model have proven it to be robust and universal. It is widely applicable, negating the need to learn separate strategies for different types of patient education endeavors. Although impossible to master in 1 hour, a brief introduction to the model followed by role-playing adequately prepares a physician for use of the model in a half day. Studies suggest that physicians who have an understanding of the underlying psychology of the patient education encounter not only perceived office counseling to be less difficult but engaged a greater percentage of patients in interventions to benefit their health.

The last decade has produced evidence-based research backing the transtheoretical model as both an explanation of previously mysterious patient behavior and a method for success in frequently frustrating battles with patients over their lifestyle choices. Our research suggests that residents are searching for a better method of patient education, yet few programs have formal curricula in place to teach residents how to be successful in office counseling. Instead of memorizing mnemonics or intervention-specific criteria for counseling, a working knowledge of how people decide to make permanent change.

Victoria Neale, PhD, MPH
Editor, Letters to the Editor Section

Editor’s Note: Send letters to the editor to vneale@med.wayne.edu or to my attention at Family Medicine Letters to the Editor Section, Wayne State University, Department of Family Medicine, 101 East Alexandrine, Detroit, MI 48201. 313-577-7680. Fax: 313-577-3070. Electronic submissions (e-mail or on disk) are preferred. We publish Letters to the Editor under three categories: “In Response” (letters in response to recently published articles), “New Research” (letters reporting original research), or “Comment” (comments from readers).

New Research

Transtheoretical Model Useful for Patient Education

To the Editor:

The ability to effectively and succinctly educate patients during an office visit has become more important than ever. One of the most studied methods used to meet this goal is called the transtheoretical model.1 Instead of viewing change as an all or nothing phenomenon, it delineates six stages that represent a spectrum of patient attitudes, from one who in no way considering a change in behavior to a person who no longer has to consciously choose to continue the new behavior—it has become intrinsic. Additionally, the model also describes the cognitive processes a person uses to transition from one stage to another. We performed a survey of family practice residents to determine how successful they felt in office encounters and also to quantify their knowledge of the transtheoretical model.

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allows physicians to respond to a
great variety of health behavior is-
ues that arise during patient en-
counters. The universality of the
transtheoretical model makes it an
ideal strategy.

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Medical Student Participation Valuable

To the Editor:
During the 1990s, several US med-
icul changes in an attempt to en-
courage more medical students to select ca-
careers in primary care. Three of these
projects were done on the national level: the Interdisciplinary General-
List Curriculum (IGC) Project, the Undergraduate Medical Education for the 21st Century (UME-21) Project, and the Robert Wood Johnson Foundation’s Generalist Physician Initiative (RWJ-GPI). Details of these projects have been published previously.1-3

The role of medical students at
the national level on these projects varied from the presence of at least one student on the planning commit-
Reasearch from the IGC project asserts that, “The input from
the [student representatives] was invaluable to the Executive Com-
mittee and the project as a whole.”4 However, no prior research has clearly documented students’ roles and involvement on these commit-
tees.

To address this question, we con-
ducted a survey of all planning com-
mittee members for the IGC, UME-21, and RWJ-GPI projects. This
survey was administered by mail
and consisted of Likert-scaled state-
ments regarding the perceived roles
of medical students and the partici-
pants’ beliefs about the appropriate
volvement of medical students on national curricular reform projects.
A total of 70 surveys were
mailed, and 46 usable responses
were received, for a response rate of 65.7%. There was universal agreement (100%) among respond-
ents that discussing changes with
medical students was an important
d part of the curricular reform project. Most respondents (95.7%) also agreed that medical students pro-
vide unique and important informa-
tion when developing curricula. However, 50% of respondents felt that medical students were not
aware of issues that are important
to designing and changing medical
 school curricula. There was no dif-
f erence between responses from
the IGC and UME-21 committee mem-
ers, compared to responses from
RWJ-GPI committee members.

The most important roles that medical students were perceived to
hold included discussing issues from a consumer’s perspective and
knowledge of what students need to succeed in medical school. Res-
pondents were less likely to be-
lieve that students had a role in the
leadership of these projects or pro-
vided any expertise on medical edu-
cation.

In summary, there was universal agreement that medical student par-
ticipation and input were a valuable part of the curricular reform pro-
cess. Despite this, 50% of respond-
ents felt that medical students were
not aware of the issues that are im-
portant to designing and changing
a medical school curriculum. Therefore, students must bring to the cur-
ricular change process something other than knowledge about medi-
cal school curricula that is highly valued by medical school faculty
and administrators. Further research should focus on determining what
specific qualities medical students add to the curricular change pro-
cess. Research is also needed to understand how medical students perceive their roles on curricular projects.

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The Inhibition of Stuttering: A Viable Alternative to Contemporary Therapy

To the Editor:
Stuttering, the debilitating disor-
ter of communication that develops
during early childhood, permeates
early every aspect of life, often
making childhood, adolescence,
and even adulthood seemingly im-
possible. This disorder has been
treated for decades in every man-
ner imaginable, from psychoanaly-
sis to radical surgeries and even
glossectomies. For the last 40 years, practitioners of stuttering therapy have adva-
cated systematic retrain-
ing of the peripheral speech mecha-

ism in an attempt to create speech
movements believed to be incompat-
ble with stuttering.1 Such re-

training has often resulted in “pseudoﬂuent” or “labored” speech, characterized by unnaturalness, droning, and conspicuousness. Further, these new speech patterns have shown a strong history of instability and propensity for relapse, despite the countless hours taken to establish them. However, the disorder continues to be treated by many who use these behavioral techniques in an attempt to bring this “involuntary disorder” seemingly under “voluntary control.”

No compelling evidence exists to support the notion that people who stutter have a compromised respiratory, laryngeal, or articulatory system, the target systems for the modiﬁcation of speech patterns, according to contemporary therapeutic milieus. Rather, the major corpus of current evidence suggests, and most “experts” now concur, that stuttering is an involuntary central neurological disorder. Therefore, logically speaking, attempting to combat the disorder by altering speech patterns without attacking the source of the pathology seems only to provide temporary relief from the overt symptoms of stuttering. As such, these methods appear to be largely ineﬀective in treating the disorder, a contention that is obvious to most and most notably to the person who stutters.

Our research group suggests that stuttering can be inhibited at a central level, closer to its source, by using a speaking condition known as “choral speech” and its permutations. When people who stutter speak the same material in unison with another speaker, disruptions of stuttering are usually totally absent. For centuries, choral speech has been known to be the most powerful stuttering inhibitor in existence, immediately and effortlessly inhibiting stuttering, and generating ﬂuent speech in even the most severe cases. It is a phenomenon that best exempliﬁes the inhibition of stuttering and a benchmark for all other methods of ﬂuency enhancement. Other permutations of this eﬀect such as the use of delayed auditory feedback (DAF) and frequency altered feedback (FAF), shadow speech, and visual choral speech have also been found to show similar increases in ﬂuency, further supporting this notion.

Rather than continuing to retrain an unﬂawed speech motor system, we suggest redirecting stuttering research and therapy toward taking advantage of this accessible, easily derived, and eﬀortless inhibitor of stuttering. Prosthetic devices (eg, all-in-the-ear ﬂuency aids) that emulate choral speech (by using DAF and FAF) seem promising, and pharmacological agents for general inhibition also show potential, with more speciﬁc pharmacological stuttering inhibitors possibly looming in scientiﬁc horizons. The data is irrefutable—current stuttering therapies have fallen short of their promises, and stuttering inhibition should be further explored. In the best interest of all those who stutter, the medical community, often being the ﬁrst point of contact for those who stutter, should be aware of these viable alternatives.

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REFERENCES


Comment

Mnemonics Helpful for Physician-Patient Communication

To the Editor:

I read with much interest the May 2002 Family Medicine issue dedicated to physician-patient communication and applaud the comprehensive selection of articles published. The articles and their cited references failed to mention and discuss some important explanatory model frameworks for communicating with patients of all backgrounds and abilities, which deserve pointing out. These frameworks include BATHE (Background, Aﬀect, Trouble, Handling, Empathy), and ETHNIC (Explanation, Treatment, Healers, Negotiate, Intervention, Collaborate).

As a practicing family physician and faculty member at a family practice residency program, I have found these explanatory model frameworks to be highly useful. They are not intended to replace the standard medical history process but rather are proposed to serve as a framework within which to facilitate physician-patient communication exploring the psychosocial context (BATHE) and cross-cultural issues (ETHNIC) during clinical encounters. Further empirical research is needed to study these explanatory model frameworks.

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REFERENCES