Reassurance is not for the faint of heart

by Brent Kvern MD CCFP

I've been an academic family physician for pretty well my whole career. I am now at the point where I check with learners whether or not I have already shared with them one of my various discourses (or, as some might opine, canned "spiels") on various aspects of patient care.

"Have we talked about…" is the opener I use to check if I have already tried to stimulate a particular learner's thoughts on, and to make the implicit explicit when dealing with, common patient interactions and situations is well known around the clinic. Other learners who may be overhearing this conversational starter of mine sometimes roll their eyes or just nod in recognition as they move out of range. One of my favorite topics concerns a totally personal, completely clinically unproven, but easily applicable three-step approach to increase the effectiveness of a clinician's use of reassurance.

Turns out that reassurance is, like most things, more complex than it initially seems. At risk of reassurance being the proverbial simple but wrong solution to a complex problem, I believe a family physician's approach to the use of reassurance is worth thinking about carefully and articulating how we can make helpful strategies explicit. Care in family medicine must go beyond intent to the skillful and thoughtful application of all the tools available to us.

Pincus *et al.*[1] undertook a systematic review of the use of reassurance in primary care. To none of the readers of this blog's surprise I'm sure, the studies they decided to include are very heterogeneous and not linked to patient outcomes. These studies don't tell us a lot and the very common "more research is needed" ends their summary. Yet every family physician uses reassurance. Are we all misguided? *Giroldi et al.*[2] explored reassuring strategies used by GPs. They found that: there is paucity of evidence regarding effective ways of using reassurance; physicians promote trust, safety, and comfort to try to increase patients' acceptances of reassurance; and physicians try to influence patients' cognitions by challenging beliefs of the seriousness of the condition. Thus, a natural combination of affective and cognitive reassurance strategies seems to be what family physicians use.

My simple, three step application of the reassurance model is aimed to increase the effectiveness of any clinician's use of reassurance (i.e. assuming that effectiveness equates to avoiding the bad outcome of patients' perceiving reassurance as a form of brush-off or disrespect, and that used in this fashion, patients benefit therapeutically).

- **Step one** - Ensure that the patient has been heard and feels respected. Active listening and appropriate exploration of the patient's concerns, ideas, feelings and worries help create a space where the patient feels heard and respected. The affective component of reassurance is built on this foundation;
- **Step two** - Be definitive. My favorite phrasing is "Based on what you have told me and my

examination today, I am not worried." There is nothing less reassuring than wishy-washy phrasing from a physician who wants to leave wiggle room;

- **Step three** - Frame the concern. Ask yourself "What would elevate this presentation from the bothersome to something worrisome for me?" and share that with the patient. Thus, something like "If you get a high fever, start coughing up blood, the pain changes and becomes much more intense." (I aim to leave the patient with more than one but less than four things to be on the lookout for - so it can be retained in their short-term memory for a while.) I share with the patient the red flags that signal something more significant may be developing and needs to be followed up. The patient is not dismissed but becomes an active partner in what to watch for thus hopefully channelling, if not reducing, their anxiety and worry - the rationale for the clinician's use of reassurance in the first place.

References

1. Pincus T, Holt N, Vogel S, Underwood M, Savage R, Walsh DA, Taylor SJ. Cognitive and affective reassurance and patient outcomes in primary care: a systematic review. Pain 2013 154(11):2407-16.

2. Giroldi E, Veldhuijzen W, Leijten C, Welter D, Weijden TVD, Muris J, Vleuten CVD. 'No need to worry': An exploration of general practitioners' reassuring strategies. BMC Family Practice 2014 15(1).