GENERAL PRACTICE

The role of the GP in helping patients stop smoking

by Drs CL Betson & TH Lam

General practitioners need simple, effective guidelines to help patients stop smoking. The guidelines presented here focus on the GP, but can easily be taught to other health personnel such as nurses.

It is over 40 years since the serious health effects of tobacco smoking were established. Now, tobacco use is known to be the single largest cause of preventable morbidity and mortality in developed countries, and threatens to create an even worse situation in developing countries.

Less than half of all physicians actually ask patients about their smoking status and urge those that smoke to quit.

In spite of this knowledge, many people continue to smoke. In the United Kingdom, almost a third of the adult population smoke cigarettes and in the United States a quarter of the population now smoke. Smoking prevalence in Asia ranges from a low of 16% in Hong Kong and Singapore to a high of about 48% in Cambodia and 41% in the Philippines (Table 1).

What is even more disturbing is the number of young people who are beginning to smoke; in the United States, for example, about 3000 under-18s start each day.

Few doctors now smoke and most are quick to acknowledge the role of smoking in illness and death.

However, less than half of all physicians actually ask patients about their smoking status and urge those that smoke to quit. This has been termed irresponsible medical practice and even malpractice in some circles, because help for quitting is arguably the most appropriate regimen doctors can prescribe. It is certainly more cost-effective than providing treatment for smoking related diseases.

Why then, are many dedicated doctors, reluctant to advise and assist patients who smoke to quit? Lack of time, inadequate remuneration and lack of training in the management of tobacco dependence are reasons most often cited.

Physician intervention

Nearly 90% of people who overcome their addiction to nicotine do so by themselves, because they have a strong desire to stop smoking. So, why spend time and energy encouraging smokers to quit? The answer is three-fold:

- Patients regard physicians as an important and credible source of information. Even minimal contact advice by doctors to stop smoking can motivate as many as 70% of smoking patients. Furthermore, studies have shown that if advice is supplemented with self-help leaflets and follow-up, there is a 5-10% long-term cessation rate.
- The health benefits of quitting are overwhelming — it is the single most important step for preservation of health that a smoker can take.
- It is part of every physician's responsibility to promote health and give advice to patients about the causes of ill health. Smokers are known to visit their doctors more often than non-smokers — an average of about four times a year. Children of parents who smoke are prone to more respiratory infections than children of parents that do not smoke. All these visits represent "teachable moments" and the opportunity to assist smokers to quit.

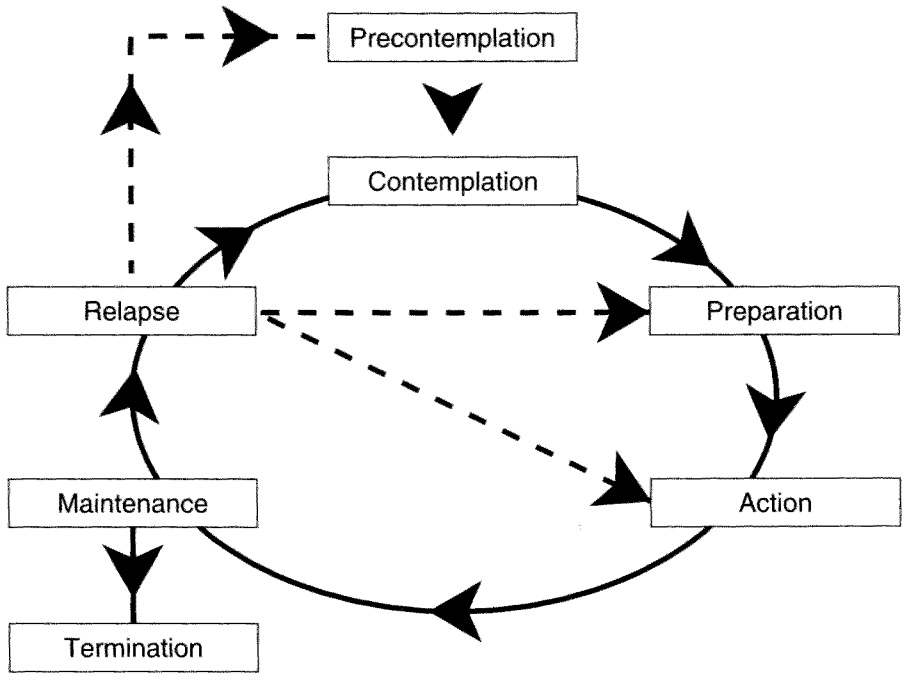

Figure 1. Stages of change in smoking cessation behavior (Prochaska & DiClemente).

The change model

This concept of change grew out of research on addiction behavior and attempts to explain an individual's "readiness to change." The "stages of change" model described by Prochaska & DiClemente (Figure 1), describes the range of motivational stages of a patient's experience. The approach a physician takes with patients who smoke will be more successful if the stage of the patient's readiness to change is determined before advice is given.

- Precontemplation: The stage patients are in when they are not interested in considering change; they have either not thought about it seriously or just do not want to change.
- Contemplation: This is when patients are unsure or are considering change. They are not yet ready to make a commitment but they are weighing the pros and cons of a change in their behavior.
- Action: This is the stage that involves doing something about the desired change. These patients are abstaining from cigarettes, using nicotine patches, attending classes etc.
- Maintenance: Patients sustain the desired change; the ex-smoker.
- Relapse: Occurs when patients revert to smoking.

The concept of readiness to change can be clinically useful in two ways. First, it reminds physicians that smoking cessation, like other behavior change, is a process and not a discrete event. Sometimes, the most realistic goal is to get the patient to think about making a change — to move from precontemplation to contemplation or from relapse back to contemplation. Reference to this model will enable the physician to use his/her time most efficiently.

If a patient is in the precontemplation stage and the physician provides information about cessation techniques, the most likely result will be resistance.

Table 1. Smoking prevalence in the Asia-Pacific region.

	Male	Female	Total (%)
Cambodia	80-100%	2-10%	
China	61	7	34
Hong Kong	29	3	16
Indonesia	60	10	35
Japan	60	13	36
Korea, Republic	68	7	37
Malaysia	41	5	23
Philippines	43	29	41
Singapore	64	18	16
Taiwan, China	29	2	32
Thailand	48	21	25
Vietnam	46	4	
Urban	50-80		
Rural	30	1	31

Table 2. The five A's of smoking cessation.

- **Ask** about the smoking status of every patient and at every opportunity
- **Advise** all patients who smoke to stop
- **Assist** patients in their cessation effort
- **Arrange** follow-up
- **Anticipate** experimentation by children and young adults, and offer guidance.

The smoking cessation intervention five A's

The US National Cancer Institute manual *How to Help Your Patients Stop Smoking* promotes a simple, efficient, office-based smoking cessation intervention consisting of four A's and a fifth for physicians who care for children and young adults (Table 2).

Ask: For physicians to have any impact on tobacco-related diseases they must at least identify all smoking patients. Making smoking status a "vital sign" is as important as taking a blood pressure, pulse, temperature, measuring weight or testing urine, and should be charted. The chart should be marked with a special sticker or other identifying mark, visible to the patient, which can remind the physician to counsel the patient each time he/she is seen.

Whenever possible, the advice to stop smoking should be tied to the patient's personal situation or interests.

Parents should be asked about their child's exposure to environmental tobacco smoke. In addition, since studies in Hong Kong show that children as young as seven years of age experiment with cigarettes, all children over that age should be asked about their own use of tobacco.

Advice: All physicians should advise every patient who smokes to stop. This advice should be repeated at every visit in a firm and clear message.

However, it is often useful, if time permits, to ask patients what they know about the harmful effects of smoking before offering quitting advice. This creates the opportunity to correct misinformation and educate patients about the range of problems associated with tobacco use.

For example, it has been found that while most smokers know that smoking is associated with lung cancer and heart disease, few are aware of the link between smoking and impotence, low back pain or even cervical cancer. Many people are shocked to learn that in developed countries, the number of deaths from cigarettes each year exceeds the total annual deaths from alcohol, homicide, suicide, auto accidents, AIDS and illegal drugs combined.

Whenever possible, the advice to stop smoking should be tied to the patient's personal situation or interests. This would be obvious if a patient attended for an upper respiratory infection and easy if the consultation were for diabetes or hypertension.

However, it can also be effective to promote the message to a young woman attending for an unrelated problem, if smoking is linked to risks of respiratory illness in her children. The personal message should also be promoted for those who work in occupations in which smoking poses an additive risk.

The following dialog is an example of what could occur when a physician considers the patients' stage of change (e.g. precontemplation) and tailors advice to quit:

Doctor: Do you use tobacco?
Patient: Yes, I do. I smoke cigarettes.
Doctor: How many cigarettes a day do you usually smoke?
Patient: About 15-20.
Doctor: Have you ever thought about quitting?
Patient: No, not really. I enjoy it too much.
Doctor: What do you know about the harmful effects of cigarette smoking?
Patient: Well, I know it causes lung cancer.
Doctor: Yes, it does. It is also related to heart disease, peptic ulcers (etc. etc.) What would it take for you to think about giving it up?
Patient: Well, I suppose if I got cancer or had a heart attack I would stop.
Doctor: Why wait? Most smokers experience some harmful effects from smoking. (Pause) I would strongly suggest that you think about stopping. If you want to talk more about that, we can schedule another appointment. I'd be happy to work with you and help you to stop. It is the most important thing you can do for your health.
Patient: OK. I'll think about it. Thanks doctor.

Sometimes, patients do not want to try quitting because they are afraid of failure. Physicians and patients must remember that it is not uncommon for a few unsuccessful attempts to precede complete cessation. Patients must not be made to feel guilty or ashamed if they have tried and failed. Rather, they need to be supported and praised for their attempt and should be encouraged to try again.

Assist: The time to help in a more active fashion is when the patient indicates a willingness to stop smoking.

The first step is to set a quit-date. For some patients, that might be immediately, but many need a short time to prepare for change. This time can be spent examining his/her own smoking behavior, learning about cessation techniques, carrying a personalized list of reasons for stopping smoking and seeking support from friends and family. This knowledge can be useful in predicting situations that might trigger a relapse and help the patient avoid such situations.

On the quit date, the patient should be encouraged to clear out all smoking related cues such as ash trays, cigarette packs and lighters from his/her surroundings.

Other activities that symbolize a complete break with tobacco consumption can also be suggested, including cleaning the house and car or getting his/her teeth polished. New routines need to be substituted for old and it may be helpful to avoid the places and situations where smoking behavior is reinforced, such as in bars.

It is now well established that NRT is effective in relieving withdrawal symptoms and achieving short-term smoking cessation.

Patients should be encouraged to try new activities to take the place of smoking. Taking a deep breath, chewing sugarless gum or sucking on hard candies may be helpful.

A reasonable exercise regimen has also been found to help many patients. Physicians should be aware of smoking cessation programs in their area, in case some patients want to attend. Some smokers report that hypnosis or acupuncture is effective and, although these modalities have not been well studied, patients may be encouraged to do whatever they think helpful as long as it is not harmful.

Nicotine replacement therapy

A plethora of data on nicotine replacement therapy (NRT) is available with many rigorous, placebo-controlled trials investigating the efficacy of this approach.

It is now well established that NRT is effective in relieving withdrawal symptoms and achieving short-term smoking cessation.

A meta-analysis of 53 randomized controlled trials of NRT shows a doubling of cessation in those using active preparations, compared with placebo. Success is higher when NRT is used in heavier smokers and those who have tried unsuccessfully to quit. Complications are rare but smokers must receive proper instruction and clear warning not to smoke while using NRT.

There are currently two forms of nicotine replacement available: nicotine gum and the transdermal nicotine patch.

The patch has a higher success rate, perhaps because of better compliance and ease of use, but there are patients who still prefer the gum. If the physician considers a patient an appropriate candidate for NRT, it should be started on the quit date, *after* the patient has stopped smoking. If NRT is combined with self-help material, counseling and follow-up, there is a higher chance of success.

NRT, like any pharmacological adjuvant, cannot be taken casually and while success rates are promising, putting a patch on a patient should not signal the end of the physician's responsibility. NRT only addresses the physiological aspect of nicotine addiction and the psychological aspects of dependence must also be managed.

Arrange: The follow-up visit with the patient who is attempting to stop smoking is the visit that most physicians are likely to neglect. There are still no (or at best poor) reimbursement incentives for physicians to follow up patients, and when patients are unable to pay for these visits they are neglected. Nonetheless, the follow-up visit is important in the successful management of patients addicted to nicotine.

The first follow-up visit should be scheduled near the quit date. If a patient is going to relapse, this usually occurs within two weeks. Subsequent visits should be scheduled one week and then one month after stopping.

During this phase, patients require reinforcement and support. Their personal skills and strengths need to be mentioned frequently. Telephone calls to the patient offer another way to ensure contact and offer support.

If a major disaster in the form of morbidity and mortality rates is to be avoided in Asia, all physicians must be committed to smoking prevention and cessation efforts.

Anticipate: The best cure for tobacco addiction is prevention. Trying to prevent young people from taking their first cigarette is just as important as helping adult smokers to quit, if not more so.

Physicians can assume that their young patients are vulnerable to the false promises of the tobacco industry, seductive advertising campaigns and the influence of friends or parents who smoke. Other predictors of smoking initiation include poor school performance, lack of career plans and engagement in other high risk behaviors such as drinking alcohol.

Anticipating the temptation and counseling every young person about smoking is the key to protecting our future generations. Physicians should point out that most people do not smoke and emphasize the short-term effects of cigarette smoking such as bad breath, yellow teeth, respiratory complaints and having less money for other activities.

It is critical to teach young people how to "say no" to the offer of a cigarette. Engaging in a short, simple role-play may be the key to helping a child refuse this offer. Modeling is more effective than telling. In that light, maintaining smoke-free medical offices and having self-help material available in the waiting area also signals the priority of this activity to all your patients.

Conclusion

While smoking is declining in most developed countries, it is increasing at an alarming rate in developing countries. American and British tobacco companies have targeted Asian women and young people as potentially lucrative markets. If a major disaster in the form of morbidity and mortality rates is to be avoided in Asia, all physicians must be committed to smoking prevention and cessation efforts.

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