ABCss: s is for smoking

JOHN LITT MB BS

PAT PHILLIPS MB BS, MA(Oxon), FRACP, MRACMA, GradDipHealthEcon(UNE)

The case studies in this series focus on the ABCss of diabetes care (A_{1c}, blood pressure, cholesterol, smoking, salicylates), how to get them closer to target and how to keep them there.

Case scenario

Sam is visiting the surgery because he has run out of his cholesterol tablets. However, he says, he has been taking his diabetes and blood pressure tablets so his blood pressure can be taken and his glycosylated haemoglobin (A_{1c}) checked while he is here.

As he takes off his coat so the sphygmomanometer cuff can be put on, you smell tobacco smoke. After measuring his blood pressure (which is a bit high at 156/82 mmHg), you ask Sam how many cigarettes he smokes each day. He looks a bit sheepish and tells you, 'about 10 to 15 a day, but I'm cutting back steadily'.

Although you do not have much time right now, you do not want to miss the opportunity to address Sam's smoking habit.

Questions

- How can you get smoking on the agenda without offending Sam?
- How could you best use one minute to assist Sam? And three minutes?
- How likely is Sam to respond to these interventions and try quitting?
- If Sam does decide to quit, is nicotine replacement therapy likely to help him? What other help is available to him?
- If Sam does quit, how likely is he to be a nonsmoker 12 months later? What factors might influence his continuing abstinence?

Dr Litt is Senior Lecturer, Department of General Practice, Flinders University, Flinders Medical Centre, Bedford Park. Dr Phillips is Senior Director, Endocrinology, North Western Adelaide Health Service, The Queen Elizabeth Hospital, Woodville, SA.

Getting smoking on the agenda

While most smokers do not object to being asked about their smoking, obtaining more than the basic information is usually not easy unless they can be reassured they will not be lectured about smoking. They expect to be 'harassed' and this tends to put them in a defensive frame of mind.

A few tips to bear in mind when raising the issue of smoking with a patient are discussed below and listed in Table 1.

Be alert for sensitivity

Sensitivity is the norm. Nevertheless, when the issue of smoking is raised sensitively and discussed nonjudgementally, patient satisfaction is often higher than when it is not discussed.[1-3]

Normalise enquiry

If everyone is being asked then patients are less likely to feel singled out. Asking everyone also increases the recognition of smoking status and can prompt patients to think about quitting.[4,5]

Understand the patient's perspective

Smoking may play an important role in the person's life. Many smokers see quitting like killing their best friend.[6] Quitting smoking involves many changes – for example, what to do when they are feeling stressed, how to keep their weight down, not joining their friends at smoko, losing the 'time out' that a cigarette may give. Understanding the issues and challenges for patients will help you to engage them in the quitting process. Remember that the number of significant others in a person's immediate family and friends who are smokers is a potent predictor of the likelihood of the person relapsing after quitting.[7]

Table 1. Asking a patient about smoking

Be alert for sensitivity
Normalise enquiry
Understand the patient's perspective
Separate information from the 'persuasive imperative'
Avoid dangerous assumptions
Establish and maintain common ground
Keep confrontation in reserve
Leave the door open

continued

Table 2. The 5As approach to smoking cessation*

5As	If only 1 minute available	If more time available (about 3 minutes)
Ask	Identify and document smoking status routinely and review at least every 12 months: current, ex, or never smoker?	Explore smoking status further
Assess	Identify: • interest in quitting • barriers to quitting, e.g. what would be the hardest thing about quitting? • level of nicotine dependence – time to first cigarette in the morning (<30 mins), number smoked per day (>15 cigarettes), previous symptoms of withdrawal	Explore: • motivation and confidence • barriers to quitting • quitting history – what worked, what didn't work, what tipped him or her back? • high risk situations – which cigarette would be the hardest to give up, when might slips occur (even one puff greatly increases the risk of relapse)?
Advise	Provide brief, clear personalised and nonjudgemental advice to quit Set quit date	Address the three main domains – dependence, habit, triggers (especially negative emotions) Brainstorm solutions – provide options, explore what is likely to support his or her ability to quit Negotiate/advise how to deal with high risk situations
Assist	Offer a Quitbook and give the Quitline number (137 QUIT) Negotiate a separate smoking cessation orientated consultation	Enrol in an active call back program (12 weeks) Discuss/offer pharmacotherapy Develop a plan to deal with nicotine withdrawal, habit, negative moods, weight gain, stress, high risk situations
Arrange	Follow up (ideally in first seven days)	Recruit support (partner, family and friends)

* Based on the Quit SA website's resource for GPs:GP desk prompt -5As (www.quitsa.org.au/cms_resources/documents/resource_gpdeskprompt.pdf).

Separate information from the 'persuasive imperative'

Patients are very sensitive to judgements being made about their health-related behaviour.[8] While many doctors recognise this, it unfortunately does not stop us being somewhat judgemental.[8,9] Patients do need personalised information about the risks of smoking to them. Downplaying the risks, scepticism about the medical evidence, a sense of fatalism and inevitability, normalising the dangers of smoking because of the many other risks to health, and the belief that smoking is worth the probable health damage are all common beliefs that need to be countered with clear and accurate information.[10-12]

Three ingredients are necessary for a person to make a successful lifestyle behaviour change:

- concern about his or her current behaviour
- a belief that changing will be beneficial to him or her
- a perception that he or she will be able to change.

Avoid dangerous assumptions

Dangerous assumptions that doctors may make include:[13]

- the patient ought to change
- now is the right time
- my way is best.

Establish and maintain common ground

Ensuring agreement on what the problem is and respecting the patient's autonomy helps the communication process and improves health outcomes.[14] If you want to talk about a patient's smoking but he or she does not wish to discuss it, do not push the issue. Instead, address the patient's concerns and the reasons behind his or her reticence. Getting a patient's permission to discuss smoking and promising not to give a lecture are useful steps that provide a nonjudgemental signal to the patient.[15,16]

Keep confrontation in reserve

Although confrontation works occasionally, more often it provokes reactance, or resistance.[13,17] When patients react in this way to a personal threat, they become defensive and tend to dig in or harden their beliefs. Such a reaction can make it more difficult to raise the topic again as the patient expects to be confronted.

Leave the door open

If first you don't succeed, try again. Patients see their GP five times a year on average, so there will be further opportunities to

discuss smoking. Quitting smoking will only occasionally result from a single consultation, but one consultation can start the ball rolling.

Best use of time

The 5As

One straightforward option for spending a few minutes productively with Sam is to use the 5As – ask, assess, advise, assist and arrange. However, before doing so, ensure that Sam is prepared to talk about his smoking. The 5As approach is summarised in Table 2.

Ask. Ask Sam if he is interested in quitting.

Assess. Ask Sam how confident he is that he would succeed if he tries quitting. Get him to rate his chances on a 10-point scale where 10 is very confident and 0 is not confident at all. Then ask, 'What would need to happen to increase the score from 3 (or whatever low score he gives) to 9?' If he has an initial high score (say 8 or more), ask him 'Why is your confidence an 8 and not a 2?' This should give some insight into what is underpinning his confidence.

Remember that many heavy smokers believe that they can quit at any time so do not need to think about it until it is really necessary. A useful counter to this view is to tell patients that the more they smoke, the more likely they are to be dependent on nicotine and the more difficult it will be to quit. Also ask about whether they have ever quit for any period, and what happened when they did.

If you think Sam may be nicotine dependent, ask when he has his first cigarette of the day and the number he smokes each day. If he is having his first cigarette within 30 minutes of waking up and smoking more than 15 a day, he is likely to be nicotine dependent.

Advise. Provide Sam with brief, concise and nonjudgemental advice on how to quit. Mention the risks of smoking and the benefits of quitting.

Assist. Offer support and reassure Sam that he will not be lectured about his smoking. Refer him to the Quitline and outline the benefits of the Quitline active callback program. (The Quitline is the phone support service of the National Tobacco Campaign, a Federal, State and Territory health initiative, and is discussed in detail later.) Discuss pharmacotherapy if there is time.

Arrange. Offer Sam a follow up appointment for review of progress and pharmacotherapy. Enlist the support of his family and friends.

Other options

If Sam is very sensitive about his smoking (as many smokers are) and seems to overreact to questions, another option is to use the minute to outline an approach to managing his smoking. This would include an offer of practical help to quit, reassurance that he will not be given a lecture, acknowledgement of how difficult it is stop smoking and exploration of how he feels about quitting.

Many smokers erroneously believe that they should be able to quit smoking on their own and that asking for help is a sign of weakness. Remember that the unassisted quit rate is 3 to 5%,[18] and that GPs can increase this four to sixfold by using a range of proven strategies. These strategies include focusing on those smokers who express interest in quitting, arranging at least one follow up visit and getting the smoker to take some form of nicotine replacement therapy; each of these can double the success rate,[4,5] and collectively they can increase the likelihood of quitting significantly.

A further option is to encourage Sam to see your practice nurse who can talk to him about the steps involved in quitting (using the 5As approach).[19,20]

Likelihood of quitting smoking

Whether Sam is likely to respond to these interventions and try quitting depends to a great extent on how the message is delivered. There is good evidence that patient satisfaction in smokers is higher when doctors address smoking.[1,2] The challenge is to do it in a manner that is not too confronting. The moral imperative should be separated from the useful information that you can offer the patient. Externalise the patient's smoking through forming an alliance; for example, 'How can you and I work together on your smoking?'

Most surveys of smokers demonstrate that up to two-thirds of people using cigarettes are interested in quitting and health concerns are a potent stimulus for thinking about quitting.[21] The challenge is often the smokers' perceived confidence of success.[11,22] Some patients really want to quit but feel they can't, so they don't try. Many doctors mistakenly perceive this as lack of interest in quitting, when it may in reality reflect an inability to be able to quit despite interest.

Most smokers will make a serious quit attempt at least once a year. The secret to successful quitting is getting them to understand that quitting is more challenging without some form of help. A useful strategy is to liken quitting to participating in a triathlon. The latter requires three independent sets of skills: running, swimming and cycling. Quitting also involves three sets of skills:

- overcoming the physical dependence on nicotine
- dealing with the habit of smoking
- managing negative emotions, such as boredom, anxiety, anger and depression.

Using a medication like nicotine replacement will only help with nicotine withdrawal; it will not address the habit or help with the negative emotions. All the randomised controlled trials of pharmacotherapy in smoking cessation have involved some form of counselling, some quite intensive. Consequently, bupropion or some form of nicotine replacement should not be prescribed on its own. Varenicline, a selective $\alpha 4\beta 2$ nicotinic acetylcholine receptor partial agonist, is a further alternative to assist smokers to quit but has not yet been released in Australia.[23-25] A recent 12-month follow up

Table 3. Quitting: what works, what doesn't and what might[27]

What works

- Counselling – individual, group, phone
- Follow up – visits, phone calls
- Pharmacotherapy – nicotine replacement therapy, bupropion

What doesn't

- Written materials alone
- Aversion therapy, acupuncture

What might

- Hypnotherapy

trial has reported that varenicline was superior to buproprion in reducing relapse rates.[26]

Strategies that work in quitting and those that do not are summarised in Table 3.[27]

Many smokers feel that quitting will just be a matter of not smoking anymore, without realising that smoking is playing a big role in their life (e.g. as a coping strategy, as a means of keeping their weight down and as time out from a stressful day).[11,12,28] It is important to show Sam that you are interested and that you will not tell him what to do.

Nicotine replacement therapy and other help

Most forms of pharmacotherapy double the success rate in smoking cessation.[29,30] Up to two-thirds of smokers are nicotine dependent so it is useful to determine whether the patient is nicotine dependent (see above, under 'Best use of time').[29,31]

Nicotine replacement therapy

Many smokers do not get good instructions about how to take the various forms of nicotine replacement therapy (patches: NicabateCQ, Nicorette Patch, QuitX Patch; lozenges: NicabateCQ Lozenges; chewing gums: Nicorette Chewing Gum, Nicotinell Chewing Gum, QuitX Chewing Gum; inhaler: Nicorette Inhaler; sublingual tablets: Nicorette Microtab). Often more than one form of nicotine replacement therapy is needed; for example, a nicotine patch plus some form of quicker delivery of nicotine in the morning to deal with early morning cravings.

Bupropion

An alternative therapy for nicotine dependence is bupropion sustained release (Clorprax, Zyban SR), a selective catecholamine (norepinephrine and dopamine) reuptake inhibitor initially developed for use as an antidepressant that has also been shown to act as a competitive α3β4 nicotinic antagonist. Common side effects of bupropion include difficulty sleeping, dry mouth, headache, dizziness, anxiety and nausea. Bupropion sustained release is available as a PBS authority item once per year.

Increasingly, smokers are using a combination of bupropion and nicotine replacement therapy. Sam's employer may provide a subsidy that may help.

Quitline

The other key strategy is to refer Sam to the Quitline in his State or Territory, where Quitline counsellors provide advice and assistance to smokers who want to quit, including the offer of a copy of the self-help *Quit Book*, and the opportunity to enrol in an active callback program. This active Quitline phone follow up service operates in most States and Territories and is very effective.[32,33] The Quitline is answered 24 hours a day, but Quitline counsellors are only available during business hours and at certain times at weekends. An interpreter service is available.

Sam can contact the Quitline himself (phone number 137 QUIT) or you, his GP, can refer him by phone or fax and they will contact him. Fax referral forms are available on the Quitnow website

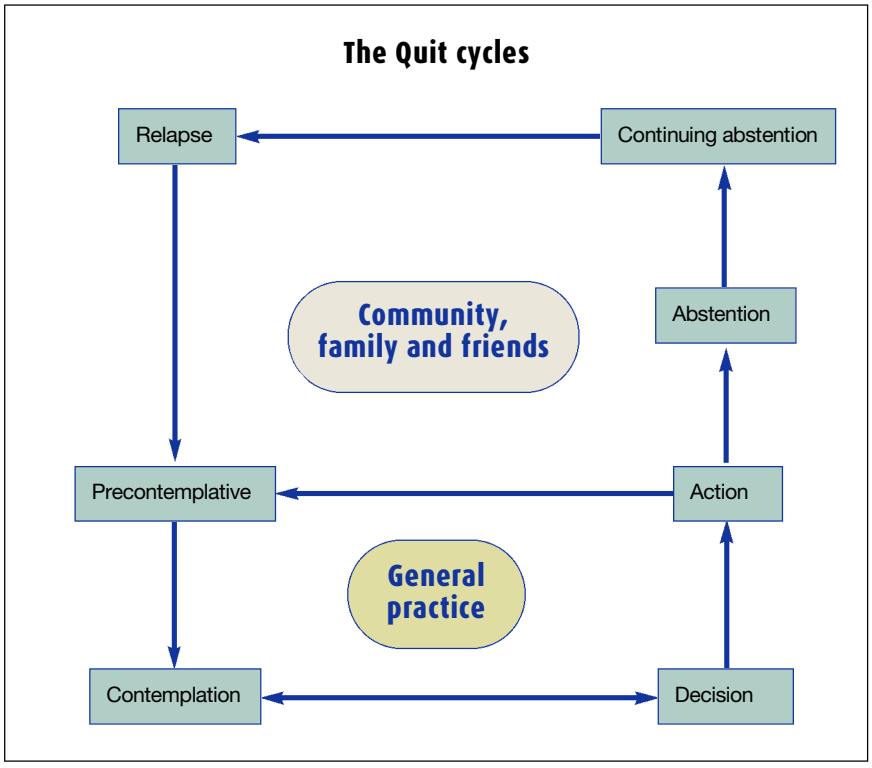

Figure. Long term smoking abstention is influenced by community factors.

(www.quitnow. info.au), as are other resources, such as the *Quit Book* and *Smoking Cessation Guidelines for Australian General Practice*.

Less than 5% of the population of smokers have called the Quitline. There is a lot of scope for improvement, especially since many clinicians are not yet referring smokers for smoking cessation counselling.[34,35]

If Sam has a partner who smokes then it will be harder for him to quit. However, if the partner tries to quit at the same time, the success for both is doubled.[36,37]

Other therapies

Strategies such as hypnotherapy and acupuncture do not appear to be effective in smoking cessation. While they may work for some, in general the systematic reviews show no benefit.[4]

Likelihood of continuing abstinence

Twelve-month quit rates depend on the approach taken. In the absence of support, 3 to 7% of quitters will still be non-smokers. If Sam is enrolled in the Quitline active callback program and gets support and some form of pharmacotherapy from you, then his quit rate could be as high as 33% at 12 months.

It is important to remember that most of the factors influencing Sam's continuing abstention in the long term lie in the general community (Figure). The program set up for Sam can only influence his behaviour when the Quitline calls back, you send a letter of support or he returns for a visit.

Larger environmental factors, such as advertising, restrictions on smoking behaviour and cigarette prices, are powerful influences. There may also be direct factors influencing Sam's future behaviour, such as other smokers in his household or his circle of friends, enjoyable regular activities associated with smoking behaviour and the role of smoking in dealing with issues such as stress and weight management.

Internet resources for smoking cessation

Smoking cessation guidelines for Australian general practice
www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document- smoking_cessation-cnt.htm

Quitnow – Resources for health professionals
www.quitnow.info.au/internet/quitnow/publishing.nsf/content/health_professionals-lp

QUIT SA resources for health professionals
www.quitsa.org.au/aspx/quitsa_resources.aspx

5As – desk prompt (GPs Assisting Smokers Program)
www.quitsa.org.au/cms_resources/documents/resource_gpdeskprompt.pdf

Pharmacotherapy for smoking cessation
www.quitsa.org.au/cms_resources/documents/resource_gpcardbuproprion05.pdf
www.quitsa.org.au/cms_resources/documents/resource_gpNRTcard05.pdf

Sam's previous attempts to quit or to change another important lifestyle behaviour should be explored. What helped and what hindered? How did he maintain the positive and deal with the negative influences? How did he/could he recruit family and friends to be part of his long term support team? What will he do if he relapses (as many do)? Sam may need five to eight attempts at quitting before finally succeeding. Will he feel able to seek your help or advice from the Quitline?

It should be stressed to Sam that help will always be available and that you will work with him rather than judge or lecture him. Mention of ongoing abstinence should be added to the agenda of future consultations, such as 'Do you realise it is now two years since you stopped smoking. Pretty damn good!'

A final word

Referring to the analogy of quitting smoking and participating in a triathlon, Sam is the triathlete, and you and the other resources are his support team.

To start the process of quitting, Sam must answer 'Yes' to three questions about smoking as an issue in his life:

- Do I care? Yes, smoking is a life issue for me.
- Will it work? Yes, quitting will improve my life.
- Can I do it? Yes, with a program I can quit.

To help Sam succeed, you, his GP, need to establish:

- the routine of the '5As' as part of your usual practice
- the organisation within your practice to support quit attempts and ongoing abstention – for example, computerised prompts and using practice nurses to also provide counselling (see the RACGP *Putting Prevention into Practice* monograph for a summary of effective practice-based implementation strategies)[38]

A list of internet resources to assist GPs when encouraging smokers to quit is given in the box above. MT

A list of references is available on request to the editorial office.

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