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Invited Commentary

Engaging Patients and Clinicians in Treating Tobacco Addiction

Judith J. Prochaska, PhD, MPH

This year marked the 50th anniversary of the Surgeon General's 1964 report on the health consequences of smoking.¹ Tobacco use is causally linked to diseases of nearly all



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bodily organs, overall deficits in health, and considerable medical costs. Annually, 480 000 deaths in the United States are attributed to tobacco, with millions more living with smoking-attributable diseases. Worldwide, tobacco-related deaths are expected to reach 1 billion during the 21st century.²

Although there have been dramatic declines in smoking among adults in the United States over the past 50 years, not all groups have benefitted equally. Smoking has become increasingly concentrated among the poor, the less educated, and individuals with co-occurring psychiatric or addictive disorders. In 2012, an estimated 42 million people, or 18% of all adults 18 years or older, smoked cigarettes.³ By education, smoking prevalence was 42% among persons with a graduate education development (GED) certificate compared with 6% among those with graduate degrees and 9% with undergraduate degrees. By income, 17% of persons above the poverty level smoke compared with 28% below the poverty level. The smoking prevalence among individuals with mental illness or addictive disorders ranges from 40% to 60%.⁴ The Affordable Care Act's requirement that health care plans cover tobacco treatment will expand access to cessation medication and counseling to these more vulnerable groups. Patient and clinician engagement will be critical to maximizing this opportunity.

In this issue, Cunningham⁵ analyzes survey data from 8656 current and retired autoworkers and their spouses, testing the association between patient engagement in medical care and physician tobacco treatment counseling. The assessment of patient engagement, which was nonspecific with reference to time and health concerns, had patients report whether for a medical visit, they ever brought in information from a website, had a family member or friend accompany them to the visit as an advocate or support, created a list of questions to ask of the clinician, or took notes on what the clinician said. Cunningham⁵ found that more highly engaged patients were more likely to report that clinicians addressed tobacco use with them. Furthermore, highly engaged patients who were counseled on tobacco use by their clinicians were the most likely to attempt to quit smoking (75%), whereas patients with low levels of engagement who were not counseled by clinicians were the least likely to make a quit attempt (46%). Notably, if counseled by their clinician, 60% of patients with low engagement attempted to quit smoking.

Patients with multiple chronic conditions reported being more engaged in their medical treatment, likely by necessity,

and were more likely to be advised and counseled by their clinician to quit smoking, perhaps reflecting greater medical contact opportunities for intervention as well as clinician concern about smoking complications in patients with existing disease. Similarly, patient ratings of their physical and mental health as fair or poor were associated with greater smoking prevalence, greater patient engagement, and for physical health only, with greater clinician attention to smoking; that clinicians' treatment of tobacco was not similarly increased in the presence of fair or poor mental health may reflect traditional clinical views that tobacco is less relevant or more difficult to treat in the presence of mental illness. It is important to note that, with increased attention to the intersection of tobacco and mental health, building evidence indicates that smokers with mental health concerns are motivated to quit, are able to quit, and quitting smoking does not compromise their mental health recovery.⁴

Cunningham's⁵ data were cross-sectional, limiting causal inferences. Patient and clinician behavior are mutually influenced, and engagement can be time and situation dependent. As Cunningham⁵ warned, lack of patient engagement should not be presumed to mean unwillingness to make important health changes, such as quitting smoking. Notably, 70% of adult smokers in the United States want to quit, and decades of research indicate clinicians can have an important impact, doubling the likelihood of their patients' achieving long-term abstinence.⁶

Evidence-Based Treatment for Tobacco Use and Dependence

Recommended by the Clinical Practice Guideline for treating tobacco use and dependence, maximal treatment effectiveness combines US Food and Drug Administration (FDA)-approved cessation medications with a behavior change program.⁶ Clinicians are recommended to use the "5-As" in treating tobacco use: *Ask* all patients about tobacco use, *Advise* those who smoke to quit, *Assess* readiness to quit, provide *Assistance* with quitting, and *Arrange* follow-up. For patients not ready to quit, brief motivational messages are recommended to raise the pros of quitting with an ongoing offer to help when they become ready to quit. For patients ready to quit, treatment plans should be designed, including (1) personalized motivations and benefits of quitting; (2) past quit attempts—what helped, what led to relapse; (3) support from others; (4) the quit date—within 2 weeks; (5) use of pharmacotherapy, when not contraindicated (eg, nicotine replacement in the form of patch, gum, lozenge, nasal spray, and inhaler, bupropion hydrochloride, varenicline tartrate); and (6) attention to anticipated challenges, particularly during the first few weeks (eg, nicotine withdrawal, stress).

At a minimum, clinicians are recommended to incorporate brief tobacco interventions as part of their routine care with all patients. Simply informing patients of their treatment choices can be a powerful intervention, done in less than a minute. The national toll-free tobacco quit-line number (1-800-QUIT-NOW), now in its 10th year, enables all Americans access to tobacco cessation counseling at no cost. When time or logistics do not permit more comprehensive counseling, at a minimum: *Ask*, *Advise*, and *Refer* patients who are willing to quit to a telephone quit-line or other community-based resource for additional assistance in quitting.

How Do e-Cigarettes Fit Into Clinicians' Tobacco Treatment Toolbox?

Clinicians are being asked to weigh in on the benefits and risks of electronic or e-cigarettes as a novel harm reduction or cessation strategy. e-Cigarettes are battery-powered devices that generate an aerosol for inhalation typically containing nicotine. Some propose e-cigarettes could save lives, by removing combustion and carbon monoxide, while others warn that aggressive marketing, child-friendly flavorings (eg, cotton candy, gummy bears), and unregulated access of e-cigarettes could hook a new generation on nicotine and renormalize smoking. Consumers of all ages are trying e-cigarettes, some are becoming regular (daily) users, though even among daily e-cigarette users, dual use of conventional cigarettes is common. The FDA does not permit

marketing of e-cigarettes as a cessation product, and treatment efficacy has not been established.⁷ With the large number of e-product devices and nicotine juice formulations on the market, safety is a concern. From September 2010 to February 2014, the Centers for Disease Control and Prevention observed an increase from 1 to 215 e-cigarette-related calls per month to poison centers, more than half due to children younger than 5 years ingesting, inhaling, or absorbing the e-cigarette nicotine liquid through the skin or eyes.⁸ Clinicians should be aware of the evolving marketplace, and, consistent with good clinical practice, should recommend only FDA-approved cessation medications and evidence-based behavioral strategies.

Five decades after the Surgeon General's initial report, the pervasive negative health consequences of tobacco use are well understood. As the leading preventable cause of death, patients expect clinicians to ask about tobacco use, and those who use tobacco expect to be encouraged to quit. In a study of health habit counseling for exercise, diet, alcohol, illicit drugs, tobacco, sexual health, and human immunodeficiency virus and sexually transmitted diseases prevention, only the assessment and treatment of tobacco use was significantly associated with full patient satisfaction with the clinical encounter.⁹ Clinician attention to tobacco can enhance clinical rapport, and the findings of Cunningham⁵ reinforce the broader literature on the critical role clinicians play in addressing tobacco addiction.

ARTICLE INFORMATION

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