Clinician Perseverance

Helping patients overcoming tobacco dependence

by Jane E. Anderson, MD, MS, and Michael C. Fiore, MD, MPH

"To cease smoking is the easiest thing I ever did; I ought to know because I've done it a thousand times."

This sage comment from Mark Twain captures what is a frustrating reality for the majority of smokers. They may be able to quit for a period of time—even months—but something precipitates a relapse and they find themselves back to full-time smoking, as though they had never quit. A contemporary smoker embarking on her fifth serious quit attempt summarized: "Quitting is easy. It's staying quit that's tough."

Physicians, too, experience the frustration of working with patients who want to quit smoking but remain unsuccessful despite numerous tries. How many quit attempts are enough? When do you become discouraged and decide this is a patient who "just can't quit?"

In 1996, the first comprehensive, evidence-based guideline for clinical treatment of tobacco addiction was released. *The Smoking Cessation Clinical Practice Guideline (AHCPR #18)* evaluated the extant scientific literature on promoting cessation and provided clinicians with strategies for helping patients interested in making a quit attempt. These strategies included systematizing the identification of tobacco users and offering smoking cessation treatment at *every* office visit and *every* hospital admission for *every* smoker. This idea of routinely incorporating cessation intervention was further bolstered last year at the State Medical Society annual meeting when delegates adopted a resolution encouraging all physicians to inquire about tobacco use at every clinical encounter (*SMS Annual Report*, 2000).

Because of the rapidly expanding body of research in the field of tobacco dependence, as well as the introduction of effective new clinical treatments, the AHCPR Guideline was updated at the University of Wisconsin's Center for Tobacco Research and Intervention and released in 2000 as a *Public Health Service Report: Treating Tobacco Use and Dependence*. A key tenet of the 2000 Guideline is the concept of tobacco dependence as a chronic disease.

The Guideline emphasizes a chronic disease model that recognizes the long-term nature of the disorder. Tobacco addiction carries a vulnerability to relapse that persists over time and often requires repeated intervention. It is *expected* that there will be periods of relapse and remission. A failure to appreciate the true nature of tobacco dependence may undercut a clinician's motivation to treat tobacco use consistently and consequently reduce the patient's chances of quitting successfully.

According to recent Gallup and Harris polls, over 70% of smokers have attempted to quit in their lifetimes. The average number of quit attempts per smoker ranges from 4 to 7. For some, it may take a dozen attempts or more before long-term cessation is achieved. Not surprisingly, it is easy to become discouraged. Smokers often feel like a "failure" or like they will never be able to quit for good. Physicians may feel like they have nothing more to offer the patient who has gone back to smoking for the umpteenth time.

It is advantageous to consider treatment of tobacco dependence in the same paradigm as treatment of other chronic conditions such as hypertension, hyperlipidemia, and diabetes. Appropriate man-

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agement of such chronic disorders requires a collaborative effort between the patient and the physician. The physician must be committed to providing long-term counseling, support, and reinforcement of treatment at each visit. Referral to allied health professionals for more intense counseling may be required (e.g. just as a diabetic patient might be referred to a registered dietician for more detailed dietary counseling, a smoker might be referred to a cessation specialist or support group).

Medications are an essential component of treatment as well. There are currently 5 first-line medications shown to be safe and efficacious for treating tobacco dependence (bupropion SR, nicotine patch, gum, inhaler, and nasal spray). These may be used individually or in combination. Just as with antihypertensives, it may take some "tweaking" to find the right dosage and length of therapy most appropriate for each patient. In some cases it may take a combination of medications (e.g. bupropion SR and nicotine patch).

Realistic expectations about the quitting process are crucial. For the clinician, expectations guide interventions. If tobacco dependence is viewed as a chronic condition where occasional relapses are accepted as part of the process, it becomes easier to provide consistent and continuing support.

A newspaper editor in Oshkosh has written several columns about her own experiences quitting smoking. In one narrative, she writes, "Smokers shouldn't be discouraged about failures, though. What really counts is the one time you succeed, and you'll never have a chance at success unless you keep trying" (*Oshkosh Northwestern*, 12/30/2000). The PHS Report provides a blueprint for effective interventions that will increase the likelihood of your patients' successful quitting. It is up to each clinician to put the Guideline into practice and persevere with patients.

Note: Printed copies of the US Public Health Service's *Clinical Practice Guideline: Treating Tobacco Use and Dependence* (including a *Quick Reference Guide for Clinicians*, a *Clinician Tear Sheet*, and a *Consumer Guide*) are available from any of the following Public Health Service clearinghouses: the Agency for Healthcare Research and Quality (800-358.9295); Centers for Disease Control and Prevention (800-CDC-1311); and the National Cancer Institute (800-4-CANCER).

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