

## Public health

# Are clinicians intervening with their patients who smoke? A "real-world" assessment of 45 clinics in the upper Midwest

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**Objective:** To determine the level of intervention provided by primary care physicians to individuals who smoke. **Setting:** 45 primary care clinics throughout the upper Midwest. **Patients:** 6,086 men and women (M:F = 1:2), ages 50 to 68, who sought medical care at any one of the 45 primary care clinics and completed two questionnaires regarding preventive medical services received during the previous 3 years (1990-1993). **Results:** Of patients who smoke, 92% reported that their clinician had asked about their smoking status. Additionally, 86% reported being informed at their clinic of the dangers of tobacco use. A smaller percentage of individuals (60.1%) reported being explicitly advised on how to quit, and fewer still (27.2%) reported being referred to a stop smoking program. **Conclusions:** While most clinicians inquire about their patients' smoking status and recommend they quit, there currently exists a deficiency in the translation of these recommendations into concise, explicit instructions on how to quit. By increasing the frequency of clinicians giving specific advice about how to quit, the overall success rate of the public health campaign against tobacco use will be greatly enhanced. *Wis Med J. 1995;94(5):266-272.*

**T**HE SUCCESS RATE of the ongoing public health campaign against tobacco use hinges in part on health care providers seizing their

unique opportunity to intervene with patients who smoke. In Wisconsin, more than 70% of smokers express a desire to quit and have attempted to do so at least once.<sup>1</sup> Moreover, smokers routinely cite physician advice as an important motivator in their decision to make a quit attempt.<sup>2</sup> Finally, more than 70% of all smokers see their physician at least once a year making clinicians uniquely poised to aid this captive audience.<sup>3</sup>

Unfortunately, many smokers report that their physicians have neither advised them to quit nor provided them with specific assistance for quitting successfully.<sup>2</sup> Sixty-three percent of current smokers visiting health care settings report not having received any advice to quit from their clinician during the previous 12 months.<sup>2</sup> This low rate of intervention is particularly unfortunate since physician intervention has been shown to increase cessation success rates two- to six-fold.<sup>4</sup> These data, coupled with the fact that pa-

tients value their physician's advice, suggest that clinicians are missing a significant opportunity to improve the health of their patients who smoke.

One innovative approach, in addition to training clinicians to intervene with their patients who smoke, is to change the organizational structure of clinics to promote intervention. In a recent study designed to assess the effects of a simple institutional change to promote cessation intervention, researchers at the University of Wisconsin expanded routine vital sign collection to include smoking status.<sup>5</sup> Progress note paper was printed with a vital sign stamp that included smoking status, and this information was documented by a medical assistant prior to the patient seeing a clinician. This minor change in clinic protocol was designed to facilitate the identification of smokers and ultimately increase clinician intervention with patients who smoke. This simple measure resulted in a doubling (from 26% to 53%) in the rate of smokers reporting they were advised to quit. These findings suggest that such institutional changes may be key steps in reversing the low rates of smoking cessation intervention in clinical practice.

Current data on rates of clinical intervention with patients who use tobacco are essential before implementing institutional changes in clinic systems. This is particularly important as more health care in America is delivered in a managed care environment where protocols involving large numbers of patients and clinicians are more common. To provide these data, we evaluated the

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practices of clinicians and reports of patients from a study of 45 clinics throughout the upper Midwest. These data offered a unique perspective on current, "real world" clinical interventions with patients who smoke.

### Methods

**Project overview.** The Primary Care Prevention Project (PCPP) is a multi-year study to assess and improve the provision of cancer prevention services to adults, ages 50 to 68. The study populations are from 45 primary care group practices in the upper Midwest. Data were collected using patient questionnaires, medical record audits, physician questionnaires, and a structural audit. The goals of the study are to: describe current preventive services provided by physicians to patients; identify correlates of the provision of these services; and to investigate two process interventions designed to increase efficiency of delivery of physician preventive services. The current report is based on baseline patient questionnaire data obtained prior to the study interventions. In addition to assessing tobacco use, the PCPP addressed other cancer counseling and screening interventions such as diet, breast self-examination, clinical breast examination, mammography, digital rectal examinations, stool occult testing, sigmoidoscopy, cholesterol testing, Papanicolaou testing, and pelvic examinations.

**Subjects and procedures.** To describe current clinical practices related to tobacco use, we examined responses from 6,132 patients who obtained their usual medical care at one of 45 PCPP primary care clinics from 1990 to 1993. Each of these clinics was staffed by 3 to 10 physicians who had practiced at a given location for a minimum of 3 years. The study population was restricted to patients aged 50 to 68 that were determined to be regular patients; namely, those having made at least two visits to a

Table 1.--Demographic characteristics (n=6086).

	Nonsmoker	Smoker	Overall
<i>Overall population</i>	84% (5102)	16% (984)	100% (6086)
<i>Sex</i>			
Male	85% (1860)	15% (339)	100% (2199)
Female	83% (3242)	17% (645)	100% (3887)
<i>Age</i>			
50-54	81% (916)	19% (209)	18% (1125)
55-59	83% (2248)	17% (461)	45% (2709)
60-65	86% (1938)	14% (314)	37% (2252)
<i>Asked about smoking status in previous 3 years</i>	72% (3665)	92% (905)	75% (4570)
<i>Median number of visits to the clinic during previous 3 years</i>	7	7	7

clinic during the past 5 years, with one of these visits occurring in the past 2 years. Thus, the study assessed a population which is usually targeted for cancer screening procedures.

A stratified random sampling procedure was used to select patients representative of each physician's caseload and to provide an estimate of the preventive care implemented by the practice rather than that furnished by the individual physician. A 1:2 male-to-female ratio of participants was employed to provide a larger female population for female-specific cancer screening procedures.

Potential subjects totalling 12,525 were selected from patient records of participating clinics using the above specified inclusion criteria. Each potential subject was mailed a short patient questionnaire (SPQ) to determine eligibility and to obtain informed consent under a procedure approved by the University of Wisconsin Committee for the Protection of Human Subjects, and other ethical review boards as applicable for particular clinics. Approximately 2 weeks after mailing the SPQ, a reminder card was sent to the non-respondents followed by a second questionnaire 2 weeks later. Of those initially selected, 6,889 patients

(55%) returned the SPQ. Five weeks after this mailing, consenting participants were sent a long patient questionnaire (LPQ) designed to assess theoretically relevant constructs relating to cancer prevention. The 6,132 participants who completed and returned the LPQ served as our database. This represents 89% of the patients that initially completed the SPQ and 49% of the initially identified patient population.

The LPQ asked participants whether they were current or former smokers, and whether their smoking status had been inquired about during any of their clinic visits during the last 3 years. If they affirmed that they currently smoked, they were questioned concerning how long they had smoked and how many cigarettes per day. Additionally, they were asked if anyone in the clinic over the past 3 years had spoken to them about the dangers of smoking. They were then asked to rate from 1 to 4 (1= strongly agree, 4= strongly disagree) the following four questions that were designed to determine, in their opinion, their physician's interest in helping them quit smoking:

- my doctor tries to get me to stop smoking;
- my doctor seems to believe that it is important for me to stop

smoking;

- my doctor is willing to give me advice about convincing me to stop smoking; and
- my doctor seems interested in helping me to stop smoking.

Means, standard deviations, and proportions were computed for the overall sample and for the various subgroupings of patients (eg, men and women). For selected comparisons involving proportions, two-sided  $\chi^2$  tests of independence were computed to test for differences between subgroups of interest. For selected comparisons involving continuous-level variables (eg, number of cigarettes smoked per day), two-sided t-tests were computed to test for differences between groups.

### Results

Among the 6,132 eligible patients who completed a long patient questionnaire, and had solicited medical care at one of the 45 PCPP facilities during the previous 2 years, 6,086 reported their smoking status and served as the basis for all further analyses. These 6,086 patients included 3,887 (64%) women and 2,199 (36%) men. Some of the sociodemographic characteristics of the assessed population are shown

in Table 1. Among these 6,086 patients, 984 or 16% (17% among women, 15% among men) reported that they were current smokers. This rate of smoking is lower than that reported in the 1993 National Health Interview survey, a representative assessment of 20,860 adult Americans, which found an overall smoking rate of 26% among adults aged 45 to 64 years old (23% among women, 29% among men).<sup>6</sup>

Overall, 75% of all patients reported that they had been asked about their smoking status by anyone in the clinic during any visit over the last 3 years, with a slightly higher rate among men than among women (78% and 74%, respectively;  $\chi^2=11.1$ ,  $p<.001$ ). Patients who were current smokers reported they were asked about tobacco use at a higher rate than did non-smokers (92% and 72%, respectively;  $\chi^2=172.1$ ,  $p<.001$ ).

Male smokers reported a mean of 22 cigarettes consumed daily and female smokers reported a mean of 18 [t(966)=17.6,  $p<.001$ ]. Among American smokers in 1991, the mean number of cigarettes smoked was 22 per day for men and 18 per day for women.<sup>7</sup> Our sample also reported a long history of smoking. Overall, the men had been smoking ciga-

rettes for an average of 38 years, while the women had been smoking for an average of 34 years at the time of the survey [t(968)=20.1,  $p<.001$ ]. The smoking history of this population is summarized in Table 2.

Table 3 summarizes the rates at which smokers reported that their tobacco use was assessed and addressed during their clinic visits. Of smokers who responded, 86% (83% of men and 88% of women,  $\chi^2=4.7$ ,  $p<0.05$ ) reported having been told about the health risks of smoking by someone in their clinic over the past 3 years. When smokers were asked if anyone in the clinic had advised them to quit smoking over the past 3 years, 83% of men and 85% of women responded affirmatively. When asked if anyone in the clinic had talked to them about how to stop smoking, men and women responded affirmatively at a similar rate (58% vs. 61%, respectively,  $\chi^2=.945$ , ns). Finally, when asked if anyone in the clinic had referred the smoker to a stop-smoking program over the past 3 years, a similar percentage of men and women responded affirmatively (25% and 28%, respectively,  $\chi^2=1.5$ , ns).

To determine if the clinicians

Table 2.--Cigarette use by smokers (n=984).

	Cigarettes smoked/day				Years smoking		Mean # yrs smoking	
	1-10	11-20	21+	Mean #/ smoker	1-20	21-39		40-58
Overall population	25% (241)	47% (452)	28% (273)	19	9% (83)	45% (439)	46% (448)	36
Sex								
Male	18% (61)	43% (144)	38% (128)	22	4% (13)	37% (124)	59% (200)	38
Female	28% (180)	49% (308)	23% (145)	18	11% (70)	50% (315)	39% (248)	34
Age								
50-54	27% (55)	36% (75)	37% (77)	21	10% (21)	77% (158)	13% (26)	32
55-59	25% (112)	49% (222)	26% (118)	19	10% (44)	46% (207)	45% (203)	35
60-65	24% (73)	51% (157)	25% (78)	19	6% (18)	24% (74)	70% (219)	39

were adequately conveying the importance of stopping smoking, patients rated their agreement with four statements about intervention. These data are presented in Table 4. In response to the question "Do you believe your doctor tries to get you to stop smoking?" 78% of men and 79% of women responded affirmatively ("Strongly Agree or Agree"). In response to the question "Do you believe that your doctor thinks it important for you to stop smoking?" more than 87% of both sexes responded affirmatively. In response to the statement "My doctor is willing to give advice about convincing me to stop smoking" 80% of men and 78% of women responded affirmatively. Finally, in response to the statement "My doctor seems interested in helping me to stop smoking" 75% of men and 74% of women responded affirmatively.

Lastly, we assessed the rate at which this older population of patients visited their clinics. Over the previous 3 years, the median number of visits made by both men and women and smokers and nonsmokers was seven (about two visits per year) for all groupings.

## Discussion

This study of "real world" clinics in the upper Midwest gives us a current perspective on rates of clinical assessment and intervention with older patients who smoke. While more than 90% of smokers reported that someone at their clinic had asked them whether they smoked, and 84% report having been told to quit, only 60% were advised on how to go about doing so, and fewer than 30% report being referred to a stop smoking program.

These results raise a number of questions regarding the clinician's role in smoking cessation interventions. First, do clinicians ask their patients if they smoke? Our results show that most patients' smoking status is being assessed by their clinicians. More than 75% of all patients--including an encouraging 92% of smokers--report being asked this question. These findings are substantially higher than a recent US population-based report that reported 37% of all patients who had visited a clinic in the past 12 months as being asked about their smoking status.<sup>2</sup> While the higher identification rate in this study may reflect

progress by clinicians over time in addressing this issue, other factors may contribute. For example, among this older population, the health complications resulting from chronic smoking may have already become clinically apparent, prompting a higher rate of clinician inquiry about smoking status. This result also may suggest a hopeful development--public health efforts over the last decade to increase rates of clinician assessment and intervention with smokers are working. Finally, recall bias<sup>8</sup> may account in part for the extremely high rates that participants in this survey reported being asked about their smoking status. Recall bias may result from two factors--the long (3-year) period during which individuals were asked to recall clinician inquiries, and the belief that their personal clinicians would be remiss had they not addressed this issue.

Second, do physicians assist their patients in stopping smoking? While 86% of smokers report being advised of the health risks of smoking and 84% being advised to quit, only 60% report being counseled about how to go about doing so.

Table 3.--Rates of clinician intervention with patients who smoke (n=984).

	...told you about the health risks of smoking?		...advised you to quit smoking?		...talked to you about how to stop smoking?		...referred you to a stop-smoking program?	
	Yes	No	Yes	No	Yes	No	Yes	No
	<i>Overall population</i>	86% (839)	14% (136)	84% (825)	16% (153)	60% (587)	40% (390)	27% (264)
<i>Sex</i>								
Male	83% (278)	17% (58)	83% (281)	17% (56)	58% (196)	42% (142)	25% (83)	75% (252)
Female	88% (561)	12% (78)	85% (544)	15% (97)	61% (391)	39% (248)	28% (181)	72% (456)
<i>Age</i>								
50-54	86% (179)	14% (29)	86% (180)	14% (29)	63% (131)	37% (77)	33% (68)	67% (140)
55-59	87% (396)	13% (61)	85% (392)	15% (67)	61% (281)	39% (177)	28% (127)	72% (329)
60-65	85% (264)	15% (46)	82% (253)	18% (57)	56% (175)	44% (136)	22% (69)	78% (239)

Finally, only 27% report ever being referred to a stop smoking program. These findings are encouraging compared to previous studies. Frank,<sup>9</sup> in a California study, reported 50% of patients as having been told to quit compared to 37% reported in a 1993 national report<sup>2</sup> and 44% by Anda et al<sup>10</sup> in Michigan.

Although the higher percentage of smokers advised to quit observed in this study is encouraging, this percentage may also be partially attributed to cessation interventions prompted by medical complications resulting from life-long smoking in these older Americans. If this is the case, clinician training must focus on inspiring interventions with smokers before the advanced complications of tobacco use are clinically apparent. The use of institutionalized prompts that identify a smoker

prior to clinical evidence of a tobacco-related illness might serve this purpose. Additionally, it is also possible that regional factors may be responsible for the higher rates of assessment and intervention. The population sampled in our study is geographically stable and predominantly rural when compared with more transient urban populations. These demographic characteristics encourage long-term patient-physician relationships and may promote a higher level of intervention than in other settings.

Third, are clinicians providing patients with specific advice and assistance on how to quit? While a very high percentage of smokers reported that their clinician had inquired regarding their smoking status and more than 80% reported they were urged to quit, a significantly smaller percentage (60%) re-

ported that they were offered specific advice on how to do so. This finding highlights an important shortcoming in current smoking cessation intervention practice—providing patients with the necessary resources to overcome this powerful addiction. This finding is also consistent with other surveys of physicians indicating that they feel ill prepared to assist their patients who smoke.<sup>11</sup> To assist clinicians, the National Cancer Institute has adopted a brief but effective intervention strategy for clinicians, *How to Help Your Patients Stop Smoking*.<sup>12</sup> This simple intervention plan, designed to be completed in about 3 minutes, urges clinicians to address the 4As with every patient: Ask about smoking at every visit, Advise all smokers in a clear and unequivocal manner to quit, Assist smokers in quitting by setting a stop date, provid-

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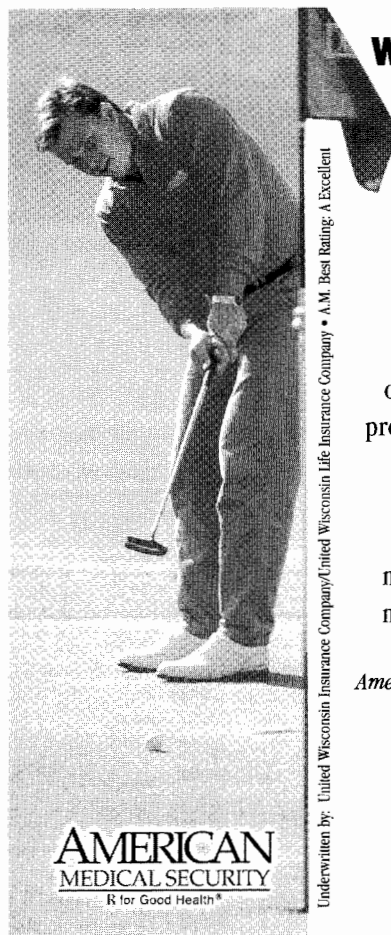
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Table 4.--Physician interest in smoking cessation as reported by patients (n=984).

My doctor:	...tries to get me to stop smoking.		...seems to believe that it is important for me to stop smoking.		...is willing to give advice about convincing me to stop smoking.		...seems interested in helping me to stop smoking.	
	Yes	No	Yes	No	Yes	No	Yes	No
Overall population	78% (758)	22% (208)	87% (841)	13% (124)	79% (753)	21% (264)	74% (713)	26% (251)
Sex								
Male	78% (260)	22% (75)	87% (291)	13% (42)	80% (264)	20% (68)	75% (252)	25% (85)
Female	79% (498)	21% (133)	87% (550)	13% (82)	78% (489)	22% (136)	74% (461)	26% (166)
Age								
50-54	78% (159)	22% (46)	88% (181)	12% (25)	78% (160)	22% (44)	77% (157)	23% (47)
55-59	80% (359)	20% (92)	88% (398)	12% (54)	81% (364)	19% (84)	76% (340)	24% (108)
60-65	77% (240)	23% (70)	85% (262)	15% (45)	75% (229)	25% (76)	70% (216)	30% (91)

ing self help materials, and prescribing nicotine replacement therapy when appropriate, and Arrange at least one follow-up visit within 2 weeks of the quit date. The manual is available free of charge from the NCI (1-800-4CANCER), and has been demonstrated to significantly improve quit rates in primary care clinics.<sup>11</sup>

Fourth, do patients believe their physician is interested in helping them stop smoking? This question was designed to address the effect of the physician's provision of cessation advice as viewed through the eyes of the smoker. More than 75% of smokers in our sample feel their clinician is interested in helping them stop smoking and almost 90% recognize the emphasis their clinician places on their quitting. Four out of five smokers view their clinician as willing to advise them to stop smoking and more than 78% feel their clinician tries to get them to stop. These data are valuable for two reasons. First, they illustrate that patients who smoke are recognizing their physicians as cessation advocates, an important finding since the advice of a clinician is a powerful

motivator for quitting.<sup>2</sup> Second, these results can be used as a barometer to measure the effectiveness of clinician intervention as viewed through the eyes of the smoker. In this manner, it is possible to obtain an estimate of the effectiveness of clinician intervention, as reported by the smoking population that is being helped.

One notable finding is that only 27% of smokers reported that their clinician had referred them to attend a stop smoking program. This is of interest because formal cessation programs tend to produce higher success rates than do minimal programs.<sup>13</sup> While this percentage might on first review appear discouragingly low, it may in fact be appropriate when considered in relation to the other findings in this population. These clinicians may be practicing smoking cessation using a stepped-care approach, a model sometimes advocated by tobacco control researchers.<sup>14</sup> This model proposes that all clinicians should provide a minimal intervention as a first line therapy with all of their patients who smoke. According to the model, referral to formal smok-

ing cessation clinics would be restricted to patients who desired more intensive interventions or those who were unresponsive to the minimal clinic intervention by the primary clinician. A stepped-care approach to smoking cessation also is consistent with two important findings regarding smoking cessation: first, most successful smokers quit without the aid of a formal smoking cessation program<sup>15</sup> and second, smokers infrequently take advantage of smoking cessation programs even when readily available.<sup>16</sup> Given the higher rates of effectiveness of intensive intervention, one modification of the stepped-care approach outlined above would be to provide all smokers with a minimal intervention during every clinic visit, as well as information regarding more intense and effective treatments for those smokers willing to attend such programs.

Due to the demographics of the population sampled in this study, there are certain limitations that must be taken into consideration while interpreting these results. The population surveyed consisted exclusively of individuals aged 50 to

68 at baseline. Consequently, these data cannot be considered representative of all age groups. Moreover, because this research was conducted in the upper Midwest, few urban clinics were included. As a result, this population was probably more geographically stable than the overall US population. Finally, this population was homogeneous from a racial and ethnic perspective. More than 98% of the total population consisted of whites. For these reasons, it would be inappropriate to generalize these findings to urban and nonwhite populations.

In summary, this study demonstrates both progress and challenges in confronting tobacco use in primary care clinics. The progress is highlighted by our findings of very high rates of clinicians assessing and advising smokers to quit. An important challenge remains to educate and motivate clinicians to provide specific assistance to smokers in overcoming tobacco addiction. Given their unique access to patients who smoke, clinics and clinicians need to take this key additional step so as to maximize the likelihood that their patients will overcome tobacco use--the chief avoidable risk to their current and future health.<sup>17</sup>

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## PCF Board of Governors approves fee reduction

THE BOARD OF GOVERNORS for the Patients Compensation Fund voted unanimously May 17 to reduce current PCF fee rates by 11.2 percent overall as a direct result of the enactment of the law placing a \$350,000 cap on non-economic damages in professional medical liability actions. Because of a change in the risk relativity of Fund Class 3 physicians, the actual rate reductions will be 7.2% for classes one, two and four and 20.2% for Class 3 physicians. The current PCF rates for classes one through four are: \$3,150; \$6,300; \$15,750; and \$18,900. The reduced rates effective July 1 will be: \$2,923; \$5,846; \$12,569; and \$17,538.

The rate is, of course, subject to legislative change. It is unlikely, however, that the July 1 fund fees will be amended in any way. ♦