

2. Kotz D., Willemsen M., Brown J., West R. Light smokers are less likely to receive advice to quit from their GP than moderate-to-heavy smokers: a comparison of national survey data from the Netherlands and England. *Eur J Gen Pract* 2013; **19**: 99–105.
3. Chavannes N. H., Kaper J., Frijling B. D., van der Laan J. R., Jansen P. W. M., Guerrouj S., *et al.* NHG-Standaard Stoppen met roken [Guidelines on smoking cessation by the Dutch College of General Practitioners]. *Huisarts Wet* 2007; **50**: 306–14.
4. Kotz D., Wagena E. J., Wesseling G. Smoking cessation practices of Dutch general practitioners, cardiologists, and lung physicians. *Respir Med* 2007; **101**: 568–73.
5. Murray R. L., McNeill A. Reducing the social gradient in smoking: initiatives in the United Kingdom. *Drug Alcohol Rev* 2012; **31**: 693–7.
6. Kotz D., Brown J., West R. Prospective cohort study of the effectiveness of smoking cessation treatments used in the 'real world'. *Mayo Clin Proc* 2014; **89**: 1360–7.
7. Kaper J., Wagena E. J., Willemsen M. C., van Schayck M. C. Reimbursement for smoking cessation treatment may double the abstinence rate: results of a randomized trial. *Addiction* 2005; **100**: 1012–20.
8. Kaper J., Wagena E. J., Willemsen M. C., van Schayck C. P. A randomized controlled trial to assess the effects of reimbursing the costs of smoking cessation therapy on sustained abstinence. *Addiction* 2006; **101**: 1656–61.

TREATING MORE SMOKERS, MORE OF THE TIME, MORE SUCCESSFULLY

The authors [1] address an extremely important question; namely, how can we engage more smokers in smoking treatment during their health-care visits? Clearly, too few smokers leave their clinics with strong evidence-based treatment arranged or in place [2]. The authors suggest a bold strategy to achieve higher rates of engagement in smoking treatment, i.e. using the 'opt-out' principle to provide treatment to smokers making health-care visits. In essence, this would seem to mean that clinicians offer counseling and/or medication to all smokers without gaining smokers' buy-in or agreement. This strategy seems consistent with data showing that smokers' willingness to quit (i.e. 'willingness') is labile; thus, it may be unwise to set much store in it [3]. While the opt-out approach is innovative, and we are highly supportive of seizing every health-care visit to intervene with patients who smoke, questions remain regarding how best to do that.

The authors juxtapose the opt-out approach to guideline-based treatment. Most guidelines recommend that all smokers be encouraged strongly to make a quit attempt using evidence-based treatment; i.e. smokers should be given strong, clear and personalized advice to quit (e.g. [4]). If the smoker is unwilling to try to quit, s/he would then be given motivational treatment to encourage entry into cessation treatment. This conflicts with the authors' statement that: 'Guidelines in many countries recommend that health care providers a) ask patients if they are 'ready' to quit using tobacco and b) provide treatment *only* to those who

state they are ready to quit'. Virtually all guidelines call for all smokers to receive treatment: motivational or cessation.

Under the opt-out approach, it seems that the clinician would try to encourage smokers to agree to cessation treatment regardless of the patient's stated willingness. This may pressure smokers to assent to treatment despite their having low motivation to quit. While the authors express doubt about the relation between motivation and cessation success, there is evidence that unwilling, unmotivated smokers (e.g. [5]) are relatively unlikely to even make quit attempts [6,7], and low intrinsic motivation to quit may reduce quitting success [8,9]. Indeed, when we tried to provide cessation treatment to 'unwilling' smokers at a health-care visit, few accepted such treatment and there was little evidence of clinical benefit [10]. It may be that patient 'buy-in' is needed for optimal behavior change [11]. An alternative [12,13] is to assess each smoker's quitting goal; if a smoker is willing to make a quit attempt, he or she would receive evidence-based cessation treatment. 'Unwilling' smokers, however, would be urged to enter a 'motivation' treatment (which differs from the 'motivational counseling' mentioned by the authors) that is designed to reduce smoking and prepare them to quit. Such treatment appears to be reliably efficacious [4,12–15] and differs markedly from cessation treatment; (1) consistent with chronic care, the expectation is that treatment is prolonged and there is no failure marker to encourage attrition, (2) it uses a different pharmacotherapy than does cessation treatment (nicotine gum or mini-lozenge versus combination nicotine replacement therapy [14,15]) and (3) it focuses upon smoking reduction. We believe that there are at least three important reasons to adopt such an approach. (1) Offering a smoking reduction goal to 'unwilling' smokers may significantly increase the proportion of smokers who enter treatment [16]. (2) Such motivation treatments [12,13] encourage treatment continuation, promoting chronic care, and they ultimately boost cessation success [14,15,17]. (3) There is evidence that the different phases of smoking treatment (e.g. motivation, preparation, cessation) offer different challenges and opportunities, which have treatment implications [12]. Thus, while the nicotine patch works well as a cessation aid, we find that it works poorly as a motivation intervention [14,15]. Therefore, rather than funneling smokers into cessation treatment, it might be better to engage in some assessment in order to provide them with treatment that is congruent with both their intrinsic goals (for which there is 'buy-in') and the phase-related challenges they face [13].

At present, it is too early to tell which sort of approach will yield the greatest benefits to smokers. Multiple strategies (e.g. [18]) should be explored in an effort to take greater advantage of the health-care visit as an opportunity to engage smokers in evidence-based treatment.

Declaration of interest

T.B.B has not served as a paid consultant to any for-profit interests related to this work; he has served as a paid and non-paid consultant to governmental and non-profit interests related to this work. M.C.F. has not served as a paid consultant to any for-profit interests related to this work; he has served as a paid and non-paid consultant to governmental and non-profit interests related to this work.

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References

- Richter K., Ellerbeck E. It's time to change the default for tobacco treatment. *Addiction* 2015; **110**: 381–386.
- Centers for Disease Control and Prevention. Quitting smoking among adults—United States 2001–2010. *Morb Mortal Wkly Rep* 2011; **60**: 1513–9.
- Hughes J. R., Solomon L. J., Fingar J. R., Naud S., Helzer J. E., Callas P. W. The natural history of efforts to stop smoking: a prospective cohort study. *Drug Alcohol Depend* 2013; **128**: 171–4.
- Fiore M. C., Jaen C. R., Baker T. B., Bailey W. C., Benowitz N., Curry S. J. *et al.* Treating Tobacco Use and Dependence: 2008 Update. Rockville, MD: US Department of Health and Human Services, US Public Health Service; 2008.
- Dijkstra A., de Vries H., Bakker M. Pros and cons of quitting, self-efficacy, and the stages of change in smoking cessation. *J Consult Clin Psychol* 1996; **64**: 758–63.
- Kotz D., Brown J., West R. Predictive validity of the Motivation To Stop Scale (MTSS): a single-item measure of motivation to stop smoking. *Drug Alcohol Depend* 2013; **128**: 15–9.
- Smit E. S., Hoving C., Schelleman-Offermans K., West R., de Vries H. Predictors of successful and unsuccessful quit attempts among smokers motivated to quit. *Addict Behav* 2014; **39**: 1318–24.
- Curry S. J., Grothaus L., McBride C. Reasons for quitting: intrinsic and extrinsic motivation for smoking cessation in a population-based sample of smokers. *Addict Behav* 1997; **22**: 727–39.
- Castro Y., Cano M. A., Businelle M. S., Correa-Fernandez V., Heppner W. L., Mazas C. A. *et al.* A cross-lagged path analysis of five intrapersonal determinants of smoking cessation. *Drug Alcohol Depend* 2014; **137**: 98–105.
- Smith S. S., Fiore M. C., Jorenby D. E., Baker T. B. Data analytic report from a single-center, parallel, randomized, double-blind, placebo-controlled, 1-year pilot study of the effects of Zyban (bupropion hydrochloride sustained release tablets) as an aid to smoking cessation in adult chronic cigarette smokers who are not motivated to quit smoking. Protocol AK1A4010. Unpublished manuscript available from the authors. 2000.
- Laska K. M., Gurman A. S., Wampold B. E. Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy (Chic)* 2014; **51**(4): 467–481.
- Baker T. B., Mermelstein R., Collins L. M., Piper M. E., Jorenby D. E., Smith S. S. *et al.* New methods for tobacco dependence treatment research. *Ann Behav Med* 2011; **41**: 192–207.
- Schlam T. R., Baker T. B. Interventions for tobacco smoking. Invited review. *Annu Rev Clin Psychol* 2013; **9**: 675–702.
- Cook J. W., Mermelstein R. J., Schlam T. R., Piper M. E., Smith S. S., Jorenby D. E. *et al.* editors. Identifying optimal strategies for increasing smokers' motivation to quit. 20th Annual Convention of the Society for Research on Nicotine and Tobacco (SRNT), Seattle, WA, 2014.
- Piper M. E., Schlam T. R., Cook J. W., Smith S. S., Jorenby D. E., Mermelstein R. J. *et al.* Identifying optimal smoking cessation intervention components for smoking cessation. 22nd Annual Meeting of The Society for Prevention Research (SPR), Washington, DC, 2014.
- Piper M. E., Baker T. B., Mermelstein R., Collins L. M., Fraser D. L., Jorenby D. E. *et al.* Recruiting and engaging smokers in treatment in a primary care setting: developing a chronic care model implemented through a modified electronic health record. *Transl Behav Med* 2013; **3**: 253–63.
- Moore D., Aveyard P., Connock M., Wang D., Fry-Smith A., Barton P. Effectiveness and safety of nicotine replacement therapy assisted reduction to stop smoking: systematic review and meta-analysis. *BMJ* 2009; **338**: b1024.
- Ellerbeck E. E., Mahnken J. D., Cupertino A. P., Cox L. S., Greiner K. A., Mussulman L. M. *et al.* Effect of varying levels of disease management on smoking cessation: a randomized trial. *Ann Intern Med* 2009; **150**: 437–46.

THE ETHICS OF AN OPT-OUT DEFAULT IN TOBACCO TREATMENT

In their paper [1], Richter & Ellenberg advance an argument that a key way to improve public health is to reduce the number of smokers by increasing the uptake of tobacco cessation (and, one might add, harm reduction) programmes by current smokers. They note that in many health systems the default position is that patients seeking clinical care are only offered tobacco treatment if, in the opinion of the clinician, they are either expressing a wish to quit smoking or otherwise give signs of 'readiness to quit'. They argue further that this creates a barrier to treatment, which can be removed by mandating clinicians to offer tobacco treatment to all patients who smoke without assessing 'readiness to quit', leaving the decision to the patients as to whether or not they take up this offer of treatment. The theory here is that some patients who might otherwise not have been considered 'ready to quit' by their clinicians will accept the offer of treatment, and that some