Tobacco Dependence
A Chronic Disease

Asthma is a chronic, possibly life-threatening disease for which effective treatments are continually studied and made available. It is difficult to imagine a chest physician seeing a patient for some other ailment, and knowing that person also has asthma, offering nothing beyond the admonition, “You need to control your asthma.” Yet, as pointed out by Anderson and colleagues in this issue of CHEST (see page 932), tobacco dependence is a chronic disease, can be life-threatening, and is a disease for which effective treatments are continually studied and made available. However, it is not at all difficult to imagine a chest physician seeing a patient, knowing that the person smokes, and offering nothing beyond the admonition, “You need to quit smoking.”

Many health-care providers have not routinely treated tobacco use as they do other chronic diseases. Fiore and colleagues report that in a population-based survey, <15% of smokers reported being offered assistance in quitting by their physicians. There are a number of understandable reasons for this, not the least of which is that many health-care providers have not considered tobacco dependence as a chronic disease. According to the clinical practice guideline,1 “A failure to appreciate the chronic nature of tobacco dependence may undercut clinicians’ motivation to treat tobacco use consistently.” In recognizing the chronicity of tobacco dependence, health-care providers have a better conceptual model for treatment of this problem.

The review of the updated guideline by Fiore and colleagues provides a succinct set of recommendations that, if followed, provide optimal, state-of-the-art treatment for patients who smoke. With a treatment as minimal as a 3- to 10-min counseling session, we can expect 16% of patients to quit; increasing the “dose” to include pharmacotherapy and more intensive behavioral counseling can lead to a near 30% quit rate. Fiore and colleagues offer guidance on how to decide the appropriate dose for a given patient. Not all patients want to—or feel ready to—quit at a given office visit. For those who aren’t ready, a minimal dose of advice along with a motivational message will be more appropriate than aggressive treatment. Also consistent with the chronic disease model, smokers who quit are subject to episodes of relapse, and the guideline advises clinicians to be prepared for this likelihood and provides recommendations for addressing relapse.1

At the time of publication of the updated guideline, the Executive Summary included the lament that, although the first guideline inspired much change, clinicians still too frequently fail to intervene with patients who smoke.1 Armed with the view of tobacco dependence as a chronic disorder and with the evidence-based recommendations of Fiore and colleagues, health-care providers should perceive fewer barriers to treating this problem, a problem that still affects more than one in five adults in this country. However, even if clinicians begin to treat tobacco dependence using a chronic disease model, one barrier remains: insurers are not adopting this view. The guideline specifically addresses this dilemma by including recommendations for health-care administrators, insurers, and purchasers that include the coverage of tobacco-dependence treatments (behavioral and pharmacologic) for all subscribers and reimbursing clinicians for delivery of effective treatment and including such interventions among defined clinical duties.1 This is not only a guideline recommendation, but a Healthy People 2010 objective: increase insurance coverage of evidence-based treatment for nicotine dependency to 100%.2

The guideline panel encouraged “a culture of health care in which failure to treat tobacco use... constitutes an inappropriate standard of care.”3 What should be the role of the American College of Chest Physicians and chest physicians in promoting this culture? The answer may lie in the literature on disseminating practice guidelines. As noted by Smith3 in an issue of CHEST, although evidence-based guidelines are intended to change behavior by providing definitive information on best practices, an information-dissemination approach is not sufficient to change provider behavior. An array of strategies to influence environmental factors and to change behavior must be employed to promote widespread guideline adoption.4

A method that has been relatively effective in changing behavior is the use of opinion leaders. Chest physicians can serve as opinion leaders in the area of treating smoking cessation as a chronic disease. The first task is to adopt the guideline recommendations. Make smoking status the new vital sign. The patient education committee of our college has set as a goal for all members to use smoking status as a vital sign. While the BP is being checked, the office assistance simply asks if the patient has ever smoked. If the patient has, then he...
or she is asked about smoking any cigarettes in the last 30 days. These two questions allow everyone to be categorized as either a “never smoker,” a “previous smoker,” or a “current smoker.” The office system may need to be changed to ensure that this vital sign is recorded for every visit. When a smoker is identified, use the “4A’s” or the “4R’s” as described by Fiore and colleagues. The next task is to help diffuse this practice by taking advantage of all opportunities to let others know about implementing the guideline. This includes opportunities ranging from professional meetings to casual conversations with colleagues.

As an opinion leader, an additional task is to make an overt effort to influence administrators and insurers that this is the standard of care. As specialists who see much of the morbidity caused by tobacco use, chest clinicians are in an excellent position to educate others regarding the potential life and cost savings that can result from consistently treating tobacco dependence. This effort to educate administrators and insurers can include very concrete strategies such as explaining the importance of smoking as a vital sign, holding seminars on reimbursement for smoking cessation, and distributing cost-efficacy information for years of life saved from smoking-cessation programs when compared to mammography, Papanicolaou tests, cholesterol treatment, and treatment of high BP. Of course, smoking-cessation treatment costs much less per year of life saved than any of the above.

Chest physicians who serve as role models for all health-care providers and who can influence the health-care system will be the leaders in applying the standard of care for this chronic disorder.

Connie L. Kohler, DrPH
William C. Bailey, MD, FCCP
Birmingham, AL

Dr. Kohler is Assistant Professor, Department of Health Behavior, School of Public Health, and Dr. Bailey is Professor, Lung Health Center, Division of Pulmonary and Critical Care Medicine, School of Medicine, University of Alabama at Birmingham. Correspondence to: Connie L. Kohler, DrPH; 1530 3rd Ave South, Birmingham, AL 35229-0022; e-mail: ckohler@uab.edu

REFERENCES
3 Smith WR. Evidence for the effectiveness of techniques to change physician behavior. Chest 2000; 118:88–175