

## The smoking paradox: why is Australia's biggest killer being neglected?

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By Dr Colin Mendelsohn, Tobacco Treatment Specialist at the Brain & Mind Research Institute, Camperdown, Sydney and Vice-President of the Australian Association of Smoking Cessation Professionals.  
[www.colinmendelsohn.com.au](http://www.colinmendelsohn.com.au)



Smoking is the single greatest preventable cause of death and illness in Australia, but a recent study confirmed that doctors are less likely to treat smoking than many other major health risk factors.

The study, published in the American Journal of Public Health earlier this year, found smoking patients received medication for smoking at fewer visits (4.4 per cent) than patients with hypertension (57.4 per cent), diabetes (46.2 per cent) and hyperlipidaemia (47.1 per cent). Smokers were also less likely to receive behavioural counselling.

### **This finding is paradoxical.**

Smoking is the single greatest cause of death and illness. Effective treatments are readily available, and quitting leads to dramatic and rapid improvements in health.

Quitting smoking reduces mortality by 36 per cent for patients with cardiovascular disease, which compares favourably with the effectiveness of widely used treatments such as statins (29 per cent reduction in mortality), aspirin (15 per cent), Beta-blockers (23 per cent) and ACE inhibitors (23 per cent).

In spite of this, smoking is often neglected in medical practice

Smoking is a genuine medical condition requiring urgent management.

Smoking (nicotine dependence) is defined by the American Psychiatric Association in its Diagnostic and Statistical Manual of Mental Disorders as a substance abuse disorder, not simply a lifestyle choice or bad habit.

Without assistance, quitting is typically a journey of repeated unsuccessful attempts over many years. Each individual attempt has only a 3 to 5 per cent chance of success which comes at a high cost. For every year that abstinence is delayed beyond the age of 35 years, a smoker loses on average three months of life expectancy.

Many now argue that smoking should be reframed as a chronic condition like hypertension and diabetes, and treated in the same way. Chronic conditions require long-term management with patients re-engaged and supported over time with evidence-based therapies.

Why, then, is smoking being neglected in medical practice?

Doctors have reported a number of barriers to intervention, each of which can be overcome.

### **Lack of time**

It is a reality of current medical practice that doctors are time poor.

Many do not raise the subject of smoking because of time pressures, assuming that effective action to encourage quitting must be complex and time-consuming. But this is not the case.

Interventions that take as little as a minute can be effective, such as asking a patient if she or he is a smoker, advising him or her to quit, and providing a script for nicotine patches.

Another quick solution for busy doctors is to use the Ask-Advise-Refer protocol. This involves asking all patients if they smoke, advising smokers to quit and referring them to a specialist service for treatment. This fits the current model of medical practice where patients are referred to medical specialists for further care of specific disorders.

A national network of tobacco treatment specialists is now available through the Australian Association of Smoking Cessation Professionals (AASCP).

Members are health professionals, including GPs, nurses, psychologists, drug and alcohol workers and pharmacists, who are accredited annually and use best practice evidence-based treatments.

Tobacco treatment specialists can be found in most areas by visiting the Association's website at [www.aascp.org.au](http://www.aascp.org.au).

Other referral options include the Quitline (call 137 848) and a range of hospital and health service smoking clinics.

### **Fear of alienating smokers**

Doctors often raise the concern that addressing smoking might alienate smokers, especially those who are not ready to quit. But research shows that, actually, the opposite is true. Patients report greater overall satisfaction with consultations where smoking is raised. In fact, satisfaction increases as more assistance is provided.

It is important to raise the subject of smoking in a non-confrontational and non-judgemental way to minimise the risk of a hostile response.

Australian smoking cessation guidelines suggest asking 'How do you feel about your smoking?' which can open a dialogue without the smoker feeling under pressure.

The subject of smoking should be raised at every opportunity at follow-up visits.

### **Lack of skills**

Smoking cessation is neglected in undergraduate training and there are few opportunities to acquire the necessary skills and knowledge. It is no wonder that many doctors lack the confidence to counsel smokers.

Doctors who wish to learn more could consider joining AASCP, which provides regular training and education for members.

The Association provides a monthly webinar that can be accessed on any computer; a monthly newsletter with clinical papers, news and treatment tips; an annual conference; and a peer-reviewed journal, the Journal of Smoking Cessation. The Association also provides networking opportunities and an interactive online forum for sharing information and raising queries.

Another educational opportunity is the Australian Smoking Cessation Conference 2013 which is being held from 6 to 8 November in Sydney ([www.sydney.edu.au/bmri/ascc2013](http://www.sydney.edu.au/bmri/ascc2013)). The overriding aim of the conference is "Translating the research into practice", and it aims to update practitioners on the latest practical, evidence-based skills and information to help smokers quit.

The four conference themes are smoking and mental illness, adolescent smoking, smoking in pregnancy and in indigenous populations. The program includes four interactive workshops on the major themes, as well as

presentations from leading international and Australian experts designed to enhance everyday clinical practice.

The conference is being organised under the auspices of Sydney University, in collaboration with the Australian Association of Smoking Cessation Professionals. The Australian Medical Association is an official supporter of the conference.

## Lack of efficacy

Doctors often express a sense of despondency regarding smoking, which is no surprise given that the majority of attempts to quit fail. Doctors see many more failed attempts at quitting than successes.

However, a large body of research shows that interventions by medical practitioners are effective.

Even brief advice increases quit rates by 70 per cent compared with no advice or usual care. More intensive interventions are even more effective.

It is important to have realistic expectations. Even with a comprehensive best-practice program of medication and counselling, success rates for a given quit attempt are typically only 25 to 30 per cent.

For most smokers, successfully quitting requires repeated attempts over time. Relapse is a normal part of the journey and doctors should be prepared to repeatedly raise the subject and try to re-engage the smoker in further attempts.

Repeated failed attempts are discouraging and can lead to a fear of failure, which often underlies an unwillingness to try again. However, this belief is often based on past 'cold turkey' quit experiences rather than the use of evidence-based therapies and professional support. Patients should be encouraged to keep trying to quit using proven and effective treatments.

Unsuccessful attempts should be reframed as 'learning experiences'. The smoker learns something from each attempt, making the next attempt more likely to succeed. The only failure is to stop trying.

In contrast to the magnitude of its health effects, smoking is relatively neglected in medical practice.

However, brief interventions by doctors are effective and can enhance patient satisfaction.

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