

## New Guideline on Treating Tobacco Use and Dependence: 2008 Update Is an Opportunity to Advance

The United States Public Health Service clinical practice guideline “Treating Tobacco Use and Dependence: 2008 Update”<sup>1</sup> was recently published and the Executive Summary is reprinted in this issue of *RESPIRATORY CARE*.<sup>2</sup> Smoking still poses a serious public health challenge, and respiratory therapists, physicians, nurses, and many other professionals are playing a role in addressing this challenge. Survey data indicate that respiratory therapists acknowledge that smoking cessation is worthwhile and that it should be part of their job, a fact<sup>3</sup> also recognized by the American Association for Respiratory Care.<sup>4</sup> This is important because, in a study of 1,898 patients, those who reported that they had been asked about tobacco use or were advised to quit during their latest visit had a 10% greater satisfaction rating and 5% less dissatisfaction than those who did not report such discussions.<sup>5</sup> Further, new Medicare/Medicaid billing codes to support smoking-cessation services by non-physicians reduce an important barrier to increased participation by more clinicians.

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Even so, the 2008 version of the smoking-cessation guidelines<sup>1</sup> is a reminder that all health professionals, including respiratory therapists, need to more effectively engage all patients who smoke. These guidelines provide concrete steps to create an office-based system for delivering preventive services. Many practical tools, such as the “5 A’s” counseling protocol, are included to provide research-supported strategies for addressing smoking cessation with patients. New recommended evidence-based strategies included in the updated guidelines include:

- Self-help materials (printed and Web-based) help patients quit smoking and are legitimate tools to recommend to patients.
- Combining medication with counseling for smoking cessation is more effective than either medication or counseling alone, and multiple counseling sessions increase the likelihood of success.
- Motivational techniques appear to increase a patient’s likelihood of making a future quit attempt, so they

should be used even with those not willing to quit at present.

- Concerning medications, the nicotine lozenge and varenicline (but monitor for psychiatric adverse effects) are considered effective smoking-cessation treatments that patients should be encouraged to use. Interventions identified as effective in the 2008 guidelines are recommended for all individuals except when medically contraindicated or with specific patients found to be nonresponsive.
- “Light” smokers should be identified, strongly encouraged to quit smoking, and offered counseling for cessation.

Some of the recommendations in the 2000 version of the guidelines have been changed in the 2008 update. Of special note to readers of *RESPIRATORY CARE*:

- Increasing evidence shows screening and assessment practices such as expanding vital signs to include tobacco-use status, or other reminder systems to ask about smoking significantly increase the rate of clinician intervention.
- The types of counseling and behavioral therapies recommended for inclusion in smoking-cessation interventions have been reduced from 3 to 2: counseling with practical skills/problem-solving, and providing support/encouragement.
- Though clinicians should still encourage patients to use effective medications for tobacco-dependence treatment, more exceptions are specified in the 2008 update.
- The 2008 update makes a stronger recommendation for using combined treatments, such as nicotine patch plus another form of nicotine replacement therapy or slow-release bupropion, and specific combinations and durations are listed.
- Tobacco use and dependence interventions should remain in measures of overall health-care quality, including outcome measures, such as short-term and long-term abstinence rates.
- The 2000 guideline’s counseling and behavioral interventions recommendations on children and adoles-

cents have been narrowed to only adolescents. Pediatric clinicians should ask parents about tobacco use and offer them cessation advice and assistance.

- Stronger evidence now supports the recommendation to identify smokeless tobacco users and provide counseling cessation interventions.

However, each of us has to decide to make this a priority in our work and to persist with developing the skills needed to more effectively assist these patients, because not working to develop a comprehensive clinic strategy greatly limits the potential for effectiveness. When working with our patients, not asking them about smoking status, not advising them to quit tobacco, not enhancing motivation to quit, and not teaching them how to quit when they are ready is giving tacit approval to a patient's unhealthy habit, which leads to preventable morbidity and mortality.

The 2008 guidelines illustrate that the knowledge base for helping our patients quit smoking is still evolving. Even so, the knowledge and intervention skills needed do exist, can be learned, and our effectiveness can be improved with practice. In addition to learning the "5A's" protocol described in the 2008 update, We suggest that there are 3 necessary conditions to make our counseling encounters with patients most productive:

1. Clinicians must not only know about the mechanisms, treatments, and local supportive community resources for addressing tobacco-cessation problems; we must also use practical solutions to common problems/barriers patients face when attempting changes. This knowledge is necessary so that patients can be taught what to expect during the quitting process, especially common problems that often cause relapse. The new guidelines provide much of this information. We can learn about the barriers and problems to quitting by simply asking the patient to talk about the most difficult cravings and the feelings, activities, and nicotine level preceding the craving. Anticipatory planning with the patient on how to deal with the problem differently gives the patient a better chance of avoiding relapse.

2. The patient must make a decision to stop smoking and adopt healthier behaviors in place of smoking. Patients are more likely to make this decision when they realize that more can be gained from quitting than continuing to smoke. The clinician's goal is to try to influence the patient's choice before serious medical consequences ensue. Just informing a patient about health risks, though necessary, is usually not sufficient for a decision to change. An alternative is to discuss at each visit how a patient's change in lung function threatens important activities and relationships. If time does not permit a discussion, then at minimum give an effective advice statement by looking the

patient in the eyes and saying with sincerity and firmness, you must quit smoking.

3. Once the patient commits to quitting, s/he must be taught how to quit. Smoking intervention cannot be delegated to a few experts; we need a team approach that starts with making smoking status a vital sign obtained from each patient.<sup>6</sup> As with many routine clinical procedures, clinicians' patient-motivating and teaching skills differ, but we must all be committed to improving our skills—our patients need us to be so. Clinical staff need to work together to develop a plan for how smoking cessation will be incorporated into our daily activities. One practical way to start is to make it part of shift report. Hospitals must incorporate smoking status into patient-intake forms, and automatic referrals should be generated. Private-practice quality audits should include smoking ask-and-assist frequencies. Home-care clinicians should include smoking-surveillance and quit-assist as part of disease management programs.

The 2008 guidelines contain valuable information to guide our practice and help us inform and persuade others to join the growing movement to overcome tobacco use and dependence. Become familiar with the guideline and, more importantly, use its many recommendations. At the very least, hone your advice statement to patients until you can deliver it confidently, persuasively, and honestly. You have to know it and "own" it to be convincing. If each of us did just that, more of our patients would quit smoking and avoid the morbidity and premature death that can result from continued smoking.

**Jonathan B Waugh PhD RRT RPFT**  
Respiratory Therapy Program  
Critical Care Sciences Department

**Christopher D Lorish PhD**  
School of Medicine (retired)

University of Alabama at Birmingham  
Birmingham, Alabama

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Correspondence: Jonathan B Waugh PhD RRT RPFT, Respiratory Therapy Program, Clinical and Diagnostic Sciences, University of Alabama at Birmingham, 1705 University Boulevard, SHPB 455, Birmingham AL 35294-1212.



Two posters from the USSR concerned with the harmful effects of smoking tobacco  
World Health Organization photo  
Translation (above): "Stop smoking, tobacco is a poison."  
(below) "That's how you burn up your health..."  
Courtesy, National Library of Medicine