

## Tobacco 101: Clinical Practice Guidelines—5 A's

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One of the most important aspects of tobacco dependence treatment in the year 2003 is our ability to base strategies on a foundation of evidence-based research. The cornerstone of this research is the updated Public Health Service (PHS) Guidelines, "Treating Tobacco Use and Dependence."<sup>1</sup> A key feature of these guidelines is the conceptualization of tobacco use as a chronic illness rather than a "bad habit." Thus, the focus of treatment is not merely on changing a lifestyle, but on aggressively combating a life-threatening disease process through the use of medication, counseling, and social interventions. The tobacco dependence treatment guidelines are broad in scope, but there are specific recommendations, known as the 5 A's, aimed at brief clinician interventions:

- **ASK** about tobacco use from every patient at every visit
- **ADVISE** smokers to quit
- **ASSESS** readiness to make a quit attempt
- **ASSIST** in the quit attempt
- **ARRANGE** follow up contact to prevent relapse

**ASK:** The first step in successful tobacco dependence treatment is the systematic identification of all smokers. This is best achieved through both individual and system-wide efforts. Practitioners should ask all patients, at every visit, if they smoke. Identifying tobacco users at every visit detects changes in behavior over time and keeps tobacco use as a visible issue for the practice. System approaches, such as sticker chart reminders, flow sheets, and collection of tobacco use as a vital sign, are all effective at consistently identifying smokers.<sup>2,3</sup>

**ADVISE:** Messages to quit that come from clinicians have an impact. Clinician advice should be strong, clear, and personalized. For example, one might say, "as your clinician, I must tell you that quitting smoking is the single most important thing you can do to improve your health." This simple message can be augmented by personalized information. While advising a smoker to quit takes only a few minutes, it is a powerful intervention.

**ASSESS:** This recommendation asks clinicians to assess the patient's willingness to quit. There is strong evidence that tailoring interventions to the appropriate stage of behavior change is effective.<sup>4</sup> That is, a smoker who does not perceive smoking as a health risk (precontemplation), would not benefit from a prescription for nicotine patches. Conversely, a smoker ready to set a quit date (preparation) should not get advice that focuses on the health effects of smoking. For those smokers unwilling to quit at the present time, the focus should turn to motivational techniques.

**ASSIST:** Once patients decide to quit, the clinician can assist them in many ways. Setting the quit date itself establishes a contract between the smoker and the provider and is a powerful

tool. Encourage specific plans, and offer to check on the patient's progress. Clinicians have the best impact on success rates by prescribing medications, which, reportedly, doubles abstinence rates.<sup>1,5</sup> All smokers attempting to quit should receive pharmacotherapy, unless under special circumstances.<sup>1</sup> In New Jersey, clinicians also can refer smokers to the state's Comprehensive Tobacco Control Program's nicotine dependence services.<sup>6</sup>

**ARRANGE:** Following up with patients is key, but often overlooked. Regular follow-up by the provider increases cessation rates up to two-fold.<sup>7</sup> The natural history of quitting is one of repeated attempts and variable success. Treatment for the chronic disease of smoking must be continuously re-evaluated and appropriately modified, in a way similar to the evaluation of hypertensive patients who cannot remain on the same medication regimen for their entire lives. Continued follow-up allows the smoker and provider to anticipate obstacles and deal with them effectively.

By following these clinically proven steps, providers can have the best chance of successfully helping smokers quit. These interventions are meant to be brief, often requiring less than three minutes of direct clinician time, and, as mentioned earlier, are

greatly augmented by system-changes at the practice or institutional level. Through individual clinical efforts, as well as broad system interventions, evidence-based treatment will help greatly reduce the burden of this leading public health crisis.

1. M. C. Fiore et al. "Treating Tobacco Use and Dependence: Clinical Practice Guideline" (Rockville, Md., US Department of Health and Human Services. Public Health Service, 2000), <http://www.surgeongeneral.gov/tobacco/tobaqrq.html>.
2. M. C. Fiore et al. "Smoking Status as the New Vital Sign: Effect on Assessment and Intervention in Patients Who Smoke," *Mayo Clin Proc* 70, no. 3, (1995): 209-213.
3. M. D. Robinson, S. L. Laurent, and J. M. Little JM Jr. "Including Smoking Status as a New Vital Sign: It Works," *Journal of Family Practice* 40, no.6 (1995):556-561.
4. J. Prochaska and M. G. Goldstein MG "Process of Smoking Cessation. Implications for Clinicians," *Clin Chest Med* 12, no.4(1991):727-735.
5. V. Prochazka. "New Developments in Smoking Cessation," *Chest* 117, no.4, Suppl 1 (2000):169s-175s.
6. J. Foulds et al. "Tobacco Dependence Treatment Services in New Jersey," *New Jersey Medicine*, 99, no. 3 (2002): 23-28.
7. A.V. Prochazka. "New Developments in Smoking Cessation," *Chest* 117, no.4, Suppl 1 (2000):169s-175s.

