Words as Therapy: Smoking Cessation

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Physician advice has been shown to be one of the most effective smoking cessation interventions.[1] Despite this, little attention has been paid to how the physician should approach the subject of smoking cessation.

The words that a physician chooses to discuss smoking with a patient should be considered no less a therapeutic agent than the pharmacologic agent that the physician prescribes. Rarely in medical school, residency training, CME courses, or the literature, however, does one encounter specific information on how to select the proper *verbal* "drug of choice," much less the indications, contraindications, route of administration, dosage, strength, side effects, route of elimination, and possible interactions of such advice.

Smoking cessation counseling is not really that different from any other medical intervention. Consider a clinical encounter involving a urinary tract infection (UTI): the patient complains of frequency, urgency, and dysuria; a culture is taken; a sensitivity test is done; and an antibiotic is selected and prescribed. The patient generally gets better in a few days and is well in a week or two. With smoking cessation, one does a culture by doing a general assessment of the patient and the patient's situation, performs a sensitivity test by asking the question "What brand do you smoke?" and selects the verbal "antibiotic" based on a combination of these.

Success in smoking cessation interventions must be placed in perspective. If the patient with a UTI came back in a few weeks with continued symptoms, the physician would not say, "Gosh, I'm sorry but we tried an antibiotic and it didn't work. I guess you'll have to suffer until you get better on your own or get pyelonephritis, sepsis, and die." Of course not, and smoking should be no different. If the first verbal antibiotic for smoking cessation does not work, another should be tried, and another, and another, until success is achieved. Verbal antibiotics, like other therapy, must be individualized by considering dose (enough to be therapeutic, yet not toxic), timing (frequency and relation to other words) and absorption and elimination (factors that enhance or detract). Each intervention should be considered a learning experience for both the physician and the patient rather than a source of frustration. A sense of humor is critical. Realistic expectations are a must. Achieving a cessation rate of 10% among all patients who smoke after 1 year of intervention can be disappointing for a physician who is used to a near 100% success rate for treating UTIs. Yet that 10% is four to five times higher than the norm.

Physicians are quite familiar with the many excuses, rationalizations, denials, and delaying tactics patients use to justify continuing to smoke. Listed below are 5 of the most important questions for the physician to ask in reference to smoking, and 20 of the most commonly encountered excuses given by patients. Each is followed by an appropriate response and a short discussion that may help improve the outcome of smoking cessation efforts.

Physician Questions

"Do you use tobacco?"

This question should be asked as part of taking vital signs on every visit.[2] The utility of this simple screening test is far greater than that of other, more elaborate screening tests that physicians use. If the test results are "positive," the physician has identified a powerful predictor of both acute and chronic disease in the patient and his family. Asking the question while obtaining other vital signs signifies to all patients that tobacco use is a very important factor in their health. For children and teenagers, the visit may be one of the few opportunities to discuss tobacco use before their experimentation with cigarettes and subsequent addiction to nicotine. For those teenag-

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ers who do smoke, a most effective technique (developed by Alan Blum, MD) is to reply, "Come on, you're too old to smoke. That's kid stuff." This approach to tobacco use demythologizes the notion that smoking makes them look more mature.

"What brand do you smoke?"

People, especially young people, smoke to project the image that advertisers have created for a particular brand: macho, mature, sexy, successful, or popular. Since smoking in reality causes the *opposite* images, the very same tactics used to promote cigarettes can also be used by physicians to discourage smoking. Along with the patient's history and a general psychological assessment, a knowledge of the advertising imagery created for the patient's brand of cigarette will enable the physician to develop a strategy to "counter-advertise."

For example, if a 15-year-old female patient smokes Virginia Slims (or other fashion image brand), she is probably trying to appear sexy and independent. Discuss how smoking causes "zoo breath," yellow teeth, and premature facial wrinkling, or how Philip Morris is exploiting her by making her think she has "come a long way" to obtain independence when actually they are getting her hooked. Quoting statistics about possible death or disease 30 to 40 years into the future rarely works with teenagers or adults.

The patient who smokes Carlton (or other low tar brand) is already concerned about his health. Ask him if he would buy bread marketed as "lowest in poison" or soup that had "only 3 mg arsenic."[3] The patient who smokes Doral (or other value-pack) cigarettes or another generic brand might be motivated by the yearly and lifetime savings he could accumulate if he quit smoking.

"Have you set a quit date?"

The answer to this question is an indicator of the patient's readiness to stop smoking. If the patient responds "Yes," then follow with "When?" and "What is it about that date that makes it a good one?" This will provide the physician with important additional information about what motivates the patient. "Why not today?" should be the next question. These four questions rapidly identify "blockers" that need to be dealt with immediately.

If the patient has not already set a quit date, follow with "Can we set one right now?" If "Yes," then start at the sequence above. If "No," then explore his rationale with a statement such as, "Help me understand that decision." This will provide the physician with enormous insight into the patient's reasoning, which may also prove helpful in counseling other patients who smoke. More often than not, a patient's rationale is based on inaccurate or incomplete information. So the physician will have another opportunity to educate the patient and further encourage him along the path toward becoming a nonsmoker.

"Would you be willing to sign a contract that would commit both of us to your becoming a nonsmoker?"

Explain that the physician's part of the contract is to be available to offer support and information to the patient. The patient's part is to (1) stop smoking, (2) call if there are any problems or questions, and (3) return for follow-up even if he starts smoking again. This third commitment is most important since many patients either are too embarrassed if they relapse or feel smoking is too trivial a problem to warrant a visit to the physician.

Many physicians use a written contract signed by both the patient and physician and include it as part of the medical record. Others write out the contract in the patient's chart as the two are discussing it, after which both the physician and the patient sign the contract in the chart. Whether it is smoking cessation suggestions written on a prescription blank or a specially designed contract, something tangible for the patient to take home can enhance the effectiveness of the intervention.[4] The smoking cessation kit of the American Academy of Family Physicians has a number of helpful items for this purpose.[5] Take-home reminders also serve to communicate to the patient the important message that prescriptions and therapy go beyond medications.

"What can I do to help?"

Perhaps the most important purpose of this question is assuring the patient that smoking cessation is important and that the physician is available to help. Rewards and challenges can be beneficial. As reinforcement, some physicians provide incentives for their patients such as gifts or discounted fees for follow-up visits to encourage compliance and reward success. Others ask the patient to save the amount of money he would have spent on tobacco (two packs per day = about $1000 per year). If the patient is still a nonsmoker after 1 year, the money is used to celebrate; if he has resumed his smoking habit, the money is donated to a charity of the *physician's* choice.

A more tangible stimulus might be to give the patient a quarter to keep in his billfold. When he gets the urge to smoke, he is asked to look at the quarter first and think of all the reasons why he became a nonsmoker. If

he decides to smoke anyway, he must give the charity $2.50 for each cigarette he smokes during the first 30 days. This discourages the rationalization that if he smokes just one or two cigarettes, he may as well go back to his regular habit.

Patient Blockers

Patients often devise blockers that they use to avoid dealing with uncomfortable issues such as tobacco use. By anticipating these blockers and learning appropriate responses, the physician can quickly move the patient toward a decision-making point as well as identifying motivating factors that will most likely result in a successful intervention. The following exchanges between physician and patient illustrate this process*:

PATIENT: "I've tried everything and I just can't stop smoking."
PHYSICIAN: "What exactly have you tried? I'd like to write these down here in your chart."

This sends a signal to the patient that you are serious about smoking cessation, that you are going to take the time to deal with it, and that you want to investigate further the problems encountered in trying to stop.

"Every attempt teaches us something even if it doesn't work. What have you tried and what problems did you encounter?" This keys the physician as to whether the problem is with the symptoms of nicotine withdrawal—which can then be explained to the patient as a temporary problem—with the actual smoking habit, or with being placed in situations where smoking occurs or is reinforced (eg, work, parties, alcohol consumption).

"Most people go through several attempts before success. The average is five different attempts. Let's develop a plan that's best for you." This acknowledges that it can be a difficult process but not one so difficult that success cannot be achieved.

PATIENT: "Smoking helps my nerves."
PHYSICIAN: "Nervousness is one of the many symptoms of nicotine withdrawal and it will pass in about 3 days. Perhaps your so-called nervousness is not due to your personality as much as it is to nicotine withdrawal. Were you a nervous person before you started smoking?"

This acknowledges the fact that there may be symptoms encountered but allays some of the anxiety in the fact that these will be transient. Further exploration and explanation of the patient's exact symptoms may be helpful.

"What sort of things make you nervous?" If cigarettes are being used to help the patient deal with problems that cause nervousness or anxiety, then the problems need to be corrected as much as possible before they result in more debilitating symptomatology or substance abuses.

PATIENT: "Smoking helps me deal with my problems."
PHYSICIAN: "Problems should be dealt with. Smoking will not improve a problem. What kind of problems are you having?"

It is not uncommon that this response opens a floodgate for the patient. While it may seem unproductive at the time, allowing patients to ventilate, assisting them with problem-solving, or referring them to appropriate counseling will, in the long run, be helpful to them in terms of both medical and psychological health.

PATIENT: "I really don't want to stop smoking."
PHYSICIAN: "You're an intelligent person. With all you know about the health hazards and costs of smoking, help me understand how you arrived at that decision."

This acknowledges that the patient is intelligent yet forces him to consider why he, an intelligent individual, would willingly choose to die prematurely. It forces him to verbally justify the obvious conflict. It may help to have the patient list all of the health problems smoking causes. Although his list will probably be incomplete, verbalizing what he does know is very effective and allows the physician to augment the list and correct any misconceptions.

PATIENT: "Smoking can't be that bad."
PHYSICIAN: "How bad does it have to be?"

This allows the patient to set his own level of "badness." In most instances, once the patient quantifies how bad smoking would have to be for him to quit, the physician can point out with specific examples that smoking is indeed *that* bad.

PATIENT: "If my spouse would stop smoking, I would."
PHYSICIAN: "Great, can I make an appointment for you both next week?"

**Adapted, with additions, from Table 11.1 in Richards JW, Blum A: "Health Promotion." In: Taylor RB, ed.* Family Medicine Principles and Practice *(ed 3). New York: Springer-Verlag 1988:100. With permission from the publisher.*

This is usually an excuse, and such a response can get an acknowledgment that it is not the real reason. If it is the real reason, then it gives the physician an opportunity to help both patients. Asking "What would it take to get him or her to stop?" provides the physician with insight into the problems for the spouse as well.

PATIENT: "I enjoy smoking."
PHYSICIAN: "What exactly do you *enjoy* about smoking?"

This gets to the actual agenda quickly and allows the physician to hone in on the patient's perception of the word *enjoy*. Most often it is not that patients enjoy smoking so much as they do *not* enjoy the way they feel when they are not smoking: the early, subtle and not so subtle symptoms of nicotine withdrawal. Additional follow-up questions might be,

"Is there an alternative activity that would serve as a substitute?"

"Is this enjoyment worth the risk of pain, suffering, or premature death?"

"Is this enjoyment worth $x amount of money?" (Calculate the spending over 1, 10, 30 years, etc)

PATIENT: "I'll stop smoking when I really want to."
PHYSICIAN: "Exactly when will that be?"

This is an attempt to get the patient to commit to a particular or significant date or event, such as pregnancy or a first myocardial infarction. If that happens, the physician should proceed with "What is it about that date?" as outlined above. "How will you know when that is?" This is a search for motivators. "What will it take to make you really want to?" This is an attempt to identify a consequence, event, or date to use as a motivating point. "What can I do to help you want to?" This positions the physician as an advocate rather than an adversary.

PATIENT: "I've switched to a low tar cigarette (cigar, pipe or smokeless tobacco)" or "I've cut down on my smoking."
PHYSICIAN: "You must be worried about your health."

This may reveal possible motivators.

"Are you under the impression that low tar is less deadly?" This gives you a chance to demythologize the rhetoric about low tar and low nicotine that the tobacco industry has propagated. Explain that people who smoke these cigarettes usually inhale deeper and hold the smoke in longer to ensure that the nicotine they crave is absorbed. These cigarettes may in fact be *more* harmful since exposure to the other 3000 chemicals in tobacco is increased.

"You mean low poison?" This gives you a chance to talk about the many deadly ingredients in addition to tar.

"You know that's like saying that you've decided to jump from a 20-story building instead of a 50-story building."

Do not respond with "That's good." Patients will hear only that and feel that they have done all they need to do. Rather, the physician should move the discussion to the proper end point with "When are you going to stop?"

PATIENT: "I'm too old to stop smoking."
PHYSICIAN: "If you stop smoking today, you'll increase both the quality and length of your life."

Quitting has been shown to increase both the quality and length of life no matter how old a person is when he or she quits.

PATIENT: "The harm from smoking has already been done."
PHYSICIAN: "The moment you quit your health will begin to improve."

The physician must explain smoking's acute and chronic effects on the body. For example, within 30 to 60 minutes after the last cigarette, stress on the heart as a result of increased pulse rate and increased blood pressure caused by nicotine begins to drop. The risk of death from a heart attack or stroke decreases immediately. About 5 years after the patient has quit smoking, his chances of dying from a heart attack have dropped to the level of people who never smoked. Risk of acute respiratory infections (eg, colds, bronchitis) diminish rapidly after quitting. If no serious consequences have occurred after 10 years, the former smoker's chances of dying of lung cancer drop almost to that of the general population. Approximately 12% of a smoker's hemoglobin carries carbon monoxide instead of oxygen. In 120 days (red blood cell turnover time) the patient will enjoy a 12% boost in oxygen in his or her blood and a resultant boost in stamina.

PATIENT: "I'll gain weight if I quit smoking."
PHYSICIAN: "The majority of smokers don't, and those who do gain an average of only 5 lbs."

Many smokers believe weight gain is inevitable after quitting. Brand names such as "slims" and "thins" reinforce this mistaken impression. One problem is that patients who do gain weight in the first few weeks

resume smoking to lose the weight rather than wait to see if they will lose the weight later on. It is estimated that the health risk of smoking one pack per day is equal to being 100 pounds overweight! Patients should give their eating habits and weight at least 1 year to settle after smoking cessation.

PATIENT: "My cardiologist smokes. If it were really that bad, surely he would quit."
PHYSICIAN: "Doctors are just as capable of becoming addicted to nicotine as other people. Why not quit as an example for your cardiologist. It might be just the impetus he needs to quit."

Smoking by physicians in general has dropped to about 5%, and the younger the physician, the less likely he is to smoke.

PATIENT: "My uncle lived to be 92, and he smoked like a chimney."
PHYSICIAN: "Everyone has a story like that because not everyone who smokes dies prematurely. In fact, of those people who do smoke, only about half will die prematurely. Taking your chances with smoking is like playing Russian roulette with three bullets in a six-chambered pistol."

PATIENT: "You have to die of something."
PHYSICIAN: "True enough. But why die 7 to 18 years early?"

Furthermore, death caused by tobacco can follow a long period of suffering. Have the patient hold his nose and breathe through a straw for 10 minutes to experience life with chronic obstructive pulmonary disease (COPD). Explain that this is just one example of reality for a long-time smoker.

PATIENT: "I'm not hurting anybody but myself."
PHYSICIAN: "Not true. Secondhand smoke causes death and disease."

Explain that smoke harms others who happen to be in the area where you are smoking. Furthermore, harmful substances in cigarette smoke linger in the air and are recycled by the ventilation system. Parents who smoke harm both their born and unborn children.

PATIENT: "I know it can cause my baby problems, so I go outside to smoke."
PHYSICIAN: "Your intentions are good, but unfortunately the chemicals are still in your clothes."

When a smoker holds an infant, the baby's nose is usually pressed right into the adult's clothes and he has no choice but to breathe in the fumes.

PATIENT: "Why should I quit smoking?"
PHYSICIAN: "Health, wealth, and stealth."

Health: Everyone thinks they know all the health problems that smoking and secondhand smoke cause, but most patients underestimate and fail to personalize the common dangers of smoking: cancer, heart disease, COPD, and stroke. The key to using health as a reason to quit is to link smoking to a health problem the patient or a family member have, or are concerned about having (eg, impotence, heart attack).

Wealth: A high school freshman might respond to information that cash saved by not buying cigarettes could be used to purchase a stereo at the end of a year or a car after 3 to 4 years. A young executive might be persuaded to give up his two-pack-a-day habit by being told that the same money placed in a 10% annuity, compounded annually, would be worth $1.7 million dollars upon retirement.

Stealth: By pointing out the deceitful marketing and unethical business practices of the manufacturer of the patient's brand of cigarettes, the patient will often become angry enough to "stop doing business with them." In developing these strategies, the physician creates an alliance with the patient against an enemy, the companies selling them tobacco.

PATIENT: "Cigarettes have always helped me when things got tough. How can I leave my best friend?"

Understandably, patients are reluctant to give up their "best friend." Two strategies work well in this circumstance. The physician might suggest that the patient just not have the *next* cigarette. Stop smoking one cigarette at a time, much like Alcoholics Anonymous. The other is to permit the patient one cigarette a year (to visit his friend). The day of the Great American Smokeout is an appropriate choice.

PATIENT: "If tobacco were really that bad, the government wouldn't allow it to be sold, allow it to be advertised, subsidize it, etc."

PHYSICIAN: "It *is* that bad, but money talks. Why not write your representatives in Washington and let *them* answer your question."

Smoking Cessation—An Integral Part of Practice

Smoking cessation interventions should be as natural as any other therapeutic patient encounter. Smoking is a disease that affects approximately 30% of our patients. When one considers the impact of tobacco on health, it is certainly worthy of every physician's attention and efforts.

Suppose a patient who presented with a "cough" also had a suspicious lesion on his forehead suggestive of basal cell carcinoma. What physician would not mention that the lesion is of concern? Yet, if the same individual presented with tobacco breath, a pack of cigarettes in his pocket, or selective yellowing of his finger nail, the physician might complete the entire encounter without even making a casual comment about the importance of not smoking.

If this hypothetical patient refused biopsy of the skin lesion (eg, he "didn't have time today," "didn't think it was really that important," or "it really wasn't bothering him"), most physicians would say, "Maybe I haven't made myself clear. This is a serious matter and I must insist. . . ." Many physicians still consider smoking a "personal choice" issue rather than a medical issue. But choosing not to stop smoking is not unlike choosing not to have a basal cell carcinoma removed, and what physician would accept that choice without a major effort to convince the patient otherwise?

During the year before the release of the first Surgeon General's Report in 1964, Americans consumed 525 billion cigarettes.[6] In 1990, Americans consumed 525 billion cigarettes.[7]

Choose your words wisely, we have a long way to go.

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