

Should Emergency Departments Help Smokers Quit? Annals Emergency Medicine Editorial

The reality that emergency departments have become the default site of care for the 46 million uninsured Americans, the millions more resident uninsured foreigners, and surprisingly large numbers of insured patients is a mixed blessing.^{1,2} On the down side, it means that emergency departments are being asked to remedy fundamental problems in the organization and financing of medical services—problems for which they have responsibility but no authority. On the up side, emergency departments have the potential to address important health problems in our society. One such problem, tobacco use, is the subject of a paper by Vokes and colleagues in this issue of the journal³. The facts regarding the damage from smoking are grim. Over 44 million smokers exist in the United States. Each year 440,000 patients die from smoking-related causes, including cancer, heart disease, and lung disease⁴. Smoking shortens a life span by 8-12 years⁵ and those last few years can be miserable, especially for patients with end stage pulmonary obstructive disease or metastatic cancer. Furthermore, the health of non-smokers is imperiled by exposure to second hand smoke, leading to a host of medical complications among children and adults⁶.

But not all the news about smoking is grim. Fewer people are starting to smoke, and more smokers are quitting. Adult smoking rates are at a modern low (20.9%), and youth smoking is at a 30 year trough.^{7,8} There are now more ex-smokers than current smokers. And there is mounting evidence that intervention by physicians and other clinicians—by giving advice, counseling, and pharmacotherapy—can improve the chances of quitting smoking^{4,9}. Notwithstanding the press of their other responsibilities, emergency departments are uniquely situated to help smokers quit, as asserted both by Vokes and in a recent statement of emergency medicine organizations¹⁰. This uniqueness stems from two facts. First, smokers are disproportionately represented among emergency department users, accounting for 40% of all such visits^{11,12}. Second, emergency departments are the primary source of care for about a third of all Americans, and these patients have unusually high rates of smoking, possibly as great as 50%.^{11,13}.

Vokes reports on smoking cessation practices in two emergency department settings—one urban and one suburban—both within the same emergency medicine residency training program. The study analyzed audiotape encounters for 871 adult (age 18-65) non-emergent women in the two sites for all conversations about smoking and smoking cessation. Only slightly more than 50% of the patients were orally screened for smoking, with a mean discussion time of a Calvin Coolidge-like 28 seconds. One third of the patients were smokers. The authors acknowledge that their study may understate the real smoking prevalence in the two sites because emergent patients (who were excluded) typically have higher rates of smoking. Of the identified smokers, only 56% were advised to quit, only 20% were counseled, and only 8 (13% of the smokers) were given any kind of referral—six to a primary care physician and one each to a telephone quitline and to nicotine replacement therapy.

Though the limited number of observations, and the exclusion of men and emergent cases, might cast doubt on the generalizability of the Vokes results, they are very congruent with a recent survey of seven different clinician groups conducted for the Robert Wood Johnson Foundation by Mathematica Policy Research (Strouse, R, unpublished report, 2003-04). The survey confirmed low smoking rates among all health professionals (5.7% among the 408 emergency medicine physicians surveyed) as well as a low rate of smoking cessation practices. Only 31 % of emergency medicine physicians reported ever offering smoking cessation materials and 49% reported ever referring patients for cessation. Only 5% were knowledgeable about the Public Health Guideline⁹ on smoking cessation; 83% had never heard of it and 12% were aware of it but had not read it. Finally, 58% felt that offering smoking cessation services is not appropriate for emergency departments. Reasons for this viewpoint included competing priorities (70% of those surveyed), that cessation should be the responsibility of primary care physicians (78%), and that there is no reimbursement for cessation activities (82%). The take home message of both the Vokes report and the Robert Wood Johnson survey is that emergency departments don't regard smoking as an "emergency". Though that is an understandable attitude, it also means that a potential opportunity to improve the health of the patients served by emergency departments is lost. How can we reconcile the need for emergency departments to fulfill their prime social mission—caring for emergencies—and still help with problems like smoking?

Our experience at the Smoking Cessation Leadership Center at UCSF indicates that there is a way that emergency departments can become important bulwarks in tobacco control (as urged in the statement of emergency medicine organizations¹⁰) without jeopardizing their efficiency or their ability to serve their communities. In essence, emergency departments should choose one or more of the following strategies: offer state-of-the-art cessation services on site within the emergency department; refer smokers to a well-developed system within their own or adjacent institution; or, at a minimum, **ask** about cessation, **advise** to quit, and **refer** to a toll-free telephone quitline.⁴ By calling the national number (1-800-QUIT NOW) callers will be referred to the quitline in their state. If no response is received, their call will be fielded at a center at the National Cancer Institute. The scientific evidence supporting the use of quitlines is strong, and they are well accepted by clinicians and patients.^{14,15} We have been impressed by how many health professionals have adopted this "**Ask, Advise, Refer**" model. We have called it "Take 30 Seconds and Save a Life." That is only 2 seconds more than the amount of time spent on counseling smokers in the Vokes study.

For those emergency departments wishing to help smokers quit, I would suggest the following. First, read the statement recently published in this journal that argues that "tobacco control fits within the traditions of other ED-based public health practices, such as injury prevention." Second, consult our Center's website <http://smokingcessationleadership.ucsf.edu> for assistance and information on how to develop programs. This includes the at-cost provision of plastic wallet-sized quit cards that provide the national 1-800 QUIT NOW number, as well as models of posters that could be used to dispense the cards. Third, our Center is working with the American College of Emergency Physicians to develop ways to make emergency departments more attuned to

patients' smoking status and how to offer cessation. Finally, consult with your hospital administration, which is being evaluated regularly by the Joint Commission on Accreditation of Health Care Organizations as to how well it is identifying smokers and offering them treatment in three medical conditions (acute myocardial infarction, congestive heart failure, and community-acquired pneumonia). The portal of entry for each of these is frequently through the emergency department.¹⁶

Our vision is that all smokers visiting an emergency department should have their smoking status ascertained. All smokers, not just those with smoking-related health concerns—as advocated by Vokes—should receive at least a referral to a telephone quitline, and hopefully more.

Emergency departments are vital community resources. This is an exciting time for tobacco control in this country, and we are on the verge of making great progress in smoking rates, thereby yielding significant health improvements. As shown by Vokes and colleagues, emergency medicine is not yet a robust partner in that effort.³ But it could be and it should be, as acknowledged by its own leaders¹⁰. For as little as two seconds more per smoker, emergency departments could be a part of an historic health breakthrough.

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References

1. Institute of Medicine, Committee on the Consequences of Uninsurance (2003). *A Shared Destiny: Community Effects of Uninsurance*. Washington, DC: National Academies Press
2. Weber EJ, Showstack JA, Hunt KA, Colby DC, Callahan ML. Does lack of a usual source of care or health insurance increase the likelihood of an emergency department visit? Results of a national population-based study. *Annals of Emergency Medicine*, 2005 Jan;45(1):4-12.
3. Vokes NI, Bailey JM, Rhodes KV. "Should I give my smoking lecture now or later?" Characterizing ED provider smoking discussions and cessation counseling. *Annals of Emergency Medicine*, 2006; 46:xxxxx
4. Schroeder SA. What to do with the patient who smokes? Medical Grand Rounds at UCSF. *Journal of the American Medical Association* 294:482-87, 2005
5. Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observation on male British doctors. *BMJ*. 2004;328:1519

6. Proposed identification of environmental tobacco smoke as a toxic air contaminant. June 24, 2005, California Environmental Protection Agency. Office of Environmental Health Hazard Assessment. Available at <http://repositories.cdlib.org/tc/surveys/CALEPA2005/>
7. Centers for Disease Control and Prevention. State-specific prevalence of cigarette smoking and quitting among adults—United States, 2004. *MMWR Morb Mortal Wkly Rep.* 2005;54:1124-27
8. Johnston LD, O'Malley PM, Bachman JG, and Schulenberg JE. (2006) *Monitoring the Future: National results on adolescent drug use: Overview of key findings, 2005.* (NIH Publication No. 06-5882). Bethesda, MD: National Institute on Drug Abuse
9. Fiore MC, Bailey WC, Cohen SF, et al. *Treating Tobacco Use and Dependence: Clinical Practice Guideline.* Rockville, Md: Dept of Health and Human Services; June 2000
10. Bernstein SL, Boudreaux ED, Cydulka RK et al. Tobacco control interventions in the Emergency Department: A joint statement of emergency medicine organizations (Executive Summary) *Annals of Emergency Medicine* 2006 46:xxxx
11. Lowenstein SR, Tomlinson D, Koziol-McLain J, Prochazka A. Smoking habits of emergency department patients: an opportunity for disease prevention (abstract). *Acad Emerg Med* 1995;2:165-171
12. Boudreaux ED, Baumann BM, Friedman K, Zeidonis DM. Smoking stage of change and interest in an emergency department-based intervention. *Acad Emerg Med.* 2005 Mar; 12 (3):211-8
13. Bernstein E, Bernstein J. *Case studies in Emergency Medicine and Health of the Public.* Boston: Jones and Bartlett, 1996
14. Zhu S-H, Anderson CM. Tobacco Quitlines: Where they've been and where they're going. In *VA in the Vanguard: Building on success in smoking cessation.* SL Isaacs, SA Schroeder, and JA Simon, editors. Proceedings of a conference held in San Francisco, CA Sept 21, 2004.
15. Ossip-Klein D, McIntosh. Quitlines in North America: evidence base and applications. *Am J Med Sci* 2003;326:201-205
16. Williams SC, Morton DJ, Jay KD, Koss RG, Schroeder SA., and Loeb JM. Smoking cessation counseling in U.S. hospitals: A comparison of high and low performers. *J Clinical Outcomes Management* 2005; 12:345-352