

S K Hammond,

School of Public Health, University of California,
Berkeley, California, USACorrespondence to: Manel Nebot, Institut Municipal
de Salut Pública, Plaça Lesseps 1, 08023
Barcelona, Spain; mnebot@imsb.bcn.es/
bexsa@readyssoft.es

Acknowledgements

We especially wish to thank Charles Perrino and Pablo Villegas from the School of Public Health, University of California, Berkeley, and the Institute for Global Tobacco Control at the Johns Hopkins School of Public Health, Baltimore, for its support in carrying out this study.

References

- 1 **US Environmental Protection Agency.** *Respiratory health effects of passive smoking: lung cancer and other disorders.* Washington, DC: Office of Health and Environmental Assessment, 1992. (Publication No EPA/600/6-90/006F.)
- 2 **Kreuzer M, Krauss M, Kreienbrock L, et al.** Environmental tobacco smoke and lung cancer: a case-control study in Germany. *Am J Epidemiol* 2000;**151**:241–50.
- 3 **Hackshaw A, Law M, Wald N.** The accumulated evidence on lung cancer and environmental tobacco smoke. *BMJ* 1997;**315**:980–8.
- 4 **Hammond SK, Leaderer BP.** A diffusion monitor to measure exposure to passive smoking. *Environ Sci Technol* 1987;**21**:494–7.
- 5 **Leaderer BP, Hammond SK.** Evaluation of vapor-phase nicotine and respirable suspended particle mass as markers for Environmental Tobacco Smoke. *Environ Sci Technol* 1991;**25**:770–7.
- 6 **Siegel M.** Involuntary smoking in the restaurant workplace. *JAMA* 1993;**270**:490–3.
- 7 **Chapman S.** Smoking in public places. *BMJ* 1996;**312**:1051–2.
- 8 **Hammond SK.** Exposure of US workers to environmental tobacco smoke. *Environ Health Perspect* 1999;**107**:329–40.
- 9 **Llei 10/1991,** de 10 de maig, de modificació de la llei 20/1985 de prevenció i assistència en materia de substancies que poden generar dependencia. DOGC num.1445, maig 1991 [Law restricting smoking in Catalonia].

A smoking cessation telephone resource: feasibility and preliminary evidence on the effect on health care provider adherence to smoking cessation guidelines

Physicians have frequent opportunities to intervene with their smoking patients as approximately 70% of smokers see a physician each year.¹ Even brief counselling by a physician significantly improves the rate of smoking cessation according to meta-analyses performed by the Tobacco Use and Dependence Guideline Panel and summarised as “ask, advise, assist, and arrange follow-up” in the Agency for Health Care Policy and Research (AHCPR) guidelines.² Despite these evidence based recommendations, physicians identify only about half of current smokers, advise less than half, and assist and arrange follow up with a small minority.³ There are several explanations for this disparity between physicians’ knowledge and their actual behaviour including inadequate training, resource and time constraints, and lack of information on community cessation resources.

Office systems that screen patients for smoking status increase the rate of smoking

Table 1 Adherence of health care providers to smoking cessation interventions

Intervention	Baseline (n=54)	Post-implementation (n=111)	Relative risk Post-implementation v baseline (95% CI)
Asked	37 (69%)	71 (64%)	0.9 (0.7 to 1.2)
Advised to quit	29 (55%)*	65 (59%)	1.1 (0.8 to 1.4)
Quit date discussed	5 (9%)	14 (13%)	1.4 (0.5 to 3.6)
Assistance offered	14 (26%)	46 (41%)†	1.6 (1.0 to 2.6)
Follow up arranged	9 (17%)	38 (34%)‡	2.1 (1.1 to 3.9)

*One subject’s data missing for this item, n=53.

†p=0.052 versus baseline.

‡p<0.02 versus baseline.

CI, confidence interval

cessation interventions by health care providers.⁴ We hypothesised that providers would be more likely to adhere to the AHCPR guidelines if they could delegate the time consuming steps of *assistance* and *follow up* to a telephone cessation resource.

This pilot study assessed the feasibility of a central telephone smoking cessation resource that would proactively call smokers who gave their provider consent for referral. We also evaluated whether providers would be then more likely to adhere to the smoking cessation guidelines. In a quasi-experimental pre-test, post-test design, a sample of patients seen for any type of visit with a provider in three participating primary care clinics in Vermont were interviewed at exit from the clinic. Only current smokers were asked about their providers’ adherence to guidelines. The primary outcome measure was the proportion of current smokers who reported being asked, advised, assisted, and having follow up arranged at baseline and four months after implementation of the resource.

Two hundred and nine patients were referred to the resource from the three clinics over the four month duration of resource availability. We estimated that this represented 20% of the total number of smokers seen at the clinics during this time period. We interviewed 54 smokers at baseline and 111 smokers four months after implementation. After the intervention, rates of asking and advising about smoking were not significantly changed from baseline (table 1). The increase in the proportion of smokers who were offered assistance did not reach significance (p = 0.052). There was a significant increase in those who had follow-up arranged (table 1).

Our study demonstrates that a smoking cessation proactive telephone resource is feasible and that providers will refer patients to such a resource. The resource had a contact rate of only 52% of referred current smokers, which we attribute to the resource not having evening calling hours, a significant limitation. Implementation of this proactive smoking cessation telephone resource was associated with improved arrangement of follow up. These preliminary data suggest that further studies of the effect of referral resources on adherence of physicians to guidelines are warranted. Because of the non-randomised design of this pilot study, we cannot attribute improvements in provider adherence solely to the availability of the telephone resource, as provider focus groups, surveys, and training also may have increased adherence to the guidelines. Only a randomised study can address this issue.

T W Marcy

National Cancer Institute, Division of Cancer Prevention, Office of Preventive Oncology, Rockville, Maryland; Office of Health Promotion Research, University of Vermont College of Medicine, Burlington, Vermont; Vermont Cancer Center, University of Vermont, Vermont USA
twmarcy@together.net

L J Solomon

Vermont Cancer Center, and Department of Psychology, University of Vermont

G S Dana, R Secker-Walker

Office of Health Promotion Research, University of Vermont College of Medicine, Burlington, and Vermont Cancer Center, University of Vermont

J M Skelly

Biometry Facility, University of Vermont

Acknowledgements

Financial support: Robert Wood Johnson Foundation, Princeton, New Jersey (Award 035850), University of Vermont Patient Oriented Research (Award 6-28529).

References

- 1 **Davis R.** Uniting physicians against smoking: the need for a coordinated national strategy. *JAMA* 1988;**259**:2900–1.
- 2 **Fiore M, Bailey W, Cohen S, et al.** *Treating tobacco use and dependence.* Rockville, Maryland: US Department of Health and Human Services. Public Health Service, 2000.
- 3 **Goldstein M, Niaura R, Willey-Lessne C, et al.** Physicians counseling smokers: a population-based survey of patients’ perceptions of health care provider-delivered smoking cessation interventions. *Arch Intern Med* 1997;**157**:1313–19.
- 4 **Fiore M, Jorenby D, Schensky A, et al.** Smoking status as the new vital sign: effect on assessment and intervention in patients who smoke. *Mayo Clin Proc* 1995;**70**:209–13.

Ophthalmologists’ and optometrists’ attitudes and behaviours regarding tobacco cessation intervention

Although health care providers can be effective in motivating and helping patients to quit their tobacco use,^{1–7} the potential role of eye care professionals has been under recognised. Several chronic ocular diseases are associated with smoking,⁸ including formation of cataracts and age related macular degeneration (a leading cause of blindness).^{8,9} As a cardiovascular risk factor, smoking may also play a role in the development of anterior ischaemic optic neuropathy.¹⁰ In addition, smoking may increase the risk of ocular disease from other disorders, such as diabetes, the main cause of blindness in persons 20–74 years of age.¹¹