Smoking cessation counseling in the acute care setting

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At any given time, relatively few people who smoke are inpatients. Hence, most efforts at counseling people to end smoking take place outside the hospital. However, it behooves us to remember the importance of taking advantage of the opportunity afforded by hospitalization to counsel our patients to stop smoking. This is especially important when patients are admitted for illnesses that may be smoking-related, like acute myocardial infarction or community-acquired pneumonia.

The guidelines for managing these diseases long have agreed that smoking cessation is essential. The American College of Cardiology notes:

Smoking triggers coronary spasm, reduces the anti-ischemic effects of beta-adrenoreceptor blockers, and doubles mortality after acute MI. Smoking cessation reduces rates of reinfarction and death within a year of quitting, but one third to one half of patients with acute MI relapse within 6 to 12 months.1 A comparable recommendation is found in the American Thoracic Society’s guidelines for management of community-acquired pneumonia.2 Smokers with pneumonia clearly are more likely to remain at risk.

The circumstance of having an illness serious enough to require hospitalization constitutes a “teachable moment.” A recent study found that the experience of hospitalization itself may be a major factor in determining the achievement of long-term smoking cessation, particularly in patients with smoking-related illness.3

In the face of such unanimity, one would expect smoking cessation counseling of such patients to be routine. And yet, a study of Medicare beneficiaries admitted for acute MI in 2000-20014 found that 57% of the charts reviewed had no documentation that the patient had been counseled to stop smoking prior to discharge. Wisconsin did a little better—42% of charts had no such documentation—but enormous opportunity for improvement remains.

MetaStar has been working to improve these rates in Wisconsin hospitals for the past dozen years. We suspect that somewhat more smoking cessation counseling takes place than the numbers indicate, because such counseling is not always documented. But it is clear that many inpatients for whom smoking cessation counseling is highly indicated do not receive it.

Where we have seen increases in the rate at which such patients are counseled, they have tended to result from the adoption and utilization of systems designed to ensure that counseling takes place more-or-less automatically. Such systems can be as simple as a checklist for nurses and discharge planners. The trend toward adoption of electronic health records offers an even greater opportunity to ensure that no patient who smokes—particularly no smoker admitted for smoking-related causes—leaves the hospital without being counseled to quit.

What can physicians do? They can inquire as to whether their hospitalized patients who smoke have been counseled. They can ask that systems to guarantee that counseling takes place be adopted. And of course, a physician who tells a patient to stop smoking is apt to have more credibility than anybody else. It is understandable that physicians concentrate on curing patients of the acute diseases that brought them to the hospital, and that preventive considerations may be far from physicians’ minds. But at the appropriate point at the end of the hospital stay, a word to a patient can be just the thing that gets that patient to quit.

References
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