Commentary

The New Vital Sign

Assessing and Documenting Smoking Status

AT THE turn of the last century, the American medical community developed a standardized assessment to help clinicians confront the leading cause of death at that time, infectious disease. This assessment, known as vital signs, included temperature, pulse rate, respiratory rate, and, later, blood pressure.[1-3] Over time, the measurement of vital signs became an expected part of every clinic visit and an essential component of the database physicians use to evaluate, diagnose, and treat patients.

See also pp 3139 and 3172.

As we approach the next century, American medicine is challenged by a different cause of illness and death-tobacco use. Cigarettes are now responsible for more than 430000 deaths each year in the United States.[4] As with past epidemics of this magnitude, institutional changes in the practice of medicine must be adopted to overcome the enormous disease burden resulting from tobacco use.

Making smoking status the "new vital sign" is a simple way to confront the chief avoidable cause of illness and death in our society today. This small but fundamental change in clinical practice will begin to address a current weakness in the way we practice medicine—the failure to universally assess, document, and intervene with patients who smoke. Current standards of practice warrant appropriate documentation and intervention for elevated blood pressure, increased temperature, and arrhythmias. Adding smoking status as a new vital sign will significantly increase the likelihood for intervention in this important area as well.

In the current issue of THE JOURNAL, Frank and colleagues[5] provide compelling evidence that this institutional change is needed. These authors, in a large, well-conducted study, have convincingly documented that fewer than half of all smokers reported that they had ever been advised by their physicians to quit or cut down. This disappointingly low rate of smoking status assessment was observed across most sociodemographic subpopulations and was particularly low among young smokers and women who both smoked and used oral contraceptives. A meager 4% of smokers reported that their physician had helped them quit. These findings are regrettably similar to those of an earlier study of smokers in Michigan, only 44% of whom reported that a physician had ever told them to quit.[6] In both of these studies, had smoking status been assessed during the routine documentation of vital signs, these distressingly low rates could have been markedly improved.

Most patients don't object to having their blood pressure measured during every clinic visit, and there are no data to suggest that they would object to the regular assessment of smoking status, particularly if presented in the context of routine preventive care.[7,8] In fact, assessing smoking status at every visit might, by itself, motivate some smokers to consider making a quit attempt. Making smoking status a vital sign would also promote the guidelines of the US Preventive Services Task Force[9] that "tobacco cessation counseling should be offered on a regular basis to all patients who smoke cigarettes" and the National Health Promotion and Disease Prevention Objectives for the Year 2000[10] to "increase to at least 75% the proportion of primary care and oral health care providers who routinely advise cessation and provide assistance and follow-up for all of their tobacco-using patients."

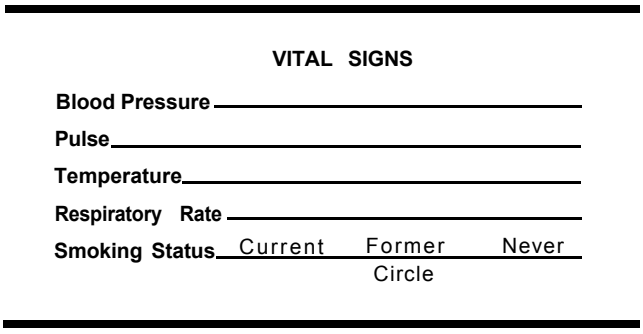
The singularly devastating health impact of cigarette smoking warrants the unique institutional response of expanding the vital signs. While not by itself sufficient, the elevation of smoking assessment to the priority status of "a vital sign" would be an important first step in a coordinated action plan for physicians to aggressively confront smoking. This action plan would include the following:

• *Assess and document smoking status as part of the vital signs for every patient during every clinical visit.* Seventy percent of smokers visit a physician each year,[11] and most of them are motivated to quit. Adding smoking status to the vital signs assessment, an activity usually completed by a nurse or medical assistant prior to the physician's encounter, will ensure that all smokers are identified. A model vital sign stamp[12] that includes smoking status assessment is shown in the Figure.

• *Learn and use a brief intervention message to help patients to quit.* Physicians, once aware of the smoking status of their patients, can then focus on moving smokers from the stage of contemplating quitting to making a quit attempt. To do this, physicians must become comfortable with a brief clinical intervention to assist their patients who smoke. The National Cancer Institute has developed guidelines, based on the results of a large series of clinical trials, for an effective, 2- to 3-minute clinical intervention for physicians *(How to Help Your Patients Quit Smoking)*.[13] These guidelines and the National Cancer Institute's program to train 100,000 physicians are summarized in an important report by Manley and colleagues[14] in this issue of THE JOURNAL. These authors have estimated that 3 million smokers would quit annually if this intervention were universally adopted and succeeded with as few as 10% of American smokers. While physicians routinely advise and counsel patients with diabetes, hypertension, or even a sprained ankle, they have lagged in delivering a brief

From the Department of Medicine and the Tobacco Research and Intervention Program, University of Wisconsin Medical School, Madison.

Reprint requests to Tobacco Research and Intervention Program. University of Wisconsin Medical School, 7275 Medical Sciences Center, 1300 University Ave, Madison, WI 53706 (Dr Fiore).



Vital signs stamp.

but effective message to their patients who smoke.

• *Recognize cigarette smoking as a chronic disease and provide appropriate long-term assistance to patients who smoke.* As with hypertension, diabetes, or congestive heart failure, cigarette smoking can be considered a chronic disease, requiring ongoing attention and treatment. Since smokers may be at various stages in the quitting process, physicians must continue to assist their smoking patients, often through repeated contacts over many months or years. Recent quitters are at particularly high risk for relapse for several months after quitting. This group will particularly benefit from follow-up visits for smoking cessation.[15]

• *Expect modest success rates among patients who try to quit smoking.* As with other chronic diseases, the treatment of cigarette smoking must continue even in the face of very modest "cure" rates. A realistic smoking cessation rate of 5% to 10% can be expected from a brief clinical intervention (such as the one described by Manley and colleagues[14]). While most physicians would be elated by a 10% remission rate with unmedicated hypertensive patients, many clinicians become discouraged with smoking cessation interventions because of high relapse rates. If clinicians universally achieved a 5% to 10% successful cessation rate each year among all of their patients who smoke, the impact would be enormous.

• *Establish expertise in the diagnosis and pharmacologic treatment of nicotine addiction.* Surgeon General Koop. in his landmark *1988* report on *The Health Consequences of Smoking*,[16] concluded that cigarettes and other forms of tobacco are addicting and that nicotine is the drug in tobacco that causes addiction. While this view is now widely accepted, physicians have not effectively used pharmacologic treatments to help smokers quit. This has been particularly true with nicotine gum, the incorrect and insufficient use of which has been well documented.[17] Understanding the role of pharmacologic adjuvants in smoking cessation treatment will become even more important over the next year, when a new product, the transdermal nicotine patch, is expected to be licensed by the Food and Drug Administration. The transdermal patch has shown great promise as an aid to smoking cessation[18,19] and will likely be an important component of smoking cessation treatment through the 1990s.

• *Play a public health role in confronting cigarette smoking.* The power of physicians to influence health behavior in this country is immense. In fact, physicians are one of the few groups that have the logistical and moral force to confront the pandemic of tobacco addiction, illness, and death.[20] Through targeted actions, physicians can markedly change the social climate that condones the aggressive promotion of the only legal product in our society today that, when used as intended, results in illness and death. No matter how successful smoking cessation activities are in this country, they will be rendered ineffective if the US tobacco industry continues to enlist 1 million new young people into the ranks of addicted smokers each year.[21] At a minimum, physicians should support a total ban on tobacco product advertising and promotion, enforcement of local and state ordinances that outlaw the sale of cigarettes to minors, a ban on cigarette vending machines, and innovative preventive education efforts to convince young people never to start smoking.

The article by Frank and colleagues[5] provides compelling evidence that clinicians are failing to adequately address the needs of their patients who smoke. Manley and colleagues[14] have outlined a simple and effective model to intervene with the patients. Adding smoking status as a new vital sign will provide the institutional framework by which the epidemic of tobacco use can be universally confronted. Through these clinical and public health interventions, clinicians can have a positive impact on the national goal of a smoke-free society by the year 2000.

Michael C. Fiore, MD, MPH

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