

### **Smoking cessation intervention in clinical practice.**

Cornuz J. *Onkologie* 25(5): 413-418, 2002. (31 refs.)

Physicians are in a unique position to advise smokers to quit because of their ability to integrate the various aspects of nicotine dependence. This review provides an overview on interventions with smokers presenting in a primary care setting. Strategies used for smoking cessation counseling differ according to patient's readiness to quit. For smokers who do not intent to quit smoking, physicians should inform and sensitize patients about tobacco use and cessation, especially by personalizing benefits to quit and challenging smokers' beliefs. For smokers who are insecure, physicians should use motivational strategies, such as discussing barriers to cessation and their solutions. For smokers ready to quit, the physician should show strong support, help set a quitting date, prescribe pharmaceutical therapies for nicotine dependence, such as replacement therapy and/or bupropion, with instructions for use, and suggest behavioral strategies to prevent relapse. Copyright 2002, Karger Publishing.

### **Family medical doctors and fourth year medical students fail alcohol competency.**

Gold MS; Van Susteren TJ; Frost-Pineda K. *Journal of Addictive Diseases* 21(2): 115, 2002. (0 refs.)

Peer-reviewed questions were selected for a national survey to assess physicians' alcohol competency in alcohol issues. A random national sample of family physicians was selected and interviewed for the sample. A convenience sample of fourth year medical students answered the same questions. Performance on the questionnaire provides clear evidence that physicians are not adequately trained in alcohol issues. Physicians are encouraged by the National Institute on Alcohol Abuse and Alcoholism to screen all patients for alcohol abuse, dependence, and consumption that place patients at risk for adverse events, yet physicians were uncertain how to screen for alcohol abuse. To take accurate histories, physicians must be able to quantify how much alcohol is consumed, but 85.5 percent of the physicians and 92.5 percent of the students could not identify standard drink equivalency. While information about alcohol's benefits continues to be disseminated, a surprising 36.4 percent of physicians and 67.4 percent of students were unable to correctly identify the cardiovascular complications of alcohol dependent patients. Family physicians and medical students also performed poorly on questions about alcohol metabolism,

medical complications, and fetal alcohol syndrome. Prevention of alcohol-related problems requires the active involvement of alcohol-issues competent physicians, but physician competency for alcohol issues is lacking in medical school and does not appear to improve as physicians practice. Copyright 2002, The Haworth Press, Inc.

### **Gender differences in predictors of initiation, retention, and completion in an HMO-based substance abuse treatment program.**

Green CA; Polen MR; Dickinson DM; Lynch FL; Bennett MD. *Journal of Substance Abuse Treatment* 23(4): 285-295, 2002. (57 refs.)

We studied gender differences in treatment process indicators among 293 HMO members recommended for substance abuse treatment. Treatment initiation, completion, and time spent in treatment did not differ by gender, but factors predicting these outcomes differed markedly. Initiation was predicted in women by alcohol diagnoses; in men, by being employed or married. Failure to initiate treatment was predicted in women by mental health diagnoses; in men, by less education. Treatment completion was predicted in women by higher income and legal/agency referral; in men, by older age. Failure to complete was predicted in women by more dependence diagnoses and higher Addiction Severity Index Employment scores; in men, by worse psychiatric status, receiving Medicaid, and motivation for entering treatment. More time spent in treatment was predicted, in women, by alcohol or opiate diagnoses and legal/agency referral; in men, by fewer mental health diagnoses, higher education, domestic violence victim status, and prior 12-step attendance. Clinical implications of results are discussed. reserved. Copyright 2002, Pergamon Press.

### **Identification of alcohol abuse in primary care using the EDAC Test. (meeting abstract).**

Harasymiw J; Bean P. *Journal of Addictive Diseases* 21(2): 120, 2002. (0 refs.)

The EDAC test combines the results of a panel of 13 automated blood tests using linear discriminant function (LDF) analysis to provide a unique statistical profile for each alcohol consumption group. This study evaluated the EDAC test's ability to identify self-reported drinking behavior. Subjects (N = 1,355) were grouped as follows: group 1 (n = 739; heavy drinkers, over 4 drinks/day); group 2 (n = 75; at-risk drinkers, 2-4 drinks/day); and

group 3 (n = 541; light drinkers, 0-2 drinks/day). In group 1, the EDAC test classified 48 percent correctly as heavy drinkers, 24 percent as at-risk drinkers, and 28 percent as light drinkers. In group 2, the test correctly classified 36 percent as at-risk drinkers, 13 percent as heavy drinkers, and 51 percent as light drinkers. In group 3, the test correctly classified 91 percent as light drinkers, 7 percent as at-risk drinkers, and 3 percent as heavy drinkers. A standard primary care population of 1,000 subjects is estimated to have 200 heavy drinkers, 300 at-risk drinkers, and 500 light drinkers. Screening this standard population with the EDAC test results in 96 subjects correctly identified as heavy drinkers, 39 subjects drinking 2-4 drinks/day classified as heavy drinkers, and 15 subjects drinking 0-2 drinks/day falsely classified as heavy drinkers. Thus the positive predictive value (PPV) of the EDAC test for the heavy drinking group is 0.9 ( $96+39/96+39+15 = 0.9$ ), which means the EDAC test would accurately identify 90 percent of true heavy drinkers and at-risk drinkers attending primary care. Copyright 2002, The Haworth Press, Inc.

#### **Reported cessation advice given to African Americans by health care providers in a community health clinic.**

Pollak KI; Taiwo B; Lyna P; Baldwin M; Lipkus IM; Bepko G; McBride CM. *Journal of Community Health* 27(6): 381-393, 2002. (33 refs.)

Physician smoking cessation advice has been shown to be effective in encouraging patients to attempt cessation. Few studies have examined factors associated with patient-reported physician advice in an inner city community health clinic. Smokers identified via chart review and provider referral met with a study "smoking specialist." Eligible participants self-identified as African American, smoked at least 1 cigarette per day in the prior 7 days, were 18 or older, had access to a telephone, and agreed to consider blood testing for genetic susceptibility to lung cancer. Of the 869 smokers identified, 487 were eligible and completed a brief in-person and a more extensive follow-up telephone survey within one week after their visit. Patient reports of smoking cessation advice by providers were regressed on patient demographic, smoking, health, and social support variables. Seventy percent of participants reported that they had been advised to quit smoking. Smokers who were older, did not smoke menthol cigarettes, were in poorer health, and who had a regular health care provider were most likely to report having received advice. Patients in this community health setting reported high rates of provider advice to quit smoking. Yet, even in this optimal condition, young healthy smokers did not report receiving advice, even when they were ready to quit smoking. Providers may need additional training and prompting to counsel young healthy smokers about the

importance of cessation. Copyright 2002, Human Sciences Press, Inc.

#### **Unrecognized alcohol and medication interactions.**

Saitz R; Horton NJ; Moskowitz MA; Samet JH. *Substance Abuse* 23(2): 137-138, 2002

This study examined the prevalence of potential alcohol and medication interactions in hazardous drinkers in a primary care setting, the association between this medication use and alcohol consumption, and whether users of medications known to interact with alcohol are counseled by physicians about drinking. Hazardous drinkers (N = 312), as defined by CAGE questionnaire and drinking amounts, were interviewed just prior to a visit with a primary care physician to determine the current (30 days) prevalence of use of medications that can interact with alcohol. Alcohol consumption was assessed by trained interviewers using a validated calendar method. Immediately after the physician visit, patients reported whether there had been a discussion about alcohol. Subjects saw one of 41 physicians. Most (78 percent) reported current use of medication that can interact with alcohol: 59 percent used nonsteroidal anti-inflammatory drugs; 44 percent acetaminophen; 16 percent antihistamines; 10 percent each narcotics, antidepressants, and medication for sleep; 6 percent anxiolytics; and 3 percent blood thinners (warfarin). Users of these medications drank more drinks per drinking day ( $p = 0.04$ ) and binge drank more often ( $p = 0.03$ ) in the past month than nonusers. There was no discussion of alcohol use with the physician for 37 percent of users and 40 percent of nonusers of medications that can interact with alcohol. The results suggest that potentially dangerous alcohol-medication interactions are common and unrecognized by primary care physicians. Copyright 2002, Association for Medical Education & Research in Substance Abuse.

#### **Providing physicians with patient-specific information increases the likelihood of alcohol counseling and decreases patient drinking.**

Saitz R; Horton NJ; Sullivan LM; Moskowitz MA; Samet JH. *Substance Abuse* 23(2): 123-124, 2002

The study tested whether providing primary care physicians (PCPs) with patients' alcohol screening results and individualized recommendations increases the likelihood of alcohol counseling by the PCP and decreases patient drinking. PCPs were randomized to an intervention or control group, with stratification by level of training (resident or faculty). During office visits, intervention PCPs received patients' alcohol screening results, a readiness to change measure, and action recommendations based on problem severity; control physicians received no such information. Eligible patients visiting these PCPs were

current hazardous or harmful drinkers. PCP counseling was assessed by patient report immediately after the visit and was categorized as (1) specific counseling; (2) any advice regarding drinking; and (3) occurrence of any alcohol-related discussion. Of 41 PCPs, 20 were in the intervention group and 48 percent were residents. The 312 patients drank a mean of 6 drinks per drinking day; 36 percent were in precontemplation, 32 percent in contemplation regarding changing drinking. For faculty PCPs, mean counseling rates were higher in the intervention group. Mean counseling rates for residents did not differ significantly by randomized group. Hierarchical models considering patient level data confirmed that the impact of the intervention on counseling differed by resident/faculty status. At 6 months, 76 percent completed follow-up. Patients who saw intervention physicians drank an average of 2.4 fewer drinks per drinking day. Copyright 2002, Association for Medical Education & Research in Substance Abuse.

**Pediatric, practice-based, randomized trial of drinking and smoking prevention and bicycle helmet, gun, and seatbelt safety promotion.**

Stevens MM; Olson AL; Gaffney CA; Tosteson TD; Mott LA; Starr P. *Pediatrics* 109(3): 490-497, 2002. (32 refs.) Objective. To prevent early adolescent health risk behaviors and to maintain or improve safety behaviors, we compared the effects of 2 interventions, delivered through pediatric primary care practices. The interventions, based on an office systems' approach, sought to prevent early drinking and smoking or to influence bicycle helmet use, gun storage, and seatbelt safety for children who were followed from fifth/sixth grades through eighth/ninth grades. Design. Settings and Participants. Twelve pediatric practices in New England were paired according to practice size and assigned randomly within pairs to deliver the multicomponent interventions, which built on pediatric primary care clinicians performing as counselors and role models during health supervision visits and other office encounters. Intervention. One intervention arm focused on alcohol and tobacco use. The other intervention arm focused on gun safety, bicycle helmet, and seatbelt use. Office systems provided infrastructure that supported the clinician's role. Clinician messages encouraged family communication and rule setting about the issues of the middle school years. The intervention was initiated during a health supervision visit and continued for 36 months. Both child and parent received quarterly newsletters to reinforce the clinician messages. Outcome Measures. The primary outcomes were ever drinking alcohol, ever smoking, ever using smokeless tobacco, using a bicycle helmet in the previous year, using a seatbelt in the previous 30 days, and guns in the child's home in locked

storage. Results. The pediatric practices recruited 85% (N = 3525) of the practices' fifth/sixth grade children and their responding parents. We obtained 36 months' follow-up data on 2183 child-parent pairs. Chart audit verified that the intervention was implemented. Additional data from interviews and surveys showed that parents, children, and pediatric clinicians found the intervention useful. Despite this, comparisons between the 2 study arms show no significant intervention effects in the prevention of alcohol and tobacco use or gun storage or seatbelt safety. There was a negative effect in the alcohol arm. Only bicycle helmet use showed a positive outcome. Conclusion. With rigorous evaluation, 2 office interventions failed to produce desired outcomes. Coordinated multiple settings for prevention interventions are probably necessary. Copyright 2002, American Academy of Pediatrics.

**Prevention of tobacco use in adolescents: Review of current findings and implications for healthcare providers.**

Vickers KS; Thomas JL; Patten CA; Mrazek DA. *Current Opinion in Pediatrics* 14(6): 708-712, 2002. (38 refs.)

This paper reviews recent research on adolescent smoking initiation and youth tobacco prevention and control strategies. Gender, ethnicity, family factors, and genetics are associated with smoking initiation and adolescent tobacco use. Evidence indicates that comprehensive tobacco control programs are an effective strategy for reducing adolescent smoking, and even modest gains from prevention and cessation efforts could lead to substantial reductions in the morbidity and mortality costs of smoking. Clinicians have an important role in prevention and treatment of tobacco use in adolescents, and the rate of delivery of clinical preventive services in this area should be increased. Consequently, clinicians working with adolescents should be familiar with established guidelines regarding tobacco use prevention and treatment and use general outpatient office visits as an important opportunity to prevent tobacco use. Copyright 2002, Lippincott, Williams and Wilkins.

**Survey of physicians knowledge regarding awareness of maternal alcohol use and the diagnosis of FAS.**

Nevin AC; Christopher P; Nulman I; Koren G; Einarson A. *BMC Family Practice* 3(1): 2-6, 2002. (13 refs.)

Alcohol is the most widely used drug in the world that is a human teratogen whose use among women of childbearing age has been steadily increasing. It is also probable that Fetal Alcohol Syndrome is under-diagnosed by physicians. The objectives of this study were twofold: (1) to evaluate the experience, knowledge and confidence of family physicians with respect to the diagnosis of FAS; and (2) to evaluate physicians' awareness of maternal drinking

patterns. A multiple choice anonymous questionnaire was sent to a randomly selected group of family physicians in the Metropolitan Toronto (Canada) area. Overall, 6/75 (8 percent) of family physicians reported that they had actually diagnosed a child with FAS; 17.9 percent had suspicions but did not make a diagnosis and 12.7 percent reported making a referral to confirm the diagnosis. Physician rated confidence in the ability to diagnose FAS was low, with 49 percent feeling they had very little confidence. Seventy-five percent reported counselling pregnant women and 60.8 percent reported counselling childbearing women in general on the use of alcohol. When asked what screening test they used to detect the use of alcohol, 75 percent described frequency/quantity. Not a single respondent identified using the currently accepted screening method for alcohol use (TWEAK) which is recommended by The Centre for Addiction and Mental Health. It is concluded that family physicians do not feel confident about diagnosing FAS. Copyright 2002, BioMed Central.

**Stages of change analysis of smokers attending clinics for the medically underserved.**

Gil KM; Schrop SL; Kline SC; Kimble EA; McCord G; McCormick KF et al. *Journal of Family Practice* 51(12): NIL\_3-NIL\_10, 2002. (33 refs.)

**OBJECTIVE** To determine whether smokers at clinics providing care for the medically underserved can be characterized according to the transtheoretical stages of change model. **STUDY DESIGN** Prospective, descriptive

study. **POPULATION** Smokers in the waiting rooms of clinics providing care for the medically underserved. **OUTCOMES MEASURED** Standardized questionnaires that assessed stages of change, processes of change, decisional balance, and self-efficacy and temptation. **RESULTS** The smoking rate of subjects interviewed at 4 clinics was 44%. Two hundred current smokers completed the questionnaires. Smokers claiming that they planned to quit within 6 months scored higher on experiential process statements that are consistent with quitting smoking than did smokers who claimed they were not planning to quit within 6 months. They also scored higher on behavioral statements related to quitting. Concerns about the negative aspects of smoking were more important to smokers planning to quit than to smokers not planning to quit, whereas the statements assessing positive aspects of smoking were rated the same. Fifty-five percent of the smokers were smoking a pack or more each day and reported smoking more during negative situations and from habit than did smokers who smoked less than a pack a day. **CONCLUSIONS** Smokers planning to quit who still smoke at least a pack a day may benefit from counseling to decrease smoking for specific reasons or from pharmacologic aids. Smokers at the clinics who planned to quit smoking reported experiences and behaviors that were consistent with their stated desire to quit and should be counseled in the same fashion as smokers from more traditional practices. Copyright 2002, Dowden Publishing Corporation.