ESTABLISHING A SMOKING cessation clinic

Pharmacists can play a big part in helping people to stop smoking. This article describes a practice pharmacist's involvement in a team approach to providing support to smokers

By Alison McCormick, BSc, MRPharmS

Smoking is the largest single cause of preventable, serious ill-health and premature death in Britain.[1] In Scotland, smoking causes an estimated 13,000 deaths each year.[2] Of the 28 per cent of people who smoke, half will die as a result of their habit.[3] Smoking is also responsible for 82 per cent of lung cancer deaths, 25 per cent of heart disease deaths and 83 per cent of deaths from bronchitis and emphysema. It also doubles the risk of stroke.

Eyemouth Medical Practice, in the Borders region of Scotland, is situated in a small, coastal town and covers a large, rural area. Three full-time and two part-time general practitioners look after about 6,000 patients. While I was undertaking a patient medication reviews in patients aged between 60 and 75 years old who were on more than five medicines, it became obvious that many were suffering from coronary heart disease (CHD) or chronic obstructive pulmonary disease (COPD), were overweight and were smokers. It appeared that 21 per cent of the patients with CHD and 63 per cent of those with COPD were still smoking.

During this time, a secondary prevention CHD training programme (Hearts in the Borders) involving all health professionals was taking place locally. I suggested to the lead GP in our practice that we hold a smoking cessation clinic to coincide with No Smoking Day (March 2000) and that we should invite all patients with CHD from the medication review clinic who were still smoking. A letter was sent to 14 patients with a tear-off slip for reply.

The first group meeting

A one-hour programme was drawn up that included information and advice on stopping smoking, a talk by an ex-smoker, a short video, a demonstration of the various nicotine replacement therapy (NRT) products available, provision of leaflets, information about quit lines and a question and answer session. Carbon monoxide monitoring was introduced in later sessions.

Full details were taken of each patient's "smoking picture", based on a form provided in "Helping patients set themselves free from smoking: Information for health professionals", a leaflet available from Novartis. This enabled us to recommend the right strength of nicotine patch or gum to people.

Patients were informed that their smoking status would be documented at three, six, nine and 12 months after attending the group, but that this was not intended to be a policing action. Attendance at the clinic was entered into the notes and the general practice administration support system (GPASS) computer record, using the relevant clinical Read Code. In addition, I created a record card, and a photocopy of this, containing full details, was kept in the patient's clinical notes for future reference (Figure 1). Patients who attended the clinic were encouraged to think about their commitment and motivation to stop, and were invited to return the following week to start on NRT therapy, if appropriate.

The first group proved so successful that it was decided to continue running a smoking cessation clinic within the practice. We decided that it should be held every six weeks, in order to give patients four or five follow-up sessions with intensive support. One of the local health visitors was approached to help run the group and this released the GP from a regular commitment, although she was still available for advice. All Health Boards in Scotland were given Tobacco Tax money from the Scottish Exectutive. Some of this money was allocated to our Practice to offset administration costs costs, nursing staff costs and GP time. All staff were notified that the meetings would be taking place, and leaflets and fliers were made available in the consulting rooms. Relevant posters and information were displayed in the waiting room inviting patients who were motivated to stop smoking to attend.

All smokers who were motivated to give up were encouraged to decide on a stop date and to tell their partner and friends when it was. A lot of time was spent helping people to talk about their "tough times" and to think of or write down ways in which they thought they might cope with them. They were advised to avoid setting a stop date close to any potentially stressful situations, such as hospital appointments, holidays, Christmas, or nights out with other smokers. Patients could elect to have intensive support either from the group or a "buddy", to use commercial quit-lines or to telephone the

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Figure 1: Clinic record card

SMOKING CESSATION CLINIC RECORD CARD

Surname | Forenames

Address | Date of birth

Tel:

GP | First date seen at clinic | CO reading

Attendance at clinic | NRT before?

Individual session | Within last year?

Medical condition

Drug interactions

Advice given | Comments

Patient motivated and committed to support group?

Patient suitable for: | Collect Rx from chemist/surgery

Dose | GP | Date

Attendance at clinics

Patient stopped (months)

practice pharmacist for advice. Any patient who did not want to be part of a group or who could not attend the Friday afternoon clinic was given an individual half-hour appointment with the pharmacist.

It was decided at one of the regular practice meetings to draw up a protocol with the practice pharmacist for referring motivated patients to the group (Figure 2).

Introducing amfebutamone

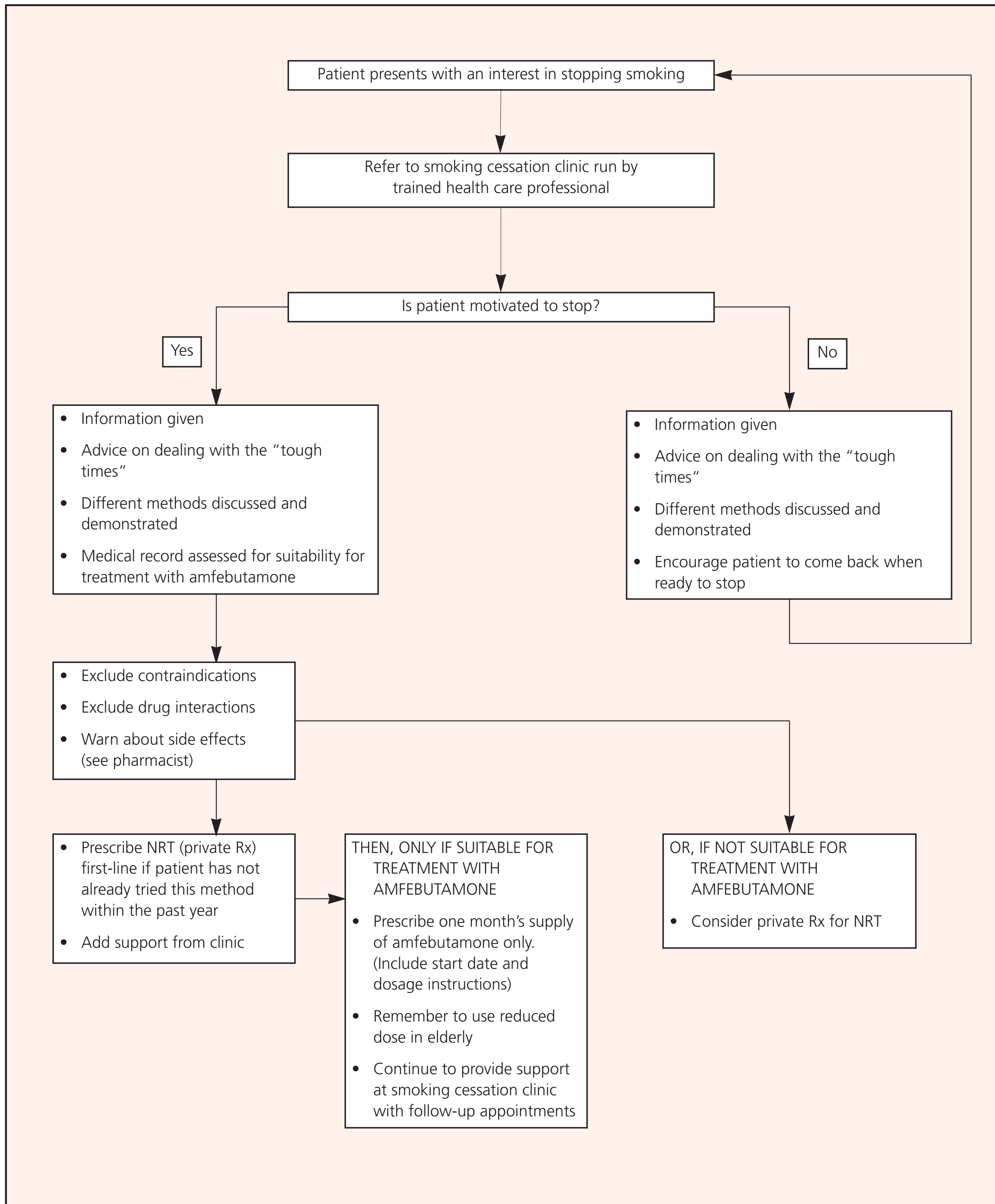
With the launch of amfebutamone (bupropion, Zyban) in June 2000, it became imperative to set up an appropriate screening process because many patients saw the drug as a "magic bullet". We expected an influx of interested patients as a result.

We agreed that patients would only be considered for amfebutamone if they had unsuccessfully tried a full course of NRT within the past year. If the criteria were not met, then a private prescription for NRT was offered. (NRT was not available on prescription at this time.) I thoroughly checked the patient's medical records for potential contraindications and drug interactions, and patients were warned about possible side effects and risks. The members of the practice involved in giving amfebutamone to patients agreed to monitor side effects and to report adverse reactions to the Committee on Safety of Medicines through the yellow card system. The health visitor and a treatment room nurse attended the relevant smoking cessation training and became fully integrated into the team.

The use of a carbon monoxide monitor is thought to be a useful way of demonstrating both the effects of smoking and the rapid benefits of stopping. A carbon monoxide monitor was donated to the practice by GlaxoSmithKline to be used voluntarily by patients at the first meeting and on stopping.[4] Readings were recorded in the patient's record card.

All the GPs were encouraged to give three minutes of advice to patients at consultations, if appropriate, using the "four As" (ask, advise, assist and arrange follow-up).[4,5] Patients who appeared to be motivated to stop smoking were given information and the date of the next available smoking

Figure 2: Protocol for referral of motivated patients (before NRT available on prescription)



cessation clinic. A brief medical history was passed on to the pharmacist, which was helpful when meeting patients for the first time.

It is well documented that most smokers who present for help with stopping smoking have already made several attempts to give up. Motivation to stop was judged by which point in the Prochaska Circle cycle of change they were at.[6] Some patients only came to one meeting and were judged to be still in the precontemplative stage, but many joined later groups to try again. Interestingly, after a while, the team instinctively knew which people would succeed in giving up.

About 70 per cent of patients were motivated to stop smoking because of health reasons rather than financial ones. Eyemouth is probably not unique in having a black market in readily available, cheap cigarettes. Off-shore workers are also allocated a monthly allowance of cheap cigarettes and, even when trying to give up, are tempted to take the allowance “just in case”. In addition, the allowance can be sold on to someone else on returning to shore.

Results

So far, 80 of the 92 patients who have attended the smoking cessation clinic have been sent a questionnaire and we have had a 47 per cent response rate. The questionnaire asks about current smoking status and duration of being a non-smoker from first attending the clinic. If patients said that they had relapsed, we asked them to state what made them start smoking again (the most common reason being stress-related events, such as relationship breakdown). Data were also collected on how useful people had found the support of the clinic, which indicated that 95 per cent thought that it was very helpful or excellent. Only one person claimed that it had been of no help. Two people mentioned that it would be useful to hold an evening session to accommodate work commitments.

The whole questionnaire was sent out after three months and an amended one to non-smokers at six, nine and 12 months. Because amfebutamone was a new drug, an extra questionnaire asking about side effects was included and went to 33 patients. A higher proportion of patients returned this questionnaire (73 per cent).

The responses revealed that the most common side effects experienced were dry mouth, insomnia and headache (Table 1). The drug was withdrawn from four patients, two of whom developed urticaria, one who suffered from severe chest pain, and one who developed severe depression.

Discussion

The smoking cessation clinic at Eyemouth has now run for a year. Our first group (14 patients) has demonstrated that using NRT plus intensive support more than doubles the chances of giving up, with the stop rate currently standing at 28.6 per cent for all smokers who attended. The success rate for motivated patients (n=10) stands at 40 per cent, thus proving that motivation on the part of the patient is fundamental to success.

Subsequent groups have not yet run for a full year but 26 out of a total of 80 people have stopped smoking three months after attending the clinic. Figures for patients in the four groups that were prescribed amfebutamone have revealed that 13 out of 33 have stopped smoking at three months.

Many patients have tried to stop smoking on numerous occasions before coming to the clinic and have not succeeded. This may have been because they did not complete a full course of NRT, did not receive support from family and friends, or more often, because something stressful happened.

In this practice, we often encounter a vicious circle of social deprivation, family problems, redundancy, ill health, depression and smoking. By holding the clinic in the familiar setting of the health centre we believe that patients are able to make a more informed choice before stopping. The follow-up sessions are vital, providing regular support to patients as they go through the difficult process of treating both the addiction and the habit.

The way forward

On No Smoking day this year, the Government announced that NRT would be deregulated and would be available on prescription. Certain products are to be made available from supermarkets and other retail outlets. Because of this change, our protocol will have to be revised. But the GPs and the no smoking team are adamant that motivated patients should still be referred to the clinic, rather than just receiving a prescription without accompanying support.

Points for the future include:

- Involving all members of the smoking cessation team in the initial, larger meeting
- Using the treatment room nurse to oversee the practical week-to-week running of the programme
- Freeing the pharmacist to concentrate on checking patients’ medical details and medication
- Using the pharmacist to give training and support to the smoking cessation team and to act as a liaison between the GPs and patients
- Continuing to monitor the effectiveness of the smoking cessation clinic through regular data collection
- Encouraging health visitors to advise pregnant smokers to give up
- Inviting the local dentist to give brief advice on quitting, because he is in an ideal position to do so and has a captive audience!
- Using community pharmacists to reinforce advice when handing out prescriptions, and to counsel and encourage patients to complete the course

The imminent appointment of a smoking co-ordinator to cover the whole of this area could have major implications for improving the health of patients within the Borders region. In addition, a new and important development will be the discussion of our findings with the local health care co-operative. We hope to help other medical practices that are interested in starting their own clinics.

Eyemouth is proud of starting the first smoking cessation clinic in a practice setting in the Borders PCT. It is hoped the service will expand in the light of our findings and that

Table 1: Side effects experienced by patients on amfebutamone

Side effect	Number
Dry mouth	12
Insomnia/vivid dreams	12
Headache	7
Nausea/vomiting	6
Depression	5
Rash	2
Chest pain	2
Taste disturbance	2
Urticaria	1

our enthusiasm to help patients to stop smoking will continue to improve patient care.

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