

Addressing Tobacco Addiction: A Neglected Cornerstone of Preventive Cardiology?

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In March, a study by Chen et al was published in *Circulation* (121(11):1280-2) reporting a decline in heart attacks among Medicare patients, news of which was hailed in *The Wall Street Journal* with the headline, "*Some Success Fighting Heart Disease.*" That month I also received a brochure for a continuing medical education symposium entitled, "*Coronary Atherosclerosis Prevention and Education.*" The program was sponsored by a nationally recognized center for cardiovascular excellence. Although the reduction in heart disease reported in *Circulation*, as well as in other journals over the past decade, was attributed first and foremost to smoking cessation, I was disappointed that none of the nearly 40 talks and workshops at the symposium was devoted to smoking. Nor was the importance of mastering approaches to tobacco use cessation and relapse prevention---as well as primary prevention strategies in the clinic and community---included in the course objectives.

No doubt the need to convey messages to patients about smoking was duly noted during the five-day course (how could it not have been?). But surely a presentation or workshop on approaches to the patient who uses tobacco deserves a featured place among talks on diabetes, radiation risks in imaging, women and heart disease, markers for atherosclerosis, atrial fibrillation, ECG review, complications of surgery, cardiac problems in pregnancy, sleep apnea, congenital heart disease, ischemia, anticoagulation, aortic disease, heart problems in athletes, cardiac rehabilitation, hypertension, and several ones on lipid management. As it stands, the course could well be renamed the "Symposium on the Secondary and Tertiary Prevention of Coronary Atherosclerosis."

To be sure, this program is hardly unique. The same neglect of tobacco cessation and prevention is found in the CME brochures I've received in recent years for cardiology-in-primary-care courses from leading medical schools and heart centers in California, Florida, Georgia, Maryland, Ohio, Tennessee, Wisconsin, and other states. . The American Heart Association itself is virtually missing-in-action on smoking in the CME courses it sponsors.

After more than 35 years of studying, writing, and speaking on the physician's role in smoking cessation and prevention, I have a pretty good idea why this subject has held so little appeal for CME course directors and attendees alike. It's a combination of the perception that smoking cessation is intellectually simplistic (ie, beneath most physicians) as well as a time-consuming investment with little chance of observable success. At the other extreme, the clinical guideline on smoking cessation, which I have criticized as overly complicated while serving as a reviewer for all three of its editions, weighs in at a daunting 250-plus pages. Invasive procedures, in contrast, are more technically challenging, immediately gratifying, and reimbursable.

And it is ironic that personalized educational approaches, which patients so appreciate in their physician, take a backseat in these courses to the higher-cost technological and pharmacological interventions of which we are so enamored. Even among non-technical interventions, the cardiology and medical school communities alike have paid little more than lip service to smoking prevention and cessation, in stark contrast to treatments for, say, hypertension and hyperlipidemia.

We all acknowledge that managing hypertension and hyperlipidemia involves a strong component of education in lifestyle modification. Merely providing a prescription for a modestly effective, highly promoted, and high-priced medication for smoking cessation or a nicotine replacement product that a patient can already purchase over the counter is woefully inadequate. Fully a third to a half of patients who smoke say they have not been advised by their physicians to stop. And among those who are counseled, we do not even know what is said or how the subject comes up. Incredibly, such direct observation in the course of normal clinical practice has never been studied.

In addition to that perceived lack of intellectual challenge, I also have observed the lack of self-efficacy on the part of physicians, the reluctance to risk offending patients, the push by drug and device companies for a pharmacologic and electronic approach to heart disease and, until relatively recently, the lack of billable reimbursement for smoking cessation.

What's urgently needed, and long overdue, in my opinion, are engaging, longitudinal, continuity-of-care experiences in lifestyles education and behavior modification of patients by medical students beginning in their first year and continuing in each phase of medical school and residency training. Sadly and astonishingly for all the lip service paid to the toll taken by tobacco, such a curricular component does not yet exist at a single medical school. The result is that residents and upper level medical students know a decent amount about even rare cardiovascular conditions but next to nothing about enhancing patients' ability to stop smoking, to lose weight, to exercise, or even to relax.

I am disappointed that medical schools in general and cardiology courses in particular are not placing the most preventable cause of heart disease among their highest priorities. With a venerable tradition of world-renowned cardiologists on its faculty, we hope that Emory will be in the vanguard of this effort. Nearly half a century after the publication of the landmark Surgeon General's report on Smoking and Health, I expect nothing less.