



ADVISING PATIENTS TO STOP SMOKING TO THE EDITOR:

An otherwise useful review by Okuyemi, Ahluwalia, and Wadland¹ of the evaluation and treatment of tobacco use disorder promotes asking every patient about tobacco use at every visit. We conducted a qualitative interview study with smokers. Several found being asked about smoking at visits for non-smoking-related conditions intrusive and offensive.²

A 53-year-old woman commented, "If I went down there [to the doctor] with a broken finger, they would say, 'Do you smoke?' They blame smoking for everything. It aggravates me." A 30-year-old woman said, "I found that when I've gone up for a bad ankle, he said, 'You shouldn't smoke.' I think, 'Well, I have not come about that.' There is a certain doctor . . . that I won't see . . . because of smoking." We obtained accounts of individuals who altered their help-seeking behavior in ways that could seriously harm their health to avoid ritualized interventions about smoking.

There appears to be an assumption that the 5As approach (ask, advise, assess, assist, and arrange) is free of adverse effects. But as with any intervention, it has potential disadvantages. Our study provided evidence that giving brief advice regarding smoking cessation may damage patient-physician rapport, increase resistance to change, and result in patients' failure to consult physicians for serious symptoms. Studies evaluating interventions, such as the 5As approach, have not adequately evaluated adverse effects. Until the potential harm is better studied, clinicians should remain cautious about implementation.

*Christopher C. Butler, MD
Faculty of Health Sciences
McMaster University
Hamilton, Ontario, Canada*

DR OKUYEMI RESPONDED AS FOLLOWS:

The purpose of our article was to summarize the best evidence on the evaluation and treatment of tobacco use disorder in a format useful to practicing physicians. Our review promotes the assessment of tobacco use status at every visit, as recommended by the US Public Health Service Clinical Practice Guideline panel.

The issue raised by Dr Butler is not new or unique

to smoking cessation. For various chronic medical conditions, patients may not appreciate physicians' advice on treatment adherence. Many physicians encounter patients who are offended at first by medical advice, only to express gratitude for it later. The clinical practice guideline recommends that tobacco use be treated like other chronic medical conditions and be considered a fifth vital sign. Since more than 400,000 deaths a year are attributable to smoking and approximately \$100 billion in direct medical and indirect nonmedical costs is incurred, smoking cessation advice should be provided often and repeatedly.

The qualitative study by Butler and colleagues² of 42 patients found that patients did not believe physicians' words could influence their smoking, but this is contrary to consistent findings by a vast majority of studies. Some have suggested that advice to quit should be given only during "smoking-related" visits or "teachable moments."³ Following this precept violates principles of primary prevention: to intervene before medical consequences have occurred.

Physicians should not badger patients. A patient with a sprained ankle could be told, however, "I noticed that the nurse recorded that you were a current smoker. It is in your best interest to quit. If you would like to talk about it now, we can do so. Otherwise, we can discuss it at another visit. Here is a handout." Rather than suggesting reasons for physicians not to advise patients to quit smoking at every opportunity, discussions in the literature should focus on training physicians to tailor their advice to each patient's readiness to change.

*Kola Okuyemi, MD, MPH
Kansas City, Kansas*

REFERENCES

1. Okuyemi KS, Ahluwalia JS, Wadland WC. The evaluation and treatment of tobacco use disorder. *J Fam Pract* 2001; 50:981-7.
2. Butler CC, Pill RM, Stott NCH. A qualitative study of patients' perceptions of doctors' advice to quit smoking; implications for opportunistic health promotion. *BMJ* 1998; 316:1878-81.
3. Jaen CR, McIlvain H, Pol L, Phillips RL Jr, Flocke S, Crabtree BF. Tailoring tobacco counseling to the competing demands in the clinical encounter. *J Fam Pract* 2001; 50:859-63.

WHICH DATABASE FOR WHICH SEARCH?

TO THE EDITOR:

By ranking electronic databases according to the percentage of questions answered, Brian S. Alper and colleagues¹ imply that all electronic databases

are alike and can be compared in this fashion. They omit the key second step in the process of efficiently finding good answers to one's clinical questions: to devise a search strategy that answers the question, "Which database is most likely to efficiently yield the answer I'm seeking?"

Evidence-based medicine (EBM) databases, such as TRIP, and journals of secondary publication that catalogue high-quality, predigested information are small, but the answers found are more likely to approximate the best available evidence. However, searching them will be futile if one's question pertains to an issue for which good evidence on the topic does not exist. This explains the low ranking of TRIP in contrast with databases such as MDConsult, which are information rich and produce sensitive searches (yield more answers) but lack built-in quality filters (the answers don't necessarily represent the best available evidence).

Take, for example, the following question: "What is the safest and most effective drug treatment for a 2-month-old infant who is not gaining weight because of severe gastroesophageal reflux disease (GERD)?" MDConsult yielded 3 textbook references, 595 journal articles, and 13 guidelines. The sheer volume of citations precluded me from satisfactorily answering my question.

In contrast, TRIP yielded 5 evidence-based links, one of which was relevant to my patient but provided an incomplete answer (less sensitive, more specific). For this question, DynaMed proved to be the most appropriate database, confirming the lack of efficacy of cisapride; recommending ranitidine as first-line therapy, based on its safety and efficacy; and providing the appropriate dose and a reference.

Unfortunately, there is currently no "one-size-fits-all" electronic database. Different questions are best answered by different databases. This situation requires clinicians to develop a pragmatic search strategy that will direct them to the database most likely to yield the answer to each question as it arises.

*Eamon C. Armstrong, MD
Lehigh Valley Hospital
Allentown, Pennsylvania*

DRS ALPER, STEVERMER, WHITE, AND
EWIGMAN RESPONDED AS FOLLOWS:

Dr Armstrong makes several excellent points. We agree that individual electronic databases have unique

strengths and weaknesses. The ideal database would be valid, relevant, convenient, fast, and affordable. Since we lacked the resources to evaluate all these factors, investigators and consultants from the Family Practice Inquiries Network (FPIN) Consortium agreed that the ability to obtain an adequate answer was the single most important factor for this initial study. We defined an answer as adequate if it provided a reasonable course of action for a family physician. This approach is used by most clinicians; research shows that convenient and relevant resources are selected over evidence-based resources.²⁻⁴

We also agree that clinicians need pragmatic search strategies. An individual's specific strategy depends on available resources, types of information sought, experience and skill of the searcher, and an understanding of what can be found. We are currently conducting research to better define such strategies. As members of FPIN, we share the goal of creating a single database using the best existing evidence and designed for the practicing family physician, thereby simplifying this process.

In the meantime, for searches that maximize both validity and efficiency we currently recommend initial searches using evidence-based databases followed by searches using highly referenced databases. Evidence-based databases have been developed through systematic literature searching (eg, Clinical Evidence or the Cochrane Library) or through systematic literature surveillance (eg, ACP Journal Club Online, DynaMed, InfoRetriever, or TRIP). Highly referenced databases provide reference support specifically linked to included statements. Among these databases are DynaMed, Praxis.MD, Scientific American Medicine, and UpToDate.

*Brian S. Alper, MD, MSPH
James J. Stevermer, MD, MSPH
David S. White, MD
Bernard G. Ewigman, MD, MSPH
University of Missouri School of Medicine
Columbia
www.fpin.org*

REFERENCES

1. Alper BS, Stevermer JJ, White DS, Ewigman BG. Answering family physicians' clinical questions using electronic medical databases. *J Fam Pract* 2001; 50:960-5.
2. Ely JW, Osheroff JA, Ebell MH, et al. Analysis of questions asked by family doctors regarding patient care. *BMJ* 1999; 319:358-61.
3. Gorman PN, Helfand M. Information seeking in primary care: how physicians choose which clinical questions to pursue and which to leave unanswered. *Med Decis Mak* 1995; 15:113-9.
4. Connelly DP, Rich EC, Curley SP, Kelly JT. Knowledge resource preferences of family physicians. *J Fam Pract* 1990; 30:353-9.

JFP