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COMMENTARY

System-centred tobacco management: From 'whole-person' to 'whole-system' change

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Abstract

Patient-centred tobacco management is a pragmatic approach for helping smokers achieve their goals in terms of either cessation or harm reduction. However, the success of the approach is dependent on clinicians embracing and delivering it as intended. There are a number of structural and systemic organisational barriers which are limiting clinician-delivered patient-centred tobacco dependence. In response, 'whole system' approaches which help support clinicians in the delivery of patient-centred tobacco management are required. Health system changes to support clinicians and facilitate the delivery of patient-centred tobacco management are worth further investigation, particularly in settings where tobacco smoking rates are high. [Bonevski B. System-centred tobacco management: From 'whole-person' to 'whole-system' change. *Drug Alcohol Rev* 2014;33:99–101]

Key words: smoking cessation, nicotine dependence, patient-centred care, systems change.

In this issue of the journal, Gould provides a timely and well-thought out reminder to all clinicians for the need to provide tobacco management that is tailored to the individual smoker or patient centred [1]. In contrast to disease-centred care, patient-centred care is a 'whole person' orientation to health care that en courages partnerships between clinicians, patients and families to deliver medical care that is attentive to the needs, values and preferences of patients [2]. Traditionally, patient-centred care is used to refer to the standards of care that should apply to people with a clinical condition when providing these patients with medical treatment. It is time that this approach is extended to include management of health risk factors, such as tobacco smoking, and not only clinical care [3]. Gould's article provides a useful guide for clinicians on the key elements of patient-centred care for tobacco management [1].

The evidence for the effectiveness of tobacco-dependence treatment is some of the strongest available for any therapeutic procedure and supported by numerous trials (see the entire Cochrane Collaboration Tobacco Addiction Review Group reviews for a comprehensive list of treatments that do and do not work). A combination of behavioural counselling techniques and stop smoking medicines is well supported by the evidence [4], and to facilitate a tailored approach, a number of algorithms [5,6] and options for treatments—for example, abrupt stopping or gradual reduction in smoking [7]—are available. Clinical practice guidelines and standards for clinicians provide clear guidance for tailoring therapy for people at different points in the quitting smoking continuum and with varying levels of nicotine addiction [8,9].

Patient-centred care is not only about *which* tobacco treatments are delivered but *how* the treatment is delivered [10,11]. Enhanced communication skills, family involvement, access to information and shared decision making are central components of the paradigm [2,11]. These considerations are important in the context of

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a tobacco smoking population which is increasingly demonstrating lower education levels, lower health literacy, limited access to health services and limited involvement in care [12,13]. There is growing evidence that involving people in their health care is fostering their sense of self-determination and self-responsibility, and has positive effects in terms of motivation to change health behaviours and adherence to health interventions [14].

The question then becomes not whether we should be promoting a patient-centred approach to tobacco management, but of how to encourage clinicians to provide patient-centred tobacco management. There is ample evidence that clinicians struggle to provide their patients with even brief advice to stop smoking both in the primary care [15,16] and hospital settings [17].

Clinicians do not avoid providing patient-centred tobacco management because they choose not to or due to a lack of evidence of effectiveness. They fail to provide patient-centred tobacco management because they lack time, skills, experience, confidence, support staff, resources, and often in some settings, organisational support and policies to address tobacco effectively [17,18]. These are all enabling factors, and without them it is difficult to change clinician practices. Building a system around clinicians which enables, and even promotes, patient-centred tobacco management to be conducted would seem a crucial missing piece of the puzzle. To fill this gap, more research is needed on the effectiveness of systems change interventions that aim to help organisations and clinicians provide patient-centred tobacco management.

Originating in the USA [19,20], the systems change approach acknowledges that it is not the individual clinician that decides what standard or type of care an individual patient should receive. Rather, it is a 'whole system' orientation which focusses on the organisational and systemic factors that influence the quality of care provision. It also aims to build the capacity of organisations and staff within them to address tobacco smoking. It provides a number of strategies that health service administrators, managers and staff can adopt to facilitate delivery of tobacco-dependence treatment. Table 1 summarises some of the key strategies of the approach adapted for the Australian setting.

While the evidence base for systems change for tobacco management is growing [20,21], there continue to be substantial unknowns in this field. In particular, the effectiveness of systems change strategies at promoting the delivery of patient-centred tobacco management in settings that care for socio-economically disadvantaged populations, such as mental health and addictions treatment settings, remains untested [22]. These treatment services provide care for populations with high smoking rates who, as a result, experience heightened health and financial burden due to tobacco. Non-health settings such as Prisons and social and community service organisations are also practical settings for reaching smokers from socio-economically disadvantaged groups [22,23]. Promoting patient-centred tobacco management in these settings is likely to result in the highest yield of beneficial effects by reducing inequities in tobacco-related disease burden.

Table 1. *Systems-level strategies to facilitate patient-centred tobacco management*[a]

	Strategy
1	Implement a tobacco-user identification system in every clinic. Assess smoking status, nicotine dependence and record on patient notes.
2	Provide education, resources and feedback to promote clinician action. Include training in communication and counselling skills.
3	Dedicate staff to provide tobacco-dependence treatment and assess the delivery of this treatment in staff performance evaluations.
4	Promote clinic policies that support and provide tobacco-dependence treatments.
5	Offer tobacco dependence treatments free of charge or subsidised.
6	Reimburse clinicians for delivery of effective tobacco-dependence treatments and include these interventions among the defined duties of clinicians.

[a]Adapted from Reference [19].

Figure 1. *Illustration of whole of system approach leading to patient-centred tobacco management.*

Conclusion

Patient-centred tobacco management is a pragmatic approach for helping smokers achieve their goals in terms of either cessation or harm reduction. However, the success of the approach is dependent on clinicians embracing and delivering it as intended. There are a number of structural and systemic organisational barriers which are limiting clinician-delivered patient-centred tobacco dependence. In response, 'whole system' approaches which help support clinicians in the delivery of patient-centred tobacco management are required (see Figure 1). Health system changes to support clinicians and facilitate the delivery of patient-centred tobacco management are worth further investigation, particularly in settings where tobacco smoking rates are high.

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