Declaration of interest

T.B.B has not served as a paid consultant to any for-profit interests related to this work; he has served as a paid and non-paid consultant to governmental and non-profit interests related to this work. M.C.F. has not served as a paid consultant to any for-profit interests related to this work; he has served as a paid and non-paid consultant to governmental and non-profit interests related to this work.

Acknowledgement

This work was supported by NCI award 1 P01 CA180945-01.

Keywords Chronic care, primary care, smoking treatment, motivation, cessation, unwilling smokers.

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References

1. Richter K., Ellerbeck E. It’s time to change the default for tobacco treatment. Addiction 2015; 110: 381–386.
2. Centers for Disease Control and Prevention. Quitting smoking among adults—United States 2001–2010. Morb Mortal Wkly Rep 2011; 60: 1513–9.
3. Hughes J. R., Solomon L. J., Fingar J. R., Naud S., Helzer J. E., Callas P. W. The natural history of efforts to stop smoking: a prospective cohort study. Drug Alcohol Depend 2013; 128: 171–4.
4. Fiore M. C., Jaen C. R., Baker T. B., Bailey W. C., Benowitz N., Curry S. J. et al. Treating Tobacco Use and Dependence: 2008 Update. Rockville, MD: US Department of Health and Human Services, US Public Health Service; 2008.
5. Dijkstra A., de Vries H., Bakker M. Pros and cons of quitting, self-efficacy, and the stages of change in smoking cessation. J Consult Clin Psychol 1996; 64: 758–63.
6. Kotz D., Brown J., West R. Predictive validity of the Motivation To Stop Scale (MTSS): a single-item measure of motivation to stop smoking. Drug Alcohol Depend 2013; 128: 15–9.
7. Smit E. S., Hoving C., Schelleman-Offermans K., West R., de Vries H. Predictors of successful and unsuccessful quit attempts among smokers motivated to quit. Addict Behav 2014; 39: 1318–24.
8. Curry S. J., Grothaus L., McBride C. Reasons for quitting: intrinsic and extrinsic motivation for smoking cessation in a population-based sample of smokers. Addict Behav 1997; 22: 727–39.
9. Castro Y., Cano M. A., Businelle M. S., Correa-Fernandez V., Heppner W. L., Mazus C. A. et al. A cross-lagged path analysis of five intrapersonal determinants of smoking cessation. Drug Alcohol Depend 2014; 137: 98–105.
10. Smith S. S., Fiore M. C., Jorenby D. E., Baker T. B. Data analytic report from a single-center, parallel, randomized, double-blind, placebo-controlled, 1-year pilot study of the effects of Zyban (bupropion hydrochloride sustained release tablets) as an aid to smoking cessation in adult chronic cigarette smokers who are not motivated to quit smoking. Protocol AK1A4010. Unpublished manuscript available from the authors. 2000.
11. Laska K. M., Gurman A. S., Wampold B. E. Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. Psychotherapy (Chic) 2014; 51(4): 467–481.
12. Baker T. B., Mermelstein R., Collins L. M., Piper M. E., Jorenby D. E., Smith S. S. et al. New methods for tobacco dependence treatment research. Ann Behav Med 2011; 41: 192–207.
13. Schlam T. R., Baker T. B. Interventions for tobacco smoking. Invited review. Annu Rev Clin Psychol 2013; 9: 675–702.
14. Cook J. W., Mermelstein R. J., Schlam T. R., Piper M. E., Smith S. S., Jorenby D. E. et al. Identifying optimal strategies for increasing smokers’ motivation to quit. 20th Annual Convention of the Society for Research on Nicotine and Tobacco (SRNT), Seattle, WA, 2014.
15. Piper M. E., Schlam T. R., Cook J. W., Smith S. S., Jorenby D. E., Mermelstein R. J. et al. Identifying optimal smoking cessation intervention components for smoking cessation. 22nd Annual Meeting of The Society for Prevention Research (SPR), Washington, DC, 2014.
16. Piper M. E., Baker T. B., Mermelstein R., Collins L. M., Fraser D. L., Jorenby D. E. et al. Recruiting and engaging smokers in treatment in a primary care setting: developing a chronic care model implemented through a modified electronic health record. Transl Behav Med 2013; 3: 253–63.
17. Moore D., Aveyard P., Connock M., Wang D., Fry-Smith A., Barton E. Effectiveness and safety of nicotine replacement therapy assisted reduction to stop smoking: systematic review and meta-analysis. BMJ 2009; 338: b1024.
18. Ellerbeck E. F., Malherke J. D., Cupertino A. P., Cox L. S., Greiner K. A., Musselman L. M. et al. Effect of varying levels of disease management on smoking cessation: a randomized trial. Ann Intern Med 2009; 150: 437–46.

THE ETHICS OF AN OPT-OUT DEFAULT IN TOBACCO TREATMENT

In their paper [1], Richter & Ellenberg advance an argument that a key way to improve public health is to reduce the number of smokers by increasing the uptake of tobacco cessation (and, one might add, harm reduction) programmes by current smokers. They note that in many health systems the default position is that patients seeking clinical care are only offered tobacco treatment if, in the opinion of the clinician, they are either expressing a wish to quit smoking or otherwise give signs of ‘readiness to quit’. They argue further that this creates a barrier to treatment, which can be removed by mandating clinicians to offer tobacco treatment to all patients who smoke without assessing ‘readiness to quit’, leaving the decision to the patients as to whether or not they take up this offer of treatment. The theory here is that some patients who might otherwise not have been considered ‘ready to quit’ by their clinicians will accept the offer of treatment, and that some...
of those will complete treatment successfully. Moreover, it is assumed that no (or minimally few) patients who would accept treatment under the current default will reject it under the new default. While the authors mention the possibility that the simple offer of treatment, by communicating implicitly that the treatment will be beneficial to the patient, will actively influence some patients to agree, they do not rely on this influence as the mechanism of action underlying the intervention. They simply suggest that offering treatment to more people will probably lead to more people accepting the offer, with net beneficial consequences.

The strongest part of their practical argument is the claim that requiring clinicians to assess the patient’s readiness to quit before offering treatment is inefficient and unreliable in identifying which patients will accept treatment and may complete it. What this boils down to, when we strip away the fashionable language of ‘nudges’, is the proposal that clinicians should offer tobacco treatment to any patient who needs it, and that the test of need is simply that the patient is a tobacco user. It is the patient’s behaviour which is the clinical sign, not their psychological state (readiness or otherwise to quit). This seems reasonable. The authors present some suggestive evidence which indicates that offering treatment to all smokers is effective, and it does not put off patients from accepting or completing treatment.

The ethical status of the proposed shift to an ‘opt-out’ default is more complicated. One detail is that the default being changed here is the default for the clinician, not the patient. In any medical treatment, the patient is offered treatment in line with the clinician’s judgement of what is in their best interests, and the patient refuses or accepts. In this sense, all medical treatment has an opt-out default from the patient’s point of view. Thus, Richter & Ellenberg’s intervention is really targeted at clinicians’ behaviour. The question then arises as to whether they have shown whether there is evidence for the efficacy of interventions to change clinicians’ behaviour; they have not. Some clinicians will offer treatment, some will not, as before. The intervention here is, in a sense, to call ‘offering all patients treatment’ a ‘nudge’ or ‘default change’ will be more or less influential on clinicians’ behaviour.

Another detail concerns the impact of this intervention on the clinician–patient relationship. It is already debated whether treating lawful, albeit harmful, behaviours as clinical disorders is acceptable to patients. Similarly, there is room for debate over whether there is a distinction between treating illness and actively promoting health and wellbeing, and whether, if such a distinction holds, there is a difference between a moral imperative to promote health and wellbeing in the same way that there is a clinical obligation to treat illness. Pure ethics aside, at least some patients will resent the offer of tobacco treatment when their primary presenting complaint is something (they say as) unrelated—for instance, arthritis or depression. One way to put the point is this: assessing the ‘readiness to quit’ might be understood as ‘getting to know the patient’ and establishing a clinical relationship which has the quality of care and respect. Simply requiring clinicians to default to an offer of treatment as a matter of standard practice without taking note of the importance of this relationship might prove to be offensive to some patients and counterproductive in more.

In conclusion, while Richter & Ellenberg have a sensible proposal, we need a better understanding of whether it works in practice, and what impact it has on clinician–patient relationships, before we can agree that an opt-out for the offer of treatment is mandatory best practice.

Declarations of interest

The author is a member of the Tobacco Advisory Group of the Royal College of Physicians of London. The author has no financial or other connections with the tobacco, alcohol, or gaming industries, and no conflicts of interest arising from organizations that seek to provide help with or promote recovery from addiction.

Keywords  Behaviour change, medical ethics, nudges, public health, tobacco, tobacco treatment.

Acknowledgements

The writing of this article was part funded by the Medical Research Council, via the UK Centre for Tobacco and Alcohol Studies, reference MR/K023195/1.

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Reference

1. Richter K. P., Ellerbeck E. F. It’s time to change the default for tobacco treatment. Addiction 2015; 110: 381–386.

RESPONSE TO COMMENTARIES:
CHANGING THE TREATMENT DEFAULT WILL IMPROVE DECISION-MAKING

The title of Baker & Fiore’s [1] response summarizes well the goal of this debate—how to treat more smokers, better. Authors in this debate [1–3] agree on many points, especially the importance of patients and providers working together to determine the course of treatment. However, assessing willingness to quit—or even assessing treatment goals—before discussing treatment options could lead to unnecessarily poor decision-making.