Cigarettes kill half their lifelong users.[1][2]

Different countries are at different stages of smoking epidemic, with a three to four decade lag between the peak in smoking prevalence and the subsequent peak in smoking related deaths.[1] Worldwide, approximately 5 million people will die from tobacco-related illnesses this year. By 2030, it is estimated that this figure will have doubled.[3]

The smoking epidemic
Adapted from Lopez AD, Collishaw NE, Piha T. A descriptive model of the cigarette epidemic in developed countries. Tobacco Control 1994; 3: 242-247

Around one billion people smoke worldwide, with over three-quarters of the world's smokers living in low- and middle-income countries, [4] where smoking rates are increasing rapidly. Even within European countries, smoking prevalence is higher in lower socioeconomic groups contributing substantially to health inequalities.[5][6]

The prevalence of smoking has been falling in most high-income countries for the past two decades but in low- and middle-income countries smoking rates are increasing.[4] Moreover, people from lower-income countries are generally less aware of the well-documented health risks from smoking and the substantial health benefits of smoking cessation.[4]

Healthcare professionals are at the forefront of the action against smoking. This IPCRG smoking cessation guideline, which draws on expertise from a range of countries, (see List of contributors) aims to offer practical advice for primary care clinicians working in countries at all stages of the epidemic.

The benefits of quitting
Stopping smoking leads to significant health benefits to the individual, some of which (such as oxygen levels returning to normal and elimination of carbon monoxide) occur within hours.[7] Other health improvements (recovery of taste, decline in coughing and wheezing) take a few months, and benefits (such as reduction of cardiovascular and cancer risk) continue to accrue over years (see Beneficial effects of stopping smoking). Preventive approaches with young people can prevent disease 30-50 years in the future, whereas smoking cessation in current adult smokers brings population health
gain more quickly, over 20 to 30 years.[8]

The role of government policy
Many governments have instituted tobacco control policy changes that help to create a more supportive environment for smokers who want to quit. Effective policies include bans on tobacco advertising and sponsorship, regular price rises, stronger public health warning labels, smoking bans in all public places (workplaces, restaurants, bars and pubs).[9] Support for smoke free policies typically increases among smokers and non-smokers alike once the policies are introduced.[9]

Any healthcare professional who wishes to support moves to lobby for population-level tobacco control policies can access guidance from Action on Smoking and Health. www.newash.org.uk/

Many patients want to quit
Nearly three quarters of smokers report that they want to stop smoking when asked in surveys and studies.[10] Unaided quit attempts are common, but the success rate is low. Nicotine is highly addictive; smoking is a chronic relapsing condition, and in the general population of smokers trying to stop, the relapse rate is high. The natural population cessation rate, measured over a long period in one country where the tobacco control movement is long established, is less than 2% each year.[12]

What can primary care do?
At the very least, primary care health professionals could consider creating a ‘smoke-free’ surgery (see 2. Creating a smoking aware practice) where smoking is banned and smoking cessation literature (quit booklets, leaflets, stickers, quitline numbers) is available to patients in the waiting area.

At an individual patient level, primary care health professionals can influence smoking rates in their country by systematically providing opportunistic advice and offering support to all attending patients who smoke. (see 2. Creating a smoking aware practice, 3. Quitlines and other sources of support, 4. Supporting quit attempts: a motivational approach). Brief smoking cessation intervention in primary care is effective, with reported quit rates of 2 to 3%. [13] Pharmacological approaches to smoking cessation enhance quit rates following brief advice and behavioural support, though not all licensed products are available in all countries. (see 5. Pharmacotherapies to assist smoking cessation). The combination of brief advice coupled with use of pharmacotherapy, proactive follow up and linkage with a quit line can result in quit rates of up to 20%.[14] [15]

Most smokers see their family doctor at least once a year.[16] Offering primary care doctors the opportunity to offer at least brief advice on smoking cessation. Many highlight the family doctor as a key source of advice (and influence) about smoking.[17] [18] Despite professional concerns about possible negative impacts on the consultation, patient satisfaction with the consultation is generally higher when smoking is addressed.[19][20]

Nurses and lay advisors also have a role to play in offering effective smoking cessation interventions and can be important collaborators in primary care efforts to support smoking cessation where primary care nurse support is available.[21]

Time constraints are a real issue in primary care and though quit rates are significantly higher with intensive intervention the quit rate achieved from a brief intervention of only a few minutes is still worthwhile (see 2. Creating a smoking aware practice). Think about a one minute smoking cessation strategy that could be used with all patients who smoke.[22]

Barriers to smoking cessation
Smoking cessation is difficult and there are a number of patient barriers to quitting, including:

- Nicotine is highly addictive.[23] Significant withdrawal symptoms occur in at least half of smokers when they try to quit.[24] (see Effects of nicotine withdrawal).
- Smokers find it difficult to imagine life without cigarettes;
- Some smokers believe that they should be able to quit without help;
- Long-term successful quitting may require a number of quit attempts and relapses may put patients off making a renewed effort.
- Some smokers may not fully realise the health risks attached to smoking or, indeed, accept them.
- Some smokers may have a limited repertoire of strategies to deal with negative emotions.[25]
- Some smokers may have a misperception that quitting is easy so no need to tackle the problem now.[26]
Moreover, a number of primary care physician barriers may impede seeking and taking the opportunity to give smoking cessation advice. These include:

- The belief that giving brief advice is ineffective and unlikely to yield benefit
- Concern over upsetting patients due to sensitivities about smoking;
- Reluctance to jeopardise doctor-patient relationship.[27]
- Perceived lack of patient motivation
- Lack of time;
- Lack of training, skills and resources,[28][29] resulting in use of ineffective strategies and under-use of effective interventions.[30][31][32]

The IPCRG smoking cessation practical guidance
The following chapters provide primary care clinicians with practical guidance for supporting smoking cessation within their practices.

1. Creating a smoking-aware practice
2. Quitlines and other sources of support
3. Supporting quit attempts: a motivational approach
4. Pharmacotherapies to assist smoking cessation
5. Alternative approaches to smoking cessation
6. Smoking cessation advice for special groups

The guidance has been developed with expertise from a number of countries [link to list of contributors] and in consultation with all member countries of the IPCRG. Many of these countries have smoking cessation advice available in a range of languages including some full evidence-based guidelines.