Delivering Tobacco Control Interventions in Adolescent Health Care Visits: Time for Action

In this issue of *Pediatrics*, Schauer et al1 from the Centers for Disease Control and Prevention’s Office on Smoking and Health report on data from the 2011 Youth Tobacco Survey, a nationally representative sample of >18,000 6th- through 12th-grade students. They examined tobacco use and tobacco control measures, the rate of smoking, and the likelihood of being asked about smoking and being advised to quit or assisted with quitting by a clinician.

This year marks the 50th anniversary of the first Surgeon General’s report on tobacco.2 In these 5 decades, the evidence base for the harms caused by tobacco and for the opportunity for clinicians to prevent initiation and to promote smoking cessation have continued to grow stronger. As has been seen in other youth surveys, >90% of the adolescents in this survey reported having seen a clinician in the past year. Nonetheless, rates of discussing tobacco remain relatively low, despite clear evidence for the harms of tobacco use and increasingly strong recommendations for routine counseling for prevention and cessation. These findings are critically important for child and adolescent health care delivery and should challenge both researchers and clinicians. The 4As (Ask, Advise, Assess, Arrange) tobacco cessation counseling guidelines have existed for decades; and specific pediatric and adolescent guidelines, adding the fifth A (Anticipate) for anticipatory guidance, date to 1991.3 The adolescents surveyed have health care encounters, as is true for most teens and even most young adults,4 and adolescents are highly accurate in reporting the care they have received from their clinician.5 But the majority of adolescents’ health care encounters and clinical visits did not include discussion or interventions into the leading preventable cause of disease and death. Although the prevalence of being asked and advised about smoking was highest among youth who were smokers, these numbers, too, were low, reaching barely half of smokers with counseling interventions.

Many of the interventions needed to protect children, youth, and nonsmokers from tobacco require policy changes, rather than clinical interventions. Nonetheless, these findings are an important reminder that clinical interventions are also needed and that fully implementing strongly recommended evidence-based guidelines remains a difficult goal. It is important to recognize that this problem is not unique to pediatric care or to adolescents. For example, among adults who saw a physician or other clinician in the past year, only 66.7% of smokers were counseled to quit, 23.2% of respondents were asked about secondhand smoke exposure, and only 17.3% were advised to keep their homes smoke-free.6

Without more vigorous action to achieve universal screening and counseling, effective cessation delivery and eventual elimination of tobacco and nicotine addiction remain an elusive goal. These rates of adolescent

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tobacco prevention and cessation counseling in primary and specialty care settings are a painful reminder of how slow our health care system is to adopt even highly effective, low-cost, lifesaving interventions. Numerous tools exist to help clinicians implement tobacco cessation counseling and to ask the right questions in their practices (see www.aap.org/richmondcenter). However, additional new investments and efforts to implement clinical practice change are urgently needed. Our society and our patients cannot afford another 50 years of premature death and disease from tobacco.

REFERENCES


IF THE SHOE (COLOR) FITS, WEAR IT: Our family loves soccer. My children played youth soccer for their high school and college teams, so we had dozens of old, used, and outgrown cleats around the house (which we have since donated to families with young children). One interesting observation was that only the more recently purchased cleats were anything but black. I remember my daughter buying the first colorful pair: they were grey with an orange heel. I appreciated the color, as while I could usually distinguish my daughter from other blond pony-tailed soccer players, it was easier to pick her out of the crowd with her orange cleats. As reported in The New York Times (Fashion & Style: June 6, 2014), colorful cleats are the new normal. I watched many World Cup soccer games this summer and I do not think I saw a single player wearing black cleats. Instead, players were wearing red, bright green, pink, and even multi-colored cleats.

There are several reasons for the explosion in colorful footwear. One is that players want to be expressive. Another is that synthetic materials are now quite comfortable and can more easily be dyed than kangaroo leather (that many players had historically preferred). Finally, marketing is quite important and fashion is big business. Sales for colored shoes have dramatically increased among youth players in recent years and at least one company expects that 80% of cleats on sale this summer will be brightly colored. Cleat makers know that soccer cleats worn during the World Cup are the only piece of major equipment that does not have to be produced by a single manufacturer. This means that while the shirt, shorts, and socks all have to be produced by the same company, each soccer player can choose any cleats he desires. So, if Lionel Messi is wearing lizard green cleats and scores several goals, his cleats may attract more attention to the shoe maker and improve sales. Now, if only lizard green cleats could actually make you play as well as Messi — that would be a feat!

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