Anti-smoking advice in general practice consultations: general practitioners' attitudes, reported practice and perceived problems

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SUMMARY

Background. *Anti-smoking advice from general practitioners has proven efficacy. However, general practitioners do not exploit a large proportion of opportunities to discuss smoking with patients.*

Aim. *A study aimed to explore general practitioners' attitudes towards discussing smoking with patients and to assess how these influence the quantity of anti-smoking advice that general practitioners report giving during routine consultations. It also aimed to determine the extent to which general practitioners report using evidence-based interventions against smoking and to discover the problems they experience when discussing smoking with patients.*

Method. *A postal survey of all 468 general practitioners on the Leicestershire Family Health Services Authority list was conducted. General practitioners' attitudes were assessed by scoring 13 attitude statements using a six-point Likert-type scale. They were also asked to rank (from a list of 12 items) the five approaches that they found most productive and (from a list of 11 items) the five problems that they most commonly encountered when giving anti-smoking advice to patients.*

Results. *A total of 327 questionnaires (70%) were returned. Most respondents (97%) thought that their advice was more effective when linked to patients' presenting problems and 65% reported that linking their anti-smoking advice to patients' presenting complaints was one of their three most preferred approaches to discussing smoking. Advising all presenting smokers to quit was considered by 40% of respondents to be an appropriate use of time but 76% reported that patients' lack of motivation was one of the three most commonly encountered problems. An analysis of the ratings of the 13 statements suggested that general practitioners who reported the greatest smoking cessation activity during routine consultations held more positive attitudes towards discussing smoking with patients.*

Conclusion. *This study suggests that general practitioners believe that their anti-smoking advice is more effective when linked to patients' presenting complaints, and this belief appears to be reflected in the way in which general practitioners approach smoking cessation with patients. The findings may indicate that general practitioners are unlikely to accept a role in a population-based anti-smoking strategy which demands that they discuss smoking with all presenting smokers.*

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Introduction

SMOKING remains a massive public health problem in the United Kingdom.[1] Brief anti-smoking advice given by general practitioners in routine consultations has been demonstrated to have a beneficial effect on patients' smoking cessation rates.[2] Recent reviews have recommended that general practitioners give brief anti-smoking advice to the greatest possible number of smokers as the small effect that general practitioners have is magnified by smokers' repeated contacts with them.[3-5] It is estimated that 500 000 smokers would quit annually if all general practitioners in the UK adopted a population-based strategy of advising all presenting smokers to quit.[2] It has been suggested that the systematic application of this strategy should be a 'leading intervention' in a nationwide anti-smoking campaign,[6] and a Health Education Authority publication has urged general practitioners to enquire about the smoking habits of all patients.[1] Changes in general practitioners' health promotion payments[7] are likely to shift emphasis to the consultation as the setting where patients receive most anti-smoking advice in general practice. Consequently, the development of brief interventions against smoking for use by general practitioners has been identified as one of the priorities for health promotion in primary care.[8] This seems to be a sensible recommendation as it has been found that a simple protocol that can easily be incorporated into daily practice increased the amount, quality and effectiveness of anti-smoking advice delivered by doctors in the United States of America.[9] A call has been made to develop similar protocols for use in the UK.[3]

Unfortunately, it has been found that many general practitioners do not exploit every opportunity during consultations to discuss smoking.[10,11] The reasons for this remain unclear. Lack of time and inadequate training have been suggested as possible constraints to general practitioners using interventions against smoking.[12] Research shows that general practitioners hold positive attitudes towards their role in promoting smoking cessation,[12-14] but it is not known whether general practitioners' attitudes can influence their smoking cessation activity during routine consultations. A study was undertaken that aimed to explore this question. It also aimed to describe the extent to which general practitioners report using evidence-based interventions against smoking when attempting to persuade smokers to quit, and to discover the problems faced by general practitioners when discussing smoking with patients.

Method

Questionnaire and sample

A questionnaire was piloted in the Leicester University Department of General Practice. A revised pilot questionnaire was sent to 20 general practitioners selected randomly from the Nottinghamshire Family Health Services Authority list. The final

version was posted to all 468 general practitioners on the Leicestershire Family Health Services Authority list in May 1994. Two reminders were sent to non-respondents. A regional sample was used because survey respondents were to be recruited to a follow-up study at a later date. Information on whether or not the general practitioners were members of the Royal College of General Practitioners was obtained from the RCGP membership list, and the number of years since each general practitioner qualified as a doctor was obtained from the medical register.

The questionnaire requested information on general practitioners' demographic details, whether any clinics or organized sessions to help patients stop smoking were run in the practice and whether the general practitioners had received any training in how to persuade patients to stop smoking. They were also asked to estimate the number of smokers that they had advised to stop smoking in their most recent surgery. The general practitioners stated whether this surgery was typical of their usual practice.

Attitude statements

General practitioners' attitudes towards discussing smoking during routine consultations were explored by 13 attitude statements[15] using a six-point Likert-type scale. Respondents could choose one response from strongly agree (scoring one) to strongly disagree (scoring six). The scale had no neutral point, forcing a choice for each statement.

Five statements explored the extent to which general practitioners believed that they could be effective in promoting smoking cessation, as a lack of perceived effectiveness has been identified as a potential constraint to general practitioners' activity in promoting smoking cessation.[12] Another potential constraint, lack of time,[12] was explored in two statements. Another statement investigated whether general practitioners targeted their anti-smoking advice at selected patients. The other five statements were intended to measure general practitioners' enthusiasm for discussing smoking with patients, which the authors hypothesized may influence general practitioners' behaviour with regard to their provision of anti-smoking advice. The mean scores of general practitioners who reported advising more than two smokers (the modal value determined by this study) to quit during their most recent surgery (where reported as typical) were compared with the scores of general practitioners who reported advising two or fewer smokers to quit, using the Mann Whitney-*U* test.

Approaches to discussing smoking

General practitioners were presented with a randomly ordered list of 12 approaches to discussing smoking with patients and were asked to rank the five they found most productive, from most useful to fifth most useful. Some items were included because they have a proven effect on smoking cessation. Randomized controlled trials have shown that providing written anti-smoking advice[2,3] and prescribing nicotine replacement therapy[16] aid smoking cessation; follow up of smokers also has beneficial effects.[3,17] A review published in 1992 summarized the evidence that suggests that providing advice on how to deal with withdrawal symptoms, simultaneous peer group or family cessation, patients' self-belief in their ability to quit and gradually cutting down the number of cigarettes smoked are all associated with successful smoking cessation.[18] This review also summarized the evidence that attempts to give up smoking are more likely to succeed if the patient is motivated by health rather than financial considerations.[18] Thus, an item about exploring patients' motives for smoking or wanting to give up was included in the list. An item was included to assess whether general practitioners link their anti-smoking advice to patients' smoking-related problems because this has been shown to be a popular approach among general practitioners.[12] It should be noted, however, that the efficacy of this approach is untested in the UK. An item about smoking clinics was included because many practices run these. Frightening the patient and highlighting the dangers of passive smoking were both added after piloting revealed that these may be common approaches used by general practitioners. Adequate space was left for the respondents to add approaches to the list.

Problems when discussing smoking

From a randomly ordered list of 11 items, general practitioners were asked to rank the five problems that they most commonly encountered when discussing smoking with patients. Most of the items on the 'problems' list were obtained from a previous qualitative study[19] and a recent survey.[12] An item concerning respondents' smoking habits was included because it has been suggested that general practitioners who smoke are less likely than those who do not smoke to give anti-smoking advice to their patients.[20] The chi square test was used to compare details of respondents with those of non-respondents. All questionnaires were coded by T C and statistical analyses were run on *SPSSPC+ 4.0*.

Results

In total, 327 questionnaires were returned from 468 general practitioners, giving a response rate of 69.9%. One hundred and nineteen respondents (36.6%) were current members of the RCGP compared with 36 of the 141 non-respondents (25.5%) ($\chi^2 = 5.7$, 1 degree of freedom (df), $P<0.05$; data missing for two respondents) and 74 respondents (23.1%) qualified less than 10 years ago compared with 14 non-respondents (10.1%) ($\chi^2 = 10.8$, 1 df, $P<0.01$; data missing for six respondents and two non-respondents).

Of the 327 respondents, 150 (45.9%) reported that their practices held regular sessions to help smokers quit and 111 (33.9%) had received training in smoking cessation.

An estimate of the number of smokers advised to quit during the most recent surgery was given by 307 general practitioners, of whom 288 reported this surgery as being typical of their usual practice. The number of patients who were reported to have been advised to stop smoking were: six or more, by 2.8% of the 288 general practitioners; five, by 5.2%; four, by 7.6%; three, by 18.1%; two, by 34.4%; one, by 21.5%; and none, by 10.4%. The modal number of patients who were advised to stop smoking was two.

Attitude statements

Table 1 shows how general practitioners responded to the attitude statements. Responses have been dichotomized for simplicity. Of 320 respondents, 97.2% agreed that their anti-smoking advice was more effective when linked to an individual's presenting complaint. However, 60.4% of 326 respondents did not agree that discussing smoking with all presenting smokers was an appropriate use of time.

Table 2 contains the analysis of attitude statement responses. Compared with general practitioners who reported lower anti-smoking activity, those who reported greater anti-smoking activity had significantly higher mean scores on statements assessing positive attitudes towards discussing smoking with patients.

Approaches to and problems when discussing smoking

Tables 3 and 4 contain general practitioners' rankings of their most popular approaches towards discussing smoking with

Table 1. General practitioners' responses to statements measuring attitudes towards discussing smoking during routine consultations.

Statement	% of respondents who Agreed[a]	Disagreed[b]
Anti-smoking advice is more effective when linked to an individual's presenting problem (n = 320)	*97.2*	*2.8*
I can be effective in persuading some patients to stop smoking (n = 322)	*84.8*	*15.2*
Discussing smoking with patients can be rewarding (n = 321)	*61.4*	*38.6*
My anti-smoking advice is more effective than any other anti-smoking education my patients receive (n = 311)	*60.8*	*39.2*
Discussing smoking with all smokers is not an appropriate use of time (n = 326)	*60.4*	*39.6*
When patients continue to smoke despite repeated advice to stop, anti-smoking advice can still have a worthwhile effect (n = 326)	*60.4*	*39.6*
I do not discuss smoking with all smokers but with those whom I feel will respond to advice (n = 324)	*48.8*	*51.2*
Anti-smoking advice is equally effective whether the smoker is ill with a smoking-related problem or well (n = 324)	*48.8*	*51.2*
I prefer not to discuss smoking unless the patient is ill with a smoking-related problem (n = 324)	*15.4*	*84.6*
Discussing smoking with all smokers is likely to do more harm than good (n = 324)	*14.2*	*85.8*
I dislike discussing smoking in routine consultations (n = 324)	*13.6*	*86.4*
Giving anti-smoking advice during routine consultations should not be part of my job (n = 325)	*13.2*	*86.8*
I prefer not to discuss smoking with patients unless they raise the subject (n = 324)	*4.3*	*95.7*

n = number of respondents to statement. [a]Responses: strongly agree, agree or tend to agree. [b]Responses: strongly disagree, disagree or tend to disagree.

patients and the problems most commonly encountered when discussing smoking. Respondents' first three ranked choices are used to emphasize the approaches and problems that general practitioners feel most strongly about. Some general practitioners had difficulty deciding and ranked a number of items equally. This caused inflation of the possible number of first, second and third choices. Of 310 respondents, 64.9% reported that linking their anti-smoking advice to patients' presenting complaints was one of their three most preferred approaches to discussing smoking. Patients' lack of motivation was considered by 76.1% of 305 respondents to be one of the three problems most commonly encountered when discussing smoking.

Forty six general practitioners (14.1%) gave open responses to the question asking about their preferred approaches towards discussing smoking with patients. Many open comments were a restatement of closed responses, providing details about general practitioners' choice of words or written materials. Twenty eight responses could be amalgamated into four groups that were not represented in the list of closed responses: 10 general practitioners mentioned stressing a financial motive for the patient to quit, six reported using various types of complementary medicine (such as acupuncture), six mentioned approaches that helped raise patients' motivation to quit; and six said that they gave advice about health risks in a neutral fashion.

Open responses about the problems encountered when giving anti-smoking advice were given by 47 general practitioners (14.4%). The most common responses were comments that many patients deny that smoking is harming them, even when they acknowledge the general health risks of smoking (mentioned by 13 general practitioners). Other problems mentioned were: difficulties in overcoming the addictive aspects of smoking (eight general practitioners); young smokers' perceptions of increased status in their peer groups (six); knowing the right time to give advice (six); patients' fear of weight gain (four); and the lack of a consistent governmental approach against smoking (four general practitioners). The remaining open responses to this question were mentioned by two or fewer general practitioners or were restated closed responses.

Discussion

This survey provides insight into general practitioners' attitudes towards giving anti-smoking advice during consultations. Although confined to one family health services authority area, responses show concordance with previous work,[12-14] suggesting that the findings may be generalizable. As in previous surveys,[12,14] general practitioners in this sample were found to be positive about discussing smoking with patients, but responses indicated that they do not follow a population-based anti-smoking strategy. Sixty six per cent of respondents recalled advising two or fewer smokers to quit in their most recent surgery. As about 30% of presenting patients may be smokers,[21] it is likely that more than two smokers would attend most general practitioners' surgeries. Also, it is probable that non-respondents would have lower levels of smoking cessation activity.[22] Consequently, it is probable that the amount of anti-smoking advice that respondents reported giving represents an overestimate of the anti-smoking activity of all general practitioners surveyed.

The results suggest that general practitioners reporting the most smoking cessation activity hold more positive attitudes towards discussing smoking with patients. Using a conservative Bonferroni correction[23] (multiplying each P value by 13, the number of hypothesis tests performed) to allow for multiple comparisons, the responses to the first three statements are significantly different at the 5% probability level. General practitioners who take a more active anti-smoking stance appear to be more enthusiastic about using a population-based approach, put greater value on giving repeated advice and are more likely to select patients whom they feel will respond to anti-smoking advice. Caution must be exercised in interpreting the practical significance of these data. It is possible that observed differences merely reflect variation in the ways in which general practitioners respond to questionnaires. Alternatively, the variation in attitudes may mirror differences in general practitioners' clinical behaviour.

General practitioners' reluctance to discuss smoking with all presenting smokers could be explained by their experience of patients' responses to unwanted advice. Many patients resent receiving anti-smoking advice that is not relevant to their reason for consulting,[24] and up to 50% of smokers do not consider their smoking habit to be a problem.[25] Additionally, most general practitioners' advice that is aimed at changing patients' behaviour probably consists of simple exhortations to stop.[10] This combination of non-motivated smokers and inflexible general practitioner styles may explain general practitioners' reported difficulties in motivating smokers to quit. General practitioners

Table 2. Scores of attitude statements by general practitioners who reported advising more than two smokers to quit and those who reported advising two or fewer smokers to quit, during their most recent surgeries.

Statement	Mean score[a] (range) of GPs advising ⩽ two patients	> two patients	Z
Anti-smoking advice is more effective when linked to an individual's presenting problem (*n* = 188/97)	2.0	1.9	1.78
I can be effective in persuading some patients to stop smoking (*n* = 190/95)	2.6	2.4	2.00*
Discussing smoking with patients can be rewarding (*n* = 188/97)	3.4	3.0	2.75**
My anti-smoking advice is more effective than any other anti-smoking education my patients receive (*n* = 187/92)	3.4	3.1	2.14*
Discussing smoking with all smokers is not an appropriate use of time (*n* = 188/97)	3.6	4.3	3.53***
When patients continue to smoke despite repeated advice to stop, anti-smoking advice can still have a worthwhile effect (*n* = 190/77)	3.5	3.0	3.32***
I do not discuss smoking with all smokers but with those whom I feel will respond to advice (*n* = 190/97)	3.6	3.2	3.05**
Anti-smoking advice is equally effective whether the smoker is ill with a smoking-related problem or well (*n* = 190/96)	4.0	3.7	2.18*
I prefer not to discuss smoking unless the patient is ill with a smoking-related problem (*n* = 190/97)	4.4	4.6	1.82
Discussing smoking with all smokers is likely to do more harm than good (*n* = 190/97)	4.5	4.7	2.01*
I dislike discussing smoking in routine consultations (*n* = 189/97)	4.5	4.8	2.45*
Giving anti-smoking advice during routine consultations is not part of my job (*n* = 190/97)	4.5	4.9	2.92**
I prefer not to discuss smoking with patients unless they raise the subject (*n* = 190/77)	4.8	5.0	2.46**

n = number of respondents in group advising two or fewer/more than two patients. [a]Score of 1 = strongly agree; score of 6 = strongly disagree. Comparison of scores between groups, Mann Whitney *U*-test: *$P<0.05$; **$P<0.01$; ***$P<0.001$.

Table 3. General practitioners' ranking[a] of their preferred approaches to discussing smoking with patients.

Approach	% (95% CI) of 310 GPs[b] selecting approach as first, second or third choice
Linking advice to patient's smoking-related problem	*64.9* (*58.5* to *69.2*)
Exploring and attempting to influence patient's motives for smoking	*34.5* (*29.2* to *40.4*)
Highlighting the effects that passive smoking has on children or spouse	*30.3* (*25.2* to *35.4*)
Increasing smoker's confidence in his or her ability to quit (by highlighting past successes)	*26.5* (*21.2* to *31.0*)
Referring to primary-care based anti-smoking group	*22.2* (*17.6* to *26.9*)
Prescribing/advising nicotine replacement therapy	*21.3* (*16.7* to *25.8*)
Suggesting that the smoker persuades others in peer group/family to attempt quitting simultaneously	*20.9* (*16.4* to *25.8*)
Giving advice on withdrawal symptoms	*20.3* (*15.8* to *24.8*)
Frightening the patient with strong advice about consequences of smoking	*19.4* (*14.9* to *23.8*)
Offering follow-up appointment	*18.1* (*13.8* to *22.3*)
Giving written advice (leaflet)	*15.8* (*11.7* to *19.9*)
Encouraging cutting down before attempting to stop	*10.0* (*6.7* to *13.3*)

CI = confidence interval. [a]GPs were asked to rank the five approaches they found most productive when discussing smoking with patients. [b]A total of 310 respondents gave answers which could be used for analysis, 41 of whom ranked a number of items equally.

who report more smoking cessation activity may have developed flexible ways of dealing with the smokers' lack of motivation, helping them retain their belief that giving repeated anti-smoking advice is an appropriate use of time.

This survey reinforces the previous finding that general practitioners are more likely to discuss smoking in the presence of relevant symptoms.[12] An important finding in this study was the widespread belief that anti-smoking advice is more effective when linked to an individual's presenting problem: 97% of respondents held this conviction and it deserves careful attention. It has been proved that by advising all presenting smokers to stop smoking, general practitioners have a small beneficial effect on their patients' smoking habits.[2] It is possible, however, that the smokers who give up do so as a result of anti-smoking advice that is directly linked to their presenting complaint. Further research is needed to determine if this is so. If anti-smoking advice is more effective when linked to patients' presenting complaints, it would be sensible to encourage general practitioners' anti-smoking interventions in these situations rather than continuing to encourage a population-based strategy that general practitioners appear reluctant to apply.

The ranking of items regarding preferred approaches towards discussing smoking with patients represents a consensus of general practitioners' opinion that is validated by the small number of open comments. This consensus suggests that general practitioners do not use an evidence-based approach towards smoking cessation. The popularity of giving advice linked to patients' smoking-related problems is expected because general practitioners, in this study, reported to believe that advice given in this context is more effective. There is, however, no evidence to support this. It is worth noting that few general practitioners reported giving patients leaflets or asking patients to make follow-up appointments as being preferred approaches, despite the proven efficacy of both of these practices.[2,17] The lack of leafleting could

Table 4. General practitioners' ranking[a] of problems encountered when discussing smoking with patients.

Problem	% (95% CI) of 305 GPs[b] selecting problem as first, second or third choice
Patient's lack of motivation	*76.1 (70.9 to 80.5)*
Patients enjoy smoking or use it to help cope with stress	*52.1 (46.2 to 57.4)*
Smoking not usually an immediate concern of patients	*45.2 (39.4 to 51.2)*
Lack of time prevents discussion of smoking in detail	*26.9 (21.9 to 31.8)*
Lack of time prevents smoking being raised as often as desired	*25.9 (21.3 to 29.8)*
Patients do not understand importance of stopping smoking	*25.9 (21.3 to 29.9)*
Patients do not listen to advice	*13.4 (9.9 to 17.4)*
Patients easily forget advice	*10.5 (9.1 to 14.2)*
Unwanted advice upsets GP–patient relationship	*9.8 (6.8 to 13.1)*
Lack of GP skill	*5.6 (2.7 to 7.8)*
GP is a smoker	*2.3 (0.9 to 3.8)*

CI = confidence interval. [a]GPs were asked to rank the five problems they most commonly encountered when discussing smoking with patients. [b]A total of 305 respondents gave answers which could be used for analysis, 34 of whom ranked a number of items equally.

be remedied by audit. The reported time constraints probably make it unrealistic to expect general practitioners to encourage follow-up appointments solely to discuss smoking.

This study suggests that general practitioners' attitudes may influence their smoking cessation activity. In particular, it appears that general practitioners are unlikely to accept a leading role in a population-based anti-smoking strategy. The principal finding, however, is that general practitioners believe that their anti-smoking advice is most effective when linked to patients' presenting complaints. The way in which general practitioners approach the topic of smoking cessation seems to reflect this. This hypothesis needs to be tested as it has important implications for the future direction of general practice efforts to promote smoking cessation.

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Food for thought...

'The use of ultrasound in general practice enables general practitioners and midwives to reassure many women who have bleeding in early pregnancy, since these women have a good prognosis if fetal heart movement is detected and the fetus appears normal: approximately 19 in 20 women with a viable pregnancy will not have a miscarriage before the 20th week'

Everett CB, Preece E. Women with bleeding in the first 20 weeks of pregnancy: value of general practice ultrasound in detecting fetal heart movement. January *Journal*, p. 7.