AFRICAN-AMERICAN PHYSICIANS AND SMOKING CESSATION COUNSELING

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While African-American physicians can play a key role in encouraging black patients who smoke to quit, little is known about the views and activities of these physicians with respect to antitobacco programming. In the process of developing a protocol for encouraging physicians' smoking cessation intervention, 96 African-American physicians completed a survey indicating their knowledge, attitudes, and practices relating to stop smoking counseling. Few physicians reported patient help-seeking behavior and 47.9% cited lack of patient motivation as a key barrier to intervention. Only 46.8% believed that it is possible to accomplish a lot of cessation help in a few minutes time, and 34.4% believed that setting up and maintaining an office protocol would require a great deal of effort. Explaining health risks (71.9%) and enrolling patients in programs (66.6%) were perceived as keys to patient cessation; fewer than half of the physicians surveyed discuss specific strategies for quitting with their patients. Physicians indicated a willingness to offer more counseling in the future and were open to a range of strategies for learning more about effective approaches. Our findings support the need for dissemination of such information, particularly among specialists, to support antitobacco efforts among African-American physicians. (J Natl Med Assoc. 1997;89:534-542.)

Key words: smoking cessation
◆ African Americans

Smoking is a critical health problem for African Americans. While smoking prevalence among African Americans has decreased,[1-3] the decline has

been less striking than among whites.[4,5] Although many black smokers are motivated to stop smoking and make serious quit attempts,[6-9] their cessation activities have not produced as much long-term success as for other smokers[1,8] regardless of socioeconomic status.[5,10] Cultural and socioeconomic factors are implicated.[11,12] As is true for the US population as a whole, African Americans who are poor, unmarried, unemployed, and have less education are more likely to smoke and less likely to quit,[5, 13-18] and only one third of African-American households are middle class or above.[19] Blacks also may be more addicted smokers.[5,6,10,20]

People of color are exposed to aggressive targeted tobacco industry recruitment efforts,[21-23] and despite their lower cigarette consumption, menthol and tar/nicotine preference created by this advertising may increase nicotine absorption and carcinogen

exposure.[5,6,8,12,17,20] Although there is evidence of increased antitobacco programming in the African-American community,[24,25] access remains problematic.[7,20,26] Black smokers may be counseled to quit by physicians less frequently than white smokers.[26,27] The implications of these patterns are clear: black Americans are disproportionately affected by the health consequences of tobacco use.[3,26,28,29]

African-American physicians can play a key role in encouraging black smokers to quit. Approximately 70% of smokers see a physician at least annually,[30] black physicians are more likely than white physicians to care for black patients and poor patients,[31] and physician-delivered smoking cessation interventions have demonstrated efficacy.[32-34] However, despite evidence that physician counseling is increasing,[27,35-37] significant barriers to physician intervention persist,[32,38-40] physicians frequently give higher estimates of smoking cessation counseling than do their patients, and there is considerable room for increased intervention, particularly among people of color.[17,27,35,41]

Little research is available regarding specific barriers to smoking cessation counseling among African-American physicians. In a survey of 64 black physicians in New York State regarding nondrug treatment of hypertension, inadequate training, time required, lack of confidence in the efficacy of this approach, and reimbursement issues,[42] issues not unlike those identified by physicians in general,[43] were noted. Black physicians may face additional obstacles that specifically relate to their patient mix and practice settings, ie, sicker patients, longer health-care visits, more acute complaints, chronic conditions, functional limitations, and psychosocial symptoms.[31] Moreover, African-American patients are more likely to receive care in emergency departments, and to identify an emergency department as a regular source of care than white patients.[31,44]

While training can increase the confidence and motivation of doctors serving black low-income patients in inner-city hospital settings to provide smoking cessation counseling,[45] characteristics of these practice settings may well discourage time spent on such counseling.[46] Because race/ethnicity often is not reported in the description of respondents in physician surveys[43,47-51] and black physicians comprise only approximately 3% of the physician pool nationally, it is unlikely that their views are well represented in physician surveys. Further investigation of knowledge, attitudes, and practices related to anti-smoking counseling among black physicians could benefit antitobacco public health intervention efforts.

METHODS

Between April and September 1994, focus groups and a mailed survey (two waves, 2 months apart) were conducted in the process of designing a protocol for encouraging physician counseling using "Pathways to Freedom: Winning the Fight Against Tobacco," a smoking cessation program tailored to African Americans developed by the Fox Chase Cancer Center, Philadelphia, Pennsylvania with funding from the National Cancer Institute.[52] Physicians were recruited through two major organizations of black medical professionals in Los Angeles, the Association of Black Women Physicians (N=320) and the local affiliate of the National Medical Association, the Charles R. Drew Medical Society (N=715), and through a large community health center, the Watts Health Center (N=50). Surveys were accompanied by a letter signed by the president of the respective organizations encouraging participation.

Of 1085 mailed questionnaires, 129 were returned (return rate=11.9%). Duplicate listings were removed, and 23 questionnaires were blank or incomplete (ie, physician not in practice, retired, died, etc). Of the 106 physicians who completed the questionnaire, 96 (90.6%) were African American. The brief (21 item) questionnaire identified physician and practice characteristics, and physician knowledge, attitudes, and practices relevant to patients' smoking and antitobacco programming. Missing, refused, and don't know responses were included in all calculations except as noted. No information was available regarding nonrespondents; therefore, comparisons between nonrespondents and survey participants were not possible.

RESULTS

Characteristics of participating physicians and their practices are reported in Table 1. Half of the physicians indicated that 48% or fewer of their patients were black, 20% or fewer of their patients were Latino, 10% or fewer were white, and 5% or fewer were Asian. Physicians estimated that about 30% of their patients were current smokers.

Concerning smoking related knowledge, 21.9% agreed (strongly agreed/agreed) that most smokers don't want to stop smoking, 14.6% were neutral, and 57.3% disagreed (strongly disagreed/disagreed).

Table 1. Characteristics of Physicians and Physicians' Practices*	
Characteristic	**%**
Mean age (years)†	46.3‡
<40	37.2
40 to 49	32.1
50 to 59	14.1
60 to 69	10.3
≥70	6.4
Practice setting§	
Private practice (group)	41.7
Managed care	24.0
Private practice (solo)	14.6
Community health center	6.2
Other (academic/teaching hospital, mobile unit, outpatient clinic, etc)	12.5
Gender	
Male	49.0
Female	51.0
Years in practice	
<10	36.5
11 to 19	36.5
≥20	27.1
Specialty	
Primary care	
Obstetrics/gynecology	15.6
Family/general practice	14.6
Pediatrics	13.5
Internal medicine	11.5
Specialty	
Surgery/ENT/orthopedics	13.5
Psychiatry	6.2
Preventive medicine	5.2
Emergency medicine	4.2
Other	15.7
Smoking status of physicians§	
Current smoker	1.0
Former smoker	31.3
Never smoked	66.7

*N=96.
†N=78.
‡Standard deviation=13.08.
§N=95.

Most physicians (88.5%) disagreed that a patient who has stopped smoking for a year need not worry about relapsing, and 68.8% agreed that quitting will stop or reverse most adverse health effects of smoking. While 83.3% of physicians agreed that smoking causes more death and disease than any other preventable factor, 14% disagreed or were neutral. A small number of physicians agreed (9.4%) or were

neutral (18.8%) that changing from regular to "light" cigarettes reduces the risk of heart attack.

Regarding attitudinal items, nearly half (46.8%) agreed when asked whether it was possible for a physician to accomplish a lot of smoking cessation help in a few minutes time; 20.8% were neutral. Few physicians (7.3%) agreed that it is inappropriate to counsel patients who present with specific non-smoking-related problems; none perceived practitioners who provide smoking cessation as engaging in a "get rich quick scheme" although 14.6% were neutral on this subject. About one third (34.4%) agreed that setting up and maintaining an office protocol for smoking cessation would require a great deal of effort or support. More than half (52.1%) of the physicians agreed that informing patients about the health consequences of smoking was the most important component of an effective cessation message. Nearly two thirds of the respondents agreed (21.9%) or were neutral (41.7%) when asked whether nicotine gum and patches are too expensive to recommend to most patients, and agreed that they would like to learn more about how to deliver smoking cessation advice (62.5%).

A Pearson product-moment correlation analysis found that the only statistically significant correlations across attitudinal items ($P<.05$) were in the expected directions: positive statements directly correlated with positive statements, negative statements with negative statements, and negative and positive statements correlated inversely ($r=.232-.330$). Thus, physicians were relatively consistent in their attitudes toward counseling. More knowledgeable practitioners were more likely to express positive attitudes toward counseling and less knowledgeable practitioners were more likely to respond negatively in those correlations achieving statistical significance ($r=.216-.472$).

Low levels of patient help-seeking or interest in quitting if offered help were reported (Table 2). Fewer physicians in this survey (25%) reported spending ≥3 minutes counseling new patients than reported elsewhere,[43,51] although frequency of counseling at follow-up was comparable to other reports (Table 3).[43] In describing specific counseling activities (Table 4), most respondents, like physicians in other surveys,[43,47,50,53-55] indicated a decreasing level of activity along the hierarchy from agreeing that a smoke-free practice environment is very important and maintaining a nonsmoking environment, to identifying patients' smoking status and advising patients to quit, to counseling patients

regarding specific strategies and implementing an office system for program delivery.

Approximately three quarters of the respondents indicated that they identify patients who smoke, somewhat less than in other surveys conducted among primary care physicians,[49,50,51,53,55] but comparable with a survey that included physicians from a range of specialties (internists, family practitioners, and surgeons) as did our survey.[56] Although again somewhat less than reported elsewhere,[50,53] most respondents reported advising their patients to quit (85.4%) or to cut down on the number of cigarettes they smoke (78.1%)).

Perceived obstacles to patients quitting included smoking among family, friends, and colleagues (77%); previous unsuccessful attempts (64.6%); lack of knowledge about alternative strategies for coping with stress (62.5%); lack of social support (59.4%); withdrawal symptoms (57.3%); and exposure to targeted advertising (56.2%). Fewer respondents identified fear of weight gain (46.9%), a lack of access to culturally sensitive programs (43.8%), or lack of culturally appropriate smoking cessation materials (38.6%). Physicians in our study, as elsewhere,[43,47,50] were more likely to point to a lack of patient motivation (47.9%), time pressure and patient load (44.8%), and patients being overwhelmed by stressors (30.2%) than to inadequate training (28.1%), lack of culturally appropriate materials or programming (26%), cost or lack of reimbursement (18.8%), pro-smoking cues in the environment (17.7%), a fear of smokers leaving the practice if pressured to quit (12.5%), or staff resistance (7.3%), as hindering program implementation.

To facilitate patient cessation, 71.9% noted that they needed to explain the health risks of smoking to their patients, and two thirds noted that they needed to enroll their patients in programs. Fewer physicians saw the need to set a quit date (34.4%), prescribe medication (30.2%), or just tell patients to quit (19.8%). Three physicians indicated that they could do nothing, one because nothing works, and two others because it is not the physician's role to get people to stop smoking. When asked how much time they would spend counseling smokers to quit if provided with a culturally sensitive stop-smoking program, 17.7% responded ≥6, 68.8% 1 to 5 minutes, and 7.3% no time at all.

With the exception of prescribing medication (nicotine gum or patch, antianxiety agents, and antidepressants), a majority of physicians not currently

Table 2. Physician Perception of Patient Help-Seeking Behavior*			
	% of Physicians Perceiving That Among Their Patients		
	None	<Half	≥Half
Request help to stop smoking	10.4	62.5	13.6
Have ever initiated a discussion about smoking with you	18.8	51.0	16.7
Would be interested in help with smoking cessation if you were to offer it	7.3	52.0	26.0
Would try to quit if you encouraged them to	3.1	55.2	27.1
*N=96.			

engaged in a range of counseling practices indicated that they would be willing to provide such services in the future (Table 4). Most physicians indicated that easy-to-read manuals or guides (81.3%), videos (77.1%), a packet of implementation aides (61.5%), CME workshops or seminars (60.4%), and a trainer to provide in-office staff (57.3%) or physician instruction (58.3%) would be helpful in establishing smoking cessation counseling in practice. In developing a program to encourage physician intervention, 78.1% of those surveyed identified information about physician counseling that could be done in a few minutes time as very important, a higher proportion than for any other program feature, including the importance of the physician role in cessation (68.8%), actions by staff members (62.5%), and the cultural sensitivity of the materials (63.5%).

Finally, some significant ($P<.05$) relationships emerged from initial bivariate analyses of the relationship between physician attributes (gender, primary care/specialty, age, and smoking status) and knowledge, attitudinal, and counseling items. Specialty versus primary care and gender accounted for most of the significant associations with counseling characteristics. To further explore these findings, since statistically significant correlations were found across attitudinal and knowledge items, multivariate analyses were carried out using gender and specialty/primary care successively as the dependent variable in logistic regression models, controlling for age. All counseling characteristics bivariately associated with the dependent variable at a level of $P\leq.10$ or less

Table 3. Average Time Spent in the Previous Month Counseling African-American Patients Who Smoke*

Time	New Patient Visit	Follow-Up Visit
Did not discuss	19.8%	15.6%
1 to 2 minutes	45.8%	47.9%
≥3 minutes	25.0%	18.8%
*N=96.		

were entered into the model as independent variables in a stepwise procedure; those that emerged at the last step then were entered in a fixed-model logistic regression analysis and the results assessed.

Gender was significantly associated with the physician's belief that it is inappropriate to counsel patients who present with specific but nonsmoking related problems, with female physicians less likely than males to agree with this statement (odds ratio [OR]=0.05; 95% confidence [CI] interval=0.003, 0.71; n=69; 14% of males agree versus 2% of females, n=92). Specialty versus primary care was significantly associated with time spent counseling regular patients who smoke, with those physicians who spend some or a lot of time more likely to be in primary care (OR=9.4; 95% CI=3.83, 23.21; n=75; 5% of primary care physicians versus 36% of specialty did not discuss at all with regular patient, n=79). Similar but not statistically significant results were found with respect to time spent counseling new patients who smoke (13% of primary care physicians versus 33% of specialty care did not discuss it at all with new patients, n=87). Physicians who indicated that they would be willing to spend at least 4 minutes counseling patients if provided with a culturally sensitive stop-smoking program were significantly more likely to be in primary care (OR=4.33; 95% CI=1.29, 4.5; n=75; 64% of primary care versus 35% of specialty physicians would be willing to spend at least 4 minutes, n=90).

DISCUSSION

Smoking prevalence among African Americans, their health burden from smoking, and their difficulties in achieving desired cessation goals underscore the need to increase prevention and cessation efforts in this community. Even evidence that smoking rates are lower among black than other adolescents does not support a relaxation of antitobacco efforts as smoking among black adolescents is increasing; smoking prevalence among non-

Hispanic black male high school students nearly doubled from 1991 (14.1%) to 1995 (27.8%).[57] Physicians in general, and black physicians specifically, can make a valuable contribution to such efforts. Findings from our self-report survey cannot be generalized to all African-American or other physicians, cannot be accepted as an accurate description of actual physician activities, and may over-represent those who do more and put activities in the most favorable light.[43,47,55] Nonetheless, our results do suggest several key points that could prove useful in tailoring programs to encourage physician intervention.

Our respondents, as physicians surveyed elsewhere, recognize the health implications of smoking and smoking cessation, support provision of counseling, and report that they do, in fact, intervene with patients who smoke. Nonetheless, our findings and data from other studies suggest that there is considerable room for expanded physician effort in terms of time spent counseling patients and provision of specific behavioral recommendations. Some studies report that physicians discuss "specific steps to take" and "bring up the subject of cessation at later visits."[48,50] However, our respondents' efforts seem similar to the limited behavioral counseling that is described more frequently,[43,47,51,54] with emphasis on referring patients elsewhere for help, on providing patients with information about health risks, and on advising patients to quit. This raises some significant issues.

While referrals to outside programs represent a valuable supplement to physician counseling for some patients and at least some progress in terms of physician intervention,[47] depending on such referrals is not advisable.[58,59] Most smokers who stop smoking, including most black ex-smokers,[20] quit on their own, and physician advice can support such attempts. Group programs are not always accessible, especially for black smokers,[20] and when used do not work for all smokers. Patients do not always follow through on referrals even when group sessions are available at reasonable or no cost,[43] and referrals and physician follow-up actually may occur infrequently.[47,50,60] While two thirds of our physicians described referral as the most important thing they could do to help their patients who smoke, fewer than half reported actually making such referrals to outside agencies or support groups. The greater expressed preference for referral here than indicated elsewhere[47,50] may reflect the growing influence of

Table 4. Physicians' Self-Reported Antitobacco Current Practices and Possible Future Practices

Practice	Currently (%)	Not Currently/Would Be Willing in Future(%)
Advise patients who smoke to quit	85.4	71.4
Advise smokers about health risks	84.4	66.7
Identify patients who smoke	78.1	66.7
Advise smokers to reduce number of cigarettes smoked	78.1	57.1
Discuss alternative ways for managing stress	51.0	76.6
Make referrals to an outside agency or support group	47.9	70.0
Discuss strategies for coping with withdrawal symptoms	45.8	78.8
Prescribe nicotine patch	35.4	32.3
Prescribe nicotine gum	34.4	36.5
Have patient education conducted by staff members	29.2	50.0
Distribute materials	29.2	64.7
Prescribe antianxiety agents	25.0	26.4
Prescribe antidepressants	21.9	24.0
Show a 10-minute video in waiting room	9.4	60.9

managed care leading to increased in-house referral, the social desirability of reporting referral behavior, or problem-shifting. Whatever the reason, a focus on referral can undermine physicians themselves delivering counseling and advice.

Physician-targeted programs should encourage all physicians to establish and maintain a stop-smoking focus within their own practices. Further, these programs should underscore that much effective counseling can be provided by a physician in a few minutes. Although physician counseling can be effective even when limited,[61] more than half of our respondents did not recognize that this is the case. This point is particularly important for specialists who may not see it as their role to provide "opportunistic" cessation counseling. Physicians in general, and specialists in particular, might well be willing to counsel their patients if they were made aware that much can be accomplished through brief intervention.

A focus on the health consequences of smoking, the severity of these consequences, and the gains realized from cessation should be retained in programs targeting increased physician intervention. Although the numbers may be small, there are health-care providers for whom this information would be important. Physicians who disagreed or were neutral when asked if smoking causes more death and disease than any other preventable factor may be demonstrating particular awareness of the other difficulties and dangers facing their African-American patients. However, these views also may indicate the need for health facts, especially as they relate to black smokers.

Low-dosage smokers are less likely to be counseled to quit.[27] By ensuring that physicians are aware that all tobacco products are harmful at every dosage level, doctors may be encouraged to counsel all smokers and to challenge misconceptions about the relative safety of low-dosage smoking[6] or of "light" or any other cigarettes. This is particularly important with regard to African Americans who are more likely than whites to be light/moderate smokers[5,12] and are more likely to smoke menthol cigarettes.[8,6,20] Likewise, recognizing the health gains from quitting is critical if physicians are to serve as forceful cessation advocates. Health messages that communicate health risks and the addictive nature of smoking are also important for patients, especially for older, less well educated, current smokers.[62,11]

However, all physicians, and particularly specialists, also need to be advised that informing patients of the dangers of tobacco use and exhorting patients to cut down or quit in the absence of specific behavioral messages regarding how to stop smoking and stay quit may simply not be effective. This may be particularly true for black smokers who often face severe stressors that make cessation especially difficult to achieve.[20]

Physicians need to be made aware of the process involved in quitting, why behavioral messages are important, and what they can do—specifically, concretely, simply—that can help their patients quit and stay quit. Many of the physicians in our study, as in other studies,[43,47,50] see patient attitudes, receptivity, and interest as key barriers to physician intervention,

expressing pessimism regarding patient motivation to stop smoking, and physicians may be more likely to counsel patients they believe to be ready to change this behavior.[24] Physicians need to be informed of the widespread interest in cessation among African Americans, the extent to which black smokers do try to quit, and the appropriateness of discussing specific steps in the quitting process whether or not their patients raise the subject of cessation.[6,20,63]

Finally, while office-based programming that goes beyond physician counseling can play a critical role in maintaining antitobacco efforts,[32,64-67] our survey and other research[54] indicates that the potential for such programming is not realized.[43,47,50,54,55] As in other physician surveys,[43] time and patient load were seen by many of the physicians we surveyed as obstacles to counseling. This would seem to suggest that an office-based system, which alleviates the need for the physician to deliver all of the advice or counseling, could reduce an important barrier to delivering stop-smoking help in medical settings.

Cost or reimbursement, sometimes identified as key barriers,[56] were described as obstacles by fewer than one in five of our respondents, and staff resistance and the lack of culturally sensitive programs or physician training[27] also were cited infrequently as significant obstacles to program implementation. These views would seem to further support such programming. However, physicians may resist initiating these activities because of the belief that implementation would require great effort; nearly 60% of the physicians we surveyed agreed with this view or were neutral.

Interventions targeted to physicians need to underscore the value of building stop-smoking programming into the usual office routine and the extent to which this can be accomplished with minimal disruption in the practice setting. While a lack of training has sometimes been described as a barrier to physician counseling,[43,56] many of our respondents, as physicians in other studies,[54,55] do not describe themselves as unprepared to offer this help. Nonetheless, most of our physicians expressed considerable openness to receiving information on the role they can play and the "how to" of playing it well, and more than half of our respondents agreed that virtually every educational element about which they were queried (ie, video, manuals, etc) would be useful in adopting a stop-smoking program.

Physician-targeted interventions have successfully increased physician motivation, confidence, and counseling in many cases, including inner-city set-tings where physicians serve low-income and multi-ethnic patient populations.[32,45,54,66,68] Although more difficult to demonstrate, there is evidence that physician intervention does change patient behavior.[24,34,69] Even if only a small percentage of counseled smokers actually quit, this can represent many thousands of patients, in light of the number of smokers who see a physician each year. To increase their value, smoking cessation programs and services, as well as training and dissemination strategies, need to be tailored to the practice needs of physicians, particularly those serving minority ethnic groups, poor, and otherwise underserved populations.[20,70] To further guide intervention efforts, more research is needed with respect to smoking-related knowledge, attitudes, and practices not only of black physicians, but of all physicians and physicians in training[31,45] who serve African Americans and other populations most in need and least likely to receive these life-saving preventive health services.

Acknowledgments

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