Smoking: attitudes of Costa Rican physicians and opportunities for intervention

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The aim of this study was to obtain information, using a written questionnaire, on the knowledge, smoking behaviour, and attitudes of Costa Rican physicians about smoking as a health issue. A random sample of 650 physicians was chosen from a list of active physicians; 287 of them were covered by survey between August 1993 and October 1994, and 217 (76%) responded with data for the study. While 40% of the physicians who participated were ex-smokers, 19% were current smokers; 67% of these two groups combined reported smoking in the workplace. Only 49% believed that physicians could be a nonsmoking role model; the majority (87%) had asked patients about their smoking status. The only cessation technique consistently used (90%) was counselling about the dangers of smoking. Measures such as setting a date to quit smoking and nicotine replacement were rarely recommended ($\leqslant$2%). Nearly all the physicians (99%) considered smoking to be a major health issue. These results showed a high prevalence of smoking among Costa Rican physicians, with little recognition of the need for them to set an example as a role model. While they were knowledgeable about the health risks of smoking, they did not recommend any of the proven techniques to help their patients to quit smoking. A clear consensus for more strict tobacco regulation exists, but to date little has been done to act on this.

Voir page 320 le résumé en français. En la página 321 figura un resumen en español.

Introduction

In developing countries, the decline in infant mortality and prevalence of communicable diseases has shifted the disease profile towards chronic diseases (*1, 2*), which are influenced by behavioural and lifestyle risk factors that are amenable to change (*3*). For example, a simple intervention such as advice from physicians to their patients that smoking is hazardous has been shown to increase smoking cessation rates (*4*).

In developed countries, current morbidity associated with smoking is due to the past high prevalence of the habit, which is now declining. It has been estimated that, during the 1990s, tobacco will remain the single largest cause of premature death in developed countries (*5*). In Canada, studies between 1986 and 1992 reported smoking prevalences of 26–29%, down from a peak of 50% in 1965 (*6, 7*). This contrasts with the situation in Latin American countries, such as Costa Rica, where smoking-related morbidity is only now becoming apparent because of a high prevalence of tobacco use; the current 28% smoking prevalence in this country, unlike the situation in Canada, is showing signs of increasing (*1*).

In 1991, smoking-attributable mortality in Canada was estimated to be responsible for 26% of all male and 15% of all female deaths (*8*). These mortality figures are very closely related to the Canadian population's smoking behaviour two decades ago; despite the current fall in smoking prevalence, it is expected that smoking-related disease will continue to be a significant cause of mortality during the next decade (*9*). While few studies are available, it is known that in Costa Rica the principal causes of death among adults since 1970 have been chronic noncommunicable diseases such as heart disease and neoplasms (*1*). Using lung cancer as a marker, smoking-related morbidity in Costa Rica is still low, but has been increasing since the mid-1970s (*10*).

The major transnational tobacco corporations have been experiencing declines in cigarette sales in developed countries (*11*). These companies have therefore shifted their efforts to new markets in Latin America and elsewhere in the developing world, where they are aggressively promoting tobacco products (*12*). In these countries, there is little to obstruct the growth of the tobacco industry, and cigarettes can be marketed and sold freely and relatively cheaply.

A number of anti-smoking and smoking-cessation initiatives have been developed in North America, which have been shown to be effective in reducing smoking-associated morbidity (*2*). Costa

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Rica has the opportunity to adopt similar programmes and legislation to modify risk behaviours before the problem reaches the magnitude currently being experienced in North America. With universal access to state-insured health care services and a focus on health promotion, Costa Rica is in an excellent position to adopt public health measures to combat the smoking epidemic. Several anti-smoking initiatives have been initiated (*1*), such as warnings on cigarette packs, prohibition of sales to minors, and restrictions (even if only minimal) on advertising (*13*), but cigarettes are still cheap and lack the heavy tax burden imposed in developed countries. At present, the anti-smoking initiatives are sporadic and regulations are not enforced, and there is no unified anti-smoking plan (*1*). In addition, there is a noteworthy absence of physician involvement, and training programmes and support structures are needed to promote physician-assisted smoking cessation.

Physicians can play several critical roles, such as role model, provider of information, identifier/modifier of risk behaviours, lobbyist and researcher (*14*), which they are beginning to fulfil in North America. Smoking prevalence among them has declined to <10% (*15, 16*), and specific programmes to help them promote smoking cessation have been created (*17*). To date, there are no data available on the prevalence of smoking among Costa Rican physicians, or on their activities in smoking cessation. The present study was therefore designed to elicit information on these physicians' knowledge and attitudes to smoking, as well as their own smoking habits. It is hoped that the results will facilitate the enlistment of Costa Rican physicians in anti-smoking efforts and to set an example in health promotion for the rest of Latin America.

Methods

A list of all active physicians (approximately 3500) was obtained from the College of Physicians and Surgeons of Costa Rica. For logistical reasons, this list excluded about 200 physicians who worked in the outlying provinces of Guanacaste and Limon (*18*), those who did not have clinical contact with patients (approximately 100), and those not affiliated with a hospital or clinic. The latter were a minority, since about 80% of physicians in Costa Rica work part-time in hospitals or clinics (*18*). Using a computerized random number generator, a sample of 650 physicians was chosen from the list.

A questionnaire was developed based on various Canadian sources (*7, 17*) and consultations with Costa Rican physicians, researchers and health promoters. This instrument was designed to gather demographic data (including self-assignment as a smoker, ex-smoker or nonsmoker), personal smoking habits, attitudes to smoking and to anti-smoking measures, knowledge of smoking-related issues and health hazards, as well as practice patterns and use of smoking cessation techniques. The questions required one of three response types: yes/no, multiple choice, and free text. All the multiple choice questions included an "other — please specify" option, and popular answers from these were later assigned a code for purposes of analysis. Respondents were allowed to select more than one response for the multiple choice questions. The responses to free text questions were later grouped according to common content and re-coded as multiple choice for the purposes of statistical analysis. The survey form was initially written in English, the multiple choice items being based in large part upon North American smoking research patterns (*17*). A Spanish translation was tested on Costa Rican physicians who were not in the study sample to evaluate the clarity of meaning and ethnocultural appropriateness, and modified where needed. The final text was translated back into English.

The survey questionnaires were delivered directly to physicians in small clinics, while batches of questionnaires were given to department heads to be passed on to the named physicians in our randomly selected list. The free and informed consent of all the participants was obtained. The completed questionnaires were retrieved by the investigators; about a third of these were distributed and collected in August 1993, the rest in the summer and autumn of 1994.

The findings were entered into a computerized database for analysis. Confidence intervals for proportions were calculated as exact binomial 95% confidence intervals (95% CI) in Epi Info version 6.02. Contingency table analyses (odds ratios) and Kolmogorov–Smirnov goodness-of-fit for normal distributions were calculated using SPSS for Windows version 6.0.

Results

Of the 650 physicians selected to receive the survey forms, 287 were contacted and 217 completed the survey. The low rate of successful physician contact (287/650) was due to a change of address (place of practice) or retirement or death of the physicians, although the list was the current one available. Based on the numbers originally intended for the survey, the response rate was 33% (217/650); but based on the numbers contacted, the response rate was 76% (217/287).

The characteristics of the physicians surveyed are presented in Table 1, along with the corresponding data for all physicians in the country (*18*). Males predominated in our sample and, on average, were slightly older than the females, whose entry into the profession was more recent. The sample included physicians from a variety of specialities, whose numbers reflected the proportions for the whole country.

Overall, 19% of the physicians surveyed described themselves as "current smokers" (95% CI = 14–25%), 40% reported that they no longer

smoked ("ex-smokers", 95% CI = 33–46%), and 41% had never smoked ("never-smokers", 95% CI = 34–48%). Thus, a total of 59% of physicians had smoked at some time ("ever-smokers"). There was little difference in the ever-smoking rates between women (60%) and men (59%), but when smoking status was analysed by both age and sex (Table 2) some trends emerged. Women in the older age group were less likely than those under 40 years of age to have ever smoked, while the opposite pattern was observed among the men. Although these findings did not achieve statistical significance, they suggest that young women physicians may be taking up smoking in increasing numbers, while the number of male smokers may be decreasing. No significant difference in smoking rates was found between general practitioners and specialists. Among the ever-smokers, 95% smoked cigarettes and only 5% were pipe or cigar smokers.

Our data show that more smokers (49%) than never-smokers (28%) were likely to have another person in their household who smoked (OR = 2.40; 95% CI = 1.35–4.29), which is consistent with the findings of others in this field. Among the ever-smokers in our survey, 71% reported smoking 5–20 cigarettes per day (median, 12 per day; mean 17 per day); and 67% reported smoking in their workplace. Considering the current smokers only, 88% stated that they would like to quit, and 68% had made at least one serious attempt to stop smoking. Only 69% stated that they smoked every day.

The commonest reason given by physicians in the sample for not smoking, or for quitting smoking, was to avoid health problems, either themselves (83%) or in others (67%). Cost did not feature prominently (12%). Reasons for not smoking differed significantly between never-smokers and ever-smokers. Never-smokers (57%) were more likely than ever-smokers (40%) to regard themselves as a "non-smoking role model" (OR = 0.49; 95% CI = 0.28–0.85). More never-smokers (33%) than ever-smokers (20%) endorsed "unacceptable to family and friends" as a reason for not smoking (OR = 0.50; 95% CI = 0.27–0.85), and more never-smokers (81%) than ever-smokers (57%) cited "danger to others" (OR = 0.31; 95% CI = 0.17–0.59). More never-smokers (61%) than ever-smokers (31%) also cited "danger during pregnancy" (OR = 0.28; 95% CI = 0.16–0.50).

Two-thirds of the physicians surveyed listed the health risks of smoking as the major problem, with many of them listing specific pathologies (Table 3). There were no significant differences in the problems reported by smokers, ex-smokers and never-smokers. Although 23% of physicians cited a high and increasing prevalence of smoking as a major problem, all physicians had difficulty in estimating the smoking prevalence in Costa Rica. While their estimates ranged in a normal distribution from 5% to 90% (mean ± SD = 41.24 ± 19.45%; $P = 0.0001$), the true figure was closer to 28% (*1*).

Table 1. **Characteristics of the physicians surveyed**

	Physicians sampled	95% confidence interval	All Costa Rican physicians
Sex (n = 216)			
Women	29% (63)[a]	23–36%	27%
Men	71% (153)	64–77%	73%
Mean age (years) (n = 217)			
Overall	41 ± 9	—	N/A[b]
Women	37 ± 6	—	N/A
Men	43 ± 9	—	N/A
Year of graduation (n = 206)			
Before 1960	3% (6)[a]	1–6%	12%
1960–1969	13% (26)	8–18%	13%
1970–1979	34% (70)	28–41%	21%
1980–1989	41% (85)	34–48%	41%
1990–1994	9% (19)	6–14%	13%
Mean years in practice (n =206)	15 ± 8	—	N/A
Speciality (n = 217)			
Family/general practice	30% (66)[a]	24–37%	43%
Internal medicine	28% (61)	22–35%	13%
Surgery	9% (19)	5–13%	11%
Psychiatry	8% (18)	5–13%	3%
Paediatrics	7% (15)	4–11%	10%
Obstetrics/gynaecology	3% (7)	1–7 %	6%
Other	14% (31)	10–20%	13%

[a] These figures in parentheses are the actual number of physicians.

[b] N/A: data not available.

Table 2. **Smoking prevalence by sex and age among 216 physicians**

	Current and ex-smokers	Odds ratio	Current smokers	Odds ratio
Women (n = 63)				
Age > 40 years	50% (8)[a]	0.57 *0.18–1.78*[b]	13% (2)	0.34 *0.07–1.68*
Age ⩽40 years	64% (30)		30% (14)	
Men (n = 153)				
Age > 40 years	62% (50)	1.29 *0.68–2.46*	9% (7)[c]	0.26 *0.10–0.67*
Age ⩽ 40 years	56% (40)		26% (19)	

[a] Figures in parentheses are the actual number of physicians.

[b] Figures in italics are 95% confidence intervals.

[c] Results in bold are statistically significant (P<0.05).

A total of 87% of physicians stated that they had discussed the question of smoking with their patients, and 94% said they took some initiative with regard to this. Specialists (83%) were significantly less likely than general practitioners and family physicians (95%) to ask their patients about smoking (OR = 0.28; 95% CI = 0.09–0.83). The initiatives taken primarily involved advising patients to quit and/or

Table 3. **Reasons why smoking is a health problem in Costa Rica (free text field) determined from the responses of 213 physicians**

Reason	No.
Health hazards	143 (67)[a]
Pulmonary disease	56 (26)
Heart disease	50 (24)
Cancer	27 (13)
Vascular disease	9 (4)
Gastric disease	3 (1)
High/increasing prevalence	48 (23)
Problem among youth	20 (9)
Problems of passive smoking	9 (4)
Smoking publicity/propaganda	6 (3)
Problem for lower socioeconomic classes	3 (1)

[a] Figures in parentheses are percentages.

Table 4. **Smoking cessation techniques recommended to patients (free text field), determined from the responses of 177 physicians**

Techniques	No. of Physicians
Advice to quit/counsel re: dangers	159 (90)[a]
Behavioural techniques	4 (2)
Nicotine replacement	3 (2)
Cessation group	1 (1)
Set date for quitting	—
Smoking-cessation visit	—
Follow-up visits	—
Cut down gradually	3 (2)
Anxiolytics/anti-depressants	1 (1)

[a] Figures in parentheses are percentages.

Table 5. **Physicians' views on smoking-related issues**

Reason	No. of responses
Should the price be raised?	
Yes	157 (75)[a]
Less tobacco use	119 (81)
Luxury	11 (7)
Protect youth	9 (6)
No	54 (25)
Ineffective	53 (98)
Should there be designated smoking areas?	
Yes	159 (75)
Nonsmokers' rights	86 (58)
Passive smoking	42 (28)
Smokers' rights	13 (9)
No	56 (25)
Prohibit completely	27 (49)
Shows tolerance	16 (30)
Will make it worse	5 (9)
Help to quit instead	4 (7)

[a] Figures in parentheses are percentages.

explaining the dangers of smoking (Table 4). Only four physicians described using behavioural techniques to help their patients to quit, three prescribed nicotine replacement, and two referred them to a smoking cessation group. No physician recommended using other techniques such as setting a target date to stop smoking (quit date), or re-booking for a smoking-cessation visit, or scheduling follow-up visits to monitor therapy. Some physicians described using non-recommended techniques, such as cutting down gradually (3 physicians) and one physician had prescribed anxiolytics and anti-depressants to his smoking patients.

All but two of the physicians in the study agreed that smoking represented a health problem in Costa Rica (99%), while three-quarters of them thought the price of cigarettes should increase (Table 5). The latter viewpoint was adhered to by more never-smokers (83%) than ever-smokers (68%) (OR = 0.44; 95% CI = 0.23–0.87), most of them believing that this would decrease the number of people who smoked or the amount smoked per capita or both. A few mentioned other reasons for raising the price of cigarettes, including to protect youth and to tax smoking as a luxury. There were no significant differences in the reasons given based on the individual's smoking status. Of the 54 people who said that the price of cigarettes should not be raised, all but one felt that raising the price would have no effect on smokers. Some even said that smokers would deny necessities to themselves and their families in order to be able to buy cigarettes. Most respondents (80% of ever-smokers and 66% of never-smokers) felt that there should be designated smoking areas (OR = 1.96; 95% CI = 1.06–3.62); the reason given was mostly concern for nonsmokers, with about half specifically mentioning the dangers of passive smoking. Only 9% stated that there should be nonsmoking areas based on the rights of smokers. There were no significant differences in these reasons between ever-smokers and never-smokers. Of those who were opposed to designated smoking areas, nearly half felt that smoking in public areas should be prohibited completely.

Discussion

This study was designed to determine how far the physicians' understanding of smoking affected their ability to help patients to quit, and to elucidate the differences between physicians in Costa Rica and in Canada. Previous studies had shown that there were real cultural differences between Anglo-Americans and Costa Ricans (*19*). Such differences, if ignored, could undermine the success of any medical intervention transferred from one cultural setting to another. Our results lead to a number of recommendations for the advancement of physician-supported smoking cessation in Costa Rica.

As a nonsmoking role model, Costa Rican physicians were mixed; 19% of them were currently smokers, compared with <10% among North American physicians in recent studies (*15, 16*). Unfortunately, we have no earlier data with which to compare the current smoking prevalence among

Costa Rican physicians. Our finding of 19% prevalence is lower than the 28% in the general population in Costa Rica. According to data acquired in the 1970s, education appeared to correlate directly with smoking in Costa Rica (*1*), which does not agree with our finding of a lower smoking rate among physicians. In addition, we found a large proportion (59%) of ex-smokers in our sample. These findings, taken together, may indicate that the prevalence of smoking among Costa Rican physicians is declining, and may already be moving towards the "developed world" pattern , where the educated, upper socio-economic classes have been giving up smoking.

Of great concern is the fact that two-thirds of smoking physicians admitted to smoking in their workplace, where patients and others could observe their behaviour. Perhaps the most striking indicator that Costa Rican physicians were not setting an example against smoking is that less than half of those surveyed believed in physicians as a nonsmoking role model. In contrast, 90% of Canadian physicians surveyed saw themselves as anti-smoking role models (*15*). The high smoking prevalence found in this study is important for reasons other than an abundance of poor role models. Studies in North America (*20*) have shown that smoking physicians are less successful in decreasing smoking among their patients than their non-smoking colleagues.

Unlike findings in Canada, cost was not a deterrent to smoking in this population, perhaps because of the low price of cigarettes and the relative wealth of physicians. Costa Rican physicians appeared to smoke for much the same reasons as Canadian smokers (data not shown). According to a 1989 survey, 70% of Canadian smokers smoked >10 cigarettes per day, while Costa Rican studies suggest an average of <10 cigarettes per day (*1, 3*). Our data are consistent with these studies, and suggest that most smokers in Costa Rica would be considered "light" to "moderate" smokers. There is substantial evidence from North American studies to suggest that light/moderate smokers are more amenable to behaviour change programmes than heavy smokers (*21*). This implies that Costa Rica is currently at an ideal time to implement effective smoking cessation interventions, before tobacco use grows and the number of heavy smokers increases.

Another critical role for physicians is to provide information promoting smoking cessation. In general, Costa Rican physicians are knowledgeable about many of the health risks associated with smoking (Table 3), but are less clear on the epidemiology of smoking in Costa Rica. The fact that the physicians were unable to estimate even approximately the actual smoking prevalence in the Costa Rican population is of concern, and stands in stark contrast to recent data demonstrating that Canadian physicians were able to estimate the smoking prevalence in their local practice area with remarkable accuracy (*22*). This may reflect the paucity of epidemiological studies of the Costa Rican population.

As identifiers and modifiers of risk behaviour Costa Rican physicians demonstrate practices that are similar to North American physicians. Most physicians reported asking their patients about smoking, which is similar to North American findings (*23*). Most physicians in our sample advised against smoking, which in itself may cause 10–25% of those counselled to reduce or eliminate their tobacco consumption (*4*). However, very few recommended any of the behavioural or pharmacological techniques proven to be effective in assisting smoking cessation. The respondents uniformly admitted to not using known successful smoking cessation methods. As physician education programmes have proved to result in more effective use of cessation strategies (*15*), this is an area of intervention that needs to be developed in Costa Rica.

The role of the physician in health promotion remains a poorly studied area. Many feel that the medical community as a whole should use its influence to lobby for change in public policy. Our study clearly demonstrates that there is a consensus among physicians in two areas related to public policy. First, 75% of physicians thought the price of cigarettes should be raised as a deterrent to smoking. In places where taxation of cigarettes is significant, it has been shown to decrease tobacco consumption and to be an important deterrent to new smokers (*24*). Second, 75% of respondents favoured designated smoking areas. Of the 25% who opposed smoking areas, half felt that public smoking should be completely prohibited.

In all, there is a clear consensus for more strict regulation of tobacco use among Costa Rican physicians. It has been suggested by several that the best way to act on this consensus would be for the College of Physicians and Surgeons of Costa Rica to issue a clear statement against smoking, and to begin extensive work organizing and supporting anti-smoking public awareness campaigns. Smoking and its related mortality and morbidity are beginning to take their toll in Costa Rica, and will most certainly escalate. Costa Rica is somewhat unique among Latin American countries in that the public health and clinical medicine infrastructures are already adequate for early and definitive interventions to stop this epidemic. A model from the developed world that could be followed is the recent Policy Summary on Tobacco and Health issued by the Canadian Medical Association (*25*), which called for "a comprehensive approach to tobacco control, including legislation to control promotion, packaging, access, product content and price, . . . programs to reduce tobacco use, . . . [and] measures to hold the tobacco industry accountable." This approach deserves further study.

Our survey demonstrates that Costa Rican physicians are not unlike Canadian physicians with respect to their knowledge and attitudes about smoking, but more closely resemble North American physicians of two to three decades ago with respect to personal smoking habits and knowledge about smoking cessation techniques. In Canada, smoking

cessation training is implemented in medical schools and is available to practising physicians as continuing medical education. These programmes could be adapted for use in Costa Rica.

Costa Rican physicians are in a position to lead their country in combating the smoking epidemic and preventing serious morbidity and mortality in the population. We hope that our findings will encourage them to take up this challenge. ■

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Résumé

Tabagisme : attitude des médecins costa-riciens et possibilités d'intervention

Dans les pays en développement, la baisse de la mortalité infantile et des maladies transmissibles a fait évoluer le profil pathologique vers les maladies chroniques. Celles-ci sont influencées par des facteurs de risque (tabagisme, par exemple) liés à des comportements et des modes de vie qui peuvent être modifiés. On sait ainsi que les recommandations des médecins à leurs patients de ne pas fumer parce que c'est dangereux ont conduit un nombre croissant de personnes à renoncer au tabac.

Un certain nombre d'initiatives prises en Amérique du Nord ont réussi à faire baisser la morbidité liée au tabagisme, et les médecins commencent à jouer plusieurs rôles clés dans ce pays : ils deviennent, par exemple, des modèles de comportement et des sources d'information, ils permettent d'identifier et/ou de modifier les comportements à risque, ils sont membres d'un groupe de pression ou encore chercheurs. Pour réduire les comportements à risque avant que la consommation de tabac n'atteigne les mêmes proportions qu'en Amérique du Nord des pays comme le Costa Rica pourraient s'inspirer de ces initiatives pour élaborer leurs propres programmes et leur propre législation tout en tenant compte des différences socioculturelles. Au Costa Rica, il n'existe à ce jour aucune donnée sur la prévalence du tabagisme chez les médecins ou sur l'efficacité dont ils font preuve pour encourager l'abstinence tabagique.

La présente étude a servi à recueillir des informations — au moyen d'un questionnaire écrit — sur les connaissances, le comportement et l'attitude des médecins costa-riciens concernant la consommation de tabac. A partir d'une liste de médecins en exercice un échantillon aléatoire de 650 personnes a été retenu. Quelque 287 médecins ont reçu le questionnaire entre août 1993 et octobre 1994, et 217 (76%) y ont répondu.

Les résultats ont montré que 40% étaient d'anciens fumeurs et que 19% fumaient toujours; 67% de ces derniers déclaraient fumer sur leur lieu de travail. Les médecins costa-riciens connaissaient les dangers du tabac pour la santé, mais seulement 49% estimaient qu'ils pourraient montrer l'exemple en ne fumant pas. Quelque 87% des médecins ont interrogé leurs patients sur leur consommation de tabac, et 94% ont pris des mesures dans ce domaine. Mais la seule mesure prise systématiquement a été de mettre en garde contre les dangers du tabac (90%). Des méthodes éprouvées comme la fixation d'une date pour arrêter de fumer ou l'emploi de succédanés de nicotine ont été rarement recommandées ($\leqslant$2%). Presque tous les médecins (99%) jugeaient que le tabagisme étaient un problème de santé majeur; 75% se sont prononcés en faveur d'une augmentation du prix des cigarettes et de l'aménagement d'espaces non fumeurs dans les lieux publics.

La prévalence du tabagisme chez les médecins costa-riciens semble diminuer, encore qu'elle reste bien supérieure à celle observée chez les médecins en Amérique du Nord. On n'a guère reconnu qu'il était nécessaire que les médecins montrent l'exemple en ne fumant pas. Le fait que deux tiers des médecins fumeurs avouaient fumer là où les patients pouvaient les voir était particulièrement préoccupant. Si les médecins costa-riciens connaissaient bien les dangers du tabac pour la santé, ils ne connaissaient guère en revanche l'épidémiologie du tabagisme dans leur pays. Par ailleurs, les médecins interrogés n'utilisaient aucune des techniques éprouvées pour aider leurs patients à renoncer à fumer.

Il existe clairement un consensus en faveur d'une réglementation antitabac plus rigoureuse, mais à ce jour peu de choses ont été faites dans ce sens. Les médecins costa-riciens sont en mesure de jouer un rôle précurseur dans la lutte contre l'épidémie de tabagisme et dans la prévention de la morbidité et de la mortalité au niveau national. Les résultats de notre enquête devraient les aider à relever ce défi.

Resumen

Tabaquismo: actitudes de los médicos de Costa Rica y oportunidades de intervención

En los países en desarrollo la disminución de la mortalidad infantil y de las enfermedades transmisibles ha desplazado el perfil de morbilidad hacia las enfermedades crónicas. En estas últimas influyen factores de riesgo relacionados con el comportamiento y el modo de vida, como el hábito de fumar, pero esos factores son susceptibles de modificación. Por ejemplo, se sabe que el hecho de que los médicos recuerden a sus pacientes que el tabaco es dañino conduce a mayores tasas de abandono del hábito de fumar.

Un cierto número de iniciativas emprendidas en América del Norte se han revelado eficaces en lo que respecta a reducir la morbilidad asociada al tabaco, y los médicos están empezando a desempeñar allí varias funciones críticas en ese sentido, como son las de dar ejemplo con la propia conducta, suministrar información, identificar y modificar los comportamiento de riesgo, presionar a las instancias pertinentes e investigar. Otros países como Costa Rica podrían crear sus propios programas y legislación a partir de esas experiencias, teniendo en cuenta las diferencias socioculturales, a fin de reducir los comportamientos de riesgo en la población antes de que el problema del tabaquismo alcance la magnitud que hoy tiene en América del Norte. Hasta ahora no se disponía en Costa Rica de datos relativos a la prevalencia del tabaquismo entre los médicos y a la contribución real de éstos al fomento del abandono del hábito de fumar.

En el presente estudio se utilizó un cuestionario para reunir información sobre los conocimientos, el comportamiento y las actitudes de los médicos costarricenses en relación con el tabaco. A partir de una lista de médicos en activo se obtuvo una muestra aleatoria de 650 personas. En total 287 médicos recibieron el cuestionario entre agosto de 1993 y octubre de 1994, y 217 (76%) lo devolvieron cumplimentado.

Los resultados mostraron que el 40% de los médicos eran ex fumadores y el 19% aún fumaba, y que en el 67% de esos casos se consumía o había consumido tabaco en el lugar de trabajo. Los médicos costarricenses conocían los riesgos del tabaco para la salud, pero menos de la mitad de ellos (49%) pensaban que podían inducir a dejar el tabaco dando ejemplo con su conducta. Un 87% de los médicos preguntaba a los pacientes si fumaban, y el 94% de ellos tomaba alguna medida en ese sentido. La única medida tomada sistemáticamente consistía en subrayar los peligros del tabaco (90%). Rara vez se recomendaban técnicas de reconocida eficacia como son el hecho de fijar una fecha para dejar de fumar o el tratamiento sustitutivo con nicotina ($\leqslant$ 2%). Casi todos los médicos (99%) consideraban que el tabaquismo representa un problema sanitario grave; el 75% creía que debería aumentarse el precio de los cigarrillos y que en los lugares públicos debería haber zonas para no fumadores.

La prevalencia del tabaquismo entre los médicos de Costa Rica parece estar disminuyendo, pero es aún mucho mayor que entre los médicos de América del Norte. Apenas se reconocía la necesidad de que el médico dé ejemplo dejando de fumar. Especialmente preocupante era el hecho de que las dos terceras partes de los médicos que fumaban reconocían que lo hacían incluso en el trabajo, en lugares donde los pacientes podían verlos. Los médicos costarricenses conocían el tipo de riesgos para la salud asociados al tabaco, pero tenían una idea más vaga del impacto epidemiológico del mismo en su país. Además, los médicos encuestados no utilizaban ninguna de las técnicas de probada eficacia disponibles para ayudar a sus pacientes a dejar de fumar.

Existe un consenso claro a favor de una reglamentación más estricta contra el tabaco, pero hasta la fecha apenas se ha hecho nada al respecto. Los médicos de Costa Rica ocupan una posición idónea para dirigir al país en sus esfuerzos de lucha contra la epidemia de tabaquismo y de reducción de la morbilidad y la mortalidad en la población. Nuestras conclusiones deberían ayudarles a afrontar ese desafío.

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