



Use of Medical Counseling for the Prevention and Control of Smoking in the Municipality of Old Havana

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ABSTRACT *Physicians have an important responsibility for addressing smoking cessation and prevention with their patients. The objective of this study was to describe the use of physician counseling for the prevention and control of smoking and to predict its use according to physician characteristics. A cross-sectional survey of a random sample of 121 family physicians in one municipality of the city of Havana was used to address sociodemographic factors, years of practice in the community, smoking status, use of physician counseling in daily practice (ask, advise, and assist), and the role of physician counseling as an intervention. Summary statistics were used as well as canonical and discriminant analyses. The prevalence of smoking among the physicians was 18%. The smoking status of patients was determined “almost always” by 32% of doctors. Twenty-five percent asked their patients whether they intended to stop smoking; 35% recommended smoking cessation; and 38% gave advice on how to achieve this. More than half (58%) explored factors that might influence cessation in their patients, and 12% reported doing this “frequently.” Physician characteristics were associated significantly with preventive behavior, with community involvement, and with the perceived value of physician counseling and smoking status. Physician responses were associated with actual practice in 82% of the cases. Predisposing, facilitating, and reinforcing factors for preventive behavior were strong determinants of active involvement by physicians in daily practice. Training of health professionals must include smoking cessation.*

KEYWORDS *Cuba, Physician counseling, Smoking cessation.*

INTRODUCTION

The important role of the health sector, especially of physicians, in the prevention and control of smoking is well documented.¹ Physician support has been shown to increase abstinence. Furthermore, when physicians and, in general, health care professionals engage in active intervention, they are able to significantly lower the prevalence of smoking.

In the United Kingdom, an intervention lasting 4 weeks that involved a rapid assessment of smokers, with or without information handouts given by general

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practitioners, resulted in increased smoking cessation. After 1 year of follow-up, it was found that the results were better than those observed in 10 specialized clinics. Similar results have been found in the United States and Australia, especially in small communities.^{2,3} About 70% of those who smoke more than a packet of cigarettes daily acknowledged that they could stop if their physicians counseled them accordingly. Between 10% and 25% of smokers succeed in reducing or quitting smoking if their physicians become involved.⁴

We set out to describe the use of physician counseling for the prevention and control of smoking in the community, to determine the frequency of physicians asking about smoking status during medical visits as well as their attitudes toward smoking cessation, the frequency with which they recommended smoking cessation, and the frequency of assessing need for assistance, and to determine the self-appraisal of physicians about their ability to motivate patients to quit smoking.

METHODOLOGY

We conducted a cross-sectional survey of a computer-generated random sample of 121 family physicians from a registry of physicians in the municipality of Old Havana. We estimated that approximately 30% of physicians would be counseling patients about smoking cessation. The interviews were conducted by trained and experienced interviewers who had also tested the questionnaire previously on physicians in another municipality.

Participating physicians were assured of anonymity. The following variables were included in the questionnaire: sociodemographic (gender and locale), year of graduation and number of years of work in the community of current employment, personal smoking habits, use of counseling (ask, advise, and assist), and attitudes and beliefs about the role of physicians in having an impact on this addiction (a lot, a little, or none). In Cuba, at the time of this study (1997), there was an awareness only of three A's—ask, advise, and assist—therefore, arrange and assess were not included in the survey.

We began with a simple univariate descriptive analysis that gave us means, proportions, standard deviations, and odds ratios with 95% confidence limits. We did a retrospective canonical correlational analysis to determine which variables were related to physician characteristics influencing the use of counseling. Finally, we did a discriminant analysis to determine which sociodemographic variables predicted the use of preventive measures. Levels of significance were based on the probability of a type I error of .05.

RESULTS

We interviewed 114 physicians, of whom 67% were female. The average number of years since graduation for the cohort was longer (double) than the number of years worked in the community; however, there was no correlation for individuals. Among the physicians in the municipality, 18% were smokers [confidence interval (CI)=11–25]. Among women, 16% smoked (CI=10–36), and among men, 21% smoked (CI=8–26). Less than 40% of physicians applied the three A's (ask, advise, and assist) nearly always, with less than 25% by physicians who were smokers (Table).

For the entire cohort, the reasons for not asking patients if they smoke were, in decreasing frequency, “not a new case” (34%), “the lack of a routine” (27%), “the

TABLE. Preventive practice by physicians according to their smoking status (in decreasing frequency)

| Preventive practice | Smoker | | Nonsmoker | | Odds ratio (95% CI) |
|--|--------|----|-----------|----|---------------------|
| | n | % | n | % | |
| 1. Determines smoking status | | | | | |
| Nearly always | 2 | 10 | 34 | 36 | 0.09 (0.01–0.47) |
| Hardly ever | 13 | 65 | 19 | 20 | |
| 2. Asks about intention to stop | | | | | |
| Nearly always | 1 | 5 | 27 | 29 | 0.07 (0.00–0.59) |
| Hardly ever | 11 | 55 | 20 | 21 | |
| 3. Recommends cessation | | | | | |
| Nearly always | 4 | 20 | 36 | 38 | 0.19 (0.04–0.7) |
| Hardly ever | 11 | 55 | 19 | 20 | |
| 4. Gives instructions on how to stop smoking | | | | | |
| Nearly always | 5 | 25 | 38 | 40 | 0.16 (0.04–0.64) |
| Hardly ever | 10 | 50 | 12 | 13 | |

presence of an illness related to smoking” (22%), and “lack of time” (17%) (Fig. 1). For those who not at all or rarely asked whether their patients wanted to quit smoking, the predominant reasons were “lack of a routine” (54%), “the presence of an illness related to smoking” (27%), “lack of time” (15%), and “having more important things to do” (4%) (Fig. 2).

Physicians’ awareness about the goals of medical intervention included reduction in the daily consumption of cigarettes, referral to smoking cessation services in the municipality, daily record of cigarettes smoked, and acupuncture. Two thirds of the physicians (66%) stated that they did not know what instructions to give to their patients who smoked. Forty-seven percent of physicians stated that they knew the prevalence of smoking in their area, and 45% stated that they knew how many patients had a positive attitude toward smoking cessation. Those who believed that their advice could influence a decrease in smoking in the community constituted

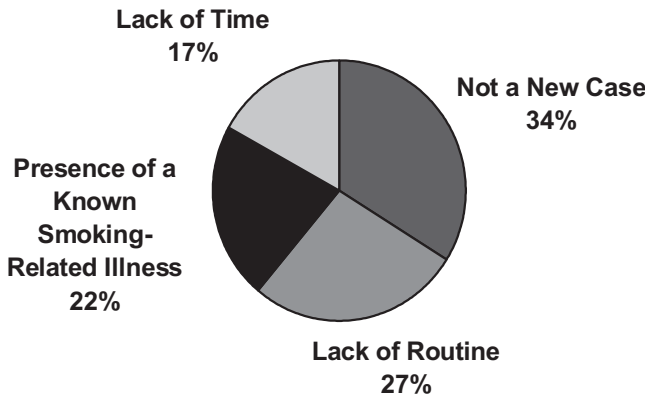


FIGURE 1. Reasons for not asking patients whether they smoke.

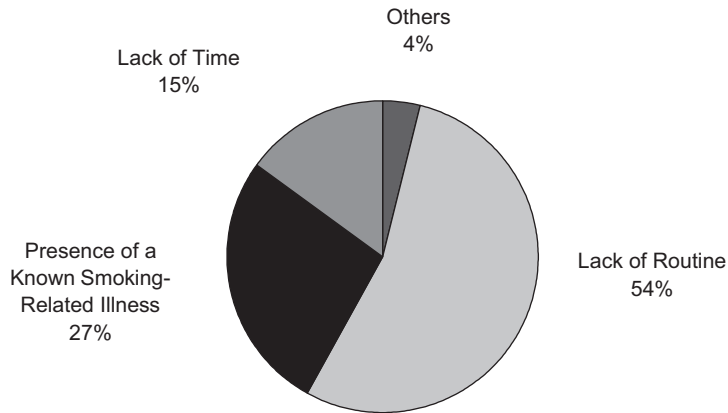


FIGURE 2. Explanations by physicians who not all or rarely ask whether their patients plan to stop smoking.

58% (66 physicians); 12% (8 physicians) believed “a lot” that they could have a positive influence. There were 8% who stated that they did not know what role they could play in effecting change.

The coefficient of canonical correlation was 0.66 ($P < .001$). The highest canonical correlation obtained was 0.58, with the following variables:

$$U_1 = 0.07 \text{ gender} + 0.08 \text{ location} - 0.89 \text{ time} + 0.03 \text{ years} - 0.72 \text{ smoking} + 0.51 \text{ perceived value of counseling}$$

$$V_1 = 0.28 \text{ asked regarding smoking} + 0.04 \text{ asked regarding desire to stop} + 0.63 \text{ advice} + 0.02 \text{ awareness}$$

U_1 is a vector of independent variables, whereas V_1 is a vector of dependent variables in the matrix.

These results indicate that physicians who spent more time working in the community were nonsmokers and that those who valued the use of counseling were more likely to recommend smoking cessation to their patients. From the discriminant analysis, the variables that best discriminated between physicians who recommended smoking cessation and those who did not recommend were years of work in the community, smoking status of the physician, and perceived value of the effectiveness of physician counseling. These results were in agreement with those found in the canonical analysis. We found that 82% of the cases were correctly classified by the discriminant function.

DISCUSSION

The lack of knowledge regarding smoking assessment indicates the need for relevant skill training. It appeared that most physicians do not appreciate their role as agents of change in the community. For more than 10 years, the American Medical Association has advised physicians to determine the smoking status of their patients and to encourage them to quit smoking, offering them support or information to help achieve this.⁴ One of the most important reasons for this strategy is the high

proportion of individuals who consult their physicians yearly. In Cuba, no fewer than 85% of smokers seek medical advice on a yearly basis.⁵ Furthermore, most patients who smoke are very receptive to advice about smoking cessation from their physicians such that even a minimal intervention can result in an increase in overall smoking cessation.^{4,6,7} The opinion of physicians about their inability to influence smoking cessation constitutes an important barrier impeding the expansion of preventive measures.⁸ Many believe that warning patients about problems associated with smoking has no effect on them. However, many smokers indicate that a physician's interest in their smoking, expressed by advice to quit, motivates them to consider quitting.⁹

It is clear that being a smoker has an influence on the use of smoking prevention practice in a medical care setting. The prevalence of smoking among physicians, overall and by gender, was lower than that found in the First National Survey of Risk Factors and Preventive Activities for Chronic Noncommunicable Diseases in 1995 as well as in other surveys conducted by the Cuban Institute of Research and Internal Needs Assessment in 1990 and 1998, which indicates a favorable finding.

Our analyses demonstrate inadequacies among predisposing factors (knowledge, beliefs, and attitudes) facilitating factors (training and access) as well as reinforcing factors for preventive activities (time set aside for prevention). These constitute significant barriers to the use of physician counseling for the prevention and control of smoking in the municipality of Old Havana. Optimizing these factors would help reduce the barriers.

We recommend that physicians be trained with greater emphasis on prevention, underscoring the importance of the use of counseling during medical encounters on a daily basis.

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