The silent treatment ~
why GPs and patients don't talk about smoking

No Smoking Day

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No Smoking Day

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Written by Doreen McIntyre, Chief Executive, No Smoking Day and Kay Scott, Qualitative Researcher
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EXECUTIVE SUMMARY

Five discussion groups (two with GPs and three with smokers) were conducted to explore attitudes towards the role of the GP in smoking cessation.

Consistent with published research, GPs in this sample were generally opposed to giving brief opportunistic advice annually to all smokers. They considered such activity unrewarding for themselves, annoying for patients, ineffective and possibly counter-productive. Work overload and time pressures were also important barriers.

In practice, GPs tended to focus their smoking interventions on 'appropriate' or 'relevant' patients, whom they considered more receptive to the idea of giving up. The most frequently identified 'relevant' patient types were: patients with respiratory tract infections, coronary heart disease and vascular disease, those receiving HRT and oral contraception, asthmatics, new patients and those requesting help with giving up.

Most GPs felt that there were some types of patient with whom raising smoking was less appropriate, and possibly even inadvisable. These were alcoholics, drug addicts, and patients suffering from severe psychiatric problems. Some GPs also reported that they were less likely to raise smoking with socially disadvantaged patients, who were generally seen as more dependent on cigarettes, less able to stop, and most likely to feel annoyed or patronised by GPs querying their smoking behaviour.

GPs were generally very positive about patient-initiated consultations concerning smoking, particularly if these patients had been referred from cessation services. However, given work/time pressures, they felt uneasy about publicity campaigns to encourage more smokers to seek help from their GPs. Most argued that it would be more appropriate if smokers saw a nurse or specialist counsellor first.

GPs generally expressed very positive attitudes towards local NHS cessation services, because they represented a free and credible source of help for patients who wanted to give up. Most GPs felt that the existence of local services prompted them to raise smoking more often. However, some argued that specialist services were too remote, and that more money should be spent on supporting practice-based counselling activity.

GP understanding of the nature and effectiveness of specialist cessation services was patchy, and many GPs acknowledged that they would like to know more. Information about *local* services was generally considered to be more interesting and more likely to influence their practice than national data.

GPs were broadly positive about NRT; it was generally regarded as the 'front line' pharmacological treatment for smokers who want to stop. Availability on prescription was widely welcomed, particularly as it meant that NRT was now available free to low-income groups. Bupropion was regarded as a potentially more effective but *dangerous* drug, only to be used as a treatment of last resort.

GP suggestions for improving communication with smokers all related to enhancing GP motivation to raise and re-raise the issue: providing more GP-specific feedback data from local specialist services; providing financial incentives for GPs; decreasing waiting times for specialist clinics and providing more 'outreach' counsellors working in general practice settings.

Smokers felt under increasing societal pressure to stop. Despite expressing interest in wanting to give up, most were ambivalent about this; the advantages of cigarettes as (perceived) weight controlling aids, boredom relievers and stress relievers often competed with concerns about financial outlay and health. Many also suspected that they were *unable* to give up smoking up.

Most smokers felt that their GPs simply did not have the time to discuss smoking with them. They often complained that, when the issue was raised, GPs did so in an unhelpfully perfunctory manner, with little or no explanation of products or services they could offer. Simply handing out written information about cessation services could be construed as 'passing the buck', particularly if done hastily.

Most smokers reported that it would not occur to them to make an appointment with their GP to discuss giving up smoking, or only as a last resort. Many felt that this would not be a legitimate reason to seek help from GPs, particularly given that GPs were 'already too busy', and smokers were often unaware or unconvinced that GPs could provide any real help. The widely held belief that giving up was essentially a matter of personal willpower exacerbated this view.

Smoker awareness of cessation services appeared relatively high in all three research locations; however, many smokers assumed that only groups were on offer, and these did not hold universal appeal. Remoteness/inaccessibility of clinics, rumours of long waiting lists, and scepticism about their effectiveness often deterred these C2DE smokers from seeking help. Many were surprised and impressed to learn that 40-50% of smokers had successfully stopped after attending specialist services; however, 15-20% longer-term success rates were considered much less impressive.

Smoker attitudes to NRT were lukewarm, largely because of perceived ineffectiveness. Awareness of NRT on prescription was patchy, and several believed that they could only obtain NRT from GPs if they attended counselling first.

Smoker attitudes to bupropion were similar to those of GPs. It was generally perceived as a powerful and dangerous drug with potentially lethal side effects. Not surprisingly, few expressed interest in using it.

Smoker suggestions for improving communication with GPs were: encouraging GPs to place more emphasis on *solutions* they could offer (drugs and counselling), encouraging GPs to communicate how much more *effective* these were than willpower alone; and encouraging patients to make appointments with health care professionals (particularly nurses) to discuss smoking. Suggestions for increasing uptake of specialist services were: reducing waiting times, publicising 40-50% success rates more widely; providing more locally-based counsellors and providing/promoting individual as well as group support.

INTRODUCTION

No Smoking Day exists to help smokers who want to stop, and does this by promoting the range of effective services and products available in the UK – principally those provided through the NHS and major health charities. It is widely known that the majority of smokers would like to be able to stop, but many are ambivalent about trying. The reasons they give range from fears about being unable to stop, lack of understanding about what is involved in stopping, lack of awareness of the help that is available, misplaced fears about unwanted side effects of stopping (e.g. weight gain), and previous failed attempts to stop. There is a wide belief that stopping smoking requires tremendous amounts of will power to resist overwhelming cravings and temptations that will never abate.

No Smoking Day's main tasks are, therefore, to demystify the process of stopping, emphasise the benefits of stopping, and encourage smokers to use the help that is available. This report describes some of the factors currently affecting smokers' uptake of help, and offers service providers some insights into how the situation might be improved.

RESEARCH OBJECTIVES

Smoking cessation interventions delivered through the NHS are an extremely cost effective way of preserving life and reducing ill health. In theory, a key strand of NHS mediated smoking cessation activity is brief opportunistic advice given by GPs to all smokers, which has been shown to trigger a quit attempt by approximately 2% of smokers. In practice, however, many GPs are known to be resistant to the suggestion of delivering brief opportunistic advice to all patients[1].

GPs can also play an important role as referral and recommendation agents for specialist smoking cessation services. However, a recent national survey reported that 30% of GPs did not refer smokers to the services and the Health Development Agency recommends that efforts be made to increase GP activity in this area[2].

In January 2003, **No Smoking Day** undertook research to explore GPs' attitudes to raising the issue of smoking with their patients, and smokers' attitudes to discussing cessation with their GPs.

The specific research objectives were:

- **To explore GP attitudes and practices in relation to smoking cessation.**
- **To explore GP attitudes towards smoking cessation products/services.**
- **To explore patient attitudes towards discussing smoking with their GPs.**
- **To explore patient attitudes towards smoking cessation products / services.**
- **To identify any ways in which communication between GPs and patients about smoking cessation and related products/services might be improved.**

RESEARCH METHOD

Five focus group discussions were conducted, 2 with GPs and 3 with smokers.

The GP focus groups comprised 6-8 GPs from practices serving a variety of different patient populations. All GP respondents were non-smokers, and all reported some involvement in giving smoking-related advice. Of the 14 GPs who participated, 13 were males and 1 was female.

The smoker sample comprised male and female smokers from lower income (C2DE) groups. Two of the 3 smoker groups were 45-65 year-olds, and the third group consisted of younger women either approaching childbearing age *or* with young children under 5 years of age. All respondents were regular smokers (a mix of light and heavy) who expressed some interest in the notion of giving up; a recruitment filter was used to ensure that all had visited their GP within the last 12 months.

Fieldwork was conducted in January and February 2003. Discussions followed semi-structured topic guides, and were tape recorded and transcribed for subsequent content analysis.

RESEARCH FINDINGS

1
GPs : ATTITUDES TO DISCUSSING SMOKING WITH PATIENTS

The GP participating in this research were a heterogeneous group, with a range of interests and styles of working. Most seemed to relish their relative autonomy, and felt slightly resentful of the imposition of increasing numbers of national guidelines and frameworks which did not always coincide with what they considered to be the best use of their time. Several commented that academics and politicians had little idea of what life was like 'on the front line', and that national recommendations often lacked practical relevance or applicability.

> *These people are not in the front line, the academics. It's not simply a case of only having a 7-minute consultation; you're running late because you've been called out and lots of people sitting in the waiting room getting irate…*

This was considered particularly true of the national smoking cessation guidelines, which suggest that GPs should advise current smokers to stop during routine consultations at least once a year[3]. Almost all GPs argued that 'mechanistic' intervention of this kind was unappealing, impractical, unrewarding and ineffective.

> *Just to have a tick-box exercise once a year is just a waste of everybody's time. Much more useful if you can seize on something that's happening and relate that to their smoking.*

One of the main barriers to routine opportunistic brief intervention on smoking was that GPs simply did not believe that raising and re-raising smoking routinely in unrelated contexts was a useful or productive way to proceed. Whilst they accepted that it might be justifiable on theoretical grounds, most argued that, in practice, a 'blanket' approach of this kind was unrewarding for doctors, annoying for patients, and possibly even counter-productive.

> It's soul-destroying work, day in and day out.

> *You get a bit fed up targeting everybody, particularly the ones who clearly don't want to give up smoking…on the whole, I feel it doesn't help that much.*

> My job is to educate people and prompt them now and again, but not to get up their noses and treat them like children.

> *If you just walk in and I start quizzing you about smoking, it does more harm to the doctor-patient relationship than good.*

A further key barrier was work overload. Many GPs argued that, 'in the real world', they simply did not have the time to raise smoking during brief consultation slots that were usually already running late, and already overloaded with other issues that they or the patient wanted to address.

Furthermore, the suggestion that GP smoking advice only needed to be 1-3 minutes was regarded with some scepticism; many argued that, in reality, raising the issue of smoking cessation in a useful way (rather than simply a box-ticking manner) often led to a discussion that took considerably longer; patients often started to relate their latest attempts to give up and why they had failed, ask questions about products and services offered by the GP and so on.

One GP in the sample *was* routinely targeting all smokers with cessation advice; this highly motivated GP had set up a scheme whereby all smokers on the practice database were called in for a health check, in the course of which they were encouraged to give up. However, the nurse rather than the GP conducted these checks.

In practice, almost all GPs were focusing their smoking-related activity on what they considered to be 'relevant' or 'appropriate' consultations, when patients were considered more likely to respond to the advice given *and/or* the importance of giving up was particularly high. The nature of 'appropriate' consultations is discussed below.

> *It has to be focused and it has to be appropriate. The GP has to have the energy and the patient has to be in a receptive mood.*

2
GPs : 'APPROPRIATE' CONSULTATIONS

To most GPs, 'appropriate' patients were those suffering from respiratory tract infections, coronary heart disease and vascular disease, patients receiving HRT and the oral contraceptive, asthmatics, new patients, and patients who specifically asked for help with giving up (see next section). Antenatal patients and diabetic patients were also mentioned, but rarely seemed top of mind.

> The ones that really concern me are the chronic bronchitics and the ones with severe angina, and this is where I dangle the carrot…"have you thought about smoking, having another go at stopping?" and see how they respond.

> *Heart attack, you are going to bang the table a bit, but I don't tend to go looking for people who are smoking and try and stop them, because to me that is pretty pointless.*

Most GPs felt that 'relevant' patients, particularly those who were experiencing symptoms of illness or asking for help, were much more receptive to the suggestion that they might give up smoking, and that therefore raising smoking in this context was an effective use of their time. They also found it easier, as there was an obvious reason to raise it. However, it is known that patients with smoking-related illnesses like heart disease are in fact some of the least likely to stop smoking.[4] [5]

GPs also felt that there were some situations in which raising the issue of smoking cessation was definitely *not* appropriate, and even inadvisable. They generally felt that alcoholics, drug addicts and patients suffering from serious psychiatric problems often had other, more serious problems to address. One GP argued that encouraging psychiatric patients to give up could actually be detrimental for their health.

> *Sometimes I tell them not to stop – you get an awful lot of anxious, stressed, depressed people who depend on a cigarette just to remain stable. There are some people you have to give permission to allow them to continue to smoke, otherwise it's increased medication, increased instability. It's a question of what you've got in your life.*

However, research on smoking among patients with mental health problems provides a somewhat different picture of the real situation. Around half of people with mental health problems express a desire to stop.[6]

Several GPs acknowledged that were less likely to raise or pursue the issue of smoking with socially disadvantaged patients. These doctors felt that such patients were generally less receptive to the suggestion of giving up smoking, more likely to feel patronised by GPs repeatedly querying their smoking behaviour, and less *able* to stop.

> It's usually the people whose socio-economic class is very low, they're in need of the most help we can give them and you don't want to drive them away, so you've got to be careful about it.
>
> *Amongst the poor and those with social problems, smoking is just not their number one priority. It's about paying off their debts, housing problems, drugs and alcohol on the estate…they see smoking cessation as in irrelevance to their everyday lives.*
>
> These people don't succeed as much because they've got all sorts of pressures… the paper's falling off the walls, they've got two bedrooms and four children, smoking is the one way they can sit down and say, 'just leave the kids, I'm going to sit down and have a fag'.

Again however, research among smokers on low income reveals similar levels of interest in stopping smoking to those found in more affluent groups.[7] Furthermore, smokers who feel least able to stop are arguably those who would benefit most from the intensive support provided by specialist services.

3
GPs : ATTITUDES TO PATIENT - INITIATED SMOKING CONSULTATIONS

Most GPs reported a small but steady trickle of patients approaching them for help with giving up smoking, either in the context of consultations about another issue, or occasionally during a consultation made specifically to ask for help with giving up smoking.

Most dedicated smoking-related consultations were said to result from referrals by specialist services who wanted the patient to be prescribed cessation products, or pharmacists who had referred patients to their GP in order to obtain a prescription for NRT. GPs reported that it was relatively unusual for patients to make appointments to discuss smoking unless referred in this way. Several reported that they had experienced a flurry of unprompted visits from patients seeking bupropion when it was first launched, but there was a general consensus that such requests had become much less frequent since negative media coverage concerning the safety of the drug.

GPs were generally very positive about patient-initiated consultations concerning smoking. Most felt that patients who had taken this course of action were highly motivated, and therefore worth spending time with because they were genuinely interested in trying to stop. Furthermore, GPs were generally very keen on the idea of patients visiting the GP for pharmaceutical support *after* they had contacted specialist services. Most felt that this model of approaching cessation was a good one, because the patient was taking responsibility for their health *and* the time-consuming counselling work was being done by someone else (who was appropriately trained and had the time to do this work).

Despite this enthusiasm for patient-initiated consultations, most GPs responded negatively to the suggestion that greater encouragement (e.g. posters in waiting rooms) could be given to patients to make an appointment to discuss smoking with their GP. Resistance stemmed mainly from concerns about additional workload; many also felt that it was more appropriate for patients initially to discuss smoking cessation support with Practice Nurses or specialist counsellors, who could then refer patients on for pharmaceutical support if deemed necessary.

4
GPs : NATURE OF GP INTERVENTIONS

Discussion revealed that there was relatively little consistency between GPs regarding the way in which the topic of smoking was addressed. Some GPs appeared to be much more directive in their communication style than others; some emphasised the health damage caused by smoking, others focused exclusively on possible solutions; some simply gave out cessation service leaflets or cards to smokers with a recommendation to 'phone this number'; others tended to go into much more detail about the range of products available, and the nature of the services on offer.

GPs also varied their approach with different patients and consultation contexts. Most reported that they pushed the stop smoking message harder with patients with smoking-related symptoms.

> It depends on how much time I've got…it also depends on how the patient responds to the message from me.
>
> *I suppose I am more dogmatic and lecturing to those I feel are really suffering from their smoking…diabetics with high cholesterol or whatever.*
>
> If they come in with chronic respiratory disease and they still smoke, I say, 'you've got to stop smoking, it will kill you!'

It should be noted that some GPs were much better informed about the nature and effectiveness of local cessation services than others; those who knew least about the services seemed less likely to mention them to their patients, and 2 of the 14 GPs in the sample reported that they had never referred a patient to the local specialist services. There was also some variation in GP readiness to promote NRT and bupropion to their patients; these issues are explored more fully in the next section.

5
GPs : ATTITUDES TO CESSATION SERVICES

A clear majority of GPs in this research felt that the establishment of specialist smoking cessation services to which they could refer patients for help was a very good thing. GPs often commented that prior to the introduction of these services, there was an unmet need for counselling and support for smokers who wanted to give up. Such work was generally acknowledged to be too time-consuming for GPs and was not generally seen as a GP role. Prior to the establishment of specialist services, some GPs had referred patients to the Practice Nurse, others had handed out leaflets or telephone helpline numbers; one had referred smokers to alternative therapists, largely because they – unlike GPs – were able to offer patients time.

> *Before (the local specialist service), we used to refer more people to the hypnotherapists and acupuncturists because they had more time to spend, they have 45-minute appointments.*

Against this background, many GPs were delighted to have access to a free, credible, NHS service to which they could refer smokers. This was generally seen as good for patients and something of a relief for GPs.

> I'm just pleased because if someone says, 'I want to stop smoking', it takes an enormous length of time - I'm thrilled to bits but I know they need a lot of support and I can't give that time, so I think it's wonderful that you've got these really nice people, really skilled, who have the time and the know-how…it's absolutely wonderful.

Several commented that the existence of specialist services and NRT on prescription prompted them to raise, or re-raise, the issue of smoking more often with patients, because they felt they had something to offer.

> *I think since smoking cessation came in, it's picked up our awareness a little bit and, for me anyway, it's a little bit more motivation to have a go again.*

A minority of GPs, however, felt less positive about specialist services, and were rarely referring patients. In part, this seemed to reflect a poor understanding of what the services did, how they did it, and how effective they were. In addition, some GPs with a high proportion of socially disadvantaged patients were less enthusiastic about referring to specialist services, because they were considered to be too remote. These GPs argued that the money would have been better spent on supporting practice-based counselling activity.

> The Government should be funding us to get our nurses trained.

> *I've never done a referral to a specialist service – in practice, it's so far away from where we are – two bus rides away for most.*

> (The local Health Authority) spent a massive amount of money under the label of smoking cessation, but I don't know where it went…it certainly didn't come to me to fund my time to spend with patients.

Other GPs were much less critical of specialist services, however, because they had access to outreach specialist counsellors working from their surgery or within the local community. This approach was thought to be much more accessible and appealing to disadvantaged groups.

GP awareness and understanding of specialist services varied. To some extent, this seemed to reflect individual differences in uptake of training sessions; it may also reflect how closely GPs read mailings about cessation.

> *They're specially trained nurses and counsellors, aren't they, they're ex-smokers themselves, something like that. I wish I knew more about it.*

> We went to the initial meetings and they send us data on each practice in the PCT, telling us how many patients you have referred as a statistic, to see how you compare with other practices, which is encouraging.

Regarding effectiveness, most GPs knew that the 4-week success rates of the clinics were around 40-50%, with subsequent drop-off. There was some cynicism amongst GPs about the focus on short-term success rates, but several commented that they found the relatively high four-week cessation statistic very useful as a tool to encourage patients to attend the service.

> *It's 58% if you go to (local service) – that's what I've been quoting to my patients. It drops down at 6 months.*

Some GPs in the sample were much less certain about service success rates, and a minority were completely unaware how much difference the addition of intensive counselling and pharmacological support could make to cessation rates.

> I'm sure with a bit of intensive support you can get the percentage up by 1 or 2%, but in practice someone is either motivated or they're not…and obviously, going cold turkey is the best way.

The incremental success rates of increased intensity interventions has been well documented, and is illustrated in current smoking cessation guidelines: the incremental effect on 6-month abstinence of intensive support plus NRT or bupropion is 13-19% [1].

Those who were initially least well informed about the services were often impressed by the 40-50% four week service success rates discussed in the groups, particularly if these figures were from their local service. Interestingly, feedback about local service activity seemed to be much more motivating to GPs than large-scale national statistics; at core, they wanted to know how things would impact on their patients and their practice.

> *I'd like to know how much it affects me, where I practice and my patients…if it was as much as 47%, I'd get stuck in.*

Several GPs commented that waiting lists for accessing cessation services were relatively long – reportedly up to 6 months in one London borough – and how unsatisfactory this was for both patient and doctor. Some GPs offered interim support in the form of a visit or visits to the Practice Nurse; others, however, appeared to have little awareness of how demotivating a wait could be.

> *If they've been smoking for 13 years, they can wait another four weeks.*

The true picture of waiting times is rather varied from service to service. Some services report no waiting lists at all – where waiting time is involved it is usually because of the life cycle of groups. Many services offer a range of options including drop-in, 1-1 support or groups, and some offer a "rolling group" arrangement allowing smokers to join in at any time.

6
GPs : ATTITUDES TO NRT AND BUPROPION

GPs were generally very positive about prescribable NRT: as with cessation services, they were pleased that they now had something tangible to offer smokers – rather than simply 'lecturing' them to give up. Several GPs also commented that they were pleased to be able to offer NRT free to low income groups.

> *I think my smoking service has been revolutionised by the nicotine (replacement) products on prescription.*
>
> Cost was certainly a deterrent for some people. It's been great to be able to say, 'yes, I'll give you the patches.'

Most GPs saw nicotine replacement therapy as the first line pharmacological therapy for smokers who wanted to give up. Some prescribed it immediately when smokers expressed interest in giving up, others referred patients to specialist services and waited to see if the services felt that NRT was appropriate. Either way, NRT was viewed as a relatively uncontroversial treatment, which enhanced some smokers' ability to give up.

GP attitudes to bupropion were completely different. Bupropion was universally regarded as a strong, potentially dangerous drug, which most were reluctant to prescribe. Bupropion's effectiveness as a cessation aid was rarely questioned – in fact, most GPs seemed to believe that it was more effective than NRT. However, all had serious concerns about the safety of the drug.

> *Zyban has got such a bad reputation, you're loath to prescribe it. And I've had quite nasty side effects – night sweats, feeling spaced out, aggression, swelling of the tongue…*
>
> There was a report about an air hostess who died…we don't get many people asking for it now…and I had a chap who suffered with severe chest pains and we had to stop it. That frightened me a bit.

I had a lot of success with Zyban initially, about 30%, but now there's a duty to counsel the patients that there's a 1 in 1000 risk of fits…it creates all sorts of problems because of the link with driving.

Although bupropion was known to have been approved by NICE, all GPs in this sample regarded it as a treatment of last resort, only to be used when all other avenues had failed. Most GPs seemed to be prescribing bupropion *only* to patients who attended specialist counselling, arguing that this was the procedure advocated by the NICE guidelines.

If they come in for Zyban, I say go to the (specialist service) because they need you to jump through the hoop, the Government want you to jump through the hoop.

The implication of the guidelines is that the first line should be nicotine replacement and if they aren't suitable, Zyban.

Unprompted patient requests for bupropion were said to have been relatively common initially, but such requests were said to have fallen off dramatically since the adverse media publicity about the drug. Some reported they were still receiving occasional requests from patients who had friends or relations for whom bupropion had 'worked'. Such requests were typically responded to by a referral to the cessation service.

When the cessation clinics came on line, I stopped prescribing Zyban on demand, I insisted they contact the smoking cessation clinic, jumped through the various hoops and then if it was felt necessary that we needed Zyban, I'd give a prescription. That's my current attitude.

7

GPs : SUGGESTIONS FOR IMPROVING COMMUNICATION ABOUT SMOKING

Many GPs commented that more (or more high profile) feedback about referral patterns and outcomes from local specialist services, particularly if GP-specific and comparative, would enhance their motivation to keep smoking on the consultation agenda.

> I think I need to be told where I stand, how I am performing. This sort of feedback would keep me interested in it, otherwise you're like a straw blowing in the wind; you don't know how you're doing.

Several also argued that financial incentives for GPs and primary care teams to address smoking cessation would not go amiss.

> *I think it would help if it was more incentivised, smoking cessation. For instance, running asthma and diabetes clinics, GPs get a small payment . . . and immunisation…we're hovering around 79% and we need to get it up to 80%…that's a major incentive for us.*

The suggestion of putting up posters in waiting rooms inviting patients to make an appointment to find out how GPs can help was not well received, because it suggested increased demand. Even the most pro-cessation GPs responded with alarm.

> Much as I'm a great advocate of stopping people smoking, I wouldn't want to encourage more patients to come and see me about it because there just aren't enough hours in the day.

Given GP workloads and specialist service waiting lists, many GPs felt that the funding of more specialist counsellors should be a priority. To some extent, this reflected the widely held view that cessation counselling was primarily a nurse role. Many GPs, particularly those in London, argued that additional nurses should be practice-based, in order to increase accessibility and appeal to socioeconomically disadvantaged patients.

> *I think the way forward is to have a pool of specialist nurses who go to each practice once a week to do a specialist clinic…that's the way ahead.*

8
SMOKERS : ATTITUDES TO GIVING UP

Initial 'warm-up' discussion with smokers revealed that, although cigarette smoking was still seen as a social bonding activity within immediate friendship groups, the wider social climate towards smokers was seen as becoming increasingly hostile. Many smokers commented on the increasing difficulty or embarrassment of smoking in public places (e.g. restaurants, workplaces, planes), and some complained of feeling 'persecuted' because they were smokers. Recent high-profile TV advertising campaigns had also contributed to the feeling that society was becoming increasingly intolerant of smoking. On the other hand, many smokers argued that the government was being duplicitous by funding 'stop-smoking' campaigns whilst continuing to permit the sale and promotion of cigarettes.

All smokers in this research had expressed some interest in giving up. The cost of cigarettes and the social stigmatisation of smokers were often important motivational factors in wanting to give up, and these immediate concerns were often more salient than longer term, more remote concerns about health.

Despite expressing interest in wanting to give up, discussion revealed that many smokers held highly ambivalent views about continuing to smoke, and often imbued cigarettes with positive as well as negative attributes. Cigarettes were variously spoken of as a comfort, a boredom reliever, a coping mechanism and a way of controlling eating/weight. Moreover, some smokers admitted that, although they wished they didn't smoke, they still *enjoyed* a cigarette.

A further problem was that many smokers felt that they were simply *unable* to give smoking up. Some characterized this as addiction, but many (particularly women) spoke of lack of willpower, and felt guilty or ashamed at their inability to stop.

Smokers' feelings of stigmatisation and inability to stop had important implications for their attitudes towards seeking help from doctors, and the type of interventions they wanted health professionals to offer.

9
SMOKERS : ATTITUDES TOWARDS DISCUSSING SMOKING WITH GPS

Smokers' experiences of discussing smoking with GPs were, inevitably, varied. Some reported that their GPs raised the issue of smoking every time they visited the doctor; others claimed that their GPs rarely, if ever, mentioned the issue. Women with small children often commented that midwives and nurses raised smoking much more frequently than GPs. Many patients felt that their GPs simply did not have the time to discuss smoking cessation with them.

> *The doctors haven't got the time, have they? They want you in there, sort it out, give you a prescription, out the door, in with the next one…it's not their fault, there's just not enough of them to go round.* Male smoker 45-65 yrs

> I keep an eye on the clock when I go to the doctor's – you can see the time ticking away and it panics me, it's horrible! You feel anxious, you feel I'd better not take his time up. Female smoker 45-65 yrs

> *It's like they've got no time for you, really, have they? You feel rushed…it's like 'quick, quick, quick'.* Female smoker 18-30 yrs

> I think they stand back and don't say anything because they know you're going to ask questions and prolong the appointment.
> Female smoker 45-65 yrs

Many smokers also complained that, if the issue of smoking was raised, GPs discussed it in an unhelpfully perfunctory manner, with little or no explanation of products or services on offer. Handing out written information about stop smoking services could evidently be construed as 'passing the buck', particularly if done hastily.

> *Whenever I go for anything, he'll say 'are you a smoker?' and I'll say 'yes' and he says, 'well you shouldn't'. That's all I get.* Male smoker 45-65 yrs

> He just asked me how many I smoked a day, typed it into a computer and that was it. Female smoker 45-65 yrs

> *I think a lot of them just hand out this NHS thing, 'here's the freephone number, and to me that's like passing the buck. You feel as if they're not really interested.* Female smoker 45-65 yrs

When GPs did raise the smoking issue, they were often perceived as admonishing or 'getting at' patients, rather than encouraging them to stop – or explaining how they might be able to help. Arguably, some of these negative perceptions were related to smokers' sensitivities as well as the manner in which the subject was raised; smokers (particularly women) often commented that simply being asked about smoking by a doctor (particularly a male) made them feel stupid, guilty and ashamed.

> I just feel ashamed, he must think, 'Is she stupid, spending all that money on cigarettes?'…and it's health as well…I've got mild asthma and I know I shouldn't smoke. Female smoker 45-65 yrs

> *I feel he's looking down on me…they make you feel like you've done something wrong.* Female smoker 18-30 yrs

The manner in which questions were asked and information supplied evidently had huge significance for smokers. A minority of respondents reported that their GPs had intervened in a much more helpful and encouraging way.

> *The doctor was very encouraging to my husband – he said we'll send you to the non-smoking centre and explained how they would be able to help him – and he said to come back if there was anything else we wanted to talk about, or if he needed a prescription. He was very good.* Female smoker 45-65 yrs

Most smokers recognised that the rather abrupt way in which many GPs raised smoking probably reflected time and work pressures to a large extent. However, many felt that there was little point in raising the issue unless some positive information and/or encouragement were supplied.

10
SMOKERS : ATTITUDES TO SEEKING CESSATION HELP FROM GPS

Given that doctors were perceived as extremely busy, that discussing smoking with doctors often made smokers feel uncomfortable, and that awareness of what doctors could offer (and its effectiveness) was patchy, the suggestion of proactively making an appointment to discuss giving up smoking with the GP held little appeal. Several commented that this course of action would be a last resort.

> I don't see how the doctor could help you…If I got desperate I'd go to the doctors, but that would be the last thing I'd think of. Female smoker 18-30 yrs

> *Smoking, you think it's within yourself to stop smoking, you think, 'fancy going to the doctor – he's busy enough already!'* Female smokers 45-65 yrs

The concept of making an appointment to discuss smoking with a *nurse* held more appeal to some smokers, particularly women. Women generally anticipated that nurses would be more understanding, less judgemental, less time pressured and more encouraging than GPs.

> *I would rather see the nurse because it's not so formal. And I know it sounds silly, but I would feel I was wasting the doctor's time because she should be treating the ill people. Mine's just a habit.* Female smokers 18-30 yrs

> If they had a Practice Nurse you could see, that you could make an appointment with regarding smoking, that would be much better…you feel more at ease talking to a nurse…then she could refer you to the doctor if she felt it was necessary. Female smoker 45-65 yrs

Others said that they would rather ask a pharmacist for advice, or phone the telephone helpline advertised on the television. But, given the widely held belief that giving up was essentially a matter of personal willpower, many were sceptical about how helpful any of these sources would be.

> *I think ultimately, it's down to you, anyway. It's all willpower.*
> Female smoker 45-65 yrs

11
SMOKERS : ATTITUDES TO CESSATION SERVICES

Most smokers were aware of the existence of specialist stop smoking services in their area. Awareness was derived from a number of sources – ringing the national helpline, local advertising, word of mouth, and occasionally health professionals (midwives and dentists as well as nurses and GPs).

Smokers tended to refer to the services as 'stop smoking groups', and many assumed that group therapy was the only type of support on offer. This was evidently not to everybody's taste.

> *It's a bit like Alcoholics Anonymous – staring at each other…. I might go with a friend…* Female smoker 18-30 yrs

In principle, older female smokers found the notion of specialist counselling (groups) most appealing – several had previously participated in weight loss support groups such as Weightwatchers or Slimming World. Many smokers, however, even amongst this group, questioned whether counselling or groups could really help smokers to give up. Most were surprised and impressed to learn that 40-50% of smokers had succeeded in stopping 4 weeks after attending the services[2], but mentioning 15-20% long-term abstinence rates had a much less positive impact.

For C2DE smokers, there were also practical barriers. Several respondents echoed the GP view that their local services were too far away to appeal; it was generally agreed that two bus rides was too far, and that practice-based or community-based help would be more appealing.

A further barrier cited by some smokers was the waiting time, which many had heard of. Smokers generally felt that if they were in the frame of mind to make a cessation attempt, they wanted (and needed) to do it without delay, whilst the time was right.

> It was the wait that put me off. I've heard people say that when you ring that number, you've got to wait weeks and weeks to see these counsellors…and if I can put it off, I will. Female smoker 45-65 yrs

12
SMOKERS : ATTITUDES TO NRT AND BUPROPION

Smoker attitudes to NRT were lukewarm, largely because of perceived ineffectiveness. Many smokers expressed the view that NRT didn't work, largely because they themselves or others they knew had tried NRT products and failed.

> *How good are they? Because you're never told, are you? Lots of people don't take patches because they think they don't work.* Male smoker 45-65 yrs

Cost was also an issue for some; smokers often complained that NRT was expensive, and were reluctant to pay out over £10 for something that might not work. Awareness of NRT on prescription was patchy – some had been told by friends, others by pharmacists, and a few had been told by their GPs. Smokers on low incomes generally welcomed the fact that they were able to obtain patches free on prescription; however, several believed that they had to attend counselling first, and this could be off-putting.

> I asked about patches but I'd got to go on this course and prove that I could pack up smoking before he'd prescribe them. Male smoker 45-65 yrs

Smoker perceptions of bupropion, where known, were very similar to those of GPs. Younger women knew very little about bupropion, and most had never heard of it. Awareness was much higher amongst older respondents, but it was almost universally perceived (thanks to sensationalist media coverage) as a powerful and dangerous drug with potentially lethal side effects. Not surprisingly, interest in trying it was extremely low.

> That Zyban, I wouldn't take anything like that because you can get hooked on that as well…it's like an antidepressant. Female smoker 45-65 yrs

> *I've heard it can affect your heart. Another thing I've heard is that it hasn't been tested properly.* Male smoker 45-65 yrs

> Somebody actually died, or so it said in the paper. They had blood clots. I don't think I'd take it – I'd be too frightened. Female smoker 45-65 yrs

13
SMOKERS : SUGGESTIONS FOR IMPROVING COMMUNICATION

There was a general consensus amongst smokers that GP interventions about smoking would seem more helpful if they placed greater emphasis on explaining the type of help they could offer (groups, individual counselling, pharmacological aids), and raising awareness of how much more *effective* these forms of help were than willpower alone.

> *We all know the dangers of smoking, we don't need that drumming into us. We need them to be more reassuring and more positive…you need someone to say, I know it's hard, but encourage you… Maybe they should not tell us to give up, but say ' if you want to, try this'…you want to know 'this works because so many people have tried it and found it really helpful'.*
> Female smoker 18-30 yrs

As explained in section 10 above, most smokers were resistant to the idea of proactively seeking help about smoking from their GPs, largely because of perceived GP time/workload pressures and the belief that they could do little to help. Some felt that encouraging posters in waiting rooms, highlighting the types of help available and inviting patients to make an appointment with the doctor or nurse to discuss giving up would be useful. However, those who were interested in this idea generally felt much more comfortable with the idea of making an appointment to see a (less time-pressured, probably more empathic) nurse than a (busy, time-poor, probably less empathic) doctor. This was particularly true of female smokers.

When smokers were asked how uptake of cessation services might be improved, their suggestions were: reducing waiting times for access to counsellors; publicising four week success rates more widely; providing (and promoting) individual as well as group support; and basing counsellors in local surgeries rather than distant centres. The latter point was considered particularly important.

RECOMMENDATIONS FOR IMPROVING UPTAKE OF NHS SMOKING CESSATION SERVICES

Two main issues emerge from this report: firstly, the communication gap between smokers and their GPs, and secondly, the information gap between GPs and the specialist NHS services. The following recomendations to motivate GPs, improve GP-smoker communication, and increase uptake of local cessation services are offered:

- **Ensure that all GPs are made aware of the types of NHS cessation support available to their patients (groups and individual, central and local, pharmaceutical and behavioural), including information about waiting times and success rates.**
- **Motivate GPs to refer more patients to specialist services by providing them with:**
  - **practice-specific or practioner-specific feedback about referral rates, with comparative data from other local practices.**
  - **clear information about the incremental effect intensive support has on validated cessation rates.**
- **Encourage GPs to place more emphasis on forms of *help* within brief interventions, and how much more *effective* these are than willpower alone.**
- **Ensure that GPs and the general public are provided with accurate information about the safety of bupropion.**
- **Amongst smokers, promote wider awareness of NRT and bupropion on prescription, and clarify whether or not this is contingent upon attendance at counselling.**
- **Enhance accessibility of specialist services, eg with more outreach provision in Primary Care and community premises, to encourage uptake of services among socially disadvantaged groups.**

REFERENCES

[1] West R, McNeill AD, Raw M. Smoking cessation guidelines for health professionals: an update. Thorax 2000; 55: 987-999

[2] West R, McNeill AD, Raw M. Meeting Department of Health smoking cessation targets – recommendations for primary care trusts. Health Development Agency, London 2003

[3] Raw M, McNeill AD, West R. Smoking cessation guidelines for health professionals. A guide to effective smoking cessation interventions for the health care system. Thorax 1998, 53: suppl 5 (1): S1-19

[4] Hajek P, Taylor TZ, Mills P. Brief intervention during hospital admission to help patients to give up smoking after myocardial infarction and bypass surgery: randomised controlled trial. BMJ. 2002 Jan 12; 324 (7329): 87-9

[5] Senore C, Battista RN, Shapiro SH et al. Predictors of smoking cessation following physicians' counselling. Prev Med 1998; 27: 412-21

[6] Meltzer H, Gill B, Petticrew M et al. Economic activity and social functioning of adults with psychiatric disorders (OPCS Surveys of Psychiatric Morbidity in Great Britain Report 3). London, HMSO; 1995

[7] Jarvis M. The challenge for reducing inequalities: analysis of the General Household Survey 1998. Presentation to Department of Health Seminar January 2001

The silent treatment ~
why GPs and patients don't talk about smoking

Maalinta aan Sigaarka la cabbin ee sanadka
Sigarayi Birakma Günü
Ngày không hút thuốc
Diwrnod Dim Smygu
धूम्रपान निषेध दिवस
No Smoking Day
Roja Cigara Navaxandine

No Smoking Day Campaign Office:

59 Redchurch Street, London E2 7DJ

mail@nosmokingday.org.uk
www.nosmokingday.org.uk