Anti-smoking advice from general practitioners: is a population-based approach to advice-giving feasible?

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SUMMARY

General practitioners' (GPs') advice against smoking has a small, beneficial effect on patients' smoking. Consequently, GPs have been urged to adopt a population-based approach to advice-giving that involves discussing smoking repeatedly with the maximum possible number of smokers. This discussion paper assesses how far GPs' current clinical practice is from a population-based approach to advice-giving and finds that GPs prefer a problem-orientated approach to advising those who present with smoking-related problems. Discussion focuses on the feasibility of suggesting that GPs adopt a population-based approach instead.

Keywords: smoking cessation; health promotion, general practitioner.

Introduction

BRIEF advice against smoking is the simplest anti-smoking intervention primary care physicians can provide and it is the most frequently studied.[1] Trials have been completed in many different primary care settings and these have been collated in systematic reviews[2-5] which conclude that general practitioners' (GPs') brief advice against smoking causes 2–3% of those advised to stop smoking, that supportive follow-up increases quit rates, and intensive advice is more effective than less intensive advice. One analysis of the literature also concludes that providing a consistent, repeated anti-smoking message maximises the efficacy of anti-smoking advice.[5] This message has recently been emphasised by evidence-based guidelines for the management of smoking cessation that have been published in the United Kingdom[6] and in the United States of America.[7] Additionally, the UK government published a White Paper[8] explaining how policy can best address the smoking epidemic. These documents argue, correctly, that anti-smoking interventions delivered by doctors are effective and that the widespread delivery of these interventions in primary care could reduce smoking prevalence. They also propose that GPs should take a population-based approach to advice-giving that involves discussing smoking repeatedly with the maximum possible number of smokers to have the greatest possible effect on population smoking rates.

Both the guidelines[6,7] and the White Paper[8] acknowledge that a population-based approach to advice-giving is far from general practitioners' current clinical practice, but neither suggests how this could be achieved (at the time of writing this discussion paper, the UK smoking cessation guidelines[6] were in the process of being updated — see Postscript on page 1003).

This article assesses how far current practice is from a population-based approach and whether or not it is feasible or desirable to suggest that GPs adopt this approach. This is done by reviewing literature on (a) how often UK general practitioners advise patients against smoking and (b) what influences this aspect of UK GPs' clinical behaviour. The structures of primary care differ greatly between countries, so it is likely that different factors will influence family physicians' clinical behaviour in these different contexts. Consequently, we restrict our review and discussion mainly to GP advice-giving in the context of UK general practice. Searches of the Medline, PsychLIT and Assia databases, with reference checking, identified papers that describe the frequency of and help explain GPs' advice-giving behaviour. Some papers that are known to the authors were also used where these were not identified by searching. Identified papers had a variety of keywords and it is possible that others remained unidentified. This review must therefore be viewed as selective rather than exhaustive, though we have tried to be as representative of the available literature as possible.

How often do GPs discuss smoking with patients?

Knowing how often GPs currently discuss smoking with patients helps us to assess the likelihood of them adopting a population-based approach. Ideally, to answer this question accurately, we need information from studies where GPs' behaviour with patients is observed. Few UK studies have actually done this, so we also report those that used patient recall and GPs' self-report of their behaviour to quantify rates of advice-giving.

Up to 60% of smokers have no recollection of discussing smoking with their GP at any time.[9] This increases to 70–73% if smokers are asked whether they recall advice within the last year[10,11] and in a study of individual consultations 76% of smokers reported that smoking was not discussed. Sixty-four per cent of Oxford GPs[12] and 49% of Scottish GPs[13] reported discussing smoking routinely in all or nearly all consultations with smokers. The validity of the Oxford survey is questionable though since, as a concomitant survey of smokers in the region[10] found, only 36% recalled ever discussing smoking with their GP. Finally, estimates from a 1994 Leicestershire survey suggested that GPs advise fewer than 35% of smokers attending their surgeries to stop.[14]

Observing GPs' consulting behaviour should give the most accurate estimates of how frequently they discuss smoking with patients. In 1983, Boulton and Williams audiotaped a large number of consultations from 16 GPs. General practitioners discussed smoking in 16% of smokers' consultations but gave clear advice to stop in only 10%.[15] In 1995, a study of 42 Leicestershire GPs using video-recorded surgeries found that GPs discussed smoking in 29% of smokers' consultations.[16,17]

These studies reveal a low level of anti-smoking advice-giving. General practitioners do not advise against smoking in the

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majority of consultations with smokers but probably cover the topic in only 20% to 30%. Findings are fairly consistent between studies using patient recall and observation of GPs' consulting behaviour; however, these methods may overestimate advice-giving activity. Patients tend to report advice when it has not been given[18] and GPs' awareness of video-recording or audiotaping could result in them giving more advice than usual. Also, GPs agreeing to video-recording[19] (and possibly other observation methods) differ qualitatively from others. This may introduce recruitment bias where doctors who are more enthusiastic about advice-giving participate in studies. Surveys of GPs report more frequent advice-giving activity, but self-report is likely to overestimate this by favourable response bias.[20] It is also possible that GPs and patients differ in their perceptions of what constitutes 'anti-smoking advice' and this could help explain the observed discrepancies between GPs' self-report and patients' recall of anti-smoking advice. However, we are not aware of any research investigating this topic.

The next section considers the influences on GPs' advice-giving and assesses the feasibility of encouraging movement from the current low levels of anti-smoking advice-giving to a population-based approach.

Explaining GPs' practice

Understanding why GPs discuss smoking with only a minority of smokers could help to suggest ways in which their advice-giving can be increased. As both doctors and patients are likely to influence this aspect of clinical behaviour, studies exploring the issue from the perspectives of both are considered. There have been few studies that exclusively investigate GPs' attitudes towards discussing smoking in general practice consultations.[13,14] However, GPs cite giving advice against smoking as one of their most important preventive activities[21,22] so studies that explore GPs' and patients' attitudes towards preventive medicine in general are also used. We acknowledge that understanding clinical behaviour is difficult, or perhaps impossible, but the research summarised below provides us with some insight into this.

General practitioners acknowledge that advising patients against smoking is part of their job and they have a responsibility to advise smokers to stop.[12-14,23-27] They are consistently positive about the need to address patients' smoking during their routine consultations.[12-14,23] There is evidence, however, that GPs are more likely to discuss smoking with patients who have smoking-related problems. In the GP surveys cited above,[12-14] larger proportions of GPs (over 90%) reported that they were likely to discuss smoking when patients had 'relevant symptoms' than routinely in every consultation. General practitioners also report their preferred mode of discussing smoking as linking advice to patients' smoking-related problems,[14] with 97% feeling that their advice was likely to be more effective in this context. Smokers' consulting patterns differ from non-smokers. Overall rates are lower for smokers of both sexes aged over 45, especially for preventive care where perhaps smoking is likely to be an issue. However, at all ages smokers are significantly more likely to consult for mental health problems[28] and in these types of consultations GPs may find it more difficult to discuss smoking.

Additionally, some GPs report time constraints as a disincentive against raising the topic of smoking with patients.[12-14,27,29] For GPs, preventive medicine mainly constitutes giving lifestyle (or 'stop smoking') advice during routine consultations and they prefer to discuss lifestyle issues in the context of relevant problems.[14,27] Qualitative studies indicate that although GPs feel their anti-smoking advice is important, few feel that it is relevant in all consultations[12-14] as the time required for this would detract from the curative workload.[25] To avoid confrontation with patients, GPs tend to restrict advice-giving to situations where patients present with smoking-related problems.[30] This helps explain why GPs prefer a problem-based approach towards discussing smoking with patients and also why they report time constraints: GPs simply do not appear to perceive that there is an appropriate opportunity to discuss smoking in many of their consultations.

General practitioners' reports of preferring this problem-orientated approach towards advice-giving are corroborated by information from patients.[11] Those suffering from hypertension, ischaemic heart disease or diabetes are all more likely to recall GPs' advice against smoking, suggesting that GPs are indeed more likely to discuss smoking when patients have smoking-related morbidity.[11] Finally, in both studies that involved observation of consultations,[15-17] GPs were more likely to discuss smoking when patients presented with smoking-related problems.

Although GPs' lack of time is an important issue it is not the only barrier to the provision of anti-smoking advice. Increasing consultation time results in only a modest increase in the number of discussions about smoking that take place.[31] Surveys and interview studies with GPs highlight other problems that they feel hinder discussion of smoking. General practitioners find giving anti-smoking advice challenging. They find it difficult to persuade resistant patients to adopt 'correct' ideas about unhealthy attitudes and behaviours,[12,13,26] Consequently, GPs prefer giving lifestyle advice when smokers have already decided to stop.[12-14,25,26] and avoid discussing smoking in detail with smokers who give negative reactions when the topic is mentioned.[30] Doctors also find it hard to advise smokers who are stressed or whose social environment militates against cessation.[25,27] Accordingly, some GPs are ambivalent about the effectiveness of their advice,[12,13,25-27] calling for more training[12,13,26] to improve their communication of health promotion messages.[12,13,26] Few doctors appear to blame patients for their inability to change unhealthy behaviour and one study reported a minority of GPs who considered patients were not intelligent enough to understand health promotion messages.[26]

Influence of smokers' views

Surveys of patients[9,32] suggest that people believe GPs should be interested in 'smoking problems' but only 40–50% of smokers actually consider they have a smoking problem.[9,32] Although the vast majority of smokers are happy for their doctor to raise the topic of smoking, many of those with little motivation to stop do not welcome advice about how they should stop.[33] Stott and Pill explored working class women's views,[34] and some women in their study found lifestyle (smoking) advice unacceptable if it was not directly linked to either their health or a current smoking-related problem. Some even rejected outright the notion that GPs should advise them about their lifestyle. They felt that advice should be given sensitively: they were more likely to listen to a GP with whom they had a good relationship and who respected their autonomy in decisions about lifestyle issues. These findings were reiterated in a broader population by a later study concerned purely with smokers' views of GPs' anti-smoking advice.[35] Smokers felt it was up to them to decide when they are ready to stop and disliked repeated, ritualistic anti-smoking advice. Again, smokers who were not ready to stop were more likely to react negatively towards GPs' advice. It appears, therefore, that if GPs are to raise and discuss the issue of smoking without provoking negative reactions then they must tailor their discussion to the patient's readiness to stop smoking.

How feasible is a population-based approach?

General practitioners' and patients' views appear to be complementary. For example, GPs report problems in getting patients motivated to stop and some smokers report irritation about being advised to stop when they are not ready to do so. Also, both GPs and patients seem more comfortable discussing smoking in the context of smoking-related problems. To achieve a population-based approach to advice-giving, GPs need to change from advising only 20–30% of patients who smoke to advising almost all smokers who consult with them to stop. This is a daunting prospect as there appear to be many and varied barriers towards advice-giving rather than a few easily modifiable ones. Furthermore, the culture of general practice as defined by doctors' and patients' views seems to encourage a problem-orientated approach to advice-giving. It is not clear how these views, and in particular GPs' fears of upsetting patients, could be overcome: unless a way is found it is unlikely that GPs will ever discuss smoking repeatedly with the majority of their patients.

An alternative approach towards increasing the rates of advice-giving GPs would be to encourage them to make more use of problem-orientated opportunities. Exhorting doctors to discuss smoking whenever patients present for preventive care or with smoking-related problems is likely to be a more acceptable message to GPs and perhaps is more likely to be heeded. This approach could result in GPs advising greater numbers of smokers but is inconsistent with current guidelines[6] and so needs to be examined in more detail.

The systematic review finding that providing a consistent, repeated anti-smoking message maximises the efficacy of advice[5] has been used to suggest that GPs should advise all smokers to stop and to repeat this at every opportunity.[6,8] This finding is based on the observation that smokers who are advised more frequently to stop are more likely to do so. However, most trials of primary care doctors' anti-smoking advice have involved short follow-up periods. Although participating doctors have discussed smoking with all presenting smokers this has usually only been for brief periods: less than a year in most studies. The majority of smokers will have been advised only once and repeated advice will not have been given. Where primary care studies have involved doctors providing follow-up and repeated advice, only motivated smokers will have repeatedly attended for this. Smokers who are motivated to stop are more likely to do so and they differ from unselected ones attending their GP who will, on average, be less motivated. It is impossible to say whether the increased quit rates among smokers who are repeatedly advised is owing to doctors giving more advice or to the smokers being more motivated to stop. As one cannot predict which smokers will respond positively to GPs' anti-smoking advice (by stopping), any method of increasing GPs' rates of advice-giving is likely to promote smoking cessation among their patients. Consequently, advising a problem-orientated advice-giving strategy is not inconsistent with current evidence. It should be noted, though that using this approach to the issue may result in more patients developing symptoms before any effective anti-smoking intervention is delivered. This could diminish the potential health gain from anti-smoking advice.

We know that GPs' brief advice against smoking is effective but we have no idea which smokers will quit in response to being advised. General practitioners need objective ways of identifying how ready smokers are to try to stop smoking as they consult with them. Smokers who are motivated to try to stop appear to behave differently during primary care consultations than non-motivated ones,[36] but further work is needed to confirm whether or not these behaviours can predict future smoking behaviour. This could help GPs to concentrate their advice most effectively on those smokers who are most likely to change their behaviour. In answer to the question posed by the title of this article, a population-based approach towards advice-giving is untested and does not appear feasible in the UK at this present time. Given the concerns of clinicians and patients about this approach, perhaps we should reconsider whether this is a desirable aim.

Postscript

An update to the UK smoking cessation guidelines[6] has now been published.[37] These revised guidelines pay particular attention to how GPs and other primary health care workers might implement an evidence-based approach to smoking cessation. Significantly, the problems for GPs in implementing a population-based approach to advice-giving are acknowledged and discussed. A new recommendation that GPs aim to discuss smoking with patients and to document this at least annually is made. Additionally, the revised guidelines make constructive suggestions about how the primary health care team can be organised to support smokers who are motivated to stop. We recommend that GPs read the revised guidelines and evaluate their clinical practice in the light of these.

Key points

- General practitioners' anti-smoking advice causes a small proportion of smokers to stop.
- Previously, GPs have been urged to repeatedly advise as many smokers as possible against smoking (a population-based approach).
- General practitioners prefer to discuss smoking when patients present with smoking-related problems — moving to a population-based approach would involve a very substantial change in advice-giving behaviour.
- Merely urging GPs to discuss smoking more frequently with patients is unlikely to result in increased advice-giving.
- Recently updated guidelines on the management of smoking cessation acknowledge the barriers to a population-based approach and make constructive recommendations for primary health care teams.

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