

Factors influencing discussion of smoking between general practitioners and patients who smoke: a qualitative study

T COLEMAN

E MURPHY

F CHEATER

SUMMARY

Background. Anti-smoking advice from general practitioners (GPs) is effective and recent evidence-based guidelines urge GPs to advise all patients against smoking at every opportunity. GPs do not exploit many opportunities to discuss smoking with patients and the reasons for this are unclear.

Aim. To elicit, relate, and interpret GPs' accounts of why they discuss smoking with some patients and not others.

Method. Thirty-nine Leicestershire GPs were purposively selected so as to have a range of attitudes towards discussing smoking with patients. Each GP had one surgery session video-recorded and afterwards participated in a qualitative, semi-structured interview. Prior to each interview, GPs were shown a video-recording of one of their consultations with a smoker to enhance their recall of events.

Results. Being aware of patients' smoking status did not necessarily result in GPs discussing smoking with patients. GPs were keen to preserve good doctor-patient relationships and avoid negative responses from patients once the topic of smoking had been raised, and this was felt to be best achieved by restricting most discussions about smoking to situations where patients presented with smoking-related problems and in circumstances where the doctors perceived the doctor-patient relationship was strong. Doctors also thought it important to address patients' agendas relating to the current consultation before discussing smoking.

Conclusions. General practitioners have strong reasons for preferring to discuss smoking when patients present with smoking-related problems. Those wishing to increase the amount of advice-giving by GPs might be more successful if they encouraged GPs to make greater use of problem-orientated opportunities to discuss smoking.

Keywords: smoking; health advice; doctor-patient relationship; patient attitude.

Introduction

SMOKING remains a major public health problem in the United Kingdom¹ and general practitioners' (GPs') brief advice against smoking has a small but significant beneficial effect on patients' smoking rates.² For every 50 smokers whom GPs advise to stop, one or two will consequently do so.² There

have been calls for GPs to advise repeatedly the maximum possible number of smokers against their habit.^{3,4} Proponents of this population-based advice-giving strategy argue that using this approach will maximise GPs' effects on population smoking rates. More recently, evidence-based guidelines have again exhorted doctors to utilise a population-based approach towards giving anti-smoking advice.^{5,6}

General practitioners use few opportunities for discussing smoking with patients, advising only a minority of those who consult with them.⁷ The reasons for this are unclear. However, GPs do report preferring to discuss smoking when patients have smoking-related problems,⁷⁻¹⁰ and patients with smoking-related morbidity are more likely to recall their GP's advice.¹¹ Also, one study audio-taped routine consultations and found that, when GPs discussed smoking, they almost always related this to patients' problems.¹² It is important to understand the factors that influence whether or not GPs discuss smoking with patients. We sought to gain some insight into this by listening to GPs' accounts of their behaviour during consultations with patients who smoke.

Method

Subjects

The methods of purposive sampling and recruitment of GPs for this study are described in detail elsewhere.¹³⁻¹⁵ Ethical approval was granted by the Leicestershire Ethics Committee. Briefly, we measured Leicestershire GPs' attitudes towards discussing smoking with patients using a reliable and valid postal questionnaire.^{7,14} We then selected doctors with diverse attitudes towards discussing smoking and asked them to take part.¹³ The 42 participating GPs who agreed to take part were younger and more likely to work in teaching and training practices than non-participants.¹⁵

Data collection

We used a novel methodology, in which GPs were shown a video recording of one of their consultations with a smoker and later were interviewed about why they had or had not discussed smoking. We hoped that video-stimulated recall would enhance GPs' memories of events in consultations and help generate accounts of why they chose to discuss or avoid discussion of smoking.

We video-recorded one surgery session for each GP and asked all attending adult patients to give details of their smoking status on a pre-consultation questionnaire. Subsequently we asked patients to allow their consultation to be video-recorded. Details of data collection appear elsewhere.^{15,16} After each surgery all the smokers' consultations were viewed to select those most appropriate to show to the GPs.

Purposive sampling of consultations

Our choice of consultations to show to GPs was crucial as we wanted to hear GPs' accounts of their behaviour in an appropri-

T Coleman, MD, MRCP, clinical lecturer in general practice; and F Cheater, PhD, MA, RGN, senior lecturer in clinical audit (nursing), Department of General Practice and Primary Health Care, University of Leicester, Leicester General Hospital. E Murphy, PhD, MA, MSc, senior lecturer, School of Sociology and Social Policy, University of Nottingham. Submitted: 18 January 1999; final acceptance: 21 June 1999.

© British Journal of General Practice, 2000, 50, 207-210.

ate variety of consultations. Previous research suggested that the presence or absence of patients' smoking-related problems might influence doctors' decisions to discuss smoking.^{7-9,11,12} We also considered it important to hear doctors' accounts for their behaviour in consultations where smoking had and had not been discussed. Box 1 summarises the four types of consultations from which we purposively sampled. For each GP we aimed to show one consultation where smoking had been discussed and one where it had not. We also tried to ensure that we used the four consultation types as equally as possible in the study as a whole.

Interviews

Full details of interview technique are given elsewhere.¹⁷ After watching a recorded consultation with the GP, a semi-structured interview guide was used that focused on the discussion of smoking or its absence. Despite concentrating on this one area of consulting behaviour, GP were encouraged to give their own accounts. Topics included opinions of the whole consultation, priorities within the consultation, thoughts about why discussion of smoking had arisen (or not), comments on the style or approach used to discuss smoking, and approaches to discussing smoking used in other consultations. Interviews lasted 35 to 75 minutes, up to three consultations were shown to each interviewee, and most interviews were completed on the day of video-recording.¹⁷ Interviews were audio-taped and transcribed verbatim.

Analysis

Box 2 summarises the process of data analysis, and several points require emphasis. Both the themes and the categories upon which this analysis is based were derived from the data rather than being imposed by the analyst.¹⁸ The definitions of the emergent themes and categories were checked against the data and subsequently refined in an iterative process.¹⁹ During the final coding (Box 2, point 5) this iterative process continued and interview text was compared with written descriptors. In a few instances the data could not fit into existing definitions, so these were refined and new definitions agreed. We aimed to describe the main themes emerging from interviews and not to develop a typology for categorising individual GPs. After coding all interviews, we collated interview text from themes and categories relating to the research question to identify important issues. Finally, a sub-sample of five randomly-selected transcripts was read by FC, and this confirmed that these contained data that supported the principal findings of the study reported below.

Type 1

Smoking is discussed in the context of a presenting complaint which the interviewee perceives is smoking-related.

Type 2

Smoking is not discussed and the patient presents with a complaint which the interviewee perceives is smoking-related.

Type 3

Consultation in which smoking is discussed and the interviewee perceives there is no smoking-related complaint.

Type 4

Consultation in which smoking is not discussed and the interviewee perceives there is no smoking-related complaint.

Box 1. The four types of consultations considered important for purposive sampling. 'Discussion of smoking' is defined as any mention of smoking by doctor or patient. 'The interviewee' is the GP who was video-recorded.

Results

To help readers to assess the influence of video-recording on the interview study, we present brief, numerical data on this topic first. Of the 42 video-recorded GPs, two had no smokers attend their surgeries and one declined to be interviewed, so we base our findings on 39 interviews. Ninety-nine per cent of attending patients gave their smoking status on the pre-consultation questionnaire, and 86% consented to video-recording.¹⁶ Self-reported smokers were not more likely to withhold consent to recording, but younger patients and those with overt mental health problems were.¹⁶ Of the 86 video-recordings shown to GPs, 33 involved talk about smoking and in 25 of these the doctor thought a smoking-related problem was present.¹⁷

We report our interpretation of GPs' accounts below. Quotes from GPs appear in italics and are attributed to individual GPs by code numbers (eg DR124). Non-italic quotes from GPs with these code numbers appear in Box 3 or 4 illustrating points made.

Factors influencing GPs' awareness of patients' smoking status

Clinical cues, such as the smell of smoke or tar-stained hands, as well as medical records (where accurate), alerted doctors to patients' smoking status. In consultations where GPs perceived patients to be well, with no medical problems (eg oral contraceptive check or blood pressure check), doctors felt less time pressure and were more likely to enquire about smoking. Additionally, the requirement to make registration health checks or collect health promotion data prompted occasional enquiry about smoking. However, GPs expressed doubts about its usefulness:

'We're supposed to get a record [of patients' smoking status] for health promotion purposes so that's why we do it. Whether we act on it of course is a different matter...' (DR209.)

General practitioners' accounts illustrated that, even when they are aware of patients' smoking status, they do not routinely discuss this further. Different factors influence whether GPs try to encourage smokers to stop and the most important of these are discussed below.

Doctor-patient relationship (Box 3)

Maintaining good relationships with patients was of paramount importance to GPs. A frequently-cited barrier to discussing smoking was a fear of harming the doctor-patient relationship. This fear seemed to explain the problem-based approach that GPs employed

1. Both authors independently read the first 13 interview transcripts to identify 'themes': the principal factors that appear to influence discussion about smoking.
2. TC codes transcripts for themes. Data relating to each theme assembled. TC and EM independently read this and identify 'categories': variations in GPs' thinking within themes.
3. TC and EM agree working definitions for emerging categories and themes. TC codes the 13 transcripts using these.
4. TC and EM discuss and refine definitions of themes and categories.
5. TC begins re-coding all available and subsequent transcripts using definitions in 4. above. During this process some definitions are altered after discussion between researchers.

Box 2. Process of data analysis. Details of working definitions, revisions, and final definitions of themes and categories are available elsewhere.¹⁵

'The patient came in with an overriding problem which I think was her sole priority. If I'd tried to raise [smoking] with her, it would have been inappropriate and she may well have been offended.' (DR114.)

'I think [the patient] would vote with her feet and not bother coming back ... in terms of her attitude to smoking. I don't think it achieves one jot.' (DR294 explains why he avoided repeated discussion of smoking with a patient.)

'Apparently, I told her she was diabetic and told her the smoking must stop and she left [the practice]. She felt it [diabetes] was out of control and she had to make her own decisions.' (DR265.)

'If you know the patient ... then you can link it [anti-smoking advice] with advice you have given in the past ... and I always write in the notes, the next time they come up and say something about smoking.' (DR182.)

Box 3. Doctor-patient relationship.

'Basically, having brought it [smoking] up on previous occasions, he does not react very favourably to it. He does have some sort of paranoid views as well, so I really don't want to provoke him too much.' (DR293.)

'Obviously, if you know the way they are going to take [anti-smoking advice], I think you are less guarded about what you say, because you know how they are going to react to it.' (DR182.)

'I think I decided against [advising him against smoking] on the basis that I thought I would open a can of worms that I didn't want to open ... because I foresaw the psychological consequences of him stopping smoking.' (DR63.)

Box 4. Patients' responses.

towards raising the topic of smoking. GPs reasoned that patients presenting with smoking-related problems were more likely to consider discussion of smoking 'relevant', to listen to the doctors' advice, and to be less likely to become annoyed when asked about smoking (DR114). Many GPs cited previous experiences of upsetting patients to support their view that giving repeated advice to patients without smoking-related problems is counter-productive (DR294, DR265). A number also stated their belief that this did not help patients stop smoking (DR294). Consequently, doctors avoided giving repeated advice in consultations where smoking was not contributing to patients' medical problems.

Where GPs perceived their relationship with a patient to be poor or requiring development (e.g. temporary residents or new patients), they were less likely to discuss smoking. Since discussing smoking could engender confrontation with some patients, GPs preferred to have some knowledge of the patient before doing so. Conversely, where GPs knew patients well and had a good relationship with them, they were happier to discuss smoking (DR182). GPs infrequently raised the topic of smoking in the absence of a smoking-related problem. On the few occasions where they did, GPs explained that they felt comfortable doing so because they had discussed the issue previously with the patient. GPs, therefore, contextualised giving advice against smoking in their ongoing, longitudinal relationships with patients.

Importance of patients' responses (Box 4)

General practitioners' accounts suggested that their advice-giving behaviour is influenced by their perceptions of patients' likely responses. Doctors avoided broaching the topic of smoking if they anticipated negative responses. Where patients' previous responses to discussion of smoking were negative, GPs were reluctant to raise this again (DR293). GPs guessed how patients

would react to advice given prior knowledge of patients. Where doctors had greater knowledge of patients, they generally felt more confident about mentioning smoking because they could anticipate how patients might respond (DR182).

General practitioners avoided talk about smoking where they knew patients had previous psychological morbidity (such as depression or addictions). Some patients observed on video were addicted to heroin, butane gas, or psychotropic drugs. Doctors felt that smoking harmed these people less than their addictions, and, in addition, that they were very unlikely to be able to stop smoking. GPs encouraged smokers with depression or anxiety states to postpone their attempts at stopping smoking because they anticipated that these patients would also be unsuccessful. GPs wanted smokers to stop, but did not actively promote this when they expected patients' problems to be made worse by quit attempts (DR63).

Once GPs had made the decision to ask about smoking, their assessments of patients' responses determined whether they pursued the topic in more detail. Where patients seemed motivated or interested in talking about smoking, doctors were happier to discuss it further. Alternatively, where patients appeared uninterested or unreceptive to discussion, GPs were less likely to continue with further discussion. Doctors used verbal and non-verbal cues to assess whether patients were motivated to stop smoking or not:

'I've got to sense in them quite a substantial commitment. It's not necessarily the words they use, it's the feeling they give you.' (DR63.)

'She's obviously motivated or she will be ... She is fairly comfortable and relaxed about bringing it [smoking] up. I mean, I mentioned it, she didn't appear threatened or defensive.' (DR207.)

Importance of patients' agendas

When deciding whether or not to raise the issue of smoking, GPs were careful to determine how appropriate they felt this was in the context of the current consultation. GPs thought it important to address the problems that concerned patients most ('patients' agendas'), because patients were more satisfied with consultations when doctors managed this. GPs were wary of discussing smoking in consultations where patients might consider it irrelevant. Doctors felt that, with limited available time, they should address patients' agendas, as this would avoid patients becoming unnecessarily irritated. In particular, GPs expressed strong reservations about discussing smoking in consultations where patients were distressed or upset. Doctors felt that, in these circumstances, patients would be most likely to feel their problems ignored if smoking were raised.

'If at the end of all this I started to ask her about smoking, I wonder whether she would go away thinking "Well, did the doctor hear anything of what I was talking about?"' (DR50.)

Discussion

General practitioners' desire for harmonious relationships with patients appears to strongly influence the way they choose to raise and pursue discussion of smoking with patients. Additionally, GPs' perceptions of patients' responses to advice seems to influence their advice-giving. These factors help explain why GPs are more likely to discuss smoking with patients who have smoking-related problems. Previous studies have not reported how the importance that GPs attach to preserving doctor-patient relationships influences the way they discuss

smoking with patients: this is a new finding. Others, however, have documented that patients can become irritated by GPs' anti-smoking advice.²⁰⁻²³ Our study suggests that these negative responses to advice may contribute towards GPs restricting talk about smoking to contexts where they anticipate neutral or positive reactions from patients.

Methodological issues

One novel aspect of our research method was the use of video-recorded consultations with semi-structured interviews which has been discussed and compared with similar approaches elsewhere.¹⁷ Video-recording introduced bias into our patient and GP samples, so we must assess how this could affect our findings.

Younger patients and those with overt mental health problems were under-represented on video.¹⁶ Accordingly, some factors which GPs perceive as influential in discussing smoking with these types of patients may not have been identified during interviews. Younger GPs and those working in teaching or training practices were more likely to agree to be video-recorded.¹³ It is possible, therefore, that relevant information could be obtained by further interviews with older doctors working in less developed practices. However, by sampling GPs with a variety of attitudes towards discussing smoking, we may have minimised the importance of GPs' demographic characteristics which may have an impact on the completeness of our description.^{13,14} More positively, using video-recordings may have stimulated GPs' recall of less memorable consultations and generated discussion of issues that would have not been aired without them.¹⁷

We cannot be certain that video recording did not influence doctors' or patients' behaviour. GPs did not discuss smoking more frequently than in previous studies,^{15,24} so we may have been successful in observing 'normal' GP behaviour. Previous research suggests that video recording does not affect GPs' consulting behaviour,²⁵ but, unfortunately, there is little evidence about the effects on patients' behaviour.

Implications of findings

Recommendations that urge GPs to discuss smoking repeatedly and as frequently as possible⁴⁻⁶ ignore the context in which doctors practise. These population-based approaches are at odds with the problem-based approach that our results suggest that GPs feel is most appropriate to their role. Consequently, these recommendations are unlikely to be followed.

General practitioners' decisions to discuss smoking with patients are multifactorial and complex, suggesting that any single-issue interventions to increase the amount of advice they give will have limited success. For example, increasing general practice consultation length causes only a modest increase in rates of advice-giving,²⁴ perhaps because time is one of many factors that influence GPs' decisions to discuss smoking with patients. Similarly, interventions that raise GPs' awareness of patients' smoking status will not necessarily cause doctors to promote smoking cessation by patients. Researchers or policy-makers wishing to increase GPs' rates of anti-smoking advice-giving need to consider our findings carefully. It appears that strategies which encourage GPs' to increase their advice-giving in a problem-based manner are likely to be most successful. The alternative would involve changing practitioners' beliefs about giving anti-smoking advice during routine consultations and this represents a far greater challenge.

References

1. Health Education Authority. *The smoking epidemic: a prescription for change*. London: HEA, 1993.

2. Ashenden R, Silagy C, Weller D. A systematic review of the effectiveness of promoting lifestyle change in general practice. *Fam Pract* 1997; **14**: 160-176.
3. Russell MA, Wilson C, Taylor C, Baker CD. Effect of general practitioners' advice against smoking. *BMJ* 1979; **2**: 231-235.
4. Royal College of General Practitioners. *Combined reports on prevention*: [Reports of a Working Party appointed by the Council of the Royal College of General Practitioners.] London: RCGP, 1981.
5. Fiore MC, Bailey WC, Cohen SJ. *Smoking Cessation. Clinical Practice Guideline No 18*. Rockville, MD: U.S. [AHCPR Publication No.96-0692.] Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, 1998.
6. Raw M, McNeil A, West R. Smoking cessation guidelines for health professionals. *BMJ* 1999; **318**: 182-185.
7. Coleman T, Wilson A. Anti-smoking advice in general practice consultations: general practitioners' attitudes, reported practice, and perceived problems. *Br J Gen Pract* 1996; **46**: 87-91.
8. Coulter A, Schofield T. Prevention in general practice: the views of doctors in the Oxford region. *Br J Gen Pract* 1991; **41**: 140-143.
9. Lennox AS, Taylor R. Smoking cessation activity within primary health care in Scotland: present constraints and their implications. *Health Educ J* 1995; **54**: 48-60.
10. Williams A, Boulton M. Thinking prevention: concepts and constructs in general practice. In: Lock M, Gordon D, (eds). *Biomedicine examined*. London: Reidel, 1988.
11. Silagy C, Muir J, Coulter A, et al. Lifestyle advice in general practice: rates recalled by patients. *BMJ* 1992; **305**: 871-874.
12. Boulton MG, Williams A. Health education in general practice consultations: doctor's advice on diet, smoking and alcohol. *Health Educ J* 1983; **42**: 57-63.
13. Coleman T. Sampling for qualitative research using quantitative methods. 2. Characteristics of GPs who agree to video-taping of consultations. *Fam Pract* 1996; **13**: 531-535.
14. Coleman T, Williams M, Wilson A. Sampling for qualitative research using quantitative methods. 1. Measuring GPs' attitudes towards discussing smoking with patients. *Fam Pract* 1996; **13**: 526-530.
15. Coleman T. *Anti-smoking advice in general practice consultations: a description of factors influencing provision of advice and the development of a method for describing smokers' responses*. [MD thesis.] University of Leicester, 1998.
16. Coleman T, Manku-Scott T. Comparison of video-recorded consultations with those in which patients' consent is withheld. *Br J Gen Pract* 1998; **48**: 971-974.
17. Coleman T, Murphy E. Combining qualitative interviews with video-recorded consultations: gaining insight into general practitioners' decision-making. *Fam Pract* 1999; **16**: 173-178.
18. Fitzpatrick R, Boulton M. Qualitative research in health care: I. The scope and validity of methods. *J Eval Clin Pract* 1996; **2**: 123-130.
19. Strauss A, Corbin J. *Basics of qualitative research: grounded theory procedures and techniques*. Newbury Park, California: Sage Publications Inc, 1998;197-223.
20. Catford JC, Nutbeam D. Prevention in practice: what Wessex general practitioners are doing. *BMJ* 1984; **288**: 832-834.
21. Williams SJ, Calnan M. Perspectives on prevention: the views of General Practitioners. *Sociol Health Illness* 1994; **16**: 372-393.
22. Stott NC, Pill RM. 'Advise yes, dictate no'. Patients' views on health promotion in the consultation. *Fam Pract* 1990; **7**: 125-131.
23. Butler CC, Pill R, Stott NC. Qualitative study of patients' perceptions of doctors' advice to quit smoking: implications for opportunistic health promotion. *BMJ* 1998; **316**: 1878-1881.
24. Wilson A, McDonald P, Hayes L, Cooney J. Health promotion in the general practice consultation: a minute makes a difference. *BMJ* 1992; **304**: 227-230.
25. Pringle M, Stewart-Evans C. Does awareness of being video-recorded affect doctors' consultation behaviour? *Br J Gen Pract* 1990; **40**: 455-458.

Acknowledgements

We wish to thank Mrs. Margaret Whatley for her secretarial help and Dr. Andrew Wilson for his advice and support. We also wish to thank the GPs who took part in the study. This research was funded by the Scientific Foundation Board of the Royal College of General Practitioners and Trent NHS Executive and Trent NHS Executive.

Address for correspondence

Tim Coleman, Department of General Practice and Primary Health Care, University of Leicester, Leicester General Hospital, Gwendolen Road, Leicester, LE5 4PW. E-mail: TJC3@le.ac.uk