Health, smoking and doctors' advice

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SUMMARY. One hundred and sixty-seven individuals with chronic conditions were interviewed about their smoking history and current habits as part of two larger studies on health care. The interviews were lengthy and permitted individuals to comment freely on reasons for stopping or continuing smoking and the role of doctors' advice in these decisions. Only 22 per cent had never smoked. The youngest and males were most likely to have smoked. At time of interview, 51 per cent of those who had ever smoked were still smoking. Those with circulatory disorders, in contrast to respiratory or musculoskeletal disorders, were most likely to have stopped. Perceptions of doctors' advice varied by both age and diagnosis, with the elderly claiming to have received little medical advice. Those with histories of circulatory disorders reported receiving advice more frequently. Doctors may have advised these individuals more frequently because there was threat to life, but it is also possible that individuals with life-threatening disorders are more likely to recall such advice.

Introduction

PEOPLE with chronic conditions are of interest with regard to smoking because they have frequent contact with health professionals, because they might be expected to be more aware of the dangers of smoking and because they have particular reason to be concerned about maintaining their health. Some may be suffering from conditions with which smoking is aetiologically associated; others may have symptoms which are aggravated by smoking. At the same time, many may find smoking increasingly pleasurable as they face a life of growing restrictions. Awareness and a general acceptance of beliefs about the hazards of smoking are particularly relevant for this population faced with the realities of declining health.

In our paper we focus on the smoking behaviour and beliefs of a sample of individuals with chronic conditions. Particular attention is paid to the ways in which this group perceives and rationalizes behaviour which could exacerbate their conditions. In addition, we examine their attitudes towards medical advice on smoking and consider the implications of variations in attitudes and reactions to such advice, for health education and for effective medical advice.

Methods

A sample of 167 people with chronic conditions was drawn from two sources: general practitioners' lists and respondents to a community health survey. People whose main disorders were psychiatric or due to sight, speech or hearing difficulties were excluded; so were patients with cancer. All were interviewed to find out about their health status, degree of disablement and current medical care, including use of prescribed and non-prescribed medications. Data were also collected on smoking history, current smoking habits and advice on smoking given by doctors. All respondents were between ages 30 and 74 and lived in their own homes. The interviews were conducted in North London during 1979–1980.*

Respondents were divided into smokers (light smokers, regular smokers, ex-smokers) and non-smokers. People who smoked more than five cigarettes a day were defined as regular smokers and those who smoked five or fewer as light smokers. Of the 63 ex-smokers, three had given up cigarettes within the year prior to interview, while the remainder had stopped smoking from 18 months to 25 years previously.

Results

Smoking behaviour by age and sex

The proportions of smokers, former smokers and non-smokers are given in Table 1. Table 2 shows the age

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*The sampling methods are described in greater detail in an unpublished document available from B. Thom.

Table 1. Smokers, former smokers and non-smokers (percentages).

	Women	Men	Total
Ever smoked*			
Regular smokers	50	20	39
Light smokers	15	8	12
Ex-smokers	35	72	49
Total	100 (n=81)	100 (n=49)	100 (n=130)
Never smoked	28	11	22
Total	100 (n=122)	100 (n=55)	100 (n=177)

*Significance tested on the population who had ever smoked.
$\chi^2=16.772$; p 001.

Table 2. Relationship between age and smoking (percentages).

Age	Per cent in sample	Ever smoked	Ex-smoker
< 50	21	34	22
50–60	46	22	43
65–74	33	14	68

distribution of the sample and the relationships between age and smoking. In the sample as a whole, women were less likely than men to have begun smoking. Fewer women than men at each age level ever took up smoking, but men were significantly more likely than women to have stopped smoking. These age- and sex-related patterns of smoking behaviour are similar to those found among more general populations (Capell, 1978; Dicken, 1978; Department of Health, Education and Welfare, 1979).

Smoking behaviour by diagnosis

The respondents were categorized into four broad groups according to their diagnosis: those with respiratory disorders (25 per cent), circulatory problems (25 per cent), musculoskeletal disorders (33 per cent) and finally, residual diagnoses covering a broad range of other conditions (17 per cent). For the purposes of this paper, circulatory and respiratory disorders were considered smoking-related, in contrast to the musculoskeletal and 'other' disorders which were not viewed as aetiologically related to smoking.

Twelve per cent of those with circulatory problems, 20 per cent of the respiratory cases, 26 per cent of those with musculoskeletal disorders and 34 per cent of people with other conditions had never smoked. The smoking status of the remainder is shown in Table 3.

The proportion of those having smoking-related disorders who had ever smoked did not vary by age group.

Table 3. Smoking status by diagnosis (percentages).

	Respiratory	Circulatory	Musculoskeletal	Other
Current smokers	64	27	66	47
Ex-smokers	36	73	34	53
Total	100 (n=33)	100 (n=37)	100 (n=41)	100 (n=19)

$\chi^2=14.426$; $p<.001$

There was only one diagnostic category (circulatory disorders) in which women were almost as likely as men to have given up smoking (67 per cent of women and 79 per cent of men).

Reasons for stopping smoking

When asked why they had given up smoking, the majority of respondents (64 per cent) gave health factors as their primary reason. Sometimes decisions to stop smoking followed a frightening, acute episode which forced the individual to face up to the possible consequences of continued smoking. One woman with chronic bronchitis described her experience as follows:

> "I used to smoke till about three years ago, when I took ill and had to call an ambulance. I just couldn't breathe at all. I was fighting for breath that night and from then on I stopped—I mean, I didn't want another turn like that."

People with circulatory disorders were more likely than others to mention a frightening episode, usually a heart attack, and this explanation may partially account for the greater proportion of them who had given up. A further 13 per cent of respondents said they were forced to stop because of an illness or hospitalization during which it was impossible for them to smoke. Another 15 per cent claimed they stopped because smoking made them feel ill. Only 6 per cent said they had given up smoking because of the cost of cigarettes and even fewer claimed to have stopped for social or religious reasons.

There were no differences by sex or age in the reasons for giving up. However, when health reasons for stopping were divided into those who did so with and without doctors' advice, small differences emerged by diagnostic groups. Approximately a third of those in each diagnostic group had stopped for health reasons without a doctor's advice. Following advice, individuals with circulatory disorders were most likely to have stopped (43 per cent), those with respiratory disorders next most likely (33 per cent), and all others least likely (21 per cent).

Although the numbers are small, these results would seem to reinforce the importance of life-threatening conditions to individuals as motives for giving up smoking and suggest that doctors' advice may be taken more seriously under such circumstances.

Perceptions of doctors' advice

All current smokers were asked if they had ever received medical advice about their smoking habits. Just over half (53 per cent) claimed that they had. Age, unlike sex, was related to whether respondents claimed to have received advice; 87 per cent of those over age 65 said they had never been advised, compared to just over a third in each of the other age groups.

Within the middle-aged group (50–64) those with smoking-related conditions claimed to have been offered advice twice as frequently as did those without such conditions (87 and 41 per cent respectively). Among the 15 people still smoking in the oldest age group, only two of the six with respiratory or circulatory disorders reported receiving advice regarding their smoking. None of the other nine claimed to have received such advice.

These data suggest that doctors are more likely to advise younger smokers and, particularly among the middle-aged, those with smoking-related disorders. The paucity of advice reported by the elderly suggests that this group may be less likely to recall advice, especially if given many years earlier. Alternatively, doctors may feel it is of little importance to attempt to alter the smoking habits of elderly people because they believe that the quality of life transcends other considerations in treating this age group.

Patients' comments on the nature of the advice they had received from their doctors varied widely and reflected stages of illness, commitment to smoking, attitudes to doctors as authority figures and so forth. It would certainly appear that timing, the type of warning and/or support provided by the doctor may be critical factors in helping some patients. The following provide examples of different responses to advice as reported by patients.

Doctor's advice

1. Doctor is sanctioning behaviour:

"Not even my thyroid doctor said to stop smoking. He said, 'If you feel in a state . . . if you feel depresssed or anything like that, just have a cigarette.' So that's why I carried on."

2. Doctor's warning considered too indefinite:

"I've been told I would be better if I didn't smoke but I have never actually been told definitely to stop smoking."

3. Feeling of overkill from doctor:

"You know, I've just heard it so many times before—obviously I don't bother. I say, 'I know', and it's not going to stop me. I'll stop when I feel I want to."

4. Outright rejection of doctor's advice:

"The doctor said if I wanted to see my children grow up I should stop smoking straightaway. At the time it frightened me but then the urge to smoke is greater than to take notice of what he said."

Table 4. Per cent of respondents giving reasons for continuing smoking, by sex.*

Reasons given	Women	Men	Total
Coping mechanism	*56*	*30*	*52*
Habit	*46*	*30*	*43*
Hedonism	*4*	*50*	*12*
Positively beneficial	*13*	*20*	*14*
Denial	*13*	—	*10*
Fatalism	*13*	—	*10*
Harmless to respondent	*6*	*10*	*7*
Miscellaneous reasons	*21*	*20*	*21*
Total number of respondents	*48*	*10*	*58*
Total number of responses	*82*	*16*	*98*

*Totals more than 100 per cent because of multiple responses.

Why people smoke

The reasons why patients continued to smoke are given in Table 4. Many of these reasons were similar to those given in other studies (McKennell and Thomas, 1967; Department of Health, Education and Welfare, 1979). As in other research, women predominantly explained their behaviour as a means of coping (Department of Health and Human Services, 1980). Men were most likely to continue because of hedonism. No major differences by age group were found.

While almost all respondents indicated some knowledge of the health effects of continued smoking and responded in terms of coping, habit or hedonism, some (37 per cent) also denied harmful effects or gave a variety of reasons in an effort to justify their behaviour in rational terms. Women were more likely to provide such justifications (48 per cent contrasted with 20 per cent of the men).

Of those with circulatory disorders who were still smoking, none offered any secondary justifications for their behaviour. However, 37 per cent of those with musculoskeletal and other conditions offered such explanations and almost half (45 per cent) of those with respiratory disorders did so.

The main reasons for continuing to smoke did not vary between diagnostic groups, but there were differences in secondary reasons. The most common additional justification claimed that smoking was positively beneficial to the respondent's health. Two thirds of those with respiratory disorders said so, claiming that it cleared their chest or eased their breathing in the morning. Typical responses to the various categories of justification shown in Table 4 are as follows:

Coping

Boredom:

"My trouble is at work on the switchboard. We can get rather busy and then we can get slack and there are no calls at all—and you are sitting there and you don't know what to do, so you light up a cigarette."

Nerves, relaxing:

"It calms me down."
"If I am worried and I smoke a cigarette I just sit and start relaxing."
"When I get a little bit uptight, it is the first thing I go for."
"That's to keep me from going out of my mind in this place (home)."

Habit

"It's a habit as much as anything." "It's obviously a physical addiction . . . I think it is probably just the nicotine. I'm probably psychologically addicted as well, actually."

Hedonism

"It gives me a feeling of satisfaction."
"I just happen to enjoy smoking."

Fatalism

"I'm not particularly worried about it because I look at it quite philosophically. Fifty per cent of my grandparents died of cancer, the other half didn't, so with a bit of luck I'm like the other half."
"My husband thinks I might get something awful like cancer, but if you are going to die one way or another, I might as well die happy as die miserable."

Denial

"Nothing's been proved . . . it's just a lot of figures. Anyway, I'm just an ashtray smoker."

Positively beneficial to health

"During the day I don't get a lot of satisfaction from smoking but, as I told the doctor, sometimes in the morning I find a cigarette helps me start breathing again . . . I seem to be able to get going and get my breath again."

Harmless to respondent

"I've been smoking since I was 17 and it hasn't made any difference to me. I seem to be as fit as anything."

Miscellaneous

"Quitting is too unpleasant; when I stopped smoking I was very agitated. You know, I tend to snap at people. I stopped for about a month and I thought, 'Oh, I can't stand this'."
"I haven't any other vices."

Conclusion

As demonstrated in this study, many patients do recall receiving advice on smoking from their doctors. However, such advice appears to be perceived differently by different kinds of patient. The immediate life threat associated with continued smoking and circulatory disorders may prompt doctors to offer advice more frequently and forcibly to this patient group than to others. Such patients may well be more receptive to such advice, particularly if proffered during an enforced period of abstinence while hospitalized for their condition or after a shock experience.

The fact that individuals with respiratory disorders do not stop smoking with any greater frequency than people with non-smoking-related health problems suggests that the more gradual nature of the risk may influence them. That is, doctors may be more casual about providing advice or, alternatively, patients may be less receptive to hearing it. The finding that this group offered more justification than any other diagnostic group for continuing their smoking may well indicate that they received but rejected medical advice.

Forcing oneself to cough by smoking on getting up in the morning appears to be a common experience among individuals with respiratory disorders. In the short term such behaviour may well be efficacious. It has clearly been elevated to a folk belief among some smokers. The early morning cigarette has become a form of self-medication, analogous in many ways to the use of nasal sprays which eventually exacerbate the problem they are intended to cure. Doctors may therefore want to question patients with respiratory disorders regarding their reasons for continuing to smoke, and, rather than laughing, offer concrete alternative means of clearing the chest of early morning phlegm.

If the aim of health education by doctors is to modify smoking or other behaviour, then, as demonstrated in this paper, the experiences, beliefs and perceptions of patients should be identified and understood. Tailor-made advice is needed which will also take account of the diagnosis, life situation and age of the individual. Such advice may have to be reinforced periodically and revised to meet changes in the life situation and therefore receptivity of the patients. This approach allows the doctor to give personal advice and avoids the moral overtones commonly perceived in generalized statements about smoking.

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