Anti-smoking education in Oxfordshire general practices

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SUMMARY. A postal questionnaire survey of 360 Oxfordshire general practitioners and health visitors on the subject of anti-smoking education was conducted in May–June 1980. Two mailings produced a response rate of 87 per cent. Involvement in anti-smoking education was felt to be more relevant for the doctors than for the health visitors. Health visitors thought that health education officers had a major role to play; they were also more likely than doctors to use literature as an aid in counselling smokers. In general, the mass media were not thought to be effective in helping individual smokers to give up the habit. Both doctors and health visitors were in favour of their professional organizations exerting pressure on Parliament, but only one respondent had ever written to an MP about smoking.

Introduction

TOBACCO smoking is the single most important cause of preventable ill-health in developed countries (WHO, 1975). Yet, despite a great deal of health education activity over the years, the proportion of cigarette smokers in the population has only recently begun to decline. Giving up smoking has largely accounted for this fall. Among women in particular, there has been little change in the number taking up the habit (Capell, 1978).

The medical consultation is a situation in which advice against the habit can be given to individual smokers by a person in a position of authority (Leventhal, 1973; Ball and Turner, 1974). It has been suggested that if all general practitioners in this country gave anti-smoking advice, backed up by a simple pamphlet and a promise to check on the patient's progress, they could produce the same effect as 10,000 special anti-smoking clinics (Russell *et al.*, 1979). However, little information has been collected concerning the attitudes of general practitioners towards smoking, nor of their anti-smoking activities (RCGP, 1981).

In a survey concerned with health education and disease screening in Northamptonshire, general practitioners reported that they often asked patients about smoking and that they discouraged the habit, but they were pessimistic about the impact of these activities (Mosser, unpublished data). We have conducted a similar survey, concerned only with smoking, in general practices in Oxfordshire. Health visitors were included in our sample as, like general practitioners, they have repeated contact with large numbers of patients, but even less is known about how they view the smoking issue.

Aim

Our aim was to elicit candid self-reports of current activities and beliefs about anti-smoking education in such a way as to allow comparison of the two professional groups.

Methods

The survey included all those general practices in which the doctors were contracted to the Oxfordshire Family Practitioner Committee (FPC) to provide general medical services and in which the health visitors were employed by the Oxfordshire Area Health Authority (Teaching). Practices were excluded if:

1. The principal practice address lay outside Oxfordshire.
2. The doctors provided only family planning services.
3. The health visitors were employed by neighbouring

health authorities, even though the practice itself lay within Oxfordshire.

4. Some of the doctors were contracted only to the FPC of a neighbouring area, as is the case in certain border practices.

Eligible practices were divided at random into two groups (A and B) after being ranked by the number of partners and in alphabetical order according to the senior partner's name.

In group A practices, all the doctors and health visitors were sent a questionnaire and covering letter asking them to report their activities in anti-smoking education. The questions asked how and in what way they attempted to help apparently healthy smokers to give up smoking, and how often they discussed the subject with patients for whom a personal or family history or an intercurrent condition increased the potential risks from smoking.

In group B practices, all the doctors and health visitors were sent a questionnaire about their beliefs about anti-smoking education. They were asked to define the role of their own and other professional groups in regard to anti-smoking education, what internal factors (expense, aesthetic distaste, health and so on) motivate smokers to give up, and what external influences (such as advice from health professions, hypnosis and nicotine chewing-gum) are effective.

Respondents in both groups were asked about their smoking history and professional background, and about the policy towards smoking in the practices in which they worked.

The questionnaires and covering letters were sent in May 1980. A reminder letter plus a second questionnaire, identical to the first, was posted to the non-respondents three to four weeks later. With the exception of first questionnaires sent to health visitors, which were returned via the health authority courier network, all the questionnaires were reply-paid.

Results

Of the 360 individuals surveyed, completed questionnaires were returned by 314, an overall response rate of 87.2 per cent. Eighteen replies were completed anonymously. In addition, two doctors replied saying they did not want to participate in the survey. The response rate varied from 84.6 to 90.6 per cent among the four subgroups defined by profession and survey group.

Comparability of groups A and B

Apart from an excess of women doctors in the beliefs group (B), there were no significant differences between the two groups, for either profession, in terms of their year of qualification, years spent working in general practice, size of practice, smoking status of respondents or cigarette consumption of the smokers.

Of the 208 general practitioners who replied, 22 per cent were current smokers, 39 per cent ex-smokers and 39 per cent life-long non-smokers. The corresponding figures for the 106 health visitor respondents were 7, 30 and 63 per cent.

Since the allocation to survey groups was random and the groups were balanced, it may be inferred that the replies of one group to a given question should be representative of those that would have been received had the whole study sample been asked all the questions. Moreover, replies from group A about anti-smoking activities may be compared with those from group B about beliefs.

Role of the general practitioner

Responses to the question "To what extent in your opinion should the general practitioner be involved in efforts to curb smoking?" revealed very similar views for both professions. Seventy-four per cent of the doctors and 70 per cent of the health visitors considered that the doctor should have a 'major' involvement (as opposed to 'minor' involvement or 'involvement not appropriate'). This view did not vary with the respondent's own smoking status, year of graduation, time spent working in general practice or number of partners in the practice.

Given that most respondents felt that major involvement by general practitioners in trying to curb smoking was appropriate, it is reasonable to examine aspects of this role both within and outside the practice. Table 1 (first column) gives the views of group B doctors about four possible anti-smoking activities outside their practice.

Doctors who had ever smoked, and particularly those who smoked currently, were less likely to agree that general practitioners have a role in setting an example. Overall, however, there was close agreement between the proportions who did not smoke currently (78 per cent) and who agreed that doctors should set a non-smoking example (84 per cent). Current smokers were also less in favour of exerting pressure on Parliament via their professional organizations.

Despite almost 30 per cent of the group B doctors expressing broad agreement that general practitioners should exert pressure on their own member of Parliament, only one doctor in group A (0.9 per cent of that sample) reported ever having written to his MP on the subject of smoking.

With regard to anti-smoking activities within their day-to-day practice, nearly three quarters (73.7 per cent) of doctors in group A reported that they "usually initiate discussion of smoking with basically healthy adults who smoke". Replies of all doctors (group A plus group B) about other anti-smoking activities in their practice are summarized in Table 2.

Role of the health visitor

Both the professional groups, but particularly the gen-

eral practitioners, believed that doctors should be more involved in efforts to curb smoking than health visitors. Only 56 per cent of respondents assigned a major role to health visitors; 70 per cent assigned a major role to doctors.

Nevertheless, health visitors appeared to view anti-smoking activities outside their day-to-day practice more favourably than doctors (Table 1). None of the 55 health visitors in group A reported having written to an MP about any aspect of smoking. As with doctors, the smoking behaviour of the health visitors closely matched their beliefs about setting an example—93 per cent were non-smokers, and the same proportion agreed that health visitors should set an example.

Although health visitors in group B were in favour of a range of anti-smoking activities outside their day-to-day work, only 46 per cent in group A reported that they usually initiated discussion about smoking with patients, and less than 10 per cent of the whole sample reported that they usually record their patients' smoking status.

Role of the health education officer

The views of general practitioners and health visitors about the role of the health education officers (HEOs) differed significantly ($p < 0.05$). Ninety-two per cent of the health visitors but only 72 per cent of the general practitioners considered that major involvement of HEOs in efforts to curb smoking was appropriate; five general practitioners but no health visitors considered involvement of HEOs was inappropriate. The remainder of each group thought minor involvement of HEOs was in order.

Not only did the health visitors differ significantly from the doctors on this point, but they were much less divided over the HEOs' role than over their own.

In addition to full-time health education personnel, the Area Health Education Unit also provides an important source of literature. Group A respondents were asked, "With regard to basically healthy adults who smoke, how often do you utilize literature prepared by agencies such as the Health Education Council?" Table 3 shows that answers to this question highlighted a very significant difference between the two groups.

Table 1. Possible activities outside the practice.

Anti-smoking activity	General practitioner agrees GP has a role (per cent)	Health visitor agrees HV has a role (per cent)
Setting a non-smoking example	*83.7*	*93.7*
Making public statements/ addressing community groups	*43.7*	*54.3*
Exerting pressure on own MP	*28.4*	*30.0*
Exerting pressure on Parliament via professional organizations	*64.4*	*68.9*

Role of Parliament

We have seen that general practitioners and health visitors agree that their professional organizations, if not themselves as individuals, should exert pressure for parliamentary action in relation to smoking. When asked whether "the smoking problem was a matter for legislation rather than education", 67 per cent of the doctors and 82 per cent of the health visitors considered activity on both fronts was required. Thirteen and 6 per cent respectively agreed it was a problem for legislation, and the remainder of each group indicated that education rather than legislation was the answer.

Role of the mass media

While group A respondents were asked about their use of health education literature (Table 3), those in group B were asked whether mass media campaigns in general were effective in causing patients to stop smoking. Most thought that they were not (40 per cent) or were undecided (44 per cent), and only four respondents (2.8 per cent) thought that such campaigns were the most effective of nine possible external methods of influencing people.

Table 2. Possible activities for doctors within their practice: doctors' self-report.

Question	Yes	Per cent	No	Per cent	Total
Do you usually record the smoking status of your patients?	124	*62.3*	75	*37.7*	199
Does your practice have a policy of no smoking on the practice premises by:					
patients?	181	*88.7*	23	*11.3*	204
practice personnel of all types when dealing with patients?	189	*91.7*	17	*8.3*	206
practice personnel of all types when not dealing with patients?	76	*37.6*	126	*62.4*	202

Table 3. Use of literature in dealing with healthy adults who smoke.

	Never		Sometimes		Often		Always	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
General practitioners (n=114)	61	*53.5*	45	*39.5*	8	*7.0*	0	*0.0*
Health visitors (n= 55)	3	*5.5*	27	*49.0*	22	*40.0*	3	*5.5*
Total	64	*37.8*	72	*42.6*	30	*17.8*	3	*1.8*

Discussion

In excluding from our survey certain practices on the Oxfordshire FPC list our aim was to arrive at a group of practices which would reflect anti-smoking education as it affects the average patient in our area.

The response rate of 87.2 per cent was comparable to that achieved by Mosser in his survey of Northamptonshire general practices (unpublished data) and to that in a survey about cancer prevention in south-east Wales (Bluck, 1975).

In both these previous studies, differences in the professional and practice backgrounds of respondents and non-respondents were small. A similar analysis for our survey revealed no differences in the size or type ('health centre' versus 'other') of doctors' practices, but doctors who qualified before 1964 and health visitors based in health centres were overrepresented in the non-responder group. However, the smoking habits of responding doctors closely resembled those of a national sample of similar size (OPCS, 1977); those of responding health visitors were weighted in the direction of non-smoking, as compared to a sample of HVs and domiciliary midwives included in the OPCS survey.

In all studies of this kind interpretation of the data hinges on the accuracy of self-reports. There is some evidence in Oxfordshire that actual recording of patients' smoking histories is much less common than is indicated by our survey, at least for middle-aged men. Whereas nearly two thirds of the general practitioners reported that they usually recorded a smoking history, a retrospective records search revealed written histories in less than one third of notes relating to 1,000 men of middle age (Fleming and Lawrence, 1981). Such discrepancies need to be borne in mind whenever self-reports of current activities are reviewed.

Nevertheless, among the sample of general practitioners and health visitors surveyed there was broad acceptance that the doctor, and to a lesser extent the health visitor, has a major role to play in efforts to curb smoking. This finding may encourage those who want to see general practice play an increasing role in preventive medicine, but may to some extent reflect the success of such advocates in convincing doctors and health visitors that this is an appropriate task for general practice.

For both the doctors and the health visitors in our survey, the proportion who did not smoke currently was very similar to the proportion who agreed that their profession has a role to play in setting a non-smoking example. At the same time, almost half of the doctors who were smokers reported that their patients were asked not to smoke while on the practice premises. Only a minority of doctors, however, reported that their practice had a total non-smoking rule; personnel were reported as being permitted to smoke when not dealing with patients by 62 per cent of doctors. It seems that the doctors have not been able to convince other staff that the health service as a whole has an example to set.

Three other findings deserve particular comment. First, 5 per cent of doctors believe that the health education officer has no contribution to make in tackling the smoking problem, and few doctors regularly use health education literature as an adjunct to counselling smokers, although the combination of advice, literature and warning about follow-up is one of the most effective yet tested systematically in general practice (Russell *et al.*, 1979).

Second, doctors and health visitors remain unimpressed by the long-term effectiveness of the mass media in helping smokers to stop smoking, but the reasons underlying this view were not explored in this survey.

Finally, the majority of both professions are in favour of continued pressure on Parliament via their professional organizations so that legislation may be combined with education. However, while a sizeable minority was in favour of a personal approach to MPs, the gap between belief and action had been bridged only by one individual.

If primary health care is to help reduce smoking and its associated mortality and morbidity, then many of its practitioners will have to bridge the gap between the positive attitudes we have demonstrated and effective activity in their day-to-day work. It will be the responsibility of the advocates of this strategy to provide continued encouragement, to ensure that further relevant research is carried out and that its results are conveyed to those in the front line. Closer links between individual general practices and central organizations such as the Health Education Council, Action on Smoking and Health and local health education units might further these aims.

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Words our patients use

'Wabbit'—lethargic and exhausted so that movement is almost impossible (Glasgow).

"He clemmed himself to death"—starved himself (Derbyshire).

"So and so has had a pull"—not been very well lately (Swansea).

'Mazy'—confused (North Staffordshire).

"I'm feeling kind of comical, doctor"—I am feeling peculiar (County Wicklow, Eire).

'Anguish'—used when describing a bruise. One says, "It's the anguish coming out"; if the 'anguish' comes out, all is well. 'Anguish' can also refer to phlegm or a pain (Devon).

"He didn't need an operation, they just scaled it away"—medical treatment as opposed to surgical (East Riding).

'Gowl'—a gummy secretion in the eye (said in the OED to be obsolete except in dialect usage; South Yorkshire).