

How to help your patients quit: Practice-based strategies for smoking cessation

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Abstract: A behavior change workshop was conducted during the regional meeting of Wonca in Kuala Lumpur, Malaysia, in April 2002. It highlighted that general practitioners and primary care workers are key agents in facilitating smoking cessation. Participants from a variety of Asia Pacific countries shared their experiences regarding the problems associated with smoking cessation. Barriers to smoking cessation can be divided into 'Patient', 'Doctor' and 'System'. Practice-based strategies for smoking cessation are effective and will assist the general practitioner/family physician in helping patients quit smoking. Effective implementation requires a supportive infrastructure.

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Key words: practice-based strategies, prevention, primary care, program implementation, smoking, tobacco cessation.

Introduction

Cigarette smoking is a major cause of preventable morbidity and mortality in modern society. Tobacco is responsible for the deaths of 3–5 million people worldwide each year.¹ Tobacco use can be reduced through a comprehensive approach that involves a number of public health and education strategies and access to a range of products and services to assist it.

Specific strategies to reduce smoking include:

- a dedicated telephone number that can be called by individuals to obtain information and support on giving up smoking and which is staffed by experienced smoking cessation counsellors; for example, the Quitline in Australia
- regulation of tobacco advertising
- smoke-free environments (e.g. workplaces)
- restrictions on tobacco sales to minors and increasing the price of tobacco products through taxation.

As the front line in the provision of health services, the general practitioner (GP)/family physician has an important role to play in the 'big picture' of tobacco control.^{2,3} In addition to brief, individual counseling

during the doctor–patient consultation, there are many practice-based strategies that can promote smoking cessation. These include brochures on quitting smoking in the waiting room and stickers that clearly identify smokers on their medical record.^{4–6} According to Deming's 85:15 rule, approximately 85% of opportunities for improvement lie with changing processes in a system whereas 15% lie with changing individuals.⁷

Despite clear and strong evidence regarding effective ways of improving smoking cessation, implementation remains both patchy and problematic.^{8,9} The Behavior Change Special Interest Group workshop at Wonca highlighted that GPs and primary care workers are key agents in smoking cessation. Barriers in smoking cessation can be divided into 'Patient', 'Doctor' and 'System'. Although practice-based strategies for tobacco cessation can assist the GP/family physician in helping patients quit smoking, effective implementation should be specific, multifaceted and have a supportive infrastructure.^{4,10}

A supportive infrastructure is an environment that passively and actively supports the clinicians in offering a range of prevention activities. For example, passive support is provided to the doctor's smoking cessation efforts by having QUIT and smoking cessation material on the notice board in the waiting room, having smoking cessation material on display also in the waiting room and any phone support contact number prominently displayed within the waiting

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room. More active infrastructure support includes handing out a brief questionnaire to every attending patient that identifies their smoking status and interest in quitting and then entering that information onto the practice's computer system so that it prompts the GP when that patient has a consultation. Other active strategies include having a coordinator of all the practice-based strategies who monitors the impact of the program. This infrastructure improves the awareness of the GP about smoking cessation and takes some of the more mundane, but important activities, such as inquiring about the patient's smoking habit, out of the GPs domain. If these strategies are conducted systematically at the practice level, they have been shown to increase the number of attempts to quit smoking that are made by the patient.^{2,10}

The workshop reported here was conducted at the 12th Asia Pacific Wonca Regional Conference in Kuala Lumpur, Malaysia, in 2002 to focus on practice-based strategies for tobacco control in the general practice setting and participants from several Asia Pacific countries were invited to share their experiences.

Identifying barriers

Participants at the workshop were asked to identify barriers to smoking cessation and these were classified under three main headings: Patient barriers, GP barriers, and System Barriers (Table 1) These barriers were similar to those described in published reports.^{11,12}

However, there are some barriers that may be particularly relevant to the Asia Pacific region. One doctor from Malaysia articulated her frustration with the difficulties of utilizing practice staff to encourage smoking cessation.

In Malaysia, the average smoker is a 40-year-old male. Hence he will not listen to the nurse to quit smoking (as the nurse is female), and the patient won't listen to the male medical attendant either – because the medical attendant smokes as well!

Many workshop participants felt that they lacked skills in motivational interviewing and that this was a barrier to encouraging smoking cessation in their patients. In addition, participants articulated that there was a lack of GP education and training material available to teach these skills. Participants reported that many of the pharmacotherapies for smoking cessation such as nicotine replacement therapies (NRT) and bupropion are not readily available in Asia Pacific countries.

Implementation strategies

Workshop participants were then asked to describe what implementation strategies would enhance their smoking cessation activities. These ranged from training doctors to changing the practice environment (Table 2).

In the second half of the workshop, some general guidelines about practice-based strategies for tobacco cessation were presented to the participants. One important concept that helped to focus the discussion was the reality pyramid (Fig. 1), which was developed by Litt *et al.* during the GPs Assisting Smokers Program (GASP project)⁹ and reflects several key principles.

First, tasks requiring increasing amounts of consultation time (depicted as a series of higher levels of the pyramid) are likely to be provided by a diminishing number of GPs. For example, many GPs are prepared to provide brief advice, but few routinely offer a comprehensive range of behavioral strategies that may take as little as 5–10 minutes. Disposable time (the time available to address the GP's own agenda) varies from none on a busy day up to a maximum of approximately 2–5 minutes with a typical average of 30–60 seconds per routine consultation. On average, Australian GPs spend 44 seconds in a routine consultation on smoking cessation.⁸ The bottom level of the pyramid reflects 'no GP time' within the consultation and hence the activities are directed towards the practice, which should be attractive to busy GPs

Table 1 Barriers to smoking cessation

Patient	General practitioner	System
Not interested in stopping smoking Smoking is a stress reliever	Fear of failure Low priority for the attending GP/FP	Lack of feedback data Lack of time/lack of financial incentives
Lack of peer support to quit smoking	Lack of counseling skills of the attending GP/FP	Pharmacotherapy for smoking cessation not available in all countries
Poor role models-GP's and health care workers who smoke	Fear of upsetting the doctor-patient relationship	Lack of coordination with support agencies and organizations

FP, family physician; GP, general practitioner.

Table 2 Implementation strategies for smoking cessation**Infrastructure**

Ask about smoking status of ALL patients

Highlight smoking status on the patient's medical record

Have QUIT programs targeting doctors and other health workers who smoke

Have smoking cessation pamphlets, posters, and educational videos available in the waiting room

Make clinics smoke free (i.e., people are not be permitted to smoke in the premises)

Educate GPs on how to change the clinic setting as part of putting prevention into practice (e.g. use of RACGP 'Greenbook' on evidence-based implementation strategies⁴)

Involve practice nurses/medical ancillary staff e.g. coordination, flagging case notes, counseling

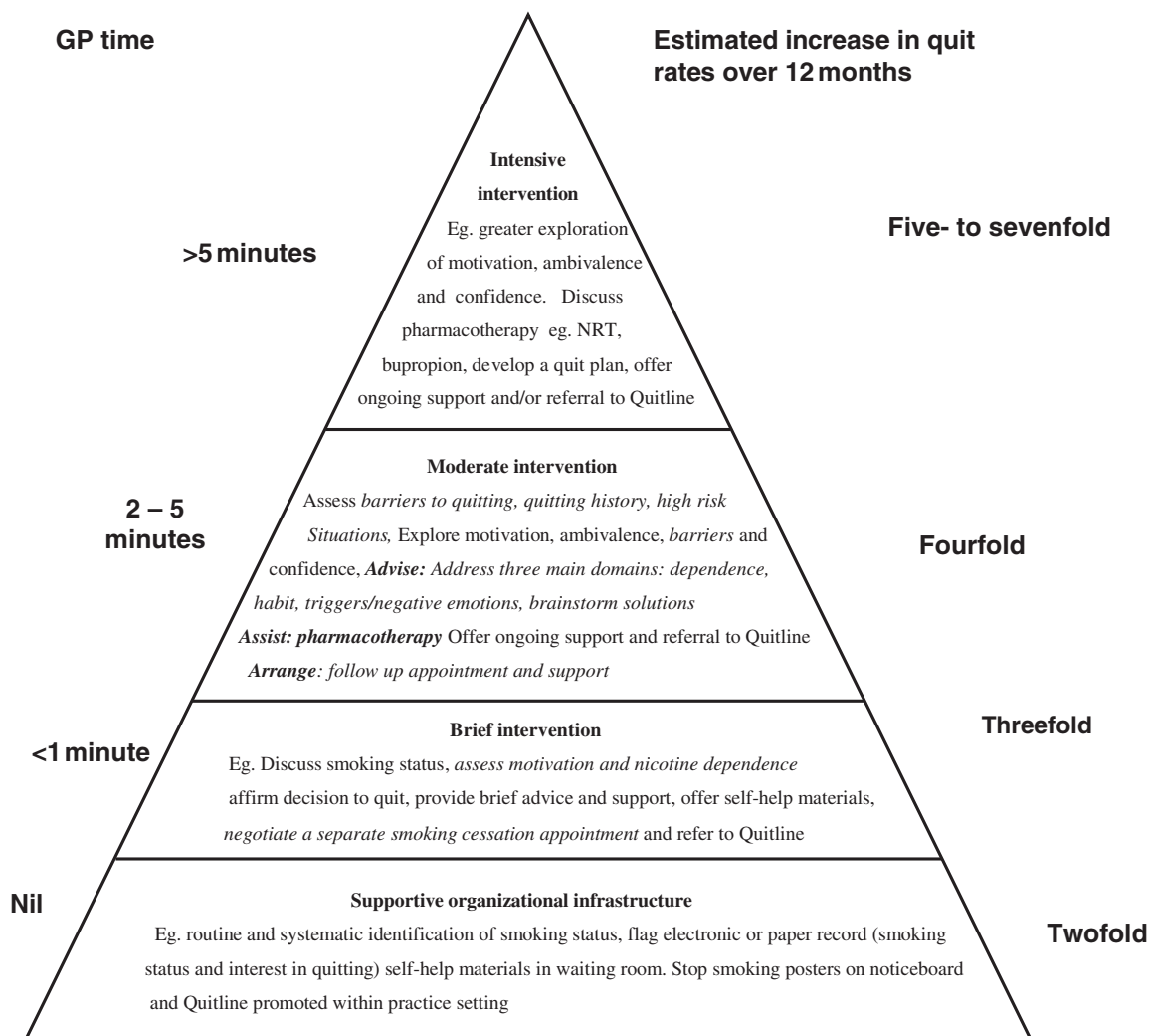
Refer smokers to Quitline

Training

Train doctors in motivational interviewing and brief behavioral interventions

Personalize advice

GP, general practitioner; RACGP, Royal Australian College of General Practitioners.

**Figure 1** Reality pyramid. NRT, nicotine replacement therapy.

who do not even have 30 seconds of disposable time. A meta-analysis of nine randomized controlled trials found that having a screening process in place to identify smokers resulted in a threefold increase in the likelihood that the doctor would conduct a smoking cessation intervention with patients who smoke.²

The second aspect of the reality pyramid is that 'less can be more', which is a variant of the population health paradox.^{13,14} If most GPs set up their practice to flag the smoking status of patients and offer referral (and QUIT books), the impact of these activities will be greater than the effect of a few GPs who offer a more intensive intervention. Specifically, using the lower levels of the pyramid has a greater impact because the reach (or number of smokers who are offered these approaches) is much greater than with the more intensive strategies.

Finally, the pyramid symbolizes a series of sequential steps that GPs can take should they wish to increase the intensity of their program. As one ascends the pyramid, the level of intervention increases. The segmentation into time intervals that are commonly available to GPs assists them in choosing what to offer if they had more time in a consultation. Effective interventions are reframed in terms of the amount of time required to provide them to patients. The ascending layers of the pyramid provide some guidance as to which activities are more worthwhile in a given amount of time. The base of the pyramid represents no GP consultation time; it reflects the activities that should be developed within the practice environment and contains the key elements of a supportive organizational infrastructure. Organizing the practice to systematically flag smoking status and ascertain interest in quitting doubles the smoking cessation rate, from 3%¹⁵ to approximately 6%.² For very busy practitioners, this represents an option that will not increase the pressure on the precious time available within the consultation. Few GPs are willing to take up the opportunity at the top of the pyramid to provide intensive counseling. If they do provide 20 minutes of brief counseling supported by pharmacotherapy, support and follow up then the quit rate is up to 5–7 times higher,² a strong argument that GPs can offer to patients (and themselves) regarding the value of GP input.

The basic tenets of this supportive organizational infrastructure for putting prevention into practice^{4,9} include:

- a clear, realistic and achievable plan
- one overall practice coordinator (facilitator) for the plan
- allocation of specific roles, tasks and responsibilities
- identification of both costs and benefits

5 A's

- **Ask** – systematically identify and document smoking status at every visit.
- **Advise** – give clear, personalized, supportive advice on quitting smoking.
- **Assess** – the patient's interest in quitting and level of nicotine dependence.
- **Assist** – aid the patient in quitting with self help materials, developing a plan, discussing nicotine withdrawal.
- **Arrange** – schedule follow up contact for immediate review and ongoing support.

Figure 2 The five As.

- incorporation of feedback and ongoing review (e.g. practice surveys, practice management meetings)
- using a range (minimum three to four) of implementation strategies (e.g. Quit smoking posters in the waiting room, screening of patients for smoking, prompts/reminders on case notes).

Brief advice complements a supportive organizational infrastructure and increases the effectiveness. The effective components of brief advice include the five As,² which can be used by the doctor to assist the patient in quitting smoking (Fig. 2). The GASP project team has reformatted the 5A's to highlight what can be done in less than a minute (Fig. 3).

Summary of implications for GPs

- The GPs are key agents in smoking cessation as they have access to the community, the opportunity to address smoking cessation and are effective, credible agents of change.
- At a microskills level: doctors should use the five As.
- At a macrosystem level: practice-based strategies for tobacco cessation will assist patients to quit smoking. Effective implementation should be specific, multifaceted and have a supportive infrastructure.

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Dr John Litt designed the approach for the Wonca workshop, wrote significant sections of the initial draft and provided the substantive intellectual content, Dr Mee Yoke Ling contributed significantly to the first draft and co-coordinated the workshop in

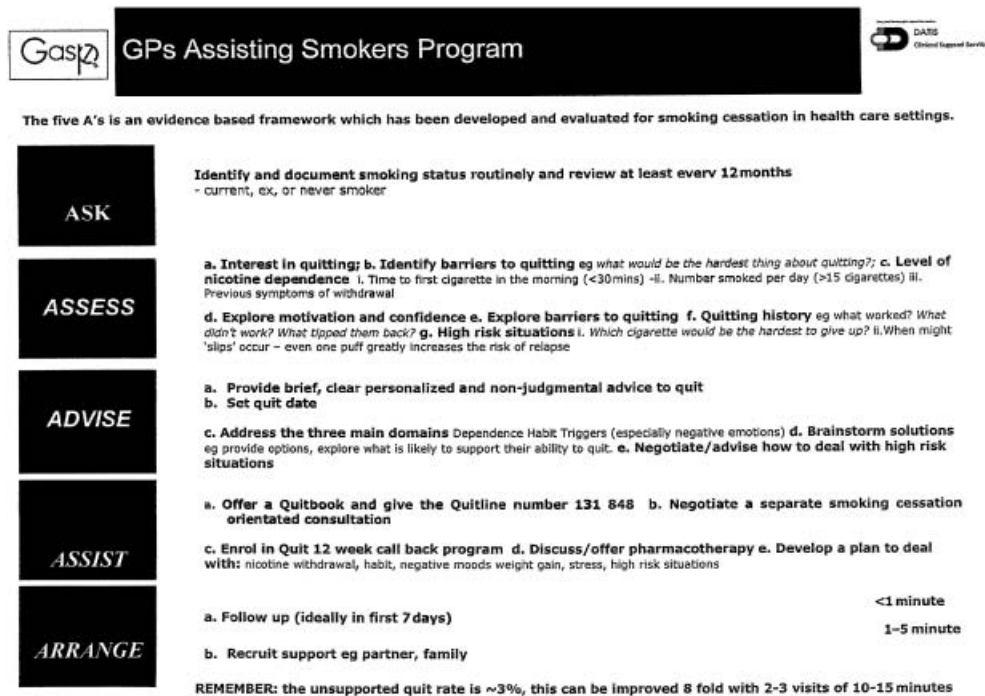


Figure 3 The 5A's: what can GPs do in a minute.

Kuala Lumpur and Professor Brian McAvoy contributed editorial comment to the first draft and co-ordinated the workshop in Kuala Lumpur. Debra Rowett (Drug and Therapeutic Information Service),

Tania Shelby-James (Senior GASP Project officer) and David Edwards (QUIT SA) from the GASP team also contributed to the development of the GASP materials (see Fig. 3).

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