

Missed Opportunities for Anti-Smoking Education at Community Health Centres in the Cape Metropolitan Area.

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Key words:

smoking, missed opportunities,
education, prevention, screening

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Abstract

Objectives- To determine the extent of missed opportunities regarding antismoking education for people 15 years and older, who attend Community Health Centres (CHC) in the Cape Town Metropolitan Area for reasons unrelated to smoking cessation.

Methods- A Descriptive Cross-sectional Survey was conducted using 6 randomly selected CHC. A sample of 1358 patients was selected of whom 850 were smokers.

Results - The overall smoking prevalence was 62,6 % (95%CI 60,0%-65,2%). Of the total group 652 (76,7 %; 95%CI 73,86%-78,54%) indicated that they did not receive any antismoking advice during their attendance at CHC. In addition, 601 (81,9 %; 95%CI 78,43%-85,37%) of the 734 patients seen by a doctor indicated that they did not receive antismoking advice from their doctor. Of the 116 patients seen by a primary health care sister, 67 (57,8%; 95%CI

48.82%-66,78%) indicated that they did not receive any antismoking advice on the day of their visit. Of 112 asthmatic patients who smoked, 80 (71,4 %; 95%CI 63,04%-79,76%) did not receive any antismoking advice on the index day of their visit to the CHC. The record audit revealed that 592 (69,6 %; 95%CI 66,51%-72,69%) of patients presented with a smoking related presenting complaint and 641 (75,4%; 95%CI 72,51-78,29%) patients did not have their smoking status recorded in their folders.

Conclusions - Opportunities for antismoking education are missed in patients attending CHC. All patients attending CHC and especially those in high-risk groups should be routinely educated against smoking, irrespective of their presenting complaints. Such educational efforts should be recorded prominently in the patient's record.

SA Fam Pract 2000;22(6): 9-14

Introduction

Tobacco smoking is the most important cause of preventable disease and premature death in developed countries¹ and the control of cigarette smoking could achieve more than any other single measure in the field of preventive medicine.²

The deleterious effects of smoking on health have been extensively documented and smoking is considered by the World Health Organisation to be the single most important cause of preventable morbidity, mortality and disability³. Smoking related diseases are the major cause of death in the

developed countries, and while smoking rates are declining in these countries, tobacco consumption is increasing in developing countries.⁴

The black population of Southern Africa has yet to experience its epidemic of smoking related diseases.

Yach and Martin have shown that the prevalence (1992) of smoking among adults in the South African context is 31,5%⁵ and more recent prevalence figures reveal that the "coloured" population group had the highest smoking rate nationally at 59%, an increase of 12% since 1992.⁶

In South Africa and specifically the Western Cape an alarmingly high smoking prevalence was found in black and "coloured" men, where SASPREN⁷ in a primary care survey showed that 68.6% and 73.3% respectively were current smokers (ages 25 to 44 years).

Health workers and especially doctors are in a unique position to help smokers become ex-smokers. Patients want to talk to doctors about their health, and they expect to get help and guidance from their doctor.⁸ They think the doctor is the most reliable source of health information.⁹ If doctors do not advise patients to stop smoking, smokers may interpret the doctor's silence to mean that smoking cessation is not important, or that the smoker does not have the ability to quit.¹⁰

Health workers should be constantly identifying smokers and encouraging them to quit since no other intervention is as cost-effective.^{11,12} Controlled trials have shown that a small but appreciable proportion (about 5%) of smokers would quit smoking after simple but firm advice from their GP.¹³ Yet the average practitioner seldom raises the issue of smoking during a consultation. GPs frequently do not know which of their patients smoke and as often fail to advise them to stop even when this is part of the treatment.

Higher quitting rates have been reported in patients who had their smoking state recorded.¹³ Perhaps the time has come to design record folders which give as much prominence to a smoking habit entry as is now given to allergies and immunisation state. Such an innovation might act as a reminder to GPs of the important potential for health education, which exists at every consultation.¹⁴ Sanders and colleagues found a low level of participation by practice nurses in anti-smoking education and suggested that the main

reasons for this were: a lack of relevant training; nurses' lack of confidence in their own effectiveness; and the definition of the practice nurse's role as being predominantly confined to treatment room duties.¹⁵ They suggested further that the most appropriate role for the prevention nurse, is not in giving initial advice to stop, (which may be best done opportunistically by the GP), but in the provision of longer term support and follow-up, which may be necessary to achieve sustained cessation.¹⁵

Similar work has been done in Cape Town where Strebel, Kuhn and Yach looked at determinants of cigarette smoking in the black township population and emphasised the need for primary prevention of smoking in women and boys.¹⁶

This study aims to determine the proportions of missed opportunities regarding anti-smoking education for coloured people 15 years and older, who attend Community Health Centres in the Cape Town Metropolitan area for reasons unrelated to smoking cessation.

Methods

This was a Descriptive Cross-sectional Survey.

Missed opportunity was defined to exist for a particular patient if all of the following criteria were present: intervention regarding smoking cessation was indicated, the patient was receptive to such intervention but did not receive such intervention.

The target population included all patients 15 years and older attending CHC's in the Cape Metropolitan Area. The sampling unit is the individual CHC. The CHC at which the investigator works was excluded to prevent bias. The following 6 CHC were randomly selected: Elsies River (ERCHC); Heideveld (HCHC); Hanover Park (HPCHC); Lotus River (LRCHC); Mitchells Plain (MPCHC) and Retreat (RCHC).

A smoking related complaint exists when the complaint of a smoker is known to be associated with smoking and/or is directly aggravated by tobacco smoking. Only those patients, who consulted either a doctor or a primary health care sister at the CHC, were included. Patients had to be able to converse in Afrikaans or English. Patients under 15 years of age, those attending for repeat prescription, dressings, and emergency patients were excluded. Every third patient seen by a medical officer or primary health care sister was interviewed. An attempt was made to interview patients in private using a structured self-administered questionnaire. Five professional teachers were selected from the community to become field workers and trained to conduct interviews. The technique of exit-interviews was

employed. Informed consent was obtained from all patients interviewed.

On leaving the CHC or while waiting at the dispensary, patients were asked to complete a questionnaire eliciting the following information:

- i. Demographic data.
- ii. The presenting complaints.
- iii. The smoking status of such patients.
- iv. Whether they have received any smoking education at that visit or previous visits.
- v. Whether they would have liked such intervention from the CHC.
- vi. Who should provide such intervention?
- vii. Utilisation of other anti-smoking aids such as pamphlets, posters and videos by the CHC staff.

The questionnaire had been subjected to a pilot study.

The responses to the questionnaire were anonymous. If a patient indicated that advice regarding smoking cessation would be welcomed it was briefly

provided by the field worker and further suitable arrangements made for consultation and counselling at a later visit. An independent medical officer who remained masked to the smoking status of the patients performed the record audit.

The research and ethics committee of the University of Stellenbosch approved this study. Permission was also obtained from the Medical Superintendent responsible for the CHC to conduct the study and to audit patient records for entries regarding smoking status.

Statistical Analysis

Results were analysed using the Epi6 statistical analysis program.¹⁷ Categorical variables were compared

by means of the chi-square test. P-values of less than 0,05 were regarded as statistically significant. 95%

confidence intervals were calculated for proportions and rounded off to the nearest integer.

Results

Of the total sample of 1 358 patients interviewed, 850 were smokers, bringing the overall prevalence at selected CHC to 62,6% (95% CI: 60,0% - 65,2%) with Hanover Park CHC 67,5% and Retreat CHC 56% the highest and lowest respectively (Fig. I).

Eleven patients refused to participate after the aims of the study were explained. This group of eleven consisted of 7 smokers and 4 non-smokers. The reasons cited include disinterest and no time. Of 850 smokers included in the study 591 (69,5%) were female and 62,8% unemployed. A total of 799 (91,6%) respondents agreed that smoking is harmful to their health and 84,2%

indicated that they had attempted to stop smoking on at least one occasion. A total of 823 (94,4%) of patients indicated that they wanted to stop smoking and 98,7% would try to stop if advised by their doctor. However 76,7% of patients indicated that they did not receive any antismoking advice on the day of their attendance at CHC.

Out of 734 patients seen by doctors on the index visit, 601 (81,9%) indicated that they did not receive antismoking advice from their doctor (Fig II); and of the 116 patients seen by the primary health care sisters on the index visit; 67 (57,8%) indicated that they have not

received any advice regarding smoking cessation (Fig. III).

Of 112 smoking asthmatic patients 80 (71,4%) did not receive any antismoking advice from the doctor. Of 185 hypertensive patients 141 (76,2%) indicated that they did not receive any antismoking advice from the doctor as did 109 (88,6%) of diabetic patients.

However 803 (94,5%) patients indicated that they would return to their respective CHC for antismoking counselling should they decide to stop smoking. The record audit revealed that 641 (75,4%) of patients did not have their smoking status recorded in their folders (Fig. IV) and that 592 (69,6%) had a smoking-related presenting complaint.

Figure I: Smoking prevalence at community health centres in the Cape Town metropolitan area

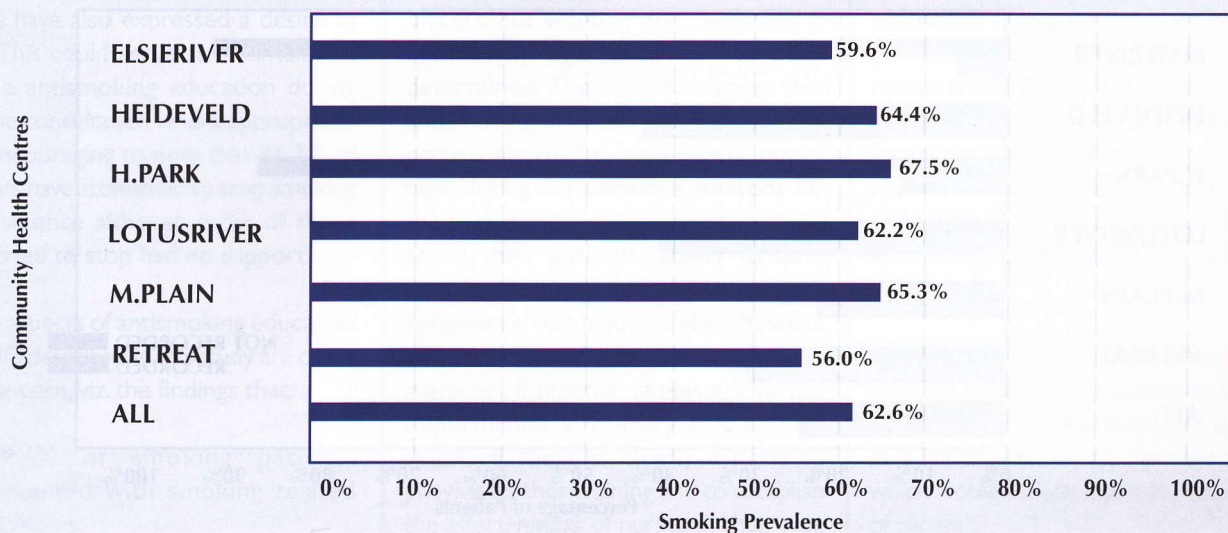


Figure II: Percentage of patients who received antismoking advice from the doctor

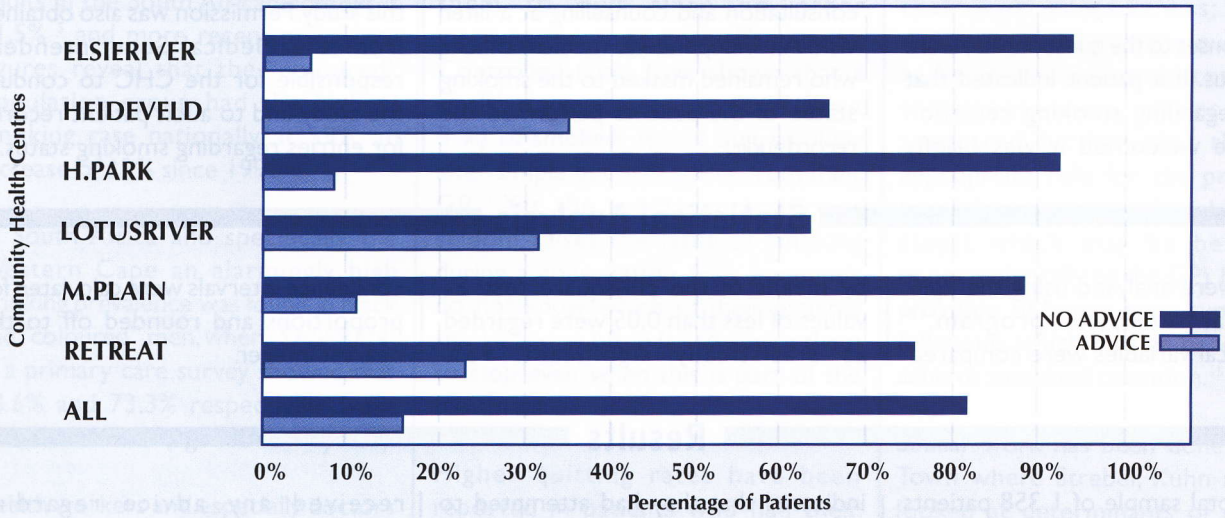


Figure III: Percentage of patients who received antismoking advice from the sister

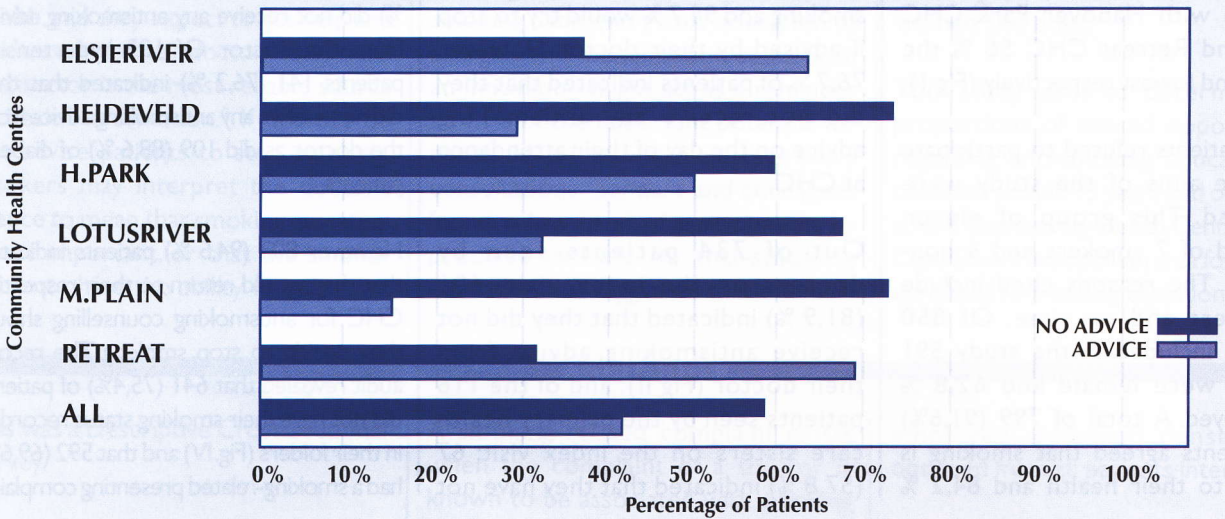
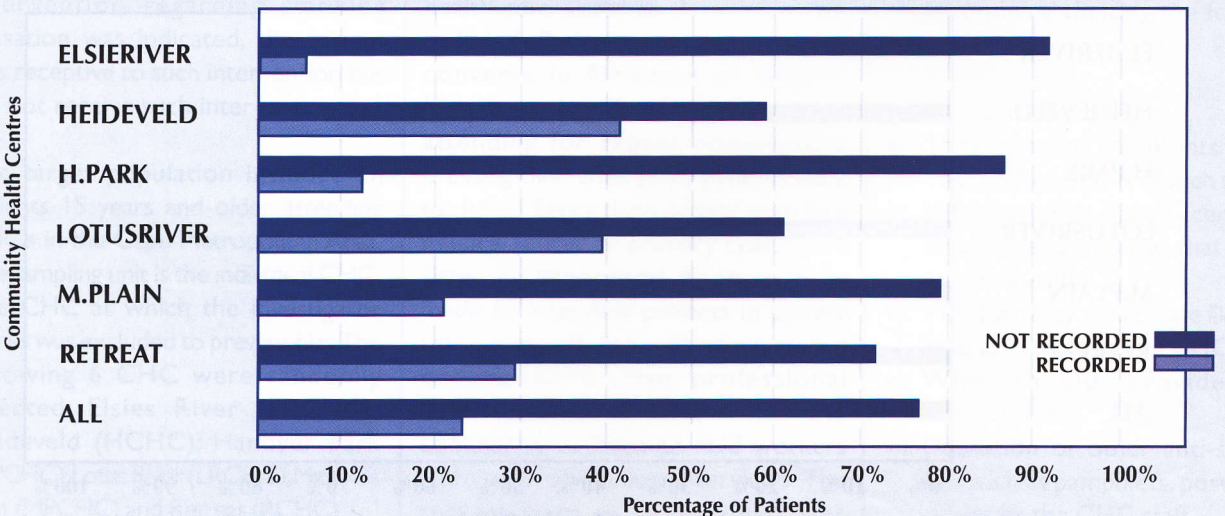


Figure IV: Percentage of patients who had their smoking status recorded in the folder



Discussion

Although studies have shown that many patients fail to recall information given by doctors^{18,19} and the proportion of patients who had actually received advice from the primary health care practitioner may thus have been much higher than indicated by the responses to the questionnaire, this study has shown that a high proportion of potential opportunities for antismoking education are currently being missed in patients attending selected CHC in the Cape Town Metropolitan Area.

Primary Health Care is widely being acknowledged as being of vital importance in health promotion generally¹⁹ and in smoking cessation in particular. With the overall smoking prevalence in CHC as high as 62,6 %, urgent intervention is required to improve the situation. As more females attend CHC, 69,5 % of this study population, an important strategy would include targeting female patients who are at the centre of the family as a role model. Thus preventing women from starting to smoke can influence the health of her unborn child and children in the household. In addition the younger age group, 15 to 44 years, constitutes the highest proportion of smoking patients (68,2 %) and therefore should be targeted in an attempt to discourage them from starting to smoke. The vast majority (91,6 %) of patients are aware of the harmful effects of smoking and 94,4% have also expressed a desire to stop. This could serve as a stimulus to initiate antismoking education during routine consultation where appropriate. It is encouraging to note that 84,2 % of patients have attempted to stop smoking at least once although most of those who tried to stop had no support.

Some aspects of antismoking education at CHC described in this study are cause for concern, viz. the findings that:

- i. 69,6% of smoking patients presented with smoking related problems;

- ii. 56 % of smoking patients were never advised or assisted to stop smoking since they had started attending CHC for smoking related complaints;
- iii. 76,7% of smoking patients were not advised against smoking on the day of their index visits;
- iv. 81,9 % of patients indicated that their doctors did not mention anything about smoking cessation during consultation;
- v. 75,4% of patients did not have their smoking status recorded in their folders;
- vi. 57,8 % of patients stated that the primary health care sister did not advise them against smoking during a consultation;
- vii. 80 (71,4 %) out of 112 smoking asthmatic patients did not receive advice against smoking on the index visit.

Despite these concerns 97,5% of patients feel that the doctor is the most appropriate person to assist them with smoking cessation and expect the doctor to be competent in doing so. It is also encouraging to note that 803 (94,5%) patients indicated that they would return to their respective CHC for counselling should they decide to stop smoking.

Primary health care sisters seem to have performed better than the medical officers, but whether this difference is statistically significant has not been determined. The results suggest that antismoking activities do not regularly occur despite the longer time sisters have during consultations. Reasons for this performance may include pessimism about their patients' ability to quit; limitations in their own training in behavioural techniques; and as shown in this study a paucity of effective support materials. If practice nurses are to use opportunities in primary care to help smokers, there is clearly a need to provide further training and to establish the effectiveness of nurses in their role

as smoking educators. Little is known about the attitudes and beliefs of practice nurses about smoking advice, the smoking behaviours of practice nurses and whether this influences their advice to smokers or their specific needs for further training.²⁰ Several studies^{21,22} have indicated that minimal advice and counselling about quitting given by primary health practitioners or nurses to patients on routine visits in the primary care setting are highly cost-effective²⁴ and are particularly successful, if the caregivers are adequately trained in cessation counselling methods.^{21,22,23,24,25,26}

Health education resources in antismoking education however were used surprisingly infrequently, suggesting a need for closer links between health education and primary health practitioners to ensure that booklets and leaflets are put into use.

Constantly changing staff, results in a disturbing number of different doctors consulted at each CHC. This leads to a lack of continuity of care and a poor doctor-patient relationship, which may increase missed opportunities. Due to the previous fragmentation of health centres in South Africa the CHC have until recently been involved in curative services only and it is probable that the medical and nursing staff do not perceive prevention as falling within their sphere of responsibility. This may increase the probability of missing opportunities for preventative intervention. However, the recent trend towards a district health system should improve on the previous fragmented approach to health care and provide a rapid integration of preventive and curative components of health care into a metropolitan based district health system.

A limitation of the study is the fact that it does not include Xhosa-speaking patients, but it is hoped that this research may serve as a stimulus for more definitive work, which would include a broader spectrum of patients.

The main recommendation arising from this research is that all smoking patients should be routinely advised against smoking irrespective of what their presenting complaints are. Effective support and strategies for follow-up are required. Obtaining a smoking history and recording it prominently in the folder is a minimum step. This expression of interest alone may be sufficient to encourage some patients to change their habit.

Compliance of primary health care practitioners in recording the smoking status of their patients should be improved. Designing folders with prominence to smoking status as is

currently given to allergy and immunisation status should be considered. Such an innovation might act as a reminder to primary health practitioners of the important potential for health education, which exists in every consultation. Antismoking advice is not only free, simple, and practical, but should be given routinely as it has been shown in controlled trials to be cost-effective. Patients are also more likely to stop smoking if they receive antismoking messages in a variety of forms and from a number of sources. In addition to giving tailored individual advice, high-risk groups such as potential smokers (young scholars), females and those with additional risk factors should be targeted.

The potentially greater benefits of changing lifestyle (i.e. smoking cessation) when multiple risk factors of IHD are present,²⁷ need to be more widely disseminated.

Lifestyle modification (in particular smoking cessation programmes) is not only a question of influencing and persuading the general public, but the mobilisation of primary health care professionals to support this endeavour may present another challenge. It is hoped that these findings will contribute to the implementation of change and increased awareness of tobacco smoking as the most important cause of preventable disease and premature mortality in developed countries.

Acknowledgements

The authors would like to thank the following people for their contributions:

Dr. Kenith Landers and Dr. Jimmy Volmink, for comments on the protocol, Mrs. Patricia Pather for typing the manuscript, Mr. V. McPherson; Mrs. C. McPherson,

Mr. A. Pather, Mr. H. Van der Merwe, Mr. G. Kiewit - for doing the fieldwork. Dr. C. Bezuidenhout for conducting the record auditing. Mr. Roelf Sayed - for valuable assistance with Epi6 and the statistical analysis. Doctors in charge and receptionists of the participating

Community Health Centres for their co-operation and assistance. The Medical Superintendents for permission to perform research at the Community Health Centres. Financial assistance from the University of Stellenbosch; The Harry Crossley Foundation.

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