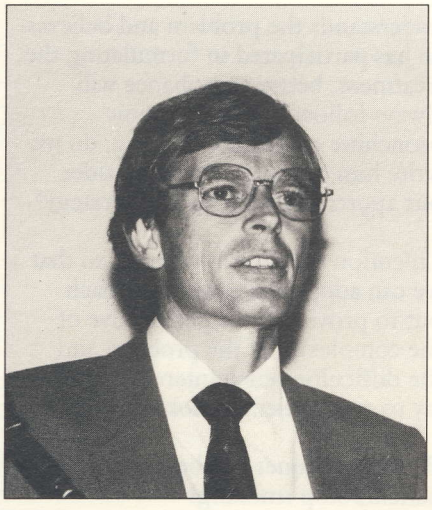
The Family Practitioner's Role in Smoking Cessation — Guy Parr



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Curriculum vitae

Guy Parr studied at UCT where he obtained a BSc (Med) in 1970 and MBChB in 1973. After internship at Groote Schuur Hospital, he spent 2 years in Europe, with various GP-locums in London. He returned to the RSA and after being a Medical Registrar at Groote Schuur (1977-1978) he started as a GP in Claremont. He is interested in academic medicine, family therapy and holistic medicine. Guy is married with 3 children, and when he has free time he loves sailing and running.

Summary

Smoking is the most wide-spread example of drug dependence, and although most GPs feel a sense of inadequacy in this field, they themselves are the most powerful therapeutic tools in getting their patients to stop. The problem of non-compliance is discussed and a few helpful suggestions are given, especially the value of a good doctor-patient relationship.

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Smoking; Physician-patient Relations; Patient Co-operation.

Introduction

Smoking as a learned addictive behaviour, is our most wide-spread example of drug dependance. Like other drugs that produce dependence, smoking has the following characteristics[1]:

1. It (nicotine) is psycho-active and produces a desired effect.
2. It creates dependance that leads to compulsive use, despite the risk of, or presence of significant associated illness.
3. Abrupt cessation can produce both psychological and physiological distress that often over-shadows the desirable effect of smoking. Hence many people continue to smoke merely to avoid nicotine withdrawal.
4. There is a strong tendency among former users to relapse. We all know of "experts" like Mark Twain who have given up hundreds of times. The percentage of smokers who remain abstinent one year after intervention, ranges from as low as 4%[3] in unselected groups, to 50% in selected, motivated groups.[2] Only about 20% of people who try to stop smoking ever succeed.

Probably the best results in smoking cessation were achieved in the 17th century Persia where you could be decapitated if caught smoking.[4] The treatment was 100% successful but the side-effects were intolerable.

Smoking is an activity that commences innocuously in adolescence or early adulthood, often as a result of peer pressure and is an attempt by the individual to appear socially accomplished. It progresses to become a learned behaviour in which the physical ritual of smoking provides a psychological crutch which, together with the increased alertness and relief from anxiety provided by the nicotine, may lead to escalating addictive smoking.[5]

What is the role of the family physician?

In Britain the average adult will visit his GP three times a year.[5] In South Africa attendances vary with socio-economic factors, but many of the patients who smoke heavily and have other coronary risk factors, will have a similar pattern of attendance. The family doctor is in a unique position where he will see the smoker (and other family members) over a prolonged period, often in an individual face-to-face setting. Basic features of good family practice are continuing, comprehensive and preventative care. The good family

physician is in an ideal position to screen his patients for potential health risks, like smoking, and should know when and how to intervene. He should be able to provide factual information in a way that is relevant and acceptable to the individual concerned and motivate the patient to follow this advice. As physicians we are seen by society to have both scientific knowledge and charismatic authority (God given!) and when used in the setting of a good doctor-patient relationship, this is a very powerful therapeutic tool.

How well do primary care physicians actually do in assisting patients to stop smoking?

In one study only 40% of smokers who contacted their doctor in the preceding year reported being told to stop smoking.[6] In another study, a mere 3% of primary care physicians believed that they were successful in helping their patients to stop smoking.[7] Accepting that many patients may "forget" the advice we give them, it seems that we may only make use of half the opportunities we have for significant intervention - and even when we do, our patients do not follow our advice!

... a learned addictive behaviour.

Why is this?

We know that smoking is highly addictive and its continued use is encouraged by both media and peer pressure. The majority of physicians feel a sense of inadequacy in their ability to stop patients smoking. They may lack the skill to intervene and provide long-term support, the physician may smoke himself and actively avoid the subject. Most doctors will be products of medical schools where hours of study are spent on the patho-physiology of heart disease while little attention is given to developing inter-personal skills that are necessary in helping patients change destructive behaviour and develop better coping mechanisms. Less than half the medical schools in North America and none in South Africa offer courses on smoking prevention.[6]

... our most wide-spread example of drug dependence.

Patient compliance is not merely the result of receiving advice from a physician. Many of us have a misguided belief that our patients owe us compliance in return for our care. When they do not comply, we become critical and often rejecting of the patient.[8] Long term compliance with important medication maybe as low as 50% and is often lower for dietary advice.[8] The problem with noncompliance is rarely one of knowledge. It often reflects the inability of an authoritarian physician to involve the patient in the decision making process and hence preventing the patient from personally investing in the outcome of his therapy. A good doctor-patient relationship in which the patient believes that the doctor has an understanding of him as a whole-being (and not a disease process), is essential to good compliance. If the patient understands the problem and believes he has participated in formulating the treatment, better compliance will always follow. When a chronic bronchitic continues smoking, do we write him off or do we re-consider our approach and try a new strategy?

I mention these problems not so that we can adopt a nihilistic approach but to provide some perspective of the complexity of the problem and the difficulties encountered when we try to stop patients smoking.

What techniques can be used to help patients stop smoking?

A physician's primary role is to motivate the smoker to *want* to stop. Simple, directed and informative advice does have a good role. In one study such advice given (in less than 2 minutes) by GPs to a random group of smokers with re-inforcement at follow-up consultation, resulted in a 5% long term cessation (cf 0,3% control). In another study a group of London Civil Servants[2] were screened for coronary risk factors and were given clear-cut advice to stop smoking. This resulted in a 39% cessation after one year (cf 9% control). If this information is given while the patient is in a coronary care unit, the cessation rate increases to 63%. Similarly, intervention at an appropriate time in family practice, such as in early pregnancy or when a

The doctor himself is the most powerful therapeutic tool in motivating his patient to stop smoking.

family member has a smoking-related illness, will improve compliance.

The simultaneous use of nicotine resin gum (Nicorette) has doubled long-term success rate in some studies. When used correctly, over a period of three months and then tailed off, Nicorette provides an alternative nicotine source. Although nicotine in this form is still harmful, it is far safer than smoking and addiction to the gum is infrequent (less than 7%). This is useful in the heavier longstanding smoker who may experience significant nicotine withdrawal.

There are no "safe" cigarettes and most smokers switching to low tar, low nicotine cigarettes adjust their inhalation pattern to maintain nicotine levels.

Behaviour modification using aversive conditioning is helpful in some patients. Cigarette smoking is a learned behaviour and aversive conditioning aims to unlearn this. "Rapid-smoking" in which the patient puffs rapidly on a cigarette until he feels sick – preferably in an unpleasant environment, has good results when used by selected motivated patients under supervision, particularly when followed by Nicorette (70% cessation after 3 months).[2] This is the basis of commercial anti-smoking courses which also utilise positive reinforcement in a therapeutic support group.

Hypnosis has a more limited success with studies showing 13-20% cessation in selected groups after 3-6 months.[2] Acupuncture was found to be no more effective than a control group. The poor results of these modalities is probably linked to the passivity of patients undergoing treatment and their belief that the treatment itself is a substitute for will-power.

Many family physicians will hold part-time industrial medical appointments as company doctors and it is imperative that they make use of this authority to limit smoking opportunities in work-places. Similar influence can be used in other settings such as sporting bodies and community organisations where a