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Exploring the views of healthcare professionals on increasing smoking cessation advice for patients

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Abstract

Background: Smoking cessation advice provided by healthcare professionals can be effective in increasing smoking cessation among patients. Any successful intervention will require staff knowledge of local barriers to implementation. However, the views of Irish healthcare professionals on increasing the provision of smoking cessation advice and the associated barriers remain unexplored.

Aims: To explore the views of Irish healthcare professionals on barriers to increasing smoking cessation advice for patients in a large Irish university teaching hospital.

Method: Semi-structured interviews were conducted separately with 16 healthcare professionals in a large Irish university teaching hospital.

Results: The main barriers identified were patient and staff attitudes, time and service constraints, information not readily available, and issues and opinions on a smoke-free campus policy in a hospital setting.

Conclusion: Our results revealed several barriers, expressed by Irish healthcare professionals, to providing smoking cessation advice to patients. This supports the need to implement a multi-component intervention in a hospital setting to improve the rate of provision of smoking cessation advice in patients by healthcare professionals.

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Introduction

Smoking is the single most important preventable cause of illness, chronic disability, and death in Ireland.[1,2] According to the Health Survey Ireland 2015, 23% of the Irish population are smokers.[2] Smokers lose an average of 10-15 years from their life expectancy;[1] according to the HSE website on smoking cessation, "one in every two smokers will die of tobacco-related disease".[3,4] Every year, there are over 5,000 deaths due to tobacco in Ireland.[2] To combat this problem, healthcare professionals (HCPs) are encouraged to provide cessation advice to patients who are smokers. Based on a Cochrane review in 2008, brief cessation advice provided by doctors increases the possibility of smokers being successful in quitting.[5] The Health Survey Ireland 2015 reported that a "majority (63%) of smokers are trying to, planning to or considering quitting".[2] However, there is a low prevalence of provision of cessation advice by HCPs, in Ireland and more widely. An Irish study (2012) found that 61% of hospitalised patients were asked about smoking status, and only 44% of current smokers received advice from HCPs.[6] This was also recently explored in another Irish study (2014) carried out in two large Irish university teaching hospitals, which reported that 62% of inpatients did not receive smoking cessation advice, despite 55% being interested in quitting when asked.[7] In a German study, only 39% of patients who smoked recalled being counselled to quit,[8] while only 10.5% of general practitioners in Montreal and 22.6% of university hospital physicians in Turkey offered smoking cessation advice.[9,10] Use of the Ottawa Model for Smoking Cessation (OMSC) has been proposed to accomplish a systematic approach to the delivery of cessation advice by HCPs to patients

in an Irish hospital setting. A study evaluating the OMSC showed that 69% of smokers receiving the OMSC intervention achieved six-month continuous abstinence, suggesting that it is a successful cessation model.[11] A cross-sectional study in Japan reported HCPs lacking knowledge and training, and patients' unwillingness to quit, as potential barriers to smoking cessation care.[12] In the UK, a qualitative study showed that patients were more likely to consider cessation when referred to a separate specialist smoking cessation centre, and this service was favoured by HCPs because they felt that they lacked the time and expertise to intervene during daily practice.[13] The views of HCPs on increasing the provision of smoking cessation advice in Ireland are not well elucidated. This study aims to explore the views of HCPs on current barriers to the provision of cessation advice to patients, and their recommendations on how to increase such advice, in a large university teaching hospital.

Methods

Participants and setting

Venue-based and snowball sampling methods were employed, whereby 16 HCPs were recruited from Beaumont Hospital. Once a HCP was interviewed, they then recommended two to three others who might consider participating in the project. Each HCP was contacted in turn, and the researcher (SYH) met those who agreed to participate, and conducted the interviews within the allocated timeframe. Participants were selected and interviewed if they fulfilled the criteria: a healthcare professional working in an environment where they would have daily contact with patients. Interview appointments were arranged from July 4-11, 2012. HCPs were categorised as doctors, surgeons, nurses and allied HCPs to ensure anonymity.

Procedure

Ethical approval was given by the Beaumont Hospital Ethics (Medical Research) Committee. Each participant was given a leaflet about the study and its purpose, and a consent form to sign prior to the interview. A set list of open-ended questions was used to maintain consistency (**Figure 1**). All participants were interviewed by the same interviewer. Each session lasted 15-30 minutes, and was recorded with the respondent's permission. Participants were questioned on their smoking status, whether they routinely provide cessation advice, barriers to delivering such advice to patients, and recommendations.

Analysis

Digital recordings were analysed and fully transcribed. A thematic

- Do you smoke?
- Do you routinely record patients' smoking status?
- Do you routinely provide patients who are smokers with smoking cessation advice?
- Do you follow up on all these patients that you provide with smoking cessation advice?
- On average, how many years of life would you estimate for smokers to lose in comparison to non-smokers?
- Do you refer patients to a community smoking cessation programme or any other that is similar?
- Are you familiar with the 5As model, 5Rs model or the Ottawa model?
- If the 5As model were implemented in this hospital, do you think it would be effective?
- If the 5Rs model were implemented in this hospital, do you think it would be effective?
- What do you think about the Ottawa model, if it were to be implemented in this hospital?
- Do you think practice-based supports such as stickers on a patient's chart, or posters or emails, would increase the rate of delivery of smoking cessation advice to patients?
- Do you think brief smoking cessation advice from a healthcare professional is effective in increasing quit rates?
- How long do you think brief smoking cessation advice should take?
- Present results suggest that 10-15 minutes is the optimal length for provision of smoking cessation advice. How realistic do you think this is? What do you think of this?
- Do you have any other recommendations for improving the rate of recording patients' smoking status and providing smoking cessation advice?
- What do you think about this hospital as a smoke-free campus? Would that help patients?
- In this hospital, what systematic barriers do you and your staff experience in terms of recording patients' smoking status and providing smoking cessation advice?

FIGURE 1: List of interview questions.

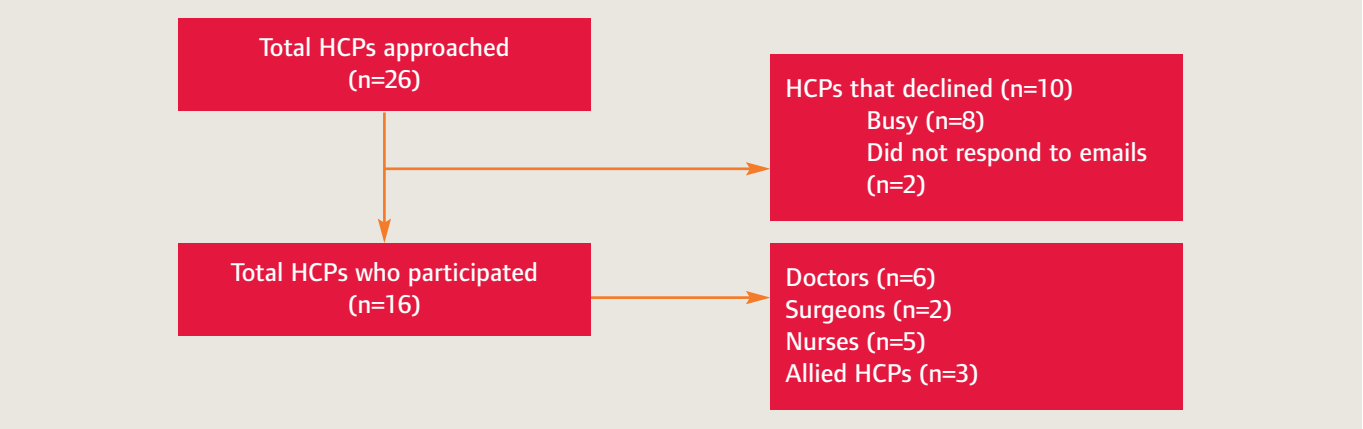

FIGURE 2: Flow chart illustrating recruitment of HCPs.

analysis was done to identify the main themes (barriers and recommendations) relating to smoking cessation from interview transcripts. Significant key words, phrases and quotes from transcripts were identified and marked with 'descriptive tags' or codes by a researcher (SYH). Coded transcripts were then reviewed by another researcher (MB) to ensure the reliability of the first author's (SYH) codings and to see if any further themes could be detected in the transcripts. Once both researchers (SYH, MB) agreed on the codings, all codes that were thematically similar were grouped together and labelled as a category, which became the organising themes of our analysis.

Results

HCP recruitment and participation

Of the 26 HCPs approached, 16 agreed to participate. Of the 10 that declined to participate, eight stated that they were busy and two did not respond to the emails. The HCPs who participated were doctors (n=6), surgeons (n=2), nurses (n=5) and allied HCPs (n=3), none of whom currently smoked. One nurse had stopped smoking 11 years previously (**Figure 2**).

Current practice

Most HCPs (75%; 12/16) routinely recorded patients' smoking status on admission, 18.75% (3/16) did not do this routinely, and 6.25% (1/16) did not record patients' smoking status at all. The 18.75% (3/16) of participants recorded smoking status when reminded to do so (i.e., on admission note or social history), or when it was relevant to the patient's medical condition (i.e., if the patient had a respiratory condition).

Only 43.75% (7/16) of the interviewed participants provided smoking cessation advice to patients routinely, 37.5% (6/16) did not routinely provide it, and 18.75% (3/16) did not provide it at all. The time spent for provision of cessation advice was less than five minutes.

"We would contact the smoking cessation officer, but we don't offer advice for patients who come in." (Interview 3 – nurse)

"We would [provide cessation advice] in young breast cancer patients who are getting better and will live a long life, but if it's somebody who is quite sick and palliative, it's not really considered important to do that." (Interview 10 – allied healthcare professional)

"I am not sure whether everyone does anything other than record [smoking status] as part of the history that they take." (Interview 6 – doctor)

There was also lack of routine documentation of patients' smoking history by staff. According to one nurse, patients' smoking history was not "written in black and white" and there was no "specific column for it".

"Sometimes it's pack years, sometimes it's 'ex-smoker gave up 15 years ago', but not the amount. Maybe [it would be documented more] if there was a routine hospital policy on how you document and to always document it." (Interview 10 – allied HCP)

Barriers to delivering smoking cessation advice

All HCPs interviewed viewed the provision of smoking cessation advice as effective in increasing quit rates among patients. However, several barriers were reported when providing patients with such advice.

1. Patient and staff attitudes

Participants said that it can be difficult to encourage patients to quit smoking when they have no intentions of quitting at all.

"When you start talking to a patient about smoking, you can see them shut off. Most patients when asked, they smile and, it's like, 'I suppose

you are going to give me a lecture now'…" (Interview 6 – doctor)
It was also voiced that patients come to the hospital for specific medical problems and not smoking cessation, making it difficult for HCPs to initiate.
"The patient didn't come to quit smoking, they came for [a different] problem, so it won't have an impact." (Interview 1 – surgeon)

One noted that there was no routine management for smoking cessation.
"It was maybe done once or twice during a patient's stay. I haven't seen it done any more." (Interview 13 – doctor)

With regard to staff attitudes, participants felt that there was a "huge lack of awareness", as most doctors "don't know the actual process of referring someone for smoking cessation". Furthermore, most HCPs do not think that this is their primary goal, and believe that they are not the "primary people" to give cessation advice. Both of these factors contributed greatly to the lack of provision of cessation advice to patients.
"They are not coming to me actually to see that [smoking cessation], they are coming to me to diagnose a tumour, or treat their COPD with whatever medication. That is what I'm supposed to do as a doctor." (Interview 15 – doctor)

The lack of knowledge among junior staff also contributed to a lack of provision of smoking cessation advice. This resulted in HCPs not providing cessation advice routinely or intensively in the hospital. Another doctor suggested that staff should be educated on "actual smoking-related illnesses and the latest figures on how smoking impacts on patients" in addition to cessation advice.
"I think [smoking cessation advice] needs to come from all members of the teams, because I think just one advising them to stop smoking is not helpful." (Interview 11 – allied HCP)

2. Time and service constraints

Most respondents viewed time as a major factor in providing brief cessation advice to patients.
"We just lack time to talk to patients." (Interview 14 – doctor)

"You have to do so much work. There is no time to spend per patient to give cessation advice." (Interview 1 – surgeon)

Having a part-time smoking cessation officer (three days per week) was among the barriers faced by HCPs, as referrals made were "not always consistent" (Interview 15 – doctor).

One nurse voiced the opinion that there should be immediate access to a cessation officer at all times.
"You can't send people over and say 'we will have them talk to you tomorrow'." (Interview 3 – nurse)

One surgeon suggested that a smoking cessation clinic should be available in the hospital for patients willing to quit (Interview 1 – surgeon). With the heavy workload and the time constraints every HCP has, having a smoking cessation clinic where patients could be followed up consistently and seen primarily for cessation would be a great improvement. Facilities such as community smoking cessation programmes, support groups and follow-up services for patients on pharmacotherapy for cessation are unavailable, affecting the quit rates among patients.
"I think it's important when a patient avails of a service, they should be followed up within six months." (Interview 16 – allied HCP)

"There are no community cessation programmes and facilities available." (Interview 15 – doctor)

Staff shortages in the hospital contributed to inconsistent provision of cessation advice. One nurse suggested that having a cessation nurse assigned to wards to follow up on patients would improve the rate of delivering cessation advice.
"I think if someone was assigned specifically, a nurse to go around and check what patients are smokers and sit down [with them], maybe that will help." (Interview 5 – nurse)

3. Information not readily available

One practical barrier expressed by participants was a lack of availability of information on smoking cessation. Without information leaflets and posters readily available throughout the hospital, HCPs can only provide cessation advice verbally.
"There aren't any information leaflets and things like that. So maybe if there were leaflets on the wards, it might help inpatients as well." (Interview 8 – doctor)

"When you are in A&E admitting patients, you always ask about smoking history and it's at the forefront of your mind … By the time they make it to the wards, it's forgotten, and you deal with their acute problems." (Interview 8 – doctor)

4. Smoke-free campus

During the study period, the hospital had just implemented a smoke-free campus policy and experienced several issues. Patients

smoking in a hospital affects not only their health, but also subjects non-smoking parties to passive smoking, so with the hospital being designated a smoke-free campus, there would have to be an increase in the rate of provision of cessation advice and encouraging patients to quit smoking. Hospital staff would also theoretically be motivated and encouraged to quit smoking, as there is a "restriction they have to respect" (Interview 1 – surgeon). However, the idea of the smoke-free campus was not supported by all. One doctor said it "is not fair for the palliative patients", despite helping other patients with smoking cessation, and suggested that exceptions should be made for these patients (Interview 9 – doctor).

Discussion

This is the first qualitative study to explore the views of HCPs in Ireland on the barriers to increasing smoking cessation advice for patients. The main barriers identified from our study were time and service constraints, patient and staff attitudes, information not readily available, and issues with the smoke-free campus policy. Time constraint was viewed as the major barrier to the provision of smoking cessation advice to patients by HCPs. In an Irish study, 74% of nurses had no time to provide cessation advice to patients.[14] In another study, smoking cessation counselling was perceived as too time-consuming by physicians.[8] According to Duffy *et al.*, having trained nurses to deliver cessation care to patients is ideal, as nurses are well informed on patients' medical conditions, nursing time is more cost-effective compared to physician time, and nurses have access to and immediate rapport with patients.[15] Future research should investigate the suitability of nurses to deliver cessation care. Another barrier perceived was that HCPs underestimate the relevance of cessation advice to the patients and do not regard it as their primary goal and priority. This was reflected in other research: 76.3% of physical therapists asked patients' smoking status but only 21.6% reported assisting patients to quit smoking (due to lack of training).[16] Despite HCPs being aware of the importance of smoking cessation, there is a lack of knowledge as regards counselling patients. Desalu *et al.* found that 67% of physicians were aware of smoking cessation but only 30.3% had knowledge on cessation counselling and 66.3% had poor knowledge of interventions.[17] An Irish study reported that 65% of nurses lacked training in delivering cessation advice.[14] Smoking patients who received cessation advice from two or more types of HCP had an almost three-fold increase in quit attempts and readiness to quit in the next six months.[18]

With regard to patient attitudes, patient resistance or unwillingness to quit smoking was also among the barriers. Dentists and general practitioners in the UK reported patient resistance as a barrier.[19,20] However, Duffy *et al.* reported that only 17% of inpatient veteran smokers received advice, despite more than two-thirds being motivated to quit.[15] In Ireland, Bartels *et al.* reported that 40% of smokers would like to receive cessation advice.[6] A further barrier identified was the lack of a facility to follow up patients who had received smoking cessation advice from HCPs. It has been demonstrated previously that cessation rates were higher in groups receiving extended counselling (22% versus 20% in the control group) and follow-up (28% versus 24% in the control group) compared with those receiving brief advice.[21] Training residents and labelling medical records with reminders has more than doubled the percentage (from 9% to 23%) of patients receiving advice.[22] Intervention, including a follow-up call, showed a rise in the six-month continuous abstinence rate (29.4% vs. 18.3%).[11] Rigotti *et al.* confirmed that intensive intervention with follow-up support increased cessation rates.[23] Multi-component interventions that increase provision of cessation advice have demonstrated some success. Freund *et al.* implemented a multi-strategic approach, which involved seven broad intervention strategy areas, and this was effective in increasing hospital smoking care delivery and provision of nicotine replacement therapy.[24] A further multi-strategic intervention trial showed that improving the routine provision of cessation care practices in a hospital setting is achievable.[25] This confirms the need for multi-component intervention to increase the efficiency of provision of cessation advice in a hospital setting.

This study has several limitations. Results were based on interview sessions with HCPs, leading to recollections and biases of individuals affecting the data's accuracy. The sample size was 16 HCPs from a single large university teaching hospital, suggesting that the sample may not be representative of the entire HCP population. However, the HCPs interviewed are involved with patients directly in their clinical practice and would be the ones providing cessation advice directly.

Conclusion

This study investigated the views of HCPs on increasing smoking cessation advice for patients. We identified several barriers expressed by HCPs to providing cessation advice to patients. With the knowledge of these barriers, we are able to understand and overcome them, and to personalise and improve the provision of smoking cessation advice to patients, thus increasing smoking cessation rates. Overall, this supports the need to implement a multi-component, hospital-based intervention, or specialist cessation care, to promote and increase the rate of provision of smoking cessation advice to patients by HCPs.

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