Management of smokers motivated to quit: a qualitative study of smokers and GPs

Andrew Wilsona,*, Shona Agarwala, Sheila Bonasb, Ged Murtagha, Tim Colemanc, Nicholas Tauba and Julia Chernovaa

aDepartment of Health Sciences, bDepartment of Medical and Social Care Education, University of Leicester, Leicester, UK and cDivision of Primary Care, School of Community and Health Sciences, University of Nottingham, Nottingham, UK.

*Correspondence to Andrew Wilson, Department of Health Sciences, University of Leicester, 22 Princess Road West, Leicester LE1 6TP, UK; Email: aw7@le.ac.uk

Received 17 November 2009; Revised 16 March 2010; Accepted 4 April 2010.

Background. The National Institute for Health and Clinical Excellence (NICE) guidelines state that GPs should manage smokers motivated to quit by offering referral to Stop Smoking Services (SSS) and that nicotine addiction treatment (NAT) should be offered only to those who decline referral.

Objective. To explore how smokers motivated to quit are managed in the GP consultation, specifically how treatment and referral are negotiated from the perspectives of both parties.

Methods. Twenty patients, identified in a consultation with their GP as motivated to quit smoking, and 10 participating GPs were interviewed. Interviews were recorded, transcribed, coded and analysed using the framework approach.

Results. Three strategies (treatment and follow-up by the GP, referral to SSS without treatment and immediate treatment with referral for follow-up) were evidenced in patient and GP accounts. Most patients were satisfied with their management and how this was negotiated, but some expressed surprise or dissatisfaction with lack of immediate treatment and questioned the need for referral to SSS. GPs welcomed the availability of SSS but some felt it important that they themselves also continued to support a quit attempt. Several saw advantages in offering NAT at the time the patient was motivated to stop.

Conclusions. Smokers appear less convinced than GPs about the value of referral to SSS, although these differences may be resolved through negotiation. An alternative strategy to that proposed by NICE, which may be more acceptable to some smokers, is immediate treatment with subsequent support from SSS.

Keywords. Consultation, health promotion, qualitative research.

Introduction

In the UK, smoking accounts for >80% of deaths from chronic obstructive pulmonary disease and a third and a fifth of deaths from cancer and ischaemic heart disease, respectively.1 Half of all smokers die prematurely but stopping significantly extends life expectancy.2 The success of a quit attempt using nicotine addiction treatment (NAT) and behavioural support is about three times more likely to succeed after a year than an unsupported attempt (15% compared to 5%).3 General practice remains the most common source of effective advice about smoking,4 and the GP contract sets targets for advice about cessation.5 In England and Wales, National Institute for Health and Clinical Excellence (NICE) guidelines recommend GPs to offer brief advice to all smokers and to refer those motivated to quit to a support programme from trained advisers, offering NAT with follow-up only to those who decline referral.6 This guidance differs from that given in some other countries; for example, Australian guidelines suggest follow-up and medication by the GP with additional rather than substitute support from external agencies.7

In the UK, Stop Smoking Services (SSS), employing trained advisers, are now established nationally in community settings, including some general practices, and have been shown to be effective.8,9 Although a majority of GPs welcome their existence,10 referral rates remain low.11 In a recent survey of patients prescribed NAT by their GP, we found that only 64% reported that they were advised to attend SSS.12 Between practices, this rate ranged from 18% to 90% of patients. Furthermore, of those referred to SSS, only 63%
management of SSS and feel that they are not sufficiently personal or easy to access. GP may also choose to treat smokers themselves as part of their management of smoking-related conditions and to utilize the continuity and trust of an established doctor-patient relationship. In the UK, there has been no direct comparison between in-house and external support, but a recent trial in Australia found that additional support from a telephone support line more than doubled cessation rates.

Another reason that SSS are underutilized could be that smokers wishing to stop want support quickly, rather than waiting for an appointment to make a planned quit attempt. This is supported by observational evidence that unplanned quit attempts may be more successful than planned attempts and that 37% of quit attempts are made without planning. The authors of these studies have suggested that their findings point to the need to make treatment available for unplanned quit attempts.

In this study, we explored how the decision to treat and/or refer motivated smokers is negotiated from the perspective of the patient and doctor.

Methods

Fifty GPs were recruited from the database of the Primary Care Research Network East Midlands and South Yorkshire. The configuration of SSS varied across the region; in some areas, smoking advisers were practice based, whereas in others, they were based in other locations. Each GP was asked to recruit motivated smokers aged ≥16 years, identified in routine consultations. Eligibility was confirmed by the GP obtaining an affirmative answer to the two following questions: ‘Do you want to stop smoking for good?’ and ‘Are you interested in making a serious quit attempt in the near future?’ as has been recommended to assess motivation. Exclusion criteria were patients with severe dementia, learning difficulties, physical or mental illness and those unable to conduct an interview in English.

At the end of the consultation, GPs explained the study to the patient, emphasizing that participation would not affect their management. If the patient expressed interest, they were handed a study pack and a preliminary consent form to return to the research team. On receipt of the consent form, the researcher contacted the participants by telephone to answer any questions about the study and to confirm consent. Patients were interviewed in their home between 2 and 4 weeks of recruitment to maximize recall. Written consent was obtained at that time.

A patient interview topic guide was devised from the literature. This included three themes: expectations of how the GP would help them stop smoking, how they were managed and views about their management. A semi-structured approach enabled further probing and clarification as necessary.

We also conducted face-to-face qualitative interviews with GPs who were purposively sampled from those participating in the study to reflect a range of differing management choices, as elicited by a short questionnaire. An interview topic guide was developed from the literature. The interview included three themes; the GP’s preferred management strategy, the degree to which they were prepared to negotiate this and difficulties they had implementing it.

The transcribed data from both sets of interviews were analysed using the framework analysis approach. This involved a careful examination of the data using the themes derived from the interview guides. Using these as a starting point, responses were analysed to identify relevant emergent subthemes and issues, which evidenced elaborations of the themes. The data were examined and re-examined by five authors (SA, SB, GM, TC and AW) until consensus was reached on the relevant subthemes and categories emergent from patients’ responses.

The study was approved by Leicestershire, Northamptonshire & Rutland Research Ethics Committee.

Results

Patient interviews

Twenty interviews were conducted with patients and analysed using the predetermined themes outlined above. Numbers in parentheses are patient identifiers.

Theme 1: Patient expectations

Patients had varied expectations, ranging from well-formulated requests for specific NATs or referral to a nurse or counsellor to support cessation, through to a wish to discuss all the options with their GP.

I wanted to get a prescription for the nicotine patches to help me stop smoking (15)

I did hope I would be able to get Zyban (bupropion) or something like that that would actually put me off cigarettes (27)

I was hoping she’d link me up with the NHS nurse … so I could get some help from her, you know carry on after seeing the doctor, carry on with her because I’ve seen her before, I’ve tried before to give up smoking (7)

I wanted to know the options I could do … to stop smoking (28)

Some patients also expressed views about what they did not expect or would not want, including referral for behavioural support.
I didn’t think I was going to be referred to somebody else, I thought the doctor would basically have done it (17)

I won’t take the counselling for my depression so he knows I won’t take the counselling for the stopping me smoking ...(2)

**Theme 2: advice/management offered**

The three strategies outlined earlier (treatment and follow-up by the GP, referral to smoking cessation services without treatment and treatment with referral for follow-up) were all evidenced in patient reports. In general, GPs were reported as responsive to requests made for particular strategies and prepared to discuss options. However, in some cases, patients reported negotiating immediate treatment rather than waiting to see a smoking advisor.

I think she did just say, you know, there are a few options and then obviously went through ... all the different options (23)

That’s when he mentioned the stop smoking service which I’ll refer you to... he was a bit reluctant to give me tablets ... as he wanted me to see the nurse ... I told him about the patches and gum and how they hadn’t worked. I told him that I had heard about Zyban and really wanted to give that a go... he wasn’t keen to give me a prescription as he wanted me to go and see a nurse at the clinic ... so I said I’d go and see the nurse if he would get me started on the tablets (25)

**Theme 3: Views on management**

In general, patients appeared satisfied with the management they received. Several reported that their views, particularly about support from an adviser, had changed as a result of discussion with the GP.

I didn’t agree with why he wanted to send me to the nurse but I do agree with the advice now. The nurses are the experts with smoking aren’t they ... I can see the nurse every week for support and get the patches so I’m pretty happy with that ... she gave me some good advice as well as the patches. She mentioned that it was a good idea to set a quit date (1)

Two issues about which some patients expressed dissatisfaction were firstly the lack of immediate treatment and secondly referral to SSS when the patient felt that the GP would have been in a better position to support a quit attempt because of familiarity and continuity.

I’d have liked a prescription that day, I would ... I definitely would have liked that ‘cos I would definitely have made an effort to stop smoking ... I feel I’d have gone ahead with that. At that time ‘cos I was a bit scared with my blood pressure and that and I felt that if I’d had that prescription I’d had the patches or something then I’d have tried to stop there and then but now it’s gone into three weeks (6)

I think he (GP) could have basically tried and helped me a little bit more than what he actually did instead of talking me through the factors and then referring me to somebody else (17)

I thought it was best to go to the doctor... you can ring up a stop smoking line or I could have gone to the chemist ... but he (the GP) wanted me to do one of those two things before seeing him and I was like I’d rather just do it with you ... I’m not gonna call up somebody up over the phone ... and I knew him better so I wanted to start off with him and then carry on ... (9)

**GP interviews**

Ten GP were interviewed. Transcriptions were analysed using the following framework of themes.

**Theme 1: preferred management plan and rationale**

In general, GPs welcomed support from smoking cessation services. It was appreciated that these services could provide more time than was available from the GP and that there was guidance that some treatments should only be used with support.

... again from the point of view of trying to manage workload, obviously I prefer to send them to a smoking service that is already set up, that doesn’t take my time ... I’ve got other patients wanting to see me, you know patients always complain they can’t get in to see you doctor you know, so if I clog up my appointments with patients having the stopping smoking services from me ... then I’ll have more problems (4)

... and clearly now with the NICE guidance and the fact that before we can prescribe Champix (varenicline) they need to have seen a smoking advisor, that’s potentially going to be one of the options, you may as well refer them anyway because you can’t prescribe it ... or you shouldn’t prescribe it until they’ve been to see a smoking cessation advisor (38)

However, some GPs also felt it important that they themselves continued to support a quit attempt, emphasizing the importance of continuity and trust within the doctor–patient relationship. There were differing views about the effectiveness of GP versus smoking advisor.

I’ll usually say go and see STOP (stop smoking service) and get follow up there and I usually also
say, well why don’t you just come and see in a month and tell me how (it’s going)? so I’m not completely just referring and abandoning them (3)

If you actually took the ones who actually walk through the door and said I want help to stop smoking . . . then I think I’m just . . . probably as good as anybody else (11)

Several GPs saw advantages in issuing a prescription at the time the patient was motivated to stop, rather than waiting to see a smoking advisor, both to increase success and to respond to patient expectations.

I would give them a prescription here and now and I’d say why don’t you come and see our smoking cessation advisor as a follow up and she can give you some more of these and take it from there . . . it may improve their chances of success (1)

I make sure they have a prescription for at least a few week’s worth whilst they got started. I personally believe if you don’t strike while the iron’s hot then you may miss the boat with this . . . if when they come wanting to quit smoking they do expect to leave with a prescription . . .(35)

**Theme 2: flexibility/responsiveness to patient preferences**

Although most GPs had a preferred strategy, they recognized the importance of adapting this in response to patients’ preferences, including choice of drug and follow-up. There was also recognition, based on prior knowledge, that some patients would decline, or fail to follow-up, referral to SSS.

I think whatever you’re doing needs to be negotiated with them and individualised so that you’re not sort of imposing your views on them and then sort of get some idea of what they want. You know, do they want to give it up themselves, do they want some kind of support, have they tried nicotine patches, is that what they envisaged, do they want tablets, is it Champix (varenicline) or you know bupropion . . .(3)

We prescribe the full range of anti-smoking drugs if required and we’ll tailor the follow-up to the patient, we’ll offer you a weekly follow-up for the four week initial period if they want it . . . but a lot of patients have trouble fitting it into their work schedules so we’ll do it on a fortnightly or even a monthly basis and we have carbon monoxide meters so we can record . . . at the one month’s time whether they’re actually getting down less than six . . . and if we’re not too rushed in the first consultation we may record a . . . a first one which will hopefully be greater than six (11)

. . . knowing that they probably wouldn’t go elsewhere, patients who are being been very resistant and who you think might actually do it with your support as opposed to taking the initiative and going elsewhere even if it is within the practice . . . seeing another person can be difficult (37)

. . . I don’t want to upset a patient by demanding they go and see a nurse if they don’t want to. I may feel this would be their best option but if this doesn’t fit in with their circumstances they it is just doomed to fail . . .(4)

**Theme 3: Difficulties/obstacles to implementing chosen strategy**

GPs did not appear to experience difficulties adapting their preferred strategy to patient preferences. They did mention some practical difficulties with smoking cessation services, specifically lack of communication, both with the patient and with the practice.

I think there’s a problem with phone support from our local (service) a big criticism that I get repeatedly is that they don’t respond to messages very often . . . so although there’s the contact number on their card when you ring it you often get through to an answer phone . . . and often that’s not responded to (39)

I have already mentioned the problem with the lack of communication between the stop smoking clinic outside the practice . . .(4)

**Discussion**

Interviews with patients and GPs demonstrated that three distinct strategies were being used to manage smokers motivated to quit. These strategies were treatment and follow-up by the GP, referral to smoking cessation services without treatment and treatment with referral for follow-up. However, interviews with GPs suggested that, although they may have a preferred strategy, they needed to be flexible so as to provide an intervention that was acceptable to patients, perhaps after explanation and negotiation.

Interviews provided more detail about findings from quantitative studies that most patients receiving support to quit attended with the aim of addressing this issue, often expecting a prescription. We also identified some cases where a consultation with the GP was chosen precisely because he or she was considered by the patient to be the best placed individual to provide support, for example, because the GP knew the patient well and understood their health beliefs and attitudes towards behaviourial support. This echoes findings from other studies that patients with long-term problems prioritize interpersonal continuity with their GP above other aspects of primary care.21
GPs’ preferred strategies were based on evidence that both NAT and follow-up improve quit rates, and there was support for the contribution of smoking cessation services, particularly in offering time to support the smoker and in freeing up time for the GP. There were divergent views on whether GPs themselves had a role in following up smokers undertaking a quit attempt, either as an alternative or as an addition to cessation services and some criticism of the lack of feedback from these services. Given the fact that most smokers only quit after a series of quit attempts and that most patients consult their GP regularly, better communication could enable the GP either to reinforce a successful quit attempt or to discuss initiating another attempt if the previous one had failed.

Interviews with patients and GPs provided new information about how management was negotiated within the consultation. One area of negotiation was referral to smoking cessation services for ongoing support of a quit attempt. There seemed to be a low level of awareness among patients that this might be offered, but in general, patients appeared persuaded that this would be helpful.

Negotiation also occurred with issuing NAT pending a referral to smoking cessation services. Although this was the strategy reported by several GPs, patient interviews suggested that in some cases, the GP adopted this strategy because the patient felt that they would be more successful if a quit attempt was immediate rather than planned. Although previous literature has differentiated between unplanned and planned quit attempts, the urgency with which a smoker wants to quit is more likely to be a continuum. This is supported by a recent survey showing that of smokers reporting an ‘unplanned’ quit attempt (defined as agreeing to the statement ‘I did not plan the quit attempt in advance, I just did it’), >25% had used nicotine replacement therapy and 5% had been supported by SSS.17

Other countries that seek to establish referral protocols for the utilization of specialist smoking cessation services can learn from experiences in the UK. Not all smokers are happy to wait for referral for specialist support, as the negotiation we observed reflects.

A limitation of this study is the self-selection of participants and relatively small number of interviews. Although we felt that we had reached saturation within our sample, there are obvious selection biases operating in that GPs who were less interested or active in smoking cessation may not have been represented in our sample. Similarly, our patient sample may not reflect the full range of attitudes; for example, those dissatisfied with their management may have been less willing to agree to an interview.

Implications for practice and further research

Our results confirm that immediate treatment of smokers identified as motivated to quit with subsequent support from smoking cessation services is a strategy that is used by GPs and is congruent with the preferences and expectations of some patients. It also has a theoretical basis, as outlined in the introduction. This approach needs to be compared with the more established strategy of referral, with quitting postponed until support from SSS is in place.

It remains unknown whether or not delayed or immediate support is more effective, but to ensure that the maximum numbers of smokers who are motivated to stop smoking make quit attempts, a diversity of strategies for delivering treatments of known efficacy should be provided within primary care. Findings demonstrate the need for GPs to have the necessary skills to manage the process of matching smokers to the most appropriate treatment strategy to meet their needs.

There is also a need for further work on how GPs and SSS can work together more effectively, so each can contribute their strengths and expertise to initiating and supporting quit attempts.

Acknowledgements

We are grateful to the Primary Care Research Network, East Midlands and South Yorkshire for their help in recruiting general practices. TC is a member of The UK Centre for Tobacco Control Studies, a UK Clinical Research Collaboration Public Health Research: Centre of Excellence which receives funding from British Heart Foundation, Cancer Research UK, Economic and Social Research Council, Medical Research Council and the National Institute for Health Research, under the auspices of the UK Clinical Research Collaboration, is gratefully acknowledged.

Declaration

Funding: Cancer Research UK (07/Q2502/23).
Ethical approval: Leicestershire, Northamptonshire & Rutland Research Ethics Committee.
Conflicts of interest: none.

References


