

Physician advice for smoking cessation in primary care: Time for a paradigm shift?

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Abstract

General practitioners are often exhorted to routinely counsel patients who smoke about quitting in light of current evidence-based medicine (EBM) guidelines suggesting that such brief interventions provide an easy and effective way of increasing quit rates. Drawing on semi-structured interviews conducted with 25 smokers and 10 general practitioners (GPs) in British Columbia, Canada, this article explores smokers' and GPs' perspectives on smoking cessation interventions in primary care settings. Study findings indicate that both patients and GPs believe smoking is best broached when it is patient-initiated or raised in the context of smoking-related health issues, and there was a broader consensus that the role of doctors is to provide education and information rather than coercing smokers to quit. However, smokers wanted further recognition of the difficulties of quitting smoking and many questioned the competence of GPs to deal with addiction-related issues. Similar barriers to smoking cessation were raised by smokers and GPs – primarily inadequate time and resources. Based on these findings, we argue that the assumption that primary care consultations provide an important venue for encouraging smokers to quit deserves reconsideration based on the complexity of this issue, the circumstances in which most GPs practice, and the danger of alienating smokers. Questions are raised about whether current EBM guidelines are an adequate tool for guiding individual clinical interactions between GPs and smokers.

Introduction

In recent years, it has become a truism in public health circles that general practitioners (GPs) have a critical role to play in primary prevention activities.¹ Smoking is one area where the provision of lifestyle advice in primary care has been pushed in a particularly aggressive fashion. The perceived value of such interventions stems from the findings of a variety of systematic reviews that brief physician advice delivered in the context of routine care increases quit rates. For example, a Cochrane Review of 41 controlled trials (Stead, Bergson and Lancaster 2008) found that physicians providing brief, opportunistic advice to smokers who are not selected for motivation increases quit rates between one to three percent – a sizeable effect at the broader population level. In light of this evidence, organisations such as the National Institute for Health and Clinical Excellence (NICE 2006), the Office of the Surgeon General (2000), and Health Canada (2008) have formally recommended such interventions as standard 'good practice' for doctors and encouraged them to intervene systematically with all smokers they interact with (Rollnick, Butler and Stott 1997).

The definition of a brief physician-delivered smoking cessation intervention varies somewhat from country to country, but generally consists of advice to stop smoking and an assessment of the patient's readiness to quit, along with the offer of pharmacological and/or behavioural therapy if smokers indicate their willingness to make a quit attempt (Office of the Surgeon General 2000; NICE 2006; Health Canada 2008). However, the frequency with which GPs are expected to intervene with smokers differs between North America and Europe. In both the US and Canada, due to an underlying allegiance to the 'stages of change' model (Prochaska and DiClemente 1985; Prochaska and Velicer 1997), an expressed lack of readiness to give up

smoking ideally triggers a brief stage-appropriate intervention designed to increase patients' motivation to quit (see Office of the Surgeon General 2000; Health Canada 2008). UK public health guidance, on the other hand, advocates that patients who have indicated a lack of readiness to quit should be provided with a 'non-judgemental response' and their status reviewed once a year (NICE 2006: 6). The UK model differs in other important respects from that implemented in other countries as physician smoking cessation advice is integrated into a tiered system of support that includes dedicated national stop smoking services that provide smokers with intensive support to quit (see Bauld *et al.* 2010).

Despite the injunction for GPs to provide brief interventions for smoking cessation in primary care settings, studies have shown that they often fail to discuss smoking with their patients (e.g. Coleman and Wilson 1996, 2000; Coleman, Murphy and Cheater 2000) and a growing body of literature documents a variety of challenges in delivering such interventions.² GPs cite fear of harming the doctor-patient relationship as a frequent barrier to discussing smoking with patients (Coleman, Murphy and Cheater 2000; Bremberg *et al.* 2003; Pilnick and Coleman 2006). Other physician-identified barriers to greater involvement in this work include: patients' perceived unwillingness to change, time constraints, perceived ineffectiveness of interventions, lack of confidence or expertise, lack of financial incentive, and a lack of supportive resources (O'Loughlin *et al.* 2001; Young and Ward 2001; Helgason and Lund 2002; Coleman, Cheater and Murphy 2004; Vogt, Hall and Marteau 2005; Twardella and Brenner 2005; Boldemann *et al.* 2006; Coleman *et al.* 2007; Jallinoja *et al.* 2007).

While physician attitudes towards smoking cessation in primary care have been the focus of growing interest, few studies have examined smokers' own perspectives on physician-delivered advice to quit smoking. However, the limited available research in this area (conducted primarily in the UK) indicates that smokers who are not ready to quit are often resistant to such advice, becoming defensive, annoyed, or avoiding contact with their GP altogether (Butler, Pill and Stott 1998; Pilnick and Coleman 2003, 2006, 2010). In light of the strong degree of patient resistance to smoking cessation advice, many of these studies caution against routine admonitions to quit smoking in primary care settings (Coleman and Wilson 1996; Butler, Pill and Stott 1998; Coleman, Cheater and Murphy 2004). However, they generally affirm the importance of GP offices as sites where smoking cessation rates amongst unmotivated smokers might be enhanced (e.g. Coleman and Wilson 1996, 2000; Rollnick, Butler and Stott 1997; Coleman, Cheater and Murphy 2004; Pilnick and Coleman 2010). Suggestions for improving physician advice and patient receptivity towards it include: the use of problem-oriented approaches, where smoking is raised in the context of smoking-related issues (Coleman, Murphy and Cheater 2000); the provision of pharmacotherapy as a concrete endpoint to smoking cessation advice (Pilnick and Coleman 2010); and a patient-based approach where patients' receptivity to smoking cessation advice is assessed (Coleman and Wilson 1996, 2000; Rollnick, Butler and Stott 1997; Butler, Pill and Stott 1998; Coleman, Murphy and Cheater 2000; Coleman, Cheater and Murphy 2004).

In this paper we report the results of a study conducted in Vancouver, Canada between 2008-2009 comparing GPs' and smokers' perspectives on smoking cessation advice delivered in primary care settings. As such, this paper contributes to the growing body of qualitative literature exploring the *acceptability* of physician advice for smoking cessation – a body of literature that provides a critical complement (and corrective) to the current proliferation of quantitative studies examining the efficacy of such interventions. In light of the preponderance of UK research on this topic, our study also provides insight into smokers' and GPs' views on the provision of smoking cessation advice in other national and policy contexts. Although our study is small, we would like to use the findings as an opportunity to ask some hard – but in our

view necessary – questions about the continued public health allegiance to brief, routine smoking cessation interventions in primary care.

Methods

Participants

The majority of smokers were recruited through advertisements in local Vancouver newspapers. To be included in this study, participants had to be current or recent ex-smokers (i.e. quit within the past two years). Sampling was purposive, to ensure a relatively equal number of males and females and a broad spread of age groups were represented.³ In total, there were 25 participants: 21 were current smokers and four had recently quit. Thirteen men and 12 women were interviewed. The age of participants ranged from 21-75 and the majority (N=21) were white. Almost half (N=12) worked in blue-collar or semi-skilled white-collar professions, with a further six unemployed or on disability. Eight participants smoked a pack or more a day, 11 smoked more than a pack per week but less than a pack per day, and two were lighter smokers, smoking under a pack per week.

Recruiting GPs into the study proved challenging. The majority of GPs were recruited through three methods: advertisements in a professional journal available to practising GPs in the province of British Columbia; the personal networks of the research team; and snowball sampling techniques. In total, ten GPs were interviewed, including an equal number of males and females who ranged in age from 31-63. There was considerable diversity in length and type of professional experience.

Interviews

Smokers and ex-smokers received a \$25 honorarium for participating in the study and GPs received a \$50 honorarium.⁴ Two members of the research team (Bell and McCullough) individually conducted the interviews. Interviews with smokers and ex-smokers took place in person and lasted approximately an hour. With one exception, all interviews were recorded and transcribed verbatim. One participant did not want her interview recorded and so detailed notes were taken with an attempt made to capture as many verbatim quotes as possible. Interview questions were based on a semi-structured interview schedule where participants were asked about: their smoking history and habits, the public's attitude towards smoking, their interactions with their doctor around smoking, and the role of physicians in smoking cessation.

Although face-to-face interviews were initially planned with participating GPs, in light of difficulties with recruitment, interview procedures were broadened to include phone interviews in the hopes of attracting more GPs into the study. Consequently, over half the GPs (N=6) chose to be interviewed by phone rather than in person. All interviews were recorded and transcribed. Interviews with GPs lasted an average of 30 minutes and interview questions were based on a semi-structured interview schedule where participants were asked about: their smoking history, the circumstances of their practice, the sorts of patients they see, and how they deal with smoking and smoking-related issues.

Analysis

A description of key themes and findings emerged after numerous reviews of the interview transcripts. Two team members independently read the all interview transcripts in full and noted meaningful segments about personal opinions and experiences in order to develop a coding framework for the GP data and sketch out an initial framework for the smoker/ex-smoker data. However, because the smoker/ex-smoker transcripts were longer than the GP transcripts and contained considerable diversity, the coding framework for these transcripts was developed with

input from all the team members, who independently read a subset of four interview transcripts. Qualitative data analysis software was used to facilitate coding and management of the data.

The material presented in this paper relates specifically to study participants' responses in three areas: how they thought smoking cessation should be broached in primary care settings, the role of physicians in smoking cessation, and the key barriers to discussing smoking. Coded material in these areas was analysed to ascertain the major manifest and latent themes.⁵

Health centred and patient driven: Broaching smoking cessation in primary care settings *Smokers' views*

Participants had a variety of opinions on whether smoking cessation should be broached in primary care settings. Six participants, primarily recent ex-smokers and smokers trying to quit, felt that doctors should be routinely discussing the topic of smoking with them. For example, a female smoker in her early 50s stated that doctors were best placed to discuss smoking cessation: 'better there than anywhere else' and that support should be offered 'as soon as the doctor knows you're a smoker'. For several of these participants, whose experiences with GPs had generally not been positive, asking about smoking meant that the doctor cared about the patient's welfare. For example, the following exchange occurred with a female recent ex-smoker in her 50s about her interactions with her GP around quitting.

Participant: My doctor didn't give me anything [information about smoking cessation].

Interviewer: Nothing?

Participant: Nothing at all... That's why I'm telling you everything I've been doing by myself.

Interviewer: Yes. Do you—I mean, do you wish he had raised the topic of smoking 'how can I help you?' and—?

Participant: Oh yeah. I wish he *can care more about me, and give me some advice. And not be like only business* (emphasis added).

Equating advice about smoking cessation with feeling cared for by their physician was a prominent underlying theme in a number of interviews and shows the difficulties of disentangling patients' views on smoking cessation advice from their broader perceptions of care from their GP.

Yet, while some participants were supportive of a role for doctors in smoking cessation, the majority (N=19) felt that it was not a doctor's place to raise this topic unless the patient initiated the discussion or it was directly connected with a health issue the patient was experiencing. As a male smoker in his late 50s noted:

You don't walk in and they go 'You don't have athlete's foot do you? Because I have some cream here'... So, like, if you go to them and you say, 'Doc, I guess I've got some athlete's foot' and then he'll go 'Okay, I got some cream here' but for them to just kind of like come out and presume—.

This response suggests a strong degree of resistance to physician attempts to engage in unsolicited lifestyle counselling and an underlying view of the GPs' role as being responsive to patient concerns rather than 'pushing' a smoking cessation agenda. In this context, preventive activities were only appropriate if directly relevant to the patient's personal history. As a smoker in his late 20s noted:

I would discuss it if it was, like, a problem, like, if I was prone to cancer or something, from family genetics, then I would talk about it, like, talk about how to prevent it and, you know, what I had to be worried about, certain precautions, stuff like that. But I mean if

I'm going for an x-ray and the doctor says 'Oh, you've got to quit smoking', it seems weird, right?

Although such views appear to contrast with the responses of smokers who felt that their doctors should be intervening on a regular basis, in light of the fact that participants wanting support tended to be those actively interested in quitting, an underlying theme in all of the interviews was that smoking cessation needed to be patient-driven. In other words, when patients desired to quit smoking they wanted the support of their doctors in doing so. When they were not actively interested in quitting, they did not want smoking broached if it was not directly relevant to their healthcare or linked in some way.

GPs' views

GPs' view on how smoking cessation should be approached in primary care overlapped strongly with the views of smokers and ex-smokers. Although almost all of the GPs interviewed asked new patients about their smoking as part of a routine intake or annual physical, beyond this, most did not address smoking unless the patient initiated the conversation. According to a female health clinic GP in her late 30s, 'If someone expresses an interest [in quitting smoking]... then I'll say, you know, "There's a bunch of stuff out there to help you. There's the patch, there's Zyban". Like, I will usually list the options if they do seem interested'. Similarly, a female health clinic GP in her mid 50s noted: 'For me mostly it comes up if they bring it up, and that's – no, not necessarily the right thing but that's generally my approach.' Particularly interesting in the second GP's response was her sense that she was doing something wrong by *not* providing unsolicited advice, demonstrating the degree to which evidence-based guidelines have infiltrated the consciousness of GPs – even those who choose not to abide by them.

Only one GP, a male physician in his late 50s who had recently retired from private practice, emphasised the value of unsolicited smoking cessation advice and the power of the doctor to influence patients to quit:⁶

A lot of physicians just think 'well, gee whiz, what's the point? I mean I'm never going to get this person to stop smoking, he's probably been smoking for 20 years, why even try?' Well, that's not true, I mean, that's not true at all. I mean, you should, and it could just be a little intervention with a visit and say 'you know, gee, you know, you gotta get off those cigarettes'.

For most GPs, aside from patient-initiated discussions, another common trigger for smoking-related advice occurred when patients presented with health problems or symptoms that could be directly connected to the negative impact of smoking. The response of a male GP in private practice in his early 30s was typical:

Well, the major times we don't ask or we think it's not going to help I think it is not related. I mean, if someone is coming for a broken toe, we're not going to ask them. But if they come in for a chest infection or throat infection or airways history or heart or diabetes or something, then we ask them about smoking.

Here, the GP invoked a problem-centred approach to care virtually identical to that of the smoker who compared unsolicited smoking cessation advice to random queries about athlete's foot. In both cases, the underlying message was that smoking cessation advice needed to be *relevant* to the presenting problem rather than speculation on the doctor's part about what the patient 'needed'.

During the interviews it became clear that many GPs saw health issues that could be linked to smoking as an important opportunity for initiating discussions about smoking cessation –

something that has previously been noted in the literature (e.g. Coleman, Murphy and Cheater 2000). As a GP in his mid 40s noted:

If there's reasons that they come in and ask for some guidance, all I'm saying is that I use it as an opportunity to sort of review their health. I try to say 'Look, you know, I can't say how much of your health issues are related to smoking but it's really a contributing factor, and it's something that, you know, we could look at'.

Clearly, like patients, most GPs saw advice about smoking cessation as most legitimate when it was patient-initiated or able to be plausibly linked to patients' presenting condition or personal history. With only a few exceptions, both groups therefore evidenced a high degree of resistance to the population-level approach to smoking cessation where lifestyle advice was introduced without a relevant *context*.

Education, information and action: How smoking cessation advice should be delivered *Smokers' views*

The majority of participants saw the role of GPs as providing education, information and smoking cessation options. Many participants also stressed the importance of addressing smoking in a casual rather than aggressive manner and several provided examples of GPs they thought exemplified this approach. As a male smoker in his late 50s noted,

He's not pushy about it. If you want the help he'll be there for you, but he's not pushy about it at all. He doesn't – it's like I don't think people react well to the hard sell. That's probably why we don't see too many door-to-door vacuum cleaner salesmen anymore, because it really doesn't work.

A female smoker in her mid 30s similarly praised GPs who took a non-confrontational approach: I've had physicians who I really appreciate their attitude that almost make you want to quit because they just accept it and then finish what they have to deal with, and their understanding has put me at ease about it that, yes, I have to deal with this myself... They might make some points, but it's about lungs or something, but it's just very casual. It's not kind of disciplinary, and I appreciate that.

Evident once again in smokers' responses was the need for smoking cessation advice to be driven by patients rather than the GP – 'If you want the help he'll [the GP] be there for you'. Indeed, some participants observed that they would probably not visit their GP if they were 'hammered' on a regular basis about quitting, supporting Butler, Pill and Stott's (1998) earlier finding that routine, unsolicited smoking cessation advice may cause resistant smokers to avoid contact with their GP.

Yet, while the majority of smokers stressed the importance of a casual and non-threatening approach, a minority of participants thought that aggressive tactics could potentially yield positive results. Here, smoking cessation became intertwined with a broader discourse of 'care' noted above, where stern advice was seen as 'tough love' – evidence of the doctor's broader concern about the patient's welfare (see Colman 2007 for a manifestation of the 'tough love' discourse). However, it is noteworthy that none of those who thought this approach might work had actually quit smoking as a result of such tactics – something that has also been noted in previous studies (e.g. Butler, Pill and Stott 1998).

Although there was some disagreement about the ways doctors should approach smoking cessation, what smokers universally did *not* want were trite admonishments to quit without an attendant recognition of the challenges this entailed. A number of participants were therefore

critical of what they saw as their doctor's failure to understand the addictiveness of nicotine. According to a female smoker in her early 30s:

My doctors have always seem to have the nonchalant attitude 'Oh, you'd quit if you wanted. It's so easy. You just do that and do this.' You know, as if it was – because they're non-smokers... They're health professionals! They're saving the body. Do you think they'd ever light a cigarette if they want to be a doctor? No! So, they've never had the addiction, they don't know how hard it is to quit... Unless you've been addicted to a substance or cigarettes you have no clue what you're up against.

In a similar vein, a male smoker in his mid 50s noted that 'someone who has not smoked who says for you to quit has absolutely no idea'.

GPs' views

The majority of GPs saw their role primarily to be one of educating people about the health effects of smoking and emphasised that ultimately quitting smoking was the patient's responsibility. According to a female GP in her early 60s in private practice: 'I've been around long enough to realise that you can't make people do anything. They do it when they're ready and everybody knows smoking is bad. So I make it very clear that they own the problem'. The comments of a male GP in his early 30s in private practice also represent a typical response: 'I kind of have learned that the responsibility in the end it is theirs, it's the patient's, it's not mine and I'm there to educate them and to motivate them and try and help them but, you know, I can't take it home with me if, you know, my patient is continuing to smoke'.

Interestingly, although the topic of addiction came up during many of the physician interviews, few GPs highlighted the addictiveness of nicotine and the need to recognise the difficulty of quitting. The major exceptions were physicians who were self-identified smokers (N=1) and GPs with specific training in addictions (N=3). As a male GP in his early 40s who also ran a smoking cessation clinic reflected: 'this addiction, as deep it is, it's just not a 'here, take a pill, come back tomorrow' type of thing, it's really something that requires more extensive counselling and intervention to help the person quit.' The general lack of emphasis most GPs placed on nicotine addiction seems to bolster participants' complaints about the glib responses they received from their GPs about smoking cessation, and speaks to the incomplete ways in which tobacco use has been incorporated into an addictions frame (see McCullough 2011 for further discussion).

Time, training and remuneration: Barriers to discussing smoking

Smokers' views

Participants perceived there to be several key barriers to discussions of smoking cessation in primary care settings. The primary barrier identified was time and many interviewees talked about the 'huge' load of patients doctors saw on a daily basis and the difficulties of discussing smoking cessation in this context. As a male smoker in his late 50s noted:

See, they don't do much counselling, because they're not paid very much. See, they're paid a general fee for the general office visit, okay... So they don't – and if they see a lot of patients they can't spend much time. You're lucky to get a couple of minutes from them. 'What's wrong with you? How are you today? How can I help you?' It's in and out the revolving door, and you're aware of that, you know all that.

However, this implicit critique of market-driven (as opposed to patient-centred) models of care was generally tempered by a recognition of the challenging conditions under which GPs work in Canada – which are exacerbated by a severe national shortage of family physicians.⁷ Indeed, a female smoker in her early 20s questioned why doctors should be expected to routinely engage in smoking cessation with their patients in the first place:

I think putting that kind of responsibility on doctors may be a little too much to ask... They're not there to counsel you... I would like to say 'Oh yeah, let's put this on the doctor's shoulders' [but] you can't do that. They're there, if you come to them with a problem: 'you know what, I want to quit smoking cigarettes' they're there to do whatever they're authorised to do. Other than that I don't think it's fair to put that on their shoulders.

In a related vein, others observed that smokers wishing to quit were better off going to see a psychologist or someone with addictions training. Many also pointed out that doctors were more interested in prescribing Zyban or nicotine replacement products than having a conversation about smoking – approaches that were commonly dismissed as 'pill pushing'. Another group of participants also recognised that many physicians feel ill equipped to deal with smoking cessation. As a male smoker in his late 50s noted: 'they don't know how to approach the topic and still be professional about it'.

GPs' views

Once again, GPs highlighted many similar barriers to smokers and ex-smokers. First, the majority interviewed (N=6), regardless of the circumstances of their practice, noted that time was a key issue – something that has been frequently noted in the literature (see Vogt, Hall and Marteau 2005). According to a female GP in her early 50s, 'the main thing would be access to patients time-wise, both from them being able to come in and get appointments, doctors being able to spend time with them, and having the skills and resources to really help them'. Similarly, a male GP in private practice in his early 30s noted:

Usually the person has come in for some other reason and, you know, you have your 10-minute appointment or whatever and in order to do a good job with that, you sort of need that 10 minutes. And you can maybe spend a couple of minutes talking about smoking but it's hard to spend more time than that and I guess officially you're not really supposed to ask somebody to come back just to talk about smoking.

Many GPs pointed to the role of the province's Medical Services Plan (MSP) fee-for-service payment scheme in hindering their ability to make time for discussions of smoking cessation. According to a GP in his early 40s: 'MSP doesn't cover smoking cessation counselling in the office, so, you know, it's such a double-edged sword. I mean it's still an important primary prevention manoeuvre, but still the government doesn't cover for it'. The importance of payment schemes has also been highlighted in previous studies and UK research suggests that the introduction of financial incentives for GPs does lead to an increase in the percentage who discuss smoking with their patients (see Coleman *et al.* 2007).

Discussion and implications

Clearly, there was a substantial degree of overlap between the views of smokers, ex-smokers and GPs enrolled in the study about how smoking should be broached in primary care settings. With some exceptions, there was general agreement amongst both groups that discussions of smoking cessation should be patient initiated and/or raised in contexts where it is medically relevant to the health concerns patients are seeking treatment for. In general, only smokers interested in quitting or recently quit endorsed the idea that discussions of smoking cessation should be regularly initiated with patients. In such cases, they tended to be unhappy with the level of support they had received or were receiving from their doctor in their efforts to quit smoking.

However, one area highlighted primarily by smokers was the addictiveness of smoking and physicians' lack of appreciation for the difficulty of quitting. Doctors, on the other hand, tended to

see quitting as the exclusive responsibility of patients. As Schwartz (2009: 121) argues, 'holding patients to standards of responsibility that are unreasonably difficult for them to meet can be disempowering'. Such situations of disconnect can undermine trust at the patient level, as they are expected to take responsibility for quitting without adequate recognition of the difficulties this entails or resources to support them in their efforts. Aside from this divergence, smokers, ex-smokers and GPs generally mentioned very similar barriers to smoking cessation – primarily structural impediments that hindered the opportunities to engage in 'real' conversations about smoking in primary care.

Although further research is clearly needed, our study results cohere strongly with other qualitative research findings that smoking cessation advice is most effective when relayed to smokers who express a desire to quit; it is likely to annoy, anger or alienate other categories of smokers (see Butler, Pill and Stott 1998; Coleman, Murphy and Cheater 2000; Pilnick and Coleman 2003). Superficially, these findings would appear to lend support to the 'stages of change' model whereby the physician tailors interventions to the smoker's degree of readiness to quit, which is demarcated into six stages: pre-contemplation, contemplation, preparation, action and maintenance (Prochaska and Velicer 1997). However, we caution against this interpretation for several reasons. First, as several commentators have observed (e.g. Bunton *et al.* 2000; Riemsma *et al.* 2003; West 2005), despite the extraordinary embrace of the 'stages of change' model in health promotion, 'Human functioning is simply too multifaceted and multi-determined to be categorised into a few discrete stages' (Bunton *et al.* 2000: 63). Moreover, systematic reviews have found little evidence to suggest that stage-based interventions are more effective than non-stage based interventions in promoting smoking cessation (Riemsma *et al.* 2003; Aveyard *et al.* 2009). Indeed, Riemsma *et al.*'s (2003) review found that *not* intervening was equally effective as stage-based interventions in changing smoking behaviours.

While our findings indicate some support for raising discussions of smoking in the context of smoking-related health issues, this strategy is not without risk. It is worth noting that interviewees' hypothetical responses to questions about circumstances in which they might be receptive to smoking cessation advice may differ from their *actual* responses when confronted with such advice. Indeed, based on recordings of interactions between UK GPs and patients about smoking, Pilnick and Coleman (2003) found that physician attempts to draw links between patients' tobacco use and their health status elicited strong resistance.

Other strategies that have been identified as helpful in UK research, such as the provision of pharmacotherapy as a concrete endpoint to smoking cessation advice (Pilnick and Coleman 2009), also contain some risk of alienating smokers. Indeed, a number of participants in our study viewed such approaches as 'pill pushing' or an attempt to shut down further conversation about smoking. Our study findings also suggest that for those smokers who *are* actively interested in quitting, the sorts of superficial interventions that physicians are able to offer are likely to be frustrating and unsatisfying. Interestingly, our findings here present a marked departure from UK research, where a recent study has found that smokers motivated to quit often desire immediate support from their GP in the form of pharmacotherapy and do not see the need for referral to the NHS stop smoking services for intensive support (see Wilson *et al.* 2010). Such differences demonstrate the need for caution in assuming that findings of studies conducted in one cultural setting can be directly transposed into others and are suggestive of potential variations between Canada and the UK that are worthy of further exploration.⁸

Clearly, when physicians raise the topic of smoking, they enter a minefield that requires extremely sophisticated clinical communication skills and competency to navigate (Rollnick, Butler & Stott 1997; Butler, Pill and Stott 1998; Pilnick and Coleman 2003, 2006, 2010).

Specifically, physicians must traverse challenging patient interactions where the intersection of complex issues including smoking-related stigma, addiction behaviour, preconceptions of the doctor-patient relationship, individual factors (including temperament and coping style) intersect within the context of limited care resources. The standard GP is unlikely to have the necessary skills to deal with the complexities of this issue and even those with specialised training in addictions will be unable to achieve much in the course of a routine consultation. For example, one UK study of a patient-centred brief intervention smoking cessation model found that it took an average time of 9.69 minutes with each smoker (Rollnick, Butler and Stott 1997). Yet, most GP consultations in Canada are less (many considerably less) than 10 minutes in total. Indeed, many smokers and GPs in our study noted that the circumstances in which physicians practice are inimical to conversations about smoking cessation and some smokers questioned why physicians were increasingly being expected to engage in such interventions in the first place.

In light of these issues, perhaps the time has come to seriously question whether primary care consultations are an appropriate venue for encouraging smokers to quit the habit. The findings of several prior qualitative studies (e.g. Butler, Pill and Stott 1998; Coleman, Cheater and Murphy 2004) support this position – and Coleman, Cheater and Murphy (2004) explicitly recognise it as a valid interpretation of their study findings. Broader studies have also questioned whether primary care settings are an appropriate setting for prevention activities (see Yarnall *et al.* 2003) and some have suggested that ‘new methods of preventive care delivery are required, as well as a clearer focus on which services can be best provided, and by whom’ (Yarnall *et al.* 2003: 640). To date, the UK has gone furthest in experimenting with alternative modes of delivering smoking cessation support, although there is still a strong national commitment to the brief GP intervention model based on EBM assessments of its effectiveness (NICE 2006; Wilson *et al.* 2010).

At present, physician concerns regarding unsolicited smoking cessation advice are well known (Coleman, Murphy and Cheater 2000; Bremberg *et al.* 2003; Pilnick and Coleman 2003, 2006; Boleman *et al.* 2006; Helgason and Lund 2002; O’Loughlin *et al.* 2001; Young and Ward 1998; Jallinoja *et al.* 2007), and our research findings and those of other qualitative studies of smokers’ receptivity to such advice suggest that these concerns are well founded. This marked disjuncture between qualitative research findings regarding the acceptability of physician smoking cessation advice and the systematic reviews of quantitative studies regarding its effectiveness speaks to some of the limitations of EBM as an effective tool for guiding individual clinical practice. Empirical studies have consistently pointed out that EBM is problematic in the context of primary care: it is often impractical given the constraints of actual practice, ignores clinical judgment and experience, and elides patient values (Tonelli 1998; Webb 2001; Upshur 2002; Cohen, Zabri and Hersh 2004). Doubts have also been expressed about whether evidence deriving from population-level randomised controlled trials can be straightforwardly ‘read across’ to the clinical management of individual patients (Lambert 2006; see also Tonelli 1998). Since the methods of EBM are epidemiological and statistical, clinically relevant details may be hidden, overlooked or averaged out (Cohen, Zabri and Hersh 2004). This is a particular danger in the context of studies on smoking, given the inverse relationship between socioeconomic status and smoking prevalence now evident throughout the developed world (Bayer and Stuber 2006). Clearly, while benefiting individuals and benefiting populations are not mutually exclusive goals, they are distinct and occasionally conflicting ones (Tonelli 1998).

Study limitations and directions for future research

This study has several limitations. First, the findings are not representative of all smokers and GPs in British Columbia. Smokers and GPs self-selected into the study and it is likely that those who volunteered to take part were people with strong feelings on this topic. Another limitation of

our study is that it relies on accounts of how people say they want smoking cessation to be broached rather than what they actually *do* when such advice is provided. This difference between what people do and say is complicated by the fact that talk about smoking cessation is never *just* talk about smoking cessation. It is inextricably intertwined with patients' views on their healthcare interactions more broadly – smoking cessation inevitably becomes a locus through which broader views on and concerns about their relationship with their healthcare provider(s) are articulated. It is therefore imperative that further research documents actual interactions between GPs and patients along the lines of Pilnick and Coleman's (2003, 2006, 2010) work. It is also important that future studies are carried out in a variety of national and policy settings – it cannot be assumed that the findings of studies conducted in the UK speak directly to smoking cessation in primary care in other contexts or vice versa (see Bell *in review*).

Conclusion

Clearly, smoking continues to contribute to considerable morbidity and mortality and interventions to reduce tobacco use and the harms connected with it remain an important focus in public health. However, although physician-delivered advice to quit smoking seems an easy and effective intervention, both GPs and smokers express considerable concerns about this population level approach. Indeed, qualitative research has continually questioned whether brief interventions are so 'easy' for GPs to incorporate into their routine practice, especially in light of the complexities surrounding smoking, the delicacy with which the topic needs to be broached, and contemporary circumstances in which most GPs practice. Despite the support that a population-level, physician-led approach to smoking cessation has garnered based on EBM assessments of its effectiveness, we question the transferability of current EBM findings and guidelines to individual clinical encounters and suggest that further research is needed into how smokers actually respond to such advice.

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Notes

¹ This growing emphasis on health promotion and lifestyle counselling in primary care represents part of a broader ideological shift from targeting high risk or symptomatic individuals to a population-level, preventive approach to healthcare (see Lawlor, Keen and Neal 2000) that reflects public health policy interests in finding low-cost, non-institutional solutions to healthcare (Bunton 1992).

² This resistance amongst primary care physicians to a population-level approach to the provision of smoking cessation advice has been documented for lifestyle advice more broadly (see Lawlor, Keen and Neal 2000; Yarnall *et al.* 2003).

³ Initially, the study advertisements targeted all smokers/recent ex-smokers. A spreadsheet was kept of the sex, age and smoking status of all participants so that we could keep track of the basic demographic characteristics of participants. As the study progressed, advertisements became more targeted in order to focus on those groups underrepresented in our sample.

⁴ In the interests of equity, we originally decided upon a \$25 honorarium for both groups. However, given the difficulties with recruiting GPs, a consultant GP on the project advised us to raise the GP honoraria to \$50. We recognise the resulting irony that those participants who would have most benefited from the honorarium got the smallest one. That said, we would likely have had difficulty in getting ethics approval for a higher honorarium for smokers, because of concerns about the 'coercive' dimensions of high payments for low-income participants. This speaks to the ongoing debates about the use of honoraria in research studies and whether they should be seen as incentives, reimbursements or payments equivalent to hourly wages (see Dickert and Grady 1999).

⁵ Following the identification of the manifest content (the visible, surface themes), the latent themes were inferred through close readings of the coded material in order to examine the relationships between the statements proffered and draw broader conclusions regarding their underlying meanings (see Kondracki, Wellman and Amundson 2002; Graneheim and Lundman 2004 for further discussion of latent/manifest content analysis).

⁶ However, this particular GP had received training in delivering brief tobacco interventions, which likely informed his views on the need to regularly broach the topic of smoking with patients.

⁷ Canada's doctor-patient ratio is among the worst of any industrialised nation: with just 2.2 physicians per thousand people (Gulli and Lunau 2008).

⁸ Potential areas of difference include the higher levels of tobacco denormalisation in Canada than the UK (see Hammond et al. 2006; Bell et al. 2010a), which we have previously suggested contributes to the charged nature of smoking cessation discussions in primary care settings (see Bell et al. 2010b). Other differences may be related to the local specificities of British Columbia's 'west coast' lifestyle', where a high moral valence is attached to the pursuit of health and 'natural' means of pursuing it (e.g. yoga, 'nutriceuticals', etc).

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