Published in final edited form as:

J Eval Clin Pract. 2014 June ; 20(3): 281–287. doi:10.1111/jep.12124.

A qualitative assessment of provider perspectives on smoking cessation counseling

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Abstract

Objective—Few studies have examined physicians' views about counseling unmotivated smokers. This study explored physicians' perceptions of: useful strategies to motivate patients to quit, how receptive they felt patients were to these strategies, and the benefits and drawbacks of discussing smoking cessation with patients.

Methods—Fourteen semi-structured qualitative interviews were conducted with physicians and resident physicians.

Results—Strategies reported by providers included: educating about the health risks of smoking, using “scare tactics” to highlight the harmful effects, and providing advice about how to quit. Providers believed that most patients were receptive to their strategies, but noted that they lacked feedback to know for sure. Providers saw the possibility of improving patients' health and decreasing overall healthcare costs as potential benefits, but cited the potential to damage rapport, competing priorities during already rushed visits, and uncertainty about the effectiveness of their efforts as drawbacks that reduced their motivation to raise the issue with patients.

Conclusion—Physicians believe in the potential benefits of smoking cessation counseling but predominantly report focusing on enhancing patient's risk perceptions. They did not report attempting to use the wider array of recommended and empirically supported methods to counsel their patients. Providing physicians with increased training in motivational counseling and feedback about the efficacy their efforts or supplementing physician care with behavior change specialists would likely increase the benefits of counseling to patients.

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An earlier draft of this manuscript was presented as a poster at the 34th Annual Meeting of the Society of Behavioral Medicine, San Francisco, USA, on March 20, 2013.

Conflict of Interest

All authors report no conflicts of interest.

Keywords

Smoking cessation counseling; Patient-provider communication; Physician perspectives

Introduction

In the US each year, one in five deaths (443,000) are related to the use of tobacco (1). Although effective interventions have been created to address this significant public health risk (2) these are primarily aimed at assisting smokers who have decided to try to quit. Unfortunately the majority of smokers are not ready to try to quit with about 40% not planning on quitting in the next 6 months and another 40% having no plans to quit in the next month (3). Physicians have the opportunity to educate and assist their patients to quit smoking during routine consultations with the more than 70% of smokers who visit them at least once annually (6,7).

Updated in 2008, the U.S. Public Health Service's (USPHS) Clinical Practice Guideline provides strategies to assist providers in identifying tobacco users and providing effective smoking cessation counseling (2). Providers are encouraged to determine patient's readiness to quit smoking by administering "the 5 A's" (ask, advise, assess, assist, and arrange). For patients who are not yet ready or interested in quitting after receiving the advice to quit, providers are instructed to implement a brief motivational enhancement intervention called "the 5 R's" (relevance, risks, rewards, roadblocks, and repeat). It is also recommended that principles of a counseling method known as Motivational Interviewing be used to implement the 5 R's, although specific training is generally necessary (2).

Most studies of physician behavior have focused on barriers to adherence to the Guideline, with studies demonstrating that most physicians do not adhere to all components (8,9,10,11), especially the 5 R's (9,12, 13). Although research indicates physicians do not consistently follow the 5R's, little is known about how physicians do attempt to motivate their patients to quit smoking, especially since they usually lack formal motivational counseling training (8,14,15,16,17,18). Understanding the nature of physicians' naturalistic counseling practices and their attitudes toward motivational counseling for smoking cessation is important for identifying ways to improve physician practice to ensuring that patients receive effective treatment.

To address this gap, we first conducted a quantitative observational study of 38 providers and their practices to assess the content and communication styles they employ when counseling their patients about smoking (19). Results indicated that physicians generally failed to adhere to all of the components of the USPHS Guideline and relied primarily on giving information and closed questions in their discussions. To a moderate extent, physicians communicated acceptance and support for patients' autonomy, however physicians rarely communicated empathy, evoked their patient's ideas, or fostered collaboration. The purpose of the present study was to better understand physicians' own perspectives on how they try to motivate their patients to quit. We conducted semi-structured interviews with physicians in which we enquired about their: 1) strategies for motivating patients to quit smoking, 2) perceptions of how receptive patients are to these

strategies, and 3) beliefs about the benefits and drawbacks of discussing smoking cessation with patients.

Methods

Data collection procedures

Participants included a convenience sample that was recruited from a non-profit hospital in a large Midwestern city. An overview of the study was presented to physicians and resident physicians from the Department of Internal Medicine during a conference meeting. Physician and resident physicians who were interested in participating in the study provided their contact information and an interview time was scheduled with the lead investigator. Of 80 physicians and resident physicians that work in Internal Medicine, 40 attended and 24 provided contact information to participate in the study. Of the 24 who were initially interested in the study, 14 were contacted and scheduled for an interview. Ten were not interviewed due to conflicting schedule times or lack of further interest. We conducted brief semi-structured interviews with a total of 14 physicians and resident physicians. After providing informed consent, basic demographics (e.g., age, ethnicity, area of specialty) were collected, followed by 30-minute phone interviews. Participants received a \$20 gift card in appreciation of their time. All procedures were approved and monitored by the affiliated Institutional Review Boards. The interview guide focused on three research questions: 1) What strategies do providers employ to motivate patients to quit smoking?, 2) Do providers' perceive their patients as receptive to these strategies?, and 3) What are the benefits and drawbacks of routinely discussing smoking with patients? Appropriate probes garnered more detail and examples from providers' experience.

Analytic strategy

We first conducted a separate study to assess physician's adherence to the USPHS Clinical Practice Guideline and the style of counseling they employed with their patients about smoking (19). Physicians were recruited at a primary care outpatient clinic in a non-profit hospital in a large Midwestern city. For this initial study, forty-one physicians were approached with 38 agreeing to participate in the study (93%). Three refused because of limited time and/or scheduled patient appointments that day. Physicians and patients were told the study was focused on understanding counseling styles that physicians typically employ with their patients when talking about smoking. To directly observe the content and communication styles of physicians, a research assistant shadowed patients during routine practice and made audio recordings of the encounters. The audio-recordings were transcribed verbatim and any patient-physician dialogue related to smoking was coded by two independent raters based on the Clinical Practice Guideline and the Motivational Interviewing Skill Code Version 2.1 (20). The results of this initial study suggested that physicians generally failed to adhere to all of the components of the USPHS Guideline and relied primarily on giving information and closed questions in their discussions. To a moderate extent, physicians communicated acceptance and support for patients' autonomy, however physicians rarely communicated empathy, evoked their patient's ideas, or fostered collaboration.

To better understand the reasons physicians do not adhere to the Guideline, we conducted the present study to explore physicians' own perspectives on trying to motivate their patients to quit. Interviews were recorded and transcribed verbatim by three research assistants. To ensure the quality of the transcriptions, a different research assistant listened to each audio recording while reviewing the printed transcript and resolved all discrepancies. Transcripts were independently coded using content analysis for conceptual categories and emergent themes by two research assistants. Coders identified emergent themes by independently reviewing transcripts line by line while listening to the audio-recording. Coders then met in person to reach consensus on emergent themes that were then reviewed by the larger study team and content codes were generated. Coders then independently coded all of the transcripts using the content codes followed by an in person meeting to discuss discrepancies and reach consensus. Inter-rater $\alpha = .84$). Data were organized according to content codes, and quotes from physicians that exemplified the emergent themes were highlighted. The frequency of content codes for physicians and resident physicians were examined to ensure that aggregating data across groups was appropriate. Discrepancies were reviewed and consensus was reached through discussion for all themes. The larger study team then reviewed and refined themes. Data were organized according to themes, and quotes from physicians that exemplified the emergent themes were highlighted.

Results

Demographic characteristics

A total of 14 physicians (4 attendings and 10 residents) participated. Mean age was 30.9 years ($SD = 6.4$; range 24–47 years) and 50% were female. Seventy-one percent of participants were White and 21% were Asian. Nearly all participants (93%) were Internal Medicine physicians. No consistent differences were found between attendings' and residents' beliefs.

Primary study results

Strategies providers say they employ to motivate patients to quit smoking—

We characterized the strategies physicians reported using to motivate their patients to quit smoking into the following categories: (a) educating the patient on the health risks of smoking, (b) using "scare tactics" to highlight the harmful effects of smoking, and (c) providing advice and suggestions for smoking cessation. The majority of physicians (78%, $N = 11$) stated that they used an educational approach to try to motivate their patients to quit smoking. Some physicians provided general health information on the harmful effects of smoking. Other physicians used a more tailored approach that highlighted the link between the patient's own health conditions and their smoking (e.g. cardiovascular disease, COPD, and shortness of breath). Table 1 displays physicians' quotes that are exemplars of this approach. Half of the sample (50%, $N = 7$) discussed the use of scare tactics, however respondents were divided in their assessment of whether using scare tactics was an effective (21%, $N = 3$) or dangerous (29%, $N = 4$) strategy (See Table 2). Physicians who found this technique less effective, felt scare tactics may damage physician and patient rapport, which may reduce motivation to quit smoking. Additionally, some physicians said scare tactics were pointless since patients were already aware of why they should not smoke (See Table

2). A smaller proportion of physicians (36%, $N = 5$) reported favoring advice and recommendations to help patients quit smoking by using behavioral strategies, or recommending nicotine replacement therapies or different medications (e.g., varenicline, bupropion) when patients could afford them (See Table 3).

Provider's perceptions of how receptive patients are to these strategies—

Physicians had mixed feelings about how receptive their patients were to their advice (See Table 4). Many stated that receptivity depended on the patient. Over half of the physicians (57%, $N = 8$) felt patients were generally receptive. These physicians stressed the importance of communicating their desire to work with patients to help them quit smoking rather than preaching to patients. This included an understanding that quitting smoking is a long process and they do not expect immediate success. In contrast, other physicians (29%, $N = 4$) felt their time with patients would be better spent focusing on other health concerns rather than smoking. Some believed that patients usually did not care or did not want to listen (29%, $N = 4$), while others were unsure if their efforts were making any impact on patient behavior (21%, $N = 3$).

Benefits and drawbacks of having providers routinely discuss smoking with patients—

Physicians articulated many benefits and drawbacks of discussing smoking cessation with patients. Benefits related to both the individual patient and broader societal benefits. Most commonly reported benefits included: a) improving the health of patients, and b) decreasing the cost of healthcare. The drawbacks physicians discussed were related to: a) damaging the rapport with the patient, b) lack of time, and c) uncertainty of the effects of counseling.

More than half of physicians (64%, $N = 9$) expressed that discussing smoking with their patients is beneficial for their health (See Table 5). Physicians believed that highlighting the link between patients' current health problems and their smoking was a good way to motivate patients to quit, which could have far reaching positive effects on patient's overall health and quality of life. Other physicians (29%, $N = 4$) felt the benefit of discussing smoking with patients had a greater impact on society by reducing the strain on the health care system, costs for patients, and improving the health of communities and the country.

Some physicians (43%, $N = 6$) expressed concern that having a discussion about smoking may damage patient rapport (See Table 6). One physician suggested repeated discussions with patients could result in the perception that their patient is non compliant, and thus compromise the quality of the relationship, and in some cases providers' willingness to continue treating the patient. Approximately one-third of physicians (36%, $N = 5$) expressed lack of adequate time as a barrier, especially for patients with several comorbidities. Some physicians reported struggling with prioritizing issues to address, which could result in less than optimal (or no) discussion of smoking. Three physicians (21%) reported the lack of data to indicate their effectiveness as a drawback of having a discussion about smoking. These physicians expressed a lack of confidence with their counseling skills and doubted if spending the time counseling patients was worth the outcome.

Discussion and conclusion

Exploration of how physicians think about trying to motivate their patients to quit smoking revealed some variability in views. With respect to counseling strategies, the majority of physicians endorsed providing education on the health risks of smoking. They were split, however, on the use of “scare tactics” due to concern about their utility and the potential for damage to provider-patient rapport.

Physicians focused on addressing the health risks of smoking, which is consistent with the second “R” of the Guideline. This is also consistent with evidence that smokers often cite health risks as their reason for quitting (21). However, physicians appear to pay less attention to discussing the benefits or rewards of quitting (the third “R” in the Guideline) which may extend beyond the avoidance of health risks to other areas of well-being (e.g., improved self-esteem, living longer to enjoy grandchildren).

The intentional use of fear by some physicians is consistent with evidence that strong emotions can be used to increase the effect of persuasive messages (22). However, studies indicate that fear-based motivational strategies can be counter-productive if a means of avoiding or managing the problem is not available (23,24). Instilling fear may therefore be counterproductive in cases where highly addicted smokers may lack the confidence that they can quit. The split among physicians in the potential pros and cons of using fear tactics suggests that it would be useful to clarify the circumstances under which highlighting the significant health risks of smoking for the patient is likely to be effective or counterproductive.

There is ample evidence to support the importance of providing strategies that can build confidence and enhance the likelihood of success (2,25). Physicians indicated they recommended cutting down as a step toward quitting which has some empirical support (26), however, research on effective strategies to use when leading up to a quit attempt is generally lacking in the literature. For patients that decide to quit, there is clear and long-standing evidence for the superiority of providing skills-based behavioral counseling in conjunction with pharmacotherapy (27), yet only two providers noted that they used a combined approach when counseling patients. This highlights the continued lack of use of the most fundamental aspects of tobacco use treatment among physicians and underscores the need for novel strategies to ensure patients receive appropriate treatment when they want to quit.

Physicians did not discuss Motivational Interviewing strategies such as “developing discrepancy” (i.e., exploring patient goals and values and their incompatibility with smoking) and encouraging “change talk” (i.e., any statements about making a behavior change) which are recommended in the Guideline. While it is predictable that physicians who have not received training in Motivational Interviewing would not employ these strategies, use of these proven strategies with patients would likely improve patient outcomes (28,29). More importantly, physicians’ descriptions of strategies that they employ to motivate patients were predominantly focused on enhancing risk perceptions through education or “scare tactics” ignoring many other well-established factors that could be

discussed to influence patient's motivation (e.g., social influences, physiological and psychological addiction, financial cost etc.). In discussing their strategies physicians did not refer to the evidence base in behavioral medicine with only one provider describing a coherent conceptual framework of behavior change principles to guide his efforts with patients. The efforts of the vast majority of the providers to motivate their patients are therefore likely to be varied and unsystematic which is likely to diminish their impact.

A majority of physicians felt most patients were receptive to their efforts to address smoking, while nearly a third felt most patients either didn't care or didn't want to listen to advice regarding smoking, and 21% were unsure of their patients' receptivity to their efforts. Given providers' sense that many patients aren't receptive and their concerns about the potential to damage rapport, it is not surprising that many physicians don't discuss smoking at every visit, (30) despite Guideline recommendations.

Physicians noted that addressing smoking with patients could have benefits for patient health and reduced health care costs. However, they saw challenges to prioritizing smoking cessation counseling over other health issues given limited time, skepticism about the impact of their efforts given the lack of outcome data on their patients, and fear of damaging rapport. For patients to receive effective, empirically supported treatment these physician concerns will need to be addressed. Specifically, these findings suggest that specialized training in tobacco use treatment and motivational counseling strategies, tracking patient smoking outcomes, and affording more time would be critical for physicians to provide state-of-the-art care. Alternatively, to reduce the burden on the physician to have the requisite time and skills, innovative methods such as the use of a specialist behavior change counselor (31) should be considered for use in primary care.

This study provides novel qualitative data to support quantitative research documenting poor implementation of the Guideline in everyday practice. Because this study was qualitative in nature the sample size was small. The relative frequency of the different opinions offered in this study may not reflect the true prevalence of different physician views but rather provides an indication of the range of views commonly held by physicians. Participants were also from a single academic safety-net hospital so the views offered may not generalize to physicians in settings. Finally, physician reports of their behavior may not correspond with their actual behavior, however their descriptions were consistent with our prior observational study of their counseling efforts (19).

Practice Implications

Results clearly indicate that patients are unlikely to receive high quality, evidence-based counseling for smoking cessation despite physicians generally believing in its importance. Although recent changes have required medical schools to include basic patient-provider communication skills in their curricula (28,32), most practicing physicians have not received this training (33,19). Only three physicians (21%) who participated in this study reported having formal training on smoking cessation counseling.

Although this suggests more opportunities for training in counseling are needed for physicians after medical school, physicians concerns about the effectiveness of counseling

and having sufficient time also need to be resolved. Given that counseling for smoking may be more time consuming than a typical medical encounter and that it also takes time away from other important medical needs, additional innovative approaches that reduce overall physician burden may be needed. For example, physicians could be trained to provide brief (and motivational) referrals to an on-site behavioral counselor who works in coordination with the physician. In addition, e-health innovations could support more efficient and effective counseling by physicians.

Acknowledgments

Research reported in this article was partially supported by the National Cancer Institute of the National Institutes of Health under award number R01CA133068. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. The authors thank the physicians and resident physicians who participated in this research study.

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Table 1

Educating the patient on the health risks of smoking

"The thing I think is most effective is trying to tie it to something that they're currently in to see me for. So if they have complaints about shortness of breath and they have COPD, then we'll talk about that. If they're there for chest pain then they've got cardiac issues, then I talk about that. I try to talk about how smoking affects their health problems that they already have and how quitting smoking can help improve their outcomes." (Resident 1, male)

"I always include that tobacco is a contributor to medical problems the patient has, for example if a patient has high blood pressure and they're also a smoker. I kind of evaluate their knowledge before I go into my spiel about smoking cessation. So I'll ask are you aware that for example tobacco exacerbates high blood pressure, or can contribute to hardening of the arteries in conjunction with your diabetes...." (Resident 5, female)

Table 2

Using scare tactics to highlight the harmful effects of smoking

"I try to use scare tactics to a certain extent. I usually talk about how it's gonna kill you... You're gonna have a shorter life expectancy if you continue to smoke. Occasionally, if you have the time ... I always say, 'have you ever seen anyone on oxygen?' Most people have, [so] I say you're going to be just like that person if you continue to smoke." (Attending 1, male)

"If I have a young female, I would concentrate on cosmetic effects because I know they're going to be scared of that... the effects of smoking on the skin and aging. I would try to make it ugly for them. Young girls are more interested in the skin and beauty. For men, it depends, I like to assess what the man is interested in, and on what they know about smoking." (Resident 9, male)

Scare tactics are a dangerous strategy

"The docs go in and [say] that's a dirty nasty habit, it's gonna rot your teeth and destroy your lungs and give you heart disease and cancer, [but] patients know that they shouldn't be smoking." (Attending 4, female)

Table 3

Providing advice and suggestions for smoking cessation

<p><i>“I suggest things like why don’t you try to cut down to 1 or 2 cigarettes per week or once every 2 weeks and work your way down from there. Then, if they’re not quite so keen on the idea of cutting down, I suggest nicotine patches or nicotine gum. Unfortunately a lot of the times that’s not an option for our patients because they’re expensive.” (Resident 4, female)</i></p> <p><i>“I talk about quit dates, I talk about deep breathing exercises, I talk about ways to redirect their cravings, I talk about use of patches, lozenges, and gum. I’m willing to offer pharmacologic assistance for people who have access to it and don’t have any contraindications. ” (Attending 4, male)</i></p>

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Table 4

Provider's perceptions of how receptive patients are to these strategies

Patients are receptive

"It varies one person to another, but I think [they receive my smoking cessation efforts] pretty well. It's not like giving antibiotics. This is more of a continuous process. They quit and come back, quit and come back. You just have to keep on trying with them." (Resident 9, male)

Patients are uninterested

"Some of them are not interested at all, as I said. Some of them don't view smoking as a problem. So whatever you say or do will not make any difference because I mean they are convinced that this is not an issue." (Attending 2, male)

Unsure of how receptive patients are

"I don't know... It's hard, we don't keep track. We don't do the numbers." (Attending 1, male)

"I don't know, I think a lot of times; in the clinic the patients will tell you what they think you want to hear. So they're like 'yeah, you know, I know you're right, you're right'. I do the same thing, I go to the dentist to get my teeth cleaned and suddenly I think I'm gonna floss everyday. And then after a month I don't floss anymore. I think its' [smoking cessation messages] just a reminder. And sometimes those reminders bring that to the surface again." (Resident 10, female)

Table 5

Benefits of having providers routinely discuss smoking with patients

Improving the health of patients

"Well there's a lot of benefit. Number one there's a benefit with the patient because you're gonna improve several comorbidities. And you're gonna improve their quality of life, their length of life..." (Resident 1, male)

"Well what's good about it is they're preventing their death, mortality, mobility, um you're making your own job easier probably because once they quit smoking their other conditions are likely to improve." (Resident 8, female)

Decreasing the cost of healthcare in the U.S.

"The cost that comes with smoking and all the health problems associated with smoking are astronomical. If you can get people to quit smoking then I think there would be a large amount of money saved to the health care system. Not to mention the financial resource the patient would save [and] the health of our communities." (Resident 1, male)

"Overall if you want to bring down the prevalence of smoking in the community, then it benefits everybody. It benefits the country, the health care costs, it benefits everything." (Attending 3, male)

Table 6

Drawbacks of having providers discuss smoking with patients

May damage rapport with patients

"One drawback I see is when [providers] make the failure of the patient's reception to it [smoking cessation] a bigger part of the physician patient relationship. For example, I have physicians whose relationship with their patients did not go well because the patient did not listen to their advice on cutting down smoking ... and that can sometimes lead to patients switching physicians. I know a few physicians who refuse to see someone who is smoking and refuses to cut down on smoking." (Attending 1, male)

"You have to be sensitive. There are some doctors that tend to make patients feel like they're somehow morally culpable for their smoking, like they're doing something that is a sin. You're a bad person because you smoke, you're dirty, and your breath smells, and all that sort of crap. I tell people, 'listen, I know what it's like to enjoy smoking. It's not like it's hurting anyone else as long as you do it in the open,' but I tell them it's bad for you, it's hurting your body, that's why we need to talk about this. (Attending 4, male)

Competing priorities during already rushed visits

"You have to fit in important discussions about other medical issues and so I think that I address it at every clinic visit, but the time that I dedicate to counseling is probably suboptimal at some of those clinic visits. I think that it can be frustrating when you're pressed for time. I think that's the limiting factor with the counseling sessions, but it can be especially rewarding when you contributed to somebody quitting." (Resident 5, female)

Unsure of impact on patients' behavior

"Sometimes you don't know if your efforts account to anything in terms of counseling. I mean you know we like to take action, put the patient on medication and see the immediate effects. But with counseling it's kind of like you don't know what's going to happen, and a lot of these patients are lost in follow up. It's something that takes a lot of time and something you have to do appropriately to be effective." (Resident 8, female)