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PHYSICIANS' INVOLVEMENT IN THE SMOKING CESSATION PROCESS OF THEIR PATIENTS

RESULTS OF A 1998 SURVEY AMONG 4 643 BELGIAN PHYSICIANS

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Key words : Smoking cessation; Survey; Belgium; Physician

ABSTRACT

This report relates to the 1 667 responses to a selfadministered mail-back questionnaire sent by BELTA to a sample of 4 643 physicians (17.3% current smokers) who are in professional contact with patients (response rate: 35.9%).

Links between active smoking and disease are considered as well-demonstrated by 98.8% physicians and for passive smoking by 85.3%, for foetal consequences of smoking during pregnancy by 96.4%. Nicotine dependence is admitted by 83.3%. Interaction of smoking with drug metabolism is insufficiently known.

Modulation of the specific approach of smoking cessation, according to the various stages of the cessation cycle, to the level of nicotine dependence and to the psychological status of the smoker is not sufficiently perceived by the physicians. Patient's smoking status is systematically determined by less than half the physicians, of whom nearly 90% claim to inform their smoking patients on smoking-related risks, and 84.2% to tackle the problem of cessation. The intervention is mostly limited to a firm advice, completed by nicotine replacement for a maximum of 50% of smokers (especially gum and patch). Referral to specialized structures is unfrequent (between 10 and 20%). Follow up after cessation is clearly deficient.

In this retrospective study of their activity patterns, physicians' reports may reflect their intentions rather than their actual practices.

We conclude that smoking issues and cessation techniques should be more intensively taught both at graduate and postgraduate levels, in order to obtain a more active behaviour of health professionals against smoking.

1. INTRODUCTION

Smoking is the main preventable cause of death in developed countries, responsible in Belgium for a death toll of 18 600 in 1992. (1,2) Since smoking cessation markedly reduces the smoking related mortality, physicians could play a major preventing role in advising their numerous smoking patients to quit and in helping them through the distressing withdrawal period. The effectiveness of physicians' advice and of nicotine substitution therapy has been repeatedly demonstrated. (3,4) Earlier studies in Belgium and other Western countries have shown that physicians' involvement in anti-smoking activities is generally poor, as is their implication in most preventive activities. (5-8)

The Belgian Lung and Tuberculosis Association (BELTA) initiated in 1998 a large cross-sectional survey among Belgian physicians with professional patient contact, in order to assess the barriers preventing them to bridge the gap between their capabilities and their actual interventions.

Data concerning these physicians' smoking habits were recently published elsewhere (9). This report focuses on their degree of awareness about the health consequences of smoking, quit methods, and also on their

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actual behaviour during medical practice. When appropriate, comparisons are made with the results of a previous survey conducted by BELTA in 1983 among 3 205 Belgian physicians. (10)

2. MATERIALS AND METHODS

A self-administered mail-back questionnaire, with 41 multiple choice questions was sent out in March 1998 with an explanatory letter ensuring that responses would be analyzed anonymously. When no response was obtained, a second questionnaire was sent after 4 weeks. If no response was received after this first recall, nurses from BELTA repeatedly called the non-responders, between the beginning of September and 15 October 1998, to obtain answers to the main demographic questions and to determine their professional and smoking status. The numerous questions concerning the physicians' involvement in the smoking cessation process could not be asked by phone.

For sampling among the physicians those in regular contact with patients, the «random» function generator of Excel selected, in both linguistic communities, a pre-determined percentage of various categories of physicians (10% of GPs, 100% of pneumologists, 50% of cardiologists, 25% of (neuro)psychiatrists, internists and pediatricians and 5% of other specialists). In all, 4 643 physicians were sampled, or 13.4% of all physicians present in the 1998 files of practicing physicians. In the statistical analysis, the level of significance was fixed at $p < 0.05$. The full details of the technique are described elsewhere (9). The questionnaire used is available at BELTA.

3. RESULTS

Those concerning smoking status are derived from postal and telephone answers, while the data concerning doctors' awareness of smoking issues and doctors' behaviour in their consultation office are derived only from the interpretable answers to the printed questionnaires, with a response level close to 100% for most questions.

3.1. Response rate and smoking status

A total of 1 683 printed questionnaires, of which 1 667 were interpretable (35.9% of the sample) reached the BELTA and 1 360 answers (1 340 of which inter-

pretable) were obtained through telephone calls yielding a total interpretable response rate of 64.2%.

There were 54.0% never smokers, 28.7% former smokers as well as 17.3% current smokers (against 31.9% in 1983), among whom 62.2% were cigarette smokers. This low current smoking rate among physicians contrasts with the corresponding value of 30% in the general population older than 15 years in 1997, and even with that of general population having completed secondary school (24.2%) (11).

3.2. Doctors' awareness about smoking issues

3.2.1. Links between smoking and disease

Whereas the links between active smoking and disease is considered as established by 98.8% of the physicians, their level of agreement for the ill effects of passive smoking is lower (85.3%), especially among the smoking physicians (71.8%). For passive smoking, the agreement level of the pediatricians (92.7%), a category of specialists directly confronted with its effect in children is higher than that of gynecologists (84.1%) ($p=0.002$) and of the other physicians (84.7% ($p < 0.01$)).

The risk to the unborn child from smoking during pregnancy is widely recognized respectively by 96.4% of the whole group, by 98.3% of the pediatricians and by 97.7% of the gynecologists.

The increased health risk resulting from an early initiation of the smoking habit is known by 89.2% of the physicians.

The similarity between the physical dependence to nicotine and to other psycho-active drugs (alcohol and hard drugs) is accepted by 83.3% of the physicians.

In contrast, the clearly demonstrated interaction of smoking with the metabolism of various medicines (12,13) (e.g. antidepressants and analgics) is recognized by 42.9% of the physicians only, while 54.4% do not express any opinion in this issue!

For all these items, the level of agreement differs significantly between current, former and never smokers. The level in never or former smokers is higher than that of current smokers, but the level in never and former smokers is usually similar for most questions.

The reported favourable health effects of smoking on the evolution of some diseases are much less recognized: this applies for ulcerative colitis in only 24.4% and for Parkinson's disease in 7.0% of the physicians. The same is true for Alzheimer's disease, where some discrepancies persist in the literature (with nevertheless

probably an unfavourable effect of smoking) (14) : the influence of smoking is unknown to 52.0% of the physicians, and considered as deleterious by 38.5%. For the last three diseases, the level of agreement does not differ significantly between current and never smokers.

3.2.2. Information of the medical profession concerning its role in assistance for smoking cessation

The model role of the non-smoking physician is accepted by 93.7% of the 1 660 responders, but denied by 17.8% in the sub-group of 259 smoking physicians. The level of agreement with the role model role of the physician is significantly higher among never or former smokers than among current smokers.

Among the smoking physicians, 5 out of the 143 who agree with the model role do nevertheless smoke in front of their patients, a habit adopted by 8 out of the 33 (24.2%) denying the model role ($p < 0.001$).

The success rate of quit attempts is lower among stressed and especially among depressed smokers: postponing the quitting day can be considered in those conditions. Such postponing was regarded as adequate in stress situations by 34.0% of the physicians and inadequate by 42.4%, and in case of depressive states, respectively by 35.5% and 38.8%.

The Fagerström Nicotine Dependence Test (FNDDT) (15), an important tool for the choice of the optimal cessation method, is completely unknown to 69.3% of the physicians (59.1% of GPs, 87.2% of trainees and 72.1% of certified specialists); 13.7% of the physicians assert they are familiar with it, without using it (89.8% responses). Knowledge and use of the FNDDT are statistically more frequent among GPs than among certified specialists or specialists in training. According to 73.2% of the physicians, the adequate strategy is different whether the smoking attempt is the first one or a subsequent one (response rate : 83.8%). The non smoking physicians agree more frequently with this fact than those who are former or current smokers ($p = 0.03$).

During the last two years, most physicians (84.9%) did not attend any postgraduate training (lectures or conferences) concerning smoking cessation (response rate : 99.0%). Participation in postgraduate training is not statistically different between current, former or never smokers. The reasons for non attending, mentioned by 91%, are distributed almost equally between those giving it a low priority (744 physicians) and those attributing it to a lack of offer for such a training (723 physicians).

The level of attending is somewhat higher among GPs (16.7%) than among certified specialists (13.7%) and considerably lower among trainees (4.6%) (Response rate : 99.2%).

3.3. Behaviour of the physician in his consultation office

3.3.1. Assessment of the smoking status

In medical practice, the first step allowing an individual smoking cessation intervention is to assess the smoking status of the patient; ideally at each medical consultation, so that the physician can play his preventive role for the largest number of patients. Alternatively, the assessment of smoking status is sometimes targeted to patients consulting for smoking related symptoms or diseases, where the physicians' interventions towards smoking cessation have both a preventive and curative impact. Some physicians are even reluctant to give unsolicited lifestyle advice that could impair the physician-patient relationship, and therefore restrict their interventions to patients soliciting a direct aid in smoking cessation, currently rather an unusual situation in our country.

Table 1 shows that less than half the physicians use a routine assessment (47.6%), whereas a large majority claims to always assess the smoking status of their patients presenting with smoking related disease or consulting for cessation. The gradation between the systematic assessment (always) and the absence of assessment (never) is not significantly different between smoking and non smoking physicians for any of these three different approaches.

In Table 2 are shown the respective frequencies of systematic assessment of the smoking status of the patients as offered by the various categories of physicians. The percentage of specialists (certified or in training) claiming to question all their patients is higher than that of the generalists ($p = 0.04$).

The staging of the patients in the smoking cessation cycle (consonant or dissonant smoker, precontemplation, contemplation, action, relapse) is carried out by 63.0% of the physicians (901/1431 ; response rate 85.8%) and respectively by 78.3% of GP's ($n = 358$), 43.0% of the specialists in training ($n = 55$), and by 57.6% of certified specialists ($n = 480$) ($p \leq 0.002$).

The frequency of this staging is not affected by the smoking status of the physicians (response rate: 85.7%). It is more frequently performed by the physicians with

Table 1 — Assessment of the smoking status by the physician

| | Always n (%) | Frequently n (%) | Rarely n (%) | Never n (%) | Total responders n (%) |
|---|-----------------|---------------------|-----------------|----------------|---------------------------|
| In any patient | 716 (47.6) | 500 (33.3) | 207 (13.8) | 80 (5.3) | 1503 (90.3) |
| In patients with smoking related diseases | 1068 (83.2) | 151 (11.8) | 27 (2.1) | 37 (2.9) | 1283 (77.0) |
| In patients consulting for cessation | 1044 (88.1) | 46 (4.0) | 23 (2.0) | 66 (5.8) | 1139 (68.3) |

Table 2 — Routine assessment of the smoking status according to the category of the physician

| | General practitioners n (%) | Specialists in training n (%) | Certified specialists n (%) |
|---|--------------------------------|----------------------------------|--------------------------------|
| In all patients | 129 (28.0) | 60 (43.2) | 521 (58.5) |
| In patients with smoking related diseases | 370 (84.8) | 100 (78.7) | 591 (83.4) |
| In patients consulting for cessation | 410 (96.5) | 92 (80.7) | 496 (83.9) |

(81.2% ; n = 173/213) than those without (59.7% ; n = 718/1204) training concerning smoking issues ($p < 0.001$).

3.3.2. Smoking cessation interventions

Respectively 93.8% and 92.7% of the physicians claim to inform their smoking patients about smoking related risks and benefit of smoking cessation; the level of their intervention is lower ($p \leq 0.002$) among smoking than non smoking doctors. (Response rates 91.3% and 88.5%). The GP informs somewhat more frequently his patients about the risks than the specialist certified or in training ($p \leq 0.002$). Forty-five percent of physicians is claiming to tackle the problem of cessation with all their smoking patients, and 85.6% with their patients consulting for smoking related diseases; paradoxically, only 78.5% tackle the problem with patients consulting for cessation.

The rate of tackling all smoking patients is lower ($p < 0.001$) among physicians who are currently smok-

ing (31.0%) than among those who are never (46.6%) or former (49.0%) smokers. (Response rate: 84.3%)

More certified specialists (52.5%) claim to evoke cessation with all their smoking patients than other categories of physicians (34.6%) are doing. GP's more frequently (91.2%) than the other categories of physicians, claim handling cessation with their patients consulting for smoking related diseases (80.6%) or for smoking cessation (76.7%); (Response rate: 71%).

The median rates of smokers to whom physicians claim applying or advising different cessation methods are given in Table 3. Particularly striking are the low rates of smokers to whom a quit day is set, subsequent psychotherapy is offered and nicotine replacement is prescribed or advised (30-40%).

When referral to another therapist is advised, it concerns the following median rates of smokers: 90% to GPs, 15% to psychotherapists, 10% to 5 days-plan, 20% to smoking cessation clinics, 25% to others (number of responses: respectively 513, 230, 218, 241, 37).

The percentage of referrals are higher from special-

Table 3 — Smokers to whom different cessation methods are applied or advised

| | Different cessation methods | | | |
|-------------------------------------|-----------------------------|-------------|----------------|-------------|
| | Applied | | Advised | |
| | Responses n | Median % | Responses n | Median % |
| Firm advice | 878 | 90 | 565 | 90 |
| Quit day and repeated psychotherapy | 421 | 30 | 260 | 40 |
| Nicotine replacement | 608 | 30 | 466 | 40 |
| Anxiolytics | 340 | 10 | 215 | 10 |
| Homeopathy | 61 | 10 | 57 | 10 |
| Hypnosis | 59 | 10 | 67 | 10 |
| Auriculotherapy, laser, acupuncture | 125 | 10 | 109 | 10 |

Table 4 — Smokers for whom Nicotine Replacement Therapy (NRT) is considered

| | Nicotine Replacement Therapy | | | |
|-------------------------|------------------------------|-------------|----------------|-------------|
| | Prescribed directly | | Advised | |
| | Responses n | Median % | Responses n | Median % |
| General Practitioners | 307 | 50 | 132 | 50 |
| Specialists in training | 31 | 20 | 50 | 30 |
| Certified specialists | 285 | 25 | 293 | 40 |
| Others | 2 | 12.5 | 5 | 30 |

The differences are statistically significant between GPs and on the other side either specialists in training or certified specialists ($p \leq 0.02$).

ists in training (42.9%) or from certified specialists (36.7%) to GPs than from GP to GP (14.8%). Differences are statistically significant ($p < 0.001$) if one considers that no response equals no referral.

The median rate of smokers to whom nicotine replacement therapy (NRT) is prescribed directly or advised differs according to the physician's category (Ta-

ble 4) and it remains rather low, lower for specialists (certified or in training) than for GPs.

The median value of prescription is higher (50%) for those who followed a training in tobacco issues than for those who did not (30%) ($p = 0.01$).

The low use of NRT also appears in Table 5 showing the mean frequency at which the physicians declare to

Table 5 — Percentage of physicians claiming to prescribe the various forms of NRT at various frequencies

| | Gum | Patch | Spray | Inhaler | Combination |
|------------------|------|-------|-------|---------|-------------|
| Never | 55.4 | 37.4 | 92.3 | 98.2 | 92.6 |
| 1 X per year | 12.1 | 8.2 | 1.4 | 0.7 | 1.7 |
| 1 X per 6 months | 10.2 | 12.7 | 2.0 | 0.3 | 1.7 |
| 1 X per 3 months | 9.8 | 17.0 | 2.2 | 0.4 | 1.7 |
| 1 X per month | 9.7 | 17.5 | 1.7 | 0.3 | 1.8 |
| 1 x per week | 2.8 | 7.1 | 0.5 | 0.2 | 0.5 |
| Response rates % | 76.2 | 80.5 | 69.9 | 69.0 | 67.0 |

prescribe its various modalities. The patch is more often prescribed than the gum, recent formulations (spray and inhaler) are virtually not prescribed, not more than the combination of the various forms. Patches are the only form of NRT prescribed by more than half of physicians.

3.3.3. Follow up of the patients after quit advice

The follow up after quit advice is secured by a minority of the physicians only : 14.3% never; 21.3% of the physicians consider themselves as not concerned; 14.5% secure it during the first week, 42.3% after 2-3 weeks, 24.5% after 3 months, 11.1% after 6 months, 6.8% after one year,

3.3.4. Barriers to medical intervention in the cessation process

While 46.0% of the 1 667 responding physicians claim not to experience any barrier to their intervention in the smoking behaviour of their patients, the others point out different factors interfering with their interventions such as the lack of motivation of their patients (37.1%), poor efficacy of physicians' interventions (24.2%), fear of disturbing privacy (4.9%) or of antagonizing the patients (4.9%), and others (3.1%) such as lack of time of the physician or patient's problems (Response rate: 87.5%).

4. DISCUSSION

The sample interviewed in this survey is representative for the Belgian physicians who are in regular contact with patients. Nevertheless, a small minority of the

sampled physicians is predominantly involved in preventive medicine (school or occupational medicine, etc.). Furthermore, even among the practitioners with frequent patient contact, a few specialists (101/1735: 6%) (e.g. radiologists, clinical biologists, specialists in physical medicine, anesthesiologists) limit their contact to technical examinations or interventions: this does not incite them to deal with lifestyle problems, such as smoking. For a limited number of physicians, some of the questions are not relevant, causing percentage of non-responses to vary between questions.

A non-response bias clearly exists, with a response rate of 64.8% for the answers concerning smoking status and demographic data and of at best 35.9% for the other issues (awareness among physicians of smoking issues and cessation methods as well as their own interventions during their consultations).

We have estimated the physician's smoking rate after correction for non-response bias at 18.1% in a recent report. (9) However, for the other data, a control of the objectivity of the answers is difficult, even if for several reasons, one can fear that some physicians will provide the «expected» answer rather than one corresponding with their actual behaviour. It is well known from other studies (16) (17) that the frequency of counseling about smoking cessation, as estimated by the physicians, is much larger than that recalled by the smoking patients.

In our own study, we suspect an overestimation by the responders of their frequency of prescription of Nicotine Replacement Therapy (NRT), when we compare the rate of patients who were supposed to receive nicotine replacement (table 4) with the low frequency of prescription of the various nicotine formulations, reported in Table 5. Furthermore, the «sublingual nicotine tab-

let» has been erroneously included in the questionnaire at the moment of the survey before its actual availability in the pharmacist's office. We concluded to a possible interpretation of a tablet as being a piece of gum for those physicians who claimed to prescribe tablet but no gum, since the questionnaire did not mention that the tablet was sublingual: their data (n = 35) on tablets were thus transferred to those on gums in Table 4. For physicians who claimed to prescribe tablets and gum (n = 86), we preferred to discard all responses concerning NRT. In these doubtful «tablet» prescription data, the «prescription rate» was anyhow very low (once every 6 or 12 months).

Erroneous answers can also have resulted from misunderstanding of some questions, especially where the physician had the choice between applying a method him self (question intended at the GP) and advising application (question intended at the specialist who usually prefers referring the patient to his GP for further aid in giving up smoking). Finally, fatigue and exaggerated speed in answering, resulting from the large number of questions, can also have contributed to some erratic answers, like those of the 28 physicians declaring to prescribe nicotine substitution, but not mentioning any nicotine formulation used. The nearly 15% referral rate between GPs for help in giving up smoking seems somewhat surprising but could, at least partially, be explained by some degree of specialisation in smoking cessation, possibly within a GP group practice.

Even if our results should be considered with caution and could have been biased by some overestimation of the physician's involvement in the smoking cessation process (compliance response bias), several important facts remain nevertheless established and deserve to be pointed out:

1. A considerable decrease of smoking prevalence among physicians between 1983 and 1998 has been documented; it can be expected to result in the same trend within the general population, given the major model role of the medical profession.
2. The adverse effects of active smoking are generally well known by the physicians but there is somewhat less knowledge of the risks of passive smoking, as well as of the ill consequences to the unborn child and newborn from smoking during pregnancy.
3. The interactions between smoking and drug metabolism (12-13) as well as the favourable - although limited - effect of smoking on Parkinson's disease and on ulcerative colitis are generally ignored, although they are presently well documented. (18)
4. The information of the medical profession about its role and potentials in the smoking cessation process is incomplete, especially concerning the usefulness of postponing the quitting day when the smoker is stressed or at least depressed, and the difference in approach for cessation between primary quitters and relapsers. Information is also lacking about the usefulness of the Fagerström score for specifying the level of nicotine dependence, and the resulting indication for nicotine replacement. This is not surprising, since there is little or no teaching about smoking cessation techniques at the graduate level, and few physicians attend postgraduate courses on this subject.
5. The first necessary step of smoking cessation interventions, i.e. a routine smoking-status assessment among all consulting patients is far from generalized. This low detection rate is well known in other countries . (8,19,20,21) The high percentage of physicians claiming to tackle the cessation problem for the patients consulting for smoking related diseases must be considered as favourable, but if physicians want to be active in prevention, they should do it also for patients consulting for other reasons. The reported performance in transmitting the quit message is rather poor and not completed by fixing of a quit date. NRT is not frequently prescribed, especially the nasal spray and the inhaler, partially as a consequence of their recent introduction in Belgium (gum in 1984, patch in 1992, nasal spray in 1995 and inhaler in april 1998). The fact that some presentations are being sold over the counter (OTC) without prescription (gum in 1994 and patch in 1997) could also have contributed to inadequate knowledge or interest. Referral to specialized smoking cessation structures is unfrequent and follow-up after quit advice very poor, although it has been recommended by all recently published guidelines on smoking cessation (22-26) in order to increase the rate of permanent cessation. Those deficiencies also exist in other countries. (20)
6. Barriers to smoking cessation interventions evidently exist, and are probably understated in our survey. Beside the lack of motivation of patients and the belief in a low efficacy of physician's interventions frequently mentioned here and elsewhere (20), one should not forget lack of time (simple advice of cessation is very brief but an individual approach of the smoker's cessation is time-consuming), reservation towards lifestyle advices in general (27), fear to an-

tagonize patients, lack of skills (28), lack of a specific financial support or incentive from the social security (29) and the tendency of specialists to transfer the responsibility of these interventions to the GP's, who frequently dismiss it!

5. CONCLUSION

The survey has yielded useful information about strengths and especially weaknesses of the present tackling of the smoking issues.

Given the low level of physicians' involvement in the smoking cessation process, more attention is needed from universities and scientific societies to specific graduate and postgraduate teaching of the smoking issues, including cessation skills. (20) Consistently effective interventions (local consensus processes, interactive educational meetings, etc..) (30) should be conducted in order to promote behavioural changes among health professionals towards a more active antismoking attitude. These actions could lead to considerable improvement of the physician's involvement in the fight against the further threats of smoking.

RÉSUMÉ

Nous rapportons la synthèse des 1667 réponses à un questionnaire postal auto-administré, adressé par la BELTA à un échantillon de 4643 médecins belges, en contact professionnel avec des patients (taux de réponses: 35,9%), dont 17,3% étaient des fumeurs.

Les liens entre tabagisme et maladie sont considérés comme démontrés par 98,8% des médecins pour ce qui est du tabagisme actif, par 85,3% pour le tabagisme passif, par 96,4% pour les conséquences fœtales du tabagisme gravidique, par 83,3% pour la dépendance nicotinique. Les interactions du tabagisme sur le métabolisme des médicaments ne sont pas assez connues.

Les médecins ne perçoivent pas suffisamment l'approche spécifique de l'arrêt en fonction des divers stades du cycle de cessation, du degré de dépendance nicotinique et de l'état psychique du patient. Moins de la moitié des médecins déterminent le statut tabagique de tous leurs patients, alors que près de 90% affirment informer leurs patients fumeurs sur les risques-santé du tabagisme, et que 84,2% déclarent aborder avec eux le

problème de l'arrêt. Leur intervention se limite le plus souvent à un ferme conseil, qui n'est complété par la prescription d'une substitution nicotinique (surtout gomme et timbre) qu'au maximum chez 50% des fumeurs. Le recours à des structures spécialisées n'est pas fréquent (10-20%) et le suivi après le conseil d'arrêt nettement déficient.

Dans cette étude rétrospective de leurs modalités d'approche, les déclarations des médecins pourraient refléter davantage leurs intentions que leur pratique effective.

Les problèmes du tabagisme et des techniques d'arrêt devraient être enseignés de façon plus approfondie au niveau gradué et postgradué, afin d'obtenir une attitude plus interventionniste des professionnels de la santé dans la lutte contre le tabagisme.

SAMENVATTING

Dit verslag brengt een synthese van de 1667 antwoorden die bekomen werden op een zelf te beantwoorden en terug te sturen vragenlijst door BELTA verzonden naar een selectie van 4643 Belgische artsen die professioneel patiëntencontact hadden (responserate: 39,9%) van en wie 17,3% huidige rokers waren.

Het verband tussen roken en ziekte wordt voor actief roken als wel bewezen beschouwd door 98,8% van de artsen en voor passief roken door 85,3%; voor de gevolgen voor de foetus van roken tijdens de zwangerschap is dit voor 96,4% van de artsen. De nicotine afhankelijkheid wordt aanvaard door 83,3%. Interacties tussen roken en geneesmiddelenmetabolisme zijn daarentegen onvoldoende bij de artsen bekend. De artsen begrijpen onvoldoende dat de specifieke aanpak van rookstop moet gemoduleerd worden naargelang van de opéenvolgende stadia van het rookstop-proces, evenals volgens de graad van nicotine-afhankelijkheid en de psychologische toestand van de patiënt. Naar de rookgewoonten van de patiënt wordt slechts systematisch navraag gedaan door minder dan de helft van de artsen, van wie bijna 90% beweren hun rokende patiënten te informeren over de mogelijke gezondheidsschade van het roken, en 84,2% het probleem van de rookstop aanpakken. De tussenkomst wordt meestal beperkt tot een vaste rookstopadvies, aangevuld met nicotine substitutie bij ten hoogste 50% van de rokers (vooral de kauwgom en de pleister). Verwijzing naar gespecialiseerde eenheden gebeurt vrij weinig (tussen 10 en 20%).

Follow-up na rookstop laat manifest te wensen over.

In deze retrospectieve studie van hun activiteitenpatronen met betrekking tot het roken, hebben artsen wellicht eerder hun intenties weergegeven dan hun feitelijke praktijk. Wij besluiten dat over de problematiek van roken en van rookstoptechnieken zowel in het graduaat- and het postgraduaatonderwijs veel intensiever zou behandeld moeten worden, om een meer ingrijpend houding te bekomen bij de artsen.

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Mrs A. Tommelijn and S. Hauglustaine took part in the sampling and encoding process and in the data processing.

Mrs M. P. Heylen type-wrote the manuscript.

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