Primary Health Care Research and Development 2007; **8**: 68–79
doi: 10.1017/S1463423607000084

An exploration of the knowledge, attitudes and practice of members of the primary care team in relation to smoking and smoking cessation in later life

Susan Kerr, Hazel Watson and **Debbie Tolson** School of Nursing, Midwifery and Community Health, Glasgow Caledonian University, Glasgow, UK, **Murray Lough** NHS Education for Scotland, Scotland, UK and **Malcolm Brown** NHS Greater Glasgow and Clyde Partnerships, Glasgow, UK

Smokers aged 65 and over have been identified as a priority group for smoking-cessation interventions. However, despite confirmation of the benefits of cessation in later life and compelling evidence that interventions can be effective, studies have shown that members of the primary care team often fail to target this population. If these professionals are to be encouraged to broach the subject of smoking cessation with older people, it is important that barriers to the effective provision of interventions are uncovered. This article reports findings from a qualitative study that sought to do this by exploring the knowledge, attitudes and practice of members of the primary care team in relation to smoking/smoking cessation in later life. A purposive sample of health visitors, district nurses, practice nurses and general practitioners ($n = 41$) working in the west of Scotland was recruited. Data were collected during face-to-face interviews using a semi-structured interview schedule. The interviews were transcribed and then analysed using content analysis procedures. While the participants were generally convinced of the benefits of cessation many believed that few older people manage to stop smoking successfully. A pessimistic view of the success rate of older smokers appeared to negatively influence practice. In addition, a number of the participants lacked confidence in their own counselling skills and/or had limited awareness of smoking cessation resources and specialist services. These factors also appeared to preclude the provision of effective smoking-cessation interventions. Finally, there was little awareness of the content of the UK Smoking Cessation Guidelines. The findings from this study, and a parallel study that explored the health beliefs of older smokers, have been used to develop smoking cessation training designed specifically for members of the primary care team who have contact with older people who smoke. The efficacy of the training is currently being evaluated.

Key words: later life; primary care team; smoking cessation

Received: September 2005; accepted: November 2006

Introduction

Smokers aged 65 years and older are a vulnerable group who are likely to have conditions caused or complicated by smoking (Department of Health, 1998). Older smokers are also likely to die prematurely, losing on average 16 years from their projected life expectancy (Cataldo, 2003).

Although the prevalence of smoking is lower among adults over 65 years than in younger people, the actual number of older smokers is increasing steadily in the developed world, as the proportion of older adults in the population rises. In the UK adults aged 65 and older make up approximately

Address for correspondence: Dr Susan Kerr BA MSc PhD RN HV, Senior Research Fellow, School of Nursing, Midwifery and Community Health, Glasgow Caledonian University, Cowcaddens Road, Glasgow G4 OBA, UK. Email: s.m.kerr@gcal.ac.uk

15% of the population and this is set to rise to more than 19% over the next twenty years (GAD, 2002). As approximately 16% of older adults are known to smoke, there are currently around 1.5 million smokers aged 65 and over in the UK (ONS, 2002). Unchecked, the number of smokers of this age could exceed 2 million, as demographic ageing continues (GAD, 2002).

In recent years a growing body of research has demonstrated that older smokers can derive significant benefits from stopping smoking, despite having smoked for many years (Molander *et al*., 2001; Orleans, 2001). The benefits of cessation are almost immediate for conditions such as heart disease and stroke (Orleans *et al*., 2001). Stopping smoking also reduces the risk of developing cancer and stabilizes existing conditions such as chronic obstructive pulmonary disease (British Thoracic Society, 1997). Clearly, older smokers are an important target group for smoking-cessation interventions.

Healthcare contacts provide excellent opportunities for smoking-cessation interventions and interventions delivered by health professionals can be effective in triggering and supporting cessation attempts (Lancaster *et al*., 2000; Rice and Stead 2002; Silagy *et al*., 2002). This is a point highlighted in the UK Smoking Cessation Guidelines (West *et al*., 2000; NHS Health Scotland/ASHS, 2004) and it is for this reason that the World Health Organisation (WHO) dedicated its 2005 'World No Tobacco Day' to encouraging health professionals to be proactive in supporting patients'/clients' efforts to stop smoking (WHO, 2005).

In the UK, 90% of all contacts between members of the public and the National Health Services (NHS) take place in the primary care setting, with older adults (≥65 years) having contact with members of the primary care team, on average seven times per year (Health Education Authority, 1999). Members of the primary care team therefore have a crucial role to play in discussing the topic of smoking cessation with older clients/patients who smoke.

Unfortunately, despite confirmation of the benefits of cessation in later life, and compelling evidence that intervening with older adults can be effective (Ossip-Klein *et al*., 1997; Ferguson *et al*., 2005), a number of studies have shown that health professionals often fail to target this population (Maguire *et al*., 2000; Ossip-Klein, 2000). Of particular note are the results from a recent Scotland-wide survey of the health promoting activities of members of the primary care team (Watson *et al*., 2004). This study demonstrated that less than 50% of the respondents actively discussed smoking cessation with older adults and that the level of input decreased with age. In addition, almost one in four older smokers in a study undertaken by Kerr *et al.* (2004) reported that they had never been advised to stop smoking by primary care staff. Others stated that, while it had been suggested that they stop smoking, appropriate levels of information, advice and support had not been provided.

There is a dearth of age-related smoking cessation research and therefore little is known about the reasons behind this failure to intervene. If members of the primary care team are to be encouraged to broach the subject of smoking cessation with older people, it is important that barriers to the effective provision of smoking-cessation interventions are uncovered. In light of the current lack of evidence, the study reported in this article aimed to explore the knowledge, attitudes and practice of members of the primary care team in relation to smoking and smoking cessation in later life. The findings reported form part of a wider investigation that gathered data to inform the development of specially tailored smoking cessation training for members of the primary care team who have contact with older people who smoke (Kerr *et al*., 2004).

The study

Design/methodology

A qualitative approach was adopted (Morse and Field, 1998) as the intention was to explore the participants' knowledge, attitudes and practice and also because little was known about the topic under investigation.

Sample/participants

Participants were recruited through general practices located in the west of Scotland. A total of 33 practices were selected purposively, ensuring diversity in terms of socio-economic deprivation and geographical location. A pack containing an Information Sheet and Consent Form was forwarded to practice nurses (PNs), district nurses (DNs), health visitors (HVs) and general practitioners (GPs) who worked in or were 'attached' to these practices. Professionals who had contact with people aged ≥65 years and who wished to

https://doi.org/10.1017/S1463423607000084 Published online by Cambridge University Press

participate were asked to sign and return the Consent Form. Information on the total number of participants in each of the professional groups is presented in Table 1.

Data collection procedures

Data were collected during individual interviews in a private setting at the participants' workplace. Demographic data were collected and a semi-structured interview guide was used to explore the participants' knowledge, practice and attitudes towards smoking/smoking cessation in later life (ie, ⩾65 years). A summary of the areas covered is provided in Table 2. The interviews were audio-recorded.

Data analysis

A transcript of the content of each interview was prepared. When this process was complete the transcripts were returned to the participants who were asked to check the accuracy of their own transcript and to highlight any alterations they wished to be made before returning the transcript.

The interview data were then synthesized under each of the question headings and a content analysis of the complete data set was undertaken (Clifford, 1997). The content analysis involved categorizing the qualitative responses to each question and then providing a written summary of the content of these responses. As advocated by Clifford (1997), the written summary included details of the number of people who provided similar responses. The analysis of the data was undertaken by the first author and was subject to peer review.

Table 1 Respondents

	Participated
General practitioners	16
Practice nurses	7
Health visitors/health visitor support	6
District nurses/district nurse support	12
Total	41

Ethical considerations

Ethics approval was granted by the Local Research Ethics Committee. Informed consent was achieved as detailed above. Confidentiality was assured and the anonymity of the participants was protected.

The findings

Demographic data

A profile of the 41 participants is presented in Table 3.

Health effects of smoking in later life

The participants demonstrated a good awareness of the health effects of smoking in later life (ie, ⩾65 years). Knowledge of the effects of smoking is considered essential, as it should underpin discussions around the issue of smoking/smoking cessation with older people. The most commonly mentioned conditions were: chronic obstructive pulmonary disease, ischaemic heart disease, peripheral vascular disease, cancer; cerebrovascular disease, and, recurrent chest infections. Other conditions included: hypertension, osteoporosis, ageing of the skin, dental problems, and, loss of appetite. Only one participant, a health visitor, was not convinced that many of the older smokers she had contact were suffering from the effects of smoking.

Table 2 Summary of the areas discussed during the interview

Contact with older smokers that is, smokers aged 65+ years (daily/weekly contact; situation in which contact occurs)
Effects of smoking in later life (own views, views of older smokers)
Benefits of stopping smoking after 65 years (own views; views of older smokers)
Smoking cessation in later life (number of older smokers manage to stop smoking successfully; what encourages older people to stop smoking; barriers to a cessation attempt)
Provision of smoking cessation information and advice to older smokers (broaching the subject; what support is provided; success rate)
Referral of older smokers to other professionals/agencies (non-specialists and specialists; successful rate of these other professionals/agencies)
Smoking cessation training/education (details of provider, length of time and content; how useful was the training)
Smoking Cessation Guidelines (awareness of content)
Other relevant issues (participants' views)

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> It is difficult to say really, perhaps some of them [have health problems linked to smoking]. The elderly in this area tend to be quite healthy.
> (P20: HV)

Benefits of cessation

The participants were then asked to discuss their views of the benefits of stopping smoking in later life and to consider any circumstances in which they may not suggest a patient stop smoking. It was considered important to explore this issue as health professionals who are not convinced of the benefits of stopping smoking in later life are unlikely to encourage older smokers to stop. Approximately half of the participants reported that, in their view, there was always benefit in stopping smoking.

> I mean just because someone is 75 doesn't mean that I wouldn't discuss smoking. I believe there is a role for health promotion at that age.
> (P20: HV)

> I would always recommend that patients stop smoking, always hard and fast.
> (P38: GP)

Despite many of the health professionals stating that there is always benefit in stopping smoking, several reported that they considered there would be little benefit in stopping in certain circumstances. The most common circumstances described related to the diagnosis of a terminal illness and the diagnosis of lung cancer.

> I worked previously in a respiratory ward and a lot of the patients had end-stage respiratory disease and we thought, well there's no point in trying to get them to stop smoking now.
> (P03: DN)

> The only situation where I wouldn't push it would be when somebody already had lung cancer and it wasn't curable.
> (P29: GP)

A small number of the GPs stated that if a patient was in their 80s (ie, an older, older adult), they may not encourage them to stop smoking.

> If we are talking about the much older age group then the damage is already done and so stopping smoking at 85 we are not going to do an awful lot of good and we might just be making someone very miserable.
> (P23: GP)

Finally, a few of the participants stated that they generally weighed the potential physiological benefits of stopping smoking against what they perceived might be the psychological damage linked to stopping/attempting to stop smoking.

> For some of them the only joy they get is [smoking]. I entirely accept that it's making their health worse, but the bottom line is that it is about quality of life and that is what they want to do.
> (P35: GP)

> It can be too stressful for some people. The stress might be worse for their health.
> (P16: DN)

Table 3 Primary care team demographic data

	Frequency
Professional role	
Health Visitor/Support	6
District Nurse/support	12
Practice Nurse	7
General Practitioner	16
Sex	
Male	13
Female	28
Age (years)	
<25	1
25–34	2
35–44	14
45–54	21
55–64	3
Years in current role	
1–5	4
6–9	8
10–14	13
15+	16
Own smoking status	
Never smoked	27
Former smoker	12
Current smoker	2

Key factors that encourage older people to attempt to stop smoking

Participants were then asked to comment on factors that encourage older people to attempt to stop smoking. Issues such as health problems, the cost of cigarettes, family pressure, a change in society's attitudes towards smoking and the availability of

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nicotine replacement therapy (NRT) were discussed. However, it was interesting to note that approximately one third of the participants did not discuss the importance of their own role as health professionals. GPs appeared to be more certain of their potential influence that the nurse participants.

> Conversations that GPs have with patients can be influential.
>
> (P34: GP)

> I think sometimes if a doctor tells them they have to [stop] that will help them get motivated. Not always nurses, I think the doctor has more of an effect.
>
> (P12: PN)

Also of note is the fact that the view was expressed that hospital consultants are more influential that GPs.

> I think what often encourages them is if a consultant in the hospital says 'You have to stop or you're going out in a wooden box.' They don't listen to GPs as much. A hospital consultant is more like God, so to speak, they will listen to them more.
>
> (P04: PN)

Key factors that prevent older people from stopping smoking

The participants were then asked about factors that prevented older smokers from attempting to stop smoking or prevented a successful quit attempt. Insight into the barriers that prevent older people from stopping smoking is an important pre-requisite to the effective delivery of smoking-cessation interventions. Boredom and/or loneliness were mentioned by several of the participants.

> Some people are lonely. I know that it sounds ridiculous because they are still on their own, but it seems to help. It is something to do in an evening when they are sitting in on their own.
>
> (P19: PN)

Other factors related to the fact that the habit is difficult to break, that smoking is very addictive (only a quarter of the participants mentioned this) and the fact that older smokers had smoked for a long period.

> Older people have smoked for so long that it is particularly difficult. It is a habit, your body is used to it, physically you are addicted to it. It is very difficult for older people to give up.
>
> (P15: DN)

Several participants reported that older people often carried on smoking because they believed there would be little benefit in stopping, others reported that they continued because it would be too difficult to stop and a few stated that many older people do not believe that a cessation attempt will be successful.

> Some people are just very pessimistic about their chances, they don't think that they would manage to stop and so they don't want to try.
>
> (P26: GP)

The fact that many people enjoyed smoking was also perceived as a barrier.

> Some people don't get out very much and it is one of the few pleasures that they have.
>
> [P03: DN]

Finally, a number of the health professionals believed that it is very difficult for older people to stop smoking if many of their friends and family smoke.

> I think the social thing is important. If they have a drink or they go out they will share cigarettes. The smoking is the common link. You get that in families as well; you have 'smoking' families.
>
> (P37: HV)

Generally speaking the participants appeared to have a good understanding of the key barriers to smoking cessation in later life that have been identified by smokers themselves (Kerr *et al.*, 2004), although it is perhaps surprising that so few mentioned the addictive nature of smoking.

Provision of smoking cessation information and advice

Discussing smoking/smoking cessation

When asked whether they ever discussed smoking/smoking cessation with older smokers, all of the GPs reported that they did generally discuss the subject; however, from what they described, some appeared to tackle the issue more vigorously than others.

> Yes, I touch on it [smoking cessation with older people].
>
> (P30: GP)

> [Discussing smoking] has always been a very high priority.
>
> (P38: GP)

Some GPs had started to discuss the subject more frequently in anticipation of the introduction of the new General Medical Services (GMS) contract which makes the recording of patients' smoking status and any advice given a contractual obligation in the UK.

> I would say that we are discussing smoking with about 70% of our patients at the moment. The new contract is spurring that on.
>
> (P32: GP)

While the majority of the nurses said that they discussed the topic of cessation with older adults, some reported that they rarely, if ever discussed the topic. The nurses who rarely discussed the topic were district nurses or health visitors. This failure to discuss the topic of smoking cessation is a matter of concern and often appeared to be linked to concern about damaging relationships or a lack of confidence in raising the issue.

> Older smokers can be quite touchy. If I bring it up they can perceive it as criticism.
>
> (P7: DN)

> If I mention smoking I don't know where to take the conversation from there.
>
> (P37: HV)

Prescription of NRT and Bupropion (Zyban)

The GPs were asked if they prescribed NRT, as there is a strong evidence base to support the fact that people who attempt to stop smoking using NRT are twice as likely to be successful as those who do not (West *et al*., 2004). Interestingly while all of the GPs prescribed NRT, some expressed the view that some older adults were reluctant to use it.

> Older people are quite often not keen to take NRT.
>
> (P23: GP)

This reluctance in some older people to use NRT has been highlighted previously (Kerr *et al*., 2004). Of some concern is the fact that one GP stated that he believed that it was 'better' for patients not to use NRT.

> Probably the best and the quickest way to give up … is cold turkey. It is over and done within a relatively short space of time. If you put somebody on patches, that is three months you are keeping it going.
>
> (P34: GP)

The GPs were also asked if they prescribed Bupropion (Zyban). Again, the prescription of Bupropion, in situations where NRT may not be appropriate, is recommended in the NICE guidelines (NICE, 2002). Seven of the 16 GPs stated that they did not, while three prescribed it occasionally, but had never prescribed it for an older smoker.

> I do my best to avoid prescribing Zyban because of the problem with fits. I don't think that is a good road to go down … I think they are much better sticking with nicotine replacement.
>
> (P26: GP)

> I prescribe Zyban occasionally, but I have not prescribed it for older patients.
>
> (P27: GP)

Few of the nurses, other than practice nurses, stated that they referred older people to their GP for the prescription of NRT or Zyban, if they appeared to be contemplating a quit attempt.

Number of older smokers who manage to stop smoking

When asked whether many of their older patients had managed to stop smoking over the years, more than half of the participants expressed the view that very few older people manage to stop smoking successfully in later life. The belief that few older people manage to stop smoking successfully is likely to be a barrier to the provision of smoking cessation advice and support.

> I think the success rates in the elderly are much less than they are in the young.
>
> (P28: GP)

A very small number of the participants believed that the success rate for older smokers could in fact be quite good.

https://doi.org/10.1017/S1463423607000084 Published online by Cambridge University Press

> I have had upteen very good successes with older smokers and they have definitely reaped health benefits.
>
> (P38: GP)

Referral to other health professionals/agencies

The participants were asked to discuss whether they referred people who wished to stop smoking to other health professionals and/or agencies for support. Four of the GPs often referred patients to the practice nurse for additional support. In one practice the health visitor ran a smoking cessation clinic to which patients were referred. Also, some of the nurses discussed referring patients to the GP for the prescription of NRT.

> Our health visitor has been running a smoking cessation clinic … that has been a positive thing. It has given me the feeling that there is somewhere that I can send patients to who are wanting to stop.
>
> (P24: GP)

> I refer to the GP. The GP that I work with does prescribe a lot of NRT.
>
> (P04: HV)

In addition to referring patients internally within the practice, a number of participants stated that they referred patients to other NHS for 'intensive' smoking cessation support. Approximately half of the participants referred older smokers to local group support sessions (intensive support services are generally delivered in group sessions in the area where the study was conducted). While some participants stated that they referred quite regularly, others only did so occasionally.

Interestingly some of the GPs stated that they were less likely to refer older people to group support sessions than younger people. They appeared to believe that older people would not like to attend group sessions or that they preferred to access services provided in the practice. This conclusion appeared to have been reached, in some instances, without discussing the option of group support with the older person themselves. Two GPs reported that they did not refer older patients for group support.

> I think you are probably a group person or you are not, so I think there are probably quite a lot of my patients who I am judging as not being group people.
>
> (P33: GP)

> I haven't referred people to the groups … I think older people prefer to come to the surgery.
>
> (P41: GP)

The fact that older people were not offered the option of attending group sessions prevented them from accessing intensive NHS support. This is of particular concern as there is a strong evidence base to support the fact that smoking cessation support, provided by the specialists, is more likely to be effective than support delivered by non-specialists (NHS Health Scotland/ASHS, 2004; Ferguson *et al*., 2005).

In addition to referral for group support, a number of participants stated that they refer patients to pharmacies that are part of the local *Pharmacy Stop Smoking Project*. Patients who attend this service are provided with NRT and weekly one-to-one counseling for up to twelve weeks. GPs and practice nurses referred more people to this service than the district nurses and health visitors, and some referred more than others. A small number of the participants said that they were less likely to refer older people to the pharmacy service, or that older people preferred to receive support from the surgery.

> The older patients probably prefer to come to the practice. Only a few have gone to the pharmacies.
>
> (P36: PN)

Finally of concern is the fact that a small number of the nurses did not know what products or services were available to help people stop smoking.

> I don't know about any services that are available locally.
>
> (P10: HV)

The success rate of other professionals/agencies

The participants were asked whether they were aware of how successful other agencies, such as the specialist support services, were in helping older people to stop smoking. The majority of the GPs said that they received some information about group success rates at the end of the seven weekly sessions. They did not, however, receive age-specific

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information and several were more interested in success rates in the longer term.

> We get information on the quit rate at six weeks but we don't get information on the success rate at a year. I don't think that you can call someone a non-smoker at six weeks.
> (P32: GP)

Many of the nurses were unaware of how successful the group sessions were, as they received no feedback. Also, none of the participants were aware of the success rate of the local pharmacy project. Again, this type of information is essential for health professionals who aim to successfully trigger smoking cessation attempts.

Smoking cessation guidelines

Finally, the participants were asked whether they were aware of the content of the Smoking Cessation Guidelines for Scotland (HEBS/ASH Scotland, 2000). The level of awareness of the content was minimal, despite the fact that half of the participants stated that they had a copy of the guidelines.

> I haven't heard of them. I didn't realize that there are Guidelines.
> (P04: PN)

> I have probably flicked through them at some point, but I couldn't tell you what is in them.
> (P03: DN)

Interestingly, a number of comments were made about the number of Guidelines that health professionals receive.

> We have a library where lots of Guidelines are filed and gather dust.
> (P25: GP)

The key findings in relation to the knowledge, attitudes and practice of the participants are summarized in Table 4.

Discussion

This study sought to uncover the key factors that influenced the practice of members of the primary care team in relation to the delivery of brief smoking-cessation interventions. The findings are discussed below.

Too many barriers

A key point appeared to be that the health professionals believed that many barriers are likely to prevent an older person from managing to stop smoking successfully. The barriers discussed included the view that smoking is a deeply entrenched habit/addiction, that older smokers think that 'the damage is done' and so there is little point in stopping smoking, and, even if they do attempt to stop smoking, it is unlikely that they will manage to do so successfully. It is noteworthy that these issues are very similar to the barriers discussed by older smokers themselves (Kerr *et al*., 2004), although, as discussed previously, it is surprising that few of the professionals mentioned the addictive nature of smoking. The fact that most of the professionals believed there are many barriers to a successful cessation attempt was in some instances a barrier itself that is, it prevented the issue being raised effectively, or if it was raised, it limited the support that was provided.

Delivery of brief smoking-cessation interventions

All of the GPs reported that they did discuss the issue of smoking cessation. In some instances this seemed to have been encouraged by the introduction of the new GMS contract. The Quality and Outcomes Framework (QOF), which is fundamental to the GMS contract is a system that remunerates practices for achieving a number of targets (ISD, 2005). The QOF targets cover a variety of lifestyle issues and chronic diseases, with smoking and smoking-cessation intervention being key targets. Interestingly, a study undertaken prior to the introduction of the GMS contract found that GPs often did not raise the issue of cessation with clients who were known to be smokers (Coleman *et al*., 2000).

While all of the GPs stated that they provided some information and advice about stopping smoking, the quality and the quantity appeared to vary. This point was also highlighted by Coleman *et al*. (2004), who found that some GPs have a limited repertoire of techniques when working with smokers.

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Table 4 Key findings relating to knowledge, attitudes and practice

The effects of smoking in later life	• Most of the participants had a good awareness of the health effects of smoking in later life
The benefits of stopping smoking in later life	• Half of the participants believed that there is always benefit in stopping smoking in later life • Some believed that there may be little benefit in certain cases (generally linked to a terminal illness) • A few believed that the health benefits have to be weighed against the potential psychological harm that could be caused by attempting to stop smoking
Key factors that encourage older people to stop smoking/attempt to stop smoking	• Issues such as health problems, family pressure, a change in society's attitudes and the availability of NRT were discussed • Approximately one third of the participants did not discuss the importance of their own role as health professionals.
Key barriers to stopping smoking/attempting to stop	• The participants generally had a good understanding of the key barriers to a smoking cessation attempt • The key barriers discussed included: boredom; habit; the length of time that older people have smoked; the fact that older adults believe that there will be little health benefit; the fact that older adults believe that they will be unsuccessful • The addictive nature of tobacco was only highlighted by 1 in 4 of the participants
Provision of smoking cessation support	• The majority of the participants said that they provided older adults with information and advice about stopping smoking (the quantity + quality appeared to vary) • Health visitors and district nurses were less likely than practice nurses and GPs to discuss provide smoking-cessation interventions • Many of the participants believed that very few older adults manage to stop smoking successfully
Referral to other health professionals or agencies	• Some members of the primary care team were less likely to refer older adults for specialist smoking cessation support than younger smokers • There was little awareness of how effective specialist services can be
Smoking Cessation Guidelines	• There was little knowledge of the content of the Smoking Cessation Guidelines

When considering all of the participants, those who were convinced of the benefits of cessation and the fact that older smokers can successfully manage to stop smoking reported providing greater levels of support than those who were not convinced. The participants who appeared to be least likely to broach the subject of smoking cessation with older smokers were very clearly district nurses and health visitors. A partial explanation for this may be that health professionals who have contact with older people in their own homes find the topic of smoking cessation more difficult to broach, as they are a guest in the older person's home. Concern was also voiced by these nurses about the potential damage that raising the issue could do to their relationship with the patient. The issue of preserving a good relationship with patients was raised in a study by Coleman *et al.* (2000), which sought to discover why GPs raise the issue of smoking with some patients and not with others. Interestingly, none of the GPs in this study raised concerns about discussing the topic of smoking cessation and in fact many stated that they felt that patients expected them to raise the issue.

Lack of confidence/knowledge/referral

From what they described, a number of the professionals, mainly district nurses and health visitors seemed to lack confidence in their own counselling skills or they appeared to have a limited awareness of smoking cessation resources and specialist cessation services. This is of concern as it obviously

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limits their ability to provide effective smoking-cessation interventions.

Another concern is that some of the professionals who were aware of specialist services made the decision not to refer older people to these services because they did not believe that older people might wish to attend group support sessions. This is worrying as evidence from the recent National Evaluation of Smoking Cessation Services in England suggests that older people who attend specialist services are actually more likely than younger smokers to manage to stop smoking successfully (Ferguson *et al*., 2005).

A key role for members of the primary care team

As discussed in the Smoking Cessation Guidelines, one of main purposes of smoking cessation advice delivered by members of the primary care team should be to *motivate* an attempt to stop smoking (ie, to provide brief interventions) (NHS Health Scotland/ASH Scotland, 2004). Recent evidence suggests that *treatment* of nicotine addiction is best delivered by specialist services (NHS Health Scotland/ASH Scotland, 2004). Members of the primary care team should be aware that motivational strategies tailored for older smokers should take account of their beliefs about smoking. They should aim to diminish overly optimistic health beliefs that older smokers may hold, foster beliefs about the benefits of cessation and be aware of potential barriers to smoking cessation attempts (eg, low levels of self-efficacy). Members of the primary care team should also provide accurate information and advice about specialist smoking cessation services (including potential success rates) and encourage older smokers to attend. Patients/clients who do not wish to attend specialist services should be offered support from members of the primary care team.

Smoking cessation training

A small number of the participants had undertaken formal smoking cessation training. The participants who had undertaken this training appeared to be more confident in broaching the subject and in providing support, including referral to specialist services. Several others, in particular the GPs and practice nurses stated that they had attended training/educational events where smoking/smoking cessation had been discussed. Again this appeared to assist their levels of confidence.

The Smoking Cessation Guidelines recommend that all staff should receive smoking cessation training appropriate to their role, whether that be the provision of brief advice or specialist support (NHS Health Scotland/ASH Scotland, 2004).

Smoking status of health professionals

Another factor that should be acknowledged is that it is difficult for health professionals to function effectively in their role as health promoters if they smoke themselves (Rowe and MacLeod Clark, 1999; Bialous *et al*., 2004). While only two participants reported that they were current smokers (ie, 5%), there is evidence to suggest that 17% of community nurses and 3.5% of GPs in the UK are current smokers (BMA, 1999; McKenna *et al*., 2001).

Efforts should be made to encourage health professionals to stop smoking and, similar to the general public, they should be provided with appropriate levels of behavioural and pharmacological support. A number of campaigns have attempted to address this issue including the *No Butts* campaign, an initiative in the UK, which sought to give nurses the practical information and support that they need to give up (Department of Health, 2000) and the *Tobacco Free Nurses* Campaign launched in 2003 by the University of California in the USA (UCLA, 2006). This, and similar work needs to continue, as smoking levels in nurses remain high worldwide (Bialous *et al*., 2004).

The limitations of the study

A potential limitation of the study is that only one in five of those invited agreed to participate. While there is no way of knowing if the knowledge, attitudes and practice of the participants is similar to the non-participants', it would seem reasonable to speculate that the participants may have had a greater interest in smoking/smoking-cessation interventions than professionals who did not agree to participate. Also, few of the participants were current smokers.

Finally, in relation to practice, it should be noted that what is reported is the participants' perceived practice. There is no way of knowing if what was reported reflected their actual practice.

The strengths of the study

There is currently a dearth of research focusing on issues relating to smoking cessation in later life and therefore there is little evidence to inform practice. We therefore believe that this study makes a valuable contribution to the existing knowledge base.

In terms of the rigour of the study a number of strategies were used to enhance the credibility of the findings (Beck, 1993). These strategies included: audio-recording the interviews; returning the transcripts to the study participants; ratification of the data analysis process; inclusion of excerpts from the transcripts when presenting the findings. In relation to the transferability of the findings, when recruiting the participants, purposive sampling was used to ensure diversity in terms of professional group and geographical location. Finally, strategies that were used to enhance the auditability of the findings included: a description of the methods of recruitment, presentation of the topics discussed during the interview, the recording and transcription of the interviews, a description of the proced-ures used to analyse the data, the use of 'quotes' to substantiate the areas discussed in the findings.

Conclusion

Older smokers have been identified as a priority group in terms of smoking-cessation interventions. Members of the primary care team have a key role to play in encouraging older people to stop smoking; however, in order to do so effectively they must have appropriate levels of knowledge, they must have positive attitudes towards smoking cessation in later life and they must have the skills required to motivate a change in behaviour. Currently there appears to be a number of barriers that can negatively influence the delivery of effective brief smoking-cessation interventions (see Table 4). The findings from this study, and a parallel study that explored the health beliefs of older smokers, have been used to develop smoking cessation training designed to overcome these barriers. The efficacy of the tailored training, to the best of our knowledge the first of its kind in the UK, is currently being evaluated in a randomized controlled trial.

Acknowledgements

The Research Team acknowledges the support provided by our funding body, Partnership Action on Tobacco and Health (PATH), which is part of ASH Scotland and funded by the Scottish Executive. We would also like to thank our Research Advisory Group which included representatives of Age Concern, Help the Aged, NHS Health Scotland, ASH Scotland, PATH, Smoking Concerns, an older person and a lecturer in practice nursing. We appreciate the input of Dr Rosemary Whyte and Dr Tim Kelly who functioned as critical readers of the manuscript. And finally, and most importantly, we would like to acknowledge the contribution that the study participants made to the successful completion of the study.

References

Beck, C.T. 1993: Qualitative research: the evaluation of its credibility, fittingness and auditability. *Western Journal of Nursing Research* 15, 263–65.

Bialous, S.A., Sarna, L., Wewers, M.E., Froelicher, E.S. and **Danao, L.** 2004: Nurses' perspectives of smoking initiation, addiction and cessation. *Nursing Research* 53, 387–95.

BMA. 1999: *Tobacco Control Research Centre: unpublished survey data*. London: British Medical Association.

British Thoracic Society. 1997: COPD guidelines. *Thorax* 52 (Suppl), S1–28.

Cataldo, J.K. 2003: Smoking and aging, clinical implications. Part 1 Health and consequence. *Journal of Gerontological Nursing* 29, 15–20.

Clifford, C. 1997: *Qualitative research methodology in nursing and healthcare*. London: Churchill-Livingstone.

Coleman, T., Cheater, F. and **Murphy, E.** 2004: Qualitative study investigating the process of giving anti-smoking advice in general practice. *Patient Education and Counseling* 52, 159–63.

Coleman, T., Murphy, E. and **Cheater, F.** 2000: Factors influencing discussion of smoking between general practitioners and patients who smoke: a qualitative study. *British Journal of General Practice* 50, 207–10.

Department of Health. 1998: *Smoking kills: a white paper on tobacco*. London: The Stationery Office.

Department of Health. 2001: NHS Magazine. Retrieved from www.nhs.uk/nhsmagazine/archive/may/features/this16.htm

Ferguson, J., Bauld, L., Chesterman, J. and **Judge, K.** 2005: The English smoking treatment services: one year outcomes. *Addiction* 100 (Suppl), 59–69.

Government Actuary Department (GAD). 2002: Population projections by the Government Actuary. Retrieved from www.gad.gov.uk/population/prinres.html

Health Education Authority. 1999: *Older smokers: a practical resource for health professionals*. London: Health Education Authority.

HEBS/ASH Scotland. 2000: *Smoking cessation guidelines for Scotland*. Edinburgh: Health Education Board for Scotland.

ISD. 2005: Quality and outcomes framework – primary medical services, the new GMS contract and QOF. Retrieved from http://www.isdscotland.org/isd/

Kerr, S.M., Watson, H.E., Tolson, D., Lough, M. and **Brown, M.** 2004: Developing evidence-based smoking cessation training in partnership with older people and health professionals. Retrieved from http://www.ashscotland.org.uk

Lancaster, T. and **Stead, L.F.** 2000: Individual behavioural counselling for smoking cessation. *Cochrane Database of System Reviews*: 2 CD001292.

Maguire, C.P., Ryan, J., Kelly, A., O'Neill, D., Coakley, D. and **Walsh, B.** 2000: Do patient age and medical condition influence medical advice to stop smoking? *Age and Ageing* 29, 264–66.

McKenna, H., Slater, P., McCance, T., Bunting, B., Spiers, A. and **McElwee, G.** 2001: Qualified nurses' smoking prevalence: their reasons for smoking and desire to quit. *Journal of Advanced Nursing* 35, 769–75.

Molander, L., Hansson, A. and **Lunell, E.** 2001: Pharmokinetics of nicotine in healthy elderly people. *Clinical Pharmacology and Therapeutics* 69, 57–65.

Morse, J. and **Field, P.A.** 1998: *Nursing research: the application of qualitative approaches*. London: Chapman and Hall.

NHS Health Scotland/ASH Scotland. 2004: *Smoking cessation guidelines for Scotland: 2004 update*. Edinburgh: NHS Health Scotland.

NICE. 2002: *Guidelines on the use of nicotine replacement therapy (NRT) and bupropion for smoking cessation*. London: NICE.

Office for National Statistics (ONS). 2002: *Social trends*. London: The Stationery Office.

Orleans, C.T., Rimer, B.K., Cristinzio, S., Keintz, M.K. and **Fleisher, L.** 2001: A national survey of older smokers: treatment needs of a growing population. *Health Psychology* 10, 343–51.

Ossip-Klein, D.J., McIntosh, S., Utman, C., Burton, K., Spada, J. and **Guido, J.** 2000: Smokers ages 50+: who gets physician advice to quit? Preventive Medicine 31, 364–69.

Raw, M., McNeill, A. and **West, R.** 1998: Smoking cessation guidelines for health professionals. *Thorax* 53 (Suppl), S1–19.

Rice, V.H. and **Stead, L.F.** 2002: Nursing interventions for smoking cessation. *Cochrane Library Issue* 3, 1–26.

Rowe, K. and **Macleod Clark, J.** 1999: Evaluating the effectiveness of a smoking cessation intervention for nurses. *International Journal of Nursing Studies* 36, 301–11.

Silagy, C., Lancaster, T., Stead, L., Mant, D. and **Fowler, G.** 2002: Nicotine replacement therapy for smoking cessation. *Cochrane Library Issue* 3, 1–65.

Silagy, C. and **Stead, L.F.** 2002: Physician advice for smoking cessation. *Cochrane Database of Systematic Reviews* 2, CD000165.

UCLA. 2003: UCLA helping nurses quit smoking. Retrieved from www.scienceblog.com/community/older/2003/A/20036242.html

Watson, H., McIntosh, J., Tolson, D. and **Runciman, P.** 2004: *Protecting older people's health: the health promotion work of community nurses with older people in Scotland.* Glasgow: Glasgow Caledonian University.

West, R., McNeill, A. and **Raw, M.** 2000: Smoking cessation guidelines for health professionals: an update. *Thorax* 55, 987–99.

WHO. 2005: The role of health professionals in the action against tobacco. Retrieved from http://www.euro.who.int/tobaccofree/Projects/20050207