

# Role of Physicians and Human Behavior in Smoking Cessation

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**Abstract:** *Smoking is a process in which a drug is ingested and smoke is absorbed into the blood stream. Tobacco smoking is mostly used as a prescribing pathway for illicit drug consumption because burning of the dried plant leaves vaporizes and absorbs illegal drugs with accelerated ingestion through the bloodstream through the lungs and enters the body's tissue. The dried leaves of the tobacco plant, which are rolled onto a tiny square of rice paper, are one of the most widely used in smoking and make a thin, circular ring which are traditionally called "cigarettes." Cigarettes are mostly developed by manufacturers, but may also be laminated by the hand using loose tobacco & rolling paper. Other tools include cigars, pipes, bidis, hookahs, bongs & smoking vaporizers. The paper explains the impacts of smoking on the health of the human race and seeks to identify obstacles and drivers for cessation of smoking.*

**Keywords:** *Cigarettes, Drugs, Health, Smoking and Tobacco*

## 1. INTRODUCTION:

### 1. Smoking Cessation:

The process of discontinuing tobacco smoking is referred to as the smoking cessation. Tobacco nicotine is addictive, making it very long & difficult to stop. 70% of smokers wish to stop smoking and 50% report trying to stop smoking last year [1].

### 2. Tobacco and Health:

Cigarettes are made up of more than four thousand ingredients, including Nicotine, Tar, CO, propylene glycol, methoprene, butane, acetone, cadmium, arsenic, gasoline, benzene, formaldehyde, etc. The health consequences of consuming tobacco go far beyond that. A 50% risk of tobacco-related diseases die for beginners in adolescence. Acute concern for wellbeing involves dyspnoea, tachycardia, elevated blood pressure, aggravation of asthma, impotence, miscarriage and raised blood CO concentrations. Long-term health risk may be: coronary artery disease, cerebrospinal cord disease, larynx, oral cavity, stroke, lung cancer, pharynx, oesophagus (OPD). Earlier studies examined the effect of smoking on atopy and allergens sensitisation and discovered that smokers had substantially higher levels of IgE serum than reformed smokers & non-smokers. Smoking appears to cause individuals to have atopic concentration and to become mindful of allergens [2].

In comparison with bidi smokers, rhinitis has also been more common in cigarette smokers. Those who smoke do not just harm themselves, but also through secondhand smoke around them which is also called passive smoking. This is common among children, such as sudden child deaths, respiratory diseases, disease of the middle ear, gum and tooth diseases and an asthma exacerbation. Adults are considered to have lung cancer and heart failure. Kumar et al measured the levels of non-smoking breath carbon monoxide (CO) exposed to the environmental smoke of tobacco (ETS). Their level was therefore higher than that of other

staff at hotels / restaurants / bars. The average level of breath CO in ETS exposed individuals who worked in bars, dining and hotels for more than nine hours a day and in subjects with respiratory diseased conditions in comparison to the ordinary individuals was significantly higher. Bidi smoking is more widespread in India. In an assessment of breath CO levels of cigarettes and bidi smokers, it was shown that, while the mean bidi (216.8 mg) of tobacco weight was significantly below cigarettes (696 mg), The bidi ( $18.9 \pm 7.7$  ppm) average breath CO content was significantly higher than cigarette smoking ( $13.6 \pm 5.8$  ppm) when total cigarette / bidi consumption exceeded five years of packaging ( $p=0.002$ ). For the calculation of 'packs years' of smoking, one bidi can be considered a cigarette. The study also found that bidi is just as harmful as or harder than smoking cigarettes [3].

### **3. Smoking and Tuberculosis:**

The two main public health problems in developed countries are tobacco and tuberculosis (TB). The shift to a developing world in the smoking paradigm coincides with an increase in TB in these areas. In India, approximately 17% of smoking people live. Middle-aged cigars are responsible for at least one third of the cigarettes, and according to studies, lung tube is more common in this ageing community. Males are 2-4 times more prone than as females affected. Unfortunately, despite being a major health threat, smoking has received social acceptance. Smoking has been linked to socio-economic conditions such as deprivation, overcrowding, inadequate ventilation and non-natural light spaces, insufficient diet and substance consumption and often are considered to be the trigger factors for TB. Most significantly, the role of the exposure to passive smoking, second hand smoke and ETS as a contributor to active TB has not only been confirmed by smokers but also by studies [4].

### **4. Smoking and Indoor Air Pollution:**

Cigarette is a significant source of indoor pollution and one third of children in their households are subjected to tobacco smoke. In smoker homes there are significantly higher suspended particulate (SSD), sulfur ( $SO_2$ ) and nitrogen ( $NO_2$ ). Symptoms of asthma, rhinitis, and infection of the upper respiratory tract are more common. In order to curb the growing threat of tobacco, urgently necessary measures have been taken to reduce the mortality and morbidity burden caused by the use of tobacco [5].

### **5. A two-pronged approach can be effectively followed:**

- Large scale promotion to inform people of the harmful effects of the use of tobacco and
- Benefits of quitting and adequate assistance for those who really want to quit.

To date, most research surveys have covered doctors or patients, but just a few trials (a significant example is the "World Survey — the Largest International Survey of Physician and Smokers' Attitudes" 26 April 2007, the Philippine Star). The study to examine the perspectives of doctors and patients together was therefore perceived as necessary. For this research, interviews were performed with physicians and patients smokers [6].

The physician in a single medical clinic may not have consulted patient-smokers who were current or ex-smokers in this study for treatment. Survey was conducted on family doctors (GP's in private clinics & polyclinics) and on patients in current or ex-smoking primary care clinics. In specific, the goal was to establish how critical background concerns such as who introduced leaving topics and whether counseling and follow-up conversations took place. Not only factors that physicians perceived as barriers to smoking cessation were identified, but also those perceived by smokers [7].

## **2. RESEARCH QUESTION**

Identifying the motivators & barriers to cessation of smoking and evaluating the dynamics of the visit by the patient.

## **3. REVIEW OF LITERATURE**

In a paper entitled "Smoking insights and smoking among current smoking in India," the following topics are discussed at Almas Binnal, GuruRaghavendran Rajesh, JunaidAhmed, Ceena Denny, and Sangeetha U Nayak. Multiple socio-demographic influences linked to and stopping smoking were established and the research stressed the significance of recognizing and addressing these experiences in a developing world like India, as well as establishing recommendations and intervention for a successful cessation of tobacco usage [8].

The studies were carried out by Elin Roddy, Marilyn Antoniak, John Britton, Andrew Molyneux and Sarah Lewis with 39 smokers aged 21-75 from the most socio-economically deprived parts in Nottingham, Great Britain who had attempted unsuccessfully to avoid the smoking prevention program without utilizing it last year, to determine common obstacles or inspiration for using the facilities. The research document called "Barriers and motivators to gaining access to smoking cessation services amongst deprived smokers - a qualitative study" found that smokers from such disadvantaged areas had a general lack of knowledge and ignorance of the resources available to them. Free pharmacotherapy and versatile resources could allow more poor smokers to quit smoking, with a more tailored strategy for supporting nonjudgmental services [9].

The issues that were addressed include the creation of the primary care barriers model, Kooi-Yau Chean, Lé Gan Goh, Kah-Weng Liew, Chia-Chia Tan, Xin-Ling Choi and Siew-Ting Ooi. The paper 'Barriers to cessation of smoking: a qualitative study from a primary care perspective in Malaysia' concludes that five themes of specific beliefs and practices prevented smokers from leaving. Clinicians must focus on the obstacles to effectively smoking cessations, and can be driven by the prescribed time frames [10]

## **4. METHODOLOGY**

### **1. Design:**

A range of doctors and patient smokers were chosen to complete a detailed questionnaire about their commitment to smoking cessation. Doctors were even questioned about their interest in their patients' smoking prevention attempts. In order to fulfill the aim, the results were analyzed.

### **2. Instrument:**

In order to execute the experiment set of questionnaire and personal interviews were taken for both the doctors as well as patients with smoking habits.

### **3. Subjects and Data Collection:**

A cross-sectional study of medics (specialists and primary care practitioners) and patients who visited primary care services as well as existing or ex-smokers was conducted between August and October 2019. A convenience sample of GP clinics and polyclinics from eastern Singapore was used to obtain family doctors. Following their queue and waiting for the doctor, patients in polyclinics and GP clinics were approached. The question was demonstrated to sensitive smokers by qualified interviews. When the consent papers were submitted, the questionnaire was immediately handled. Both surveys were in English only.

#### 4. Sample:

##### Survey with physicians:

A survey was carried out of 3 major teaching hospitals to include respiratory doctors, endocrinologists, cardiologists and internal medicines. The questionnaires were then auto administered to specialists (respiratory physicians, endocrinologists and cardiologists) following their departmental meetings after their respective managers had obtained their permission. A combination of family doctors & polyclinicians from the private sector (primary community treatment centres) is studied. Continuous Medical Education (CME) talks would be witnessed by family physicians from private and polyclinic hospitals.

Those family doctors provided questionnaires a quarter and half hour before the CME chat. Family doctors were also contacted by telephone to obtain a better response and questionnaires were automatically managed by trained interviewers to receive a better answer.

##### *Survey with Current and Ex-smokers:*

Throughout the alpha-polyclinics, patients above 20 years of age were examined. Forms of screening were been used to recruit patients older than 20 years and current or ex-traditional smokers. The study involved patients who declared themselves to be smokers or ex-smokers .. The questionnaire was given to all Polyclinics and private clinics. The patient user was standing behind the interviewers if they had any problems addressing the queries. The details were been placed in an Excel table and evaluated with version 15.0 of SPSS. Tables 1 and 2 reflect figures for doctors and patient smokers.

Table 1: Demographic characteristics of patient smokers

Characteristics	N = 350 (68% current, 32% ex-smokers)
Gender	
Male	94
Female	6
Race	
Delhi	50
Mumbai	41
Bengaluru	9
Close relatives who smoke	
Parents	75
Spouse/partner	10
Sinblings/children	15
No. of friends smoke	
More than 10 friends smoked	58
Self-related co-morbidities	
High BP	16
Cholesterol	10
Diabetes	8
Asthma & Obesity	5
Other	28
None	33
Averages	
No. of cigarettes smoked/day	16 (Standard deviation 11)
Age (Years)	
Male	38
Female	33

Table 2: Demographic characteristics of physicians

Demographic	Percent %
Gender	
Male	70
Female	30
Age (Years)	
<45	86
>45	14

Patient smokers at alpha Polyclinics as well as in private clinics received the questionnaire themselves. In order to answer the questions, the Interviewer was standing by the patient smoker. The data were entered and analyzed via SPSS version 15.0 in an Excel spreadsheet. Table 1 and Table 2 show demographics of doctors and patient smokers.

### 5. RESULTS

180 provider doctors (response rate was 60%) comprised 23 (15%) respiratory physicians, 35 (19%), 24 (11%), endocrinologists and 98 (56%) family physicians, were surveyed. 350 smokers (60% response rate) were examined in a survey. 94% were males of 38 years of average age. 86% of hospital smoking come from polyclinics and 14% from private clinics. In general, female patients were younger than male.

The research included patients from (50% Delhi vs. 41% Mumbai, 9% Bengaluru and others). Male smoked average of 16 sticks (standard 11 sticks) whereas females smoked five sticks (standard 2.5 sticks) perday (Fig 1).

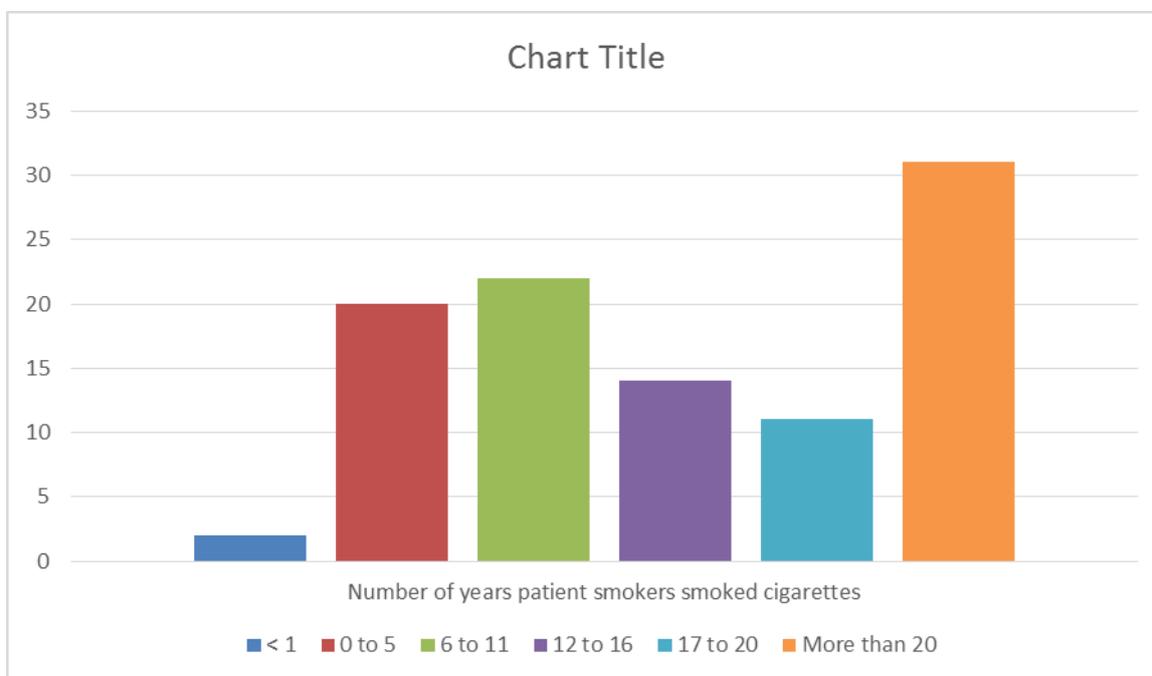


Figure 1: Number of years patient smokers smoked cigarettes

75% of the parents of the respondents cigarettes and 58% of those who drink had more than 10 friends. One third of the patient smokers confirmed good health. For the remaining two-

thirds, respiratory issues, high blood pressure, diabetes mellitus and/or hypercholesterolemia (Table 1a) were recorded. Among doctors, 70% were male doctors and 86% were up to the age of 45 years. (Table 1b). Table 1b. 78.7% of patients who drank for 6 years or longer were included in the study.

This number includes 32.6% of patient-smokers who smoked 20 years or more (Fig. 1). Of the 86% who tried to quit smoking more than half of the patient-smokers (55%) failed to quit the first time and tried to quit more than 2 times. The remaining 16% had reported never attempting to quit (Fig. 2).

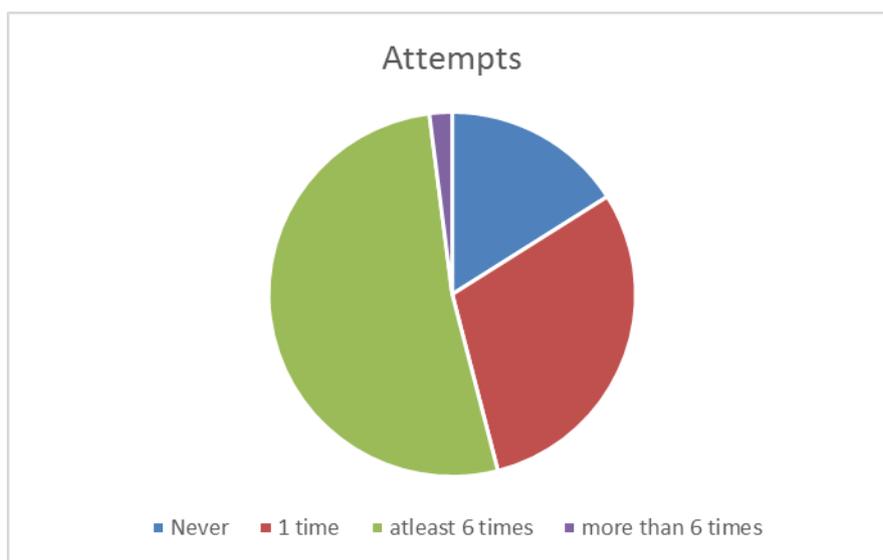


Figure 2: Quit Attempts

Patient users were questioned if they addressed smoking reduction with their doctor and just 15% confirmed they did. When the physicians were asked the same question, 53% of them said they had talked to their patient smokers about smoking cessations (Table 3).

Table 3: Physicians and smoker's reported motivation to quit smoking (%)

List of motivating factors	Physicians	Patient - smokers
Health problem concern	32.3	32
Concern about health for family and friends	26	20
Quit because of doctor's advice	20	6
Cost of smoking	11	26
Improve appearance	4.8	5
Rules and regulations from work/environment	3.9	7
Others	2	4

### Data Analysis:

#### 1.1. Motivators to Quit:

Doctors, patient smokers and others agree that personal health concerns (32 percent) are the main driving forces behind the quitting of smoking. However, the motivator second and third

were incongruously identified. The second and third main reasons behind smokers were costs (26%), family and health problems of friends (20%), while the physicians were concerned with the health problem of family and friend (26%), and the second and third were with medical advice (20%) (Table 2).

### **1. Barriers to Quit:**

The provider's doctors and smoker patients have agreed that the 2 main barriers to quitting smoking are craving / physical dependence and lacking in willing power. Both agreed that withdrawal symptoms constituted the third barrier. Smokers also mentioned two additional barriers: high smoking cessation products costs and limited family and friends support [11].

### **2. Who Initiated the Discussion on Smoking Cessation?**

The reports by the initiator for discussions of cessation of smoking diverged significantly: 76% of providers said they initiated the discussion and 62% said they initiated a discussion of cessation of smoking [12].

### **3. Why Do Smokers Not Talk to their Physicians about Smoking Cessation?**

66% of patient smokers offered key reasons for confidence in the decision to stop without medical advice (Fig . 3, Overleaf). 29% of patient smokers indicated that they had little time to visit the doctor, although 19% felt that cessation of smoking was not as necessary as other diseases. Around 18% still felt it wouldn't improve going to the hospital. Other reasons were not discussed by the doctor (10%), embarrassed about visiting the doctor (9%), not wanted a lecture from doctor 8% & 7.5% said that they prefer going to the healthcare practitioner [13].

### **4. Discussion:**

Tests reveal that the same motivators & inhibitors to avoid smoking were accepted between the provider doctor and patient-smoker. It is encouraging to remember that both the respected 'health' as the main reason for the prevention of smoking indicate that physicians will use a patient-centered method to concentrate primarily on specific problems with treatment. Nevertheless, the discussion was prompted by a disconnection between doctors and patient smokers [14].

### **5. Other studies carried out with physicians and smoker:**

A research of 3167 gps in Sweden found that even when patients have smoking-relevant problems and only a handful were interested in promoting smoking abstinence did the vast plurality of Gps considered the examination of patient smoking behaviors as an important part of their work. Fiore et al. in another survey showed that most smokers intend to stop (> 70%), but their psychiatrist has never asked more than one third of their cigarette behaviors. Help was given to less than 15% of smokers and about 3% to combat tobacco use. A qualitative study was conducted in Minnesota, United States, on physician-smoker interactions related to receiving smoking cessation prescriptions. The results showed that 90% smokers adhered to the medicines and that the rate of quitting was 55%. A smoking presence is required to become part of the position of medical professionals, and family doctors can better discuss smoking behaviors any time a smoker goes to his clinics and try to encourage smokers to quit and report at least once a year. In our research, however, only half of the doctors spoke to their smoker patients regarding smoking cessation.

Was that physicians aren't allowing the patients adequate time? Doctors are not trained? And does it not include patients? Further research is required to find the answers. It must be understood why 45% of the remaining provider doctors did not discuss smoking cessation with their patient smokers despite being medical specialists and family doctors. Are the

physicians themselves smokers? The cessation operations mentioned by Pipe et al. are less common for smokers than doctors [15].

## **6. STOP Smoking:**

The view of Harris Interactive's biggest study, the surgeon who smoke is less likely to start cessation operations [16].

## **7. A Global Survey:**

A significant contact disparity between doctors and patients smokers was identified during the biggest multinational studies of doctors and smokers' perceptions towards cessation of smoking carried out by Pfizer. The results indicate that there were substantial variation in the amount of doctors (41 percent) who say that they talk to their patients about smoking at every visit, between smoking cessation practices of doctors and the smoking experience of smokers (9 percent) who talk about smokers at each visit to the patient [17].

## **8. Reasons for smokers' reluctance to talk to physician about quitting smoking (%):**

When asked why they didn't talk to their doctor, they reported less trust with the doctor. They also thought it was not necessary to waste time with the doctor, and the information on prevention of smoking is not as necessary as certain diseases. While several doctors sought to help patients avoid smoking by therapy, sending them to quitting centers for nicotine, they also noticed that most smokers wanted to use their own methods. The research undertaken in the UK is compatible with this finding. A research analysis involving 42 physicians from the United Kingdom found that many smoking patients were suspicious of the ability of doctors' words to control smoking. The argument of doctors was that the majority of patients recognized the danger of smoking and could make their own assessments, and therefore felt that they had to quit. Our outcome was the Pfizer Global Surveys which revealed that patients don't always believe they get the support and guidance from their physician that is necessary to quit smoking successfully. STOP physicians thought that cigarettes are the most liable for leaving themselves. It may be that they ignore appropriate treatment solutions for intervention, such as elevated blood pressure or high cholesterol. Smoking is more a behavioral problem than an illness, and so innovative approaches are needed if physicians are to be motivated, supported and awarded advice on smoking. This will be best to take a more comprehensive method, analyzing incidents in patients smokers' lives over time. Further experiments conducted with GPs suggested that lack of time was the most important deterrent to the implementation of smoking cessation [18].

A survey in Germany of 657 GPs found that inadequate smoking promotion performance was closely related to perceived lack of preparation, lack of presentation content identified and a perceived lack of time. Our study shows that doctors spent less time talking to patients about the cessation of smoking. In this research of physicians, when physicians were told, "How long do you on average spend of smokers complaining about smoking?" The total time spent by sixty percent of doctors with smoking-related innovations was 2 minutes. Doctors were not asked whether they had proper training to help patient smokers. Another question is that the doctors overlook the amount of patients trying to give up and believe they have inadequate approaches to the issue. We can give the smoker the burden of leaving himself with these perceptions. Another explanation may be that smokers may feel reluctant to speak to physicians because of their socio-economic condition, linguistic difficulties and the stigma connected with them. A 2000 National Health Interview Study showed the impact of racial / ethnic disorders on the efficacy of a doctor who gave advice on the cessation of smoking. This makes the case of Singapore more pertinent due to its multi-racial population. An effect of this multiracial population might result in smoker-patients feeling shy and missing out on

the opportunities compounded by ethnic/racial disparities. In this study smoker-patients also mentioned one of the barriers to smoking cessation as lack of support from family and friends. While counselling, provider physician should involve family members or friends who would later help smoker-patients to reduce smoking. We have discussed what holds back smokers to stop smoking as well as physician's approach towards helping smoker-patients. The above reasons would certainly have a few solutions, but it is completely essential to implement and evaluate them. It is particularly promising to implement enhanced training opportunities for doctors. However, since its efficacy may only be suggested but not demonstrated in a cross-sectional survey such as the one submitted, further research should accompany implementation of such training opportunities to evaluate how much doctors use them and to what extent these measures or improved referrals actually lead to a greater effort of physicians to promote smoking cessation. Therefore, a comparative review of alternative medication and approaches for smoking cessation is relevant in terms of both expense and effect. While in tested conditions every medication has been shown to be cost-effective, when agreeing on "right" smoking interventions, the framework of convictions of physicians and patients must be taken into consideration. In case of treatment that is able to reduce disease at a lower cost and through the development of programs with a monitoring or maintenance component that combine several interventions, the cost efficiency of smoking cessation can be enhanced [19].

## 6. CONCLUSION

The providers and smoker-patients agreed that health concerns were the primary motivator for quitting smoking. Some disconnections seem to occur when doctors and patients foresee various reasons why it is difficult to quit. Patients tend not to consider care professionals as a tool for awareness and to be effective in minimizing smoke. The physicians ought to establish a friendship with the patients in order to improve the physicians' views. Nevertheless, as physicians and smokers have expressed the same views regarding smoking prevention motivators and inhibitors, their partnership should be made use of. Doctors will view their patients empathically (and not as a person as a companion or as a teacher). Throughout fact, patients will always be open to discussion and improvement.

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