"It's a question of priorities, and smoking is not one of my priorities."

Staff and Patients' Views of Factors Which Affect the Introduction of a Smoking Cessation Service in a Hospital

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Abstract

Aims and Introduction

This thesis aimed to investigate individual and structural factors affecting the introduction of a new smoking cessation service into an acute hospital in the West of Scotland. The research was carried out within the context of the growth of health promotion in hospitals and the increase in the provision of smoking cessation services in the UK and elsewhere. Smoking cessation services have been shown to be effective, however there has been little discussion of whether these are appropriate in acute hospitals. Furthermore there has been little research which has attempted to identify the factors which affect the implementation of these services or examined the attitudes of patients and staff towards them. Such research would help to assess whether these services were appropriate, and if so help to introduce them more effectively. Any findings would also have lessons for the introduction of other preventive health services.

Methods

Quantitative and qualitative methods were used. Patients took part in a survey which was carried out before the service was set up and staff were interviewed in depth as the service was being set up. Inpatients and outpatients attending the hospital for treatment in the medical department were surveyed either immediately after their outpatient appointment or during their inpatient stay. The survey aimed to determine what smoking advice was given before the service was introduced and whether patients felt such advice and the provision of a dedicated service were appropriate in this context.

The patient survey was originally intended to be repeated after the smoking cessation service had been in place for twelve months in order to estimate the effect of the service on the smoking cessation advice which patients were offered. However due to an eleven-month delay in the employment of the smoking coordinator this was not possible and the aims of the thesis were changed.

In addition twenty key people, including both clinical and management staff, were interviewed in depth. Interviewees were chosen because of their role in the hospital or because they had some impact on the development of the smoking cessation service. These interviews aimed to identify their perceptions of individual and structural barriers which would affect the implementation of the smoking cessation service in the hospital. Interviews were analysed thematically.

Results

The survey results showed that a third of the patients were current smokers. Sixty-six percent of inpatients and 40% of outpatients reported that they were asked if they smoked during their visit to the hospital, and smokers were significantly more likely to report this than non-smokers. Of those who smoked, 44% reported that they had been advised to stop smoking. However few had been offered any help to do so. The majority were unaware of any services to help smokers to stop smoking though they believed that such a service would be appropriate. Half of the smokers wanted help to stop smoking.

The findings from the in depth interviews showed that most interviewees with a clinical role believed that they routinely asked patients if they smoked and advised them to stop but only if they felt that this advice was appropriate. This depended largely on their perception of patients' motivation and whether smoking was related to their presenting illness. Clinicians who smoked were more reluctant to routinely ask patients about smoking than non-smokers. Interviewees did not accept without question that all patients should be advised to stop smoking and felt that this should be targeted at the appropriate groups. Interviewees discussed their health-promoting role and, while they believed that they were responsible for health promotion, largely preferred to give advice which was related to the work which they did and the patients presenting illness. Interviewees were concerned that the patients should be given advice at an appropriate time when they were able to listen to this and were willing to change, and concern was expressed that patients would not sustain any health change once they returned to their home environment.

One of the main themes to emerge from these interviews was that staff felt under enormous time pressures. Clinical staff, in particular, felt under pressure because of their knowledge of waiting lists and the number of patients whom they had to see. This made it difficult to engage with patients and thus give them advice. Management staff too were concerned with waiting lists and discussed at length strategies to decrease them. The smoking cessation coordinator often found it difficult to arrange to see staff because they did not have enough time to see her.

A change in government policy at the time the study was being carried out resulted in an increase in the number of smoking cessation services in general practice and decreased the need for such services in hospital.

Conclusion

In conclusion it was clear that patients felt that smoking advice was appropriate and acceptable in the hospital. Many patients wanted to stop smoking and most of these wanted help to do so. Staff were generally positive towards the provision of the smoking service and accepted that they had a health-promoting role. However barriers, in particular at a structural level, were likely to prevent the service from meeting its objectives. Specifically, it is unlikely that the culture of this hospital will be changed so that smoking cessation services are routinely offered.

Chapter One: Setting the Scene

This chapter introduces and provides a background to the thesis, which is concerned with the introduction of a new smoking cessation service into an acute hospital. It first summarises the aims and rationale for the study and gives a brief description of the methods used to meet these aims. Next it describes how the thesis is structured. It then outlines the growth of health promotion in hospitals in recent years and discusses some of the criticisms of the hospital as a setting for health promotion. It discusses the increase in smoking cessation services in the UK, the guidelines for the provision of smoking cessation advice by clinicians, and the increased expectation that patients should routinely be given encouragement to stop smoking. A brief overview of the factors that might impede the implementation of such services is then given. Finally this chapter describes the hospital where the study took place and how a new smoking cessation service was set up.

1.1 Introduction to the Implementation of Smoking Cessation Services

This study will examine the barriers that affected the implementation of a smoking cessation service into a hospital in the West of Scotland. In recent years there has been a growth in the number of health promotion and preventive health services in hospitals and an increased expectation that clinical staff should take on a health-promoting role. During this time smoking cessation services have been set up in hospitals and in primary care settings to encourage and support patients to stop smoking.

These smoking cessation services generally include both opportunistic advice from clinical staff and a dedicated service run by a member of staff, usually a nurse. However while such advice and services have been shown to be effective in helping smokers to stop, they are not routinely available (Raw et al., 1999). It seems that continuing to stress how effective these services are will not necessarily encourage clinicians to give smokers advice and encouragement to stop or to refer them to smoking cessation services. It is becoming increasingly obvious therefore that it is important to gain an insight into the factors which will facilitate or act as barriers to, and which affect the introduction and use of dedicated smoking cessation services. In this way their implementation can be made smoother and their effectiveness potentially increased.

If barriers are identified which are difficult or impossible to overcome then it is reasonable to debate whether the hospital really is the most appropriate and effective

setting for smoking cessation services and indeed, whether the goals of health promotion can be met in this environment.

At present there is very little research that investigates this question and, in particular, hardly any research that asks staff and patients what they think about the provision of smoking cessation services in a hospital and what they believe will affect the success of these services. It is probable, however, that staff and patients' attitudes towards the service will affect its successful introduction. If staff do not feel that such a service is appropriate or useful then they are unlikely to give smoking cessation advice or refer patients to a service. If patients feel that smoking advice is unsuitable in an acute hospital then this may affect their relationship with clinicians and prevent them from attending appointments in future. In addition they are unlikely to follow-up any referral to a dedicated service.

Most of the research which is available has been carried out in the USA. Because of the differences in the structure of health care systems in different countries, lessons from research carried out in one health service setting may not be transferable to another. For example, in the US patients pay for services more directly, generally through medical insurance, and this is likely to have implications for the preventive health advice that they are given. Therefore, in order to determine those factors that are likely to effect change in UK hospitals, UK research is required.

In addition the available research has generally concentrated on the views of patients alone or on a single professional group; for example, many studies include only doctors or only nurses. The implementation of a health promotion service such as smoking cessation requires both individual and structural change and the involvement of patients, as well as staff who work in different disciplines. Therefore research which is carried out only in one profession is unlikely to provide a comprehensive analysis. Furthermore, little consideration has been given to the views of non-clinical staff working in hospitals. While they might not have patient contact they may have a great deal of influence on the provision of such services and provide an insight into barriers in the system or structure of the hospital which could not be gained elsewhere. Finally, the available research has largely relied on quantitative methods. This means that the themes investigated are defined in advance, giving little opportunity for new issues to arise or for complex views to be expressed.

The present study sets out to address some of these gaps. It uses the setting-up of a new smoking cessation service in Reidpark[1] Hospital, in the West of Scotland, as a case study to explore the individual and structural barriers which are likely to affect its introduction and use. It examines these factors from the perspectives of both clinical and non-clinical staff, of the service leader, of the smoking cessation coordinator and of patients. In order to do this both quantitative and qualitative methodologies were employed.

[1] The names of the hospital and health board have been changed for reasons of confidentiality

The goals of this service were that i) clinical staff would ask all patients their smoking status and increase the amount of advice and support which they gave to smokers; and ii) a dedicated service would be set up which patients could access themselves or which clinicians could refer to. In the quantitative part of the study 412 patients attending the hospital as inpatients or outpatients were surveyed. The patient survey was carried out before the smoking cessation service began. It aimed to determine whether patients had a favourable attitude towards the provision of a new smoking cessation service in the hospital; what advice patients were presently receiving about smoking; and what patients' attitudes were towards smoking advice in hospitals.

In the qualitative part of the study twenty staff from a range of clinical and management backgrounds were interviewed in depth. These staff interviews took place as the service was being set up. The interviews aimed to give an insight into staff perspectives on the smoking cessation service and their views of their own role in smoking cessation. In particular it explored their view of their role in health promotion, their attitudes towards a smoking cessation service and whether or not they believed that patients would be willing to receive such advice. The methods used will be described in greater detail in Chapter Two.

1.2 The Structure of the Thesis

This chapter provides the background to the thesis and outlines its main aims and objectives. It also summarises the key points from the relevant literature. This is not intended to be a comprehensive review as the literature will be discussed in greater detail

in later chapters. Rather, it will serve to introduce the available research, summarise the main barriers identified, and highlight areas where further research is required. This chapter ends by describing the introduction and aims of the new smoking cessation service in Reidpark Hospital.

Chapter Two describes the qualitative and quantitative research methods used in this study and explains why these methods were chosen. It also outlines the ethical process that the study went through and considers ethical issues arising from the study. The aims of the research changed after the study began and Chapter Two will describe this and the reasons for, and implications of, these changes.

Chapters Three, Four, Five, Six and Seven are based on the findings of the research. They are each structured in a similar way. First the literature relating to each of the chapters is reviewed, then the findings are presented, and finally these findings are discussed in the context of the literature. These chapters will now be described in greater detail.

Chapter Three briefly describes the background to the implementation of smoking cessation services and the increase in these services in the hospital. Relevant findings from the analysis of the in-depth staff interviews are presented. These relate to staff opinions on their provision of such services and whether they believe it is their responsibility to encourage patients to stop smoking and to refer patients to a smoking

cessation service. Finally the findings from Reidpark Hospital are discussed with reference to these wider policy issues.

Chapter Four outlines the literature on patients' perceptions of health promotion and preventive services, particularly in relation to smoking. It then presents the quantitative results from the patient survey. While Chapter Three investigates staff's perceptions of the smoking advice which they gave, Chapter Four explores this issue from the perspective of patients. It reports on the proportion of patients smoking, how many had been asked about their smoking status and had been given advice to stop smoking, and whether or not patients felt that a smoking cessation service was appropriate in the hospital and would be used, were it to be made available.

Chapter Five reviews the literature relating to individual barriers to the implementation of the service. It then discusses the views of the hospital staff on this issue, in particular the main individual barriers that they identified. It also explores interviewees' attitudes towards their health-promoting role and whether they felt that such a role was appropriate, acceptable and possible within the confines of their job. This chapter also considers clinicians' relationships with patients and how they decide when to give patients lifestyle advice, particularly relating to smoking cessation. Finally it discusses whether interviewees believed that patients were motivated to change and what factors they considered would affect whether or not any such behaviour change would be maintained.

Chapter Six discusses structural barriers which are likely to affect the implementation of the smoking cessation service. It outlines commentaries and research papers which have previously considered this issue. It then explores the main structural barriers arising from the analyses of the staff interviews and considers in particular, shortage of time and how this is influenced by patient numbers. It also considers those jobs which staff would like to delegate and how this is likely to affect the introduction of the service, and looks at the impact of staff attitudes on the work of the smoking cessation coordinator.

Chapter Seven is a shorter chapter. Waiting lists and high patient numbers emerged as a strong theme in the interviews and this chapter examines these issues further. It begins by describing issues around waiting lists and targets in the UK. It then presents findings from clinical and management interviews on waiting lists and shows how their perspectives on this issue differ. It concludes by considering how waiting list targets impact on the implementation of health promotion initiatives.

Chapter Eight offers a "post-script" to the study. It reports on the development of the service after the research was completed. It outlines how the smoking cessation service developed and how the role of the coordinator changed. It also comments on the changes in the health service policy climate relating to the growth of smoking cessation services in primary care.

Chapter Nine provides an overall discussion for the thesis and shows how the original aims and objectives of the thesis have been addressed. Based on the findings,

recommendations are made for researchers, practitioners and policy makes. In addition it identifies lessons which can inform the implementation of other health promotion or preventive health service in future. It concludes by considering whether a dedicated smoking cessation service is appropriate in an acute hospital and whether clinical staff can be encouraged to give advice and help to smokers.

1.3. The Aims of the Thesis

The aims of the thesis changed after the service was set up. The original aims and reasons for the changes made are described in Chapter Two. The present section sets out the revised aims. This thesis aimed to identify factors at an individual and structural level, which would affect the successful introduction of a dedicated smoking cessation service in Reidpark Hospital and would affect whether clinical staff would identify which patients smoked and assist smokers to stop smoking. This was broken down into specific objectives:

1. To carry out a patient needs assessment of both outpatients and inpatients before the smoking cessation service was set up and before clinical staff were trained to help smokers. This would determine:
   a) Whether or not patients felt it was acceptable to be asked about smoking in this context;
   b) Whether patients thought that the hospital should provide services to help patients to stop smoking;

c) What smoking cessation services and advice patients received in the hospital before the smoking service was introduced;

d) How many of those surveyed were current smokers, ex-smokers or non-smokers, in order to assess whether there was a need for a smoking cessation service within the hospital; and

e) How many of the patients surveyed wanted to stop smoking and wanted help to do so.

2. To carry out interviews of key clinical and non-clinical staff working in different departments of the hospital and of the service leader and smoking cessation coordinator. These interviews took place as the service was being set up and aimed to investigate the individual and structural factors which staff perceived to affect the introduction of the new smoking cessation service, and the introduction of preventive health services generally. In particular they aimed to explore:

a) What advice and support on smoking staff gave as the service was being set up;

b) What staff's attitudes were towards encouraging smokers to stop smoking;

c) What staff's attitudes were towards the provision of a dedicated smoking cessation service;

d) How they perceived their health promoting role and whether they considered themselves to be responsible for health promotion;

e) Whether they felt patients would be willing to be asked about smoking; and

f) What factors prevented them from giving health promotion and smoking cessation advice to patients.

1.4 The Movement of Health Promotion into the Health Service in the UK

Public health successes, combined with the fact that diseases have shifted from those which require medical intervention to those which rely largely on behavioural change, mean that we are now moving towards an "era of preventive medicine" (Orlandi, 1987, p 120). As a result, the traditional role of hospitals and other health care settings in Western countries has changed from concentrating only on treating disease and easing death to aiming to keep people healthy and providing education on healthier lifestyles.

In the last few years UK Government policy papers have repeatedly emphasised that both the NHS and the government should be involved in health promotion and education (*Our Healthier Nation*; Department of Health, 1998a; *2000 Policy Futures for UK Health Report*; Dargie et al., 2000). *Scotland's Health, a Challenge to Us All* discussed the poor record of health in Scotland compared to the rest of the UK (HMSO, 1992). It also highlighted the preventive health responsibilities of clinicians. Specifically it stated that health professionals working in hospitals should provide effective patient education and counselling as part of their diagnosis, treatment and care. They should also provide appropriate ongoing care on discharge from hospital and maintain an environment that promotes and protects the health of all of those who come into contact with the health

service. This also illustrated the growing intolerance towards smoking in hospital settings by emphasising that this environment should be smoke free.

Similarly the policy document *Framework for Action* specifically set out the purposes of the National Health Service in Scotland, the first of which was "the promotion of good health" (HMSO, 1991). These documents reflect the World Health Organisation (WHO) declaration in the Ottawa Charter for Health Promotion that "the role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services" (World Health Organisation, 1986, p. 427). To further encourage the integration of health promotion in the health service, the provision of formal training in this area in both medical and nursing schools in the UK has increased (General Medical Council, 1993; McBride, 1995; Bligh 2002).

1.4.1 The network of health promoting hospitals

The expansion of the mandate of health care institutions into health promotion has received support from the WHO sponsored 'International Network of Health Promoting Hospitals.' This was founded in 1990 and aims to develop hospitals as health promoting organisations (Johnson, 1995). Hospitals that are part of this network must make health promotion part of the structure and culture of the organisation and develop strategies at the organisational level. The members of this network have recognised that hospitals must undergo profound organisational change to orient themselves towards the promotion of health. Reidpark Hospital, where the present study took place, was originally part of

this network, although membership was not maintained because the member of staff responsible for health promotion left and was not replaced for some time.

1.4.2 Defining health promotion

Can a smoking cessation service truly be defined as a health promotion service? Not everyone agrees that such services do fulfil the values of health promotion. It is useful, therefore to consider how health promotion is defined and whether or not the provision of smoking cessation advice, either in the form of brief motivation from clinical staff or from a dedicated service, meets this definition.

The WHO's definition of health promotion, which has become predominant, states that health promotion is "the process of enabling people to increase control over and to improve their health" (World Health Organisation, 1984). If one were to accept this definition, almost any initiative that aims to improve health, such as the smoking cessation service, could be considered to be health promoting. However others have criticised such lifestyle approaches (for example, Watson and Platt, 2000). These critics claim that they are reductionist, overemphasise the role of the individual and their behaviour and do little to improve the promotion of population health. In addition these approaches are accused of ignoring the context in which the individuals are living. Schmid et al.(1995, p 1207) are amongst such critics. In the context of discussing the increased importance of public health measures for improving population health in the developed world, and the general acceptance that people's behaviour and the

environments which affect them have more influence on their health than infectious diseases, they say:

> "It is unreasonable to expect large proportions of the population to make individual behaviour changes that are discouraged by the environment and existing social norms. It is equally unreasonable to expect communities or organizations to enact policy changes for which there is no broad based understanding and support."

These authors also believe that such individual risk strategy approaches have not been particularly effective and that it is important to combine health education, policy and environmental change as none of these can be sufficient alone. Furthermore as Green et al., (2000, p 9) point out, many initiatives "carry the label 'health promotion' whether they meet all, or even some, of the criteria derived from theoretical writings about health promotion."

Clearly this argument has implications for smoking cessation services, and for whether or not the service can be considered to be a health promoting one. Smokers do not choose to begin to smoke or continue to smoke only because there is no smoking cessation service to stop them. Instead smokers are influenced by a range of factors including advertising and taxation policies (Jha and Chalpouka, 2000) and socio-economic factors (Department of Health, 2000c). Therefore, in order to decrease smoking rates most effectively, an approach which targets all of these different factors must be adopted.

However if one were only to use those methods which strictly fitted into the criteria of holistic health promotion it "would exclude a wide range of interventions that nonetheless make a contribution to promoting health" (Green et al., 2000, p 9).

The exact definition of health promotion and the argument over whether such lifestyle approaches are useful, and thus whether the smoking cessation initiatives should be considered to be 'health promoting,' are outside the scope of this thesis. Such services have been shown to be effective in increasing the numbers of smokers who stop, and, while it might be the ideal for every health promoting activity to meet both the spirit and letter of the ecological definition of health promotion, it may often be impractical. In addition the establishment of these services, where patients are educated and counselled, have been designated to be an important goal for hospitals (HMSO, 1992). Therefore while the limitations of the individual approach should not be ignored, the fact that smoking cessation services may not be a perfect example of a health promoting strategy should not be used to prevent them from being set up in hospitals.

1.4.3 The hospital as a setting for health promotion

It has been assumed, often without question, that the hospital is a suitable environment for health promotion and offers a good opportunity for clinical staff to give advice to patients with whom they come into contact. Is this the case? Does the present climate in hospitals make systematic health promotion possible and is this seen to be appropriate and acceptable both to clinical staff and to patients?

Johnson (2000) has critically considered the hospital as a setting for health promotion. She points out that "our notions of health care institutions seem to be antithetical to the philosophy that underlies health promotion" (p175). While the philosophy of health promotion emphasises the empowering of individuals to make choices about their life, the "structures, policies and procedures of health care institutions seem systematically to strip power and control from individuals, families and communities."

As Johnson highlights, it is not universally accepted that health promotion belongs in hospitals. She notes that some people believe hospitals should focus on helping the sick and injured, leaving health promotion to public health and community agencies. "Those that hold that position maintain that health care institutions are currently using health promotion to serve their own ends rather than those of the community" (Johnson, 2000, p 184). She also points out that others hold the contrasting opinion that "hospitals are an important part of communities and that all institutions, particularly those involved with public services, must be actively involved in health promotion planning"(p184).

She identifies a number of issues that may limit the success of health promotion in a hospital. The following six factors are most pertinent to the present thesis:

- Organisational Factors

Hospitals are usually organised for purposes other than health promotion and therefore it is not always easy to integrate health promotion services into the existing service.

- Size and bureaucracy

The large size of hospitals, as well as the levels of bureaucracy, make it difficult to implement change. Hospitals have a difficult time responding quickly to current needs and demands as they are so caught up in fulfilling mandates to individuals and are therefore largely unresponsive to communities.

- Hierarchy

The hierarchy in hospitals and the rapid staff turnover make it hard to involve a wide range of staff in health promotion. Health promotion programmes in hospitals tend to be developed by one or two experts and then added to the menu of services offered in the institution.

- Support of clinical staff

Key professionals are often sceptical about health promotion programmes and may also lack confidence in their own health promotion skills. The culture of the hospital focuses on immediate solutions and treatment rather than on the prevention or management of the problem. In addition, beliefs regarding the lack of effectiveness of interventions can act as major barrier to an intervention.

- How clinical staff perceive their role

Health service staff often have a narrow job definition and a standardised routine. This means that multi- or inter-disciplinary areas, like health promotion, can cause dispute

about who is responsible, meaning that there is an overlap in these services, or conversely, that no one takes on this responsibility.

- Time

Inpatients generally spend less time in hospital than they did in the past. This makes it difficult for staff to develop a relationship with them and for them to have time to provide preventive health advice. The following comment, in particular, reflected my own experience of carrying out research in Reidpark Hospital, and will be described further in Chapter Two:

> "Another noteworthy aspect of the patient role, particularly with acute care settings, is how busy patients are with treatment and procedures. The acuteness of the average patient's medical condition within the hospital setting has soared over the past decades. Patients are being sent home earlier...with shortened hospital stays many patients are exhausted during their post-operative or brief convalescent period and may be unable to assume an active and full partnership with the hospital staff" (p188).

In a similar analysis of the barriers to promoting health and preventing disease in hospitals, Orlandi (1987) reminds us that patients come into hospital to solve existing problems and may not be interested in being given information about non-existing or potential problems. The author takes a classic Parsonian view, believing that the health care culture stifles patient initiative and makes them less likely to feel responsible for

their own health (Parsons, 1951). Patients are stripped of their personal belongings and told what they should eat, when they should sleep and what tests they are to have. In the author's opinion this encourages them to adopt a sick role, which relieves them of any responsibility and makes them become less able or willing to discuss broader health issues. Clearly if this were true it would make it difficult for clinical staff to discuss health promotion with patients, and for patients to feel confident enough to make changes in their life which could be maintained after they leave the hospital.

Whitehead (2000) similarly looked at the barriers to health promotion in a hospital setting, in a review of the role of health promotion in nursing. She did this within the context of the changing emphasis of the NHS to be a 'health' service rather than a 'sickness' service, and the expectation that nurses will be at the 'cutting edge' of this change. She discussed this from the perspective of nurses, believing that it is difficult for them to become health promoters as nursing is rooted in a biomedical approach rather than a humanistic approach. As a result of this, the health promotion activities they have undertaken have often had limited objectives. Furthermore when such activities have taken place they have not been well evaluated. She pointed out that nurses can also feel that they are simply blaming the patients and infringing the individual's autonomy. The ethics of health promotion will be discussed further in Chapter Five.

Whitehead also emphasised the importance of empowering individuals to promote positive health changes. However she felt that empowering patients is rarely prioritised, as there is an increased emphasis on achieving targets, resource management and

effective public relations. She concluded that there needs to be a clearer understanding of what health promotion in nursing actually means and that nurses need to be better educated and supported so that effective health promotion strategies are incorporated into everyday practice, rather then health promotion simply being "information giving." However this does not mean that this goal should be abandoned. While Coakley (1998) also recognised these barriers to health promotion in a hospital ward, she added that while such a task may be daunting it is a worthwhile goal and one which is the basis of good practice.

Orlandi (1987), Johnson (2000) and Whitehead (2000) have all pointed out how difficult it is for patients to make lifestyle changes in the hospital environment and commented on how the lack of time which clinicians have with patients forces them to prioritise patient treatment. These themes will be explored further in this thesis. It does seem that there is some concern that the hospital is not the most appropriate environment for health promotion, and that the goals of health promotion are not easily accomplished within this setting. In addition to the factors which these authors have identified, patients may be very distressed or anxious while they are in hospital because of their illness or because of wider social factors, such as their job or their family.

Most commentators who discuss the hospital as a setting for health promotion do so from the perspective of inpatients. It is likely, however, that the situation for outpatients is quite different, and it could be argued that the appropriateness of health promotion in this context might vary, depending on the reason for their hospital visit. Outpatients may be

attending hospital for routine appointments where health promotion advice might be considered to be quite appropriate. For example, people suffering from diabetes attend for regular check-ups and it is likely that lifestyle advice, particularly that related to their diabetes, would be considered to be completely appropriate in their appointment. Alternatively they might be attending to hear the results of investigations, and find, for example, that they have a serious illness. Clearly it is likely to be felt that routine advice would be completely inappropriate at that time. In addition outpatients spend much less time with clinical staff than inpatients do. Therefore staff have less of an opportunity to discuss wider health issues with them. The hospital as a setting for health promotion for outpatients, therefore, should be considered separately.

In conclusion, while it might seem on first appearances that the hospital environment is a good one in which to encourage the promotion of health and healthy lifestyles, in fact this assumption might not necessarily be true. The nature of the hospital environment and the traditional role of staff working within it, as well as other factors, may act to prevent this from happening. This has implications for the introduction of the smoking cessation service to a hospital.

1.5 The Growth of Smoking Cessation Services in UK Hospitals

It is well known that smoking is the largest cause of preventable illness and premature death in the UK (Department of Health, 1998b). Over 120 00 people a year die because

they smoke and over half of all those who smoke for most of their life die because of their habit.

The White Paper *Smoking Kills* states that "All health professionals working in hospitals or community settings should assess smoking habits and provide advice to smokers on giving up whenever possible" (Department of Health, 1998b). Such services form part of the UK Government's plan to reduce coronary heart disease (CHD) and cancer (Department of Health, 2000b). On No Smoking Day, March 15th 2000, the government announced free GP-based help for smokers who wished to stop (Department of Health, 2000b).

Action for Smoking and Health (ASH) also state that while patients with smoking-related illnesses are more likely to be encouraged to stop, any patient should be able to get help to do so (Walker, 1998). They continue:

> "Admission protocols should always ascertain the smoking status of patients. All nursing and medical staff should have access to information on help available for patients who wish to stop. Ideally advice and support should be given in advance of admission" (p23).

These documents both reinforce the expectation that smokers should be strongly encouraged to stop and emphasise that it is the responsibility of the government and the health service to effect this.

1.5.1 UK guidelines for smoking cessation services

In 1999 UK guidelines for smoking cessation, which were based on systematic reviews of effectiveness conducted by the Cochrane Tobacco Addiction Review Group and the Agency for Health Care Policy and Research (AHCPR) in the United States, were outlined (Raw et al., 1999). These were the first guidelines to be both evidence and consensus based and to be professionally endorsed by a number of groups including the Royal College of Physicians, the Royal College of General Practitioners, the British Medical Association and the Royal College of Nursing. These guidelines were based on evidence that effective support delivered through the healthcare system would help in reducing tobacco use and that such interventions have population health gains for a relatively modest expenditure. They were aimed at all health professionals, not just those in primary care. All smokers who wanted help to stop should receive it, and this help should be appropriate to their situation. That is, routine brief advice should be given to all smokers, and more intensive help, such as referral to a specialist treatment service, offered to heavy smokers most at risk from smoking-related disease.

They recommended:

> "...the integration of effective and cost-effective interventions for smoking cessation into routine clinical care throughout the healthcare system, and [that these] are aimed at health commissioners, managers and clinicians" (Raw, et al., 1999, p 182).

Essential features of the guidelines were the recommendations that clinicians should:

- Ask about smoking at every opportunity;
- Advise smokers to stop;
- Assist them with stopping; and
- Arrange follow up.

In this way it was suggested that smokers could be motivated to stop. However it was considered that heavy smokers, who were most at risk of smoking-related diseases, would have difficulty in stopping smoking. Therefore it was also recommended that a specific service should be set up to assist those smokers who were finding difficulty in stopping. In particular it was recommended that:

- Smoking cessation interventions should be commissioned in order to produce significant, cost-effective health gains in the population;
- Current practice should be reviewed, needs identified and core funding provided to integrate smoking cessation into health services. A cessation strategy should then be planned with public health specialists, and advice sought from smoking cessation specialists;
- These plans should include a specialist smoking cessation service, which should help smokers who were unsuccessful after brief intervention and support other health professionals to deliver smoking cessation interventions;

- Training should be a core part of the smoking cessation programme in all health authorities, Protected time and funding should be built into this programme;
- Provision should be made to ensure that nicotine replacement therapy was available to hospital patients who needed it, in conjunction with professional advice and cessation support;
- It should be required that all services, departments and clinics introduce systems to maintain an up to date record of the smoking status of all patients in their notes;
- All healthcare premises and their immediate surroundings should be smoke free; and
- Systems should be put in place to audit interventions for smoking cessation throughout the healthcare system.

The smoking cessation service at Reidpark Hospital was designed in line with these guidelines.

1.5.2 The effectiveness of smoking cessation advice from clinicians

Underlying the belief that it is appropriate for clinical staff to give smoking cessation advice and to refer to appropriate services, is the often implicit assumption that providing such advice will improve the smoking quit rate. Research has shown that smokers are indeed more likely to stop if advised to do so by their doctor. An early study found a 5% long-term cessation rate if GPs simply raised the subject of smoking during a routine consultation and gave brief advice (Russell et al., 1979).

1.5.1.1 Smoking Cessation Policies in Scotland

Smoking rates are showing signs of decreasing in Scottish adults. However, they still remain consistently higher than in England and Wales (Health in Scotland 2000). Smoking is the most important preventable cause of ill-health and premature death in Scotland and accounts for at least two-thirds of the excess deaths due to inequalities in health. Each year, 13 000 deaths are due to smoking - one in five of all deaths - and the NHS in Scotland spends £140 million on the treatment of smoking-related diseases (*Towards a Healthier Scotland, a White Paper on Health*, The Scottish Executive 1999).

In order to address the higher rates of smoking in Scotland, Scotland-specific policies and guidelines have been published. In the White Paper "Towards a Healthier Scotland, 1999" six headline targets were identified which were to be achieved by 2010. Four of these targets were related to smoking, or smoking-related illnesses. These were to:

- Reduce smoking among 12-15 year olds from 14% to 11%
- Reduce the proportion of women smoking during pregnancy from 29% to 20%
- Reduce premature mortality from coronary heart disease by 50%
- Reduce premature mortality from cancer by 20% (Chapter 8, Annex A).

The importance of monitoring inequalities between groups was also emphasised.

In order to work towards these targets £5 million was invested in health education/promotion campaigns in Scotland over the three years following the

publication of the White Paper. Health Boards were also given a further one million pounds in each of these years to help towards the introduction of specialist smoking cessation clinics and given an initial supply of free Nicotine Replacement Therapy. Furthermore the government made a commitment to secure new laws to ban tobacco advertising, enhance health promotion campaigns targeting young people, pregnant women and low income smokers, fund new NHS services to help smokers quit, improve facilities in pubs and restaurants for non-smokers, consult on better ways to reduce passive smoking at work and ensure that there is tougher enforcement of the law against sales of tobacco to children.

The Health Education Board for Scotland (HEBS) and ASH also jointly published Smoking Cessation Guidelines for Scotland which were based on those of Raw described in the previous section (Raw et al., 1999). These were adapted for use in Scotland and within the context of the National Health Service in Scotland (Walker, 2000). These are broadly similar to those of Raw (1999); however, their recommendations are more specific and address the issues of social support, of relapse and of continuity in care. For example, they recommend that smoking cessation support should be conducted in groups and should consist of five sessions, each lasting one hour. Moreover they also identify two instances when smoking cessation support should not be routinely offered; in the case of mental illness and of lung cancer.

In order to minimise relapse these guidelines recommend that specialist smoking cessation services should offer social support and other follow-up. Furthermore they

recommend a number of ways in which primary and secondary care could work together to ensure that the service provided for those who are attempting to stop smoking is made easier. In particular they advise that patients who are to be admitted to hospital should be informed in advance of the hospitals' smoking policy. They should also be assessed to determine whether they are ready to stop smoking and offered assistance to do so if appropriate. In this way smokers would come in to hospital better prepared to stop. Furthermore when a patient is discharged from hospital, information about cessation attempts and advice given should be included in their discharge letter so that their primary health care team can provide ongoing assistance.

References

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This finding was supported by a more recent Cochrane review of studies that aimed to assess the effectiveness of physicians advice and compared brief advice on smoking to usual care (Silagy, 2001). This review included 27 000 smokers and examined studies carried out in all health care settings though it found that most of these studies took place in primary care. A significant effect was found with an absolute difference in cessation rate at 6 months of 2.5%. (OR 1.69, 95% CI 1.45 to 1.98).

While the author of this review advised caution in interpreting these results because of the possibility of publication bias, the mixed quality of the studies and the fact that the meta-analysis was based on the results of a number of small trials, he estimated that there was one extra quitter for every 40 patients, as a result of minimal intervention from a physician.

Similar success rates have been found in General Practice (Ashenden et al., 1997). A systematic review of studies which examined the effectiveness of GPs promoting lifestyle advice, including smoking cessation, found that brief or intensive advice increased the odds of stopping smoking. They estimated that it would be necessary for GPs to provide such advice to 35 smokers to produce one quitter.

The provision of advice by nurses has also been shown to be effective (Rice and Stead, 2000). A Cochrane review of 16 studies comparing intervention to normal care found that interventions by nurses significantly increased the odds of quitting by hospitalised patients within the next six months (OR 1.50, 95% CI 1.29-1.73).

If clinicians are trained in smoking cessation techniques then this will increase smokers' cessation rate. A review which compared clinicians working in hospitals who were trained in smoking cessation to those who were not found a modest increase in the odds of stopping smoking for smokers attending clinicians who had received training, compared with patients attending control practitioners (OR 1.48, 95% C.I. 1.20 to 1.83) (Jepson, 2000).

Even if brief interventions from physicians and nurses do have some effect on smoking cessation rates, the effect might not be large enough on its own to convince clinicians that this is worthwhile. While giving advice to 35 to 40 smokers may produce one person who stops, in order to do this they would also have to have information on the smoking status of all of the patients whom they saw. As approximately 25-30% of the population smoke (Information and Statistics Division, 2001) this could mean that clinicians might have to ask the smoking status of over 150 patients to identify those who smoke, before then giving advice to all smokers and thus produce one person who has stopped smoking. In addition they may get no feedback about whether the advice they gave was effective, and so may remain unaware whether they had changed anyone's behaviour. Thus they would have little incentive to continue to provide this advice. While encouraging patients to stop smoking may increase the likelihood of them stopping and improve their health in the long run, it may not be a priority for busy clinicians who have to treat the patient's illness as well as to decide which advice to give them about their lifestyle in a limited amount of time.

1.5.3 The effectiveness of specialist smoking cessation services

The previous section considered the effect which brief interventions by clinicians could have on smoking cessation rates. This thesis also investigates a dedicated smoking cessation service and therefore this section discusses how effective such dedicated services have been at helping smokers to stop.

In the UK in the last few years there has been a growth of dedicated smoking cessation services in the NHS, first in Health Action Zones (HAZ), in an attempt to reduce health inequalities, and later in some Health Authorities in England and Health Boards in Scotland (Department of Health, 1998b). These specialist smoking cessation clinics generally offer group support and / or Nicotine Replacement Therapy (NRT). Since they were set up it has been reported that in England between April 2000 and March 2001 about 132 500 smokers in specialist services set a quit date and 49% (based on self-report) were still not smoking one month later (Department of Health, 2001). The smoking cessation services in England are currently being evaluated.

These services have also been shown to be cost-effective, working out at a cost per life year gained of £600 for smokers aged between 35-44, and £750 for those aged 45-54 (Raw et al., 2001). Further they allow clinical staff to give brief advice and to refer to services "rather than spend time trying to meet all the needs of smokers trying to quit" (p1140).

1.5.4 The hospital as a setting for smoking cessation services

In Section 4.3 the advantages and disadvantages of the hospital as a setting for health promotion were discussed. This section will consider this issue in relation to smoking cessation. The emphasis that has been placed on the effectiveness of such services suggests that there is an assumption that the hospital is an appropriate place to help smokers to stop and that the hospital provides a 'window of opportunity' to do so (Cummings et al., 1989), as the following quote illustrates:

> "Health professionals have a natural opportunity to intervene with smokers who present with medical illness. During hospitalisation smokers may be particularly receptive to assistance with smoking cessation, since they must deal with the fear and anxiety associated with illness, at the same time they experience withdrawal from nicotine and have little access to their normal coping resources" Emmons and Goldstein, 1992, p 262).

It has also often been remarked that as hospitals deal with the ill-effects of smoking it would be sensible for them to try to help people stop smoking:

> "Despite the fact that hospitals direct a large proportion of their time, effort and resources to treatment of smoking-related illnesses, scant attention is directed in such settings towards actively addressing the problem of tobacco smoking. This fact is unfortunate in that hospitalization is a period in which

individual smokers are more likely to be receptive to stopping smoking"
(Dawley, 1984, p 328).

Similar comments were made by Rigotti et al. (1997) who further suggested that smokers can be encouraged to stop in this environment as hospitals are largely smoke-free and in hospitals there is a captive audience.

As Section 5.1 described, it is now recommended that smoking cessation advice is offered at every patient encounter (Department of Health, 1998b). Some authors go further and claim that health workers should themselves be strongly encouraged to stop smoking because of their exemplary role (Battle et al., 1991). However there are frequent criticisms that clinicians are not fully utilising this opportunity.

The criticism of the hospital as a setting for health promotion also applies to smoking cessation services. Even if advice from clinical staff does improve quitting rates among smokers, does this mean that hospitals necessarily have a role in smoking cessation? Do patients accept that they might be given smoking cessation advice that they did not request, and which might not be relevant to their presenting condition? Do individual clinical staff perceive this to be an appropriate role for them to take on and do they feel that they have the time, skills and confidence to carry this out? The fact that smokers are not always encouraged to stop smoking despite evidence that such advice is effective suggests that other factors affect whether or not these services will be introduced and used effectively (Kottke et al., 1989).

Clearly therefore it is not enough to continue to reiterate to clinicians the effects which they can have. Similar concerns have been expressed in the US and one commentator suggested that the fact that help is not offered to smokers as much as it might be is due to organisational barriers, patient refusal and safety concerns. As Cooke (2000, p 113) states, "investigating the process of program adoption and implementation is as important as investigating the client outcomes." It is becoming increasingly apparent that there is a need for an investigation into the other factors which affect the implementation and success of the smoking cessation service.

1.5.5 Barriers to the implementation of smoking cessation services

The research studies will examine barriers to the implementation of health promotion or smoking cessation services will be described in greater detail in later chapters. However in order to introduce this area it is useful to outline some of the main barriers identified by one group of US researchers who have done a great deal of work in this field (Kottke et al, 1989; 1992; 1997; Solberg et al., 1997; 2002). These studies are of particular interest as, like the present thesis, they explored these barriers at an individual and structural level as well as from the perspective of both doctors and patients and they will be referred to again where relevant in later chapters. Their main points were:

- [American] physicians are limited by administrative staff, insurance companies and patients, all of whom have some influence on how preventive services are administered. Therefore inaction can be due to these external forces rather than a lack of interest;

- Public health measures do not impel action in the clinical setting, where physicians are responding to complaints of individual (and fee-paying) patients. It is difficult for clinicians to see their patient in terms of a 'population' and in order for public health to be effective, services should be described in terms of the gain for individuals;

- Urgency is prioritised over severity. Often services are measured by waiting times rather than throughput and preventive services would have to be prioritised before they would be included. Further, time constraints and patient demands mean that often the physician responds to patients' requests rather than initiating discussions over healthy behaviours;

- Preventive services are often seen as simple and do not correspond to the physician's self-image. Doctors prefer to do complex and non-routine tasks. If someone else can do a task they generally prefer not to view it as their responsibility;

- Doctors are often reluctant to refer to a service as they believe that by doing so they are seen to be endorsing it and thus it becomes their responsibility. In addition feedback is only received from preventive service if it is negative;

- Patients rarely follow through on referrals, which dissuades physicians from continuing to refer; and

- There is a shortage of resources.

They concluded that the current climate in the US was not good for implementing preventative health, although the desire was there to do so. Clinicians felt embattled and beleaguered, patients perceived access to acute care as declining and the payment system did not reward health promotion.

This research team also examined the acceptability of preventive services to the patients (Kottke et al., 1997). In particular they asked patients whether or not they wanted more preventive services, and examined whether the provision of more preventive services resulted in increased patient satisfaction. They found that while, in patient satisfaction surveys, patients *claimed* to be happier if preventive services were offered, there was not a strong correlation between preventive services given and patient satisfaction. In addition patients may want a service but not use it. However less than 4% of patients surveyed claimed they would like "to be left alone with their health habits," thus indicating a positive climate in which to carry out health education and screening.

The authors called for an examination of the barriers, at physician, patient and environmental level, which affect the introduction of preventive health services and conclude:

"If the physician is to help a patient adopt and maintain 'preventive behaviours,' the processes that influence and shape both patient and physician behaviours must be understood, the physician's role in the behavioural change must be acceptable to both the patient and the physician, and an environment that both permits the physician to act and reinforces the physician for acting appropriately must be designed for the physician" (Kottke et al., 1990, p S62).

It is likely that many of these barriers will also operate in the UK, although the lack of such research in the UK prevents comparisons being drawn. There are some important differences between the UK and US health services which are likely to have implications for the implementation of the smoking cessation service and these differences will be discussed further in later chapters. In particular the US health service is funded in a quite different way to that of the NHS and there is a far greater involvement from insurance companies. Patients in the UK do not have a history of seeing themselves as consumers and it is probable that this will make their relationship with clinical staff quite different.

While these US studies have highlighted some important factors, they concentrate on barriers from the perspective of physicians and pay little attention to the contribution of other clinical staff such as nurses, and professions allied to medicine (PAMS) such as physiotherapists and dieticians. Effective preventive health programmes require the involvement of different staff. Therefore, in order for the barriers to the implementation

of such services to be identified comprehensively, it is necessary that the views of other health professions and management are sought.

In summary, while there has been a growing health promotion movement in the health service and in hospitals and a growth in the number of smoking cessation services available in these settings, some debate has taken place as to whether this is appropriate and likely to be effective. Smoking cessation services do increase the number of smokers who stop but this alone does not mean that clinical staff will encourage smokers to stop smoking or refer them to smoking cessation services. Other barriers are beginning to be identified which also influence their smooth introduction and use.

The next section will look at the actual hospital which is the subject of this thesis, and the service that will be evaluated.

1.6. The Smoking Cessation Service in Reidpark Hospital

1.6.1 Reidpark Hospital

Reidpark Hospital in the West of Scotland is one of three acute hospitals managed by Central Region Health Board. It opened in 1977 and has around 570 beds. It provides general hospital services – including Accident & Emergency, General Medicine, Geriatric Medicine, Haematology, General Surgery, Urology, and Orthopaedics and a wide range of specialities within these disciplines.

Reidpark's catchment population is around 200 000. There is significant unemployment and associated deprivation in the local area, with the majority of local residents belonging to deprivation category 5, 6 and 7 as defined by the Carstairs index of deprivation (Carstairs and Morris, 1991).

1.6.2 The service leader

Funding for the smoking cessation service at Reidpark Hospital and to employ a smoking coordinator for three years was gained from Central Region Health Board by Dr David Cairngorn, a respiratory consultant with an interest in smoking cessation. He set out the aims and objectives of the service and remained involved in its ongoing development. He was responsible for the budget for the service and managed the smoking cessation coordinator. A working group was then set up to assist in the employment of the coordinator and the initial implementation of the service.

1.6.3 The smoking cessation coordinator

The smoking cessation coordinator, Marianne Findlay, was employed in March 2001 on a three-year contract to set up a dedicated smoking cessation service and train clinicians to give brief motivation to smokers. She had worked as a practice nurse and had set up a smoking cessation service within general practice although she did not have specific training in how to help people to stop smoking. She had also previously worked in Reidpark Hospital for a number of years. She was aware that the service was being evaluated and this had attracted her to the post.

1.6.4 Reidpark Hospital's smoking policy

In February 1990 Central Region Health Board launched a smoking policy, which declared "this policy has the overriding aim of working towards a smoke free environment in all Health Service premises within Central Health Board" (Central Region Health Board, 1993, p 3). This was implemented within the context of the *Patient's Charter* and the *Framework for Action*, which gave the NHS the clear goal of improving health in Scotland and recognised the Health Board's role as a promoter of good health (HMSO, 1991). The policy covered such initiatives as employment policy for new staff, when exceptions could be made for patients and relatives at the discretion of professional staff, support to be given by the Occupational Health Department to assist staff to stop smoking, and monitoring arrangements and disciplinary procedures to ensure compliance. This policy was to be adopted by all Units no later than 1993.

1.6.5 The aims of the smoking cessation service

The smoking cessation service was set up in line with the guidelines described in Section 5.1 (Raw et al. 1999). The aim was for the smoking cessation coordinator to provide training to clinical staff on assessing patients' smoking status, supplying brief motivation and identifying which patients required more help. Those patients who staff identified as being keen to stop smoking, but who were having difficulty in stopping, would then be referred to the smoking cessation coordinator for further help. The smoking cessation coordinator aimed to see them as quickly as possible so that they could receive help while they were still motivated. If possible she saw inpatients before they were discharged and telephoned outpatients soon after their hospital visit to arrange an appointment.
The service leader described his vision of how the smoking cessation service would work:

> I felt that we had to offer a service to support those who demonstrated a wish to quit ...not just by counselling but also guiding them through the sort of nicotine replacement, plus or minus Zyban. The second thing was, that we were quite keen to see whether, or I was keen to see whether, we could change the culture in the hospital, by changing the profile of smoking cessation stance and making sure that everybody who interfaced with a patient would bring up the issues so that the patient would be assaulted very often during their passage through the ward or through the clinic by a number of different people and I say assaulted in a facetious way I mean they should be asked whether they see smoking as a problem and whether they would like

> help and to say that we could offer that help if they would like it and so by making sure that a lot of these patients are actually asked about it several times during their journey through here ...and smoking status is recorded and that help is offered. (David Cairngorn, Consultant, Respiratory Medicine and Service Leader)

Therefore the service leader wanted the smoking cessation service to be completely integrated into the hospital so that the culture became one where patients were always asked about smoking and always offered help to smoke.

1.6.6 The progression of the smoking cessation service

The smoking cessation coordinator set up the service soon after she started work at Reidpark Hospital and informed staff of its existence by electronic mail. She also met with hospital staff to teach them about the service and how to use it most effectively. The service was also advertised on posters and in leaflets throughout the hospital. Patients could be referred to the service by any member of the hospital staff, or could refer themselves.

The smoking cessation coordinator offered a variety of services for those smokers who wished to stop. These included group support, one to one support, advice on nicotine replacement therapy (NRT) and bupropion (Zyban), advice on alternative therapies, and follow up contact support. In general patients first attended an individual appointment so that an assessment could be carried out. After this they joined a smoking cessation

support group and / or received ongoing telephone support. The development of this service will be outlined in Chapter Eight.

1.6.7 Conclusion

In conclusion, hospital staff are being increasingly encouraged to ask patients their smoking status and offer some help to stop smoking, and in some cases training has been provided in order to effect this. Dedicated smoking cessation services are also being provided in hospitals and other health care settings to provide further support for patients who smoke. Such advice and services have been shown to be effective in increasing the number of smokers who stop. However it is not universally accepted that the hospital is a suitable setting for health promotion or that smoking cessation services are appropriate in this setting, and even when smoking cessation services are available they are not always referred to as much as they might be.

Factors have been identified at the individual, organisational and structural levels which might affect the advice which staff give or affect the use of a dedicated smoking cessation service and subsequent chapters will consider these issues further. The available research, however, is limited. It was therefore necessary to rely on several key references. These have generally relied on quantitative methods and focused on one professional group, usually doctors. In addition few UK- based studies are available. As health services are different in the way in which they are funded and organised in different countries, country-specific research is necessary. The present study, which was based in the UK, uses both qualitative and quantitative methods and solicits the views of

clinical and non-clinical staff and patients and by doing so it aims to address some of these research gaps.

Chapter Two: Methods

This chapter outlines the methods of the patient survey and the staff interviews and the reasons why these methods were chosen. The administration of the patient survey and staff interview and the analysis of the data obtained are described in detail. Ethical issues and the researcher's role in the research process are also outlined and discussed. The chapter concludes by describing and commenting on changes to the aims of the project which took place after the research was underway, and the implications of these changes.

2.1 Introduction to the Methods Used

The thesis aims to identify those factors which either inhibited or facilitated the introduction of a new smoking cessation clinic in a hospital setting at both an individual and a structural level. The research questions described in Chapter One cover a wide area. To answer these questions it was necessary to seek the opinions of both patients and staff. Patients were therefore surveyed and staff interviewed in depth. The use of mixed methods is common in studies of organisations: "In organisational research it is not a mutually exclusive decision between quantitative and qualitative methodology. In reality it is very difficult to study organisations without using both sorts of methods and in any event, quantitative data always rests upon qualitative distinction." Bulmer (1988, p 17).

The patient survey was administered as a structured interview and aimed to establish what was happening in the hospital before the smoking cessation service began and to determine whether patients perceived a need for this service.

There were a number of reasons for choosing a patient survey to meet these objectives. First, surveys are particularly useful for descriptive purposes when little is known about a particular subject (Burton, 2000, p 295). Second, it was necessary to gain the views of a large and diverse sample so that the views of the patient population were reflected as accurately as possible. As Chapter One highlighted, despite the increase in smoking

cessation services there has been little research which has surveyed patients' attitudes towards such services.

Third, surveys have been described as a way of producing "information to describe, compare, and predict attitudes, opinions, valuers and behaviour based on what people say and see and what is contained in records about them and their activities" (Fink 1995, p 23). In the current study, information was gathered on people's present opinion on and attitudes towards smoking services in order to predict the future likelihood of their using such a service. Finally surveys are a useful method for gathering this kind of data as they "promote standardisation of both the asking of the question and the recording of the answers" (Bryman, 2001, p 107).

As well as the patient survey, one to one 'in depth' interviews of key staff were carried out as the service was being implemented. These sought to identify staff views of the factors that acted as barriers or facilitators to change. This method was chosen because the subjects discussed were complex and an interview allows more subtle questions and more detailed responses which could not be elicited in a standardised questionnaire (Robson, 2002). Interviews allow the interviewee to determine which topics are important rather than the interviewer pre-selecting topics for discussion and potentially missing important issues. As there was little previous research in this area a qualitative approach was necessary to identify the key issues.

The aims of the project changed for unavoidable reasons after the methods had been determined and the data collection begun. This is described in Section 11.

2.2 Developing Contacts with the Hospital and Gaining Access

Access to Reidpark Hospital was arranged through the service leader, Dr David Cairngorm, a respiratory consultant who had gained funding for and set up the service, as Chapter One describes.

It was anticipated that part of the coordinator's role would be to evaluate the service in terms of its success in helping patients to stop smoking. The working group became interested in assessing the organisational impact of the service. The Research and Development manager at Central Region Health contacted the MRC Social and Public Health Sciences Unit at Glasgow University directly to suggest that a student assess the service in terms of its impact upon the hospital as a whole. Following this, the author's PhD supervisors, Professor Graham Hart and Dr Mark Petticrew, were obtained a Chief Scientist Office PhD Studentship from the Scottish Executive to carry out this research.

Dr David Cairngorm then became the contact person for the service. He assisted me with gaining access and making contacts with staff and with general advice on the best way to proceed with the research.

2.2.1 Timetable for data collection

Data were collected between April 200 and November 2001.

Data Collected	Date
Outpatient Pilot Survey	7th April 2000
Outpatient Survey	April to November 2000
Inpatient Pilot Survey	4th December 2000
Inpatient Survey	December 2000 to February 2001
Postal Pilot Survey	September 2000
Staff Interviews	July 2001 to November 2001

2.3 The patient survey

2.3.1 Choosing the patient survey

Two of the main aims of the study were to determine the smoking cessation advice which patients had been given in their most recent appointment or inpatient stay and whether they considered smoking cessation support and advice to be appropriate in the hospital setting. It was decided that this would best be achieved by surveying patients rather than staff, for a number of reasons. First, staff would not have time to answer questions about each patient after their appointment. Outpatient clinics almost always overran and therefore attempting to speak to staff during the clinic would have been extremely disruptive. Second, if outpatient staff knew that they would be asked whether or not they had given smoking advice after each appointment it is likely that this would influence their practice. Third, in the case of inpatients, staff worked on different shifts and patients often changed wards several times during their stay. Therefore it would not be possible to obtain accurate data for inpatients by surveying staff.

Another method which was considered was that of observing patients' clinical treatment. This would have the advantages that it would not rely on patients' memories nor take up staff time. However it was decided that this method of data collection would not be appropriate. First it could have been difficult to get permission both from the ethical committee and from individual clinicians and patients. It might have been felt, for example, that the presence of a researcher was intrusive, especially if personal or emotional issues were discussed.

Second, the clinician's behaviour and the advice which they gave might have been altered by the presence of an observer. While clinicians generally did not know the exact details of the patient survey they did know that it related to smoking and to the smoking cessation service and this could have prompted them to raise this topic.

Third, patient consultations could last up to half an hour, which meant that it would have been possible only to survey six or seven patients in each clinic and patients seen by other clinicians at the same time would have been missed. Fourth, the survey also sought to determine which members of staff gave patients smoking cessation advice. Patients were often seen by several members of staff and could be sent to other departments for X-Rays or blood tests. This would mean that patients would have to be followed around the hospital for the whole of their visit to see what advice they were given by different members of staff. Furthermore, as Section 1 outlined, it was also important that patients' views on the appropriateness of the smoking service in a hospital were elicited and clearly this objective would best be met by asking them directly.

However while a patient survey seemed to be the best method to elicit accurate data it does have limitations. Outpatients were surveyed immediately after their appointment when any advice given would be fresh in the patient's mind. Even so it is impossible to be certain that outpatients' memories of their appointment were completely accurate. This is particularly true if they had been given distressing news, for example, a poor prognosis; or if they attended the hospital regularly and therefore might find it difficult to

remember which advice was given at which appointment. It is possible, also, that inpatients' accounts were less accurate than those of outpatients. Inpatients may have been very ill when they were admitted, and ill or confused for some of their stay. If they had seen several members of staff and been asked a number of questions, or if they had been in hospital some time, they may not have accurately remembered if they had been asked questions related to smoking. It also seems likely that non-smokers would be less likely to remember questions about smoking than smokers, as this question would not be pertinent to them. Many of the non-smokers commented that they could not remember whether they had been asked their smoking status, as this was not relevant to them. A more detailed description of the methods and procedure is given in the sections below.

A postal survey was also considered as it was felt that this method would be less time consuming and would also make it easier to get a representative sample of patients who had attended the hospital. This method was piloted unsuccessfully and this is discussed further in 3.5.3.

2.3.2 Using interview surveys

An interview survey is very similar to a self-completed questionnaire and has some of its advantages. Like a questionnaire, the questions can be pre-coded which speeds up later computer data entry and makes analysis easier. The difference is that rather than participants completing the questionnaire themselves, the interviewer reads the questions to them. This type of survey was used with this group for several reasons:

First it allows for problems of poor eyesight and difficulties with writing which is important in a population of often elderly or disabled patients attending hospital. Second, the interview schedule was quite complex. While the questionnaire was quick to complete and individual questions were very straightforward, some questions were only relevant for some of the respondents. Smokers, ex-smokers and never smokers answered different questions. It is far easier and quicker to administer such a questionnaire in person, when a researcher can readily move to the appropriate question, than it is for a patient, who is unfamiliar with the questionnaire content, to read it through, selecting the right questions to answer.

Third, low response rates are common in postal surveys and this is particularly likely to be the case in a sample of respondents which includes a large number of people who are sick, elderly or disabled. In addition, as the questions had to be answered *after* their appointment, patients who may have waited for some time and then spent more time seeing one or more clinical staff may not have been keen to remain any longer to fill in a questionnaire. However if asked directly by the researcher they would be far less likely to refuse, as direct requests have been shown to elicit a far higher response rate (Moore, 2000). However this method does have some disadvantages. While patients were assured of their anonymity, clearly this was not completely guaranteed in the way in which it could be if they had been asked to self-complete a questionnaire. This will be discussed further in Section 6.

2.3.3 Pilot studies

It is important to carry out a pilot study to assess the clarity and design of a questionnaire or survey. The pilot allows the researcher to check if questions have double meanings, if the target group understands the language used and if the questions are relevant. Piloting can also be used to create or refine categories of response to a question and to give an indication of the response rate. Pilots also test the administrative process; for example how long the survey or interview will take to complete, if it flows well and if it can be carried out at a time and place which is appropriate and convenient (see for example, Bryman 1989; Reynolds et al., 1993).

Advice about the number of respondents to be included in pilot studies varies. It is, of course, important to have a large enough sample to test for non-response or ambiguous questions. However a large sample can be both expensive and time consuming and can 'use up' respondents before the field study is carried out. The size and nature of the pilot study should be related to the size and complexity of the main study and it has been suggested that every important subgroup of the target population be covered (Green et al., 1988). In the present study there were three subsets of interest: outpatients, inpatients and hospital staff. Each of these were piloted and the method used will be described in the relevant sections.

2.3.4 The outpatient survey

2.3.4.1 Outpatient survey content

The interview survey was six pages long and contained 35 questions (see Appendix I). The questions were chosen to meet the aims of the research and standard questions were used when these were appropriate. The questions were also discussed with the research advisory group. This group was made up of the author's supervisors, a statistical advisor, a professor of sociology from another university and the smoking cessation service leader. Different questions were asked depending on smoking status therefore no respondent was required to answer all of the questions. The questionnaire was divided into four sections:

- Section One was completed by all respondents. Questions in this section concentrated on the present service offered and whether the patients felt there was a need for a new service. Respondents were asked their smoking status, whether they had been asked about smoking in their appointment, if they thought that this was appropriate and whether or not they felt that the hospital had a need for such a service.

- Section Two was completed by present smokers only. They were asked about the quantity of cigarettes or tobacco they currently smoked, what advice they had

been given on smoking, whether they wanted to stop and what would help them to stop.

- Section Three was completed by ex-smokers only. 'Ex-smokers' were designated as those who had given up for more than a month (Office of Population and Census Statistics, 1994). Those who had stopped smoking since they had been in hospital were not categorised as ex-smokers. Ex-smokers were asked how much cigarettes or tobacco they had smoked, how long ago they had stopped and if anything had helped them to stop.

- Section Four was completed by all respondents. It contained standard demographic questions including age, sex and marital status. These were placed at the end as respondents can find demographic questions threatening (see, for example, Brook 1977).

Questions on smoking status and quantities of tobacco, cigarettes or cigars smoked, both presently and, for ex-smokers, in the past, were taken from the General Household Survey so that the results from the clinics could be compared to the general population (Office of Population and Census Statistics, 1994).

2.3.4.2 The patient information letter

Patients were given a patient information letter before the survey, in compliance with ethical approval requirements. This letter informed patients about the research project,

advised them that they may be asked to answer a few questions after their appointment and assured them that their participation was voluntary and their responses confidential. It also gave a contact address and telephone number for the researcher. The information letter was written in clear language and was intended to be accessible and easy to read (see Appendix II).

2.3.4.3 Outpatient pilot study

The outpatient interview survey was piloted on 13 respondents at the Respiratory Outpatient Clinic on Friday 7th April and on 15 respondents at the Cardiology clinic on Friday 12th May 2000. It took approximately five minutes to complete. No patient refused to participate.

After the pilot study a number of changes took place:

- The order of the questions was changed to help the questionnaire flow more easily.
- Ex-smokers were asked why they stopped smoking and what helped them to stop, as patients in the pilot study usually volunteered this information and it helped to determine what services were currently available.
- Originally there were two separate questions asking 'Do you think it is appropriate to be asked about smoking when you are attending an appointment in the hospital?' and 'Do you think it is appropriate to be asked about smoking when you are attending this clinic.' These questions intended to determine whether patients felt that this advice was appropriate in certain circumstances but not in others. However they were

confusing, and the same answers were generally given; therefore, the second of these was omitted in the final version of the questionnaire.

- The question 'who asked you about your smoking' which was originally an open question, was changed to a closed question with the choice of responses being 'doctor', 'nurse', 'other'.

Once they agreed to participate, respondents were happy to answer all of the questions and had no difficulty in understanding them.

2.3.4.4 Selecting outpatient clinics

Six outpatient clinics were chosen from the medical unit. It was decided only to survey patients in this unit because this was where the smoking cessation service would initially be set up. The clinics chosen were diabetes/ endocrinology, respiratory, cardiology, dermatology, gastroentology and the travel clinic. These were chosen to reflect diverse conditions treated in the medical unit and because they vary in how smoking contributes towards illness treated within these specialities. The travel clinic was chosen because the infectious diseases ward was surveyed in the inpatient study and the travel clinic was part of the same department. Smoking is likely to play a major role in conditions treated in respiratory and cardiology clinics, to be of some importance in diabetes and endocrinology and of less importance in gastroentology and dermatology.

Outpatient clinics were surveyed between April 2000 and November 2000. Outpatient clinics were run on two or three mornings or afternoons a week. The survey was carried

out on each of the days on which the clinic was run. For example the respiratory outpatient clinic took place on a Monday, Tuesday and Friday and surveys were carried out on each of these days. It was important to ensure that the survey was carried out on each of the different clinic days because in some specialities different conditions were concentrated on a particular day. For example clinical staff in the respiratory clinic generally saw patients with lung disease on a Friday and those with asthma on a Monday.

Because of the layout of the outpatient waiting areas it was sometimes difficult to discern which clinic a patient had attended. This meant that there was occasionally some overlap; that is some respiratory patients may have been surveyed on a day where it was aimed to survey cardiology patients. On a few occasions this also meant that patients attending other clinics, which were not part of the target clinics, were also surveyed. The number of people who took part in each clinic can be seen in Table 2.1 below:

Table 2.1 Number of patients surveyed in each clinic

Clinic Name	Number of Patients Surveyed
Respiratory	64
Diabetes/ Endocrine	60
Cardiology	37
Dermatology	19
Gastroentology	26
Travel Clinic	8
Other	14
Total	228

Generally two consultants ran each of the clinics. They were supported by other clinical staff such as registrars, senior house officers, nurses, laboratory staff, auxiliaries and dieticians. Once these clinics were chosen the consultants were written to formally, outlining the project, informing them that it had ethical approval from the local health board and asking permission to survey their patients. It was also made it clear that the survey would not interfere with the running of the clinic in any way. None of the consultants refused permission to survey the patients. One clinic was later cancelled because the consultant was ill and an alternative date was arranged.

While the broad purpose of the study was described to clinical staff, they were not given detailed information about the questions that the patients were to be asked, nor did they request such information. The survey examined whether patients had been asked about

smoking in their last appointment or advised to stop smoking as described above. It was felt that if the clinical staff had previous knowledge of this it might influence the advice which they gave.

2.3.4.5 Outpatient survey procedure

I arrived at the selected clinic fifteen minutes before it began, introduced myself to the nurses and auxiliary staff and asked the receptionist to distribute the 'Patient Information Letter' to each patient when he or she checked in for their appointment.

Immediately after their appointment, I asked patients if they would be willing to answer a few questions. If they agreed, they were taken into a treatment room or to a quiet corner of the waiting area and asked to fill in a consent form. I then went through the questions on the interview survey. In a large number of cases a member of their family or a friend was also present at the interview. As the questions were not of a sensitive nature it is unlikely that this affected the responses given.

As there was generally more than one clinician seeing patients it was impossible to survey all patients attending the clinic. Some patients left while I was speaking to another. The survey took less than five minutes to complete

2.3.5 Inpatient survey

2.3.5.1 Inpatient survey content

The inpatient survey was very similar to the outpatient survey, so that results could be combined and comparisons made where appropriate. The inpatient survey was adapted where necessary, for example amending 'in your most recent outpatient appointment' to 'since you have been in hospital.' In addition, inpatients were asked how long they had been in hospital and in which wards they had stayed during their present admission.

2.3.5.2 Inpatient pilot study

The inpatient interview study was piloted on 30 patients in the respiratory and receiving wards on the 4th December 2000. One patient refused to participate. Therefore the response rate was 97%.

After the survey was piloted some changes were made:

- Patients were asked if they had been in any other ward apart from the current one during their present stay, in order to determine which wards were most likely to give smoking cessation advice.
- Patients were asked how long they had been in hospital rather than how long they had been in their present ward. Patients were often moved around between wards and could not always remember how long they had been in each ward.
- Some of the language used was changed slightly to enhance clarity.

2.3.5.3 Pilot of inpatient postal survey

The survey was also piloted by post to assess whether this would be less time consuming for the researcher and to estimate the likely response rate. One hundred patients were randomly selected from the list of those who had been discharged from the medical unit that week. Twenty-two people responded. In a further four cases a relative telephoned or wrote to say that the patient had died. In five cases the survey was returned saying that it was sent to the wrong address or the patient had gone away. In two cases, where the patient had died, the relative or a GP wrote to complain about the survey. In those cases we contacted the GP and the relative to apologise. Therefore it was concluded that this method would be unsuitable. Many patients would be too ill to respond, others would have died since being discharged. Other patients may have moved to a nursing home, to a hospice, to their relatives or have been readmitted. Furthermore this survey could have caused distress to patients or their relatives.

2.3.5.4 Selecting inpatient wards

Wards were selected from the medical unit to reflect a similar range of patients to those in the outpatient clinics. Obviously no exact match was possible. For example there is no equivalent of the receiving ward or infectious diseases ward in the outpatients department. Similarly, while people with diabetes attend an outpatient diabetes clinic for regular check ups, there is no defined diabetic inpatient ward.

Wards were surveyed between December 2000 and February 2001. Generally two or three week periods were left between visits to the same ward to avoid as much as possible

the same patients being surveyed twice. The number of patients surveyed in each specialty are Table 2.2 below.

Table 2.2 Number of patients surveyed on each ward

Ward Name	Number of Patients Surveyed
Infectious Diseases	26
General Medical	24
Dermatology	23
Respiratory	37
Coronary care	31
General Medical (2)	27
Medical Receiving Ward	17
Total	185

Wards selected were the receiving ward, where patients are generally admitted until they are moved to a more specialised ward, and the coronary care, cardiology, respiratory, dermatology, general medical and infectious disease wards.

Once the wards were selected the project leader introduced me to the sister or charge nurse of each of these wards. By necessity this was the person on duty at the time; because nurses work shifts, different nurses may be in charge at different times or on different days. All of the nurses were happy for the survey to go ahead.

2.3.5.5 Inpatient survey procedure

The evening before I was due to visit the wards to administer the survey, I telephoned the nurse in charge to confirm that this was still suitable. As this often was not the nurse whom I had met in my initial introductory visit, I explained the purpose of the study again and checked if it was still convenient for me to come the next day.

I then arranged for patient information letters to be distributed at the same time as nurses were distributing drugs to patients. The letters explained that I was coming to visit, and the purpose of the survey. Again, in line with ethical requirements, it also made clear that the patient did not have to participate and that this would not affect their care in the hospital. When I arrived I introduced myself to the person in charge, usually a sister or charge nurse. In some cases this was a different person to the one I had telephoned or had been introduced to at the start of the study. On one occasion on the Cardiac Care Unit I was asked to return at another time because there had been several emergencies that day.

Before I began the survey I asked the nurse if she or he felt that there were any patients to whom I should not speak because they were too ill, confused or were confined due to infection. I was unable to survey about a third of the patients for these reasons. The inpatient survey took ten minutes to complete. This was longer than it took for the outpatient survey to be complete because (i) more patients had hearing difficulties and, (ii) inpatients were more likely to be talkative.

2.3.5.6 Response Rate of the Patient Survey

Two hundred and twenty-eight outpatients were surveyed and a further 21 (13 men and 8 women) refused. Those who refused said that they were in a hurry, were being collected or were late for another appointment. The outpatient survey has a response rate of 92%.

One hundred and eighty-five inpatients were surveyed. Only one inpatient refused to take part on the grounds that he objected to surveys in general and always refused to participate. Therefore the inpatient survey had a response rate of over 99%.

2.3.6 Calculation of sample size

Sample size calculations are necessary to ensure that the size of the sample is sufficiently large to detect a difference between two populations (see for example, Bland, 1987, p 159. In general larger sample sizes have a greater power to detect smaller differences between two populations. However smaller sample sizes can detect a difference between groups if this difference is sufficiently large. Sample size calculations allow us to estimate the number of participants required for the study, without wasting time and resources collecting data from more people than is necessary. Using sample size calculations allows us to choose an appropriate number of participants which achieves both of these aims.

The project underwent unavoidable changes after the patient survey was carried out. It was originally intended that the patient survey would be carried out before the smoking cessation coordinator was employed and this survey would be repeated twelve months

after the smoking cessation service had been set up, to assess the impact of the service on the smoking cessation advice and support which patients received. However, as described further in Section 11, it was not possible to carry out the second stage of the survey. This had important implications for the calculation of the sample size. This had been calculated on the basis of the original survey design. As the survey had already been carried out it was not possible to alter the number of patients surveyed on the basis of a calculation for sample size based on the new aims. However confidence intervals are given which allow an estimate of the effects of the sample size to be made. Therefore this section will describe the original calculation upon which the sample size of the survey was based.

The patient survey sought to investigate a number of factors and both smokers and non-smokers were surveyed. To calculate the sample size, however, it was necessary to identify a key indicator. In the original aims of the study it was felt that the most important aim of the intervention was that significantly more smokers were offered some form of help to stop smoking after the introduction of the smoking service. Therefore, in order to calculate the sample size, it was necessary to have an estimate of both how many smokers would be given advice before the introduction of the service and how this would increase after service was in place. This was based on the results of similar studies.

It has been estimated that clinicians gave advice on smoking to approximately 25-30% of patients, (McIlvain et al., 1992; Rosen et al., 1995; Shiffman et al., 1998), although this may differ depending on the illness for which the patient was receiving treatment

(Emmons and Goldstein, 1992). These studies did not report whether this percentage changed after the introduction of a smoking cessation service.

Based on these figures it was assumed that 25% of patients who smoked, and who were receiving treatment in Reidpark Hospital, would be given some form of advice or counselling on their smoking. The service leader aimed that this would increase to 50% after the smoking service was implemented. If the survey was to detect an increase from 25 to 50% of smokers being offered some assistance to smoke, with a probability of 95% (i.e. to the 5% significance level) that any difference shown reflects a true difference, with a power of 80%, would require a sample size of 63 smokers in both the inpatient and outpatient sample, that is 126 in total.

All patients were surveyed, whether smokers or not. Smoking prevalence figures for Scotland in 1998 stated that 33% of adults smoke (Office of National Statistics, 2002. Therefore, to ensure that at least 63 smokers in both samples were surveyed, a sample size of approximately 200 inpatients and 200 outpatients was required. As the survey progressed it became clear that there were more smokers in the inpatient group than was originally estimated. Therefore only 185 patients were surveyed.

2.3.7 Coding and data preparation of the patient interview survey

Most of the questions in the interview schedule were closed questions, which could easily be pre-coded. The question about amount of tobacco smoked was answered in ounces or in grammes, and data were then re-coded so that all responses were in grammes.

In the following questions responses were not closed, but were written as free text and later coded into broad categories when this was appropriate:

- Whether the patient thought it was appropriate to be asked about smoking when attending the hospital, and why (all respondents).
- What services they knew of in the hospital to help patients to stop smoking (all respondents).
- What kind of help they had been offered to stop smoking (current smokers).
- What kind of help they would like to be offered (current smokers).
- Why they had given up smoking (ex-smokers).
- What helped them to stop smoking (ex-smokers).

Data were entered twice by two different members of staff. A check was then run comparing the two files for inconsistencies. Any inconsistencies were checked against the original interview survey and amended. Then the check was run again to ensure that the data were accurate. Checks for internal consistencies were also made. For example it was ensured that no ex-smokers answered questions on their current smoking status and those who said that they had not been offered help to stop smoking did not later say that a nurse had given them help to stop.

2.4 Interviews with Clinical Staff

In order to identify individual, structural and organisational factors which might affect the introduction of the smoking cessation service, semi-structured interviews with a number of key people working within the hospital were used. Qualitative researchers have described a number of reasons for using qualitative interviews. I will discuss those that are relevant to the present study.

First, there is the pragmatic reason that the data may not be available in any other form so talking and listening to people is the only way to achieve the information required (Mason, 1997). This was pertinent to the present study, as there was little knowledge of the factors which contribute to the introduction of a health promotion service. Second it was important to explore staff opinions of the service, and whether they thought it had a future, how they had heard about it and whether or not they used it. It is generally held that interviewees are more likely to express their viewpoint in a relatively open interview than a structured questionnaire (Flick, 1998). Long-term observation of meetings and staff interaction in the hospital may also have gained some insight into policy decisions and barriers to change this however would be impossible for one person to achieve within the time constraints necessary. Moreover such a method is also better for determining external processes (Denzin and Lincoln, 2000, p 825), whereas the present study is primarily concerned with staff opinions, thoughts and feelings.

Interviews are also a useful method for this kind of project since their flexibility means they can take account of the different experiences of interviewees. "Qualitative interviewing tends to be flexible, responding to the direction in which the interviewees

take the interview and perhaps adjusting the emphasis in the research as a result of significant issues that emerge in the course of interview" (Bryman 2001, p 313). In this study it was necessary that the interviews were not prescriptive, particularly as interviewees had different roles and responsibilities within the hospital. This meant that some of the questions would be pertinent to some interviewees but not to others. For example, while clinical staff had patient contact and were asked about how they referred patients to the smoking cessation service, it was not appropriate to ask management staff the same question. In addition, an interviewee's exact roles and responsibilities were not often known in advance of the interview. Because the interview was flexible it could be adapted to take account of the interviewee's job and knowledge of a particular subject, and answers could be followed up when necessary. For example, hospital policy decision-making was discussed in more detail with those staff who were involved in policy development or implementation, and in less detail with staff who expressed little interest in or knowledge of these subjects.

Finally, the need for in-depth accounts particularly in research in social organisations has been emphasised: "This requires an understanding of depth and complexity in, say, people's accounts and experiences rather than a more superficial analysis of surface comparability between accounts of a large number of people" (Mason, 1997, p 41). The qualitative section of the present study asked questions relating to topics which the interviewee may not have previously considered, and to which they might not have a clear-cut response. Therefore sensitive questions were required to elicit information and

the interviewees needed time to think about their answers, which could best be done in a one-to-one interview.

2.4.1 The interview protocol and covering letter

The themes for the interview were directed by the research questions and informed by visits to the hospital which took place in order to carry out the inpatient and outpatient survey and to attend meetings about the research. They were also informed by discussions with the smoking cessation coordinator and the project leader, as well as by the literature. While there has been little directly relevant research, research on other health service interventions and on the implementation of smoking policies has identified a number of factors which act to aid and to inhibit change and which could be further explored in the present study. Key themes identified in the literature are individual barriers, such as the role and opinion of the clinician, their perception of the patient's feelings and the patient's wish for such a service (Battle et al., 1991; Taylor et al., 1993; Allaway and Stevens 1996; Johnson 2000), and structural and system barriers such as time, enumeration practice, and hospital policy (Kottke et al., 1990); the appropriateness of health promotion services in this context (Skrabanek 1994; Ng 1997; Norton 1998); and organisational barriers (Joseph et al., 1995; Cooke et al., 1998).

Interview questions were based on these themes. The interview was divided into four sections. The first section contained contextual questions, for example biographical details, the interviewee's role and responsibilities and the team in which they worked. The second section related to health promotion, for example the interviewee's definition

of health promotion, who they believed was responsible for this, and whether or not they thought that clinical staff could influence patients' behaviour. The third section focused on the smoking cessation service, how they had heard of it and whether they would refer to it. The fourth section contained questions on change and innovation in the hospital and was concerned with communication and with hospital policy (see Appendix III for an example).

These interviews were altered so that the questions were relevant for each of the interviewees, and follow up questions were used to elicit more information when necessary. The interview was also adapted in light of other interviews. For example if the smoking coordinator commented on a problem she had experienced with one department this might have been followed up in an indirect manner with a member of that department. However no reference would be made in an interview to comments that a previous interviewee had made to ensure that confidentiality was maintained.

Interviewees were also given a letter that they could take away with them. This thanked the interviewee for taking part in the research, gave brief details of the project, reassured them of confidentiality and gave a contact address for further questions.

2.4.2 Selecting interviewees

A form of theoretical sampling was used to select the interviewees. This method was originally used to carry out grounded theory research and was described as "the process of data collection for generating theory whereby the analyst jointly collects, codes, and

analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (Glaser and Strauss, 1968, p 45. In research based on grounded theory, groups are compared and the theory is developed as the data are collected. This means that the theory emerges from the data and is continuously adapted as new information is found. Individuals are selected in order to give new insights into the theory rather than to represent a group, as is traditional in random sampling or stratification. In theoretical sampling, "Sampling is oriented to the groups whose perspectives on the issue seem to be the most instructive for analysis" (Flick 1998, p 187).

Since it was originally defined, the method of theoretical sampling has often been adapted by other qualitative researchers who do not stick rigidly to the grounded theory approach (as discussed in Silverman 1985; Mason 1997; Flick 1998). The approach of the present study is in line with that defined by Mason (1997, p 94): "theoretical sampling means selecting groups or categories to study on the basis of your research question, your theoretical position and analytical framework, and most importantly the explanation or account which you are developing."

The present study is interested in factors which act to help or impede the introduction of a smoking cessation service. Interviewees therefore were chosen purposively from different professions within the hospital, in order to elicit a range of views. Some staff were chosen because they had frequent contact with the smoking service, some were involved in policy development, funding and service delivery, and others were involved

in patient treatment and therefore would make decisions about whether or not to refer patients to the smoking cessation service. The frequent visits to the hospital to carry out the patient survey and to attend meetings helped inform the process of selecting suitable interviewees. Interviewees were not all selected in advance; rather, some interviewees were selected after earlier interviews had been carried out or from conversations with the smoking cessation coordinator. The smoking cessation coordinator was not told who was being interviewed in order to protect interviewees' confidentiality, although several interviewees did choose to tell her themselves.

Mason (1997, p94) cautions that when using theoretical sampling it is important that the sample is chosen to *test* the theory rather than just to support it and that researchers might often want to seek out 'negative instances' or 'contradictory cases.' In this study I also chose interviewees specifically because they had not referred patients to the service or because they were believed to have reservations about the service.

The interviewees selected for this study can be defined as 'expert interviewees' that is respondents in whom the interviewer is less concerned with the whole person (as in a biographical interview) and more in his or her expertise and knowledge about an area. "He or she is integrated into the study not as a single case but as representing a group of specific experts ...", in this case the interview is usually more directive and "...the range of potentially relevant information provided by the interviewee is restricted much more than in other interviews" (Flick 1998, p 91).

2.4.2.1 Key Informants

The selection of interviewees was also informed by discussions and meetings which took place with the smoking cessation coordinator as well as by frequent visits to the hospital. To some extent the smoking cessation coordinator and the consultant originally involved in the study acted as 'key informants' who helped to direct me towards people who would be useful to interview. Bryman (2001, p 297 points out that sponsors or gatekeepers can both smooth access to a service and become key informants in the subsequent fieldwork. "... Certain informants may become particularly important to the research. They often develop an appreciation of the research and direct the ethnographer to situations, events, or people likely to be helpful to the progress of the investigation." He does caution that it is important that the researcher does not begin to see social reality through the eyes of the key informant. I felt that this was avoided as much as possible first by being aware of this potential problem, second because the two people who acted in this role had differing opinions and roles and third because I had been in the hospital collecting patient data regularly for a year before the smoking cessation coordinator started and thus had formed some of my own impressions.

Appendix IV describes the interviewees, their role and position in the hospital and, where relevant, some explanation of why they were interviewed. Interviewees' names have been changed to protect anonymity.

2.4.3 Piloting the interview protocol

The protocol was piloted with four members of staff working in the hospital who agreed to take part in a pilot study. The reasons for carrying out pilots have been discussed earlier. The pilot interviewees included a Senior Registrar who had referred patients to the service, a nurse in the receiving unit who was not aware of the service, a physiotherapist and a cardiographer. The pilot was carried out to check that the questions flowed correctly and were relevant to the interviewee and also to check the timing of the interview and to ensure the equipment for recording was suitable.

After the pilots were carried out some amendments were made to the interview protocol. In addition the protocol developed throughout the interviews and was adapted for different interviewees. The following questions were added:

- If the interviewee had referred a patient to the smoking cessation coordinator interviewees were asked if they knew how she followed this up;
- If they had seen any changes since the smoking cessation coordinator was employed and what they felt her impact had been;
- How new services could be introduced more easily;
- What they thought of the new smoking cessation service; and
- How they heard about policies, whether this was adequate, and whether there was a better way of being informed.

2.4.4 Interview administration

The staff interviews were carried out between July and November 2001. The smoking cessation coordinator had been employed in March of the same year and had started to develop the service at the time of the staff interviews. Twenty-four interviewees were approached by telephone or in person. Interviewees were told about the purpose of the study and asked if they would be willing to participate. They were also assured of confidentiality. Twenty-two of those approached agreed to participate and two refused. Both of those who refused said that they were too busy and recommended a colleague. One consultant agreed to participate but, due to work pressures, had to rearrange this date five times over three months. Finally the attempt to interview him had to be abandoned, as he had no free time available. One manager had to cancel the interview as he was seconded to another post outside the health service. Therefore twenty people were interviewed in total (out of twenty-four originally approached).

Interviews lasted between thirty minutes and one hour. Interviewees were given a covering letter at the beginning of the interview. All of the interviews were carried out in a quiet room in the hospital, usually a member of staff's office. One interview had to be cut short early due to an emergency but was completed at a later date. The interviews were taped using a mini-disc recorder. These tapes were then transcribed. I then listened to the tape again while reading the transcription to check for errors. The transcriptions were then coded and analysed using QSR NVIVO 2000 version 1.2.1, a computer package which assists in the analysis of qualitative data.

2.4.5 Analysing Transcripts

Transcripts were analysed thematically. Thematic coding is generally used when the research questions relate to a specific issue, and where these questions largely drive the interview schedule. This was the case in the present study.

Coding was carried out in a similar way to that described by Flick (1998). First the first case was briefly summarised. Next the interviewee was described with regard to the research question (i.e. job title, speciality etc). The transcript was then coded, at first generally and then again with more selective coding, related to the specific themes. These themes may have arisen in response to the interview questions or may have arisen unprompted from the interviewees. At this time comments and memos were also attached to the interview. These generally related to the development of themes, comments from my experience of the fieldwork and links to sections of other relevant interviews. After this the themes and categories were cross-checked. The same coding was applied to the next case and the coding and themes were modified and added to where necessary. By doing this one has "a case-oriented display of the way the case specifically deals with the issues of the study, including constant topics ...which can be found in the viewpoints across different domains" (Flick 1998, p 190). In this way cases could be compared and similarities and differences between their viewpoints elaborated. "By developing a thematic structure which is grounded in the empirical materials for the analysis and comparison of cases, the comparability of interpretation is increased. At the same time, the procedure remains sensitive and open to the specific contents of each

individual and the social group with regard to the issue under scrutiny" (Flick 1998, p 192).

At this point the themes which appeared to be the most important were analysed in greater depth. In order to do this, matrices (i.e., tables with rows and columns) were drawn up so that themes could be displayed more clearly and patterns and links made between them. These matrices were 'role ordered', that is rows represented 'data from sets of individuals occupying different roles' (Robson 2002, p 482) and contained references to the original text.

Patterns were tested within interviews as well as between them. That is, an interviewee's response to one question was checked with their response on similar issues to see if these were related or whether certain themes clustered together, and generalisations were made. Themes and patterns were tested so that 'outliers' and 'extreme cases,' that is those who did not fit into the overall pattern, were examined in more detail and potential explanations given. Outliers were particularly important in this research as if one interviewee held a different view from the others, or was influenced by different factors this could be pertinent because of their role. For example the Clinical Director could affect funding decisions for the service regardless of clinical support. Similarly if the smoking cessation coordinator had different aims for the service from those referring to it, this would also be relevant. Miles and Huberman (1994, p267-268) point out that it is necessary to 'weigh' data as some data are stronger because of the particular knowledge of the informant. Therefore relationships were explored between

an interviewee's opinion and their role and this was described where such a relationship seemed relevant and plausible.

2.5 Conventions used in the thesis

2.5.1 Use of first and third person

The thesis will use third person throughout except when discussing the author's own experiences or insights when first person will be used. This will be most prevalent in the qualitative chapters.

2.5.2 Spacing

In the qualitative quotes two full stops (..) denote that the interviewee has paused whilst three (...) denote that some of the quotation has been omitted.

2.6. Research Ethics

In recent years there has been increasing emphasis placed on good ethical practice and on gaining ethical approval for research projects, particularly those which involve NHS patients. All health boards now have their own ethics committees and their role has been described thus:

"Research ethics committees exist to ensure, firstly, that proposed research will not expose participants to unacceptable risks and practices; and secondly, that the potential

participants can evaluate the expected consequences of their involvement and decide for themselves whether to participate" (Savulescu et al., 1996, p1391).
The present study met all of these criteria.

Most ethical debates on health issues concentrate on physical investigations, for example the side effects of drug treatment or the ethics of carrying out clinical investigations, such as biopsies or blood tests (see for example, Savulescu et al., 1996 and Medical Research Council 1999). Clearly the present project did not subject participants to any of these risks. Nonetheless, it is important that full consideration is given to ethical issues. While there may be no risk of physical damage, questionnaires and interviews can be psychologically intrusive and the gains from the research must outweigh any harm or inconvenience caused to patients. Ethical approval was sought from Central Region Health Board.

2.6.1 Ethical approval

In Central Region Health Board, ethics committees meet regularly to consider research proposals for ethical approval. The application form requires a description of the project, including its aims, objectives, study design and scientific justification. A description is also required of how informed consent is obtained and confidentiality maintained and of funding sources and any costs associated with the project. Other supporting papers which will be used as part of the research project, such as questionnaires, interview schedules, patient consent forms and patient information letters, must also be supplied at this time (Central Region Health Board, 1997).

The ethics committee stipulates that any patient involved in a study be asked to give written consent. The consent form should include their name, address and their signature. Patients must also be given an information leaflet or letter, which they can take away with them. It was agreed with the ethical approval committee that staff interviewees should also follow this procedure.

Ethical approval requires that it is made clear to the patient that they do not have to take part in the study, that they can withdraw at any time and that their decision on whether or not to participate will not affect their care in any way. Any changes made to the project must be resubmitted to the ethics committee. The present project was submitted to the ethical committee for approval in February 2000. The proposed methods were given a strong endorsement by the ethics committee and it was granted ethical approval without changes being required.

After the project began it was decided to pilot a questionnaire which would be posted to patients recently discharged from hospital (see Section 3.5.3). Approval was sought and received for this change in line with requirements. An interim report was requested and supplied in May 2002.

2.7 Ethical Considerations

Some of the ethical considerations which arose from the ethical requirements as well as those related to the patient survey, the staff interview and gaining access to the sample are discussed below.

2.7.1 Ethical considerations in the approval process

The layout and requirements of the Central Region Health Board ethical approval form are more suited to clinical studies and drug trials, rather than research projects concerned with the opinions or attitudes of patients. For example a large proportion of the questions ask about side effects, risks to which the 'subject' will be exposed, control of drug stock, storage of tissue samples, compensation, involvement in other trials and financial recompense. A project like the present one, therefore, did not fit comfortably into this format.

The ethical approval process also raised issues of confidentiality. As described in Section 6.1, a requirement of ethical approval in Central Region Health Board is that all participants must give their informed written consent. The consent form asks for the participating patient's name and address. Obviously this is necessary, if, for example, there was a potential for the research to adversely affect the patient's health or if there was a possibility that the hospital or staff could be sued because of a respondent's involvement.

However a significant part of the present study involved structured interviews with patients. At the time of the survey they were assured that any information they gave was confidential, that the interviews were anonymous and that clinical staff would only receive collated results rather than individual responses. As they were then asked to complete a consent form it was more difficult to assure participants that their anonymity would be maintained than it would have been had they been asked to complete a questionnaire. This could mean that, for example, patients would be unwilling to admit that they smoked. This might particularly be the case when the patient was attending the hospital for an illness which could be caused or exacerbated by smoking.

The focus of the structured interview was, however, on the outpatient appointment or inpatient stay rather than the patient's behaviour and the majority of questions were concerned with the appointment. While patients *were* asked if they smoked and if they would like to stop, this was done in the context of providing services rather than in relation to their illness. This should have served to minimise any reluctance the participant might have about admitting that they smoked. The fact that the smoking rates reported were similar to those for the Scottish population as a whole, as shown in Chapter Four suggests that patients did accurately report their smoking status, though it is not possible to make direct comparisons because the hospital sample differed in a number of way, for example, they were older and were more likely to be suffering from smoking-related illnesses.

As the survey progressed it became clear that patients were for the main part unconcerned about confidentiality and were not reluctant to answer any of the questions or to give their name or address. No patient refused to complete the interview survey after they had agreed to participate, nor did any patient refuse to complete a consent form. Any reluctance expressed was related to the possibility that they may be followed up at home to be asked more questions or that their address may be passed on to other people. Concerned patients were assured that this would not occur and they then seemed happy to continue with the survey.

Several factors are likely to have contributed towards patients' willingness to participate. First, the survey questions were not of a particularly intimate nature. Second, it was clear that I was supported by the hospital and patients assumed that their responses would be subject to the same levels of confidentiality as any other questions asked by hospital staff. This was reinforced by the fact that I wore a hospital identification badge, a nurse or receptionist often distributed the covering letter and on some occasions I was based in one of the treatment rooms. Third, in a hospital environment patients are generally used to being asked health-related questions by a variety of people. They are also often used to having junior doctors or student nurses present at ward rounds or appointments and in most cases are willing to accept this as part of their care. It was, however, made clear to respondents in the covering letter that they did not have to participate in the survey and permission was sought before commencing the interview.

2.7.2 Ethical issues in the patient survey

There were, however, ethical considerations related to the patient interview surveys. It is possible that some of the outpatients to whom I spoke could have been given a serious or even terminal diagnosis prior to the interview. This could have been related to their smoking. In such cases it could have been distressing for the patient to then be asked questions about smoking or even just to talk to a researcher. It is difficult to see how this could have been resolved. Obviously I could not have been informed of every patient's diagnosis before speaking to them and even if I could, this would have raised a new set of ethical concerns.

The participation of patients was voluntary and if they were distressed they could refuse to be interviewed. In some occasions in the outpatient clinics a doctor or nurse advised me not to approach a patient because they had just received bad news. In addition if a patient seemed visibly upset then I did not approach them to participate in the study. This happened four times. However the majority of outpatients would not have been given such a serious diagnosis; many of them were attending for routine checks, for example, in relation to their diabetes. My experience was that patients were happy to talk to me and were generally helpful and generous with their time, with few exceptions.

This impression was reinforced by the fact that the survey had a very high response rate and those who did refuse did not give reasons that related to the nature of the project. In fact several of those who were most seriously ill commented that while it may be too late to help them they would be happy if their experience could help others. As Foster (1996,

p 187) has noted "Reasoning people do not necessarily seek that thing which is most likely to benefit themselves. They may, for example, forgo personal benefit for the sake of some greater good. It is therefore important to consult reasoning people rather than to assume that they want good to be done to themselves."

There were also some ethical issues concerning inpatients. As mentioned previously, these patients were often very ill or confused. While I did consult with the nurse in charge of the respective wards about which patients I should not disturb, I did find that a number of patients I spoke to were confused as to my purpose in speaking to them. If it was clear that the patient did not understand the questions I apologised and withdrew, ensuring that they were not left in an anxious or disturbed state.

2.7.3 Ethical issues in the staff interviews

Confidentiality considerations were particularly relevant in the staff interviews, which were tape-recorded, were in depth, and explored some political issues. For example, interviewees were asked about their relationship with hospital management, about staff morale and about problems in the workplace. These questions could be perceived by interviewees to be sensitive and may have constrained their answers. As a relatively small number of staff were interviewed, and many of these held unique positions or worked in small departments, it would not be difficult for a colleague to identify them unless care was taken to hide their identity.

Staff participation was voluntary. They were assured of confidentiality both in the information letter given to them before their interviews and by the interviewer. Staff were told that no one would have access to the tape recordings and that while excerpts of their interview may be used, their name would not be associated with this, and any identifying details would be changed. The majority of the interviewees seemed unconcerned about confidentiality. Some of the more senior staff however did ask for further reassurance during the interview, particularly if they were discussing a controversial topic. No interviewee refused to be recorded although it is impossible to say whether they modified their responses because of the potential implications of their remarks. However much of the more sensitive information, such as budget details, were of little relevance to the research questions.

Interview tapes were kept in a locked drawer at the MRC Social and Public Health Sciences Unit. The tapes were marked with codes only and the interviewee's name was not recorded on the tape. Any identifying data were changed in written reports and I was careful that any discussion of the results with the smoking coordinator or the service leader was at a general level and that no identifying details of interviewees were given. In addition the name of the health board and hospital have also been changed.

2.8 Reflections on my Role in the Research Process

It is important that the researcher's role in the research process is discussed:

> "Qualitative research should involve critical self-scrutiny by the researcher, or active reflexivity. This means that the researcher should constantly take stock of their actions and their role in the research process, and subject these to the same critical scrutiny as the rest of the 'data.' This is based on the belief that the researcher cannot be neutral, or objective, or detached, from the knowledge and evidence they are generating. Instead they should seek to understand their role in that process. Indeed, the very act of posing difficult questions to oneself in the research process is part of the activity of reflexivity" (Mason 1997, p 5).

I would like to explore here some of the issues that arose and insights I gained from carrying out this research.

I visited the hospital fifty-four times, largely to interview patients but also to meet with the contact consultant and the smoking cessation coordinator. I spent three days shadowing the smoking cessation coordinator, attending meetings with her and sitting in on her smoking cessation groups and on her counselling sessions with patients. I also kept a diary of these visits and of the visits to the outpatient and inpatient clinics. In addition I spent seventeen days in the outpatient clinic waiting to interview patients, and nine days in the hospital wards. This helped me to understand how these clinics and wards were structured and gave me a perspective on the environment in which the staff worked. While this was not intended to be an ethnographic study, I do feel that the notes

which I took acted as an *aide memoire* and that these visits influenced the research and my understanding of the hospital in a number of ways.

First I found that outpatients had to wait for a great deal of time before being seen for their appointment. Because of the aims of the patient survey it was necessary to speak to them after their appointment was over. As mentioned in Section 7.2 at this time they may have received bad news about their illness or may be tired or stressed from the wait and the consultation. While the response rate was high, at over 95%, I did find it difficult to approach people in these circumstances. In addition the waiting rooms were often overcrowded and it was not easy to get space to carry out the survey. This helped to inform the analysis of the study and to understand the conditions in which staff were working and patients were being treated.

Second, a large number of patients were very ill and often confused and many had hearing difficulties. This was particularly evident for inpatients. This made the administration of the interview survey difficult. It also meant that I was disturbing people in order to complete a survey which was likely to have little benefit for them. This gave me an insight into the environment in which staff were working and how this might affect the preventive health work which they did. It was important to ensure that my initial assumptions did not colour my analysis of the data and this was avoided by continually examining these assumptions against the empirical data.

Third, these visits gave me an opportunity to meet some of the staff and identify appropriate interviewees. In particular I gained an impression of the staff with whom the smoking coordinator most frequently interacted and what role they played in the development of the service. This also helped to shape the questions staff were asked in the one-to-one interview schedule.

Flick (1998) cautioned that in this type of research the researcher has to ensure that they are not an 'incompetent interlocutor,' that is, to ensure that they know enough about the subject to ask intelligent questions and to be sensitive enough to know when to pursue subjects the interviewee brings up without getting lost in irrelevant topics. The frequent visits to the hospital helped to avoid this. In addition I had worked in the health service in Scotland for five years and for three of these I was based in the board of which Reidpark Hospital was part. I had also carried out research with doctors and nurses in other studies. I feel that all of these factors helped me to have a good understanding of hospital systems, environments, staff roles and the language used, and therefore to ensure that I could communicate with them without difficulty.

2.8.1 Relationships with key staff

2.8.1.1 The service leader

David Cairngorn, the consultant who initiated and developed the smoking cessation service, was also closely involved with the development of the research project. He assisted with access and was involved in regular research advisory meetings. As I

described in Section 7.3 this had implications for confidentiality. Unless care was exercised it was possible for staff members to be identified, as many of them were doing a unique job or were a member of a small team. These could be people with whom the consultant worked regularly.

A large part of the project was about perceived barriers to the implementation of the service and therefore interviewees were asked to discuss their attitude to such a service and whether or not they thought it would be a success. It was important that the anonymity of the interviewee was preserved and that any discussion of preliminary results was at a general level. However this rarely posed difficulties as the majority of each interview was spent discussing general hospital policy rather than about specific aspects of service delivery and the perceived barriers to the service did not relate to named individuals.

2.8.1.2 The smoking cessation coordinator

It was also necessary to develop a good working relationship with the smoking coordinator to keep up to date with how the service progressed and how her job developed. The nature of the research could have posed a threat to her, as she could have perceived this as being an evaluation of her work. However the study began before the smoking coordinator was employed and, she was told about it at her interview, so by taking the job she was effectively agreeing to be part of the study. At first she considered me to be an expert in smoking cessation who was assessing her work to see if it was 'correct' and I frequently had to convince her that this was not the case and explain

the purpose of my project to her. She was assured that the research aimed to identify factors that would improve the implementation of the service, rather than seeking to criticise her work in any way.

However this quote, which was taken from an interview carried out three months after she was employed, shows she had been interested in the post because of its research component, was generally interested in improving the service which she gave, and was open to advice from any source.

> "...and what interested me most was the fact that it was a research job and I would be working with somebody like you, thought I could learn quite a lot from you ...I did, I did, I was excited, I thought, 'this is good, I am going to be working with a research project' although I knew I wouldn't be doing the research. But I thought, it's going to be good to actually look at something that I have set up and what somebody else thinks about it."(Marianne Findlay, Smoking Cessation Coordinator).

As described in Section 4.2.1 the coordinator also assisted with identifying suitable interviewees. In some cases this was because she perceived a particular person as being negative or unhelpful or having prevented her from developing aspects of the service. If I chose to interview any of these people I had to be careful not to be influenced by her experience of them and also to ensure that I did not reveal any negative comments they made about the service or its future.

2.9 Research in the Health Service

"Health service research is the discipline which seeks knowledge which will lead to improvements in the delivery of health care...in comparison with research into clinical medicine, the delivery of health care has hardly been studied at all" (Crombie and Davies 1996, p 4). These authors believe that such research has potential to make a major contribution to healthcare, however they also consider that such research is particularly difficult, and identify several reasons why this is so. Those relevant to the present thesis are discussed below:

- Dealing with people: I have previously mentioned that patients were often ill, confused or vulnerable and this sometimes made it difficult to administer the survey. In addition they may have been attending the hospital because of a smoking-related illness. In some cases their illness may have been terminal. Thus a survey related to smoking could have been upsetting to them. In relation to the staff interviews, staff were extremely busy and would not obtain an immediate benefit from being interviewed.

- Threat: As I was evaluating the present provision for smokers and the introduction of the new service, this could be threatening both for those staff who were involved in treating patients and those who were involved in setting up the new service, particularly the smoking cessation coordinator.

- Ethics: In the present study the main ethical issue concerned the confidentiality of patient and staff responses.

All of these issues have been discussed in more detail in Section 6.

2.10 Organisational Research

Doing research in a hospital has similarities to doing research in any organisation. Organisations can be difficult to access and speaking to interviewees becomes a two-stage process where one must first gain access to the organisation before gaining access to the interviewee. Often there are sensitive political and ethical considerations and it is important that the researcher can offer something back to the organisation (Bryman, 1989, p 1-4).

In the present study the project leader helped facilitate access to the organisation. He was also involved in the development of the research, which meant that he could have some input into its direction. One of the aims of the research was to find out whether patients perceived a need for this service. Clearly the results of this needs assessment would be useful to him.

Another important feature of organisational research is that the organisation is always changing and, in the case of the present study, the service developing. This can make it

difficult to know when to stop collecting data; however, the researcher cannot wait in the field forever for something new to happen. Nor can one researcher hope to report on every issue which might be pertinent in an organisation.

> "The amount of information that can be gathered concerning an organization and its members is potentially infinite. It can therefore be difficult for the researcher to decide finally to leave the organization, to gather no more information, and to begin the process of analysing and documenting what data have been collected. This can be an awkward psychological leap, as there is always the possibility, usually a strong probability, that vital information has been overlooked" (Buchanan, et al., 1988, p 64).

This was a particular challenge in the present project. Because of the time constraints for the thesis and because of the original aims, which will be described in the next section, much of the data were collected as the service was being set. Each time I visited the hospital or spoke to the smoking cessation coordinator or service leader it was tempting to gather new information as the service developed. However it would have been impossible for one person to analyse and write this up within the time required. To avoid this I concentrated on answering the research questions as initially defined, and agreed in advance how much time would be spent in the hospital and the amount of data which would be collected. This techniques for managing time in research projects was

suggested by Robson (2000). Staff interviews had to be done at an early stage because of the time required to analyse the interviews and write up the final thesis.

While most of the data were collected within a particular time period, I did subsequently keep in touch with key staff and Chapter Eight will outline how the smoking cessation service developed.

2.11 Changes to Project Aims

There were some unavoidable changes to the project aims after it began and these had implications for the research design. In organisational research it is necessary for the aims to be somewhat flexible in order to respond to unpredicted developments. An organisation is something that constantly changes; staff move, work alters, policies are reviewed. Bryman (1989) has pointed out how 'quirky' and 'messy' such research is and warns that "...whatever carefully constructed views that the researcher has of the nature of social science research... those views are constantly compromised by the practical realities, opportunities and constraints presented by organisational research." (p2). Because of this he advises that rather than presenting an idealised account of this research it is more useful to have a more reflexive look at some of the problems the researcher may encounter.

The original aim of the thesis was to assess the impact of the smoking cessation service. In order to do this a before / after design was chosen, in which patients would be surveyed and staff interviewed before the smoking cessation service was set up and smoking coordinator employed. This would provide 'baseline' data on how many patients smoked, whether they had been advised or helped to stop smoking, whether they wanted help to stop smoking, felt such advice was appropriate in this setting and if they would attend a service were it to be available. The patient survey and staff interviews would then be repeated twelve to eighteen months after the service was underway. In this way the effect that the service had had on staff attitudes and the help that they gave to smokers who wished to stop could be assessed. In particular, were patients and staff aware of the service? Did significantly more patients report being asked if they smoked, encouraged to stop smoking and offered help to stop smoking after the smoking cessation service was available? Did staff attitude to the provision of health promotion and smoking cessation change after the service was in place? Therefore, for the first eighteen months, the research project proceeded in line with this design.

The smoking cessation coordinator was expected to be employed in April 2000. Due to administrative and funding difficulties, she was not employed until March 2001, eleven months later than anticipated. At first, when it became clear that the start of the service would be delayed, it was felt that the time between the 'before' and 'after' part of the project could be made shorter and the follow up could be done after twelve months rather than eighteen. However by the time the post of smoking coordinator was advertised it was clear that it would be impossible to carry out the follow up within the allotted time.

The smoking coordinator would require some time to set up the service and time for this service to have an impact. This would mean that even to carry out a follow up after twelve months, data collection for the second stage could not begin until May 2002 at the earliest. It would have been impossible to collect and analyse this data as well as write up the final thesis before November 2002 when the funding ended.

However by this time, the project had been designed and the 'baseline' patient survey carried out. It was necessary therefore to adapt the study as far as possible so that this information could be used in a meaningful way. This was done by changing the aims of the project from being a "before and after" evaluation into one which aimed to investigated the implementation of a smoking cessation service and factors which affected this. The patient survey data could then be used to assess patients' views and current practice. As I have described in Section 3.6, this change had implications for the project design, in particular the calculation of the sample size used.

The staff interviews had not been carried out at this time and therefore were designed in line with the new aims. At a later point funding was successfully sought to carry out the follow up patient survey after the thesis was complete so that the hospital and service leader would still have the assessment which they wanted.

The next five chapters will present the findings from the research. The results based on the quantitative analysis of the patient interview survey will be reported in Chapter Four

and the findings from the qualitative analysis of the interviewees reported in Chapters Three, Five, Six and Seven.

Chapter Three: Staff Attitudes Towards Smoking Cessation Services

This chapter describes the literature which reports on clinicians' perception of the smoking cessation support and advice that they give to patients. It then investigates staff perceptions of these issues, based on the analysis of the in-depth interviews. Specifically it describes how interviewees make decisions about when to give smoking cessation advice and their feelings towards the stated aims of the new smoking service, in particular whether they believe it is their responsibility to help patients stop smoking and whether they think patients should routinely be asked about smoking. Finally it examines their attitudes towards the new service. As these interviews were carried out while the smoking cessation service was being set up, they help to illustrate the climate in which it is being introduced and thus may suggest potential barriers which are likely to affect its implementation. The next chapters will develop the discussion of these factors further. This chapter concludes by discussing the findings from the staff interviews in the context of the movement towards the introduction of smoking cessation services in UK hospitals.

3.1 Clinicians Helping Smokers to Stop

Chapter One described the increasing focus on hospitals as a setting for both health promotion and smoking cessation, the attempt to shift the focus of the hospital toward being a 'health' service rather than a 'sickness service' and the increased expectation that staff will promote good health as well as treat illness. It also described the related growth of dedicated smoking cessation services in hospitals and how clinicians are being encouraged to assist smokers, with whom they come into contact, to stop (Department of Health 1998b; Department of Health 2000b). This chapter will focus on studies which ask clinicians about the smoking cessation support they offer patients, and the next chapter, on patients' perceptions of the support which they are offered.

Clearly, even before guidelines were published, some clinicians would have given advice and support to smokers, particularly those who had a smoking- related illness, although they may not have done this as routinely or consistently as the guidelines now suggest. It would be useful to determine to what extent clinicians were asking patients their smoking status and encouraging smokers to stop. This would help us to understand the climate into which these services were being introduced and to assess whether clinicians were likely to accept the introduction of these services. Follow up studies could then be carried out to determine whether their practice has altered as result of these recommendations. The remainder of this section will review the available literature which investigates the advice and support which clinical staff offer patients.

In one UK study, 422 vascular surgeons were asked about the smoking advice which they gave and their feelings towards taking on this role (Basnyat et al., 2000). Ninety-eight per cent claimed to routinely advise patients to stop smoking, 60% said that they provided some help to do so, and 74% that they followed patients up to check whether they had been successful. This survey was carried out in 1998, before the publication of the smoking cessation guidelines and in the same year as the White Paper, *Smoking Kills* (Department of Health, 1998b) was published; therefore the surgeons were unlikely to have been influenced by either of these documents. While the results are self-reported, they do suggest that the majority of this group perceived that they were already giving some advice and help on smoking and certainly felt that this was an appropriate role for them. However it is likely that they were influenced by the specialty in which they worked and by the fact that many of the patients whom they treated were suffering from a smoking-related illness. Similar results are unlikely to be found in other specialties.

Offering standard advice to smokers in health care settings is also a goal in the US Health Service and it is worthwhile to look at US research to see if lessons can be learned for the UK. A large study set out to determine how well physicians' practice corresponded with the US guidelines (Thorndike et al., 1998), specifically, in what proportion of visits (i) smoking status of patients was identified, (ii) smokers were counselled to quit and (iii) smokers were given NRT. The study used data from an ongoing annual survey of US doctors in which they were asked to complete a form about each patient visit on a randomly assigned week. Data collected from 1991 to 1995 were analysed. Three

thousand two hundred and fifty-four physicians took part, representing a response rate of between 70-74%, and data were available on 145 716 adult patients.

The results showed that doctors identified patients' smoking status at 67% of visits and this remained relatively constant over time. Smoking counselling rates increased from 16% in 1991 to 29% in 1993 and then decreased in 1995 to 21%. NRT use followed a similar pattern increasing from 0.4% of smokers in 1991 to 2.2% in 1993 and then falling to 1.3% in 1995. Primary care physicians counselled patients at a significantly higher rate than specialists and reported NRT use among patients at a significantly higher level. All physicians were at least 1.5 times more likely to identify a patient's smoking status and counsel for smoking at visits by patients with cardiovascular disease, chronic pulmonary disease or pregnancy compared to other illnesses. Once again physicians were more likely to discuss smoking if the patient's presenting problem was caused by or exacerbated by smoking and if they work in a specialty associated with smoking.

The study also found that elderly patients were less likely to be counselled than younger patients, which further suggests that doctors were making decisions about whether and what advice to give based on their own beliefs of whether this advice would be useful and would motivate patients to change. It is likely that UK clinicians would make similar decisions. However UK guidelines recommend that smoking status is ascertained and advice offered at *every* encounter, regardless of the patient's illness (Raw e. al., 1999). These results suggest that it is this aspect of the guidelines which is likely to be the most difficult to achieve.

This study is important because it has a large sample and is methodologically robust, and as doctors were asked to complete the survey immediately after each appointment it is not likely to be subject to recall bias. However this method might overestimate the amount of counselling and advice generally given because physicians may have been reminded by the report to ask patients about these issues. One finding which was of particular importance was that while the rate of counselling and prescription of NRT increased in 1993 this increase was not sustained in 1995. If any change is to be maintained, therefore, then it will be necessary to have methods which integrate this into practice and ongoing assessment to ensure that this takes place. Otherwise it is likely that the number of patients who receive advice will increase after the guidelines or policies are first implemented but that this increase will not be sustained in the longer term.

In an older US study of 115 internal medicine and family practice residents fewer doctors reported asking about smoking or offering help to stop (Jelley and Prochazka, 1991). While the response rate was low (45%), it does suggest that there has been an increase in the amount of smoking cessation offered in recent years. It has been suggested in the UK that the amount of help given may have increased in a climate in which the provision of lifestyle advice in a consultation is becoming more common and this is also likely to hold true for the US (Lancaster et al., 2000).

It is becoming increasingly apparent that clinicians must be asked directly about the support and advice they offer smokers, whether they provide smoking cessation services,

if they think that they or the hospital should provide them, and what factors influence their opinion. The next section reports on the findings from the twenty clinical staff who were interviewed. These interviews asked clinicians both what advice they gave to smokers and whether they supported the introduction of a new smoking cessation service. The methods used for the analyses of these interviews were detailed in Chapter Two.

3.2 Findings

3.2.1 The smoking cessation service

The main aim of the smoking cessation service is described in Chapter One. This was to ensure that all patients attending the hospital should be asked if they smoked. If they did and wanted to stop, staff could then encourage and motivate them, referring patients to a smoking cessation service where this was appropriate. The smoking coordinator would be responsible both for publicising her service and for training staff on how to give opportunistic advice and when to decide to refer to the service.

The service was set up and introduced without any assessment being carried out to determine what smoking cessation services or advice were presently available, what staff's current practice was in relation to smoking, or what their attitudes and opinions were towards giving smoking advice and to the provision of a smoking service within the hospital. This section will explore these themes from a staff perspective, basing this on their in-depth interviews, the analysis being directed largely by the specific questions asked. What accounts did interviewees give of their current practice in relation to

smoking and how did they explain this? Did they believe that they had an important role in helping patients to stop smoking and would they be willing to do this routinely? Did their expectations of the smoking service match the intended aims of this service? By looking at these issues we can gain an insight into the culture of the hospital before the smoking cessation services were introduced and thus have some indication of whether the climate was suitable for its introduction.

Fourteen of the twenty staff who were interviewed had direct patient contact, and the themes which are concerned with actual practice will be largely drawn from this group. These are mainly doctors and nurses, although a cardiology technician and physiotherapist were also interviewed. More general issues will be discussed with reference to all of the interviews. As Chapter Two described, interviewees were chosen because of their job, their link to the smoking cessation service, or their feelings about such a service, and this will be referred to where this helps to explain or give a context to their opinions.

3.2.2 Smoking advice given to patients

About half of those interviewed reported that they did routinely ask patients if they smoked. For example, this nurse who worked in a speciality related to smoking replied:

> "Mm.. I would probably throw it in somewhere [smoking advice] but I don't know if that is just because I have very much got a respiratory background. I think I would try and throw it in somewhere along the way in a kind of gentle

manner. That it wasn't sounding threatening or anything like that. But I mean, I think sometimes people have made their own mind up when you talk to them about smoking. But sometimes I find that after they have had time to mull it over they will come back to you and they've maybe reconsidered a little bit. Yes, so it can only be a good point I think" (Isobel Murdoch, Staff Nurse, Respiratory Medicine)

Clearly Isobel was keen to encourage smokers to stop although she felt that this did require tact and for patients to be motivated. She also believed that the speciality in which she worked influenced her views. As she was continuously confronted by the results of smoking she was prompted to advise patients to stop. References were made frequently in the interviews to the fact that those who worked in a speciality related to smoking would be more likely to give advice and those who did not would not always remember or feel that it was appropriate. This strongly suggests that this affects whether clinicians will raise the issue of smoking with patients.

Half of the interviewees did not claim to bring up smoking as a matter of routine in their consultation, however most of them often made some attempt to ask patients if they smoked. They acknowledged that whether or not they asked this might be affected by individual circumstances, or by the relevance of smoking to the presenting illness. For example this doctor who worked in a speciality unrelated to smoking replied:

"Yeah, I mean I think it's fair to say yes and I tend to do it particularly obviously with the cardiac and respiratory patients, but there are a lot of our younger people as well who are here for other reasons. I have to be honest and say that I think sometimes I forget to, otherwise they seem apparently fit young people, but certainly when it comes to the general medical work, I think we spend quite a bit of time, you know, trying to encourage people not to revert back to the habit that has been largely responsible for them coming into hospital." (Dr Michael Mackie, Consultant, Infectious Diseases)

This shows that Michael believed that it was important to give smoking advice but, like other interviewees, tended to be prompted by the nature of the patient's illness.

In general, interviewees seemed to be cautiously positive towards asking patients their smoking status. All of the clinical staff, with the exception of one nurse, believed that they tried to offer support to stop smoking as far as they were able. The nurse who did not generally offer support was herself a smoker, and felt that smokers were often stigmatised. However she claimed that she would be prepared to help smokers if this was clearly affecting the course of their illness, and if they initiated this discussion themselves. Those who did not feel confident in their skills tried to suggest alternative sources of help, whether this involved referring to a GP, telling them about nicotine replacement patches, or listening to them and trying to give advice. Not surprisingly their willingness to give advice was related closely to their confidence, their level of

skills and their feelings about how appropriate it was for the patient to receive such advice in their present situation. For example, this interviewee commented:

> "I always encourage them to stop. I say it will make a difference and back up what they've been told previously but further than that and I mean, if they come back to a clinic and say 'I've really, you know, I've really cut down,' I'll encourage them as much as I can, but, em, apart from that at the moment I feel well that that is about as much as I can do. [Right why is that then?] Em, well, it's only lately that we've got the smoking cessation nurse, em, started, you know? Obviously that's great and we will, you know, I hope we'll be able to direct patients in that direction in the future, but we haven't had sort of direct contact from her yet so I don't know how you go about referring patients or what you do." (Siobhan Jones, Cardiology Technician)

It is clear that Siobhan was not reluctant to refer to the smoking cessation service or even to give assistance herself, but lacked confidence in her own skills and felt she needed to know more about the best way to do this. Interviewees also often discussed tailoring the advice they gave to the individual patient they were seeing, commonly remarking that they could give advice but it was only useful if the patient would listen. An example of this arose in an interview with a nurse specialist. I chose to interview her because the smoking coordinator had commented that while she had talked to this nurse formally about the new service, she had yet to receive any referrals from her. I did not ask the nurse about this directly but she raised this issue herself, saying that she knew about the

service and had often asked patients if they would like to be referred to it; they always replied that they were not keen to stop smoking at the moment. Therefore she did not refer patients because she was directed by their wishes and motivation to stop rather than by any resistance which she personally had towards the smoking cessation service.

3.2.2.1 Cynicism and Frustration

Half of the interviewees, while continuing to give smoking advice, commented that they were frustrated or felt cynical about how effective this might be. This doctor explained his views:

> "What I would normally tell them, normally I would say, tell them that it's not a good idea to smoke for various health reasons. They normally reply that they know that, there's very few patients that turn round to me and say 'what a surprise doctor, I didn't realise that smoking had anything to do with my health.' And I don't go on about it because they've heard it before, they've heard it off their GP, they've heard it off the last doctor they've seen, and I sound like basically an old record that's stuck, and that can aggravate patients and I don't tend to push that point. Some patients don't appreciate being told for the 49th time to stop smoking, and I think you can actually to some extent destroy the relationship by being too pushy about it." (Dr Anthony Lecker, Consultant Gastroentologist)

This clinician was clearly frustrated at continuing to give advice which he did not think had any effect. He also felt that this was not necessary as patients were aware of the ill-effects of smoking. He was concerned that by repeating advice which they had already heard he would annoy patients and affect the relationship he had with them. This theme will be returned to in Chapter Five which discusses clinicians' acceptance of their health promotion role.

It would therefore seem that before the smoking service was introduced interviewees generally made some attempt to encourage smokers to stop, and this was most likely to happen if the patient had an illness clearly related to smoking. Interviewees were also affected by the patient's motivation and whether they felt patients would listen, as well as by their own confidence or perception of their skills in smoking cessation.

3.2.3 Interviewees' views of their responsibility for assisting smokers to stop

In the last section interviewees' perceptions of the smoking advice which they gave were explored. I was also interested in whether they felt that this *should* be part of their role. Even if interviewees did not give advice on smoking, if they felt that it was an appropriate role for them to have then it is more likely that they could be encouraged and supported to do so. Further, if despite feeling that this was part of their job, they did not do this, this would suggest that other barriers were preventing them from doing so.

All of those interviewees who discussed this issue, accepted that giving advice to stop smoking was part of their job, although they went on to qualify this in some way. A

common response was that while they may believe that they should be doing this, they do not have time to provide a great deal of support. In the last section it was clear that there was some association between whether interviewees encouraged patients to stop smoking and whether the patient was being treated for a smoking-related illness. Those who worked in specialties where smoking was not implicated so strongly in the development of diseases, similarly felt that while it may be ideal to offer support to stop smoking, this was not a priority, and, in reality, given their limited time they generally had to concentrate on other issues. For example, this doctor commented:

> "I think it is reasonable [to give advice about smoking] but then the problem is that it is part of my job to do 101 other things and it's a question of priorities, and smoking is not one of my priorities." (Dr Anthony Lecker, Consultant, Gastroentologist)

In general therefore, while in principal many of the interviewees believed they should ask patients about smoking and did not seem to be opposed to this on ethical or other grounds, in practice they were often prevented from doing so by other factors and all of the interviewees with patient contact provide reasons why they did not do this consistently. For example, Anthony pointed out while this was part of his job and reasonable to expect, it was not a priority for him as he had so may other things to do. This suggests a gap between clinicians' 'ideal' view of their job, and what they may want or feel it is their responsibility to do, and the reality of what they can do when dealing

with real patients and working within a particular system. The main structural barriers which stop them from doing this will be explored in depth in Chapter Six.

3.2.4 Choosing when to support patients to stop smoking

One aim of the new service was to ensure that all patients attending the hospital would be asked if they wished to stop, and if they did, would be offered advice to help them to do so. Interviewees were therefore asked directly if they agreed with this aim. The responses indicated that there was generally cautious agreement, that is, that interviewees were 'not against this,' rather than actively for it. They usually qualified their responses to say that they must take account of how ill the patient was, and again the theme of patient motivation arose.

For example this woman who worked in health promotion but was previously a nurse reflected several interviewees' feelings:

> "...I mean, I think if the patient does smoke, it would need to be the appropriate time to give them information, and to know if they want information. I would agree in some ways that yes, they should all be entitled to information and have it there available, but it shouldn't be enforced on everybody. If they're not interested in stopping smoking [Why is that then?] I mean, to me more people would just say absolutely no. They'll tell you straight if they want the information, and if they don't want it they shouldn't be forced. It should be either they ask for it, or if they've

asked about it, if they say yes they would like the information, fine. If they say no, fine, that's it. If they're not motivated to stop there's no point. It's a waste of their time and your time to enforce anything on them." (Kate Squires, Health Promotion Officer)

Like many interviewees, Kate felt quite strongly that patients shouldn't be 'forced' to stop smoking and she emphasised this by repeating it several times. She believed this partly because she considered that health promotion should be patient-centred and, leading on from this, that it was only worthwhile helping motivated patients rather than wasting energy on less motivated patients. Her view is not surprising as an important feature of health promotion is that it should empower individuals to make choices rather than to promote health against the wishes of the individual.

The smoking cessation coordinator was also aware of the importance of patient motivation and was careful only to give advice if she patients wanted it. On the whole she felt that patients were grateful for her support:

"...I say to them 'Is it OK if I phone you?' ... 'I'll phone you when you get home is that OK?' They'll say 'Yeah that's smashing' and I'll phone them up and they are dead grateful and really glad you phoned 'because I'm finding it awful difficult and blah blah blah...' 'right what are you doing now?' And then at the end of it I say 'Do you mind if I phone you back next week and see how you're doing?' 'Aye that's great.' And aye...you would

think that a lot of people would be going 'Oh no I don't want that.' But I find that they actually like that." (Marianne Findlay, Smoking Cessation Coordinator)

From this extract it is clear that Marianne negotiated with patients to determine whether they were receptive to advice and welcomed help rather than attempting to give advice to everyone whether they wanted it or not. However at a later point in the interview she expressed concern that some patients who were being referred were not necessarily motivated:

"Most people I meet I ask them that I say 'Do you want help to stop?' 'Ah, well, I have to stop...I've got to stop, my doctor told me I've had a near miss...I've got to stop.' But I will say 'Do you want to stop?' 'Well not really.' So it's quite difficult to get these people hooked in...I think the vast majority, it's forced on them when they come in. And it would be nice if they were prepared, it would be nice if the community knew there was a service in the hospital. That would be nice." (Marianne Findlay, Smoking Cessation Coordinator)

This meant she was often in the difficult situation of trying to help people to stop who had been advised that they should stop, but did not necessarily want to. It is clear that like other staff, she felt patients must want to stop smoking before they were referred to her service, rather than being 'forced.' She felt that patients should be better prepared

for hospital and for the smoking service, and that this would be facilitated by having better communication with the hospital. She also agreed with the opinion of Kate, the health promotion officer who pointed out earlier that it was better to target motivated patients. Other clinical staff also felt that it was better to focus their energy on motivated patients. Despite this, Marianne felt that clinicians often referred all smokers to the service without assessing first whether they were suitable. This point will be returned to in Chapter Six which analyses how clinicians' workload impacts on how they manage their time with patients and how they decided when to refer to the smoking cessation service.

3.2.4.1 Financial implications of the smoking cessation service

Two interviewees also discussed the financial implications of such standard advice. One pharmacist commented that by helping smokers to stop the health service would save money in the long run. Another senior manager, took a more negative view:

> "Well, I think I either you're going to provide them with patches or are you going to provide them with alternatives to Nicorette or whatever chewing gum, substitute whatever else. Can we afford to do that for every patient who thinks that they might like to stop? Rather than them going out and buying it themselves which is perfectly possible and I think that the Health Service would end up just subsidising everybody who thinks he might like to stop but really... and I don't think there is anything wrong with asking

patients if they would like assistance in stopping, but I don't really think we can force it on them." (Scott McGhee, Outpatient Manager)

Like other interviewees, Scott also commented that patients should not be pressured to change. The fact that so many interviewees expressed this view suggests that they considered patient choice to have been restricted in the past. When I was visiting the hospital a number of staff and patients commented to me that they felt it was unfair that there was nowhere for patients to smoke in the hospital. It is possible that they felt that this change was 'forced' and this made them wary of any initiative which might restrict smokers' choices any further. However unlike most of the other interviewees, Scott's opinions were influenced by financial considerations. As he was involved in making policy and budget decisions, and had never treated patients, this is not surprising. However he often expressed opinions which were similar to those of the Clinical Director, who also commented that the success of the service would be judged on whether it gave the best 'value for money.' This reinforces the perception that management staff were influenced by their involvement in finances. As there were competing demands for money they needed to assess the smoking cessation service against other services or ways of using this money, and so had to take a wider view. Managers' views are important because they are likely to influence whether the funding of the service is continued.

3.2.4.2 Interviewees smoking status and the smoking advice they give

In section 2.2 it became apparent that there was a relationship between the speciality in which the interviewee worked and the amount of smoking advice given. In addition, some interviewees were reluctant to give smoking advice to all patients for other reasons. For example this nurse remarked:

> "I don't feel that that's any business of the doctor, they're in with something totally and entirely different and to start going on to, you know, I think you're actually picking on them in a sense, I think you are. Where do we draw the line? I mean do you turn round and say, I've dealt with alcoholics, they get a liver, they've messed it up because of the alcohol, do you turn round and say 'look you're not getting a liver [transplant]?' Or no, we're not going to treat you because you smoke?' Where do we draw the line at compassion? Really?" (Sister Theresa Shergold, Ward Manager, General Medical Ward)

This nurse expressed the view throughout her interview that smokers were stigmatised. However she was a smoker herself and I thought that this might have influenced her opinion. I decided therefore to compare the attitudes of the interviewees who smoked with those who did not to see if there were any differences in their attitudes towards smokers or the help that they offered.

Only four of the interviewees were smokers, all of them nurses. Three of the smokers expressed similar opinions to Theresa and generally seemed more concerned with

smokers 'rights', than non-smokers were. For example they would suggest that smokers should have a place to smoke. Staff who smoke may be more sympathetic to patients who smoke as they probably have a better idea of how difficult it is to stop. As Theresa also commented "...I can't judge because I've got lots of things that I'll do in my own life that I shouldn't be doing."

This impression that clinicians who smoked felt that they had more empathy with patients who smoked was reinforced when interviewees were asked directly whether their smoking influenced the advice which they gave. All of the interviewees who smoked or had smoked in the past believed that this helped them to give advice. As one commented "They're more willing to listen to you because you've been through it the same as them" (Sylvia Ferguson, Cardiac Rehabilitation Nurse). In contrast, all of those interviewees who had never smoked felt either that their smoking status was irrelevant, or that being a non-smoker helped because patients would not listen to advice from someone who 'smelled of smoke'. None of the interviewees who had never smoked considered that smokers would be more sympathetic or would be better able to give advice to patients who smoked.

Theresa also emphasised the role of other lifestyle factors, such as alcohol and diet, in contributing towards health. This may be a strategy which smokers use because they feel guilty about smoking. Although they realise that smoking is bad for their health they justify this by pointing out that other people engage in other lifestyle behaviours which are also a risk to their health. If they consider this to be true, then they may feel

that the role of smoking in the development of ill health is exaggerated. They may believe that they should have the freedom to smoke, in the same way that others have the freedom to engage in unhealthy behaviours, and that too much emphasis is placed on smoking cessation.

Interestingly, this was also evident when I talked to patients while carrying out the patient survey. My impression was that several of the patients, particularly older women, after saying that they smoked, commented that they did not drink alcohol or 'go out with bad men.' This does suggest that smokers may use this as a strategy to rationalise their smoking behaviour. That is, while they knew that smoking was bad for their health, they did not have other habits which would negatively affect it. However this theory could not be developed further with the data available.

Theresa also seemed to feel that smokers were being targeted in order to be criticised rather than helped, and compared this to refusing to help alcoholics because this was self-inflicted. Her concerns were not solely related to smoking. Several times she expressed the view that staff interfered too much in patients' lives and could be hurtful to patients by commenting on, for example, their weight or other aspects of their lifestyle.

Just as patients may have felt embarrassed or guilty about continuing to smoke against advice or when they are ill, so staff may have felt embarrassed about smoking while working in a health profession and advising others on their lifestyle. There does seem to be a suggestion here that there should be a congruity between their role as a health

professional and their own health behaviour. Sylvia managed the incongruity between being a smoker and providing health care by saying that she did not judge or push advice because she had unhealthy behaviours of her own. Another nurse, Sister Pauline Merrils, managed this incongruity in a different way. Although she still smoked, reportedly at a lower rate than she used to, she told patients that she was an ex-smoker. In this way she felt that she could use her smoking status to empathise with patients and encourage them to stop but they could not dismiss her advice in the way which they might if they knew she was a current smoker: "Oh well what's she talking about? That nurse smokes anyway. Why can they talk about telling me not to smoke? She's doing it herself." (Sister Pauline Merrils, Outpatient Sister)

My perception that staff who smoked felt guilty about this, was reinforced when I asked them if they smoked. All of those who did smoke seemed embarrassed and defensive and never volunteered this information in advance. They often commented 'Oh, I knew you were going to ask that!' I found myself unconsciously asking about their smoking status in an increasingly casual fashion in order to avoid annoying them or making them feel uncomfortable in the interview. I also reassured those who said that they were smokers that I had no strong feelings towards smoking, or said that members of my own family smoked and I knew how difficult it was for them to stop. This was not a deliberate strategy. It suggests that just as staff who smoke ally themselves with patients who smoke, so I tried to show that I empathised with them and did not want to judge them so that they would not be defensive.

An interesting exception to the greater sympathy for smokers shown by three of the four members of staff who smoked was that of one nurse. She also smoked but did not seem to feel any contradiction between her role and her smoking status or feel ambivalent about providing smoking advice. On returning to her interview transcript to look for some explanation as to why her views differed from other interviewees, I found that this interviewee was only an occasional smoker. "I suppose in my own mind I don't consider myself a smoker, because I only have one maybe every couple of weeks, or two or three every couple of weeks." (Geraldine Gallagher, Diabetic Liaison Sister) She now smoked at such a low rate that she considered herself a non-smoker and therefore she did not feel that she was being hypocritical if she told patients who smoked to stop.

3.2.5 Acceptance of the smoking cessation service

All of the interviewees were aware of the smoking cessation service and made some reference to it without being prompted in the interview, although it is possible that this was because they knew that I had some connection with it. Without exception they all thought that such a service was a good idea. This manager who had some involvement in its set up and in the employment of the smoking coordinator described its impact:

> "Oh, I think it's a wonderful idea. My worry for Mariannne is that she would be totally inundated with the amount of referrals that she would get, and I think that's probably borne itself out, because I've had phone calls from Primary Care saying, 'I hear you have a Smoking Cessation nurse, will she come out and speak to us?' Surgical were on the phone the first week and

what have you, while she was still trying to get set up, so I mean there's a huge need for it, and you know my only worry is that she gets over burdened, and can't provide any sort of service because of the amount of calls that she's getting." (Morag Peters, Acting Service Manager)

A number of common themes are represented in this interview: (i) like a number of people involved in the set up of the smoking cessation service or its delivery, she mentioned the interest that had been shown from elsewhere to support the view that the service was a good idea; (ii) she expressed concern that Marianne would have too much work because it would be so popular; and (iii) she believed that the smoking service was a good idea because of the part smoking played in the development of so many of the diseases with which patients were admitted. Another manager who had also been a nurse gave a similar opinion:

"Considering most of our emergency medical admissions are either coming in through a smoking-related or alcohol or dietary related issues, yes, it is a good idea." (Helen Robertson, Associate Nurse Manager)

This suggested that she believed that clinicians should be responsible for preventive health treatment, rather than merely being responsible for treating the effects of their behaviour. She believed that by giving patients lifestyle advice they would change their behaviour and that this would stop them from being admitted or readmitted to the hospital. Similar opinions were expressed by many of the other interviewees and this

further reinforces the impression that interviewees accept that they have a health promotion role, and believe that if they can influence patients this will have longer-term benefits for the hospital.

3.3 Discussion

3.3.1 Clinician attitudes to smoking cessation

This chapter has provided an insight into interviewees' perceptions of the smoking advice which they gave and suggests that while interviewees may feel that it is appropriate in theory to ask about smoking, in practice other factors may prevent them from doing so. These perceptions were elicited before the smoking cessation service began and before they were trained to motivate and refer patients to help them to stop smoking. It also shows that they were largely positive towards the introduction of this service.

This is one of the few studies to provide a qualitative perspective and incorporate the views of a range of professions. This is necessary because for the successful implementation of the smoking cessation service to take place different professionals must work together, so helping to ensure that there is a consistent message from hospital staff and seamless care.

One of the aims of the new smoking cessation service was that all staff who came into contact with patients should ask them if they smoked. Although many of the interviewees claimed to do this, this depended on whether they felt that this advice was

appropriate. They seemed to believe that it was most appropriate when they worked in a speciality where smoking-related diseases were treated and when they believed that patients were motivated to change. This reflects the results of the Thorndike et al. (1998) study, which, while it used quantitative methods and was carried out in the US, showed that clinicians were failing to meet guidelines for smoking cessation advice and tended to decide when to give this advice depending on whether or not they considered it to be appropriate. They based this decision on whether or not smoking was related to the patient's illness as well as other factors.

While the clinicians in this study believed that they should be helping patients to stop smoking they did not accept without reservation that all patients should be asked about smoking, and often commented that it would be better to target this at the right group; that is, those who wanted to stop. This is interesting as it suggests that an interviewee could hold conflicting opinions; that is, at one point in the interview they may say that they ask all patients if they smoke, and at another they may say that they do not think all patients should be asked routinely if they smoke. This may mean that they ask patients if they smoke only when they consider it is suitable, or that they may ask patients if they smoke for their hospital records, but do not necessarily use this as an opportunity to advise them to stop smoking. Therefore interviewees would not necessarily accept a standard policy, where all patients are asked. They may prefer that this decision is left to their discretion; and this point will be developed further in Chapter Five when the influence of individuals' opinions is explored in greater detail. However it is difficult to see how they could identify appropriate patients without knowing which patients smoked.

I would also suggest that if clinicians are going to decide when it is and is not appropriate to advise patients then they must have the right skills to identify suitable patients and to follow this up in the most effective way. While they may advise patients to stop smoking there was little evidence that they provide any concrete support to do so, beyond referring to the new smoking cessation service.

Several interviewees were worried that patients would be forced to attend the smoking cessation service against their will or be given advice which they did not want. Those interviewees who smoked often believed that too much attention was paid to smoking in the role of ill health and that smokers were 'stigmatised.' They also felt that their smoking status helped them to identify with smokers. While generalisations cannot be made on the basis of four interviewees it is possible that smokers are less likely to give advice on smoking. If Reidpark Hospital wishes to develop its smoking cessation strategy fully it would be useful to also help staff who smoke to stop, if they wish. While such an initiative was introduced in the past, it was not well advertised, nor provided with trained people who could offer appropriate staff support. The smoking coordinator did try to help staff where possible, but had to prioritise treating patients and could not offer NRT to staff.

It is also interesting that one of the interviewees who smoked occasionally now classified herself as a non-smoker. Another nurse also pretended to patients that she no longer smoked. Parry et al. (2001) describe how some smokers whom they interviewed described themselves as 'social smokers' and by doing so distanced themselves from the

health-related implications of their smoking. It would seem that these nurses also distanced themselves from their smoking status in order to take on a role which involved encouraging patients to stop smoking.

Interviewees seemed very positive towards the provision of a smoking cessation service and, where they had contact with it, had been pleased with how it worked. They generally believed that it was needed and hoped that it would succeed. However, while aware of the service they did not usually know much about how it worked, beyond that they could refer to it. In this respect their views were in conflict with the aims of the service, that is, they tended to see the service as a way of referring all smokers, rather than assisting some smokers and passing on those who needed more help. However the interviews were carried out just as the service was being set up and the smoking coordinator had had little opportunity to motivate or train staff. It is possible that this will change as the service develops.

3.3.2 Policy recommendations on smoking cessation services

While policy papers such as *Smoking Kills* (Department of Health 1998b) recommend that all patients be advised to stop smoking and that all clinicians be involved in doing this, this will not happen if clinical staff do not believe that such a role is acceptable and possible within the environment in which they work. There is limited information on hospital staff's opinions on such policy recommendations. The present study attempts to address this and, while the findings from the interviews of twenty staff in one hospital

cannot claim to be definitive, they do suggest that clinicians have reservations which could affect the implementation of this policy.

The main reservations which they expressed here related to patient motivation and to the difficulty of integrating smoking cessation advice into an already busy consultation. These themes will be developed further in Chapter Five. Government recommendations or policies have to be practical in order to be successful. As well as recommending what should be done, they should also state how this should be done and what training and resources will be provided to support this. The smoking cessation guidelines also identified the need for appropriate training and protected time for clinical staff (Raw et al., 1999) and it is clear that this would certainly be necessary in Reidpark Hospital if the new smoking cessation service was to be introduced effectively.

Smoking Kills (Department of Health 1998b) states that additional resources will be offered for specialist smoking cessation services but it does not identify how additional time can be provided for clinicians to provide motivation to stop smoking as part of the consultation. For example, can other parts of clinicians' jobs be dropped or will extra staff be provided so that they have more time to perform an expanded role? If policy recommendations differ markedly from what clinicians feel is possible within the confines of their work this may cause frustration and stress and it is likely that these recommendations will be ignored.

3.3.3 Issues for further research

Research suggests that doctors do believe that they already ask patients about their smoking behaviour (Jelley and Prochazka, 1991; Thorndike,1998; Basnyat et al., 2000. These studies used quantitative methodology. As qualitative techniques allow more complex views to be expressed, the present study allows us to explore this further. It indicates that while this group of interviewees reported that they tend to ask patients about their smoking, they were also affected by their own smoking status, the speciality in which they worked and their perception of patient motivation. Positive attitudes expressed in a survey do not guarantee that this will be translated into behaviour. While this group of interviewees might understand and even accept policy recommendations it would seem that they treat patients as individuals and are affected by, for example, how appropriate they consider the advice to be to the particular patient, whether they believe the patient is likely to change their behaviour, and whether this is a suitable time to give advice. It is unlikely that clinicians will ever be willing to give standard advice without considering these factors. If guidelines are to be relevant then they must reflect this.

The next chapter reviews literature on patient views of the advice which they receive in their consultation. This will also give some indication of clinical practice in relation to smoking cessation advice. However more UK research is necessary. The need for more qualitative research, in particular, is clear. This is particularly important as the present research has indicated that staff may hold conflicting opinions or may support a smoking cessation policy in theory without feeling able to do anything in practice.

This chapter reported clinicians' views of the smoking advice they offered and their opinions on the introduction of a new smoking service. By doing so, some factors which may affect its introduction emerged, in particular lack of time, delegating workload and patient relationship. These will be developed further in Chapters Four, Five, Six and Seven.

Chapter Four:Patient Views on Smoking Cessation Services in the Hospital

This chapter explores barriers to the implementation of the new smoking cessation service from the perspective of the patients. It reports on the results of the patient survey which was carried out in inpatient clinics and outpatient wards before the service began. The survey aimed to assess whether patients considered that smoking advice was appropriate within the hospital context and whether there was a need for a dedicated smoking cessation service. It also aimed to identify patients' smoking status and determine their perceptions of the advice, information and support to stop smoking which was available before the new smoking cessation service began. The chapter begins by reviewing the literature which describes smoking advice and support given in clinical settings and that which explores patients' perceptions of such services. It concludes by discussing the results of this survey and the implications for the smoking cessation service.

4.1 Introduction to the Patient Survey

The last chapter explored staff attitudes towards the provision of a smoking cessation service and considered how these would affect its implementation. The importance of including patients' views when developing health services has been emphasised in recent years (Wensing and Elwyn, 2003) and one would expect that patients' attitudes would also affect the introduction of a smoking cessation service. However despite the increased emphasis on smoking cessation in hospital , there has been little examination of patient's attitudes towards them. There have also been few surveys carried out which have determined the proportion of patients attending a hospital who were current smokers, wanted to stop smoking and wanted help from hospital staff to do so. Yet this would seem to be an important first step before these services were introduced. Furthermore clinicians are more likely to give smoking cessation advice if they perceive that patients want this. A patient survey would allow clinicians to make this decision based on patients' views rather than on their own perception of what patients want. This section will review the UK, Europe and the US literature which does exist and consider strategies which have been used to improve the provision of smoking cessation advice for patients.

4.1.1 Patients views of smoking cessation support and advice

4.1.1.1 The UK setting

The previous chapter outlined previous US and UK studies which asked staff about the smoking cessation support and advice which they gave. This chapter will outline studies where patients are asked about the smoking advice they have received in health care settings. Literature searches have revealed few studies which report rates of smoking among patients in the UK, or of advice on smoking cessation given by doctors, particularly for those patients attending hospital. One of the few such UK studies surveyed 2 955 patients attending 35 general practices in the UK. It found that 35% of those who responded reported being regular smokers (Coleman et al., 2003). Of these 20%, (187) recalled discussing smoking with their GPs, and 66% (124) of those who had discussed it believed that they had received clear advice to stop. However only a small minority recalled discussion of NRT. A limitation of this study is that it relied on patients accurately remembering their most recent appointment which could have been some time ago.

Even fewer studies included hospital patients in the sample. One study which did survey both hospital patients and patients attending a GP service estimated that 18% and 25% respectively were current smokers (Kava et al., 2000). Of those who smoked, 44% of inpatients and 62% of GP patients had been asked about their smoking and the majority wanted to stop smoking. However few had been given specific support to stop. The findings also suggest that GPs were more likely than hospital doctors to encourage

smokers to stop. Both of these studies were carried out before NRT was made routinely available on prescription in the GP setting and it is likely that a far greater proportion of smokers attending general practice are now receiving support to stop smoking at the present time. However hospital doctors generally still cannot prescribe NRT and therefore it is unlikely that this would have had much effect on the smoking advice and support which they gave.

A similar small study carried out in General Practice found that 25% of the 316 patients surveyed were smokers (Duaso and Cheung, 2002). This study also asked patients if they wanted help to stop smoking and found that while 13% did want this help, only 4% reported receiving it.

In the last two of these studies the number of smokers who responded was fairly small, and only one of them included patients attending hospital. These studies do, however, suggest that in the UK smokers want to stop smoking, although there is not enough information available to conclude that they want specific help to do so.

The previous three studies also illustrate the difficulty of comparing findings in order to draw firm conclusions. For example in the Kava et al.(2000) study patients were asked if they wanted to stop smoking whereas in the Duaso and Cheung (2002) study patients were asked if they wanted support to stop smoking, which is clearly a different issue. If smoking cessation services are to be implemented into UK hospitals then clearly there is a need for further UK research which assesses whether patients would accept such

services. More current research within General Practice is also required to determine whether the provision of NRT on prescription has encouraged GPs to discuss smoking more with their patients and to prescribe NRT when applicable. If this is the case then there may be less need for hospital-based services. The findings from European and US research are often applied to the UK and the UK smoking cessation guidelines were based on US ones as Chapter One describes; it is therefore worth considering research in these contexts. This is done in the next two sections.

4.1.1.2 Patient surveys in Europe

Data available from two large Europe-wide studies did show that patients wanted support to stop smoking. The first of these, which surveyed 10 295 smokers in 17 European countries, reported that over half of men and women wanted to stop smoking although only 30% recalled having received advice from a doctor to do so (Boyle et al., 2000). This study also reported on those factors which patients believed would most influence their efforts to stop smoking, the most important being advice from a doctor. Interestingly respondents felt that such advice would carry greater weight than that from a pharmacist, nurse or dentist. This suggests that if doctors were to take responsibility for giving smoking cessation advice, a greater number of smokers would stop. It is also striking that almost half of smokers did not want to stop smoking.

A second large European study which explored the likelihood of smoking counseling being received by coronary patients found that of 1 364 smokers interviewed, smoking status was not recorded in 20% of cases and 50% continued to smoke (van Berkel et al.,

1999). Given the nature of the patient's illness this finding is particularly interesting though it is encouraging to see that half of those patients did manage to give up.

4.1.1.3 Patient surveys in the US

In a large US study, 2710 smokers were surveyed in five cross-sectional groups over a decade (Frank et al., 1991). Forty-nine percent of smokers reported that they had at some point been advised to stop smoking by a physician and 4% reported receiving help to do so. The results also showed that those in poorer health, those with more education and those who were ready to stop smoking were most likely to report being asked about smoking. This suggests that doctors are making decisions about whether and when to advise smokers to stop smoking based on whether they believe patients are motivated to change, would be able to change and would benefit from change. A particularly important finding of this study was that the number of patients who reported that they had received advice on their smoking increased in the surveys carried out in more recent years. This may be related to the changing climate in respect of smoking and increased policy directives in the US (Fiore et. al., 1996). However again it is clear that even when clinicians do advise smokers to stop they do not usually offer any help to do so.

Another recent large US study reported similar findings. Three thousand and thirty-seven smokers who had seen a doctor in the previous year were asked about the advice they had received by a doctor or any other member of staff in a medical setting (Goldstein et al., 1997). While a similar proportion had been advised to stop smoking 15% had been offered help to do so. This represents a substantial increase from the 4%

who were offered help in the Frank et al., (1991) study and does suggest that recent policy directives have had an effect. However this is still a small proportion and there is clearly room for improvement. Doctors also seemed to make similar decisions about which smokers to offer advice. The results also match those of the UK study reported earlier (Kava et al., 2000), in that a significantly greater number of respondents reported receiving help from a family physician than from a hospital doctor.

However while these US surveys reported similar findings to those in Europe and the UK previously described, one study which looked at the motivation and interest of hospital patients came to quite different conclusions (Emmons and Goldstein, 1992). Three hundred and four patients in the general medical and cardiovascular units, 16% of whom smoked, were surveyed on their motivation to stop smoking during or shortly after their hospital stay. Although the results did show that the majority of smokers wanted to stop, most of them had little interest in formal treatment to help them, preferring to quit on their own. The authors claim that this is likely to deter clinicians from giving advice or referring to a treatment programme.

These results contrasted with the larger European study where patients reported being keen to receive support to stop smoking (Boyle et al., 2000). This difference could have several explanations. First, it is possible that patient attitudes in the US differ from those of Europe. Second, the Boyle et al. (2000) study was carried out more recently and smokers' attitudes may have changed in the intervening years. Third, there was a large difference in the number of smokers surveyed. While the European survey was of over

10 000 smokers, the American study surveyed only forty-eight people who smoked and therefore it is likely that the results are less reliable. However if these data do reflect true differences between US and European patients then this is particularly interesting. The literature has shown that a similar proportion of patients in the US, UK and Europe were given advice to stop smoking. If patients in the US are less happy to receive this advice then it is possible that patient attitudes do not have a great deal of influence on clinicians' behaviour. However, further comparative research would have to be carried out on larger samples before this could be concluded.

4.1.1.4 Consistency of patients' reports

All of the studies described above relied on patients' recall of the smoking advice which they received and it is possible that it does not accurately reflect the actual advice and support they were given. However a large study referred to in the previous chapter, which used patient records rather than patient reports to estimate the provision of smoking cessation advice given to patients, found similar results (Thorndike et al., 1998). In 66% of patient visits smoking status was recorded, 22% received counselling to stop smoking and in only around 1% of cases was NRT offered. This, combined with the fact that the results from studies in different countries have generally been consistent, suggests that patient reports on the advice which they received are accurate. Furthermore where patients' reports have been compared to those of doctors, they have been shown to be accurate and reliable and to correspond well (Frank et al., 1991).

The next section will briefly describe those strategies which have been used to encourage clinicians to advise smokers to stop, in order to assess whether those factors which are perceived to be barriers act as barriers in practice.

4.1.1.5 Summary of the literature

Chapter One described policy papers and guidelines which suggest that all patients should have their smoking status recorded and should be offered assistance to stop smoking (Department of Health, 1998b; Raw et al., 1999; Dargie et al., 2000). The UK research evidence provides little information about the number of smokers attending health care services, particularly hospitals. Smoking status is often not assessed and, while smokers may be advised to stop, rarely is help offered to them to do so. It is also not clear whether patients want this help. If the goals of these policy papers are to be met then there is a great deal of scope for improvement in both recording smoking status and assisting patients to stop smoking. There is even less research available on patients' attitudes towards the provision of such advice and support. This information would help to determine whether the hospital is an appropriate setting for such services and, if so, how they could be introduced most effectively.

There is a particular need for up to date research. While the studies reported have all been carried out in the last decade there has been a great deal of change in this area in recent years. The number of smoking coordinators both in general practice and hospitals has grown (Raw, 1999) and NRT is more readily available on prescription, although this will have a greater effect on the support which GPs offer than it will on hospital doctors.

Furthermore, as noted earlier, most of the research has focused on doctors and little attention has been paid to the role of other clinicians. If, as Boyle et al. (2000) suggest, patients perceive the advice of other clinicians to be less credible, this has important implications for decisions on who should give smoking cessation advice. In particular it suggests that doctors should be involved in giving this advice and that this cannot be delegated to other health professionals.

The next section, which reports on the results of the inpatient and outpatient survey in Reidpark Hospital, will address some of these gaps. It will establish patient attitudes towards the provision of smoking cessation services as well as determining the number of patients surveyed who smoked and their perceptions of the advice hospital staff offered before the smoking cessation service was implemented. It will also establish whether smokers believe that they would use a smoking cessation service were it to be made available. The methods used in this survey were described in Chapter Two.

4.2 Results of the Patient Survey

These results are largely descriptive; however, where statistical comparisons were carried, out the probability values are given. If the probability value of any difference examined is less than 0.05 ($p<0.05$) this will be regarded as a statistically significant difference. Where the probability value is less than 0.0001 ($p<0.0001$) this is reported as $p<0.0001$ as SPSS (the computer package used) displayed results to only four decimal

places. The next section describes the characteristics of the patients surveyed at Reidpark Hospital.

4.2.1 The patients surveyed

Table 4.1 describes the age and sex distribution of the patients surveyed. Actual age was recorded but the data were later collapsed into categories for ease of comparison. A third of the sample were over 65, with almost 15% being over 75. There were approximately equal numbers of males and females among the respondents (212 males, 200 females). The mean age was 57, and there was no difference in mean age between male and female respondents (male=58, female=56, t=1.62, p=0.106).

Table 4.1 Distribution of hospital patients by gender and age group

Age Band	Male		Female		Total	
	N	(%)	N	%	N	%
Under 25	10	(4.8)	9	(4.5)	19	(4.6)
25-34	12	(5.7)	21	(10.5)	33	(8.0)
35-44	16	(7.5)	25	(12.5)	41	(10.0)
45-54	32	(15.1)	32	(16.0)	64	(15.5)
55-64	52	(24.5)	47	(23.5)	99	(24.0)
65-74	60	(28.3)	36	(18.0)	96	(23.0)
Over 75	30	(14.1)	30	(15.0)	60	(14.6)
Total	212		200	(100)	412	

Patients were surveyed in both the outpatient clinics and inpatient wards. Table 4.2 shows the age range of both outpatients and inpatients. Outpatients were significantly younger than inpatients (Outpatients 55.20, Inpatient=59.77, t=1.62, p=0.005) and 43.5% of inpatients were aged 65 or over, compared to 33.3% of outpatients. The full table giving the results of this t-test appears in Table B Appendix V. This age difference is likely to be related to the severity of their illness. Inpatients are likely to be more ill than outpatients and older people tend to have more illnesses which require hospital treatment.

Table 4.2 Distribution of patient type by age group

Age Band	Outpatient		Inpatient	
	N	%	N	%
Under 25	11	4.9	8	4.3
25-34	21	9.2	12	6.5
35-44	29	12.7	12	6.5
45-54	33	14.5	31	16.8
55-64	58	25.4	41	22.3
65-74	55	24.1	41	22.3
Over 75	21	9.2	39	21.2
Total	228	100	184	100

4.2.2 Patients' smoking status

Clearly a first important step in targeting smokers is to find out the smoking status of patients and this was one of the aims of the smoking cessation service. In this way those patients who smoked and wanted to stop could be encouraged to do so.

Table 4.3 shows the proportion of patients who were smokers, ex-smokers and non-smokers. The large majority of both male and female patients surveyed had smoked at some time in their lives (male=76%, female=71%) however only a third of the patients were current smokers. Males were significantly more likely to be ex-smokers than females, and females were significantly more likely to never have smoked (x^2=7.54, d.f.=2, p=0.023). However a similar proportion of males and females were current smokers (males=32.4%, females=33.7%).

Table 4.3: Distribution of smoking status by gender

Smoking status	Male		Female		Total		
	N	(%)	N	(%)	N	(%)	Chi-Square (p-value)
Current Smoker	69	(32.4)	70	(35.0)	139	(33.7)	7.54
Ex-smoker	93	(43.7)	63	(31.5)	156	(37.8)	(0.023)
Non-smoker	51	(23.9)	67	(33.5)	118	(28.6)	

Knowing the proportion of patients who smoke will help to determine the need for a smoking cessation service within the hospital. If the proportion were lower than in the general population then it might be more effective to target smokers in other settings. As Table 4.4 shows, 32% of males and 35% of females in the hospital sample smoked compared to 38% and 33% respectively in the Scottish population. Therefore there are enough smokers in the hospital sample to make this a suitable place to access them. The average age of hospital patients is higher than that of the population as a whole. However it is difficult to make comparisons at each age group because of the small hospital sample.

Table 4.4 Smokers in the hospital compared to the Scottish population

		Current Smokers		
		Number of hospital smokers in each age group	**Percentage of hospital smokers in each age group**	**Percentage of Scottish smokers in each age group (1998)***
Male				
	16-24	3	50.0	39
	25-34	9	75.0	42
	35-44	5	31.1	40
	45-54	11	34.4	40
	55-64	21	40.4	38
	65-74	12	20.0	25
	over 75	7	23.3	*
Total		68	32.1	38
Female				
	16-24	4	44.4	34
	25-34	7	33.3	36
	35-44	12	48	33
	45-54	14	43.8	34
	55-64	17	36.2	31
	65-74	9	35	25
	over 75	7	23.3	**
Total		70	35	33

*(Office of National Statistics, 2002)

** Figures unavailable for those aged 75 and over

4.2.2.2 Outpatients and inpatients who smoked

Comparing the two patient groups, there was a significantly higher percentage of inpatients who smoked than outpatients (40% of inpatients vs 28.5% of outpatients, x^2=6.04, d.f.=1, p=0.014). (Appendix V, Table D).

As the patients were older in the inpatient group than in the outpatient group this could mean that the difference in typical smoking status between outpatients and inpatients could be related to their age rather than to their patient status. Therefore using logistic regression analysis, the association between smoking status and patient type was examined while simultaneously controlling for age. As Table 4.5 shows, inpatients were 1.8 times more likely to be smokers than outpatients (O.R. 1.84, C.I. 1.2, 2.81, p=0.0047 after adjusting for age). It is likely that this is because smokers are more likely to suffer from illness, and inpatients have greater morbidity than outpatients.

Table 4.5 How smoking status varies by age and patient type

Variable	B	S.E.	P Value	Odds Ratio (95% Confidence Interval)
Inpatient (vs outpatients)	0.6119	0.2166	0.005	1.84 (C.I.=1.2,2.81)
Age (per year)	-0.0215	0.064	0.0008	0.98 (CI: 0.99,0.98)
Constant	0.2404	0.3709	0.5169	

4.2.2.3 Summary of background statistics

In summary, a similar proportion of male and female hospital patients surveyed reported that they were current smokers, and inpatients were significantly more likely to smoke than outpatients. The proportion of people who reported that they smoked was similar to the Scottish population although it is difficult to make a direct comparison because of the quite different age distributions; patients attending hospital were generally older than the Scottish population.

4.2.3 Do patients feel that the hospital should offer a smoking service?

Now that characteristics of the patient sample have been described, the aims of the study can be addressed. One of the most important aims was to determine whether patients felt that the hospital should offer a smoking cessation service. As the literature review described, patients' attitudes towards such a service were likely to affect its successful introduction.

The large majority of respondents (74.3%) felt that the hospital should offer a smoking cessation service. However while three-quarters of the sample believed that the hospital should offer such a service, interestingly a significantly higher proportion of smokers (22.3%) than non-smokers (12.8%) believed that the hospital should not (x^2=6.5, d.f=1, p=0.039).

One possible reason for this result was that smokers believed that they themselves would not use such a service were it to be made available. In order to explore this, smokers' responses to the question about whether they would use a smoking service were cross-tabulated with whether they felt that the hospital should have such a service; there was no relationship between these two responses (x^2=7.56, d.f.=4, p=0.109). (See Appendix V, Table C for more details). This means that smokers were not less likely to want a smoking cessation service because they knew that they would be unlikely to use it, and another explanation must be found.

4.2.4 Why do patients feel there should or should not be a smoking cessation service in the hospital?

Respondents were also asked to give a reason why they believed that there should be a smoking cessation service in the hospital. These were open questions but were later categorised into the most common responses. Of those who thought that there should be a service 97 (32%) said that smokers needed encouragement or help, 61 (20%) that smoking was bad for one's health and 12 (3.9%) said that money was spent on other

addictions and should also be spent on smoking. Of those who believed that there should not be a service 26 (39%) believed that it was "up to the person themselves to stop smoking", 13 (20%) commented that "if you want to smoke you should be able to" and 3 (4.5%) that "it would be better to provide help in other settings." The remainder of patients surveyed either did not give a reason or gave other reasons.

4.2.4.1 Do patients feel it is appropriate to be asked about smoking when they are attending the hospital?

Most patients who responded to this question thought it was appropriate to be asked about smoking when they attended the hospital for an inpatient visit or outpatient stay (347, 89.2%). Patients were given the opportunity to expand further on this and give a reason for their answer, and 194 chose to do so. These reasons were categorised into the most common responses given. Of those who made a comment and thought that such a service was appropriate, 65 (41%) said that smoking affected health and 48 (30%) that it could assist the clinician to make a diagnosis. Of those who thought it was inappropriate and gave a reason, 20 (58%) felt it was appropriate only if smoking was implicated in the development of the illness for which they were being treated and eight (24%) complained that everything was blamed on smoking. Smokers and non-smokers gave similar responses.

4.2.4.2 How many of the smokers want help to give up smoking?

Of the 133 patients who smoked and who responded to this question, 70 (52.6%) wanted help to stop smoking as shown in Table 4.6. Among those who reported that they did

not want help, this was largely because they did not want to stop. More than a third of smokers said that they did not want to stop smoking. Therefore if a patient actually wants to stop smoking then they generally want help to do so. As a large proportion of the patients surveyed were ex-smokers, it is likely that those who were still smoking were those who were finding it particularly difficult to stop, and therefore felt support would be helpful. As many of the patients surveyed were likely to be suffering from an illness caused or exacerbated by smoking then it is likely that they would be keen to stop.

Table 4.6 Do smokers want help to stop smoking?

	N	%
Would you like help to stop smoking?		
Yes	70	52.6
No, I don't want to stop	46	34.6
No, I don't want help	6	4.5
Don't Know	11	8.3
Total	133	

4.2.5 Support to stop smoking before the smoking cessation service began

The survey was carried out before the smoking service was introduced. As well as determining patient attitudes towards its introduction it also aimed to collect 'baseline' information on the type of advice and information about smoking that patients were given before the service was available.

4.2.5.1 Were patients routinely asked if they smoked by a member of the clinical staff?

One of the aims of the smoking cessation service was to encourage clinicians to ask all patients attending the hospital, regardless of the reason for attendance, whether or not they smoked. If they were currently smoking, they were to be encouraged to stop and referred for help where this was appropriate. Therefore before the service was introduced it was useful to find out the current situation. Only 51.3% of the patients reported that they were asked if they smoked. Inpatients were significantly more likely to report being asked than outpatients (65.9% compared to 39.5%, x^2 =28.65, d.f.=1, P<0.0001)

Smokers were significantly more likely to report being asked if they smoked than non-smokers (Appendix V, Table E). Sixty-six percent of smokers reported being asked if they smoked compared to 43.8% of non-smokers (x^2=18.5, d.f= 1, p<0.0001).

A higher percentage of smokers were asked if they smoked compared to non-smokers and a higher percentage of inpatients were asked if they smoked compared to outpatients. However since inpatients were more likely to be smokers, a logistic regression analysis was carried out to determine whether the likelihood of patients being asked if they smoked was independently related to their smoking status and patient status. Both factors were significantly and independently related: inpatients were 2.8 times more likely to be asked if they smoked than outpatients and smokers were 2.3 times more likely to be asked if they smoked than non-smokers (Table 4.7).

Table 4.7 Were patients asked if they smoke controlling for patient type and smoking status

Variable	B	S.E.	Significance	Odds Ratio (95% Confidence Interval)
Inpatient (vs Outpatient)	1.0317	0.2098	0.0000	2.8 (C.I.=1.86,4.23)
Smoker (vs Non-smoker)	0.8445	0.2234	0.0002	2.3 (C.I. =1.50,3.61)
Constant	-0.01649	0.2074	0.4265	

4.2.5.2 Who asked patients if they smoked?

Those patients who reported being asked their smoking status were asked to identify the professional group of the member of staff who had done this. This allowed us to determine which clinical profession tended to ask most about smoking status, and whether any clinical group could be encouraged to ask more often. As outpatients and inpatients come into contact with different members of staff the results for these are shown separately. As Table 4.8 shows, overall patients reported being asked about smoking by doctors more often than by nurses and very few commented on being asked their smoking status by any other health professional. Eighty percent of those who were asked if they smoked were asked this by a doctor, and 29% by a nurse. Inpatients were

more likely than outpatients to report being asked by a 'nurse' or 'other staff.' This is probably because inpatients are more likely to come into contact with nursing staff than outpatients, who may not see a nurse during their visit.

Table 4.8 Do different staff ask inpatients and outpatients about smoking?

	Patient Type					
	Outpatient		Inpatient		Total	
Who asked you if you smoke?	N	%	N	%	N	%
Doctor	78	89.7	88	73.9	166	80.6
Nurse	10	11.5	50	42.0	60	29.1
Other	4	4.6	16	13.4	20	9.7

NB: numbers may add up to over 100% as respondents could respond with more than one clinical group.

4.2.5.3 Did staff advise smokers to stop smoking and offer help?

The 139 respondents who were current smokers were asked if they were advised to stop smoking in either their last outpatient appointment or their present inpatient stay, almost half reported that they were. There were no group differences in terms of gender, age or patient type. Eight (6%) of patients reported that they were offered help to stop smoking in their most recent outpatient appointment or during their current inpatient stay. Four reported that they were offered NRT, three were offered Zyban and one was advised to

ask his GP for help. It is clear that before the implementation of the smoking cessation service staff did not routinely offer help to stop.

4.2.5.4 Were patients aware of any smoking cessation services which were currently available at the hospital?

Patients were asked if they knew of any smoking cessation services which the hospital provided at that time in order to find out the situation in the hospital before the smoking service was introduced. The majority (88.1%) reported that there were no such services. There were no differences in the responses given by smokers and non-smokers. At the time of the survey there was no formal smoking cessation service, although laser therapy had been offered to people in the past. Those who claimed that there was a smoking service were generally referring to laser therapy.

4.3 Discussion of the patient survey

4.3.1 Patients' attitudes to a smoking cessation service

The results showed that there was a high enough proportion of patients attending Reidpark Hospital who smoked for this to be a suitable place to base a smoking cessation service. The majority of patients also felt that this was an appropriate place to be offered support and advice to stop smoking and that the hospital should have a smoking cessation service. Furthermore, half of the smokers wanted help to stop smoking. However, prior to setting up the cessation service, patients were often not asked their smoking status and were rarely offered help to stop smoking. This would suggest that patients in Reidpark

Hospital would be willing to receive advice and support to stop smoking from a clinician and would welcome the provision of a new smoking cessation service.

Smoking is the cause of significant morbidity and mortality in the UK, with Scotland's population at particular risk of the negative health sequelae of smoking due to high population prevalence of this behaviour. Smoking cessation services can assist in helping smokers to stop and therefore decreasing smoking-related illnesses. However despite the increased emphasis on these services there are few studies which attempt to determine whether patients feel that such a service is appropriate in this setting and whether smokers want to stop smoking and want help to do so. This is extremely surprising, because if patients do not want to stop smoking, or to use services to help them, then it may be inappropriate to offer such services and they may prove ineffective. This survey helps to address the gaps in the evidence-base and the high patient response rate lends validity to these findings.

If smokers are to be offered help to stop within the health service, clearly a necessary first step is to have information on patients' smoking status. This information will make it easier to judge whether the hospital is an appropriate place in which to have a smoking cessation service or whether smokers can be more effectively targeted elsewhere. In the present survey approximately a third of hospital patients reported being current smokers, and this was higher among inpatients. Based on this, and the fact that many of those smokers surveyed are likely to be suffering from an illness caused by or exacerbated by

smoking, it does suggest that hospital is an appropriate setting within which to offer this service.

Inpatients were significantly more likely to be asked if they smoked than outpatients. There are several potential reasons for this difference. Inpatients spend more time in the hospital and see more members of staff. This means that there are likely to be more opportunities for smoking to be discussed than there would be in an outpatient clinic where staff generally have limited time available. Also inpatients are given a general health check by a doctor when they are admitted as part of the clerking-in procedure. While this does not require that patients are asked about smoking, there are questions on respiratory function and doctors often use this opportunity to ask about smoking. Nurses also keep records on inpatients. Again, these records do not contain smoking questions, but they do contain questions about breathing, and nurses may also take the opportunity at this time to ask about smoking.

A significantly higher percentage of current smokers reported being asked whether they smoked than non-smokers. This difference could be due to clinical staff's knowledge of their patients, particularly as many people attended outpatient clinics regularly or had been an outpatient before being admitted. If a patient was known to be a non-smoker or had been an ex-smoker for some time, it is unlikely that the clinician would ask them again. In addition, clinicians may be able to guess whether patients smoked because of tar stains, a smell of smoke or other signs. Further, smokers would be more likely to be

suffering from a smoking-related illness which would encourage clinicians to discuss their smoking.

An alternative explanation for this difference is recall bias. It is likely that people remember questions that are pertinent to them. Non-smokers may be more likely to forget being asked about smoking because it was not relevant, and indeed many of them made comments to this effect. Smokers, in contrast, may be more likely to remember because it made them feel guilty or uncomfortable, or made them think about giving up. It is difficult to see how this effect could be avoided. Patients were surveyed immediately after their appointment or during their inpatient stay when their memory of advice given would probably be best. However patients were often under a great deal of stress. They might have seen several staff for different tests in a brief period of time, or have received bad news about their illness. It is possible that in these circumstances they may not remember exactly where they had been asked about smoking, or even that they had been asked at all.

Although inpatients were significantly more likely than outpatients to be asked if they smoked, they were no more likely to have been advised to stop. This further supports the suggestion that more inpatients were asked if they smoked because of the clerking-in procedure rather than because clinicians wished to advise them to stop.

4.3.2 Comparisons with the literature

It is difficult to compare these figures to those of previous research because of differences in the patient groups surveyed and in the health care systems where the surveys were carried out. It does seem that a higher proportion of inpatients were asked if they smoked in this study compared with other studies, although the outpatient results were very similar to those of other surveys (Goldstein et al., 1997; Kava et al., 2000). This reinforces the conclusion that this difference was due to the admission procedure, as has been described. The proportion of smokers who were offered advice to stop smoking was very similar to that reported elsewhere in both UK (Kava et al., 2000) and US surveys (Frank et al., 1991; Goldstein et al., 1997), and, like these studies, this was rarely followed up with specific help.

The majority of patients did think it was appropriate to be asked about smoking when they attended the hospital for an inpatient visit or outpatient stay and that the hospital should have a service to help smokers to stop. In addition half of the smokers surveyed wanted help to stop smoking. These findings matched those of a Europe-wide survey which reported that 61% of UK smokers surveyed wanted help to stop smoking and there was a similar discrepancy between what patients wanted and what was available (Boyle et al., 2000). However these results are quite different from the US research which reported that the majority of smokers wished to stop on their own (Emmons and Goldstein, 1992). This discrepancy may reflect differences between US and UK smokers or between health services. It could also be related to changes in smokers' opinions in the last decade which could have been influenced by an increased anti-

smoking climate and the growth of smoking cessation support services both in the UK and the US.

4.3.3 Limitations of the patient survey

This study relies on patient reports and it is possible that smokers were not willing to report their smoking status because they were uncomfortable with this, particularly if they were ill with a smoking-related disease, or because they thought that this would be used as an opportunity to discourage them from smoking. Recall bias will always be present when respondents are asked to remember any advice given particularly when there is a high proportion of sick people. However the fact that the number of smokers in the hospital were similar to that of Scotland as a whole, and that a higher proportion of patients reported being current smokers than in other UK surveys in health care settings (Kava et al., 2000; Duaso and Cheung, 2002) suggests that the results are accurate. In addition the results are likely to be more valid than retrospective studies where patients were surveyed after they had left the hospital when their memories of the advice which they were given would be even less accurate.

Of course this does not necessarily mean that smokers will attend a service, were they to be referred, or will actually stop smoking. A UK study of hospital patients found that of 1 155 smokers referred to a smoking counsellor, 13% did not keep the first appointment and 30% did not keep subsequent appointments, although smokers who attended the service were far more likely to stop than those who did not (Prathiba et al., 1998). In a smaller US study even fewer patients referred to a service kept their appointment

(Thompson et al., 1988). Further research should determine whether or not patients who hold favourable attitudes towards a smoking cessation service are more likely to use such a service.

4.3.4 Conclusions

There are few surveys of hospital patients on smoking status and their attitudes towards dedicated services and this study helps to fill this gap by providing information on what patients want and what is presently available to them. It is also unusual in that it asks patients about the advice which they received from all clinical staff, not just doctors. The majority of patients who reported that they were asked about smoking were asked by doctors, although many inpatients also reported being asked by nurses. If hospitals are to take on a health promoting and preventive health role then staff in different professions must be involved. Future research in this area should therefore not be limited to consideration of one profession's role.

It is clear from the difference in findings between inpatients and outpatients that they cannot be treated in the same way and it would seem that the smoking cessation service would be most useful for inpatients. First, more inpatients smoke. Second, as the hospital is a non-smoking environment inpatients may need support to stop smoking while they are there even if they do not intend to maintain this when they leave. Anecdotally it seemed that many were using this as an opportunity to stop smoking, particularly those who had recently become ill with a disease for which smoking was a risk factor. Third, significantly more inpatients reported being asked if they smoked than

outpatients. Therefore as staff tend to be asking about smoking anyway, it is likely that it would be easier to encourage them to follow this question up by offering advice about smoking than it would be to encourage staff in the outpatient clinic, who never asked about smoking, to start to do so. Finally it is easier for people to see the smoking cessation coordinator while they are inpatients, whereas outpatients would have to return to the hospital to do this and may find a GP or other service more accessible.

In conclusion, if it is accepted that smoking cessation advice is to be given routinely by clinicians at each patient contact then there is room for improvement. This improvement might occur after the introduction of the smoking cessation service when smoking would be given a higher profile in the hospital and staff would feel that there is specific support which they can offer. Patients do think that such advice is acceptable and of those smokers who wished to stop, most would like help to do so. As staff are less likely to give patients advice if they think that they do not want it, it is important that they are aware that patients are actually positively disposed towards receiving such advice.

As there is a gap between the amount of advice which is being offered and the amount which patients want, from the patient's perspective there does seem to be a need for a smoking cessation service. Patient opinion is therefore unlikely to act as a barrier to the service. However patients' opinions are not the only factors which would influence the implementation of the smoking service; staffs' views are also key. The next three chapters will therefore look in more depth at staffs' perceptions of barriers to the implementation of the smoking cessation service.

Chapter Five: Implementing the smoking cessation service: individual factors

The last chapter described the patient survey, which looked both at patients' perceptions of smoking cessation support available in the hospital before the advent of the smoking cessation service and at their attitudes towards the provision of this service. Leading on from this, this chapter considers staff perceptions of factors which might aid or inhibit the implementation of this service. These themes are identified from a qualitative analysis of the staff interviews. The chapter begins by describing the relevant literature. It then presents the findings from the staff interviews. It focuses on factors at an individual level which might impact, either positively or negatively, on the implementation of the smoking cessation service, concentrating in particular on health promotion and clinicians' views of themselves as health promoters, how they communicate advice to patients, and whether patients are motivated and willing to listen to this advice. Findings are then discussed with reference to the literature.

5.1 Introduction

The new smoking cessation service at Reidpark Hospital aimed to encourage staff to give support to smokers as well as to refer them, where necessary, to the smoking cessation coordinator. Chapter Three discussed staff attitudes towards these services. In brief, while staff were generally positive towards the provision of a smoking cessation service, and often advised smokers to stop, they did not do this routinely. They tended to be influenced by the speciality within which they worked and by factors relating to the individual patient. The results of the patient survey reported in Chapter Four showed that patients generally thought it was appropriate to be asked about smoking and to be advised to stop, and they supported the provision of a smoking cessation service. However around a third of smokers did not want to stop smoking and a small minority did not want help to stop smoking. The present chapter will explore factors at an individual staff level which could affect the introduction of this service. By discussing these issues with clinicians and other health care staff, such as management, who influence their work, an insight can be gained into how staff perceive their role and how they make decisions about the information they give to patients. This information can then be used to assess whether or not the smoking cessation service can be introduced.

The focus of this chapter is on individual factors which staff believe might affect the introduction of the smoking cessation service and concentrates in particularly on staff's perception and delivery of health promotion work. The next chapter will focus on structural factors which emerged. To some extent this is an artificial division as it is

difficult to separate themes arising from a qualitative analysis of in-depth interviews in this way. However it does aid the organisation of chapters, increases clarity and allows the qualitative findings from this study to be compared to those individual factors which have been highlighted in the literature.

The remainder of this section will review the literature. As the smoking cessation service is a preventive one, this section will focus on the role of the clinician in preventive health and health promotion. The previous chapter discussed patient attitudes towards this service and concluded that patients generally felt that such a service would be appropriate. However staff *perceptions* of patient attitude may influence the advice that they give more than patients' actual attitudes. If they believe that patients may be reluctant to hear lifestyle advice they might not provide it, whether or not their perception is accurate.

This review will draw on the limited available research as well as discussing evidence from other countries, in particular the USA, taking into consideration the different health care contexts.

5.1.1 Clinicians' perceptions of their role as health promoters

Chapter One described the movement of health promotion into the hospital and how smoking cessation services have developed within this climate. In order for clinicians to believe that they have a health promoting responsibility, they must consider that such a role is acceptable to them. As Johnson (2000, p 187) points out "If key hospital staff

members do not believe in the effectiveness of health promotion or do not see it as part of their role, there will be difficulty in implementing health promotion programs." She believes that health service staff are often sceptical about such programmes and lack confidence in their own skills. They may also consider health promotion to be outside their scope of practice. Furthermore areas such as health promotion, which cut across professions, may be missed completely, as departments may largely work within their own specialty with no department taking on such services. In relation to the smoking cessation service, this means that clinical staff have to accept that giving patients advice about smoking, and referring patients to a smoking cessation service, are appropriate roles for them, for the implementation of the service to be successful.

5.1.1.1Health promotion and ethics

Clinicians may not automatically accept that they do have a health-promoting role. For example they may be constrained by ethical factors. The ethics of health promotion in the health service have been thoroughly discussed in polemical books by Illyich and Skrabanek (Illyich, 1988; Skrabanek, 1994; Skrabanek and McCormick, 1994). They argue that the doctor's role is to help a patient with their illness when they are approached, rather than to impose either their views of good health or, they believe, morality, on the population, based on what may be uncertain, confused or erroneous research. Similar opinions have been expressed by McCormick (1994) who questions the premise on which much health promotion and screening activities are based and believes that the ethical dimension of health promotion is being ignored.

These views might not be commonly held among clinical staff and there has been strong criticism of the views of Skrabanek, in particular, on smoking (Chapman, 1993). However, if clinicians are to be expected to take on a health promoting role it is important to consider what this means to them. It is clear that if they do not perceive themselves to be health promoters, or feel that general health promotion activities are inappropriate or difficult in a medical consultation, then this will affect both the help that they offer patients and whether or not they refer to preventive services such as the smoking cessation service.

There has been some discussion of ethical issues in the nursing literature. Two UK papers discuss the dilemmas which nurses face when acting as health promoters. The first of these, which considers the ethics of midwives providing smoking advice to pregnant women, comments that "the educational approach in health promotion assumes that health promoters have the right to coerce individuals to change their lifestyle and, equally, individuals have the responsibility and power to improve their own health once they have the correct information" (Ng, 1997). This author believes that nurses must consider the client's needs rather than their own goals, and that health promotion should not just be about providing information but about creating autonomy for patients to make their own decisions. In her opinion, an ethical analysis of the clinician's role is required before health promotion work is undertaken. If this is a common concern among nurses then it is likely that it will affect the advice which they provide.

Norton (1998) also questions both the assumption that health education and health promotion are part of a nurse's role and the government policy which emphasises this. Like Ng she is concerned that this may be in conflict with patient choices and wonders how far the nurse is expected to go in carrying out a health promotion role. She points out that this could vary from merely presenting the facts about smoking, to persuading their clients to stop or even extend as far as lobbying for advertising changes. She feels that it needs to be made clear how much of a preventive health role they should take on and how far they should attempt to 'manipulate, coerce or even force people by legislation, to adopt behaviour which will promote their health?' (Norton, 1998, p 1270).

While individuals have the right to accurate information, this in itself will not necessarily change behaviour, as patients may choose to take risks. It is important therefore that rather than accepting that health promotion is 'an example of unmitigated good which is accepted without debate' (Norton,1998, p 1276) nurses should explore their justification for this. In her opinion nurses can only really act at an individual level, whereas much health promotion has to be done at the level of public policy. Norton's conclusions mirror those of Ng in stating that 'nurses should recognise the inherent problems of restricting individual liberty in the pursuit of promoting the health of others.'

These papers highlight the conflict for nurses and other clinicians between their responsibility for treating individuals and specific health problems and their responsibility for applying public health and health promotion measures, which are largely appropriate to population health, to individuals. They also highlight the need for

a discussion of the ethics of health promotion and the increasing expectations that nurses and clinicians should be involved in this work. The following sections will review the existing research which considers this issue further.

5.1.1.2 Nurses' views of their health promoting role

Two UK studies examined how nurses perceived their health promotion role in general (McBride, 1994; Thomson and Kohli, 1997). Thomson and Kohli (1997) point out that while there has been an increase in the number of policy initiatives to encourage nurses to become health promoters, there has been little discussion of nurses' attitudes towards this. As part of a training needs analysis for health promotion they surveyed 107 nurses in one Scottish hospital on their current health promotion practice, attitudes and beliefs, view of their role development and priorities for further training. They found that 67% believed that health promotion interventions were an important part of nurses' work. The same proportion were interested in developing this work. Fifty-two per cent responded that they routinely discussed health and lifestyle issues with their patients, and a further 40% sometimes did.

When asked what might encourage them to develop a health promotion role, 84% of those surveyed replied. Suggestions included further training, improvements in resources and clinical practice, further consideration being given to specialist roles and changes in the hospital environment. At ward level they believed that there was a lack of time, there were low staffing levels and that more management support was required as well as financial support for courses. Nurses had positive attitudes towards assisting

patients who wanted to stop smoking; however, they believed that they should only provide this help to those who wanted to stop. Only 21% felt competent to discuss smoking cessation with patients.

The study also considered how nurses perceived patients and whether they believed that they were willing to receive advice. Fifty-one percent thought patients would be very receptive to this and a further 30% thought they would be slightly receptive. It does seem therefore that the nurses in this sample believed that they had some responsibility for health promotion and attempted to fulfill this if possible. Moreover, as the majority believed patients to be at least somewhat receptive towards this, it suggests that patients' attitudes would not deter clinicians from taking on this responsibility. However as there is a gap between what they are actually doing and what they are willing to do, it seems that other factors, such as education and time are acting as barriers. In an environment where time is already limited the authors do not give any suggestions as to how to overcome this. It also suggests that if nurses are to take on a preventive role, and if health promotion initiatives are to be implemented effectively, nurses need training, increased resources and support from management. Such structural factors will be discussed further in subsequent chapters.

Similar results were found from a postal survey of 225 nurses and 167 consultants working in an acute hospital in the UK (McBride, 1994). The majority of respondents disagreed with the statement that health education was victim blaming. However there was a difference in responses given by medical consultants and nurses. While a quarter

of nurses felt that patients found health education 'dull and boring,' almost 52% of consultants believed this. This suggests that consultants might be more reluctant than nurses to give such advice. This UK-based nursing research supports the conclusions of Ng (1997) and Norton (1998) described earlier and suggests that before health promotion initiatives are implemented, consideration must be given both to the clinicians' feelings about this role and their perception of patients' wishes. Once again, the need for time and training in order to support health promotion initiatives were emphasised.

An Australian survey of 388 nurses generated similar findings (Nagle et al., 1999). Nurses largely believed that they had a health promoting role, that smoking counselling should be part of their job and that a hospital stay was a good time to help smokers to stop. However while their knowledge of the adverse effects of smoking was high, their knowledge of effective strategies to help smokers was low. The majority also felt that patients would be positively disposed towards the provision of smoking cessation care; however, they were less certain that patients would react positively to being told how smoking was affecting their health, and only 22% felt that patients would be happy to be advised to stop. Indeed, 35% of nurses felt that patients would resent this. Nurses would be most likely to provide advice if patients requested it, and again the need for training and time and management support were highlighted. They also felt that the presence of nurse specialists, being able to follow up patients after discharge, incentives for nurses, and more confidence in their smoking cessation skills would encourage them to give further support. While the majority believed that ideally all smoking patients

should be receiving help to stop, within the limitations of the current system, less than 10% thought that patients were receiving help.

The authors conclude that, since nurses were far more likely to think they should provide help only if the patient wanted it, then patients' requests should be added to their notes to facilitate this. Furthermore, the authors conclusions are similar to that of other such studies, that is that time, adequate resources and strategic planning are necessary to reorient health care delivery and increase the availability of preventive services.

In summary, these studies suggest that nurses' views of their role as a health promoter and of the kind of health promotion and smoking cessation work they are willing to do, is affected by their perception of whether patients are willing to receive and act upon it. They may also be constrained by structural factors, and these will be discussed in the next chapter. It is not possible to determine whether these views are similar to other clinical staff working in the UK, for example, doctors, because there is so little UK research in this area. However there is some relevant US research and the next section will review this.

5.1.1.3 Doctors' views of their health promoting role

Chapter One outlined the barriers to the implementation of smoking cessation services which were defined by one research team. This section will focus on the individual barriers which they identified. They considered that doctors' views of their health-promoting role might affect the health promotion work which they did and suggested that

doctors believed that lifestyle checks were a form of 'cookbook medicine.' (Kottke et al., 1989; 1997; Kottke 1993). That is, they simply involve ticking off a series of checks, appropriate to the patient, on basis of age, gender or other factors, rather than using their unique skills and performing treatment which could not be done by anyone but them. They believed that this explains why physicians, who may be trained in preventive care and may also believe in the importance of it, do not carry it out.

To address this divergence between what physicians would like to do ideally, and what the needs of preventive medicine are, the authors suggested that it may be better that these are done by non-physicians or by those doctors who like doing this. However they did not ask other professional groups whether they would be more willing than physicians to take on this role. As there is little clear evidence that other clinical staff feel that they have more time or opportunities to provide help, or are more willing to take on this role, then this recommendation is not particularly useful. In fact it highlights the problem which was identified by Johnson (2000) described in Chapter One, Section 4.3, which is that because health promotion is multi-disciplinary it is easy for each profession to believe it is the responsibility of someone else. Moreover as Boyle et al. (2000) have shown that patients are more likely to be influenced by a doctor than by another member of staff, it is important that doctors remain involved in health promotion. This also highlights the problems which can arise when research is limited to the examination of a single profession.

Further barriers which they identified were: (i) that doctors are often reluctant to refer to services as they believe that by doing so they are seen to be endorsing it and thus it becomes their responsibility; (ii) that feedback is only received in respect of a preventive service if it is negative. There is no indication in the literature that UK clinicians are concerned about endorsing systems, rather it is more likely to be the case that they would be happy to refer patients because it would lessen their own workload. It is possible that this concern among US clinicians has arisen because of the US health care system. The second point which they raised could be addressed by providing feedback to clinicians on the success of the service.

However despite these reservations a US survey of doctors found that they did believe they had some responsibility for health promotion and smoking but, like nurses, perceived barriers to putting this into practice (Cummings et al., 1989). In this study a survey was carried out of 100 private internists and 100 internists working in areas where care was 'prepaid.' Respondents were asked questions about their practice, their attitude towards counselling, and to rate the importance of several preventive health measures and barriers to helping patients to stop smoking. The majority of respondents claimed that they kept a record of patients' smoking status and brought up the subject of smoking at every visit. However 60% estimated that they spent three minutes or less counselling smokers during new or follow-up patient visits, despite believing that smoking counselling was as important as screening for breast cancer and more worthwhile than periodic check ups. Only 6% were worried that raising the subject of smoking would cause a patient to leave their practice. They explained that they spent little time

counselling patients because they believed that smokers were not interested (74%) and that this advice was not effective. Only 41% of private internists and 28% of those working in publicly-funded hospitals felt that they were effective in getting smokers to stop smoking. Given this, it is particularly interesting that they rated smoking advice as more important than most other screening tests.

Like the nursing studies described in the previous section, they also identified barriers of time and training, and these will be described further in Chapter Six which discusses structural barriers to change. These results are quite encouraging as the majority of doctors do report that they know patients' smoking status and do provide at least some counselling to stop smoking, although self-report does tend to overestimate the amount of counselling provided. The three minutes which they report spending on discussing smoking is enough time for some brief advice and, with further training, reminders on patients notes, and feedback on success rates, it is likely that they could be encouraged to provide more and more effective counselling on smoking. Cummings (1989) also suggests that the provision of an on-site service could further support smokers to stop. This suggests that the provision of the dedicated smoking cessation service at Reidpark Hospital would encourage more clinicians to offer support.

5.1.1.4 Attitudes and behaviour

These studies have described clinicians' attitudes towards their health-promoting role on the assumption that this will influence their provision of preventive health. However, as psychology theorists have demonstrated, the link between attitudes and behaviour is not a

straightforward one (Ajzen and Madden, 1986). In a large US study, 6830 patients visiting 44 clinics completed a questionnaire about the preventive care which had taken place during their visit. The results showed that there was a weak correlation between staff attitudes and rates of providing preventive services reported by patients (Solberg et al., 1997a). This suggests that favourable attitudes towards health promotion are not enough to ensure that this work is carried out, and there are many other factors which affect physicians' behaviour. Therefore it can be difficult to predict the preventive behaviour of physicians from their desire to deliver these services. This means that it is not enough merely to educate clinicians about the benefit of health promotion, and other issues must also be addressed.

Many commentators have noted the increased expectation that clinical staff, primarily doctors and nurses should take on health promoting responsibilities and they point out that this will not occur without an insight into clinicians' perceptions of their health promoting role (Ng, 1997; Norton 1998; Johnson, 2000; Whitehead, 2000). The research suggests that clinicians are not reluctant to take on such a role, but are prevented by other factors, in particular their perception of what patients want, lack of time, lack of skills in health promotion and smoking cessation and a feeling that there is a need for greater management support. The next section will explore in more depth the research available on clinicians' perceptions of whether patients want advice.

5.1.2 Clinicians' perceptions of patients: Do they want lifestyle advice?

The previous section suggested that clinicians might decide not to give lifestyle advice because they believe that patients are not amenable to receiving this. It is worth considering this further. Once again there are few published studies where clinical staff are asked what they think patients want, and even fewer which analyse whether clinicians' perceptions of patients wishes do influence the advice which they give, and the research which has been carried out is largely US-based.

Section 1.1.3 referred to a commentary by Kottke et al. (1993) which highlighted a number of barriers which might deter clinicians from giving smoking cessation information. One such factor is that, while they get little feedback on the effectiveness of this advice, they do get complaints from patients when they are asked about an issue which they do not want to be raised.

Becker and Janz (1990) identified similar reasons for the slow integration of routine health promotion and disease prevention. This occurred despite evidence which showed that patients saw physicians as a credible source of information, and research which highlighted doctors' effectiveness in disease prevention using minimal time and effort. Lack of time and training were again highlighted as barriers as well as doctors' belief that a health-promoting role was not an appropriate one for them. In order to address these issues, the authors suggested that programmes should be implemented which would alter physicians' perceptions about how receptive patients were to such services and help them to improve their capabilities to motivate change towards healthier behaviour. They

suggested that physicians should receive feedback on their success rates, which would encourage them to give smoking advice, and a note could be taken of patients' wishes, which would allow them to target motivated and interested patients. They also suggested that physicians should attend workshops to strengthen knowledge, skills, and techniques in interventions and to maintain behaviour change.

Physicians' pessimism about their patients' ability to change their lifestyles was also cited in an older US paper which examined obstacles to family doctors giving lifestyle advice on smoking, obesity and exercise (Orleans et al., 1985). Other barriers found were a lack of confidence in their own and outside treatments, and a perception that patients would reject referral for lifestyle change treatment. This meant that primary care physicians were reluctant to treat such problems, that the risk education methods they used tended to be the least effective and that they under-utilised potential referral to outside specialists. This is likely to limit the amount of such advice which they offered.

This review has explored factors at an individual level which might affect the implementation of a smoking cessation programme into a hospital. It focused largely on attitudes towards health promotion. This is clearly important as it can help to determine whether clinicians will become involved in offering preventive services. Clinicians' perception of what patients want, whether they are receptive to lifestyle advice and whether they will alter their behaviour as a result of receiving it is also of interest. All of these factors potentially influence the health promotion and smoking cessation advice which they provide.

Most of the research which is available has focused on general practice-based lifestyle initiatives rather than those in the hospital. While there may be some similarities in terms of clinicians' attitudes and behaviour, clearly the structures and environment are quite different and therefore more hospital-based research is required. The hospital research which has been done has tended to focus on a single profession, rather than on staff as a whole, meaning that insight is gained into that profession's perspective rather than into the hospital climate. Furthermore there is a lack of qualitative research. This area is complex and an understanding of how staff perceive their own role or patients' wishes then it cannot solely be gained by survey or observational methods. Finally, UK-based research is required before insight can be gained into UK settings.

The next section will report on the qualitative findings from the staff interviews. The interview questions were informed by the literature, however, new themes also emerged from the analysis which directed further reading, which itself resulted in further analysis of the interviews.

5.2 Findings

The analysis of the interviews identified several main themes which related to factors which affected change at an individual level. All of these themes were linked and there was of course be some overlap between them. However I considered that these could be divided into three main areas: (i) how interviewees viewed their own health promotion role and what aspects of preventive health work they considered to be their responsibility;

(ii) how clinical interviewees made decisions on giving advice to patients, and, related to this; (iii) their perception of what patients want, the influence they could have on them and whether they believed that this influence was maintained. These issues will be discussed with particular reference to the smoking cessation service. By doing this a better understanding can be gained into staff's decision making processes and this, in turn, can help to inform whether or how the smoking cessation service could be implemented.

Much of the section is concerned with clinical staff's relationships with patients and therefore will be based largely on the data from sixteen interviewees who had direct patient contact. However, with the exception of the outpatient manager, all of the interviewees had had clinical experience in the past and their interviews will also be drawn on when appropriate. As noted earlier, interviewees were chosen to reflect a number of different views and therefore the role of the interviewee in the hospital and the influence which they could have was important. For example the clinical director may affect funding decisions for a service and therefore his views on this might give a greater understanding of this issue than that of a more junior member of staff. Similarly if the opinion of the service leader were to differ from other clinical staff in a key issue it may be important to highlight this in order to gain insight into why the service was developing in a different way to that which the service leader identified.

5.2.1 Health promotion: roles and responsibilities

The literature discussed how staff's perceptions of their health promotion role impacted on the advice which they gave and the responsibility which they took for health promotion. It was hypothesised that this would also affect the implementation of a preventive health service and this led to a discussion with the interviewees on this topic. Isobel described her view:

> "Absolutely everybody who works in the hospital has got some kind of duty to provide, you know, health promotion if the need arises, whether it be an auxiliary talking to a patient in a clinic corridor or whether it be the manager sitting in the first floor saying 'I think we better .. you know, do this that and the next thing,' but I think everybody has really got a duty for it." (Isobel Murdoch, Staff Nurse, Respiratory Medicine)

Interestingly all of the interviewees, regardless of their profession, who discussed responsibility for health promotion, shared Isobel's view that everyone should be responsible for health promotion and that all staff should be doing some form of health promotion work. Interviewees however did not receive any standard form of training on health promotion so it is unclear why they shared this view. However when discussing health promotion at a board level, the clinical director describes the goals of the acute hospital:

"But one of the things that we are trying to do is to develop our clinical services strategy to include the assumption that there is health promotion, so it would become part of our policy that we would try to push on to other areas of the service too, so that we don't just restrict it to the things which are obvious and easily achieved areas but that we start to bring it into our thinking, much more commonly, much more readily." (Dr Martin McKendrick, Clinical Director)

He emphasised that health promotion was taking a more central role in hospital policy and it was now expected that staff should include this within their work. It is possible that this policy has influenced staff and that this explains why interviewees shared the belief that they were all responsible for health promotion. If this is true then it suggests that those working in a strategic role in the hospital have been effective in communicating their health promotion strategy. Conversely it may be that the clinical director may represent staff's opinions and that hospital policy is formed in a bottom up manner. However this second explanation is less convincing. Sections of the interviews which were not discussed in this thesis were concerned with staff involvement in hospital policy and it seemed that, with the exception of staff with a management role, most interviewees had little such involvement and little interest in having this.

A third explanation is that external influences, such as government policy papers, could have affected both clinical staff attitudes and hospital policy. In early interviews staff were asked about their knowledge of government policy papers, however this provoked

little or no discussion and this topic was omitted in later interviews. Of course this does not mean that they do not have an effect. Interviewees could be influenced by these documents without being knowledgeable about their titles or conversant with their contents.

5.2.1.1 Lifestyle advice and the role of staff

Although there was a consensus among interviewees that they should be involved in health promotion, this does not mean that the involvement of all staff was necessarily similar or that they carried out health promotion work in the same way. Staff could hold positive attitudes towards health promotion in theory without putting it into practice. The previous extract from Isobel's interview described what different staff could do and suggested that, while all staff might have some part to play, this varied depending on their role. That is, auxiliaries may chat to patients in an outpatient clinic while assisting clinicians and helping patients move between different areas, whereas managers may make decisions on health promotion at a more strategic level. A pharmacist explained this further:

> "I would say probably clinical pharmacists can have a slight impact at ward level, just about different things, you know. Dieticians obviously play a major role as well, you know, about people's diet. Obviously the smoking cessation nurse is a new post which will affect it quite a bit. I would say probably ... all health care professionals to a point, the bulk of them in hospital. You know, the nurses will have an effect, the doctors will have an

effect, it's all, you know, when they are speaking to the patients... so I think there are probably a lot of people involved in it, but, you know, all doing a small bit and no-one really doing a massive job." (Conor O'Connolly, Junior Pharmacist)

Conor shared the dominant opinion that the responsibility for health promotion should be taken on by everyone. Like Isobel, he described the different impacts which staff could have depending on their different role. He also brought out another common theme: that some staff, such as the dietician and the smoking cessation coordinator, had a specific responsibility for health promotion because they were more clearly involved in helping patients to change their lifestyle. He considered that pharmacists, in contrast, would have less of an impact. While he was positive about their involvement in this work he was far more vague about what they could actually do. Like Conor, the majority of interviewees, after stating that health promotion was everyone's responsibility, went on to give some examples of their own involvement. For example this manager described this in his own work:

"...generally trying to spread the national strategy, there is national documents that come out about strategy or whatever. There is posters to go up and we do that, and then we put posters up throughout the department and whatever displays maybe required. Other than that, directly, no. Other than trying to co-ordinate what goes on within the department." (Scott McGhee, Outpatient Manager)

Another manager, who discussed the same issue, gave a very similar example of the work in which he was involved. It seems that while interviewees shared a view that they should each take responsibility for health promotion, they practised this in different ways. Management staff became involved in health promotion initiatives which took place at a strategic level, such as helping to set-up breast-feeding campaigns, whereas interviewees who had patient contact tended to discuss the aspects of health promotion which related to their speciality. Not surprisingly, therefore, staff got involved with health promotion at a level which related both to their role and the opportunities they might have had; whether this be in a clinical or management capacity. In addition they also considered that other members of staff had their own area of expertise and so would refer patients to them where necessary. The implications of this approach will be discussed further in Chapter Seven.

These findings supported those described in Chapter Three where it was reported that staff were more likely to provide smoking cessation counselling if this was related to their speciality, and often preferred to refer patients to a dedicated service rather than attempt to provide support themselves. It would seem that staff had an approach to the patients which reflected a 'medical model' of treatment and where treatment was largely disease-driven. This perception is reinforced by the structure of the hospital. It is divided into specialities and clinical staff work largely within one specialty, treating patients for any illness which fit into this. The increased emphasis on health promotion, and the fact that interviewees wished to help patients manage their illness as much as

they could, has meant that treatment has been extended to incorporate a health promotion component. However, rather than health promotion being 'holistic,' it has also been broken up into specialities which match that of the clinical treatment. This could make it difficult to ensure that all staff provide some smoking cessation help.

Once again the clinical director shared the attitude of the other staff:

> "Our focus has been on illness rather than health....[Health promotion] will still take up a relatively small part of our work because what we have to do is to ensure that we are providing the service that people need but we should be able to expand what we are doing to some extent." (Dr Martin McKendrick, Clinical Director)

He described the hospital policy to be one of providing a curative service and expanding this into health promotion where possible. This reflected what staff were doing at an individual level also, and suggested that this work would remain peripheral and that treatment services would be prioritised. While earlier Martin had commented that health promotion was becoming increasingly important in the hospital, he qualified this here by saying that it would still be a small part of the work because of other demands on staff time. This is to be expected. Clearly the hospital is set up to primarily to treat illness. Patients are referred so that specialist staff can help them with specific health problems and it is this work which will continue to be most important and for the hospital and the staff to prioritise. Again as there were such consistent views between interviewees, and

these views were shared by the clinical director, it is possible that hospital policy was influencing the priorities of staff. An alternative explanation for this shared view was that Martin used to be a hospital consultant. While he was speaking here as a clinical director, clearly his opinions would be informed by his experience of the hospital from the perspective of a clinician, and his knowledge that curative work had to be prioritised.

If it is true that interviewees largely perceived their health promotion responsibility to be related to the work which they were already doing, then it seems likely that they would be less willing to give patients more general advice which was not relevant to the presenting illness. The majority of interviewees did in fact express some reluctance to give lifestyle advice which was not directly relevant; sometimes commenting that this was 'intrusive' and that hospital should not be seen as a time to 'collar' patients. Michael, a consultant in infectious diseases, had earlier noted that he could see patients withdraw when he tried to give them other advice and later he went on to say:

> "I mean, I think once we've started on the general advice, it's fine, the difficulty is are we going to stop at smoking advice, or are we going to tell them about their alcohol intake while they are on holiday or are we going to talk about saturated fats? You know, I think you could prolong your appointment quite significantly if we decide to give them the 'Full Monty' health promotion advice. I think it is a difficult one. I suppose, the honest thing, is that we tend to try and .. certainly in the travel clinic, there is no doubt that the advice is linked to travel... so it will be a bit about alcohol, a

bit about unprotected sex, it will be about eating but not healthy eating more avoiding food poisoning, so we are going beyond vaccinations but not necessarily to everything..." (Dr Michael Mackie, Consultant, Infectious Diseases)

This illustrates very well how he makes the decision to offer some advice because it was relevant to his speciality but not other, similar advice, which was less relevant. Michael runs a travel clinic and so felt it was appropriate to discuss food poisoning, that is advice which is related to travel, but not healthy eating, which was more general. Once again this reinforces the theme running throughout this section that interviewees will only take on responsibilities which were related to, or were a direct extension of, their role. Michael used lack of time to explain how he made his decision. This theme will be discussed further in Chapter Seven. At an earlier point he also commented that he could not be skilled on all aspects of health promotion and that he did not have the confidence in his skills to extend this into other areas. Several other staff also commented that they could not help patients unless they had appropriate knowledge or they would 'flounder.'

In contrast a physiotherapist had a quite different explanation from the rest of the interviewees for her belief that general advice was inappropriate:

"We have to be quite careful that we treat what we are referred for, not sort of multi or other associated problems. Because we need a referral from a medical practitioner so if somebody say comes with arthritis that is what we

are treating. We are treating the arthritis. If they happen to have a bad chest then we would not be treating that because they have been referred to us with a specific problem and that's what we treat. Em, if we felt they had a respiratory problem and desperately needed treatment we might well go back to the GP and say look send me another referral and I'll treat this, but not if it's a different category of treatment." (Gillian Thomson, Physiotherapist)

This suggested that this interviewee felt that her role had strict boundaries. She believed that she must treat patients only with a referral from a medical practitioner and therefore could not always raise other health issues with patients as this would mean extending her role inappropriately. Like most of the other interviewees, she considered general health promotion to be outside her responsibility but her explanation was quite different. No other interviewee raised this concern, but most of the other clinical interviewees were doctors or nurses. If advice on smoking cessation and health promotion more generally is to become routine in the hospital, and it is expected that all staff have some responsibility for this, it is important to determine whether other staff agree with Gillian, particularly among professions allied to medicine, such as physiotherapists. Staff are unlikely to give advice if they feel that by doing so they are taking on inappropriate responsibilities and that this may cause problems with their managers or with other staff.

Only two of the interviewees were not concerned about taking on this role. One of these was the service leader:

"Of course when we interface with patients if we see that there's something that they are doing which I think is harmful to them or they could change to improve their health status then we would advise on that and usually do." (Dr David Cairngorn, Service Leader and Consultant, Respiratory Medicine)

Clearly he did feel that clinicians should give opportunistic advice and that they should be generally responsible for encouraging patients to improve their health, even if this was not exactly related to the illness with which they present. His contrasting view was not surprising as he set up the smoking cessation clinic with the aim that all smokers should be encouraged to stop at every opportunity. In order for this aim to be realised all patients would have to be asked about smoking and referred to this service, even if smoking was not a major risk factor for the illness with which they presented.

A cardiology technician also felt that general advice was important:

".... [smoking] is probably the question which comes up most with regards to this test, smoking, diet and exercise... because it makes them very aware of these three, so yes.... Because you know you are concerned with their general well-being so I mean (pause) I don't think there would be a problem. I don't think too many people would find it intrusive and I think they would probably expect to be asked." (Siobhan Jones, Cardiology Technician)

It would seem that she held a more positive attitude towards this because offering advice was actually part of her work. One of her tasks was to do exercise tests on patients where the patients ran on a treadmill and physiological measurements were taken. She commented that this generally prompted them to ask her for advice on aspects of their health and also gave her the opportunity to talk to them while they were recovering. This meant that two potential barriers to giving lifestyle advice, lack of time and feeling that patients would be annoyed, were not present. It is possible that by identifying similar opportunities, other staff could be encouraged to fit more lifestyle advice into their patient consultations. She considered this to be part of her responsibility rather than to be an additional activity which might be useful but not a priority. This meant that she was more likely to give this advice than other clinical staff who were more focused on treating the patient's illness.

5.2.1.2 General advice and specific advice

On the whole interviewees were far less happy to give general, rather than specific, advice. This is not surprising. Clearly if a clinician is treating a patient for a particular illness and is aware of the patient's habits which contribute towards this, or could help the patient manage or recover from their illness more effectively, then he or she would be likely to extend their treatment of the illness to giving related help. In this way, clinicians could choose what aspects they felt were related to their own work and by doing so, could consider that they were fulfilling a health promotion role. However they could negotiate this role in their own way and by making their own judgments on its appropriateness.

Conversely if they were expected to give standard help to all patients they could no longer interpret and communicate this as they wished. While they may be generally positive towards health promotion, the advice which they gave tended to relate to their own work and, for this group of interviewees, it does not necessarily follow that they are willing to give advice on any aspect of the patient's lifestyle. This reinforces the theme which arose in Chapter Three, that those who worked in specialities which were less affected by smoking were less likely to raise this issue and suggests that all clinicians would not necessarily be willing to do this routinely, as the service seeks to do.

5.2.2 Communicating advice to patients: decisions and mediation

The last section discussed how clinicians perceived their role as health promoters and what advice they offered to patients. In Chapter Three, Section 2.2.1 Anthony expressed concern that if patients were pushed too hard to change their behaviour this would affect clinicians' relationships with them. He felt that this could be counter-productive and make it more difficult to help patients in the future. He commented on this several times in his interview. Two interviewees, both of them from a clinical background, also commented on the negative impact which this might have on their relationship with patients. A third, Dr Michael Mackie, agreed with this and commented that "there is no doubt that some of them, you can almost physically see them, you know, withdrawing." However, he differed here in that he did not let that "upset" him or influence his decision to bring up other issues. He pointed out that he was not running a shop where patients could "come and get their vaccination and go away again." While he did seem very

sensitive to patients' concerns he did not let this stop him from giving them advice. He explained this by saying that while "springing other things on them does not go down terribly well," he was used to doing this and would continue to do so if he felt that the time was right.

Other clinicians discussed how they judged this timing and when to give patients lifestyle or health advice:

> "....but use your brains. You know? If somebody's ninety-nine and they've smoked all their life and they live on their own, and they've lost their husband recently, you're not going to say 'Right, I think you should give up smoking.' But I think the majority, if it's going to change them ... and give them a better quality of life, should." (Carol Branwell, Staff Nurse, Coronary Care Unit)

By using an extreme example, this nurse demonstrated the criteria which she used to make a decision on when to give patients advice. She commented on the patient's age, the length of time that they had smoked and the death of a partner. It would seem that she was informally assessing whether it is worthwhile for the patient to change their lifestyle and whether they would be likely to be able to do this successfully at this time in their life. Carol was particularly enthusiastic about helping patients to change and was very positive about health promotion activities which were available in the hospital. Clearly, however, she mediated this by informally deciding how appropriate this was for

the individual patient. She suggested that it was necessary to choose a time in which the patient could engage with the information and she tried to target help with this in mind.

This was a common theme recurring at different times in the interviews and most interviewees, particularly those with patient contact, gave examples of when they believed it was inappropriate to give lifestyle advice. For example one doctor said he could not discuss patient's smoking when giving them an HIV diagnosis. This would not be appropriate because they would not be able to listen, it would not be a priority for them, and they may need to use cigarettes as a prop when under stress. Like Carol, he uses an exceptional situation to demonstrate a general rule. This example represented the dominant opinion well. That is, that clinicians were happy to give advice but only if they felt that this was the right time. They chose this on the basis of whether the patient was motivated to change, able to listen and could be helped by changing their behaviour. A nurse expanded this theme:

> "...I think it very much depends on how long we have taken to do everything at the clinic with them. I think that some people would shut off very quickly and I think what needs to be said needs to be said in a relatively short time span, because I find patients do shut off when they've maybe had a lot of tests to get that morning, and if they've already seen a doctor and then they are the last to be seen by me, I think that can be a problem because they are getting tired and maybe just not listening you know, the same way as they probably would otherwise. So if I felt that that was happening I would probably make

a point of seeing them out of clinic hours and bringing them back to see me at a different time or I would maybe pop out to their house and see them, if there was a particular problem that I was worried about." (Isobel Murdoch, Staff Nurse, Respiratory Medicine)

Here Isobel showed how she assessed whether or not the patient was listening to her and how she managed this. This extract was also interesting as it gave a picture of the situation in which clinicians were working. Outpatients, in particular, may attend hospital for a short period of time during which they may see a number of different staff for different tests, results or information. Thus they may be given a lot of information at a time when this would be difficult to take in. While staff may still think lifestyle advice was important, they have to take into account these other factors and assess the amount of information that patients could deal with. Staff often commented that, as they had a short time with patients, they had to prioritise the most important information about their illness before moving on to offering further support.

Isabel is unusual in that she has attended health promotion and smoking cessation courses. A large part of her job involved helping asthma patients to manage their disease. As asthma patients need to know how to use an inhaler it is an area where health education has always been important, and the boundary between treatment and prevention blurred. In addition because she visited patients at home she was able to follow patients up to ensure that they had understood the advice which they had been

given. However most other staff would not be able to do this and had to make decisions about what patients could take in within the time of their appointment.

This informal method of assessment is consistent with that described as effective by the health promotion officer:

> "Some of them, I think, would listen..... And it's really, I think it's the staff being aware of how much information to give a patient, and when to give them it, and to give them appropriate information...I mean, you know, any patient will tell you if they don't want it. They'll tell you exactly what to do with it. But if not, quite often you can get them, they're quite keen, particularly like weight and smoking information. They can be very keen and motivated when you see them, but it's what they do with that afterwards, if they follow it up, or whatever. It's very hard to measure that." (Kate Squires, Health Promotion Officer)

Like the other interviewees she emphasised the importance of assessing when the patient is ready to change, giving them appropriate information and not overwhelming them with too much information. In this way staff would avoid feeling as frustrated as they might otherwise, patients would be more likely to receive advice which was suitable to the stage they were at or the information they could handle, and staff could feel more confident that they were taking account of patients feelings. At a later point she also refers to being involved in training staff so that they can make these assessments. None of the

interviewees in this study mentioned attending such training, either spontaneously or after being specifically asked, and this suggests that they have learned how best to give advice by experience. Training could help them to make these assessments more effectively.

The quote from Kate above also raises another issue which is pertinent to the way in which staff negotiate with patients, that while patients may be quite willing to receive behavioural advice, they may not maintain any change made. This theme will be discussed further in the next section.

5.2.3 Motivating Patients

The last section described how interviewees made implicit decisions about when to give patients advice and when such advice was inappropriate. It was evident that interviewees were also concerned with the influence which they could have on patients' behaviour and this would affect whether or not such advice was given. This section will consider further interviewees' perceptions of the influence they had on patients and the factors that influenced this.

The Clinical Director of the trust discussed the influence which he felt that the hospital could have. In so doing he highlighted several of the dominant themes which emerged in these interviews:

> "... it's possible to influence people... you can influence some patients dramatically, you can influence a large number of patients to a small extent,

you can probably, I think we have very little influence on the general public. So we would probably focus our activities in terms of influencing patients on whom we can get the message across ... and hope they would spread that to their relatives... so we can reach the public through patients, but what we can do is to perhaps reduce the further damage caused by their behaviour once we get hold of them... it's not a huge effect which we have, we're certainly aware that some patients just give lip service to what we are saying...and as we see them relatively infrequently it is difficult to reinforce this impact... if they have a life threatening illness then you can probably get them to change their lifestyle but if it is a relatively minor incident you probably won't be able to have much an impression, but we should be trying to get them at least, both through what we say and also through information we provide to them." (Dr Martin Kendrick, Clinical Director)

Martin reinforced the impression which was gained in previous sections that the advice which clinicians gave was affected by their perception of the effect it would have. In order to increase their effectiveness, clinicians were likely to use the strategy of focusing on those patients who were most likely to change.

Unlike most of the other interviewees, Martin discussed how the hospital can affect the wider community. It is likely that he was influenced by his role as director where he was involved in management and policy issues and in considering the strategic role of acute hospitals in this area. This meant that he was more likely to consider effects on the

population. The only other interviewee who discussed the influence which the hospital could have on the wider community was also a manager who commented that staff did not really have the opportunity to help patients before they were admitted to hospital. Other interviewees with direct and frequent patient contact, in contrast, were more likely to consider the individual patient.

Martin also raised several themes which will be considered further in the next section. In particular he considered that the amount of influence the hospital has on patients varied and that one of the factors which contribute towards this variation was the patient's illness. He believed that more serious illnesses acted as a greater motivator to change whereas less serious illness left little impression. Furthermore he commented that patients did not listen, often paying 'lip service' to the advice given and that the influence which they had in the hospital may not be maintained when the patient returned home.

5.2.4 Patients' response to lifestyle advice

In the previous section Martin described how hospital staff could have different influences on the patients whom they treated. All of those interviewees who discussed this gave a similar response:

> "It varies. It depends how much the patient wants to help themselves. It also depends on what type of influences, as in environment and culture and things like that and certainly some patients are much more receptive to what you tell

them to do other patients just want a quick fix and off they go again, so it varies." (Gillian Thomson, Physiotherapist)

This physiotherapist considered that patient motivation was related to outside influences on their behaviour, such as social factors. Therefore the influence which they had might not continue to be felt once the patient left the hospital. This reinforced the impression gained in the previous section. Interviewees did not take a 'blanket' approach to patients and often considered the effects of external influences on their behaviour such as their social environment.

Martin commented on how a patient's illness could act as a motivating factor to change. I looked more closely at what interviewees considered motivated patients and found that both clinical and non-clinical interviewees made a similar link, either explicitly or implicitly. They considered that those patients who were very ill were most likely to make larger lifestyle changes. Related to this was a theme which arose in half of the interviewees, that is, that patients would not maintain their behaviour change. If interviewees considered that patients were motivated by their illness, then when they start to recover they would be less likely to maintain any behaviour change. Home influences rather than hospital influences would once again be dominant.

"I have to say that I'm somewhat cynical about how successful we can be, because when I've been involved with these services ... you know ... in different hospitals... and it's the usual story the road to hell is paved with

> good intentions, and I'm sure a lot of patients, when you have them as a captive patient in hospital, having just had their heart attack then yes, they say, "I'm going to give up smoking, I'm willing to do that, I'm willing to do this and I'm going to exercise." Things change once they've survived the episode, they're out and they tend to go back to things... and I think even with the greatest amount of support and the best intentions, I think your success rate will be relatively small." (Dr Anthony Lecker, Consultant Gastroentologist)

The opinions expressed by Anthony throughout the interview were consistent with this view. He generally felt frustrated about giving advice, felt that he had a limited effect on patients and believed that his role was largely as a specialist to treat the illness that patients presented with, rather than trying to fix everything. Clearly he believed that illness motivated patients, but this influence only lasted for as long as they were in hospital. Because of this he considered that the smoking cessation service would be unsuccessful. Half of the interviewees commented that patients may want to hear advice but would not change their lifestyle or would only change it temporarily.

> "We're not having as much [impact] as we would like. A lot of patients will take heed of what you say when they're first diagnosed and they try to turn over a new leaf and they try to take more exercise and they try to cut out all the sugar from their diet and cut down on the smoking, but I am afraid they

fall by the wayside as time goes on." (Geraldine Gallagher, Diabetic Liaison Sister)

Interviewees often seemed uncertain or even cynical about the effect which they could have and the duration of this effect. Interviewees commonly believed that when patients returned to their own environment they would go back to their old behaviour. It is likely that interviewees' decision would be affected by this knowledge. If they felt that their influence only worked within the hospital they would be less inclined to continue to give advice.

5.2.5 Maintaining change

In Section 2.1 I quoted Siobhan, a cardiology technician who felt quite strongly that patients were interested in receiving lifestyle advice. Other clinical staff seemed less certain about this. Siobhan was also the most positive when discussing how much influence she felt they could have on patients.

"The majority pay a great deal of attention [to lifestyle advice]...if they've had a heart scare they've had or there have been problems it does tend to affect them quite strongly, the majority of patients.. and they do want to change things around, they do want to do things right, they want to stop smoking, if they can possibly help it, you know, they go home and they want to change, they do become fitter, they want to become fitter so they do ask you all of these questions." (Siobhan Jones, Cardiology Technician)

Her views were similar to the other interviewees in that she considered that the patient's illness (that is their 'heart scare') acted as a motivating factor towards changing their life. Her view of the effects clinicians could have however was far more positive than other staff and it is likely that this was influenced by her belief that patients wanted lifestyle support. Other interviewees often commented that patients would return to their old behaviours once they left the hospital. In contrast she believed that "they go home and they want to change." This suggested that her belief that she could influence patients and that this influence extended to the patient's life outside the hospital, made her more positive about giving such advice. It further supported the perception that if they knew they were having a longer term influence on patients this would increase staff's motivation to give this support. It is not possible to draw any firm conclusions as she was the only person who was consistently positive about the influence they could have and patient's responsiveness to this.

Interviewees often commented that patients could 'fall by the wayside as time goes on' and suggested that 'environment' and 'culture' had an influence on whether patients maintained any behaviour change they made. For example, they discussed the effects other members of the family might have. If their family smoked or ate unhealthily, then the patient would return to doing so too. Interviewees could become frustrated if they felt that any influence they had on a patient's lifestyle in hospital would become worthless after they returned home.

One nurse, however, took an alternative view of external influences. She considered that this could be used to positive effect. She believed that there had been a change in how patients were cared for, "patients went home and that was that .. now they're more interested in what you do when you go home" and that nurses' 'responsibility of care' has been extended to some extent. Throughout the interview she emphasised the role of the patients' families and how they could help.

> "I mean the mother comes in and the husband smokes and the kids all smoke... but as soon as the father gets ill, that tends to be a shake up and nine times out of ten... the wife will say... 'well I'll help you, I'll give up as well and there'll be nobody allowed to smoke in the house.' That's a step forward in the right direction. So anybody coming in to the house, any visitors even they'll no' be smoking for that time, so it all helps." (Carol Branwell, Staff Nurse, Coronary Care Unit)

She gave another example of the influence that family could have, by describing how a dietician might discuss a man's diet with his wife. She also said that while a patient may not realise how ill they had been when they had a heart attack, their family would remember and thus would encourage them to change. Therefore, unlike other clinicians, she was not discouraged because she believed that the patient would go home and back to their old behaviours. Rather, she could see opportunities to gain support from the family, thus making it easier for the patient to maintain lifestyle changes. She considered that this would have the additional benefit of improving the health of the

wider community. There is no obvious reason why she differs from the other interviewees who discussed this, however her strategy of concentrating on the positive side of external influences rather than the negative could be used for more effective change.

5.3 Discussion

5.3.1 Clinicians' Role as Health Promoters

The findings suggest that the majority of interviewees do see themselves as health promoters and that they generally do believe that health promotion is everyone's responsibility, although they have received limited training to help them to put this into practice. Interviewees tended to be more positive about giving specific advice related to the patient's illness, or their own speciality, than about giving general support. Some interviewees commented that they lacked the skills or the confidence to do this and others suggested that, as they had limited time, they had to prioritise the most important aspects of patient care as they saw it. When performing a health promotion role, they were concerned with patient motivation and generally preferred to give advice at a time when they felt that the patient was able to listen to them and ready to attempt to change their behaviour. Several interviewees commented that, while they could provide the information, it was up to the patient to make any change.

On the whole, interviewees felt that patients were not unwilling to be given lifestyle advice but also felt that the effect that this would have on their behaviour varied. There

were concerns among some staff that patients were being pushed too hard to change their behaviour, in particular to stop smoking, and that this could affect their relationship with patients. Interviewees were uncertain about the extent to which they could influence patients and were concerned that, even if patients made a positive health change while they were in hospital or were very ill, they would not necessarily maintain this change once they returned to their usual environment. For some interviewees this could lead to frustration and cynicism.

It is difficult to compare these qualitative findings with a literature which is largely based on the results of questionnaires or on a commentator's own perception of the barriers to the implementation of a preventive health initiative. However as the summary in the last paragraph showed, some dominant themes emerged.

The literature emphasised that it was necessary for clinical staff to be willing to adopt a health promotion role in order for them to perform health promotion work (Bain and McKie, 1998). The available research, which focuses on nurses' feelings towards this role, suggests that nurses do believe they should have a health promotion role, although this is often limited due to external factors (McBride, 1994; Thomson and Kohli, 1997, Nagle et al., 1999) There are few studies which question either doctors', or other health care professionals', understanding of this role.

The findings, which were based on interviews with health professionals from different backgrounds, showed that all clinical staff, regardless of their role, felt responsible for

health promotion and did try to give patients lifestyle advice. In this group there did not seem to be any difference between professions in the perception of this role. Nurses, doctors and others held similar views of their own role as health promoter. Of course this finding is not conclusive with such a small sample, but it does suggest that other clinical staff are likely to be willing to perform a health promoting role. Clearly this finding would have to be explored further in larger studies before any firmer conclusions were drawn.

It would seem therefore, at least on initial examination, that clinical staff were not resistant to carrying out health promotion work and thus this is not a major potential barrier to the implementation of such initiatives. However, they were more likely to give advice which they believed to be directly relevant to their own speciality, so in order to encourage them to give smoking cessation support or refer to the smoking coordinator, the relevance of smoking to this speciality should be stressed where possible.

However it is not enough for clinical staff to perceive that they have a health promotion role for such a role to be performed. The literature identified some other factors which may prevent clinical staff from giving advice, such as the need for education and training (Cummings et al., 1989; Becker and Janz, 1990; Nagle et al.1999) which may be related to a lack of confidence and skills (Johnson, 2000). These themes also arose in the present study. Similarly, one study highlighted the need for financial and management support (Thomson and Kohli, 1997). Therefore if preventive health strategies are to be effective it is not enough merely to issue policy directives but these need to be supported

by appropriate training programmes, and a co-ordinated approach towards the integration of a policy has to be adopted. Clinicians have to be clearly informed about what is expected of them in relation to health promotion and how far their role should extend.

5.3.2 Ethics of Health Promotion

The literature review discussed some possible ethical concerns regarding clinical staff taking on a health promotion role (Illycih, 1988; Skrabanek, 1994; Ng, 1997; Norton, 1998) While interviewees in this study did not raise ethical issues as such, some interviewees were concerned that patients would be pushed too hard to make lifestyle changes. They also mentioned the patient's home environment and the influence of their family, and believed that while clinicians could provide information it was up to the patient to decide whether they wanted to make a change. In Chapter Three, concern was also expressed by a number of interviewees, that if they tried to 'force' patients to change then this would affect their relationship with them. This issue arose again in this chapter and reflects the concern identified by Norton (1998) that if health promotion in hospital was over-emphasised patients would feel forced or manipulated into changing their behaviour. This suggests that interviewees did have some ethical concerns. In addition they preferred to take an approach to health promotion which focused on the individual they were treating, and considered other aspects of the patient's life and influences this had on them, rather than giving standard or routine advice. This is in line with health promotion theory.

5.3.3 Clinicians' Perception of their Influence

Did staff perceive that patients would make changes in their behaviour as a result of clinical advice? Previous opinion pieces have expressed scepticism (Becker and Janz, 1990, Johnson, 2000) and surveys of clinicians' opinions have found that they believed that patients did not want help to stop smoking and would not change their behaviour as a result of advice to stop (Cummings et al., 1989). Similarly Nagle et al., (1999) found that while patients may be willing to be given information, they did not want to be told to stop smoking. However one UK study did report that the majority of nurses felt that patients would be receptive to such advice (Thomson and Kohli, 1997). The present study suggests that interviewees thought that patients were not unwilling to receive advice but that they may not change their behaviour. If they did attempt to do so while ill, this behaviour change may not be subsequently maintained. Even if clinicians believed that patients were willing to receive health promotion advice, if they did not believe this would be maintained then they might consider that this is not worthwhile.

Looking directly at the impact of the provision of preventive services on patient satisfaction, some authors concluded that while there was some correlation, this was not enough to encourage clinicians to increase these services (Kottke et al., 1993; Solberg et al., 1997a). In the present study, while some interviewees expressed concern that they would affect their relationship with the patient if they pushed preventive services too hard, there was no mention of 'patient satisfaction' or of this having an influence on the information that they gave. One doctor, in particular, stressed that while patients did not

always want to hear advice this would not stop him from giving it. The studies I have referred to, which were concerned with patient satisfaction, were carried out in the US. As US doctors are paid directly for healthcare provided, it is likely that patient satisfaction will have a greater impact on these clinicians as the service will be more oriented towards the 'consumer.' Without a more thorough comparison between the US and UK healthcare system with regards to health promotion, this suggestion can only be tentative.

Several authors have concluded that in order for clinicians to increase the amount of advice that they give, it would be necessary to alter their perception of what patients wanted (see, for example, Becker and Janz 1990). Clearly this is only true if patients' views are known and they are positive about receiving smoking cessation advice. Chapter Four does suggest that patients, at least in this sample, do want smoking cessation advice in hospital. Therefore if clinicians were informed of patient's wishes it may encourage them to provide more health promotion advice.

In addition one US study pointed out that physicians were reluctant to refer patients to external services both because they believed that patients would not follow this up and because it may be seen as a personal endorsement (Kottke et al., 1993). This was not found in the present study and again this may be related to differences between the US and UK health services. The smoking cessation coordinator was aware of this potential problem and did try to address this by providing feedback on patient success.

A dominant theme concerned whether patients would maintain behaviour change and this concern discouraged clinicians from giving advice. Again, providing feedback about the success of interventions may help to address this, provided these interventions are successful. The issue of maintaining change was not discussed in the literature. One explanation of this is that there were very few qualitative studies in this subject and this information is less likely to be gained by other methods.

5.3.4 Conclusions

It is clear that there is a lack of UK- based health care delivery research in this area and while lessons may be learned from research in other countries, context must be considered. It is important to be aware that findings from other countries are not necessarily directly applicable to the UK. For example, comments made about the lack of fees for health promoting services would not affect most doctors working in the UK health service.

There is also a need for further qualitative research. If we are to understand how clinicians perceive their role, or their patients, we cannot do so purely through questionnaires or surveys where the questions are defined in advance and there is little opportunity for new themes to emerge. As this study used qualitative methods it could show, for example, how clinicians varied the advice which they gave depending on how they thought that patients would respond to it. It also showed how a positive attitude towards giving advice might not translate into actually doing so because of, for example,

being uncertain about how to motivate patients or their perception that patients were not interested.

Health promotion cuts across different professional groups and therefore research which includes all of these groups is required. This would help us to understand how staff interact and how they decide on responsibilities for different tasks – or indeed whether they perceive health promotion to be someone else's responsibility. In the present study it was clear that, while most interviewees considered that they had some responsibility for health promotion, they felt that the amount and type which they did, would vary according to their role. This could mean that they might not carry out health promotion work because they believed it was being done by someone else. In particular, as patients see doctors as a credible source of such information it is important that we understand how doctors feel about providing this information and that their training needs are identified. In addition to there being a requirement for research across different professional groups, the majority of studies in the mainstream literature have focused on doctors or nurses and have largely ignored the impact of other professionals. If these groups are to be involved in preventive health strategies then their opinions must be considered.

This chapter has largely concentrated on potential barriers at an individual level to the implementation of a smoking cessation service, in particular the perceptions of hospital staff. While it is important to be sensible of this, clearly other factors are also important. This chapter also touched on structural factors such as education, training and time and

the next chapter will explore factors at a structural level which affect the implementation of the service.

Chapter Six: Implementing the Smoking Cessation Service: Structural Barriers

The previous chapters have explored individual barriers to the implementation of the smoking-related service, primarily focusing on the views and attitudes of hospital staff and patients. This chapter explores factors at a structural level which might affect the implementation of the new smoking cessation service and other similar preventive health services. It then presents findings arising from the analysis of the staff interviews which relate to structural barriers. It discusses, in particular, clinicians' feelings that high patient numbers affect the advice which they could give. It also discusses aspects of their work on which they would like to spend less time, and explores how their lack of time impacts on the smoking cessation service. These findings are discussed with reference to the literature.

6.1. Introduction to Structural Barriers to Change

The three previous chapters described factors which might affect the introduction of the smoking cessation clinic; these factors operated largely at an individual level. It is important also to understand barriers which operate at an organisational and structural level. Health care staff do not work independently. They are influenced and shaped by the organisational and larger political environment within which they work. Even if they personally hold favourable attitudes towards a preventive health service they will not use it if not supported to do so by the organisation. In addition the introduction of any new service will also be influenced by the existing nature and priorities of the hospital and wider health policy objectives. As Lennox et al., (1998, p 140) commented "There is growing evidence that changing health professionals' attitudes and self-efficacy does not in itself guarantee sustained change in preventive behaviours, organisational factors are also important."

Previous chapters have identified the lack of available hospital-based UK research and the problem of applying research findings from General Practice studies to hospitals. Findings from such studies must be considered critically to assess whether they are also applicable to the hospital setting.

There have been a number of commentaries in the US literature. These provide a useful introduction to this area and the next section will summarise those which are relevant to the present study before moving on to considering findings from research studies.

6.1.1 US commentaries on structural barriers to preventive health

Chapter One, Section 5.5 described the work of one research team which has carried out a number of research projects on barriers to preventive health, particularly smoking cessation, both from the patients' and clinicians' perspective and at an individual and structural level (Kottke et al., 1989; 1992; 1997; Solberg et al., 1997; 2002). The previous chapter described in more detail the pertinent individual factors. Those identified at a structural level were (i) the payment system in the US, where patients or their insurance companies pay more directly for health care, has an influence over the work which clinicians can do; (ii) as public health measures are usually described in terms of population benefit, it is difficult for clinicians to translate these into advice for individuals; (iii) clinicians usually see patients at a time when their disease is advanced and therefore deal with urgent problems rather than ongoing problems; (iv) time shortages also mean that they tend to respond to patients' problems rather than initiating discussion on healthy behaviour; and (v) physicians are more likely to act in the same way as their peers than to follow the strictures of their training. With the exception of the first barrier, that is the payment system, it is likely that the others will also apply in the UK.

To address these barriers they suggest that public health measures should be described to clinicians in terms of their effect on individual patients; that preventive health services must be formally prioritised if they are to be successfully introduced; and that clinicians need to be financially rewarded for giving preventive health advice.

The first two of these proposed solutions may also be effective in the UK. However it is unlikely that financial rewards for UK hospital clinicians would be feasible. Such a technique has been successful within General Practice medicine in the UK, where doctors are rewarded for meeting targets for cervical smears (Autsoker, 1994). However a pilot scheme, which aimed to determine whether payment would increase the amount of smoking cessation advice general practitioners gave to patients, found that GPs did not think payment was appropriate(Coleman et al., 2001a). Furthermore smokers who attended practices where GPs had been offered payment for identifying smokers were no more likely to recall receiving anti-smoking advice (Coleman et al. 2001b). Even if financial remuneration did serve to motivate GPs to give lifestyle advice it is unlikely that this would be as successful in hospitals where staff generally work as part of a large team and such a scheme would be impossible to administer.

Kottke et al. (1990) also suggest that, in the US, preventive health initiatives have to be seen to be a priority by those responsible for managing and delivering health care in order for them to be implemented successfully. This makes intuitive sense; however on closer inspection it becomes clear that this would require a major shift in the provision of health care and in the work of hospitals and clinicians in the UK. Doctors, in particular, are trained to deal with medical problems rather than to be active health promoters. While patients are now more likely to visit their general practitioner or practice nurse for advice on lifestyle change they would be highly unlikely to visit a doctor working in a large acute hospital specifically for similar advice. This situation is unlikely to change in the future. While such work may be valuable and have long term benefits, and may become

more common within the general practice setting, it could never be prioritised over treating illness.

In a later paper the same research team reiterated these barriers and in addition point out that, while many initiatives to increase the use of smoking cessation interventions by clinicians have emphasised education and training, this alone will not be effective without organised and systematic support (Solberg et al., 1996). It is necessary for the organisation to provide opportunities for training and to support this both financially and in terms of providing staff time to attend training and to have their work covered while they are away. However, much of the research in smoking cessation has highlighted staff's lack of confidence in their skills and of knowledge of the most effective techniques to support smokers. The authors of these papers concluded that further education and training will correct this and will lead to an increase in the amount of advice and support offered. It is important to be cautious when drawing this conclusion, as it emphasises a 'deficit' in the individual and recommends education to 'correct' this. As Solberg et al. (1996) point out, while education may alter physicians' views it will not necessarily have an impact on their practice unless there is also organisational change.

Solberg et al. (1996) suggest that the introduction of preventive health services will be better effected by integrating them into care plans for patients. In this way they would be bought as part of a contract, thus addressing the problems of reimbursement and permitting continuous quality improvement to take place. This would ensure that clinicians were involved in choosing and monitoring projects and in preventing the

impact of new services from dissipating over time. In the UK context, if the provision of preventive health and smoking cessation advice was made a routine part of clinical practice, and if this was supported by education and the expectation that such advice would be included in routine medical histories, then it is likely that it would increase the amount of advice and support which clinicians offered.

Similar factors were highlighted in another US commentary which considered why physicians were not providing preventive health advice as much as they might (Orlandi, 1987). The author identified the need for appropriate education, not just for practising clinicians but also in medical and nursing school. Like Kottke (1993) he pointed out that there are no financial incentives, and as there are competing priorities of time, space and funding, preventive medicine needs to be highly valued before creative solutions are used to make innovation work. He also called for greater standardisation in health promotion so that health care staff could be certain about the best methods and source of materials they should use, and which innovations they should prioritise. In addition, he considered clinicians' perceptions of their role in medicine and suggested that clinicians consider preventive medicine to be simplistic and less prestigious, whereas they expect medicine to be glamorous, lucrative and challenging and to use technology.

It is unlikely that clinicians in the UK expect medicine to be glamorous or lucrative although they would probably agree that there are competing demands for their time, a lack of space and a shortage of funding and so some of these recommendations are also likely to be applicable in the UK. In particular, by standardising the health promotion

information clinicians are given, as Orlandi (1987) suggests, and training them to deliver this effectively, clinicians would make the best use of their time. Furthermore they would be confident that, if they do spend time giving preventive health advice, then this is done appropriately and effectively.

Becker and Janz, (1990) identified similar barriers in another US commentary which questioned why physicians were slow to integrate routine health promotion and disease prevention into their clinical sessions, despite the fact that research has shown this to be effective and that patients see physicians as a credible source of such information. Once again it was concluded that this was prevented by lack of time, lack of training in preventive medicine in medical education, the need for financial reimbursement, particularly from health insurance, the feeling that promoting preventive behaviours was an inappropriate role for physicians, the uncertainty they felt about the underlying medical evidence, the lack of feedback on advice and the fact that recommendations from different professional groups were inconsistent. It seems that there is a consensus that clinicians need to have a better understanding of health promotion to use it effectively. This could be partly achieved by health promotion specialists being clear about the reasons for the recommendations they make and the evidence on which this is based. Becker and Janz (1990) also commented that physicians tend to operate within a traditional disease model where symptoms are treated separately, rather than by considering a patient's health holistically. They believe that such an approach would be necessary for successful health promotion.

They concluded that giving feedback to physicians on success rates would encourage them to give smoking advice, and that active patients often act as good prompters by asking for information. They suggested that programmes must focus on altering physicians' perceptions about how receptive patients are to disease preventive services and health-promotion counselling, perhaps by indicating patients' wishes in their case notes. Physicians could also be helped to improve their capabilities to motivate patients to change by putting in place mechanisms which prompt them to ask patients about their lifestyle and by providing ongoing training which strengthen knowledge, skills, and techniques in interventions. A systematic review which looked at how evidence was implemented in practice found that reminders in patient notes did increase the amount of lifestyle advice which clinicians gave (Anon, 1999).

This section has summarised the commentaries on structural barriers to health promotion and highlighted the main barriers to implementing a preventive service. Each of the commentaries emphasised similar structural barriers and made similar recommendations for how these may be overcome. In particular, time, education, financial considerations, the need for feedback, consistency in the messages given by health promotion and the need for physicians to consider that this was an appropriate role for them to take on. However these were all written from a US perspective and were based on US research. Three of them were written by the same research team and they all concentrated on medical staff.

The next section begins by reviewing two research studies which solicited the opinions of doctors (Cummings et al, 1989) and nurses (Nagle et al. 1999) and considers whether their perceptions of structural barriers are similar to those identified in practice. It then describes a large Australian study which attempted to determine which factors affect whether doctors and midwives working in antenatal clinics gave smoking cessation counselling (Cooke et al, 1996; 1999).

6.1.2 Examining structural barriers to preventive health in practice

Chapter Five described a US study by Cummings et al.(1989) which reported a number of factors which a group of internists believed prevented them from giving smoking cessation advice. The most important factors identified were that they believed that this was not effective and that patients would not listen to them. However they also believed that they did not have enough training in preventive health and did not have time to provide advice; many of those doctors who were privately funded were also concerned about the lack of financial reimbursement.

In an Australian survey of nurses which is also described in more detail in the previous chapter, time factors and training were similarly emphasised (Nagle et al., 1999). Of those surveyed, three-quarters considered the hospital stay to be a useful time for patients to quit smoking, and that smoking counselling was part of a nurse's job and almost 60% felt that they should educate all patients about the effects of smoking on health and that nurses would make good 'quit smoking' counsellors. However, despite these positive views, 63% felt they were too busy to do this themselves and that they had inadequate training to help patients to stop smoking.

All of these studies report *perceptions* of why clinicians did not give more preventive advice; however, these perceptions may not translate into *actual* barriers. In the US Kottke et al. (1989) tested whether the provision of appropriate training and materials would actually be effective in encouraging physicians to give advice. They compared three groups of physicians, one of which had been given patient education literature and training on motivation, the second, literature alone and the third, nothing. Those who had attended the workshop and / or received materials were more likely to ask smokers to stop than those who received neither. Further, of those patients who had been asked to try to stop, 47% tried, as opposed to 30% of those who were not asked. Of those asked, 19% were successful at stopping compared to 9% of those who had not been asked. This difference in quit rate was significant; however it was not maintained twelve months later which suggests that physician advice is not successful without ongoing support.

This suggests that while training does have some effect it must be repeated at regular intervals and that physicians must be regularly reminded to raise the subject of smoking with patients. Some form of continuous quality assessment would also be necessary to ensure that this is maintained in the long term. This would, of course, require a greater investment of time and money than a one-off training package and this should be considered when deciding whether clinicians are the best people to give preventive health advice.

Another Australian study specifically focused on organisational factors relating to smoking cessation intervention in antenatal clinics (Cooke et al., 1996). This is of particular interest because it compared perceptions about barriers to actual barriers and to behaviour. The first part of this study aimed to assess current practice in delivering smoking cessation intervention for midwives and to examine the relationship between the use of smoking interventions, practitioner characteristics and organisational factors. A random sample of 424 midwives were asked to describe the type of information they had given to their last ten smoking clients. In addition data were gathered about factors relating to the organisation of the hospital and about the midwives' knowledge of smoking cessation advice and confidence in counselling. The survey examined smoking interventions given, specifically education, advice, counselling or referral to other services and staffs' perceptions of barriers to change. These interventions were examined in relation to practitioner variables (their training, smoking status, perceived ability to counsel, number of questions asked about smoking, willingness to carry out counselling); structural variables (hospital size, location, funding source, specialisation, smoking intervention policy); and work climate variables (staff commitment, staff supportiveness, supervisor support autonomy, task orientation, work pressure, clarity of rules and policies, control and attitude toward innovation).

The results showed that while clinical staff did perceive smoking cessation intervention to be part of their role, brief interventions were generally under-utilised. Midwives perceived themselves to be more willing than able to counsel for smoking cessation and this affected not only their current behaviour but also their beliefs about their future

involvement in this. They also believed that aspects of their environment (such as the lack of a smoking cessation policy), insufficient staff, shortage of time and staff inability to carry out smoking interventions, served as barriers to the use of smoking interventions in hospitals. Furthermore, the results demonstrated that those hospitals which had a smoking policy, which were publicly rather than privately funded and which were larger, were more likely to use more interventions. Midwives also reported using a greater number of smoking cessation interventions in work environments where staff were supportive of each other, and at times when their work pressure *increased*. The latter finding was the opposite to that hypothesised and it is possible that work pressure may increase because staff were carrying out more interventions.

This group may not be representative of other nurses' viewpoints as midwives are concerned with the effect of a woman's smoking on her baby's health as well as her own health and different factors may be pertinent in different specialties. However this is one of the few studies to look at the effects of organisational factors rather than just the perception of their effects, and it found that midwives' perceptions of barriers were an accurate assessment of actual barriers. It further suggests that changes in the organisation would have an effect on an individual's practice.

A later study carried out in ante-natal clinics by the same authors included doctors as well as midwives and this gives us one of the few opportunities to compare the views of different health professionals (Cooke et al., 1999). It aimed to describe the smoking intervention practices of these staff and to ascertain both organisational and practitioner

variables which predicted clinical use of these interventions, and pointed out that most studies focus on the individual and ignore the effect of the organisation. The authors gathered written information from official hospital sources on the size and structure of each hospital and its smoking policy, and surveyed 120 midwives and 84 doctors working in 20 antenatal clinics. The majority of respondents reported that they provided some interventions to support patients to stop smoking. Midwives were more likely to do so than doctors and more than half recommended that patients cut down smoking, rather than stop, advice which has been shown to be unsuccessful. Using measures which assessed 'willingness' and 'ability' to offer support, participants again assessed themselves as more willing than able to offer support. Both doctors and nurses felt that they lacked skills to help smokers to stop, with a significantly higher proportion of midwives feeling this.

Organisational barriers to smoking cessation advice were perceived by the clinicians to include a lack of good quality smoking cessation materials, training and teamwork. Those who had attended training, however, scored the same on their self-assessed 'ability to counsel' scores as those who had not. However those who worked in hospitals which offered training used more interventions than those who did not. Cooke et al. (1999) suggest that there is a diffusion of training effects and that those who attended training passed this on to their colleagues. An alternative explanation is that those hospitals who offer training on smoking cessation techniques placed a greater importance on smoking cessation in general and this is reflected in staff practice. Lack of time and pessimism about the effectiveness of smoking advice were again perceived to be important barriers.

Finally Cooke et al. (1999) produced a statistical model which combined all the relevant variables to identify the significant predictors of smoking cessation intervention. It found that perceived 'ability to counsel', participation in decisions about task performance, perceived work pressure, training in smoking cessation intervention and a belief that a policy for smoking cessation intervention existed, were all significantly and positively related to increased reporting of smoking intervention practice. The findings supported those of the previous study in that greater work pressure was associated with *higher* levels of reported intervention. The authors explained this in the same way, that is staff who gave this advice found themselves with greater time pressures. An alternative explanation which they presented was that staff who were busy were also more organised.

These are among the few studies to examine individual, structural and organisational barriers to innovation, and to compare perceptions of structural factors to actual structural factors and to include nurses as well as doctors. However respondents were asked only about their last ten smoking clients. In addition they were asked to *remember* what advice they had given after the patients had been seen without being aware in advance that they would be asked to do this. Based on smoking rates, respondents may have had to think over the last thirty or forty patients whom they had seen, remember the smoking status of each of them and then remember which smokers they had advised to stop. This data was not validated in any way, though it could be argued that all respondents were equally likely to remember the advice which they gave, and therefore that differences which emerged were the result of organisational or structural factors in different hospitals

or differences between nurses and doctors. Moreover the findings are supported by those of other studies.

The literature has therefore identified a number of structural factors which appear to affect the implementation of preventive health services in general, and smoking cessation services in particular. In the next section the findings from the interviews will be presented. It is not possible to review all of the potential structural and organisational barriers which might affect the implementation of the smoking cessation service. However some key themes arose and these will be discussed.

6.2. Findings

The analysis of the interviews identified several main themes which will be described in detail. Interviewees discussed time, and, in particular, time to engage with patients. They also discussed how they prioritised their work and which aspects of it they felt were the most important. This will be considered with reference to its effects on the smoking coordinator and the successful implementation of the smoking cessation service.

6.2.1 Engaging with patients

In Chapter Five a strong theme emerged that clinicians felt that they could not give as much support to patients because they lacked time to spend with them. This nurse explains this:

> "At times I would like to have more time to speak to my patients and do more but, last week I had, like one day I have seven patients in the one day, and

plus I had my clinic in the afternoon. So it was a case of run around the belt like crazy and you're spending, you're spending time with them and you feel as if it's quality time and then you walk away from the patient and it feels as if you've rushed it. You know? And I think some days that you don't have enough time to spend with your patients, but the biggest whack of the time I try to make as much time as I can for the patients." (Sylvia Ferguson, Cardiac Rehabilitation Nurse)

This extract showed how involved Sylvia was with patients. She seemed to take a personal interest and responsibility for them and demonstrated this throughout her interview by calling them "my patients." Sylvia largely worked with those who had just recovered from a myocardial infarction. She taught them how to manage their illness, gave them lifestyle advice and ran gentle exercise classes. She explained here that she needed 'quality' time in order to engage with patients. This would allow her to communicate with them better, find out how she could help them and thus improve the help that she could give. However she was often prevented from doing this because she knew that she had other patients whom she must also see. Another nurse described why she also felt that quality time was important:

"And things go on in people's lives which affects their diabetes, and sometimes it can...you know that there's something wrong, but it can take quite a bit of probing and talking and conversation for it to come out, and quite often there's no time for that, there's just no time because there's a

queue waiting. And we usually try to spend as long as we can with the patients, but some patients take much much longer. You know that there's a problem but you need to...you need to try and prise it out of them sometimes what the problem is. And just to be able to spend more time with the patients would be wonderful, instead of just a quick in, blood sugar, weight, and out again." (Geraldine Gallagher, Diabetic Liaison Sister)

Like Sylvia, Geraldine felt that as she was so busy and has so many people waiting to see her, that she could only perform the basic parts of her job; that is, carry out the required physical checks. One gains an impression of her ticking off the necessary tasks, in this case measuring blood sugar and weight, before moving on to the next patient, with little time to engage with the patient as an individual. She feels that patients need time to trust her and to relax enough to tell her what problems they are having in managing their diabetes. If she knows that she has patients waiting to see her in the waiting room then she cannot give each person much time. The previous chapter discussed how interviewees tried to take account of the influence of patients' homes and the wider environment. In order to do this they have to be able to develop a relationship with patients. Geraldine agreed with this. She felt that if she did not know about the patient's life outside the hospital then she could not give them advice which was appropriate to their life and the pressures which they are under, and therefore this advice might be irrelevant.

She commented at a later point in the interview that she would like more time to educate patients about their disease. This was particularly important in diabetes, the control of which requires patients to follow recommended advice on smoking, alcohol and diet. However like Sylvia she was aware that there was 'a queue waiting' and this meant that she could not be fully engaged with the patient she was treating at the time because she was under pressure to move on to the next person.

This pressure was illustrated vividly by a senior nurse who remarked that she now ensures that she makes some eye contact with patients as sometimes she hardly had time to look up from her notes. She explained that as she was more experienced she was aware of how important it was to do this, but that more junior staff were often too busy getting through their workload to remember. She added that patients sometimes wrote letters of complaint saying that they had not been asked how they were feeling. If nurses do not have time to make eye contact with patients or ask them how they are, then it is unlikely that they will be able to engage with patients enough to discuss their smoking behaviour or even to raise this issue and refer them to the smoking coordinator. Other clinical staff made very similar comments and generally felt that they should only give lifestyle advice and advice on how patients could change aspects of their lifestyle in their home environment if they had time to do this properly.

6.2.2 Time shortages and the smoking cessation service

The time pressures which staff were under had implications for the work of the smoking coordinator. She returned to this issue on several occasions in her interview. For example:

> "Actually getting to speak to the nurses on the wards, cos they are all dead busy. It's not that they don't want to see me...they are busy and they haven't got the half-hour that it needs for me to talk. So that's a big problem...the staff." (Marianne Findlay, Smoking Cessation Coordinator)

Marianne visits wards and clinics in order to teach staff about her service and to advise on when to give advice to patients who smoke and when to refer them to her. She is often unable to do this, and described one occasion where she had arranged to go to a ward to train staff and when she got there no-one was there. She felt that this was because they did not have the time to attend this training, although it may also indicate a lack of interest in smoking cessation. However if nurses do not attend training, either through a lack of motivation or a shortage of time, then it is unlikely that they will take on the responsibility for providing smoking cessation advice. After the first few months when she had attempted unsuccessfully on several occasions to arrange time with wards to visit them and provide training, she abandoned this method. Instead she visited wards or clinics on an *ad hoc* basis when she had time, seeing as many staff as possible when she was there. However this was a compromise, as she comments: "This rush rush quick 5 minutes here quick 5 minutes there isn't enough to do anything." Just as

clinicians felt that they needed time to engage with patients, Marianne felt that she needed time to engage with staff . However their lack of time made this difficult.

She explained that as she had been a hospital nurse she understood how busy clinicians were. She illustrates this later in the interview when she said that she would no longer be able to return to ward nursing as she was no longer fast enough to keep up with it, and would just get in the way of the other nurses. This strongly reinforces the impression that nurses have to work very quickly in order to get through their workload. If their present workload means that they have to rush through it, then adding another aspect to their work would present difficulties.

6.2.3 Finding time

Time, in particular the shortage of time, was a dominant theme in all of the interviews. The previous section demonstrated how this made it difficult for clinicians to spend enough time with patients to engage with them and help them in the best way. This section explores further the factors that interviewees felt took up their time most, and how this impacted on the work they could do. This doctor was asked what he would like to spend more time on, and replied:

> "More time with patients I think. That's what I find, I find that I've got increasing pressures in a sense to see more patients, I'm not saying that's necessarily generated by management or the hospital, but by the fact that there are a lot of sick people out there wanting to see me, that I cannot

> squeeze in, so to speak, time wise, and I and all my colleagues end up with waiting lists that I wish was shorter than it is unfortunately. The problem is that I know how much I can see in that amount of time and I can't see any more what I can do. If it try and squeeze more into that time then all I do is dilute the service that I can provide." (Dr Anthony Lecker, Consultant Gastroentologist)

All of the interviewees were asked directly if there was any aspect of their job which they would like to spend more time on, and all of the clinical staff replied that they would like to be able to spend more time with their patients. This doctor seemed particularly frustrated by lack of time and by competing demands. He said at an earlier point in his interview that he had to keep clear boundaries between his work and his personal life because "I could be here 24 hours a day and it still wouldn't be enough." Another consultant similarly said, "You know, I'm here all the time. I don't get home." He also pointed out how this gives him no time to do what he considers to be non-essential parts of his job, like health promotion.

Anthony's views were similar to those of the nurses, as described in the previous section. He believed that he was under pressure to limit the amount of time he spent with patients because of the number who are waiting to see him. Therefore, if he were to try to give, for example, smoking cessation advice to patients, then he would be trying to fit too much into an appointment and therefore would provide a poorer service. However while the nurses discussed how their work was affected by knowing that patients were waiting

to see them that day, in the clinic or ward, Anthony also mentioned how he was influenced by knowing that there was a waiting list for patients to come into hospital. Other doctors made similar comments. A possible explanation of this difference was that doctors managed their own waiting list and decided which patients, and how many, they would see in a clinic. Therefore while other staff may be aware of the waiting list, doctors were actually confronted by it on a regular basis. The theme of waiting lists and how they created time pressures was one which was returned to on several occasions. This had not been identified in previous studies as a barrier to the implementation of a smoking cessation or other preventive health service, though it clearly influenced the work of this group of interviewees. I decided, therefore, to explore this issue in greater depth in Chapter Seven.

As well as discussing aspects of their job on which they would like to spend more time, interviewees also discussed aspects which they thought were unnecessary or which took up more time than they wished to give. By analysing this theme further one can explore which aspects of their job interviewees perceive to be priorities and which they perceive to be less important. In addition this can provide a further insight into how they view their role and can help to identify ways in which the goals of the smoking cessation service could be met. The majority of the interviewees did discuss aspects of their job on which they would like to spend less time.

6.2.4 Administration and paperwork

As this group of interviewees had often quite separate roles and responsibilities, some of the issues raised relate to the interviewee's own job and cannot be generalised to others.

However there were very similar themes running throughout all of the interviews. This doctor's description was typical:

"You know, on most days when a pile of stuff like that comes through the mail and you've got to go through it, that's the volume of paperwork, I mean it does frustrate me. The current thing is just, you know, forests must be falling when something comes down from the Chief Executive and it is just fired out to everybody and they are not just one page, these are ten page documents, and I'm not quite sure when they think we are going to read them, and that does frustrate me, I think part of what management should be doing is sifting through these and pointing the right ones in the direction of the right people and then perhaps even synthesising a simple one-sided A4 newsletter ...that tells you what's going on, without me being required to read every single last one, because I don't, I can't read them and that just produces frustration, because you know perfectly well there might be something important in this document, but you know, it is 6 o'clock at night and the last thing you want to do is try and read some other thing that has arrived on the desk .. I mean I'm sure every speciality is the same, but well at the moment I am being e-mailed to go to a meeting in Edinburgh on bio-terrorism and being sent piles of paperwork about it and you know, I just think well, that's fine, I don't, you know, I actually did have something else I was going to do this week, which was like come into work and be a doctor (laughs)." (Dr Michael Mackie, Consultant Infectious Diseases)

This quote raises several points that were commonly made by other interviewees. First he mentioned being "frustrated" with the amount of paperwork he had, four times in this excerpt. Almost all of the clinicians who were interviewed complained about this. While few people in any profession are likely to want more paperwork and administration, the way in which this group of interviewees discussed their attitude towards this is interesting. In general the clinical staff commented, like Michael, that these tasks detracted from time they could spend with patients. Not surprisingly it seems that clinicians perceive spending time with patients to be a priority and paperwork to be far less important.

The three medical consultants interviewed were particularly unhappy with the amount of paperwork which they had to do. All of them discussed this at length, but stressed that they were happy to do this if they considered it to be relevant and related to patient care, for example, writing letters to GPs and writing up case notes. However they complained that much of the administration they had to do was not relevant. The nurses who discussed this also held similar views:

> "A lot of the paperwork can be very monotonous and it would be really helpful if, as nurses in this department, we had a secretary within the department who could help us out with letters and things like that without, you know that it is quite time consuming and it is time not wisely spent if you like. Obviously it is a source of communication but someone else could do it

you know and let us be freed up to do other things." (Isobel Murdoch, Staff Nurse, Respiratory Medicine)

Like the clinicians she felt that nurses needed more administrative support, that administrative work took up their time, and that this was not a good use of their time. This view was also expressed by the smoking coordinator, who was also a nurse. However the nurses who were interviewed expressed this view far less strongly than doctors. A likely explanation for this difference is that consultants had more administrative responsibilities related to their status. Only one of the doctors interviewed, a senior registrar, was interviewed and she did not mention paperwork. However this alone does not explain clinicians' feelings. The three senior managers who were interviewed also complained about time pressures. However they did not mention paperwork at all, although it is unlikely that they did not have any. I feel that a better explanation of this difference relates to staff's perception of their role and I will discuss this further in the next section.

6.2.5 Interviewees' perception of their role

In the previous chapter I discussed how staff's perception of their role as health educator would affect their health education work. Similarly it would seem that staff have a definition of what their job involves and prioritise those tasks which fall within this definition. In the previous quote, Michael says "I actually did have something else I was going to do ... which was like come into work and be a doctor." Discussing the same area, another consultant said with embarrassment that he was expensive and thus his time

should not be wasted with administration that someone else could do better, and, he implied, more cheaply. A third consultant, when discussing preventive health services, said that he felt this to be inappropriate, as he saw himself to be a 'specialist' and should be performing specialist roles. These clinical interviewees seem to divide their job responsibilities into two: the clinical responsibility, which involves treating patients directly and which they feel to be appropriate, and the non-clinical one, which involves administration and paperwork, and which they consider to be less appropriate or important. Later Michael pointed out that it was not that he felt such administrative issues were unimportant, but rather that clinical staff were desperately short of patient time and had to spend the little time available with patients. Clearly busy people must prioritise, and this group prioritises work which they feel involves their unique skills.

If this hypothesis is true, that is, that interviewees believe that they should carry out those tasks 'appropriate to their role,' management may be less likely to complain about paperwork because they consider this to be an important part of their job. The term 'paperwork' on its own does not mean much, as clearly all work involving 'paper' or administration is not the same. If managers consider their paperwork to draw on their specialist skills then they are less likely to feel that this takes up time they would be spending elsewhere, in the way that clinical staff do. I would like to explore further interviewees' perceptions of work which they considered to be a key part of their role. This will help us to understand whether these interviewees consider the provision of smoking cessation advice to be appropriate work or whether staff could be encouraged to make this a priority.

6.2.6 Prioritising skilled work

Interviewees were asked what they would like to spend less time on and it became clear that, as well as doctors, other interviewees also believed that some of the work which they did was appropriate to their job, whilst other work was less appropriate. For example the health promotion officer felt that she would like to have an assistant to give out leaflets and so on to free some of her time to concentrate on more skilled aspects of health promotion. Similarly the pharmacist commented:

> "I don't know if you know that in pharmacy there's obviously the advent of the checking technician, which could push us more out onto wards which is probably what will happen in future,... potentially once we get checking technicians we won't be required to check as many prescriptions etc so we could go out and do more work elsewhere, but at this stage we can't because we don't have anybody qualified," (Conor O'Conolly, Junior Pharmacist)

These two examples lend further support to the hypothesis that the parts of their job which interviewees wished to delegate were those which they considered to be less skilled or those which did not fit into their role as they perceived it. This suggests that interviewees as a group are not so concerned with paperwork *per se* but would like assistance with more routine work. This would allow them to concentrate on the more skilled work which they consider to be particular to their profession.

Only three of the interviewees felt that none of the work which they did was unnecessary. However on closer inspection all three did give examples of work which they had to do, but felt was outside their responsibility. A particularly interesting example came from this nurse:

> "I think all the aspects of my job are important, but I think there are aspects of my job that I shouldn't be doing, that doctors should be doing. This business with the wards, going round and doing sixteen ward visits, and doing sixteen changes of medication, that is not my job. I am there to educate patients. I am there to see newly diagnosed patients in the ward, and give them all their information on diabetes, or to see a patient who's really having a problem with some aspect of their diabetes. But my job isn't to do a hospital round to change medication, but that is being left to us now."
> (Geraldine Gallagher, Diabetic Liaison Sister)

Geraldine's opinion contrasts with that of other interviewees. Unlike them, she did not want to delegate any part of her job to someone who was less skilled and did not consider any of her work to be unnecessary. However she did feel that a lot of her time was spent on tasks which she should not be doing. The other interviewees gave examples of work that they felt required less skill. Geraldine, in contrast, argued that her tasks include work that she is not qualified to do and which should be done by medical staff. It is possible that she is, to some extent, the victim of busy medical staff who are passing on some of their responsibilities to her. This assumption cannot be tested further with the

available data. Her views were similar to those of the other interviewees in that she had a clear ideas of which responsibilities were hers and which should belong to someone else, and she felt that she did not have time to do 'extra' work.

In conclusion it would seem that, in order to save time, interviewees try to decide what is most important in their work and concentrate on fulfilling these responsibilities. As they feel busy and under pressure they attempt to alleviate this pressure by developing strategies to pass on work to others or by identifying areas in which this may be possible.

6.2.7 Delegation and its impact on the smoking cessation service

If staff do try to delegate or pass on work this has implications for how and whether the smoking cessation service will meet its objectives. The goal of this service was to ensure that clinical staff would provide some brief motivation to patients to help them to stop smoking, referring patients to the smoking coordinator on the occasions that they assessed that this was appropriate. A nurse working in a medical speciality where smoking was a major risk factor, and who was very positive about the smoking cessation service and the need to encourage patients to stop smoking, commented:

> "I think it's easier to have someone separate, because our problem is the time factor, as you see, we're haring about like crazy people, and to be honest I don't have time to sit and give lengthy explanations. I can give them a brief outline, and on a daily basis, I'm up-dating that, but I don't have time to sit for a good half-hour, or whatever it takes to get the message over, or even to

keep an eye on them and bring them back and say, 'Well, how are you doing? Are things settling down? Are you still smoking or have you stopped smoking?' or whatever. I don't have that option. I don't have the luxury of that, to be honest, time's our biggest factor here. So it's ideal having somebody [to refer patients to]." (Carol Branwell, Staff Nurse, Coronary Care Unit)

Carol discussed being busy, harassed and pushed for time throughout her interview. This was borne out during the interviews themselves. The first of these had to be rearranged for another date, half way through the interview, as she was constantly interrupted to deal with patient emergencies; the second interview was abruptly terminated when an incident in the local area lead to a number of emergency admissions. Once again it is clear here that a lack of time means that interviewees have to prioritise dealing with the patient's illness before giving any other preventive advice or help. This is also interesting as Carol feels that the provision of the smoking cessation service allows her to pass this aspect of her work on to someone else, whom she feels would have more time to help patients properly.

At the beginning David, the service leader, discussed how he wanted to change the culture of the hospital so that all patients were offered smoking cessation advice by clinical staff. However Carol's quote here suggests that in some ways the provision of the service might have the opposite effect, at least in this particular aspect, to what the service leader had intended. Rather than staff being encouraged to incorporate smoking

advice into their routine work, they might use the service to delegate this aspect of their work. However it was clear that he was aware of this and understood why this might happen:

> "I'm not sure how much they are taking on the business of health promotion and picking up smokers and activating the service themselves and I think that needs more work done on it repetitively. I think it may be .. staff on the ward have got so many things to do and seem to be relatively stretched, have more things to fill their time than they can achieve and I don't know that this will be given high priority. And so similarly in terms of training them to actually do a wee bit themselves, getting some key workers on different wards and different areas so that Marianne [smoking coordinator] doesn't have to do it all.. I think that would be even more difficult and there'll be a tendency to say 'I'll get Marianne to do it' rather than to actually do anything themselves. And that's happening in a number of other areas where specialist nurses are provided that they no longer do what they would have done on the wards say 'Well I'll get the service that does that' ...but I don't think it provides good holistic care for them." (Dr David Cairngorn, Service Leader and Consultant, Respiratory Medicine)

David still felt that it was important that smoking advice was incorporated more centrally into clinicians' roles, rather than added on to the range of services and advice which they offered, and that staff training was required to ensure that this happens. He wanted

clinicians to be able to provide some support themselves, only referring smokers to Marianne when it was clear that this would be useful. However, while interviewees may actually prefer to make referrals to someone else rather than take on a further responsibility, this did not necessarily mean that they were devolving responsibility for assisting patients to stop smoking. It was clear that interviewees felt that their lack of time prevented them from giving adequate smoking advice and are happy that patients can now have more assistance, as this nurse suggests:

> "Because some people do really want to stop smoking. And it's good to have a place for us to advise them to go to.... I don't know how the service works at all. She probably follows them up so she keeps in contact with them, so they feel they've got support. The way we would be doing it was just sending them out cold turkey, you know out to the wilderness again. If we said 'oh try stop smoking blah-de-blah out you go.' ... there's no point in doing it, it's a waste a time. It's a waste of time for the patient, it's a waste of time for us. Without actually following it through. You need to re-see them again. Which is not possible here, to re-see them." (Sister Pauline Merrils, Outpatient Manager)

Like Carol, this nurse felt strongly that it was not helpful to give advice which could not be supported or followed through. She also commented that she did not know much about the service. This suggested that once she refers a patient to this service she considered her task to be complete. This also seemed to justify the concern of the

service leader, that staff may not incorporate this responsibility into their own work. However unless there was a way of giving staff more time, then clearly they would pass on work to a dedicated service, particularly as they considered such a service to be more effective than trying to help patients themselves, and it may be unrealistic to expect otherwise. The interviewees believed that this service would allow them to assist patients without increasing their already heavy workloads. Therefore it appears that one of the aims of the service is being met, that is, staff are aware of this service and do refer to it. As yet there does not seem to be evidence that they are deciding when to refer patients, and when to help them themselves. The service was just being set up when these interviews were carried out and this may change in the future. However it is likely that other changes would be required in order to increase the amount of support which staff give and major changes would have to be made before smoking cessation advice becomes routine and standardised .

6.2.7.1 Dealing with inappropriate referrals

The smoking cessation coordinator also discussed this issue and how she is planning to deal with it:

> "They tend to refer straight to me but what I've started doing is when I go to see a patient...like initially...I make a member of staff come with me. If it's a follow-up aye I get them to come with me to see the paperwork that I do cos I eventually want the staff to be able to do it themselves. I don't need to do all that. Not every patient that comes into Reidpark who smokes needs my service." (Marianne Findlay, Smoking Cessation Coordinator)

At that time Marianne felt that many of the referrals which she received were inappropriate because the patient did not want to stop or could have been encouraged by the clinician rather than having to be referred to the dedicated service. She dealt with this by returning to the person who had referred the patient and discussing whether this had been the right decision. In the previous section, David, the service leader, pointed out that people tended to pass work on to specialist nurses rather than taking on this responsibility themselves. Marianne had met with specialist nurses when she started and they had advised her on how to avoid this. "...just like Nurse Sophie said to me "Don't let them away with you going in and doing everything, go in and make the nurse come with you or you will be doing it forever and a day and bored out your skull." She returned to the theme of ensuring that staff do not keep referring patients to her when they could help them themselves several times in the interview.

Marianne told me that her goal was to make herself redundant though she felt that realistically this would not happen. I discussed earlier that she had found it difficult to get time to speak to staff. If their lack of time meant that staff were not trained properly to identify suitable patients to refer to the service, then they would be more likely to refer all patients who smoked and wanted to stop. However she was tackling this possibility directly by aiming to get staff to do some of this work themselves and by speaking to them about the patients they had referred and about how they could manage this better in the future. She also felt that some staff have changed their behaviour and gave an example of a ward where nurses now gave advice themselves:

"And some are learning. They might say things like 'I gave Mrs so and so advice. She didn't need to see you' but I think 'that's good.' " (Marianne Findlay, Smoking Cessation Coordinator)

I discussed earlier that one of the biggest barriers to the implementation of the smoking cessation service was lack of time. It is clear in this section that staff manage their time by prioritising clinical work which they feel that only they can do, and passing on other work to other services if possible. This has two repercussions for the smoking cessation service. First, staff would be unlikely to provide smoking cessation advice routinely and refer patients only when they need more help, which are the aims of the guidelines (Raw et al., 1999) and of the service at Reidpark Hospital, when they already feel that they lack time to provide many other aspects of patient care. Second, and related to this, in order to help patients as much as they can while taking up as little of their time as possible, many of them may make inappropriate referrals to the service, thus overwhelming the smoking coordinator and making it impossible for her to see the most appropriate patients. Clearly both Marianne and David are aware of this and are working to stop this from happening. However it does seem that unless staff have more time, or unless smoking cessation becomes a much higher priority for them, neither of which are likely to happen immediately, then change will be slow.

6.3. Discussion

As the findings show, there is a general perception among interviewees that they lack time. Those interviewees with a clinical role felt that this affected their ability to give preventive health advice. They felt that they only had time to provide treatment for the presenting illness and that this had to be prioritised over additional lifestyle advice. Time was also necessary to develop a relationship with patients in order to find out more about their background and to provide help which would be acceptable and relevant to them. Clinicians felt under such time pressure because they were aware that patients were waiting to see them, both outside their clinic in the waiting rooms, and on waiting lists. This caused clinicians to feel they had to deal with the patient they were seeing as quickly as possible in order to move on to the next patient. Both medical and nursing staff were concerned about the pressures of patient numbers and waiting lists and all of the interviewees in clinical posts commented that they would like to have more time to spend with individual patients.

6.3.1 Time shortages

Clinical staff, in particular doctors and nurses, were frustrated by the amount of administration and paperwork which they had to do and most interviewees would have liked to delegate some aspects of their workload to others. The implications of this for the smoking cessation service were that staff would pass any smoker who indicated an interest onto this service, rather than complying with the guidelines outlined by (Department of Health 1998b) and Raw et al. (1999) as well as the goals for the smoking cessation service, all of which recommended that staff provide brief motivation and refer

only suitable patients. As staff felt under such pressure in their daily working lives they would resist taking on further responsibilities and such goals will be difficult to achieve.

In this climate it would be difficult to implement any new service, particularly any service which took up additional staff time. Therefore it will remain a challenge to the smoking coordinator to try to ensure that staff do motivate patients to stop smoking themselves and to make only appropriate referrals. This is unlikely to get easier without staff being given more time or fewer patients and without the provision of smoking cessation advice becoming a routine part of taking a patient's medical history. It is unlikely that one smoking coordinator will be able to accomplish this on her own without support at a senior level. No matter how keen staff are to promote health, or how positive they are towards preventive services, they will not be able to make changes in their work if they are limited by these practical concerns.

It is not surprising that staff felt under time pressure and that they felt that this affected the work which they did, and that this theme recurred throughout the interviews. The themes of time shortage, and the lack of suitable training recurred often in the literature as being factors which would inhibit change (Orlandi, 1987; Becker and Janz, 1990; Solberg et al., 1997).

However, as Kottke et al. (1993) point out it is not particularly useful to keep concluding that 'time' is a barrier to change without probing this further to determine why there is a time shortage or how people choose to spend their time. As the present study relied on

qualitative methods it was possible to do this. It became clear that time was short because there were so many patients to be seen and clinicians felt that they had too much paperwork to do. In general this left time only to treat patients for the presenting illness, and clinicians were not able to engage with them to discuss wider aspects of health which might or might not impact on that condition.

6.3.2 Delegation

It has also been suggested that doctors do not wish to carry out routine tasks and feel that preventive health advice does not require them to use their specialist skills (Orlandi, 1987; Kottke et al., 1993). These authors also claimed that doctors, in particular, expected their work to be exciting and glamorous. In the present study it was obvious that all staff, including doctors, nurses, managers and other clinical and support staff were busy. They preferred to do the work which most utilised their specialist skills, and to pass on other work to others, therefore managing their time in a way which they believed to be most effective. However they did not suggest that health promotion work was boring or too routine for them but, rather, that they were too busy to take it on. While it does seem that the doctors interviewed had a clear idea of work which they considered to be appropriate to their role, they did generally accept that they had a responsibility for health promotion.

If smoking cessation services are to meet the goals defined by the UK government, that is, that all patients should be asked their smoking status and all smokers offered support to stop (Department of Health, 1998b; Department of Health, 2000a) then all staff will

have to feel that this is a priority and that providing such advice is an appropriate part of their work.

6.3.3 Financial Influences on Smoking Cessation Advice

Within the US setting a number of authors have raised financial considerations, specifically that clinicians would be prevented from giving lifestyle advice because this aspect of care was not reimbursed by insurance companies (Kottke et al.,1989; 1992; Solberg et al., 1997; 2002). In line with this doctors who were publicly funded were found to give more lifestyle advice to patients than those who were privately funded (Cummings et al.1989); similarly, in Australia, more smoking cessation advice was given in those hospitals which were publicly funded (Cooke et al., 1996). In the present study, with the exception of management staff discussing budgets, no mention was made of financial issues. This is not surprising because of the nature of the funding of the NHS in the UK. However the emphasis on financial issues in the US literature in particular illustrates the quite different systems within which clinicians are working.

6.3.4 Contributions made by this research

Once again it is important to note that it is difficult to compare qualitative findings to those from a largely quantitative research literature. However qualitative research allows new areas, such as the importance of high patient numbers as a barrier to change, to emerge. It also allows interviewees to express complex views. For example while staff agreed that they had a responsibility for health promotion, in practice this was not always fulfilled because of competing demands on their time. A survey of attitudes

towards health promotion could have concluded that staff were happy to do this without finding out the extent to which this positive attitude might or might not translate into behaviour because of external constraints.

This study was also able to provide perspectives from different hospital staff on this issue because it interviewed staff from different professions. Furthermore previous research has ignored the role which management staff play in health promotion. While they might not have direct patient contact, they do organise services, control budgets and have an input into the priorities of the hospital. All of these will have an impact on the service which clinicians provide. In addition, previous research which has examined clinicians' perceptions has tended to focus on one profession, generally medicine or nursing. These professions have different roles and it cannot be assumed that they share the same values, or experience the same barriers in their work.

This is a limitation of much of the research in this area and makes it extremely difficult to look at the whole structure of the hospital and to examine barriers which occur at an organisational or structural level. Clearly research carried out in one discipline will prioritise the concerns of that discipline and will identify barriers from that perspective. If a preventive health programme which requires the involvement of several professions is to be successful, then the views of each of these professions must be sought.

The present research allows comparisons to be made between the views which staff expressed towards the service and the challenges which the smoking coordinator faced.

Interviewees were generally positive towards the provision of a smoking cessation service, but, as the smoking coordinator's interview showed, they often did not turn up for training or referred inappropriate patients, if they referred patients at all. Once again this demonstrates that positive views do not always translate into positive action.

This chapter has concentrated on structural barriers in the hospital. However it is clear that these barriers are affected by external factors, such as Government directives and funding issues. The interviewees can only give an insight into their view of the hospital. Further conclusions about factors external to the hospital would require further research, particularly at a policy level. The interviewees give their perspective on the nature of these problems but the solutions may lie elsewhere.

High patient numbers and the impact of waiting lists emerged as strong themes which inhibited change and the next chapter will discuss these themes in more detail.

Chapter Seven: Patient Numbers and Waiting Lists: Implications for the Smoking Cessation Service

Chapter Six described the literature on structural barriers to the implementation of the smoking cessation service and presented findings from staff interviews which illustrated their perceptions of these barriers. Two important themes to emerge were patient numbers and waiting lists. This chapter develops these themes further. It begins by briefly discussing the relevant UK literature. It then presents the qualitative findings related to waiting lists and patient numbers and discusses how these factors impacted on the work which the interviewees did.

7.1. Introduction to Patient Numbers and Waiting lists in the UK

There has been a great deal of attention paid to waiting lists, patient numbers and staff shortages by politicians and in the UK media and medical literature. Waiting lists are often used as an indicator of the success of the health service or of particular political policies relating to the health service and the NHS plan outlined a series of targets to decrease waiting lists and stipulated that hospitals must meet these targets by the year 2005 (Department of Health, 2000b). In particular it required that by the end of 2005 that the maximum waiting time for an outpatient appointment should be three months and for an inpatient stay, six months. This document also promised an increase in the numbers of doctors, nurses and places at medical and nursing schools to achieve these goals.

As a result, a range of different strategies has been implemented in the UK in order to attempt to meet these targets, for example, running weekend clinics (Smith, 2003), having brainstorming sessions to discuss methods to target waiting lists (Trueland 2003), and introducing an initiative which trains nurses to perform small operations (Clarke, 2000). All of these aimed to reduce waiting lists and thus meet Department of Health targets.

While the areas of waiting lists, waiting list targets and patient numbers have all been widely discussed in the UK literature, the implications this might have for the introduction of preventive health initiatives have not been considered. However, as

Chapter Six described, clinical interviewees felt that the preventive health work which they could do was limited by the time which they had. They perceived their lack of time to be directly related to the number of patients that they saw and the knowledge that there were more patients waiting to see them. Therefore, for this group of interviewees, patient numbers and waiting lists would negatively impact on the realisation of the goals of the smoking cessation service.

This chapter does not aim to review the literature on waiting lists in detail or to discuss the impact of these or patient numbers on the work of clinicians or other hospital staff. However these issues did emerge as a strong theme when the smoking cessation service was discussed. This was especially the case when interviewees were asked about the smoking advice which they gave. It is important, therefore, to explore the relevant literature further in order to provide a context to this analysis. In the remainder of this section waiting lists and patient numbers will be discussed with reference to staff morale. It will also discuss whether waiting lists are a good measure of health services and finally consider the relationship between waiting lists and patient numbers.

7.1.1 Waiting lists and staff morale

The emphasis placed on decreasing waiting lists by both the present and previous administrations has been blamed for staff feeling under constant pressure and is believed to have resulted in decreased morale and ultimately to clinical staff leaving their professions (Alderman et al., 1996; Smith and Walshe, 2001). Several commentators have also suggested that high patient numbers have lead to overwork and to problems in

recruitment and retention of nurses (Beardshaw, 1990; Alderman et al. 1996; Buchan, 1997; Corey-Lisle et al., 1999). If clinical staff do leave because of poor morale caused by overwork then there will be increased pressure on the remaining staff thus exacerbating the problem.

The NHS Plan (Department of Health, 2000b), which outlines further targets for waiting lists, may therefore decrease staff morale further and thus lead to a greater difficulty in recruiting and retaining staff. As Smith (2003) commented recently, while hospital staff may be on target to meet the standards imposed on them by the Department of Health, this has been achieved at the expense of overworked clinical and management staff and at an enormous financial cost incurred by staff overtime and overseas recruitment. It has also been stressed that if the reduction of waiting lists remains a political priority in the long term, it could have an effect on clinicians' health because they will be expected to work intensely for long periods (Scott, 1998). It seems, therefore, that the present solutions implemented to reduce waiting lists are short term ones and it is unlikely that they can be maintained. If this is true then the targets identified by the NHS Plan (Department of Health, 2000b) will not be met or will not be sustained in the longer term.

Commentators have criticised the emphasis on waiting lists and pointed out that the general public and health service staff no longer believe statistics published in this area, even if they are accurate (Brodribb, 1994; Yates, 2002a). It has been argued that this is affected by the fact that waiting lists are seen as a 'litmus test' for the NHS, and that these data are used so much for political ends (Yates, 2002b). For example lower figures

are generally reported just before a general election. If clinicians have waiting list and other targets imposed on them which they feel are unlikely to be achieved and do not reflect the care which they give, this will lead both to poor morale and act as a disincentive towards meeting these targets in the future.

The emphasis which politicians place on waiting lists is likely to have arisen from their perception that this reflects patients' concerns. It has been suggested that if there was more openness about waiting lists, how these operate and why one patient may be on a waiting list longer than another, then this would improve clinicians' relationships with patients and may also help to change political priorities (O'Rourke, 2001). One oncologist, who attracted a great deal of controversy a few years ago by complaining about staff shortages, argued that if patients understood the reasons for waiting lists then this would help doctors to enlist the support of patients to argue for change (Hayward, 2001. However it is unlikely that patients presently blame clinical staff for long waiting lists and they are more likely to believe that these are the result of government strategies or of a lack of funding. It might also be optimistic to assume that greater patient understanding of issues affecting waiting lists will lead to their involvement in campaigning for change, although arguably patients should be given information on why some people wait longer than others, or why waiting lists operate differently in different areas.

7.1.2 Measuring health care success by waiting lists

Commentators are not unhappy about the focus on waiting lists only because of their impact on working hours and on staff morale. Many also consider that this is not a particularly useful method of measuring success in health care. For example, in an editorial, Smith (1998) suggests that waiting lists have been given too much attention in both the present and previous administration and that this concern is largely spurious. He believes that rather than concentrating attention and resources on reducing waiting lists they should be concentrated on ways to improve health for more people. Furthermore he argues that waiting lists are not necessarily a bad thing as they are a way of rationing health care and lead to hospitals only treating those patients who are a priority. This view is supported by Harrsion (2000) and Fricker (1999) suggests a way off triaging patients so that equality to access of care is assured.

Medical unions also agree that waiting lists are not the best way to measure care (Green, 1999). They criticise such initiatives as Saturday surgeries, which have been used to decrease waiting lists, because they feel that they are used as a way of meeting targets with little consideration given to their financial cost and the fact that doctors cannot sustain the level of intensity of work. As discussed earlier, while they may work flat out to meet a target, they will not be able to continue this level of work in the longer term. Similarly in a nursing editorial, Scott (1998) also comments that these methods are expensive because of over time payment and further that simply reducing waiting times for patients does not mean that appropriate care is given to people who most need it. In her opinion, a more effective strategy would be to spend more money on preventive

health. However these arguments assume that the government would be prepared to be open about health care rationing and that the public would be prepared to accept that this exists and be involved in discussions about the best way to do this. This is by no means certain.

7.1.3 The influence of patient numbers on waiting lists

It is generally believed that waiting lists are caused by high patient numbers and therefore that they can be can be tackled by employing more staff or having staff work longer hours. The assumption underpins most of the initiatives which have been implemented to meet waiting list targets, as the previous section describes. However as Martin et al. (2003) point out, waiting lists have been an issue in the NHS since its inception, and as initiatives to reduce them have met with little success, it is not necessarily the case that they represent a mismatch between supply and demand.

Smethurst and Williams (2002) further develop this argument and state that initiatives to help shorten waiting lists are commonly ineffective because reductions in the length of waiting lists leads to an increase in referrals. They hypothesise that if general practitioners know that there is a small waiting list for a particular area then they will refer patients with more minor problems and therefore the waiting list will remain at the same length. They argue that as the numbers of patients who are seen by a consultant represents a small proportion of those who could be seen, then by simply providing more consultant time, this will result in a concurrent increase in referral. They explored this hypothesis by measuring the relationship between referrals and waiting list density in one

hospital and found that referral rates increased as waiting lists decreased in a number of specialities. Based on this, weekend clinics, increasing staff recruitment and other methods to reduce waiting lists will not work in the longer term because they will lead to more referrals. However while these strategies may not decrease waiting lists it could be argued that they may result in the identification and treatment of illnesses at an earlier stage, thus resulting in the long term in a decrease of NHS resources and an increase in patients' quality of life.

In conclusion it would seem that waiting list targets have lead to this area being prioritised over other aspects of health care. Clinicians are expected to work longer hours to decrease waiting lists and for many this has had a negative impact on their morale, as well as having potential longer-term implications for recruitment and retention of doctors and nurses and for their health. However it is not generally accepted that concentrating on reducing waiting lists is the best way to improve health for the maximum number of people and there is concern that this is an inefficient use of resources. As resources are finite, this will have implications for the funding of other aspects of health services.

The next section will present the findings which emerged from the staff interviews on staff's perceptions of the effects of high patient numbers and waiting lists and discuss how this might impact on the implementation of the smoking cessation service.

7.2. Findings

7.2.1 Waiting patients and busy staff

In the previous chapters it became clear that one of the biggest barriers which staff considered prevented them from giving smoking cessation and other preventative health advice was their lack of time. Clinicians in particular perceived this shortage of time to be due to the number of patients they had to see. They felt that they had to deal with each patient quickly because they were aware that there were other patients waiting to see them. Under these circumstances it was difficult to engage with patients to provide lifestyle advice. This section will investigate this further. The nurse who organised the Outpatient department gave a picture of how this worked in practice:

> "One of the doctors' lists has got about 60 or 70 patients on it for a morning or an afternoon. It's impossible to see them in that time. [so it's running late all the time?] Yes. So it just depends on the waiting lists. Because they're [doctors] told to put more patients onto the clinics. But they can't change the time of the session. Say for example the clinic starts at nine, it needs to be finished, the nurses need to have their lunch and be back to start another clinic at one or half past one. Because these rooms are then going to be used by somebody else. So it's not a matter of saying 'oh we've got 60 patients we can extend it' because then you run into the afternoon clinics... these patients must be under tremendous stress in that time. And again they've to sit 2 hours and hardly have 5 minutes. Because everybody is so

hyped up to get them all put through they probably don't have time to pay attention to the patient." (Sister Pauline Merrils, Outpatient Sister)

Pauline's views were of particular interest because she was responsible for running the outpatient clinic, and for organising office space for clinical staff and waiting space for patients and for ensuring that there were enough nurses and nursing assistants to support these clinics. This extract very clearly shows how staff often succumbed to pressure to see a high number of patients and then had difficulty in coping with this.

The high number of patients waiting to be seen in a short time was obvious when I was carrying out the survey in the outpatient clinic. The waiting areas were always crowded, there were frequently no chairs left and quite sick people could be standing around for a long time waiting to see a doctor. Therefore, if clinicians were to increase their time with patients in order to give them preventive health advice, then this would be done at the expense of treating another patient's clinical problem; which, as the last chapter showed, was the clinician's priority.

The literature described how waiting lists caused stress for staff (Alderman, 1996; Buchan, 1997; Smith, 2003. Pauline pointed out that patients, too, could find this process stressful. They may have been on a lengthy list to get an appointment and then have spent a long time in the waiting room to have a very brief appointment. I gained some insight into this while carrying out the Outpatients survey. After patients, many of whom were elderly or very ill, had been seen by a doctor or nurse they were often sent to

another part of the hospital for an X-Ray or blood test. On several occasions of which I was aware, they got lost on the way. After this they might then have to return to the same area to see the doctor again or to see another doctor or nurse. In addition patients might also be under stress because waiting to see a clinician had made them late for another appointment or to collect children from school. I noticed that patients, especially those who attended the clinic regularly and therefore were more familiar with the staff and the operation of the outpatients' clinic, sometimes approached the nurse and asked to be seen quickly. In addition the few patients who refused to take part in the patient survey generally gave as their reason the fact that they had already been there for a long time. These stresses added to any concerns which patients might have had about their illness or worries about the results of tests, and could all lead to their appointment being a very difficult time for them.

If patients seem to be in a hurry, or to be under stress, this is likely to prevent staff from discussing smoking with them. As Chapters Five and Six identified, staff felt that they should give such advice at a time when patients can listen and are willing to try to change. Furthermore, as Isobel pointed out in Chapter Five, it would be difficult for them to take in any information related to lifestyle issues in addition to that about the illness for which they were being treated.

As consultants manage their own waiting lists they are frequently confronted by the fact that there are a number of patients waiting to attend hospital as well as patients in hospital waiting to see them. This also means that they decide how many patients to see at each

clinic. The results of this system became apparent to me when I was carrying out the outpatient survey. Some consultants were well-known for attempting to see as many patients as possible. When I attended such clinics, nurses sometimes remarked that this would be a good place for me to survey patients as there would be so many of them. In addition, nursing assistants and other staff often complained that they would not be able to have a break, or that the clinic would run late as the consultant had arranged to see too many patients.

Other consultants however managed their clinics in a different way. They saw fewer patients and spent longer with each patient. This could be for a number of reasons; for example they might have been giving a patient a serious diagnosis and wish to spend longer with them, or it could indicate that the illness which they were discussing might have a complex management and they wished to ensure that patients understood this. However it does suggest that consultants were, at least to some extent, making a choice over whether to spend more time with individuals and either see less patients or always have a clinic which ran late; or whether to try to see as many patients as possible, thus avoiding lengthy waiting lists. Clearly those clinicians who spent more time with individual patients would have a greater opportunity to discuss wider aspects of their health, such as smoking. However if they were to do so it would be at the expense of seeing more patients.

Pauline later described how she would like to improve the management of the outpatient clinic so that patients did not have to spend so long on the waiting list or in the clinic

waiting for their appointment. She felt that this could be avoided by employing more staff, so that clinics could be run in the evening when the offices were empty and equipment unused. In this way she believed that she could make better use of each department. She also felt that this would be better for patients, particularly those who worked and who had minor illnesses, and would both decrease waiting list statistics and allow staff to spend more time with individual patients. Intuitively this does seem like a sensible solution but would, of course, require a large increase in the number of clinical staff or in the number of hours which they worked as the literature discussed.

7.2.2 Managing waiting lists

As waiting lists and patient numbers had such a large impact on how staff worked and their provision of smoking cessation advice I decided to investigate further the interviews with management staff to see how or whether they discussed this topic. Each of these members of staff had important roles in the hospital including organising services, influencing hospital policy and recruiting and managing staff. Their views, therefore, would be particularly important as they would have a wider impact on the organisation of the hospital and the work of the staff. I considered that they would have a different perspective on this issue from clinical staff. For example they might focus more on Government policy on waiting lists and the impact this had on the hospital, or how this affected they way in which hospital services were managed or the areas which they prioritised. This would clearly have some impact on clinicians' work.

Four staff with management responsibilities were interviewed; the Clinical Director, the Outpatient Manager, the Service Manager and the Associate Nurse Manager. All four of them made some reference to high patient numbers. The fact that all of the managers mentioned this unprompted, in response to different questions in the interview, shows that this subject was at the forefront of their minds. This senior manager discussed this in relation to staff morale:

> "Well, over the years, you constantly hear staff morale's low, and that's been since I've come into the National Health Service ...but I feel at the moment, staff morale is genuinely not good, and I think it's about the pressures and the activity within the hospital, and the fact that we're constantly striving for capacity to have patients here, and we're constantly having to move people and that creates even more work, so the pressure increases in the wards, and I think that leads to low morale, because people are feeling constantly pressured at the moment." (Morag Peters, Acting Service Manager)

Morag believed that the main cause of low staff morale is the high number of patients seen. This meant that the hospital, and thus the staff, had to operate at a full capacity which resulted in patients having to be moved from bed to bed to ensure that bed use was maximised. No other interviewer discussed the effects which this had on morale. However one of Morag's roles was to oversee the recruitment of nurses; therefore, she was likely to be influenced by those factors which she considered caused nurses to leave the hospital. This quote also showed that the wards as well as the outpatient clinics were

stretched. I mentioned in Chapter Six that I had to abandon an interview because of an incident in the local area. This led to seven patients being admitted as emergencies. Those who do not have any experience of working in a hospital might anticipate that seven emergencies in a hospital which had 570 inpatient beds would have little effect. However this was not the case. Three admissions were made to the ward in which I was carrying out the interview and staff could be seen rushing around and abandoning whatever they were doing to cope with the unexpected patients. Although most wards did not admit any of these patients, staff in other wards were all aware of it and spoke of the impact which this would have on their workload as, for example, other patients might be moved into their wards. This reinforced Morag's opinion that staff were always working at close to their maximum capacity. Therefore any unexpected event could cause a great deal of disturbance because no one has any spare time which could be utilised.

7.2.3 Organising hospital services

The pressure exerted by high patient numbers and waiting lists seemed to be felt by staff at all levels. Not surprisingly, they discussed this in terms of their own area of work and their own responsibilities. I would like to explore further the views of the clinical director. These were mirrored by the Outpatient Manager who was also involved in forming hospital policy and tended to express similar opinions. I asked the clinical director about changes that had taken place in the local Health Board:

> "There is a lot of things that have happened differently, they tend not to be often new services but they are redesigned services. The particular things that we have been looking at have been the changes as a result of moving into two new hospitals...opportunities that have been taken to try and streamline some of the contacts between services and working within a service to cut down on delays ...we've introduced a vacuum tube service for transporting laboratory specimens which substantially increases the speed with which the lab results can get back again. So that actually improves the service for a lot of patients, it reduces the delay waiting for the results. We've looked at redesigning the emergency care service...where we've put in a completely different structure for dealing with, not just accident and emergency but admission to a hospital, because resources are limited we wanted to pool resources.. pull them into a single area and reduce, have a much better input of staff into these areas and particularly more senior staff...we've looked at a

completely redesigned obstetrics service in terms of the centralised inpatient component for delivery and are having a much more expanded service...so that women haven't got to come into the hospital most of the time. Even if they have problems they can often be dealt with locally and be reassured very quickly... We also have looked at redesigning the cancer service...and trying to reduce the delays and improve the information available to patients, and we've looked at the redesign of our breast cancer service so that we can deal with all patients referred within two weeks of referral, in terms of getting a diagnosis within that time, and then if they require surgery they will have that within a week or so, so that's quite a significant change because the system was previously overloaded and patients sometimes had to wait much longer times so, these are all things that we've currently achieved and we have had a number of other programmes for redesigning service for...All ways in which they are attempting to tackle this waiting list." (Dr Martin McKendrick, Clinical Director)

This is a lengthy quote but I feel that it is valuable because of Martin's senior role as the clinical director in charge of three acute hospitals in Central Region. Martin was involved in policy and strategy at a high level and met with representatives from the health board, primary care and the community to agree on plans for the whole of the area. Therefore his interview provided some important insights into the main priorities and the future direction of the hospitals in Central Region. As we can see, he discussed a number of changes which had taken place in the hospital service. It is interesting that all

of the examples which he gave related to speeding up work and decreasing workload, for example, by centralising services in some areas and placing a greater focus on the community in others. Throughout this extract he used language associated with speed and time, for example, "reduce delays" and "reassured very quickly", and this gave a sense of urgency to the work of the hospital and of clinicians.

This extract also described how Health Board management were trying to improve services by using staff more effectively. Underlying all of these initiatives which Martin described seemed to be a desire for resources to be used in the best way. However he did not discuss these strategies simply in terms of money or resources but in terms of how services could be improved for patients, to treat their illnesses faster and make their lives easier. He gave examples of getting diagnoses back to patients faster, speeding up laboratory results and cutting down on waiting time for surgery. All of these emphasised speed and the need to see as many patients as possible. By being as efficient as possible in the organisation of services, management aimed to minimise the use of resources thus making it easier to provide other services. He concluded that all of these would help to "tackle the waiting lists."

I did not ask Martin about waiting lists, and the fact that he concluded by doing so suggests that this had been the unspoken issue underlying all of these initiatives. Once again it also demonstrated that Martin's concerns were very similar to those of the clinical staff. However he was involved in changes at a strategic level which could influence both the outpatient and inpatient waiting list. In addition he had a greater

knowledge of any new services which were being introduced or any rearrangement of existing services.

It is not surprising that Martin's concerns reflected those of the other clinical staff. Areas which the hospital board considered to be a priority would, to some extent, drive the work of the staff. Similarly staff would communicate their concerns over waiting lists and the increased pressure which they are under to see patients. Waiting lists have been a major issue in Britain, as the introduction describes; targets have been set in a number of areas, and this has been given a lot of attention in the media and by politicians in campaigns for votes. The implication of this for clinicians was that they were seeing as many patients as they could in as short a time as possible. Management staff, who may have had a greater awareness of waiting list targets and an insight into the effect which a failure to meet these targets might have, tackled waiting lists by working at a strategic level and reorganising hospital services. However it is likely that these initiatives will take time to affect the work of individual clinicians. In addition they might be focused on particular specialities and therefore will have a differential effect. However while lengthy waiting lists are likely to continue to exist, and any change to tackle this will not be immediately apparent on practice, it did seem that some attempts was being made to tackle this in Reidpark Hospital, at least in some areas. In the meantime, however, clinical and management staff's awareness of waiting lists and high patient numbers influenced the work which they did and prevented health promotion and smoking cessation advice from being given.

7.3. Discussion

7.3.1 Waiting lists and preventive health

It would appear that waiting lists and patient numbers are a major concern of both the clinical and management staff interviewed in the present sample. This is reinforced by the fact that there were no interview questions which covered waiting lists and therefore these discussions arose spontaneously from the interviewees themselves. Clinical staff were aware of patients waiting to see them outside the clinic in the waiting room and, particularly for doctors, outside the hospital, and management were concerned with organising services for patients in such a way that they could reduce waiting times. While this might not seem to have obvious implications for the implementation of the smoking cessation service, clinical interviewees considered that they were under pressure to see as many patients as possible and therefore that they often could not spend time with patients to engage with them and to provide preventive health advice.

The literature review described a number of initiatives to see a greater number of patients and by doing so, decrease waiting lists (Clarke 2000; Smith, 2003; Trueland, 2003). In the present study neither clinical or management staff discussed government targets for waiting lists directly. This does not, of course, mean that they were not aware of these targets or that it did not affect their work, as these issues had not been the subject of the interviews. However as they did discuss waiting lists and patient numbers a great deal and did not refer to government targets then it suggests that the pressure they felt under

was exerted not by these targets but their knowledge that they had a great number of patients waiting to be treated in the hospital.

While it has been shown that reducing patient numbers may not lead to a fall in waiting lists (Smethhurst and Williams 2002) neither clinical nor management interviewees discussed this issue, nor did any interviewee suggest that any of the patients they treated did not need to see them. This also suggests that they try to see as many patients as possible because they believe that these patients need their help. Management staff too, were aware of the high number of patients waiting to be treated in the hospital and the clinical director in particular was involved in strategies to decrease waiting lists and improve the service for patients. Not surprisingly, management tended to discuss waiting lists from a policy perspective and discussed strategies and procedures to reduce them. Clinicians, on the other hand, discussed waiting lists in terms of how they felt that this affected the time they could spend with each patient.

In the literature review, it was also considered that Government targets lead to an increase in work pressure and decrease in staff morale and may cause clinicians to leave their profession (Beardshaw, 1990; Brodribb, 1994; Alderman, et. all 1996; Buchan, 1997; Scott, 1998; Corey-Lisle et al. 1999; Smith 2003). The acting services manager who was interviewed felt strongly that nurses' morale was low and attributed this directly to the fact that nurses were working at capacity. However no other interviewee commented on the relationship between work pressure and staff morale and as this study did not intend to explore these areas no conclusions can be drawn.

Time will always be identified as a barrier to change and in a commentary on barriers to change described in Chapter Five, Kottke et al. (1993) assert that it is important to explore why this is. By doing so it might be possible to make changes to overcome this barrier rather than simply accepting it. The present study identified how waiting lists and patient numbers prevented management staff from making preventive health work a priority in the hospital and prevented clinical staff from being able to spend enough time with patients to provide useful lifestyle advice. This also illustrates the influence political considerations have on delivery in the NHS.

7.3.2 The NHS plan

The most important issue to arise from this analysis is the need for consistency in health care policy. The NHS plan (Department of Health, 2000a) outlines standards both for waiting lists and for smoking cessation services and *Smoking Kills* (Department of Health 1998b) emphasises the importance of smoking cessation services throughout the health service. However the findings which have emerged from my consideration of the barriers to the implementation of the smoking cessation service at Reidpark Hospital suggest that these two aims are in opposition to each other. In order to offer smoking cessation advice routinely to all patients, staff must have enough time to engage with patients to raise issues such as smoking which may not be directly related to their illness. In addition, management staff must prioritise these services and ensure that there are ongoing resources for them. However in order to meet the more pressing needs of seeing a high number of patients in order to reduce waiting lists then they need to limit

the time which they spend with each patient and thus only deal with their immediate problems. This underlines the need for different government policies to be consistent as at present the objectives of decreasing waiting lists and of providing smoking cessation advice to patients are conflicting with each other. Until this is resolved high staff work pressure and low morale is likely to continue.

7.3.3 Issues for further research

It was suggested in Section 2.1 that clinicians make decisions, whether consciously or unconsciously, either to see fewer patients and spend more time with them, or to try to see as many patients as possible. It would be interesting to test this theory further by interviewing clinical staff in greater depth about their attitude towards waiting lists and government targets and how this affects their work. Further research is also required into the views of management staff and how these views are affected by government policy. While many health service managers have previously been clinicians, managers have a greater involvement in the organisation of hospital services and should have a greater knowledge of the hospital's priorities and the reasons for these priorities.

In conclusion, staff are constrained in their ability to offer health promotion and smoking cessation advice by their shortness of time. This lack of time is perceived to be due to high patient numbers and so if the smoking cessation service is to meet its aims, that all staff offer some smoking advice, then it is necessary for additional time to be provided for them to do so.

Chapter Eight : The Smoking Cessation Service: What Happened Next?

This chapter outlines how the smoking cessation service in the hospital has developed. It provides data on the number of patients attending the service and how many successfully stopped smoking. It also describes the growth of smoking cessation services within general practice and the development of the role of the smoking coordinator. Finally the future of the smoking cessation service in the hospital is discussed.

8.1 The Development of the Smoking Cessation Service

This thesis did not aim to describe the delivery of the smoking cessation service in detail or to assess its effectiveness at helping patients to stop smoking. However such information helps to provide a context to the study. It also provides an opportunity to explore whether those factors which have been identified throughout the thesis as potential barriers were subsequently evident as actual barriers and this is discussed further in Chapter Nine.

As Chapter One describes, the smoking coordinator was employed in March 2001 and started seeing patients shortly afterwards. At the time of writing the smoking cessation service had therefore been running in the hospital for two years and there is one year remaining of the original funding. The results described in this chapter refer to the first two years of the service where these figures are available, and otherwise refer to the first year only. This will be indicated when appropriate.

8.2 How Patients Accessed the Service

Once the smoking cessation coordinator was employed and had set up the service, she advertised it by putting up posters around the hospital and e-mailing all of the hospital staff. It was intended that any member of staff could refer a patient to the service, or

patients could refer themselves. It was planned that the service would be set up in the medical unit first and the service therefore was targeted at staff and patients in this unit.

The original aim of the service, as described in Chapter One, was that the smoking coordinator would train staff to provide motivation to patients to stop smoking and would assess which patients should be sent to the smoking cessation service for further help. Therefore the smoking coordinator also visited inpatient wards and outpatient clinics to teach staff about the service and the best way to use it. She did this both formally, by arranging training sessions, and informally, by dropping into wards and clinics when she had free time.

8.3 Helping Smokers to Stop

Once an inpatient was referred, the smoking cessation coordinator visited them in the ward before they were discharged if this was possible. Otherwise she telephoned them at home after they were discharged. Outpatients who were referred were generally telephoned at home or contacted the smoking coordinator themselves. After this an appointment was arranged for an initial assessment to be made. In consultation with the patient and depending on their illness, the coordinator decided what the best method would be to help them to stop. This was usually NRT or using willpower and ongoing encouragement from the smoking cessation coordinator. The smoking cessation coordinator saw patients several times if she and the patient felt that this was necessary to help them prepare to stop smoking and to assess the best way to assist them to do so.

For the first nine months of the smoking cessation service, those who were attempting to stop smoking joined a support group facilitated by the coordinator. These groups stopped running after similar groups began in the community. The development of these community groups will be described further in Section 3.3. After the initial appointment the smoking coordinator followed up patients by telephone. She called them weekly for the first month, then after three months, six months and one year. Table 8.2 shows self-reported success at stopping smoking at each of these stages.

Seven hundred and sixty-six patients were seen in the two years since the service began. Two hundred and fifty-six were prescribed NRT and the remainder attempted to stop smoking by willpower alone. Table 8.1 shows how many patients from each specialty attended the service in the first two years.

Table 8.1 Patients attending the service by major cause of illness 2001-2003

Illness	Number	Percentage
Cardiovascular	232	30%
Post-Myocardial Infarction	66	9%
Cerebrovascular	28	4%
Vascular	37	5%
Respiratory	189	25%
Diabetes	35	5%
Cancer	43	6%
None [1]	35	5%
Other	101	13%
Total	766	

[1] Staff and relatives of patients

It is clear that a large proportion of those patients who attended the service were attending the hospital with a cardiovascular or respiratory illness. This is likely to reflect the referral pattern of the lead consultants in these two areas. The cardiology consultant made a practice of referring all his smoking patients to the service and the respiratory consultant was the person who was involved in setting it up.

8.3.1 NRT prescription

If the patient was to receive NRT then in most cases this had to be prescribed by their GP as the hospital did not have a large enough prescribing budget to pay for this. Therefore once the smoking cessation coordinator had assessed the patient, she wrote to their GPs informing them that she had seen the patient, that they were keen to stop smoking, and requesting that they be prescribed NRT. There were occasional problems at the beginning with some GPs refusing to prescribe NRT. However after NRT became routinely available on prescription and smoking cessation services were set up more frequently in the community and in general practices, this changed and GPs did prescribe NRT to patients on the smoking cessation coordinator's recommendation.

Clearly it is important that inpatients who might want to stop smoking receive help when they are in hospital, unable to smoke and motivated to stop, rather than waiting until they can see a GP. For this reason after some discussion with the pharmacy, and in consultation with patients' doctors, NRT was prescribed for inpatients in some circumstances and in May 2003 the smoking coordinator became approved as a nurse who could prescribe NRT. However as there was a limited budget for NRT in the hospital this did not have a large effect on her work.

8.3.2 The success of the service in helping smokers to stop.

Two hundred and six patients attended the service in the first year, when it was being established, and 560 in the second year. Cessation figures are presently only available

for those patients who attended the service in the first year. Table 8.2 shows how many patients had stopped smoking at each stage.

Table 8.2 Success at stopping smoking at each follow-up stage (2001)

Time of follow up	Success Rate	Validation
1 month	137 (66%)	Carbon monoxide
3 months	110 (53%)	Patient report
6 months	81 (39%)	Patient report
12 months	60 (29%)	Patient report

The percentage of those who stopped smoking at one month (66%), which includes only those whose report was validated by carbon monoxide testing, compares favourably with national findings (49%), which were based on self-report (Department of Health, 2001). The service had aimed for 15% of those who attended to have stopped smoking after one year. As 29% of smokers had stopped at this time the service has more than achieved this goal. There are no appropriate national figures to compare this with as yet. While it could be argued that self-report will over-estimate success rates this has been shown to be accurate when validated by carbon monoxide testing (Glasgow et al., 1991). Furthermore national figures also rely on self-report. Therefore if we assume that this is accurate then it represents a considerable success. Nonetheless a stronger case for the effectiveness of the smoking cessation service at Reidpark Hospital could be made if all of the results were validated by carbon monoxide testing.

8.3.3 Smoking services in General Practice and LHCC

In the lifetime of the service there has been a growing emphasis on smoking cessation in general practice as described in Chapter One and GPs are now able to prescribe NRT. In Central Health Board in the two years since the smoking cessation service was set up in Reidpark Hospital, seven out of the eight Local Health Care Cooperatives (LHCCs) have employed smoking cessation coordinators and each clinic runs 4-5 sessions weekly. Each of these clinics sees patients both as groups and as individuals, and offer home visits for the housebound. It is possible that these clinics have been set up partly as a result of the service which the smoking cessation coordinator provided in Reidpark Hospital. As she wrote to GPs to ask them to prescribe NRT for patients or to inform them of their patients' progress this could have made them aware of the need for a service within their own area. Patients, too, might have prompted this by asking for a service which was more locally available. The remaining LHCC, which does not have a coordinator, also runs three group sessions a week in different locations but does not offer individual support or home visits.

This has implications for Reidpark's smoking cessation service. Outpatients are now referred directly to their GP to access a service and inpatients are referred there for support once they leave hospital. Group meetings are no longer carried out in the hospital because there is not much demand for them and it is usually easier for patients to attend a group in their local area. This means that the smoking coordinator now largely provides support to inpatients while they are in hospital. Once they are discharged they, too, are often referred to their GP for further support.

8.3.4 Development of the role of the smoking cessation coordinator

The role of the smoking cessation coordinator has developed and changed in the last two years. As well as continuing to see patients, Marianne has also assisted with setting up several of the services in the LHCCs. She also helped another local hospital to set up their smoking cessation service and is a member of a Scotland-wide smoking cessation coordinators' network which aims to support coordinators in their work. In addition she has become involved in developing Central Health Board's strategy on smoking, and in advising on changes to the smoking policy. She also now provides regular training for student nurses in the local nursing college. As the availability of smoking cessation services in the LHCCs has increased, the smoking coordinator believes that in the future she will be spending more time training staff to motivate smokers and less time assisting smokers to stop.

8.4 Non-Smoking Policies in Hospitals

At the time of writing there is a debate in the British Medical Journal about smoking areas in hospital and whether hospitals should be smoke-free. An editorial criticised the decision of one hospital in Belfast which decided to establish seven smoking rooms at a cost of £500 000 (McKee M et al., 2003).[2] This article considered that the provision of

[2] There are two authors called McKee in this debate. Both of them hold contrasting views on the provision of smoking rooms in the hospital and both of them published their articles in the same year. Therefore I have added their initial for clarification.

smoking rooms sent out an inconsistent message at a time when the United Kingdom was coming closer to having a comprehensive tobacco policy, giving as examples new warnings on cigarette packs and a greater support for people who wished to stop. McKee M. et al. (2003) believed that it was important that hospitals reinforced this message. They also considered that patients and staff should be protected from the effects of passive smoking and concluded that it could be argued that the money spent on these smoking rooms would be better spent on expanding smoking cessation activities.

This article generated a great deal of discussion and a number of articles and letters were published in response. Some of those who responded agreed with the opinions expressed by McKee M. et al. (2003). For example Clark, (2003) believed that this had a negative impact on the health of staff and of other patients, and felt that if smokers were allowed to smoke they would not contain this to smoking rooms were they to be provided. However one of the people who had made the original decision to implement new smoking rooms in the hospital in question asserted that their decision did not conflict with their smoking cessation strategy and that this was still an important priority of the hospital (McKee, W. 2003). He believed that, given the complex socio-economic and environmental factors which affect people's smoking behaviour, it is not appropriate to prevent people from smoking while they still wish to do so. He also considered that as patients will continue to smoke then it is safer to provide a room for them to do so. Other respondents, while supporting the ban on smoking for hospital staff and visitors, believed that patients, in particularly the elderly, have the right to choose their own habits and that the adverse psychological consequences of forcing inpatients to stop smoking

while they are ill over-rides any benefits to their physical health (Maguire et al., 2003). This debate suggests that there is not universal acceptance that hospitals should be smoke-free.

8.5 Reidpark Hospitals Non-Smoking Policy

Reidpark Hospital has been a non-smoking hospital since 1993. However in the last few years two new hospitals have opened in the same health board region. These were both built with dedicated smoking areas for patients and staff. As a result of this it was decided that Reidpark would also have to have smoking rooms installed to ensure consistency across the region. This was agreed at senior level and the work was due to go ahead in 2003. However after intervention from Dr Cairngorn, the service leader, the proposal was abandoned.

At the time of writing funding for the continuation of the service is being sought.

Chapter Nine: Discussion and Conclusions

Each of the results driven chapters has ended with a short discussion of the findings reported in relation to the relevant literature. This chapter brings these together in order to consider whether the aims and objectives of the smoking cessation service have been met, to identify the individual and structural factors which are likely to affect its implementation and to conclude whether the hospital is a suitable setting for health promotion. This chapter also identifies the strengths and limitations of the research and the impacts of the methods chosen, and provides recommendations for the future.

9.1 Introduction

This thesis aimed to identify factors at an individual and structural level which would affect the successful introduction of a smoking cessation service into an acute unit. This was done as the number of health promotion services in hospitals grew and the emphasis on the provision of smoking cessation services increased (HMSO, 1992; Department of Health, 1998a; Walker 1998; Department of Health, 2000a; Department of Health, 2000b). Despite the fact that staff are encouraged to provide brief motivation to encourage smokers to stop smoking, and the expansion in the number of dedicated smoking cessation services, few studies were identified which considered patient or staff attitudes to the implementation of such services. As has been noted, much of the research is US-based (for example Kottke et al, 1989;1992;1997; Solberg et al.,1997;2002; Frank et al., 1991 Fiore et. al., 1996 Goldstein et al., 1997). The UK research which has been carried out has generally concentrated on the primary care setting (Kava et al., 2000; Duaso and Cheung, 2002; Coleman et al., 2003) and most research has concentrated on the views of a single profession, largely doctors or nurses (for example Kottke, 1993; McBride, 1994; Thomson and Kohli, 1997). Therefore it is important to carry out relevant research in the UK hospital setting and to solicit the views of hospital staff members who will be involved in the provision of this service.

The present thesis is unique both in seeking the views of patients as to the acceptability of such a service and in interviewing a range of different staff in a hospital about the factors influencing its successful implementation.

9.2 The implementation of the smoking cessation service: will it meet its objectives?

Chapter One described the goals of the smoking cessation service at Reidpark Hospital which were in line with those of Department of Health (1998b) and Raw (1999). That is, it aimed to provide a dedicated smoking cessation service and for clinicians to ask all patients their smoking status and, where appropriate, provide some brief motivation to help them stop. Both of these goals will be assessed. As the service was being set up at the same time as the research took place, it is only possible to identify factors which might influence the success of the service rather than to test these factors in practice.

9.2.1 Patient attitudes to the service

The service was aimed at patients and therefore their views were important. Patients had to accept being asked about smoking and offered help to stop by a clinician and believe that a dedicated smoking cessation service would be useful in the hospital in order for the introduction of such a service to be successful. This information could also help to inform the practice of clinical staff, as staff would be more likely to ask patients their smoking status or encourage smokers to stop if they perceived that patients wished to receive this advice and would act on it.

Chapter Four described the results of the patient survey in greater detail. In brief it indicated that the large majority of patients believed that the hospital should provide a

smoking cessation service and an even higher number thought it was appropriate to be asked their smoking status when attending hospital. Half of those who smoked wanted help to stop smoking and a third did not want to stop smoking.

The patient survey also asked patients whether they had been asked their smoking status in their most recent outpatient appointment or present inpatient stay, and, if they smoked, whether they had been offered support to stop smoking. This assessed what smoking cessation advice was available in the hospital before the service was introduced and helped to indicate staff attitudes towards the goals of the service, that is, that all patients be asked their smoking status and all smokers be advised to stop smoking and encouraged to do so. If staff were already doing this then they would be unlikely to oppose the goals of the service, although the reverse may not be true. Only 66% of inpatients and 40% of outpatients reported having been asked their smoking status and 44% reported having been advised to stop smoking. Very few patients were offered help to do so. At the time of the survey there was little help that clinicians could provide beyond encouragement and brief motivation. The results match those of two smaller studies which largely included GP patients. These studies also found that while a high percentage wanted to stop smoking, and wanted help, few were offered specific support (Kava et al., 2000; Duaso and Cheung, 2002; Coleman et al, 2003). Two larger European-wide studies reported similar results (van Berkel et al., 1999; Boyle et al., 2000). The latter of these was of particular interest as it found that patients considered advice from a doctor to carry greater weight than from another clinician. This reinforced

the importance of doctors giving smoking cessation advice rather than delegating this work to others, and of there being a unified approach by clinical staff towards smoking.

US-based studies too found that while smokers may be advised to stop smoking, few were offered help to do so (Frank et al., 1991; Goldstein et al., 1997). However a third US-based study found quite different results to those of the present study (Emmons and Goldstein, 1992). In this study, while the majority of smokers wanted to stop, most of them had little interest in formal treatment, preferring to quit on their own. This contrasts with the present survey where most smokers who wanted to stop wanted help to do so. This suggests either a difference in attitudes between US and UK patients or those attitudes have changed in the decade since Emmons and Goldstein (1992) carried out their study.

These studies are based on patients' reports which may not be completely accurate, however it does seem that there is at least some attempt made by most staff to ask about smoking and advise smokers to stop. However this is by no means consistent or universal, and if the goals of Smoking Kills, (Department of Health, 1998b) are to be met then there is a need to encourage and train clinicians to offer greater support. The present study showed that a significantly higher proportion of inpatients than outpatients were asked if they smoked; however they were no more likely to be advised to stop. It is likely that this difference reflects the admission procedure for inpatients rather than indicating a desire by clinicians to use this as an opportunity to encourage patients to stop smoking. Few patients were offered support to stop smoking. It is likely that this was

due to the lack of services available at the time of the survey to help smokers to stop, rather than any resistance to offering help on the clinician's part. Not all patients were asked if they smoked, nor were all smokers advised to stop smoking.

No previous research has asked patients if they thought it was appropriate to be asked their smoking status and to be advised to stop smoking. If my results are representative of UK hospital patients' attitudes then they suggests that such advice would meet little resistance from patients.

Patient attitudes as reported in a survey might not reflect their actual behaviour and it is possible that, despite these results, they would respond negatively to being advised to stop smoking or would fail to take up referral to the smoking cessation service. However this survey does strongly suggest that patients would support the provision of such a service in the hospital, and support being routinely being asked their smoking status and being advised to stop smoking. Furthermore the majority of smokers who want to stop smoking would like help to do so. In conclusion, based on these results, it is unlikely that patient attitudes would act as a barrier to the implementation of the smoking cessation service.

9.2.2 Factors preventing interviewees from offering smokers advice

The staff interviews can give us some insight into why they advised some patients about smoking and not others, and what factors prevented them from doing so. While many of the clinical interviewees did claim to routinely ask patients if they smoked, on closer

analysis it was clear that this was not actually routine; instead, staff made a decision about whether or not to do this based on whether they thought the question was appropriate at this time and the patient was motivated to change. Furthermore, those who worked in specialties where smoking could be implicated in the development of the disease were more likely to give smoking cessation advice than those who worked in other specialties. This is not surprising. If a patient's illness was affected by their smoking, this advice would be clearly be appropriate. In addition these staff are confronted with the results of patients' smoking on a regular basis and are thus more likely to advise smokers to stop.

In general interviewees felt that they should be helping patients to stop smoking although many believed that it would be more useful to target motivated smokers. In addition they believed that it would not be appropriate to focus on those smokers who were under stress because of other aspects of their life, such as family circumstances. While they may agree in principle that all smokers should be asked about smoking and encouraged to stop, it is clear that in practice this might be mediated by such issues. Furthermore staff felt that they had to develop a relationship with patients if the advice they gave was to be effective. This was difficult to do so in such a short time with a patient whom they might only see once every few years.

It was interesting that while clinicians made judgments about patient motivation and patients circumstances, to assess whether smoking advice would be appropriate, they did not seem to discuss with patients whether or not they wanted help on smoking cessation,

possibly because this in itself would necessitate raising the topic of smoking and thus take up their time.

It is important to emphasise that at the time of the interviews the smoking cessation service was just being set up. Prior to this clinicians could give little support to smokers to stop as in many cases they did not have the time, confidence or skills to do this themselves. As the smoking cessation service becomes further integrated it is possible that clinicians will raise the issue of smoking more often as they will be able to refer patients to this service. The next section will consider staff attitudes to the goals of the smoking cessation service and identify factors which they believe might affect these goals being realised.

9.2.2.1 Interviewees' attitudes towards the dedicated smoking cessation service

Staff interviewees were generally positive towards the provision of a dedicated smoking cessation service and it seems unlikely that there would be any resistance to its implementation. Interviewees who had had some contact with the new service and with the smoking cessation coordinator were happy that the service was available and pleased with how it worked. However they often had little insight into how they could refer smokers to the service and what methods the smoking coordinator used to assist smokers.

This positive response to the service is not surprising. The service was external to interviewees' work and would not have a negative impact on them, even if they were cynical about its likely success. Furthermore it gave them somewhere to refer smokers

and allowed those staff who wished to do so to feel that they had provided support without taking up much of their time. From this perspective it seems unlikely that staff would present barriers towards its delivery. However it does not follow that, because they held positive attitudes towards the dedicated service, this would lead them to ask patients their smoking status or attempt to motivate smokers to stop smoking.

In order to achieve the goals of the smoking cessation service, clinicians also had to determine which smokers would like to stop, which they could attempt to motivate themselves and which they should refer to the dedicated service. Clinicians who were interviewed did not discuss making any attempt to differentiate between patients who needed further help and those whom they could encourage to stop themselves, nor did they mention having received any training to do so. In general, those who had referred patients largely reported that they referred all smokers who wanted to stop smoking.

As has been indicated, at the time of the interviews the smoking cessation service had just been introduced and there had been little time for clinicians to receive training on how to identify which patients required further help. Marianne, the smoking coordinator, did feel that many patients were referred to her inappropriately and was attempting to address this by carrying out training sessions on how to use the dedicated service and by returning to staff to advise them when they had made an inappropriate referral. Therefore it is possible that clinicians will refer to the service more appropriately in the future. In some cases changes has been made and nurses reported to Marianne a few cases when they had not referred patients because they were able to help them

themselves. However as Chapters Six and Seven showed, other structural barriers meant that persuading clinicians to provide more smoking cessation advice would not be easy and this will be discussed further in Section 2.2.4.

9.2.2.2 Interviewees' Health Promotion Role and its impact on the service

Interviewees' perceptions of their health promotion role were explored in depth to determine whether they felt that they should be providing lifestyle advice at all and what they felt about health promotion generally. The majority of interviewees believed that they should have some responsibility for health promotion, although the advice which they reported giving largely related to the specialty in which they worked. Interviewees often commented that different staff would be more or less involved in health promotion depending on the job which they did.

If the goals of asking all patients their smoking status regardless of the reason they attend hospital, and providing some support for all smokers who want it, are to be achieved, then it is likely that a differentiated approach would generate greater success. That is, those who work in a speciality in which smoking is important should receive ongoing encouragement and training to help smokers to stop. In contrast, those who work in areas which are not related to smoking would need to be convinced that this was an appropriate activity, that patients wanted such advice and that it was useful and effective. They would also require greater support before they would routinely ask patients about smoking. As the issue of smoking is less likely to be raised in some specialties as part of

the consultation, a reminder of smoking status on patients' notes may also encourage clinicians to discuss smoking if appropriate.

Interviewees were also concerned with patient motivation and considered that advice was only appropriate at a time when they judged that patients would be able to make successful behaviour changes. Some interviewees were concerned that patients were pushed too hard to change their behaviour and that they would be unlikely to maintain this change after they left hospital. Clearly this would discourage the interviewee from giving such advice. However the fact that they do try to provide advice where they feel it is suitable, or when the patient asks, suggests that they could be encouraged to do so if they were supported in this work, for example by being given more administrative support or by more junior staff being recruited to whom staff could delegate. Clinicians could also be helped to identify suitable opportunities and to assess whether such support would be useful for individual patients, though clearly time for this education would be necessary.

It has been suggested that the fact that clinicians receive little feedback on the advice which they give means that they are not motivated to continue to do this (Kottke, 1993). In order to address this potential barrier, the smoking cessation coordinator did give staff feedback on the patients they had referred, although obviously this could not be done for those clinicians who had encouraged smokers to stop but had not referred. As relatively high numbers did stop smoking (based on self-report) this might encourage clinicians to refer.

However in many situations, for example when a patient is being given a serious diagnosis, or they are attending hospital for e.g. travel injections, it is unlikely that smoking advice will ever be routinely offered. This will be discussed further in Section 2.5.

9.2.2.3 Comparing the attitudes of staff and patients

Interviewing staff and surveying patients allows us to compare their responses. As indicated in the last section, staff were concerned that they should not force patients to change their behaviour and were worried that if they raised the subject of smoking inappropriately this may affect their relationship with patients. This sometimes discouraged them from giving smoking cessation advice. However their concerns were not reflected in the patient survey. While staff may have some misgivings about giving smoking advice, patients seemed to be keen to have it, or at least were not resistant to it. This suggests that staff's concerns were unfounded. However it is possible that patients' behaviour in their consultation may differ from their attitudes expressed in the patient survey. Moreover their positive attitudes towards the service may not be translated into action.

The alternative methods used for staff interviews and the patient survey may explain the differences found here to some extent. As staff were interviewed in depth they had a greater opportunity to express any ambivalence, reservations or qualifications to their views, whereas the patient survey did not provide a similar opportunity. However no

matter how positive or negative their feelings were in relation to the smoking cessation service, their actual behaviour would be greatly influenced by organisational constraints in the hospital. In addition, wider political and policy decisions both internal and external to the hospital would also influence their work. The next sections considers these issues further.

9.2.2.4 Structural barriers and their impact on the introduction of the smoking cessation service.

As Chapter Six described, the most important factor which clinicians perceived to prevent them from providing health promotion and smoking cessation advice was lack of time. This barrier has also been identified in similar research (Orlandi, 1987; Kottke et al. 1990; Kottke, 1993). Clinicians tried to see as many patients in as short a time as possible and had little opportunity to provide help with lifestyle matters unrelated to the presenting illness. In order to manage their time, both clinicians and those managers who were interviewed were keen to delegate part of their work. This meant that clinicians often saw the smoking cessation service as a way of passing on smokers for someone else to help. Clearly this would be a barrier preventing the goals of the service from being met. Clinical interviewees who were under pressure to see a high number of patients felt that they would rather that someone with the expertise and, they believed, the time to do this properly, helped smokers to stop, rather than them attempting to give advice quickly when the patient might be stressed. They considered that this would be ineffective. This would mean that while they would support the provision of the

dedicated service they would be resistant to the goal that all patients be asked if they smoked as standard.

9.2.3 Conflicting requirements of health care policies

Some commentators, particularly those writing in the medical profession, have remarked on the possibility of conflict for clinicians if they are expected to fulfill different roles, for example, as a clinician treating illness, and as a health promoter, encouraging patients to change their behaviour (see, for example, Kottke et al., 1993; Johnson, 2000). Chapter One described policy papers which emphasise the increased involvement in health promotion which clinicians are now expected to have, together with their responsibility for patients both inside and outside hospital (HMSO 1992; Department of Health 1998a; Dargie et. al. 2000). It appears that clinicians, in particular, are now expected to take on two roles. The first is that which they traditionally held, where they treated patients individually for their illness and dealt with their specific health problems. The second involves being aware of health promotion initiatives and public health and epidemiological findings, and trying to apply these population findings to the individual they are treating. It is difficult to manage the competing demands of these roles when time is so short.

However, as Chapter Seven describes, there is an additional issue. Waiting lists are also a priority and a great deal of emphasis has been placed on reducing the number of people waiting to attend hospital and the length of time which they wait (Department of Health; 2000a). Both clinical and management staff felt under enormous pressure to see as many

patients as fast as they could and this was the most dominant barrier to health promotion and to offering smoking cessation advice. If staff only have a limited amount of time which they can spend with patients, because they know they have others waiting to see them, then they have to prioritise treating the illness with which the patient is attending hospital rather than providing a holistic health promotion service. It was clear in both the management and clinical interviews that, while they may consider health promotion to be important, this was a low priority compared to seeing as many patients in as fast a time as possible. Therefore while policy papers may emphasise both of these objectives it is apparent that on the ground waiting times are believed to be more important than health promotion advice.

There are a number of potential explanations for this. First, it is likely that this ties in with clinicians' own beliefs; Chapter Six found that interviewees preferred to concentrate on areas in which they had expertise, delegating less specialist tasks to others, and thus would refer to smoking cessation services rather than providing support themselves. Second, while the government may have made a number of policy recommendations in relation to health promotion in hospital, it is waiting list statistics which are gathered and often used to evaluate hospitals, or used as an indicator of a hospital's success. Therefore it is these which the hospital staff, both clinical and management staff, must prioritise. Further qualitative research, which explored clinicians' understanding and knowledge of government policy and their perceptions of how this influences their work, would be relevant here. This could help to inform a dialogue between policy makers and people who are affected by their policies. If policy makers and politicians had an insight

into how different policies worked together or clashed with each other this could also encourage communication among them to ensure a more unified approach, and so in turn result in more effective practice.

The present research does suggest that it is naïve to expect that it is enough for a policy to be announced for it to be prioritised and implemented, but rather that other factors must be in place, in particular, time to carry out any changes as a result of the new policy and evaluation to ensure that the policy is being adequately implemented. At present, the competing requirements of different policies are likely to lead to stress and disillusionment among hospital staff. Unless these policies also set out what changes can be made to support those who must implement them, then they will not be effective.

9.2.4 The hospital as setting for health promotion

Johnson's (2000) description of the problems with the hospital as a setting for health promotion described in Chapter One showed similarities with my experience when I was carrying out staff interviews and patient surveys which required me to visit the hospital. She argued that it was difficult to provide health promotion to inpatients, as they stay for a shorter period than they did in the past and they spend much of that time seriously ill. In the case of inpatients in particular, I often found it to be frustrating, distressing and difficult to carry out the survey. Even though I had discussed in advance with the nurse which patients I should not speak to, when I approached the patients they had recommended, I frequently found they were too confused or ill to participate. On several occasions, after I had begun the survey, it became clear that it would not be possible to

complete it as the patient was not able to answer the questions and on a few occasions the patient became distressed. Under these circumstances I could see that it would be equally difficult for a doctor or nurse to engage with the patient in order to discuss their smoking behaviour.

Different problems were pertinent in the outpatient clinic where I approached patients immediately after their appointment, in order to complete the patient survey. At this time they might have just been given a serious diagnosis, which they were struggling to come to terms with, while at the same time attempting to answer my questions. Clearly if I was aware of this, or the patient was visibly upset, then I did not approach them, however, in most cases, I was not aware of the nature of their consultation. On a few occasions one particular doctor came out of his consulting room and angrily asked me not to speak to a particular patient. This obviously made me feel very uncomfortable and intrusive. However it also helped me to gain an insight into the conditions under which staff were working. On several occasions too, patients explained that they did not want to stop smoking at the present time because they had recently suffered a bereavement. I could easily see why clinicians would not want to raise the issue of a patient's smoking if, for example, they were giving the patient a terminal diagnosis or if the patient was discussing the death of their child for example. Under these circumstances I believe that clinicians could never be expected to ask a patient's smoking status routinely.

Aspects of hospital policy could have a positive effect on patients' health. Reidpark Hospital has a no-smoking policy and, with few exceptions, inpatients are unable to

smoke while they are in hospital. There has been a debate on whether such a non-smoking policy is appropriate and whether smokers' rooms should be provided for patients and this was outlined in Chapter Eight (Clark, 2003; McKee, M, 2003; McKee W., 2003). In the present study many patients commented that this had helped them to stop smoking and the fact that they had stopped while they were in hospital gave them the confidence to maintain this after they had left; many ex-smokers remarked that they had stopped smoking during a previous visit to hospital. These issues were not included in the survey so this evidence is anecdotal. Furthermore as patients had no choice over whether or not to smoke it is not a true example of health promotion, which emphasises patient empowerment. Further research which determined the effect of such a non-smoking policy on patients smoking status and whether those patients who had stopped smoking were able to maintain this would help to inform the debate on hospitals' smoking policy.

9.2.4.1 Smoking cessation as a health promotion initiative

In Chapter One the wider definitions of health promotion were discussed. This emphasised the importance not only of empowering the individual to make decisions about his or her health, but also of understanding the influence which society has on an individual's health (World Health Organisation, 1984). It has been argued that smoking cessation services therefore should not be considered to be health promoting as they overemphasise the role of the individual, ignoring the context in which they are living and do little to improve the promotion of population health (Schmid et al., 1995; Watson and Platt, 2000).

Chapter Five also outlined some ethical considerations related to clinical staff taking on a health promotion role (Illycih, 1988; Skrabanek, 1994; Ng, 1997; Norton, 1998). Neither ethical issues nor the wider definition of health promotion arose as dominant themes in the interviews. However interviewees did believe that they should consider external influences on patients. They did not comment on population approaches to decreasing tobacco consumption, such as taxation or advertising, nor did they suggest that their influence was minimal when compared with these factors. However they did discuss the impact of the patient's home and family and the difficulty which patients might have in maintaining any behaviour change once they had returned to their home environment. This demonstrated that they did consider some external influences on the patient. However they felt that their limited time made it difficult to consider this fully and that while they could provide information, it was up to the patient to decide whether they wanted to make a change.

9.2.5 Smoking cessation guidelines: Will these be adhered to?

It has been suggested throughout the thesis that the guidelines proposed by Raw (1999) and the recommendations made by the Department of Health, (1998b) that patients should be routinely offering smoking cessation advice will prove problematic in practice. Such guidelines have to be clearly defined and cannot comment on every exception in which they may not be appropriate for one individual patient. However clinicians have to treat their patients as individuals and deal with their individual needs as they understand them. It is unlikely that anyone who worked in a hospital would either

consider that helping patients to stop smoking is a bad thing or oppose a service which aimed to help those patients who wanted it. However in order not to be dismissed as irrelevant, guidelines should identify situations when exceptions to them should be made and there must be room for clinicians to be able to make their own judgment.

However one should not use these extreme situations in order to dismiss the aims expressed in the guidelines. There are many consultations when smoking advice and support would be appropriate; for example, there are many patients with chronic conditions such as asthma or diabetes who attend the hospital regularly for check ups, and many inpatients spending a lengthy amount of time in hospital recovering from a diagnosis are perfectly able to understand smoking cessation advice. In these circumstances clinicians might have time to build up a relationship with the patient and the patient would be less likely to be anxious or stressed.

9.3. Lessons for other health promotion services

This study also aimed to identify lessons learned during the set-up of the smoking cessation service which could be generalised to the implementation of other health promotion services. Since interviews involved questioning staff on their attitudes towards health promotion and their roles as health promoters generally the findings gained here are applicable to similar services.

The literature emphasised the need for clinical staff to be willing to adopt a health promotion role in order for them to perform such tasks (Bain and McKie, 1998). The available research, which focuses on nurses' beliefs about this role, suggests that nurses do believe they should have a health promotion role, although this is often limited due to external factors (McBride, 1994; Thomson and Kohli, 1997; Nagle et al., 1999).

It seemed that interviewees were ambivalent towards their role as health promoters and, while they accepted such a role in theory, just as with smoking cessation, they might not put it into practice or might consider that other members of staff could perform this work more effectively. It seems clear that a decision needs to be made about whether health promotion is a priority in the hospital. If it is the case then staff should receive training and education which helps them to do this and organisational changes should be made to support them to provide smoking cessation and other health promotion advice. For example clinicians could receive more administrative support to allow them to spend more time with patients. However if it is felt that waiting lists or other factors should be prioritised, then staff should not be made to feel guilty about not performing a health promotion role, and some limited training on their responsibilities and how they could effect small changes would be useful.

While many of the barriers identified would be applicable to health promotion it could be argued that smoking holds a unique position among lifestyle behaviours. First, it is generally accepted that smoking to any level will damage your health, whereas some alcohol consumption is considered to be safe and a clear line cannot be drawn between a

healthy diet and an unhealthy one. Furthermore there has been a growing intolerance towards smoking in recent years, as has been shown by an increase in the numbers of no-smoking areas, bans on advertising smoking and the increased enforcement of laws to stop under-age smoking, as well as by the growing number of initiatives to help people to stop smoking. It is now widely accepted that smoking affects many areas of health and smokers often feel stigmatised, guilty and uncomfortable about their smoking behaviour. This feeling is likely to be particularly pertinent in a health care environment where patients may be being treated for an illness caused or exacerbated by smoking. However those interviewees who themselves smoked were particularly concerned that smoking was stigmatised in a way that other unhealthy behaviours were not.

As Chapter Four showed, the majority of patients considered that it was appropriate to be asked whether or not they smoked, many going on to comment that smoking affects your health, or that clinicians had to have this information in order to help them with their treatment decision. The patients therefore did seem to generally accept that smoking was bad for their health and that doctors, nurses and other clinical staff had a right to ask about this as patients felt that they were trying to help them. However it is possible that if another health promotion initiative was being assessed in a similar way, such as one where dietary advice or weight control advice was routinely given, regardless of the reason why the person was attending hospital, this might elicit quite a different response. Therefore the findings obtained from the smoking cessation survey need to be compared with those from surveys on other lifestyle initiatives in order to make general recommendations about the implementation of health promotion initiatives.

9.4 The future of the smoking cessation service

The previous sections have considered whether the smoking cessation service was likely to be successfully implemented into the hospital. It has shown that patients were unlikely to oppose its introduction as they considered it to be appropriate both to have such a dedicated service and to be asked about smoking while they were in the hospital. Staff, too, generally welcomed the new dedicated service or at least were not resistant to it, as long as patients could choose whether they wanted to stop smoking and wanted to be helped. The provision of the service allowed staff to refer patients whom they were unable to help themselves.

Chapter Eight, which gave an insight into the development of this service, reinforced the generally positive perceptions of both patients and staff. The smoking coordinator had many referrals and was constantly busy helping these referrals and following up those who had stopped smoking, to ensure that this is maintained.

In Chapter One, Section 6.5, David Cairngorm, the service leader, demonstrated his enthusiasm for the smoking cessation service. He explained that he wanted to 'change the culture of the hospital' so that patients would constantly be asked about smoking from different people on their journey through the hospital. However, this second aim, that clinicians would routinely identify all smokers and provide some assistance to those who wanted to stop by themselves, was not being met at the time of the interviews. It is possible that this will change as the service develops. However it is likely that the

structural barriers, in particular, time and the emphasis which was placed on seeing a high number of patients and attempting to decrease the waiting list, will prevent this goal from being met within the current climate of the hospital.

Chapter Eight also described the increased number of smoking cessation services available in general practice. This has lead to the smoking cessation coordinator referring the majority of outpatients to these services and referring inpatients when they are discharged. Smoking support groups are therefore no longer run in the hospital; instead the smoking coordinator now concentrates on helping inpatients to stop smoking while they are in hospital and ensuring that they receive support when they leave. GP services are locally based and thus more convenient for patients. GP staff are more likely to have built up a relationship with patients as they see them more often than do hospital staff. Moreover patients may be more likely to accept lifestyle advice in this setting, where more general issues are dealt with, and where other health preventive services such as screening are provided, than they would in a hospital.

Even more importantly NRT has been shown to be the most effective way to help smokers to stop and GPs are now able to prescribe this to smokers. Hospital doctors, however, have a very limited prescribing budget and can only prescribe NRT under exceptional circumstances. All of these factors support the placement of smoking cessation services within the general practice rather than in the hospital. In addition a large UK-based study in general practice also concluded that GPs accepted that intervening against smoking was part of their role (McEwen and West, 2001).

However it is important to remember that the smoking cessation service has been very successful at helping smokers to stop smoking. Two-thirds of smokers who had received help from the coordinator had stopped smoking after one month and this had been validated by carbon monoxide testing. After twelve months almost a third had remained non-smokers, although this relies on patients' reports. These figures themselves validate the implementation of the smoking cessation service. However it is also clear that most referrals were made from the respiratory department, where the service was set up, and the cardiology department, whose lead consultant was a strong supporter of the service. This suggests that the smoking cessation service has become an addition to the range of services available in the hospital and it is unlikely that the culture of the hospital will be changed to one in which smokers in all areas are routinely offered help.

9.5 Strengths of this research

As noted throughout the thesis there is a lack of research in this area, in particular a lack of UK-based research. This thesis has attempted to redress this problem. It has provided information on the proportion of patients who smoked and who were attending Reidpark Hospital, and the advice and support available to them in this hospital.

This is also the first study within the UK to describe patient attitudes towards a smoking cessation service and explore whether patients believed that smoking advice was appropriate in hospitals. Many of the previous studies showed that clinicians were

inhibited from giving patients advice because they perceived that patients did not want it. Yet patients have generally not been asked what they want. This study has found that patients do want this advice and are likely to use a smoking cessation service. If this service is to continue this should be highlighted to clinicians.

Most previous studies in this area have focused on general practice and on one profession. Therefore this study is unique in looking at the hospital setting, in attempting to include a range of staff and in being able to compare both staff and patients' views. There has also been little research in the mainstream health literature which has considered the role of non-clinical staff. The present study could not interview a large number of managers, and further research into their role in the hospital is needed, however the interviews with managers did help to show how hospital priorities, finances and organisation impact on the work of staff and the experience of patients.

The patient survey included both inpatients and outpatients rather than surveying only one of these groups as has generally been the case (Solberg et al., 1997b; Kava et al., 2000) and surveyed patients across specialities rather than concentrating on one group, as other research has done (van Berkel et al., 1999). This allows us to compare outpatients and inpatients; for example inpatients were more likely to report being asked their smoking status. With hindsight it is obvious that an inpatient's experience of a hospital stay would be quite different from an outpatient's experience of a visit to a clinic. Therefore the results from a survey of one of these groups are not necessarily applicable

to the other. In future research these two groups should not be assumed to be similar and this research suggests that it is important to consider the opinions of both groups or at least to analyse them separately.

One of the strengths of this research was derived from the fact that in order to carry out the patient survey and staff interviewees it was necessary to visit the hospital fifty-four times. While this was time consuming, it helped me to develop an understanding of the way in which the hospital worked and the conditions under which staff were working and patients were being treated. It also helped to inform the interview topics, to identify which staff should be interviewed and to aid the discussion of whether the hospital was an appropriate setting for health promotion.

Another strength of this study was its use of qualitative methods to explore the views of staff. Previous research studies which have examine staff attitudes have largely relied on quantitative methods (Jelley and Prochazka, 1991; Thomson and Kohli, 1997; Thorndike et al. 1998; Basnyat et al., 2000). In questionnaire-based research issues cannot be followed up for clarification. This has meant that when, for example, 'time' was identified as a barrier, it was impossible to know whether different respondents had the same time constraints and whether different studies were considering 'time' in the same way. It also made it difficult to explore further what was causing time barriers and therefore to identify how these issues could be addressed practically.

Qualitative research also allows new themes to be identified rather than constraining respondents to choosing from previously defined options. In the present research this allowed one of the most interesting themes to emerge, that is, that the impact that waiting lists and patient numbers had on the health promotion work which clinicians did. While the impact of waiting lists on staff's work in general has been frequently discussed (Alderman et al., 1996, Smith and Walshe, 2001; O'Rourke, 2001) this is the first study to show the impact this has on health promotion and smoking cessation services.

9.6 Limitations of the research

This study does, of course, have limitations. It was important to include interviewees from a range of professions in the hospital as the smoking cessation service was one which required the involvement of different professions to be successful. As different professions work within different environments, motivations and interests, it is important to ensure that their opinions are reflected. However this meant that only a small number of each group could be interviewed. The majority of the clinical staff interviewed were doctors and nurses and the interview sample included only one physiotherapist, one electro-cardiograph technician and one pharmacist. Therefore the findings may not reflect the concerns of these groups, or indeed of other hospital staff. However the qualitative component of the study did not intend to be representative of all of the staff working within Reidpark Hospital. The analysis and interpretation of this data aimed to highlight main themes relating to the implementation of the smoking cessation service. Clearly if other professions are to be involved in the provision or organisation of health

promotion services then they should also be involved to a greater degree in the related research.

It is not possible to analyse every topic raised in the interviews within the time allotted to a PhD. The thesis has therefore concentrated on those issues which were the most dominant in terms of the implementation of the service. Interviewees did discuss staff communication, education and involvement in policy decisions and further analysis of this would be useful. It would also be instructive to consider further the roles of the service leader and of the smoking cessation coordinator, for example in relation to how their personalities impacted on the development of the service.

While the study aimed to explore factors which facilitated and acted as barriers to change, it focused on barriers to a greater degree. People tend to be more aware of and thus discuss things that make their work harder, and less aware of those factors which make their work easier. However there were many positive aspects of the hospital that were likely to contribute towards successful change. For example staff generally felt that communication between departments was good, that staff worked well together, and that they could choose to be involved in decisions concerning their work if they wished, although they usually did not. In addition the relationships between clinical and management staff were good. All of these areas might prove fruitful for further analysis to determine their effect on the smoking cessation service.

The patient survey was carried out before the smoking cessation service was implemented and it was originally intended that this would be followed up by another patient survey to assess the impact of the service as was described in Chapter Two. Unfortunately, as the service was set up later than originally anticipated this was not possible. However because funding was acquired to carry out a follow up survey, the original aim of assessing the impact of the service can be met eventually, although not within this PhD.

9.7 Organisational Research

One difficulty of organisational research, discussed earlier, is that it can be difficult to know when to leave the field and to start to analyse data, as the organisation will continue to change (Buchanan, et al. 1988). One important change which happened after the research was complete was the increase in smoking cessation services in primary care, and the impact that this had on the work of the smoking cessation coordinator. Because patients could attend local GP services, more of her time was spent with inpatients, or accessing GP services for patients who were leaving hospital. This demonstrates the impact which government policy has on the work of hospitals and health services generally. It also illustrates how difficult it can be to form long-term strategies in these sectors because they are subject to change depending on political decisions. Furthermore it shows how this research can act only as a snapshot taken at one stage in the development of the smoking cessation service.

9.8 Issues for further research

There is a lack of research in the area of smoking cessation services in hospital. The patient survey in the present study found that patients accepted smoking cessation services in the hospital. It would be useful however to determine whether individuals with more positive attitudes to the service were more likely to attend it. While there has been some research in general practice, clearly the hospital is quite a different environment. As health promotion strategies in hospitals increase in number then it is important that evaluations of their effectiveness, and factors which affect this, take place.

Further research is required to determine which findings can be generalised to other health promotion initiatives, and which are specific to smoking. A useful first step would be to carry out a systematic review of the literature on health promotion in the hospital setting, specifically in the UK. This could identify common themes and areas of difference between health promotion in different areas, and direct further research. In addition it would be useful to examine whether people's attitudes towards the provision of other advice, e.g. healthy diet, alcohol or weight control, differed from their attitudes towards the provision of smoking cessation advice. This would determine whether patients were generally receptive to receiving preventive advice while they were attending a hospital or whether smoking occupied a unique position.

Findings from different professional groups differed, although it was difficult to draw strong conclusions here because of the limited numbers who were interviewed. Research which compares different professional groups is required to address this gap. Further

qualitative research with other health care staff, in addition to doctors and nurses, would be useful to establish whether they share similar views towards smoking cessation and hospital-based health promotion.

9.9 Conclusions

This thesis has given an insight into the individual and structural factors which affected the implementation of a smoking cessation service in Reidpark Hospital and identified lessons for the implementation of other health promotion services. It found that while there was general support for a smoking cessation service among patients and staff, it is unlikely that this would be implemented in line with the guidelines because of structural barriers, specifically the shortage of time and the competing demands exerted by the pressure to reduce waiting lists. Therefore the present thesis supported the views of Schmid et al., (1995, p 1207) "It is unreasonable to expect large proportions of the population to make individual behaviour changes that are discouraged by the environment and existing social norms. It is equally unreasonable to expect communities or organizations to enact policy changes for which there is no broad based understanding and support."

While it is likely that the smoking cessation will continue to offer a useful service for those smokers who need it, it is unlikely that all patients who attend the hospital will be asked if they smoke, offered help to stop smoking or be motivated to do so. As there is now a large number of smoking cessation services available in general practice, then in

order to most effectively reduce the number of people who smoke, future resources should be focused on the general practice setting.

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APPENDIX I

Date	Patient Code .....
Speciality	Clinic Name .....

Section One- All

1. Is this your first appointment?

First Appointment ❑

Return ❑

2. Do you smoke at all nowadays?

Yes ❑ go to question 4

No ❑ go to question 3

3. Have you ever smoked a cigarette, a cigar or a pipe?

Yes ❑

No ❑

4. In your most recent outpatient appointment were you asked if you smoked?

Yes ❑ go to q5

No ❑ go to q6

5. Who asked you about this?

Doctor ❑

Nurse ❑

Other ❑

6. Have you been asked in a previous appointment at this clinic?

Yes ❑

No ❑

7. Do you know of any services in Reidpark hospital to help people to stop smoking?

Yes ❑

No ❑

7b. What are they?

.....

8. Do you think that Reidpark should offer such a service?

Yes ❑

No ❑

Don't Know ❑

8b.Why?

.....

9. Do you think that it is appropriate to be asked about smoking when you are attending an appointment at hospital?

Yes ❑

No ❑

Don't Know ❑

Why?

.....

Smokers go to Section Two

Ex-Smokers go to Section Three

Never Smokers go to Section Four

Section Two- Smokers

10. How many:*
Cigarettes do you usually smoke per day_____ / per week_____
(take mid point if range)

Tobacco do you smoke per day_____ / per week _____
(specify ounces or grams)

Cigars do you smoke per day_____ per week_____

11. Before coming to this clinic have you ever discussed your smoking with a GP, hospital doctor, nurse or any other health care worker?

Yes ❑ go to q12

No ❑ go to q14

12. If yes, who raised this issue?

You ❑

Your GP ❑

Another Doctor ❑

Nurse ❑

Other Health Care worker ❑
(could be more than one)

13. Before coming to this clinic where you offered advice, information or counselling to help you to stop smoking?

Yes ❑

No ❑

13b. What kind of help were you offered?

.....

14. In your last appointment were you advised to stop smoking ?

Yes ❑

No ❑

15. Were you offered advice, information or counselling to help you to stop smoking?

Yes ❑ (go to q15b)

No ❑ (go to q16)

15b. What kind of help were you offered?

.....

16. Would you like help to stop smoking?

Yes ❑ go to q17

No, don't want to stop ❑ go to Section Four

No, don't want help ❑ go to Section Four

Don't know ❑ go to Section Four
(if yes help)

17. What kind of help would you like

.....

Now Go To Section Four

Section Three- Questions for Ex-Smokers

18. Did you smoke

Regularly ❑ (go to q19)

Occasionally ❑ (go to q19)

Never (tried them once or twice) ❑ (go to Section Four)

19. How Many

Cigarettes did you smoke per day_____ / per week_____

Tobacco did you smoke per day_____ / per week _____
(please specify ounces or grams)

Cigars did you smoke per day_____ per week_____

20. For how many years did you smoke regularly*

.....

21. How long ago did you give up smoking?

.....

22. Why did you decide to stop smoking?

.....

23. Did anything help you to stop smoking?

.....

Now Go to Section Four

Section Four - Personal

Can I ask you a few questions about yourself?

24. Sex

Male ❑

Female ❑

25. Can you tell me your age?

26. Can you tell me your marital status

Married / Living with A Partner ❑

Separated /Divorced ❑

Single ❑

Widowed ❑

27. Are you in

Full-time work (over 30 hours a week)	❑ **go to Q28**
Part-time work	❑ **go to Q29**
Unemployed	❑ **go to Q29**
Looks after the family full-time	❑ **go to Q29**
In full-time education	❑ **go to Q29**
Sick or disabled	❑ **go to Q29**
Retired	❑ **go to Q29**
Other	❑ **What? ..... go to Q29**

28

a. Can you tell me what your current job is?	
b. What trade, industry or profession is that in?	
c. Are you self employed? How many employees do you have?	**self** **family only** **1-24 emps** **25 or more** **dk**
d. Or an employee	**Manager** **Foreman/super** **Other emp** **DK**

If you do not have a job
Q29

a. Can you tell me what you did before?	
b. What trade, industry or profession was that in?	
c. Were you self employed? How many employees did you have?	**self** **family only** **1-24 emps** **25 or more** **dk**
d. Or an employee	**Manager** **Foreman/super** **Other emp** **DK**

30. What about your partner? Is he/she in

Full-time work (over 30 hours a week)	❑ **go to q31**
Part-time work	❑ **go to q31**
Unemployed	❑ **go to q32**
Looks after the family full-time	❑ **go to q32**
In full-time education	❑ **go to q32**
Sick or disabled	❑ **go to q32**
Retired	❑ **go to q32**
Other	❑ **What? ..... go to q32**

31.

a. Can you tell me what his or her current job is?	
b. What trade, industry or profession is that in?	
c. Is he or she self employed? How many employees does he/she have?	self family only 1-24 emps 25 or more dk
d. Or an employee	Manager Foreman/super Other emp DK

32. If he/she does not have a job

a. Can you tell me what he/she did before?	
b. What trade, industry or profession was that in?	
c. Was he/she self employed? How many employees did he/she have?	self family only 1-24 emps 25 or more dk
d. Or an employee	Manager Foreman/super Other emp DK

Thank you very much

MRC
Medical Research Council

APPENDIX II

Patient Interviews at Outpatient Clinics

This letter is to let you know that you may be approached by Margaret Callaghan while you're waiting to be seen at the clinic or after you've been seen. Margaret may ask if you'd be willing to answer a few simple questions about smoking.

The purpose of this study is to improve services to people who smoke and who attend Reidpark Hospital. We want both smokers and non-smokers to participate so that we can hear as many views as possible.

The questionnaire is short and Margaret will go through it with you. Your name is not recorded and your answers will be kept anonymous. The doctors treating you will not be given any information from this questionnaire.

Your participation is completely voluntary. If you do not want to take part in this study or wish to stop answering questions at any time, you may do so. You don't have to give a reason and your hospital care will not be affected in any way.

Margaret will ask you to sign a consent form which gives your permission to take part in the study. This will be kept separately from the questionnaire – as the survey is anonymous it will not be possible to identify you from your answers.

The study has been approved by the Lanarkshire Health Board Research Ethics Committee. It is being carried out by the Medical Research Council (MRC) in conjunction with Lanarkshire Health Board and Reidpark Hospital.

If you have any further questions about this study or would like to find out the results please contact:

Margaret Callaghan
MRC Social and Public Health Sciences Unit
University of Glasgow
4 Lilybank Gardens
G12 8RZ
Telephone 0141-357-7546

Thank you very much for your help.

APPENDIX III

Time started .....

Time ended .....

1. Context Questions

I'd like to start off by asking you a few questions about yourself to provide some background to the interview.

1.1 Job Title

1.2 Grade / Speciality/ Area

1.3 Description of job tasks e.g. a typical day (follow this up more and let them give a lot of detail)

1.4 Can you tell me about the team you work in? (Who is in charge, who do you report to, who is on your level, who is below you – or who can you delegate to?)

1.5 How do you communicate with your team?

1.6 How much time do you spend with patients and how much on admin / meetings etc.

1.7 Career history? (how did you get to where you are today)? Length of time since qualified?

1.8 Age

1.9 How long have you worked in this hospital?

2. Health Promotion

The questions in the next section are about health promotion generally.

2.1 What would you say health promotion was?

2.2 Is this a health promoting hospital?

2.3 What does that mean to you?

2.4 How much importance does the hospital place on health promotion?

2.5 Who would you say has responsibility for health promotion?

2.6 Do you feel that health promotion is part of your own role?

2.7 What kind of health promotion work do you do?

2.8 Would you give general (opportunistic health promotion) or just related to your speciality?

2.9 Why?

2.10 What stops you doing it (or more)?

2.11 When you were training was health promotion part of your training? (Examples?)

2.12 How much influence do you think you have on patients behaviour?

2.13 How do patients feel about getting lifestyle advice as inpatients / outpatients?

2.14What influence do you think this has on their behaviour?

2.15Would you ever give advice that wasn't relevant to the presenting illness? (for example ask arthritis patient about smoking or give dietary advice to someone who was overweight?)

2.16It's been suggested that every patient attending hospital, regardless of the reason, should be given advice about smoking, What do you feel about this?

2.17Other people say that health promotion has gone too far and that people should be allowed to make their own choices without constantly being made to change. What is your opinion?

3. Smoking Cessation Service

3.1 Do you smoke?

3.2 Have you ever smoked?

3.3 If yes would you use a smoking service to stop smoking?

3.4 Does your smoking status affect the information that you give?

3.5 How many of the patients that you see do you think smoke?

3.6 Do you think that they want to stop?

3.7 Do they want help?

3.8 Do you ask patients about smoking in inpatient / outpatient visits?

3.9 Do you offer support to stop smoking?

3.9.1 What support?

3.10 If not would you be willing to do so? Under what conditions?

3.10.1 Or refer to other services?

3.11 Which patients would you try to help yourself? Which would you refer to someone else?

3.11.1 Is this if patient asks or do you initiate this?

3.12 Do you think it should be part of your job to help patients stop smoking?

3.13 Would you attend training to help patients to stop smoking? Or have you?

3.14 Do you know about the smoking service?

3.15 How did you hear about it?

3.16 Have you met the smoking cessation counsellor – can you tell me more about that?

3.17 Where you involved in any way in the set up of the new smoking service?

3.18 Do you know who was?

3.19 Would you like to have been?

3.20 Have you ever send anyone to it?

3.20.1 Do you know how it works?

3.15 Has this changed how you deal with patients who smoke? (what did you do before that).

3.16 Do you think a smoking cessation service is a good idea?

3.17 Do you foresee any difficulties with this service?

3.18 What would stop patients from using such a service?

3.19 Is this a good place to have it or do you think it is a GP or public health / government type task?

3.20 This service is funded for three years from outside the hospital do you think it would continue to be funded by the hospital after this time?

4 Barriers to Change/Innovation

4.1 Does the hospital encourage change/ innovation/ things being done in a new way?

4.2 Can you think of any other new things which have happened lately

What makes change successful or unsuccessful?

4.3 Is there too much or not enough change?

4.4 Is there anything you would like to change about the way the hospital works?

4.5 How much input do you have into services and policies? (distinguish ward level from hospital level)

4.6 How do you find out about new policies or services?

4.7 Do you feel you are involved in decision making/are listened to?

4.7.1 Would you like to be?

4.7.2 Do you think clinical staff are involved in these decisions?

Is this enough?

4.8 What do you feel about communication in the hospital?

4.9 What about communications with other departments?

4.10 Are there any aspects of your job that you think are unnecessary?

4.11 What is the relationship between clinical staff and management in this hospital?

4.12 Are there aspects which you would like to spend more time on?

4.13 What do you think about the support in your workplace?

4.14 Who would you speak to if you had problems in your work?

4.15 How doe this hospital compare to others that you have worked in?

4.16 How is your morale?

4.1.7 What about morale generally?

Interviewee	Profession	Job Title	Speciality	Reason Chosen
Marianne Findlay	Nursing	Smoking Cessation Specialist		This person ran the smoking cessation clinic
Dr Sitar Gardee	Medicine	Senior Registrar	Respiratory	Has referred several patients and been generally helpful to smoking counsellor
Geraldine Gallagher	Nursing	Diabetic Liaison Sister	Diabetes	Attended meetings on the service and would seem to be pertinent to speciality but never referred anyone.
Carol Branwell	Nursing	Staff Nurse	Coronary Care Unit	Speciality related to smoking and also long serving member of staff who seems to know everyone
Sister Theresa Shergold	Nursing	Ward Manager	General Medical	To ensure a range of positions and specialities

Gillian Thomson	Physiotherapy	Respiratory Physiotherapist	Respiratory	To ensure a range of positions and specialities. Department been difficult for smoking cessation nurse to access.
Siobhan Jones	Cardiology Technician	Electrogardiography technician	Cardiology	To ensure a range of positions and specialities
Kate Squires	Health Promotion	Health Promotion Officer	Health Promotion	Involved in set up of service and in ongoing support
Isobel Murdoch	Nursing	Respiratory Nurse	Respiratory	Gives support to smokers who wished to stop and attended training on cessation techniques
Sylvia Ferguson	Nursing	Rehabilitation Nurse	Cardiology	Mentioned by several people as someone who helped patients change their lifestyle
Morag Peters	Former Nurse	Service	Hospital	Line manager for smoking cessation

		Manager	Management	counsellor, involved in set up of service
Conor O'Connolly	Pharmacist	Junior Pharmacist	Pharmacy	Pharmacy department need to be involved in prescription of e.g. Nicotine replacement therapies and seen to be unhappy with the introduction of the service
Scott McGhee	Manager	Outpatient Manager	Management	Non-clinical manager. Involved in hospital policy and services.
Dr David Cairngorn	Medicine	Consultant Physician	Respiratory	Gained funding for smoking service and ongoing contact person
Helen Robertson	Former Nurse	Associate Nurse Manager	Management	In charge of all nursing staff, involved in hospital policy and service. Had assisted on occasions when there were problems which slowed the progression of the

				project
Dr Michael Mackie	Medicine	Consultant Physician	Infectious Diseases/ Travel Clinic	Consultant working in area with little association to smoking and often in contact with healthy people attending for injections. Also had met him previously and he had discussed guilt felt about lack of health promotion done
Patrick O'Brien	Nursing	Occupational Health Nurse	Occupational Health	This department had been involved in smoking cessation for staff and have conflicted with the new service
Sister Pauline Merrills	Nursing	Outpatient sister	Outpatients	Perceived as unhelpful to smoking counsellor and also is a smoker.
Dr Anthony Lecker	Medicine	Consultant Physician	Gastroentology	To ensure representatives of specialities. In this case one, which has little relationship

		to smoking.
Dr Martin McKendrick	Clinical Director of Central Region	Because of role and had some influence on funding and future funding of the project.

APPENDIX V

Table A Average age by gender

Sex	Mean Age	N	S.D.	Minimum	Maximum	T-Test (p-value))
Male	58.30	212	16.18	14	86	1.62
Female	55.87	200	17.08	17	87	(0.106)
Total	57.24	412	16.65	14	87	

Table B Average age by patient type

Patient Type	Mean Age	N	S.D.	Minimum	Maximum	T Test (p value)
Outpatient	55.20	228	16.26	14	86	1.65
Inpatient	59.77	184	16.83	15	87	(0.005)
Total	57.24	412	16.65	14	87	

Table C Smokers opinions on whether the hospital should offer a smoking cessation service compared to there feelings on whether they would use this service.

	Yes		No		Don't Know		Total		Chi-squared (p value)
Would you like help to stop smoking?	N	%	N	%	N	%	N	%	
Yes	54	77.1	10	14.3	6	8.6%	70	100	7.56
No	34	65.4	15	28.8	3	5.8	52	100	(0.109)
Don't Know	5	45.5	5	45.5	1	9.1	11	100	

Table D Distribution of smoking status by patient type

Do you smoke?	Outpatient		Inpatient		Total		Chi-squared p-value
	N	%	N	%	N	%	
Yes	65	28.5	74	40	139	33.7	6.04
No	163	71.5	111	60	274	66.3	0.014

Table E Were smokers and non-smokers asked if they smoked equally?

		Were you asked if you smoke?				Chi-squared p-value)
		Yes		No		
Do you smoke?		N	%	N	%	
	Yes	92	66.6	47	33.8	18.5
	No	120	43.8	154	56.2	(0.0001)
Total		212	51.3	201	48.7	