TOBACCO HABITS - ATTITUDES AND BELIEFS AMONG THE MALTESE MEDICAL AND DENTAL PROFESSION

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INTRODUCTION

Health professionals, particularly doctors and dentists are the vanguard of any society's battle against tobacco. They are knowledgeable on the impact of tobacco smoking on health and generally receive updated scientific information on this relationship. Doctors and dentists both witness the effects of smoking on their patients, often on a daily basis. They are inevitably viewed as role-models for health-related behaviour, influencing that of their patients as well as their families.(1) In their turn patients are quick to point out particular doctors who smoke as a justification for their own habits. It is, therefore, of particular interest to study the habits of doctors and dentists, as well as their attitudes to this particular form of risk behaviour and to assess their collective views. (In the rest of this paper, the word "physicians" or "health professionals" will be used to stand for "doctors and dentists" as both professions were included in all the analysis).

The World Health Organisation has declared war on tobacco through its "Action Plan on Tobacco" (2). The World Health Organisation Regional Office for Europe has set out a programme of activities towards a Smoke-free Europe including fields in which doctors might act to eliminate the epidemic of diseases caused by tobacco (3). This is understandable in view of the large scale morbidity and mortality wrought throughout the developed world by the tobacco pandemic. Malta is no exception to this scourge, and while accurate and updated data is often unavailable, several indicators point to a sizeable problem among the Maltese population. Among participating centres in the World Health Organisation based MONICA (4) project, in the first population survey (1984), Maltese males aged 35 to 64 years featured second highest with regard to average amount of cigarettes consumed daily by smokers (25 cigarettes per day). Actual prevalence of regular consumption is known to vary considerably by age and sex, being highest in males aged 55-64 years (47.3%) and lowest in similarly aged females (6.5%) (Table A). Cohort influences are known to be responsible in great part for differences among age

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TABLE A

A.1 PROPORTION OF MALES (N=929) IN DIFFERENT SMOKING CATEGORIES BY AGE

Age (years)	25-34	35-44	45-54	55-64
Non-smokers	43.7	46.4	46.7	47.9
Occasional Smokers	11.3	6.4	7.1	4.8
Regular Smokers	45.0	47.2	46.2	47.3

A.2 PROPORTION OF FEMALES (N=944) IN DIFFERENT SMOKING CATEGORIES BY AGE

Age (years)	25-34	35-44	45-54	55-64
Non-smokers	64.9	80.2	84.1	89.2
Occasional Smokers	12.1	9.3	4.6	4.3
Regular Smokers	23.0	10.5	11.3	6.5

Source: MONICA Project (Cacciottolo, J.M., 1990)

TABLE B

SMOKERS AMONG GENERAL PRACTITIONERS COMPARED TO THE WHOLE POPULATION IN 1988 IN EEC COUNTRIES

Country	G.P.'s	Population	Difference
United Kingdom	10%	35%	-25%
Ireland	20%	37%	-17%
Netherlands	29%	45%	-16%
Belgium	29%	39%	-10%
Denmark	38%	45%	-7%
Germany, F.R.	25%	32%	-7%
France	31%	35%	-4%
Greece	39%	42%	-3%
Luxembourg	36%	33%	3%
Spain	45%	41%	4%
Italy	41%	33%	8%
Portugal	39%	27%	12%
Total		**36%**	**35%**

Source: Commission of the European Communities, 1989.

TABLE i

NUMBER AND PROPORTION OF SMOKING PHYSICIANS BY AGE.

Age	Daily or Occasional smokers		Number of Physicians in this age-group
	n	% of all physicians in age group	
20-29	39	26.4	148
30-39	20	30.8	65
40-49	16	25.0	64
50-59	9	22.5	40
60-69	11	21.2	52
70-79	4	14.3	28
80+	1	25.0	4
Not known	1	100.0	1
Total	**101**	**25.1**	**402**

groups, for which close attention is given to the habits and attitudes of younger individuals.

Smoking habits among health professionals are known to be at variance with those of the population in general (5,6). A recent Commission of the European Communities report (7) quoted lower prevalences of tobacco consumption among general practitioners than populations in Northern Europe while a reversal of this phenomenon was seen in Southern Europe (Table B). In view of the marked similarity in the mortality and morbidity picture presented by the Maltese population with that from countries in Northern Europe (despite the geographical position) a similar comparison between Maltese health professionals and the population at large with regards to smoking habits would seem appropriate.

OBJECTIVES AND METHOD

In an effort to standardize the monitoring of progress of action against tobacco, the World Health Organisation Regional Office for Europe, in collaboration with the International Union Against Cancer (UICC) and the American Cancer Society, prepared a questionnaire which could be modified according to characteristics in the various countries (3). The questionnaire was formulated with the purpose of:

(1) collecting baseline date from which subsequent change could be demonstrated;
(2) providing information as a basis for planning and policy formulation towards the reduction of smoking, especially in the health professions as role leaders;
(3) providing information for the general public, promoting the trend against tobacco amongst the health professionals, especially in view of the health dangers posed by tobacco;
(4) reinforcing the health education role among health professionals, particularly within their working environment; and
(5) to emphasize the role of physicians in influencing policy, politicians and planners at every level.

With these objectives the Health Services Information Unit in collaboration with the Health Education Unit, both of the Department of Health, set forward to conduct the first such survey among doctors and dentists in April 1989. No sampling was considered necessary as the 900 or so total registered was considered a practical working number. The standardized World Health Organisation questionnaire (16 questions) was used unmodified as no alterations were considered necessary.

In April, 1989, questionnaires were posted to all listed practitioners according to lists held within the Health Service Information Unit. A reminder was sent several weeks later to encourage non-responders.

Confidentiality was considered of vital importance in achieving validity and was respected throughout the stages of this study.

In presenting the results simple statistical means and proportions (percentages) are used. Where further illustration was considered useful, distribution tables were also prepared. In the analysis of differences between proportions, the standard error was compared and tested for significance. Inevitably, only selected data could be compared, presented and tested.

RESULTS

Four hundred and two individuals answered the questionnaire and returned it to the Health Services Information unit. They included three hundred forty-seven males and fifty-five females. There was a predominance of younger participants (37% were aged 20-29), especially among females. Married individuals (300 in all or 75%) exceeded single, separated, or widowed ones. These characteristics may well be a reflection of those of the entire population of physicians. The response rate of 45%, while low, was comparable to that of other surveys of this type among health professionals in other countries (8,9,10). The overall present day prevalence of tobacco smoking (daily or occasional) in this group was of 25%. Table I presents the data for current smoking habits, by age group, among responders. Theprevalence was highest among the 30-39 year category, and appeared to diminish slightly with age. Small numbers rendered the oldest groups difficult to evaluate.

Table II shows the distribution of respondents by past smoking habit (ever smoked and ever smoked daily for at least 6 months) and sex. At one time or another in their lives, as many as 60% of respondents actually did take up smoking (235), however, about one in three of these did not continue to do so for 6 months or more. Females (who were younger on average) were less likely to start smoking at all (36%, as opposed to 62% or males), and more likely to stop within 6 months. Just over 70% of males who started to smoke continued to do so for at least 6 months, while only 40% of females persisted with their habit.

The present smoking habits of those who have smoked at some time in their life were examined, as seen in Table III. Only 65 (28%) actually still smoked on a daily basis. It was interesting that only 1 female (of 55) actually smoked every day at the time of the study. Reviewing the previous table confirms that a further 3 of 8 female physicians who have smoked for at least six months at some time in their life went on to give up the habit. This leaves an overall present day prevalence of 9% daily and

TABLE ii

SEX DISTRIBUTION OF DURATION OF SMOKING

Duration of Smoking	Males n (%)	Females n (%)	Total
Never smoked	132 (38.0)	35 (63.6)	167 (41.5)
Ever smoked (subdivided below):	215 (62.0)	20 (36.4)	235 (58.5)
Smoked daily > 6 months	153 (44.1)	8 (14.5)	161 (40.0)
Smoked daily < 6 months	61 (17.6)	12 (21.8)	73 (18.2)
No answer	1 (0.3)	0 (0.0)	1 (0.2)
Total	**347 (100)**	**55 (100)**	**402 (100)**

TABLE iii

SEX DISTRIBUTION OF SMOKING HABIT

Smoking Habit	Males n(%)	Females n (%)	Total
Daily	64 (29.8)	1 (5)	65
Occasionally	32 (14.9)	4 (20)	36
Not at all	118 (54.9)	15 (75)	133
Not Applicable	1 (0.5)	0 (0)	1
Total	**215 (100)**	**20 (100)**	**235**

TABLE iv

PERSONAL FORECAST OF SMOKING STATUS IN FIVE YEARS' TIME

Probability of being a smoker in five years time	Males		Females		Total	
	N	(%)	N	(%)	N	(%)
certainly	3	(1.4)	0	(0.0)	3	(1.3)
probably	39	(18.1)	1	(5.0)	40	(17.0)
probably not	52	(24.2)	4	(20.0)	56	(23.8)
certainly not	117	(54.4)	14	(70.0)	131	(55.7)
left out	4	(1.9)	1	(5.0)	5	(2.1)
Total	**215**	**(100)**	**20**	**(100)**	**235**	**(100)**

TABLE v

SMOKING POLICY IN WAITING-ROOM BY SMOKING STATUS OF PHYSICIANS

Smoking policy in waiting room	Smokers N	(%)	Ex-Smokers N	(%)	Non-Smokers N	(%)	N/A N
Allow smoking in waiting room	25	(36)	21	(26)	32	(30)	0
Prohibit smoking in waiting room	44	(64)	61	(74)	73	(70)	1
Total	**69**	**(100)**	**82**	**(100)**	**105**	**(100)**	**1**

occasional female smokers, as compared with 28% among men - a statistically significant difference.

It was observed that most ex-smokers claimed to have quit more than two years previously, in those replying to this question (126 of 139 or 90%). With regard to the type of tobacco smoked, all females and most males show an expected preference for manufactured cigarettes. The pipe and cigars were next in order of preference among males (12% and 9% respectively). It was interesting that at the time of survey one male was consuming chews in a possible attempt to desist from further smoking.

The above and several other findings point to an anti-tobacco trend among health professionals. This impression was confirmed by the result of self-forecasting of future smoking (within 5 years) as seen in Table IV. Only three respondents (constituting 1.3% of smokers) considered it a certainty that they would be smoking in 5 years. Adding those replying 'probably' to this question raises the figure to 43 (or 18.3% of smokers), equivalent, if it proved true, to a prevalence of only 11% of tobacco smoking amont the professions. Female respondents were, in their great majority, predicting to be 'probably' or 'certainly' not smoking. Only one female, of the 20 to ever smoke, predicted that she would probably be smoking in five years time.

A great majority of smoking health professionals considered it unwise to smoke in front of patients (90%, 95% females), recognising their position as models of behaviour. In a similar way, approximately 70% of all practitioners with waiting rooms did no tallow smoking there. Health professionals thus feel the need to express their prohibition of smoking in their clinic environment in order to set an example and to minimise the nuisance effect on non-smoking ill persons sharing the room.

The prohibition of tobacco smoking in waiting rooms was further analysed, where applicable, according to smoking habit (Tablve V). It was seen that physicians who are themselves ex-smokers are least tolerant of smoking in their clinics; non smokers are next, followed by active smokers (26%, 30% and 36% respectively allow smoking). The other side to these results is that approximately one in three practicing physicians do not expressly prohibit smoking in their own premises.

The frequency of anti-smoking advice given according to patients' medical condition (Tablve VI A) was studied. Lung and pulmonary, heart, peptic ulcer and pregnancy conditions were all considered worth giving advice in a majority of cases (over 70%). Health professionals were identifying the direct causative association between tobacco and these diseases/conditions. However advice against smoking for upper respiratory conditions, oral contraception and mouth lesions was given less often (30-70%) despite a known effect on cancers of the mouth and a precipitation of side effects for oral contraceptives with tobacco smoking. Both male and female physicians tend to agree in these priorities for anti-smoking advice and were found to deliver advice equally for the same conditions.

Frequency of advice given was also examined for smoking and non-smoking physicians separately (Table VI B). The figures show that in most cases smokers are less likely to give anti-smoking advice. The differences between the two groups was most marked (and reached a degree of statistical significance) in cases of "mouth or lip lesions", "nervousness, loss of appetite and insomnia" and especially for "any condition". These differences may bring to light an attitude of (conscious or subconscious) rejection of any tobacco responsibility for any but the strongest and most publicised associations found in medical literature.

Anti-smoking advice-giving habits were also examined: for patients with smoking-related diseases; when patients raised the question about smoking themselves; when smokers with non smoking related diseases do not themselves raise the question about smoking (Table VII). In the first two circumstances patients were very likely to get anti-smoking advice (93% and 88% respectively). However, smokers with non-related conditions were as likely as not to be advised by physicians (48%). Thus, while on-demand advice is clearly given, health professionals seem less likely to volunteer advice. These results were examined in the light of physicians' own tobacco habit (Table VIII). Ex-smokers and non-smokers (to a lesser degree) were in each case more likely to volunteer advice than current smokers. The ex-smoker tends to be selected into this category by possible bad experience with tobacco which may facilitate the ease with which he gives advice. This underlines a latent potential for health promotion in convincing health professionals who smoke to give up the habit.

Motivation for non-smoking was examined by asking the respondents to rank a number of commonly quoted reasons (Table IX). This was studied separately for smokers and non-smokers in an effort to understand underlying differences in their attitudes to smoking. It was clear that protecting one's health was of foremost importance for smokers and non-smokers alike, although non-smokers were significantly more in number in subscribing to this view. This was also true for avoiding unpleasant symptoms where it was clear that many smokers would have accepted some of the more minor side effects to tobacco smoking. Consideration for giving a good example and avoiding discomfort to others was next in importance in both groups, with a majority of participants ascribing (equally) to this view in both. Friends and family appeared particularly more effective in pressuring

TABLE viA

SMOKING ADVICE GIVEN ACCORDING TO MEDICAL CONDITION OF PATIENT

Percentage of doctors frequently (>70% of cases) giving specific stop-stop-smoking advice:	Medical Condition for which smoking advice is given
70-100% of doctors	Pulmonary disease Heart Disease Peptic Ulcer Pregnancy
30-69% of doctors	Upper respiratory conditions Oral Contraceptive Users Mouth lesions
<30% of doctors	Nervousness Insomnia Other

TABLE viB

LIKELIHOOD OF GIVING STOP-SMOKING ADVICE ANALYSED BY SMOKING STATUS OF PHYSICIAN

Medical condition	Proportion of physicians giving stop-smoking advice for patients with this condition		Significance of difference
	Smoking physician (N=101)	Non-Smoking physician (N=301)	
Lung/Pulmonary conditions	89.1	88.0	n.s.
Upper respiratory conditions	60.4	67.7	n.s.
Heart conditions	88.1	82.7	n.s.
Peptic Ulcer	70.3	73.0	n.s.
Pregnancy	85.1	82.3	n.s.
Use of oral contraceptives	44.6	52.7	n.s.
Mouth/Lip Lesions	36.6	49.3	$p<0.05$
Nervousness/Loss of appetite	15.8	27.3	$p<0.05$
Any condition	16.8	33.3	$p<0.01$

TABLE vii

REPORTED FREQUENCY OF NON-SMOKING ADVICE GIVEN IN RESPONSE TO NEED AND DEMAND

Frequency with which anti-smoking advice is given	For patients with smoking-related diseases N (%)	When patients ask N (%)	All other patients N (%)
Often	375 (93)	355 (88)	192(48)
Sometimes	11 (3)	23 (6)	126(31)
Seldom	0 (0)	2 (0)	55(14)
Never	0 (0)	0 (0)	12 (3)
Not applicable	16 (4)	22 (5)	17 (4)
Total	**402(100)**	**402(100)**	**402(100)**

smokers than was thought to be the case by non-smokers. This finding was of particular importance as it showed a clear direction for efforts in anti-smoking campaigns. On the other hand, peer pressure by colleagues, at this age anyway, was not the forceful argument for non-smoking that one might have expected it to be.

Agreement to certain statements relating: to adequacy of current knowledge for anti-smoking counselling; to smoking in hospitals; and to specific training of health professionals was assessed (Table X). Actual overall agreement with the statements is first presented and expressed as a percentage with 95% confidence intervals. It is seen that about two of every three health professionals questioned felt sufficiently prepared to counsel people on quitting smoking (despite having not benefitted from specific training themselves) while more than three out of four went on to express the need for more training about smoking cessation and prevention. There was also evident agreement as to the importance of banning or restricting smoking in hospitals.

These opinions were then re-examined in the light of responders' smoking habits. It was observed that experience with smoking (ex-smokers and non-smokers) led to a greater reporting of "sufficient knowledge" for counselling (81% ex-smokers, 72% smokers as opposed to only 55% of those who have never smoked). Another noteworthy finding, especially from the public health point of view was the subscribing of smoking physicians in their great majority (92%) to the view that smoking should be banned or restricted in hospitals.

With regards to comparisons between smoking habits among General Practitioners (and dentists in the local case) as compared to that among the general population, the local figures are of 25% for General Practitioners (daily and occasionally) versus an average of about 20% for a comparably aged Maltese population. However when one considers only the male practitioners (who were the majority of General Practitioners in the study) and the male general population (who are the great majority of smokers) then these figures re-adjust to 28% for male practitioners and 53% for the male adult population, that is considerably lower for the population as was found in Northern Europe.

DISCUSSION AND RECOMMENDATIONS

The medical and dental professions can act to combat the smoking epidemic as a pressure group, through education and by effecting environmental change at the micro level.

As a pressure group, physicians are potentially the strongest lobby in the fight against smoking. This has already been demonstrated in Malta when a declaration from the Medical Department of the Faculty of Medicine and Surgery triggered stronger legislation against tobacco (11). The power of the profession in this field lies in the fact that it is objective, has no financial interest in tobacco sales and is clearly motivated solely by an interest in public health. The strength of the medical lobby and the difficulties it will face, have been demonstrated by the British Medical Association which has set up a concerted action against tobacco in the United Kingdom (12).

Educational strategies and techniques have a central role in the fight against tobacco. In the clinical setting, doctors must counsel their clients on the health impact of tobacco. This study shows that they already do so in the setting of such conditions as chronic obstructive airways disease. They need to become more aware of the need to provide anti-tobacco advice in the setting of conditions that are less obviously connected with smoking (such as for clients on oral contraceptives).

Ex-smokers tended to give anti-tobacco advice more often than either smokers or non-smokers (Table VIII). It is not possible to tease out cause and effect here. Does increased militancy in ex-smokers result from some unpleasant experiences due to tobacco which caused them to quit in the first place? Or could it be that their conviction on the association between tobacco and disease caused them first to quit and then to try and convince their patients to follow suit? It is clear that ex-smokers are a special group of physicians with a strong motivation to combat the epidemic. Future versions of this study could focus further on doctors' reasons for quitting in the hope of obtaining a hierarchy of motives for stopping smoking among doctors. This would assist planning of educational campaigns, both for physicians and for the general public.

There is a further need identified in this study: for the provision of training on methods of smoke cessation for the professionals. Opportunities for this lie in existing programmes for undergraduate training and for continuing professional development. The need for such training is reinforced by research showing that general practitioners can be highly effective in bringing about the cessation of smoking (13).

The whole community may be regarded as a client in need of education. Doctors and dentists servin gdefined communities will find ample opportunities to give local talks and discussions. Professionals doing this should emphasise the benefits of a smoke-free lifestyle and focus on prevention rather than discussing only the harmful effects of tobacco use.

Doctors and dentists often gain

TABLE viii **LIKELIHOOD OF VOLUNTEERING ANTI-SMOKING ADVICE BY SMOKING STATUS OF PHYSICIAN**

Often given advice	SMOKING STATUS OF PHYSICIAN			
	Smoker	Ex-Smoker	Non-Smoker	AVERAGE
Patients with smoking-related diseases	84%	93%	93%	91%
On-demand	87%	89%	89%	88%
Other patients	39%	54%	48%	48%

TABLE ix **RANKING OF MOTIVES FOR NON-SMOKING ANALYSED BY SMOKING STATUS OF PHYSICIAN**

Reason for non-smoking	Proportion replying that this reason was "important"		Significance of difference
	Smokers (N=101)	Non-Smokers (N=301)	
To protect your health	90.1	96.7	p<0.05
To avoid unpleasant symptoms	62.4	73.0	p<0.05
Peer pressure (colleagues)	9.9	6.0	n.s.
Not to create discomfort	65.3	55.0	n.s.
To set a good example	56.4	59.7	n.s.
Pressure by friends and family	30.7	13.7	p<0.01

TABLE x **OPINIONS OF ALL PHYSICIANS ON THE NEED FOR ENVIORNMENTAL AND EDUCATIONAL CHANGES**

	Number who agree (out of 402) n (%)	95% Confidence Intervals
My current knowledge is sufficient to counsel patients on smoking	274 (68)	64 - 73
Need to abolish/restrict smoking in hospitals	385 (96)	94 - 98
Need to train professionals specifically in methods of helping patients quit	346 (86)	83 - 89
Need to train health professionals in smoking prevention	347 (86)	83 - 90

influential positions in their community, as members of various committees and activity groups. They may use this position to suggest environmental measures that will help to foster a smoke-free society. Does the local youth group condone smoking? If you are a company doctor, does your company have a non-smoking policy? Do sports clubs which accept tobacco sponsorship ever hear the arguments against this from medical practitioners associated with the clubs? Why are not all medical waiting-rooms explicitly smoke-free?

This study provides a snapshot of the tobacco-related attitudes, beliefs and practices among doctors and dentists in Malta at one point in time. It is generally a picture of tobacco as a dying habit among the professions. Smokers are a minority and most foresee that they will have stopped smoking in five years' time. The respondents supported anti-smoking activities in general. A majority of smoking physicians, presumably conscious of their position as role models in health behaviour, reported abstaining from tobacco in front of their patients.

It is recommended that a similar study is organised in five years' time to analyse trends. Hopefully this publication may encourage a higher response rate in the future study to help ensure greater validity in the trends observed. The trend in smoking among the health professions has the potential to set a powerful example to the community at large. It is hoped that this study may help stimulate personal and professional action for health.

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