

Tobacco Cessation Delivery by the HCPs-Status Quo Report of a Private Hospital in India

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Abstract

Background: The engagement of the HCPs in tobacco cessation delivery is suboptimal globally.

Objective: The study was done to assess the status of HCPs participation in tobacco cessation delivery in a private healthcare setup.

Methodology: A third party proforma-based one-to-one survey was planned among 115 consultants of the hospital.

Results: Fifty HCPs (43.47%) participated. Twenty three (46%) reported that their tobacco using patients inquired about quitting while 26 (52%) reported on seeking a referral, either always or sometimes. Only 16 (32%) treated their tobacco using patients; out of the rest, 17 (34%) each either did not treat or answer for their inability to engage. While 26 (58%) made at least 2 referrals per week to the TTC, among the remaining 21 (42%) who did not, 2 (4%) did not because they could treat independently, 16 (32%) despite offering no treatment while remaining 3 (6%) reasoned it as “not applicable” (to them).

Conclusions: To improve on HCPs engagement, there is a priority need to have a systems approach introduced for treating tobacco dependence along with HCPs training and participation in tobacco cessation that is sustainable.

Keywords: Tobacco; Dependence; Cessation; Quitting; Hospital; Health Care Professionals (HCPs)

Abbreviations

FCTC: Framework Convention on Tobacco Control; LMICs: Low- and Middle-Income Countries; HCPs: Health Care Professionals; GATS: Global Adult Tobacco Survey Report of India; TTC: Tobacco Treatment Clinic

Introduction

The WHO advises that the HCPs, besides raising awareness that “the quitting benefits and does so regardless of the age” [1], should screen and treat all tobacco using patients vide Article 14 of FCTC on demand reduction measure concerning tobacco cessation and treatment [2]. Even though the access and availability of tobacco control measures have improved globally, there is a huge challenge of the delivery of tobacco cessation services in LMICs [3].

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While there is an upsurge in emphasis to promote and deliver tobacco dependence treatment, the HCPs have been either ignorant about delivering tobacco dependence treatment or declining it due to (1) lack of time or financial incentive, (2) a mismatch to their qualification or specialty or (3) their being tobacco users currently. Also, there are additional factors such as their (a) lack of sensitivity to its priority need despite epidemic status of tobacco-use ubiquitously; or, (b) inability and/or indifference to integrate a public health perspective to their routine of clinical practise [6,7]. In recent years, doctors engagement in asking and advising to quit has definitely been on rise, but several studies worldwide have reported doctors inability to motivate users to quit, providing them an optimal assistance or to follow them up optimally between 60% to 76% [8-12].

Between the two rounds of GATS conducted at an interval of 7 years- GATS 1 [4] in 2009-10 and GATS 2 [5] in 2016-17, India has not been able to overcome the barrier of suboptimal delivery of tobacco cessation by the HCPs [4,5]. Overall, 62% smokers and 73% users of smokeless tobacco do not even get an advice to quit [5]. It has significantly impacted the quit rate in a high burden country like India that still has a quit rate below 2% at population level and 16.8% and 5.8% respectively for current smokers and users of smokeless tobacco [5].

While the National Tobacco Control Program (NTCP) [13] of India mandates the delivery of tobacco cessation, the larger proportion of the health sector being private still remains deprived of the service. But what if there is availability of a TTC in a private health setup with its conduct on a daily basis!? This study reports its status in presence of such a setup in reference to the HCPs participation in tobacco cessation delivery.

Objective of the Study

The present study was undertaken in a tertiary care, multi-specialty private hospital in India to determine the current status of participation of the HCPs in tobacco cessation delivery.

Method

This quantitative study was conducted in the month of May 2019 in a multi-specialty tertiary care hospital in Jaipur, India having a TTC under its De-addiction Department since September 2017. A questionnaire was structured to assess engagement of HCPs in either after treating or referring them to the TTC to unravel their practice of tobacco cessation.

Following questionnaire was structured after due deliberations with the Hospital Administration in view of the sensitivity involved of the participants to respond on their behaviour for preventive health-service whereas such is not the perceived norm in their current practice as a clinician nor such a study has ever been conducted in-house:

1. As a Medical practitioner do you feel Tobacco is a serious health problem in India
Answer: Strongly agree/ Agree/ Not sure/ Disagree/ Disagree totally
2. The ongoing tobacco cessation strategies at National & State- levels are insufficient and are largely confined to media, slogans, TV shows, without making significant ground impact.
Answer: Strongly agree/ Agree/ Not sure/ Disagree/ Disagree totally
3. Who can be major key player/s for successful tobacco cessation?
(i) _____; (ii) _____; (iii) _____
4. As you have a good rapport with your patients, do they inquire about:
A. Tobacco cessation
Answer: Always/Sometimes/Seldom/Never
B. Treatment specific referral from you?
Answer: Always/Sometimes/Seldom/Never

5. Do you feel that SDMH is adequately working for tobacco cessation?
6. Answer: Y/ N (If answered "Y", go to 5.A; If answered "N", go to 5.C)
 - A. How many do you treat yourself every week ___?
 - B. How many do refer to the in-house tobacco treatment clinic every week ___? And,
 - C. Please suggest additions/alterations to its delivery:
 - (i) _____; (ii) _____; (iii) _____

For introducing it to the HCPs in a manner that will eliminate a bias of in-house promotion of TTC, a Hospital Management student of a health management university, posted in the hospital for her 3-months internship, was engaged for one-to-one approach as a usual administrative approach through a group mail was considered to have a higher likelihood of "no response" with HCPs giving an excuse of "a miss" due to busy clinical schedule. The intern, after her due empowerment in conducting the assessment, visited offices of all the 115 HCPs, often more than once to match with their convenience and readiness to fill-up the survey proforma.

The findings, thus obtained, from 50 willing participants in a non-randomized manner over a period of 30 days, were entered in an excel sheet and analysed for a cumulative frequency of their responses in percentage.

The sole criterion for exclusion from the study was the non-availability of any consultant despite three visits to his office on three separate days in a week during the working hours (9AM to 5PM).

Results

Fifty HCPs (43.47%) participated in the study in a non-randomized manner from a total of 115. With a male-female ratio of 4:1, 64% (34 HCPs) were between the age groups of 41 - 50 and 51 - 60 years respectively (Table 1). Their ratio of being a generalist vs. a specialist was almost equal (26:24; 52% vs. 48%) (Table 2).

All concurred that tobacco is a serious health problem for India; while 38 (76%) agreed strongly, the rest 12 (24%) too were in agreement.

Seventeen (34%) participants strongly agreed that both nationally and in the State, the ongoing tobacco cessation strategies are insufficient and are largely confined to media, slogans, TV shows, without making significant ground impact. Among the rest, 26 (54%), 6 (12%) and 2 (4%) respectively responded as "Agree", "Do not know" and "Disagree".

Ten (20%) HCPs observed that their tobacco using patients "Always" ask for quitting whereas those being asked only "Sometimes", "Seldom" and "Rarely" were 13 (26%), 13 (28%) and 12 (24%) HCPs respectively whereas 1 each (4%) responded as "Did not know" and "Did not answer".

Eleven (22%) HCPs stated that their tobacco using patients "Always" seek a referral for quitting tobacco", whereas those responding as "Sometimes", "Seldom" and "Rarely" were 15 (30%), 16 (32%) and 6 (12%) HCPs respectively. Among the rest, 1 each (4%) responded as "Did not know" and "Did not answer".

Sixteen (32%) HCPs observed to be treating more than 1 patient per week for a mean of 6, whereas another 17 (34%) observed treating "none". The rest 17 (34%) gave no answer.

On question "How many patients are referred by him/her every week to the TTC?", 29 (58%) observed referring for a mean of 2 patients per week whereas 8 (16%) HCPs declined making any referrals. Two HCPs (4%) referred "none" because they also could treat for tobacco dependence and another 6 (12%) neither treat nor refer any to the TTC whereas out of the rest 13 (26%), 10 (20%) gave no answer and 3 (6%) replied as "not applicable".

Age (Years)	Female (%)	Male (%)
Below 30	1 (2)	-
31 - 40	2 (4)	9 (18)
41 - 50	2 (4)	13 (26)
51 - 60	2 (4)	15 (30)
61 - 70	1 (2)	2 (4)
Over 70	2 (4)	1 (2)
Total	10 (20)	40 (80)

Table 1: HCPs distribution age- and gender-wise.

Qualification	Number (%)
Generalists	26
Otolaryngologist	3 (6)
General Surgeon	2 (4)
Gynaecologist and Obstetrician	4 (8)
Internist	9 (16)
Orthopaedic surgeon	5 (10)
Ophthalmologist	1 (2)
Paediatrician	1 (2)
Psychiatrist	1 (2)
Specialists	24
Cardiovascular Surgeons	2 (4)
Cardiologists	3 (6)
Gastroenterologists	4 (8)
Gastroenterology Surgeons	1 (2)
Neurologists	3 (6)
Paediatric Cardiologist	1 (2)
Paediatric Gastroenterologist	1 (2)
Paediatric Surgeon	1 (2)
Plastic surgeon	1 (2)
Pulmonologist	3 (6)
Urologist	4 (8)

Table 2: HCPs distribution as per their qualification.

Discussion

While the GATS 2 [4] reported that less than 20% tobacco users desire quitting it in next 12 months [4] at population-level, the finding of 46% patients enquiring about quitting in the present study was not an unexpected outcome because patients attending a private health

sector hospital with a relatively higher educational and socio-economic status, usually have higher awareness to the harmful effects of tobacco. But, the HCPs observation of 52% patients seeking a “referral to quit” was definitely an unexpected finding.

The HCPs ability to treat tobacco dependence varied between 19% to 40% in the studies reviewed [8-12]. This matches with the finding observed in the present study of 32% HCPs reported treating tobacco use in their patients. But it also reflects, covertly though, of the inability to act similarly in the rest 68% HCPs in the present study and between 60% to 76% in the other four studies referred herein [9-12].

The observance from this study of 58% HCPs making at least two referrals per week to the TTC in a tertiary care hospital with an average daily foot-fall of over 750 patients should have received over 400 patients every week. Since the TTC is managing an average of 14 patients per week despite the fact that this oldest private-sector hospital caters to ~100 million inhabitants of two States- Rajasthan and Haryana, and that a mixed and overlapping group of 42% HCPs who neither made any referral (16%) nor treated or revealed as to why they do not, indicates the need of another study to unravel the solutions to the poorer participation of both groups of these HCPs. That it was observed despite: (a) a near-total concurrence on (1) tobacco as a serious health issue, (2) the cessation strategies and therapies are insufficient and (3) doctors are the top key player; and (b) several motivational administrative, academic and personal approaches, the need of improving intent and competence of HCPs to assist in tobacco cessation should be a top priority. Other studies too have demanded it similarly [7,9-12,14-18].

One way to do it effectively is through the hospitals by incorporating a systems approach to deliver tobacco dependence treatment. It has inherent benefits of: (1) the right mix of managerial, clinical and societal participation to motivate and assist tobacco users to quit; (2) an anticipated higher willingness of tobacco users to quit while being onsite and when their doctor/nurse recommends it; and (3) saving costs on account of a visit “some other time” or eventually due to their potential to suffer and get treated for a tobacco-related illness. That its integration should occur at all levels of healthcare and in both, governmental- and private- health sector at an earliest needs no emphasis. Further, its comprehensiveness to “screen, treat and follow-up” can help the willing tobacco users can quit in a higher number to result into an overall increase in quit rate [7,14-18].

Limitations

Although, the hospital reception screens for tobacco use by its patients, the present study could not assess if the HCPs asked their patients to quit due to an administrative guideline for not asking any personalized questions in view of the HCPs sensitivity. Due to the same reason, the present study did not assess HCPs on frequency of an advise given to quit. Both limitations on review of similar studies [8-13] revealed that (1) 70% to 100% HCPs asked their patients to quit; and, (2) about 24% to 60% HCPs gave an advise to quit; the latter observation matches with the frequencies reported in India for both current smokers and smokeless tobacco users attending a health facility- 48.4% and 31.7% respectively [5].

Conclusion and Recommendations

Since the HCPs engagement in tobacco cessation delivery, both in treating tobacco using patients and making referrals to the TTC was found suboptimal, the present study recommends implementation of a systems approach through a policy adopted formally by the hospital on priority. All the HCPs should be trained for tobacco cessation delivery through a specifically structured program that suits the complexity of the management and administrative setup of the hospital and socio-economic and educational norms of tobacco using patients. Its sustainability along with its surveillance on a regular basis to call for an accountability will be very useful for achieving their higher engagement over a longer term. In a private setup, it is critical that the HCPs receive suitable remittance and/or incentives for their optimal engagement. The current flaws in the existing referral system to the TTC and HCP as well as patient-related issues need another in-depth study.

Conflict of Interest

There is no conflict of interest.

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