

## Breaking the smoking habit in Malta

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**ABSTRACT:** Between 1991 and 1996, under the auspices of the Department of Health Promotion, the author led 14 smoking-cessation clinics in Health Centres in Malta. In their application for attendance at these clinics, smokers were asked to complete a questionnaire on their smoking habits. This study discusses the answers to these 363 questionnaires with regard to knowledge of health effects of smoking (28% did not think they would be much healthier when quitting), nicotine addiction and desire to quit (87% felt dependent 'a lot' on smoking while 94% believed in quitting with help), and the power of tobacco advertising (50% started smoking before 16 years of age) among this select group of smokers. Recommendations are made on the role of family doctors regarding the education of patients on the health effects of smoking, the provision of understanding and help to would-be quitters, and the lobby for an effective anti-tobacco-policy, including childhood education on tobacco, stronger health warnings, smoke-free public places, advertising bans and increased taxes on tobacco.

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### Background

In developed countries, tobacco smoking has reached epidemic proportions and poses a series of public health problems. According to the World Health Organisation figures<sup>1</sup>, in the early 1990's 42% of males and 24% of females in developed countries smoked, while in developing countries the corresponding percentages were 48% and 7% respectively. The Primary Care Survey<sup>2</sup> carried out in Malta in 1992 showed that 40% of men and 18% of women smoke. Clearly social and cultural factors may possibly explain the gender differences between developed and developing countries.

Looking at the tobacco problem in Maltese adults in the mid-1980's, more than half of the 25 to 64 year old men and a fifth of the women smoked, the male prevalence of smokers being one of the highest when compared with the other centres in the 1984 MONICA Survey<sup>3</sup>. While some men appear to have started to give up this habit, more young women are beginning to smoke, and if the high prevalence of smoking in younger women continues as they grow older, a marked increase in smoking related diseases in women can be expected<sup>4</sup>.

Among Maltese adolescents, cigarette smoking is common. 31% of the 20,815 schoolchildren aged 11-16 who took part in a Caritas/Pride/DISCERN Survey<sup>5</sup>

(1991) stated that they had smoked at least one cigarette in the course of the year that preceded the survey. In the ESPAD Study (Malta)<sup>6</sup> of secondary school students (1995), experimentation with smoking was found to be 'very predominant' with one out of every two students having smoked at some time.

### Introduction and Aims

Between July 1991 and June 1996, the author led 14 smoking-cessation clinics in Floriana and Qormi Health Centres in Malta, under the auspices of the Department of Health Promotion. As part of the application process, smokers were asked to complete and submit a form, which also served as a questionnaire to collect information on their smoking habits.

The aim of this study is to analyse and comment upon smoking habits among a self-selected cohort of Maltese smokers. It is based on the answers to 363 questionnaires and seeks to draw conclusions and recommendations that are relevant to family doctors as regards their role in fighting the tobacco epidemic.

Although the data only involves smokers who applied to take part in 14 smoking-cessation clinics, the study provides insight into the habits of Maltese smokers who most desire to quit. This type of smoker would also probably turn to the family doctor for help and advice in quitting, and it is proposed that the information gathered and presented is of special interest to the Maltese family physician.

### Method

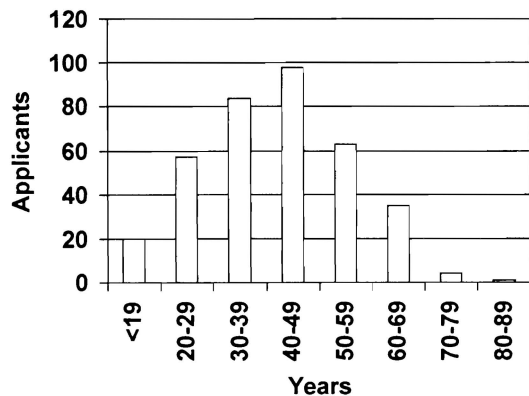
Applicants for smoking-cessation clinics organised by

the Department of Health Promotion do so both of their own free will and after the recommendation of health care professionals, relatives or friends. All 363 applications for the 14 consecutive clinics facilitated by the author were processed retrospectively, with the following results.

**Results**

Of the applicants, 68% (n=247) were male, with ages varying from 15 to 82 years (Figure 1).

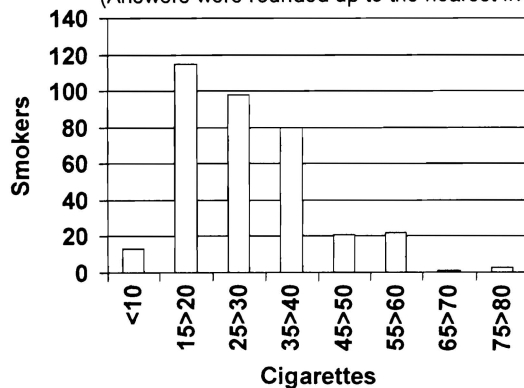
Fig. 1 - Age groups of applicants.



Smoking-cessation clinic applicants were a highly motivated group, with 94% believing that the clinics could help them quit. 57% of applicants expressed a confidence in their ability to rid themselves of their tobacco habit by believing they would not be smoking at least one year following the clinic, while another 18% were unsure.

50% of applicants started smoking before they were sixteen, with another 33% falling victims to the habit during their late teens; one applicant actually started smoking at the age of 7 years. Figure 2 shows the amount of cigarettes smoked every day by the applicants - 94% smoked 15 or more daily. The vast majority (97%) smoked filtered cigarettes, with 62% preferring one particular brand.

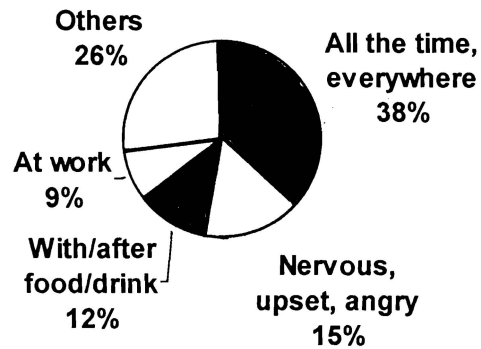
Fig. 2 - How many cigarettes do you smoke daily? (Answers were rounded up to the nearest five)



A feeling of heavy dependence on tobacco was described by 87% of applicants, with 62% revealing that they smoked their first cigarette before breakfast, a recognised symptom of nicotine addiction. The times and places when smoking takes place most often are illustrated in Figure 3.

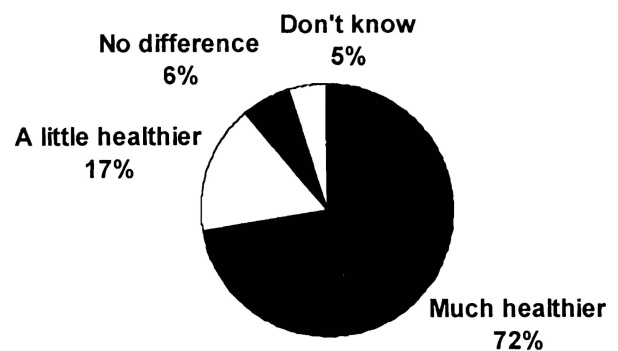
Only 16% of applicants had never tried to quit before,

Fig. 3 - When and where do you feel like a smoke?



all the rest having tried (and failed) once or twice (46%) or several times (38%). Their perception of future health after quitting smoking is shown in Figure 4.

Fig. 4 - When you quit smoking how healthier do you think you will be?



**Discussion and Recommendations**

A discussion of the above results follows, and recommendations are made which are relevant to family doctors.

*1. Education on health effects of smoking*

28% of applicants to the smoking-cessation clinics did not think that they would be much healthier when quitting smoking. Excluding those who feared that quitting would be too late for them, this may indicate a lack of knowledge of the health effects of tobacco smoking among smokers.

Family doctors therefore should seize every available opportunity (clinical or otherwise) to discuss and clarify the hazards of smoking with their clients, and emphasize the benefits of quitting. Patients are more receptive of advice when they are going through a health scare such as a chest infection, a myocardial infarction or surgery.

This advice must be reinforced, first of all by the provision of anti-smoking literature. As early as 1979, Russell et al in the UK showed that, following simple advice to stop, reinforced by a leaflet and warning of follow-up, 5% of GPs' patients were not smoking one year later<sup>7</sup>.

Secondly, the doctor must set a no-smoking example to his patients, both on a personal basis and in the clinic. In 1989, Mamo and Galea showed that 25% of Maltese doctors smoked (EEC figures varied from 10% in U.K.

to 45% in Spain), while 30% allowed smoking in their waiting rooms<sup>8</sup>.

## 2. Provision of help in quitting

The *power of nicotine addiction* was documented by the findings that nine out of ten applicants smoked 15 or more cigarettes daily and felt very dependent on smoking, nearly two-thirds of them smoked before breakfast, and over one-third smoked all the time/everywhere. Nevertheless, there also was a *strong desire to quit*, as shown by the results that about nine out of ten believed in quitting with help and had tried quitting more than once, and over half thought they would not be smoking a year later.

Family physicians should try to understand the psychological problems faced by smokers who want to fight their nicotine addiction and quit, and should do their utmost to help these would-be quitters.

This can be achieved through personal counselling (the 4 A's - Ask, Advise, Assist, Arrange - to 'How To Help Your Patients Stop Smoking'<sup>9</sup>), together with the use of nicotine replacement therapy (NRT). At present, NRT is the only way to treat the physiological addiction of nicotine. A systematic multi-trial review by Silagy et al showed a doubling of sustained smoking cessation when NRT is compared to placebo<sup>10</sup>.

Alternatively, a would-be quitter may be referred to smoking-cessation clinics that are run on a regular basis by the Department of Health Promotion, details of which may be obtained from its centre at 12 Merchants Street, Valletta (Tel: 241484).

## 3. An effective anti-tobacco-policy

The *power of tobacco advertising* on smoking is shown by the fact that half the applicants started smoking before 16 years of age (the legal age at present for purchase of tobacco) although peer pressure may also be a factor in this regard. While the great majority smoked filtered cigarettes, the form of tobacco most advertised and available, there is also a strong relationship between the brand of cigarette smoked and the level of advertising of that particular brand.

Family doctors should lobby strongly for an effective anti-tobacco policy, including:

- *The holistic education of children*, starting during the inquiring phase of primary-school age, before the rebellious and peer-pressure phase of the teens. In fact, the results of the Caritas/Pride/DISCERN Survey<sup>11</sup> strengthened the conviction of Caritas that 'education had to be its main service'. The ESPAD Study (Malta)<sup>12</sup> highlighted the importance of a holistic orientation involving attitude formation, skills training and knowledge, over and above an awareness of the dangers of tobacco and other drugs. Smoking needs to be promoted as an anti-social habit among the young and the not so young.
- *More prominent and effective health warning labels on all tobacco products*. Results of a study conducted by the Canadian Government in 1992<sup>13</sup> indicated that cigarette packs were a primary source of health information concerning tobacco (55%), second only to television (59%) and well ahead of

newspapers at 17%. There is no doubt today that smoking is just as addictive as heroin, that it is a causal risk factor for lung cancer and coronary heart disease, and that it has a deleterious effect on the foetus and on children's respiratory health. Therefore, not only should warnings be displayed in black-on-white and high on the front (occupying 25% of the area) of the packet, but they also must be specific, strong and uncompromising: "Cigarettes are addictive", "Smoking causes cancer", "Smoking causes heart disease", and "Smoking harms your family"<sup>14</sup>.

- *The prohibition of smoking in enclosed public places*, to avoid the harmful effects of environmental tobacco smoke (ETS) on non-smokers. These include asthma, middle ear infection and bronchitis or pneumonia in children, heart disease and lung cancer<sup>15</sup>. In 1997 researchers at the University of Minnesota Cancer Center<sup>16</sup> found a derivative of a tobacco-specific lung carcinogen (NNK) in the urine of non-smokers exposed to ETS under real-life conditions - the first hard evidence of how passive smoking can cause cancer. In a study modeling nicotine from ETS in office air and salivary cotinine in non-smoking U.S. workers, Repace et al (1998)<sup>17</sup> estimated that over 95% of ETS-exposed office workers exceed the Occupational Safety & Health Administration's significant risk level for heart disease mortality, and 60% exceed significant risk for lung cancer mortality.
- *A total ban on advertising, sponsorship and promotion*. A number of studies have shown that children are influenced by, and are more aware of tobacco advertising than adults<sup>18,19,20</sup>, and a U.K. survey of public attitudes found that 62% believed tobacco sponsorship of sport makes smoking glamorous to young people<sup>21</sup>. Moreover, investigations by Smee (1992)<sup>22</sup> showed that tobacco advertising bans work, while follow-up studies by Joosens (1997)<sup>23</sup> recommended that such bans be part of a wider tobacco control strategy.
- *Regular increases in tobacco taxes*, to discourage consumption and to finance health promotion and tobacco control. Moreover, Health Promotion Foundations funded by an increased levy on tobacco license fees<sup>24</sup> have been set up in some states in Australia to substitute the tobacco sponsorship of sports, the arts and popular culture.

Such lobbying to government is, of course, not easy and more often than not, ignored if done on an individual basis. However, if family doctors and other health care professionals exert such pressure through colleges, associations and other national organisations, it would be more difficult for the authorities to disregard them.

## Closing Messages

As far back as 1970, Lanfranco<sup>25</sup> had declared that 'smoking is certainly a "bad" habit, and as with all such habits difficult but not impossible to break. In this respect half-hearted measures are worse than useless and more drastic steps should be taken to "help" the

confirmed smoker to overcome his habit'.

Then, in 1985, Cacciottolo<sup>26</sup> rightly emphasized 'the duty of all persons involved in health care to inform, and encourage the Maltese public at large to give up the smoking habit, and therefore to help control this smoking epidemic'.

This was followed a year later by a Statement of Concern from the Department of Medicine University of Malta Medical School<sup>27</sup> which recommended that 'Government should accept the responsibility of carrying out more effective smoking control action and of stimulating non governmental organisations to take action also. The general objectives should be to reduce the social acceptability of smoking and to ensure a smoke-free environment for non-smokers'.

The European Code against Cancer<sup>28</sup> affirms that certain cancers can be avoided and general health improved if one adopts a healthier lifestyle. In fact, its first recommendation advises family physicians to warn their patients:

- 'Do not smoke'.
- 'Smokers, stop as quickly as possible and do not smoke in the presence of others', especially children.
- 'If you do not smoke, do not try it.'

Giving up smoking is probably the biggest single thing that smokers can do in their life to improve their health<sup>29</sup>, and the role of the family doctor is crucial in influencing them to quit smoking.

Further investigation needs to be carried out to clarify the role of psychosocial and other factors affecting the family physician's influence on such changes in lifestyle.

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This paper is dedicated to the memory of my daughter Graziella, a staunch anti-smoker, who was reborn to eternal life on the 11th February 1996 at the tender age of eight.

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