



Original article

## Physician Advice to Adolescents About Smoking: Who Gets Advised and Who Benefits Most?

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Article history: Received March 16, 2015; Accepted October 12, 2015

Keywords: Physicians; Communication; Adolescent; Smoking

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 A B S T R A C T

**Purpose:** The Clinical Practice Guidelines instruct physicians to ask their patients about smoking and to advise against tobacco use. Physicians are urged especially to attend to racial minorities and teens because of these groups' increased susceptibility to smoking. Research on race and physician advice against smoking has produced contradictory findings. The purpose of this study is to clarify the relationships between physician communication about tobacco, race, and smoking among adolescents.

**Methods:** This cross-sectional retrospective study explored (1) racial differences in rates of receiving physician communication and (2) whether the relationship between physician communication and smoking among adolescents was moderated by race. Multiple measures of smoking status were used (e.g., intentions to quit, quit attempts, quits, relapse status). We used a large (N = 5,154), predominately African-American (82.9%) sample of 11th graders.

**Results:** Regular smokers were more likely to be screened about smoking. African Americans were more frequently advised against tobacco than Caucasians. Among African Americans, nonsmokers were most likely to be both screened and advised; among Caucasians, regular were most likely to be screened and advised. Overall, physician intervention was associated with greater benefits for young African Americans, including fewer intentions to smoke, greater likelihood of quitting, and less relapse.

**Conclusions:** Physician communication about smoking may hold particular promise for African-American teens, reducing health disparities because of racial differences in smoking-related mortality and morbidity. Physicians should be encouraged to screen and advise all young people about tobacco, regardless of race or smoking status.

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 IMPLICATIONS AND  
 CONTRIBUTION

Physician interventions were associated with increased adolescent intentions to quit and quit attempts. Physicians seem to be targeting youth at risk for tobacco-related consequences—African Americans and regular smokers; there are opportunities for increased intervention among African American smokers and Caucasian nonsmokers. African Americans benefited more from physician interventions.

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Caucasian teens smoke at higher rates (15.4%) than their African-American peers (9.6%) and begin smoking at a significantly earlier age [1,2]. Nonetheless, African Americans experience increased health consequences from smoking relative to

Caucasians ([3–7]; see [7] for a review of tobacco-related health disparities). Smoking among African Americans has been associated with an increased incidence of cardiovascular disease and disproportionate morbidity and mortality from lung cancer [6–10], low birth weight, respiratory disease, and infant death compared with Caucasians [6,11]. Notably, African-American smokers are 1.5 times more likely to want to quit than Caucasian smokers [3,4,6]. However, African-American adults experience significantly more difficulty with cessation than Caucasians, and this difference in success rates extends to adolescents as

**Conflicts of Interest:** Neither of the authors has any competing interests.

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well: Among high school daily smokers, more African Americans (68.1%) than Caucasians (62.5%) try to quit smoking, but African Americans are less likely to succeed, 8.7% versus 12.2%, respectively [12].

Researchers have posited biological and psychosocial theories to explain why African Americans have lower cessation rates than Caucasians. Although African Americans smoke fewer cigarettes, they absorb 30% more nicotine and metabolize nicotine more slowly than Caucasian smokers [13,14]. In addition, about 75% of African Americans smoke menthol cigarettes, which may induce greater nicotine dependence [13]. Significant psychosocial factors may also reduce African Americans' cessation rate. The tobacco industry historically has targeted African Americans with tailored advertisements, heavy marketing, the portrayal of mentholated cigarettes as a healthier product, and strategic financial contributions [14,15]. This marketing pressure is thought to contribute to African Americans' lower quit rate [12,14,16]. In addition, difficulties with health care access may influence African Americans' cessation rates [6]. For example, African Americans as a group show diminished trust in health care providers (HCPs) [6] and less knowledge about medications and health effects [17–19]. African Americans are also less likely to be screened for smoking or advised by their HCP to quit smoking [6,20]. Finally, African Americans use fewer tobacco-cessation aids during quit attempts than Caucasian smokers [6,20].

Nonetheless, for all teens, the health care system is an important venue for tobacco interventions [6,21]. For example, those who have health care access show lower smoking prevalence and reduced smoking over time [22]. Furthermore, behavioral interventions in health care systems have been shown to have an impact on an array of health behaviors [23–25]. Whereas HCP interventions tend to have less efficacy than intensive programs, across a population, their impact can be highly significant because of their greater reach [25].

The 2008 Clinical Practice Guidelines instruct physicians to intervene with all their patients via the 5 As: *ask* about smoking status, *advise* patients to quit smoking, *assess* whether patients are ready to quit, *assist* the patient with quitting, and *arrange* follow-up visits to avoid relapses [6]. Physician advice has been shown to produce a 1%–3% increase in adult cessation above unassisted annual quitting rates of 2%–3% [26] and to be effective for both African Americans and Caucasian adults [6].

Most research demonstrating the impact of physician advice on quitting has been conducted with adults. However, intervention with teens has been recommended [6], and if successful, it would greatly reduce the negative effects of smoking. In a cross-sectional study, physician advice to quit was associated with increased odds that teens would make at least one quit attempt in the following year [27]. Another cross-sectional study found that physician communication was associated with a variety of positive findings among adolescents: more negative attitudes about smoking, more accurate knowledge of tobacco-related health damage, fewer intentions to continue to smoke, more intentions to quit, and more quit attempts [28].

The Clinical Practice Guidelines urge physicians to attend to both minorities and children/adolescents because of their susceptibility to smoking [6]. Thus, one might expect that physicians would intervene more often with African-American adolescents than Caucasians. In support of this idea, Shelley et al. [27] found that African-American adolescents were about 50% more likely to receive physician counseling than Caucasian teens. However, research on disparities in physician advising is sparse and inconsistent, with

some studies suggesting that Caucasian teens receive more advice [29] and others finding no racial differences [30].

Methodological differences across studies may account for some of this variability in results of studies examining the patient race and physician intervention against smoking. For example, in some studies youth have been asked about communication with HCPs during the past year [27], whereas other studies did not impose a time limit for the intervention. Some investigations have inquired about any interventions from HCPs, and others have asked specifically about physician communication [30]. Studies have also varied in how physician advice was measured, with some studies using physician self-report [29] and others using adolescents' self-reports [27,30].

The current retrospective observational study extended previous literature by examining racial differences in the rates of receiving varying physician tobacco interventions (i.e., no intervention, screening alone, advising alone, or both) among a predominantly African-American sample of adolescents. The present study was also the first study to examine whether the relationship between physician-delivered interventions and smoking among adolescents was moderated by race.

## Methods

### Overview and participants

Data were drawn from the Memphis Health Project, a longitudinal observational study of adolescent smoking [31]. All 39 eligible schools participated, and all students enrolled in these schools were eligible. Surveys were administered in schools by teachers, using procedures that maximized student confidentiality. Parents notified the research team if they did not want their child to participate, and students provided assent. The study was approved by the University of Memphis Institutional Review Board. Procedures are detailed elsewhere [31].

The first survey was given to a cohort of 6,967 seventh graders (79% of those eligible) and repeated annually for 9 years [31]. The characteristics of these 6,967 responders who comprised our original cohort closely matched those of the target population in this school system. The study followed this cohort longitudinally but also allowed new students to participate so the number of participants could increase over time. Our annualized loss over the course of the study was 11.4%, a rate that compares well with other studies of inner-city adolescents [32]. The current sample comprised 5,154 students assessed in the 11th grade.

### Measures and coding of items of interest

**Demographic variables.** Self-reported race was represented as a dichotomous variable (African American [1] vs. Caucasian [0]) because of small numbers of other races. Gender (male [1] vs. female [0]) was also self-reported. A proxy method was used to estimate socioeconomic status and education. Using the most recent census data, we assigned each student the average income and education level for their zip code. Thus, students were given proxy income and education levels representing the norms for their neighborhood.

**Physician communication.** Physicians' interventions were measured using adolescent self-reports of (1) physician screening for tobacco use ("Has your doctor ever asked you if you smoke?")

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