The role of smoking cessation in clinical oncology: Australian oncologists’ experiences, preferences and practices

Paul C, Day F, Chen T, Martin J, Sitas F, Weber M, Sherwood E, Barbuttis M, Varlow M

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Contact: Chris.Paul@Newcastle.edu.au
Background

Smoking post-cancer diagnosis associated with:

- Treatment toxicity and complications \(^1\text{-}^6\)
- Medication side effects \(^7\)
- Hospitalisation \(^8\text{-}^{10}\)
- Performance status \(^11\)

Morbidity \(^12\text{-}^{13}\)

Recurrence \(^14\text{-}^{15}\) or new primary cancer \(^15\text{-}^{17}\)

Length of life \(^18\text{-}^{21}\)

Optimal cancer care includes all measures known to improve long term cancer outcomes \(^22\)

• 10-20% of patients attending Australian oncology outpatient clinics are current smokers\textsuperscript{1,2}

• Survey of >1k ASCO MDs: \textsuperscript{3,4}
  • >80\% ask about tobacco use (mostly/always)
  • <40\% actively treat or refer for tobacco cessation

• Are we doing better in Australia?

Aims

• Identify Australian oncologists’ provision of smoking cessation care
• Explore factors underlying smoking care behaviour (COM-B)
• Identify training preferences
Methods

All members of MOGA
N=452

Hard copy mailed survey

Reminder email + link to online survey (x2)

N=189 (RR=42%)

RO members of TROG
N=230

Hard copy mailed survey

Reminder email + link to online survey

N=106 (RR=46%)
<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>Never</th>
<th>Rarely</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Ask your patients if they smoke or use tobacco products</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2) For patients who smoke, ask them for how long they have smoked</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5) Advise people who smoke or use tobacco products to stop smoking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6) Discuss medication options such as nicotine replacement, bupropion, varenicline, etc</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7) Actively treat patients for smoking/tobacco use cessation intervention</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8) Refer patients to a tobacco cessation support program e.g. Quitline, QuitCoach, QuitTxt</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>No Opinion/Neutral</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------------</td>
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<td>----------</td>
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<td></td>
</tr>
<tr>
<td>2) Tobacco cessation should be a standard part of cancer treatment interventions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3) Each member of the oncology team (medical, nursing, allied health) should have a role in the process of supporting smokers to quit</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4) I have had adequate training in tobacco cessation interventions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>5) Medical oncologists need more training in cessation interventions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6) Advanced trainees in medical oncology would benefit from more training in smoking cessation interventions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>7) I don’t know enough about potential interactions between cessation pharmacotherapies and cancer treatments or supportive drugs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
Results
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State</strong></td>
<td></td>
</tr>
<tr>
<td>Victoria</td>
<td>95 (32.4)</td>
</tr>
<tr>
<td>New South Wales</td>
<td>84 (28.7)</td>
</tr>
<tr>
<td>Queensland</td>
<td>61 (20.8)</td>
</tr>
<tr>
<td>South Australia</td>
<td>23 (7.8)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>17 (5.8)</td>
</tr>
<tr>
<td><strong>Primary work setting</strong></td>
<td></td>
</tr>
<tr>
<td>Metropolitan public</td>
<td>183 (62)</td>
</tr>
<tr>
<td>Regional public</td>
<td>47 (15.9)</td>
</tr>
<tr>
<td>Metropolitan private</td>
<td>40 (13.6)</td>
</tr>
<tr>
<td>Regional private</td>
<td>15 (5.1)</td>
</tr>
<tr>
<td><strong>Years worked</strong></td>
<td></td>
</tr>
<tr>
<td>20+ years</td>
<td>79 (26.8)</td>
</tr>
<tr>
<td>11-20 years</td>
<td>85 (28.8)</td>
</tr>
<tr>
<td>6-10 years</td>
<td>41 (13.9)</td>
</tr>
<tr>
<td>1-5 years</td>
<td>66 (22.4)</td>
</tr>
<tr>
<td>&lt;1 year* (more MOs)</td>
<td>22 (7.5)</td>
</tr>
<tr>
<td><strong>Primary disease sites seen</strong></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>201 (15.6)</td>
</tr>
<tr>
<td>Thoracic</td>
<td>179 (13.9)</td>
</tr>
<tr>
<td>Gastrointestinal*</td>
<td>173 (13.4)</td>
</tr>
<tr>
<td>Genitourinary*</td>
<td>156 (12.1)</td>
</tr>
<tr>
<td>Skin*</td>
<td>139 (10.8)</td>
</tr>
<tr>
<td>Other CNS, H&amp;N, Gyn, * Musc*, Haem*</td>
<td>441 (34.3)</td>
</tr>
</tbody>
</table>

*p<.01, MO v RO
Elements of smoking care provided

Proportion reporting ‘always’ or ‘most of the time’ for initial consult

- Ask
- Assess amount
- Ask if plan to quit
- Advise to quit
- Discuss pharma
- Actively treat
- Refer to program
- Brochure
- Refer to specialist

MO vs RO
Proportion reporting ‘always’ or ‘most of time’ at follow-up consultations

- Ask if smoke
- Advise/reinforce to quit
- Actively treat
- Refer to program

MO: MO
RO: RO
Patient subgroups

“Who would you regularly provide tobacco cessation assistance to?”

Proportion choosing each option

- Tobacco related cancer
- Non-tobacco related
- Curable only
- All including metastatic
- None of these

* p<.0001
Preferred approach to support

Preferred source of support

- Trained person here
- GP
- Trained person outside
- Self
- None of these

Preferred timing of support

- 1st consult
- After treatment
- During treatment
- Referrer choice
- 2nd consult
Exploring underlying factors – COMB

Michie et al 2011
Have time
No patient resistance
Have resources
Won’t impact on coping with treatment
Should be standard
Impacts outcomes
Not waste of time

- Strongly Agree
- Agree
Have time
No patient resistance
Have resources
Sufficient experience
Can get patients to quit
Os don’t need more training
Had adequate training

Won’t impact on coping with treatment
Should be standard
Impacts outcomes
Not waste of time

Proportion endorsing statement

Strongly Agree  Agree
Have time
No patient resistance
Have resources
Os don’t need more training
Had adequate training
Can get patients to quit
Sufficient experience
Know about pharmacotherapies
Won’t impact on coping with treatment
Not waste of time
Impacts outcomes
Should be standard
Proportion endorsing statement

Strongly Agree
Agree

Capability
Motivation
Opportunity
Behaviour
Training preferences

• 57% agreed basic skills were appropriate for oncologists
• 42% agreed advanced or specialist skills warranted
• 32% wanted online training
• 25% endorsed need for professional guidelines
• 22% chose f2f training at meetings/conferences
• 19% chose f2f training at their institution
Additional points from open comments

Not part of ‘treatment’
“It is difficult to meet the demands of providing information on cancer treatments themselves let alone ... time dedicated to smoking cessation”

Advisory role
“Role of oncologist to encourage and support smoking cessation but not to manage this”,
“I encourage but don’t push”

Patient Overload
“There is so much information to process”
“Many patients can or will not consider it until active anti-cancer treatment is complete”

Benefit v quality of life
Re incurable patients -“I don’t believe they necessarily need to cease smoking and I think it impacts negatively on their QoL”
Conclusions & Implications

ROs and MOs are generally supportive, but delivering cessation care will require:

• **Practical models/pathways for care which:**
  - Integrate cessation as part of broader care/treatment
  - Prioritise cessation support (beyond ‘ask and advise’)
  - Recognise chronic relapsing nature of smoking
  - Require very little time from ROs/MOs

• **Accessible, trained ‘other’ people to deliver support**

• **Data on:**
  - Patient perspective
  - GP perceived role & readiness
  - Quitline acceptability & effectiveness
  - Impacts of continued smoking in advanced disease (specific to RO/MO context)

• **Strategies to address RO/MO capability**
  - Variety in mode and depth of training

• **Strategies to address RO/MO opportunity**
  - Social opportunity (influences, cues, norms)
  - Physical opportunity (time, resources, tools)
We gratefully acknowledge ...

• Funding from Cancer Institute NSW

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• Survey completion by members of MOGA and TROG

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