Europe against cancer

FINAL REPORT

PROJECT GPs EMPOWERMENT II PHASE

Ref. N° SI2.324433 (2001 CVG2-008)

EUROPEAN NETWORK
FOR SMOKING PREVENTION

GPS EMPOWERMENT PROJECT II PHASE
REF. N° SI2.324433 (2001 CVG2-008)
A EUROPEAN PROJECT FROM 15 SEPTEMBER 2001 TO 15 SEPTEMBER 2002

THIS IS A PROJECT OF THE

EUROPEAN NETWORK FOR SMOKING PREVENTION
144, Chaussée d'Ixelles
B - 1050 Bruxelles
Belgium
www.ensp.org

Partner organisations:

A.N.P.AS. Associazione Nazionale Pubbliche Assistenze (Italy)
Community medicine Center for Tobacco Prevention (Sweden)
Danish Cancer Society (Denmark)
Hellenic Cancer Society (Greece)
Instituto da Qualidade em Saúde (Portugal)
Tabac et Liberté (France)

Associated partners:

UniTS (Università del Terzo Settore) (Italy)

CSPO Centro per lo Studio e la Prevenzione Oncologica (Italy)

This project receives financial support from the European Commission in the framework of the Europe Against Cancer Programme

TABLE OF CONTENTS

OBJECTIVES OF THE PROJECT

The main project aim of the project is to develop European guidelines on how to train doctors to sensitise their awareness against Tobacco smoke habits of their patients and to give them evidence based tools to help their patients who want or need to quit smoking.

Intermediate objectives are:

- To reach relevant GP's organisations consensus on the European guidelines identified through the project
- To identify, through the GP's updating system in each Country, best strategies so to promote them
- To identify proper channels (Universities, training agencies, etc.) and instruments (booklet, video, CD, etc.) through out which distribute/disseminate the guidelines.

Originally the project involved another partner organisation from Ireland, the Royal College of Surgeons in Ireland, Dept. of Family Medicine & General Practice Mercer's Medical Centre. This partner had to leave the project because it did not have the proper support from other organisations in Ireland.

TOTAL EXPENSES OF THE PROJECT

Total expenses of the project	454.950,63 €

FUNDING SOURCES:

Project coordinator's and partners' own contributions	156.641,32 €
The European Commission Grant	270.859,31 €

In Kind contribution	27.450,00 €

EXECUTIVE SUMMARY

Tobacco use is the chief and single largest avoidable cause of illness and death in our society. Therefore, smoking cessation in smokers has become a major goal in Public Health, since the beginning of this XXIst century.

Tabagism is a chronic disease, similar to other drug addiction, in which are involved cognitive and motivational mechanisms, emotional and psycho-social determinants. Therefore, some tobacco users achieve permanent abstinence on a first attempt at quitting, but most go on using tobacco and typically go through multiple episodes of remission and relapse.

The "worldwide epidemic of tabagism" can be substantially reduced only through comprehensive tobacco control programs that range from mainly managing the power of the tobacco industry to helping single smokers to quit.

A significant proportion of current smokers are willing to quit, but more of one third of current smokers report never having been asked about their smoking status or never been advised on how to quit smoking.

This entails that **every healthcare provider has an enormous responsibility in this arena**. They have to be able to meet the challenge head-on, since effective interventions are currently available which significantly increase the success rates of quit attempts.

In particular, **GPs are in a key position to intervene with patients who use tobacco. They can reach a wide range of population with personalized messages and can provide a continuous support to their patients.** Because of the large number of diseases correlated to smoke use, it has been estimated that at least 70% of smokers see a physician each year. Several studies of smoking cessation prevention by GPs have shown that even small actions have long-term effects. They also showed that empowerment given to GPs

in order to carry out brief and extensive counselling had a considerable influence on smoking cessation rates.

GPs Empowerment project

"GPs Empowerment Project" is a collaborative project between 5 countries (Denmark, France, Greece, Italy and Portugal) in the first phase and between 6 countries (the countries mentioned plus Sweden) in the second phase, under the ENSP contract with The European Commission (Health & Consumer protection Directorate-General).

This project has developed over two sequential phases, developed in each individual country

- **Phase I** was dedicated to a survey on General Practitioners attitude towards smoking cessation, action on smoking cessation, knowledge and the GP's own smoking status.
- **Phase II** was focused on the importance of qualifying the General Practitioners to talk about smoking cessation with their patients, in order to increase smoking cessation. This is to be achieved through the use of clinical guidelines on smoking cessation to use in daily practise. Intermediate objectives of this phase were:
    - To reach relevant GP's organizations consensus on the guidelines identified through the project
    - To identify, through the GP's updating system in each Country, best strategies to promote the identified guidelines
    - To identify proper channels (Universities, training agencies, etc.) and instruments (booklet, video, CD, etc.) through out which distribute/disseminate the guidelines.

RESULTS

1st Phase

The results of Phase I are surprisingly similar in the different countries involved in the project, which leads us to think that the answers are biased and there are more motivated non-smoking GPs among the responders than usual. **The smoking prevalence (both daily and occasional smokers) among the participating GPs is: in Denmark 15%, in Portugal 22%, in Italy 31%, in France 32%, and in Greece 35%.** The smoking rate in Denmark and Portugal is remarkably low compared to the other countries. Interestingly, Portugal also has the highest percentage of GPs that wish to stop smoking.

Almost all GPs agree (93-99%) that smoking cessation is important in their work. This is a strong argument if we want to empower General Practitioners so that they help more patients stop smoking and we believe that success is even more probable if they consider it an important issue for intervention.

There is also general agreement in the answers related to the questions about attitude since most agree that it is their duty as a GP to help and to act as a role-model for the patient. However, Danish GPs felt less obliged to give information about smoking cessation than the GPs in the other countries. French and Danish GPs are the least interested in being models for their patients. On the other hand, the French GPs are very confident about the advice they give their patients.

Less than 10% of the GPs in all countries, declares that they rarely or never discuss tobacco use with patients.

A large proportion of GPs in all countries is interested to be trained on smoking cessation strategies. Danish and French GPs

consider themselves better prepared to give information about smoking cessation than GPs of the other countries. They have also received more training and consequently they are less interested in training and material compared to Greek, Italian and Portuguese GPs. Nevertheless, more than 40% of the Danish and French GPs are interested in training and more than 65% are interested in material, so it is very relevant for all five countries to do something to empower the GPs.

2nd Phase

The job made during the second phase of the project, in the countries involved, was related to the different national level of clinical guidelines development, to the local settings and needs, and to national opportunities given by the associations and institutions specifically involved in the project.

In **Denmark**, where the Danish Medical Association developed a specific smoking policy, special attention was devoted to the development of a comprehensive strategy on how to make smoking cessation in general practice, evaluating materials, training and information that the general practitioners should be provided with. A survey, made in August, more precisely pointed out this needs, (targeted materials; strategies for a personal follow up; a catalogue of good grips, in service training, courses and education on how to do smoking cessation, information and documentation; clinical Guidelines).

A first draft of the Danish smoking cessation clinical guidelines were based on Cochrane library report and discussed with a group of general practitioners in order to: (i) make them short, clear and concrete; (ii) put emphasise on the GPs unique role; (iii) distinguish between what every GP should do and what a motivated GP may do.

A small booklet on smoking cessation in the clinic was prepared. A poster was also developed and distributed to all general practitioners in Denmark.

In **France**, Tabac & Liberté, which is the Association that actively participate to the GPs Empowerment project, established relationships with other French associations and institutions that worked in the field of tobacco dependence prevention and tobacco cessation, and developed, during phase II project, a training program and a clinical guideline on smoking cessation to be used nationally by GPs.
The training program was based on the 8 years of experience in this field of Tabac & Liberté. It was enriched, analyzed, adapted and modified taking into account the evolution of knowledge, the specific expectations of GPs and the wish to provide only useful information that can be easily used in the GPs daily practice.
The guideline on how to successfully manage tobacco cessation, are available in the Internet web site of the association.

In Greece

Guidelines on smoking cessation to be used in clinical practice for broad national use were produced with the assistance of the existing Hellenic Cancer Society's throughout the country branches.
Dissemination strategies have been discussed and planned:
- A booklet, short brochures and posters are more likely to be used
- Guidelines can be transmitted through video, CD disk or can be downloaded from the H.C.S. website which is now under innovation.
- Articles are published regularly in the HCS's official two magazines and in one by the Panhellenic Medical Association and distributed all over Greece. These articles are written mainly by members of the board of the Hellenic Antismoking and Anticancer Society.

In Italy, where Clinical guidelines on smoking cessation were recently

developed and promoted by the Minister of Health, the job made in the context of the second phase of GPs Empowerment project consisted in evaluating the implementation of the guidelines in the GPs daily practice. Experts of different Italian Organizations and Associations, especially of GPs, met for the first time and discuss about: (i) the minimal clinical intervention which should be made to effectively reduce smokers among patients; (ii) what is really feasible in the daily clinical practice for a GP without special training on the topic; (iii) what is necessary to plan and implement in order to allow the GP applying the evidence based minimal clinical intervention in his/her daily practice, according to different GPs' background and practice setting. A consensus document was developed. It was scheduled to officially present it in a press conference, and through the communication channels of the different associations and organizations of the experts who contributed to the final consensus document.

In Portugal, there is also a need, as in other European countries, for all healthcare providers to change their attitudes regarding smoking cessation, especially those working in primary care. Based on this conviction, the Institute for Quality in Health Care (Instituto da Qualidade em Saúde – IQS) promoted and sponsored several validated smoking cessation courses.

The guidelines, developed by IQS, was an evidence-based document, projected for use by GPs in their everyday work. Its major structure obeyed the general recommendations from the National Guideline Clearinghouse (USA), aiming to be the most efficacious format for practical use, and to be the most updated in terms of scientific validity. Formal meetings were arranged by IQS and the guidelines were distributed and discussed, and the practical aspects of the interventions were presented. Most of the suggestions coming from GPs concerning this matter were considered in the final version of the

guidelines. The document was disseminated at several different levels in the Portuguese National Health System, and put at the IQS web site.

In **Sweden**, by initiative from SBU – The Swedish Council on Technology Assessment in Health Care – clinical guidelines on smoking cessation were developed in 1994. In co-operation with the NGO "Doctors against tobacco" a manual for primary care doctors has been produced ("The road to a smokefree life") to be distributed to every GP in Sweden. It was planned a dissemination of the results of the project involving 100 GPs in the Stockholm region with the aim to explore the feasibility of reimbursement of a minimum of 80% recording of patients smoking habits. A series of regional conferences have been also staged where doctors and nurses in the region have been invited.

In conclusion:

1. **In all countries there is a low attitude of GPs in applying effective strategies for helping their patients who want or need to quit smoking,** despite the GPs' consciousness regarding health risks related to tobacco smoking, and despite the growing information on effectiveness of even brief intervention in smoking cessation.
2. **All the European countries participating in the GPs Empowerment Project - phase II agreed on the necessity to develop and /or implement national guidelines on smoking cessation for GPs** in order to change: (i) the attitude of clinicians not to intervene on smoking patients suggesting and supporting them in smoking cessation; (ii) the increasing trend of smoking related incidence and mortality.
3. **The guidelines developed and /or discussed in the context of this project, in the different countries**

involved, aimed at support GPs in their daily practice were scientific based documents in all countries but France, where they were prepared using the background experience of Tabac & Liberté trainers. In the other countries the guidelines were based mainly on US guidelines and Cochrane revision. In two countries (Italy and Sweden) clinical guidelines were developed out of this project and therefore more attention was devoted to dissemination or consensus strategies. Only a format specific for each country was considered, by all the partners, effective, considering the different national GPs' setting. Presently, the developed national guidelines are all available in the web site of the different organizations involved in the project. All partners planned specific dissemination strategies. It is desirable to extend to all European countries the results of this work, so that everybody can profit from it.

4. **Particular attention must be put on the smoking prevalence (both daily and occasional smokers) among the participating GPs** (in Denmark 15%, in Portugal 22%, in Italy 31%, in France 32%, and in Greece 35%) **being in relation to the attitude in applying effective strategies for helping their patients who want or need to quit smoking.**
5. **All health personal should also be involved in smoking cessation programs, at every level of the health system, as scientific literature shows to be effective. Guidelines for them should be also provided in the next future.**

INTRODUCTION

Tobacco use is the chief and single largest avoidable cause of illness and death in our society (1,2,3). It is a recognised cause of cancer, heart disease, stroke, chronic obstructive airways disease, and of complications during pregnancy (4). Therefore, smoking cessation in smokers has become a major goal in Public Health, since the beginning of this XXIst century.

Tobacco-related diseases, such as lung cancer, kill more than 4.2 million people annually in the world. By the 2020 it was estimated that 8.4 million people will die each year from tobacco-related diseases (5). In spite of its attending health risks, tobacco use remains surprisingly common. Following a number of large community-wide efforts since mid '70, the prevalence of smoking decreased in European countries, with a decline also in smoking-related mortality, especially among men (6). Women are still experiencing an increasing trend in smoking–related mortality and morbidity due to their later beginning of the habit comparing to men.

In the EU member states in 1990, there were over a quarter of a million deaths in middle age directly caused by tobacco smoking: 219 700 in men and 31 900 in women. Quite impressive are the fact that in the last decade the prevalence of smoking is increasing again in adolescent, and that almost half of the world's children have been estimated to be exposed to second-hand smoke.

Concerning the smoking habits of the population of the 6 countries involved in this project, it was observed as it follows.

In Denmark, the Danish Heart Foundation, the Danish Cancer Society and the Danish Council on Tobacco and Health (DCTH) have been monitoring the Danish population smoking habits during the past years (7). The monitoring has been performed by telephone interviews with a representative section of the Danish population over 13 years of age.

In 1999 34% of the Danish population were smoking. 30% of all women and 39% of all men were smoking. Some 27% of the women were daily smokers and 35% of the men (8).

13.000 Danes die each year from smoking related illnesses.

In France, it is estimated that the smokers represent about 1/3 of the population, ex-smokers 1/3 and the non-smokers another 1/3 (9). On average 4 out of 10 smokers want to stop smoking but only 10% of these 4/10 seek the advice of a GP, whilst 30 to 50% of smokers are highly dependent on nicotine. Tobacco abuse is very common in youngsters, especially girls. Thirty percent of pregnant women still smoke during their pregnancy and when breast-feeding. Recently, lung cancer in forty year old women has been registered.

In Greece, according to a survey performed by the University of Athens, the prevalence of smoking has increased between 1984 to 1998 from 34,8 % to 37,6% (general population, age 12 – 64), particularly in young females. A small decrease was observed in males. The heavier smokers belong to the age group of 25 – 35, 60% for males and 38% for females. Geographically, the prevalence of smoking is higher in urban areas (38,4%), the highest is noted in Thessaloniki (43%), in Athens is 39,8% and lower in semi–urban and rural areas (33,2%).

In Italy, it was described a decreasing trend of smokers from 34% in 1980 till 24.5% in 1998, due to a reduction in smoking of the male population. Nowadays there is still a high percentage of smokers in Italy with a stable value (25%) in the last five years. The highest prevalence is in the age class 35-44 years. Recently it was observed an increased prevalence in the younger age group. The largest percentage of smokers has been registered in the North-Western area and in towns. Among men it has been observed an inverse smoking prevalence in relation to educational level, the opposite was true for women. Smoking quitting rate seems higher in men compared to women as shown by yearly percentages of ex-smokers; the increasing

trend of ex-smokers in men is especially in the higher educational level group (10,11).

In Portugal, 19% of all adults are smokers (30.5% men, 8.9% women), of which 9.9% smoke twenty or more cigarettes a day (17.7% men, 2.9% women) (12). Furthermore, the prevalence of tobacco use among adolescents has risen dramatically since 1990. This is somewhat low smoking rate in Portugal is due mostly to a very low smoking habits in women. Unfortunately, this is on the rise in several strata, and the highest percentage of smokers can be found in cities.

In Sweden, during the 1980´s the prevalence of smoking decreased among adolescents but increased again towards the end of the decade. In the 1990´s the prevalence of smoking has been fairly constant in this group of younger people, and girls smoke more than boys. In year 2000, 17 percent of the men and 21 percent of the women reported to be daily smokers. Individuals with lower education smoked more than those with higher education. About 13 percent of pregnant women in Sweden smoke. It was estimated that 12 percent of all deaths among men and 4 percent of all deaths among women is attributable to smoking (13).

1.1 Nature of tobacco dependence

Tabagism is a real addiction similar to that associated with opioids, amphetamines and cocaine and, as with these drugs, it presents with many of the features of a chronic disease (14).
Some tobacco users achieve permanent abstinence on a first attempt at quitting, but most go on using tobacco and typically go through multiple episodes of remission and relapse.

For a better understanding of effective strategies against tabagism, it should be noted that smoking dependence is a complex whole of components in which are involved:

- cognitive mechanisms (self-image, problem solving skills, self-confidence, behaviours, firm believes)
- motivational mechanisms (smoke as substitute of psychological needs)
- emotional mechanisms (tabagism as an automatism to face emotional conditions)
- psycho-social mechanisms (social pressure).

According to a well-appreciated model (15), the cessation process is characterised by different motivational stages:

- *Pre-contemplation*, marked by complete absence of motivation to quit and low level of interest in health problems.
- *Contemplation* with awareness of dependence and willingness to give up, but the feeling of a personal difficulty.
- *Preparation* where the subject realizes the decision of changing.
- *Action* from which starts concretely the smoke abstention.
- *Maintenance* that allows to keep the engagement of abstinence

Therefore, the decision of quitting smoking is the result of a process where different psychological components are involved; intervention strategies should be aimed at promoting the passage through these different phases in order to obtain the definitive smoking cessation.

Taking into account the chronic character of tobacco dependence allows for a more correct therapeutic approach, wherein the need for continuing care and the relevance of active counselling are properly valued.

Role of General Practitioners (GPs)

The "worldwide epidemic of tabagism" can be substantially reduced only through comprehensive tobacco control programs that range from mainly managing the power of the tobacco industry to helping single smokers to quit.

A significant proportion of current smokers are willing to quit (16,17), but more of one third of current smokers report never having been asked about their smoking status or never been advised on how to quit smoking (3).

This entails that every healthcare provider has an enormous responsibility in this arena. They have to be able to meet the challenge head-on, since effective interventions are currently available which significantly increase the success rates of quit attempts.

Tobacco users should not be left to their own devices rather be actively encouraged and assisted to adequately terminate their addiction. They should be offered the various treatment modalities which are currently known to be effective.

Negligence and inattention from health services regarding this problem have such a high price tag in terms of preventable disease, lives lost, and economic costs, that they cannot be in any way justified. In fact, clinical research in the past two decades has clarified many tobacco dependence issues, and various effective pharmacological and counselling therapeutic strategies have been discovered.

Anyhow, despite the tragic health consequences of smoking, physicians and other health care clinicians often fail to asses and treat tobacco use consistently and effectively.

GPs provide assistance to a patient during an illness, give them the first intention care and refer their patients to other specialists/hospitals when necessary. GPs are also in a key position to intervene with patients who use tobacco. They can reach a wide range

of population with personalized messages and can provide a continuous support to their patients (1,18). Because of the large number of diseases correlated to smoke use, it has been estimated that at least 70% of smokers see a physician each year (1,19). Therefore the GPs have to face this health problem and need to deal with it at its early stage. However, the responsibility upon patients, the lack of information on effective methods or the lack of specialist backup and support may be a barrier for a GP to become involved in smoking preventive actions.

Earlier studies of smoking cessation prevention by GPs have shown that even small actions have long-term effects. These studies showed that the empowerment given to GPs in order to carry out brief and extensive counselling had a considerable influence on smoking cessation rates (20,21,22,23). It revealed that a simple leaflet given by the GP to his/her patient resulted in a significant 5% smoking cessation rate for the ongoing year, compared to a 0.3% cessation rate when no preventive action was carried out. Rosso et al., Fiore et al. and Slama et al. pointed out in their publication that the smoking cessation rate was related to not only the number of visits at the GPs but also the time spent giving them advice.

A Cochrane review demonstrated that on the whole, trained GPs were more at ease when talking about smoking cessation with their patients, although no significant difference was seen between the smoking cessation rates of the trained GPs and those who did not receive any training.. The lack of control of psychological factors such as patient's motivation, one factor of major importance when trying to stop smoking, has not been taken into account by Cochrane review. There is not a sufficient evidence of the long-term cessation effect following the intervention of a GP, too. We also have little information on the attitude a GP will have towards smoking cessation once receiving training compared to the other methods used such as giving advice or providing active support to help smoking cessation.

GPs Empowerment project

"GPs Empowerment Project" is a collaborative project between 5 countries (Denmark, France, Greece, Italy and Portugal) in the first phase and between 6 countries (the countries mentioned plus Sweden) in the second phase, under the ENSP contract with The European Commission (Health & Consumer protection Directorate-General).

This project has developed over two sequential phases, developed in each individual country:

- **Phase I**: involved 5 countries; it was dedicated to a survey on General Practitioners attitude towards smoking cessation, action on smoking cessation, knowledge and the GP's own smoking status. This phase was developed over 2000; the design and the results obtained were discussed during two international meetings in Copenhagen and Rome.
- **Phase II**: involved 6 countries; it was focused on the importance of qualifying the General Practitioners to talk about smoking cessation with their patients, in order to increase smoking cessation. This is to be achieved through the use of clinical guidelines on smoking cessation to use in general practise. This phase was developed over 2001-2002, the results being analysed over three international meetings in Pisa, Toulouse and Lisbon.

During the phase I project, a survey was designed in order to investigate about specific attitude, belief and habits of GPs regarding tobacco smoking and smoking cessation activities. When reading the results of the GP empowerment project Phase I-survey, it is important to take into account that the methods used in the questionnaire survey differ from one country to another. Each country chose its own data collection method and analysis for the data, which was then

included in the final report. Only a common questionnaire (table 1) was designed and used, therefore it is not possible to compare the results between countries due to varying methods, to possible misunderstanding of the questions and to different cultural and educational background of the GPs included in the survey in each country. However, the results give us useful suggestions and indications for future actions. The data can be also used to get an overview on the most interesting differences or similarities between GPs attitude, action and knowledge about smoking cessation in the five European countries.

The results are surprisingly similar which leads us to think that the answers are biased and there are more motivated, non-smoking GPs among the responders than usual. The smoking prevalence (both daily and occasional smokers) among the participating GPs is: in Denmark 15%, in Portugal 22%, in Italy 31%, in France 32%, and in Greece 35%. The smoking rate in Denmark and Portugal is remarkably low compared to the other countries. Interestingly, Portugal also has the highest percentage of GPs that wish to stop smoking.

Almost all GPs agree (93-99%) that smoking cessation is important in their work. This is a strong argument if we want to empower General Practitioners so that they help more patients stop smoking and we believe that success is even more probable if they consider it an important issue for intervention.

There is also general agreement in the answers related to the questions about attitude since most agree that it is their duty as a GP to help and to act as a role-model for the patient. However, Danish GPs felt less obliged to give information about smoking cessation than the GPs in the other countries. French and Danish GPs are the least interested in being models for their patients. On the other hand, the French GPs are very confident about the advice they give their patients.

Regarding the question about how often the GPs discusses tobacco use with patients, it came out that GPs seem often in doubt whether it is important to approach with smoking cessation only patients with smoking related diseases or all their smoking patients. Less than 10% of the GPs in all countries, declares that they rarely or never discuss tobacco use with patients.

Danish and French GPs consider themselves better prepared to give information about smoking cessation than GPs of the other countries. They have also received more training and consequently they are less interested in training and material compared to Greek, Italian and Portuguese GPs. Nevertheless, more than 40% of the Danish and French GPs are interested in training and more than 65% are interested in material, so it is very relevant for all five countries to do something to empower the GPs.

Table 1. The common questionnaire

Questionnaire to general practitioners on knowledge, attitudes and behaviour in relation to tobacco use and advice			
	2		
1	3 Do you agree with the following claims?		
A	It is the duty of a GP to give information about smoking cessation	Yes	No
B	It is an important intervention to give information about smoking cessation	Yes	No
C	Health personnel should set a good example by not smoking	Yes	No
	4		
D	5 Patients will accept my advice about smoking cessation	Yes	No
	6		
2	7 How often have you within the last 30 days discussed tobacco use with patients?	Routinely	(81-100%)
		In most cases	(61-80%)
		Now & then	(11-60%)
		Rarely	(1-10%)
		Never	
3	Do you feel prepared to help your patients stop smoking (E.g. discuss smoking cessation, suggest methods for smoking cessation)?	Yes	No
4	Have you ever received training in smoking cessation strategies?	Yes	No
5	Would you like to receive training in smoking cessation strategies?	Yes	No
6	Would you like to have some material to support you in helping your patients stop smoking?	Yes	No
7	Your sex:	Female	Male
8	Your age:		Years
			≤ 35
			36-45
			46-55
			56-65
			66-70
			≥ 71
9	For how long have you been practising as a GP?		____years
10	What area does your patients mainly come from?	City	Country
11	Do you smoke?	I smoke every day I smoke now and then I no longer smoke I have never smoked	
12	If you smoke, would you like to stop smoking?	Yes	No

A summary o the results achieved during the first phase in each country is hereby presented.

Denmark

In Denmark the questionnaire was send out to 3511 general practitioners as a postal survey. The GPs were participating anonymously. Altogether 1464 replied (42%). No data was available on non-responders. Results from the survey showed that the Danish general practitioners attitude towards giving information about tobacco and smoking cessation in general practise is very positive. 98% of all GPs that has participated says it is an important intervention. This means that there is no need to prepare the general practitioners about how important it is to do something to help their patients stop smoking. They already know that, and a lot of them are already doing something to help their patients.

50% of the general practitioners would like to have some training in smoking cessation strategies and 65% would like to receive some materials about smoking cessation strategies. The majority of the Danish participants were non-smoking general practitioners, thus it is possible that there were biases in the interpretations of the results. But anyhow the GP-empowerment survey gives reason to believe that the GPs not only are smoking less than the rest of the population in Denmark, but they also find it highly important (81%) to be an example for their patients by not smoking.

In conclusion, the GPs' low smoking prevalence and high percentage of positive attitude must be taken as a reflection of a great motivation in this field, which supports the process of making smoking cessation a natural part of primary health care in Denmark.

France

The results obtained came from 1417 questionnaires; 144 out of them came from members of the association Tabac & Liberté. Men were 76.5% of the total. They have been practising for 16 years on average. Women were younger then men (71% of them were under 46 years old versus 43% in men)

A large majority of the GPs agreed with the fact that it is their duty as a GP to give information to their patients and that it is an important intervention. More than 70% of them agree with the fact that health professionals have to set an example for their patients. According to more than 70% of them, patients accept their advice. One GP out of 2 talks about smoking addiction either generally or systematically. Only 7.2% said they "never" or "rarely" talk about this problem with their patients. This low percentage is probably due to a possible misunderstanding: some GPs might have understood that the question was in relation only to smoking patients. Almost 3 GPs out 4 felt they were well prepared to help patients who want to stop smoking: 70% of them had not received any training; 71% wished to receive documentation and only 40% wished to receive specific training.

Women seem to be more aware of the GPs' duty. They felt less trained than their male colleagues (66% versus 75%), indeed, a majority of male GPs were not willing to follow a training (59% versus 46.5% for women). Women were more interested in following a specific training and receiving documentation on smoking cessation programmes than their male colleagues.

The older a GP, the more he/she thought that health professionals had to set an example and thus shouldn't smoke: 68.2% of GPs under 35 years old, 70.5% of GPs between 36 and 45 years old and 79.7% of GPs over 56 years old thought they must set an example.

Moreover, the younger a GP, the less prepared he/she felt to help smoking patients and the more he/she agreed with receiving

documentation on smoking cessation programmes together with specific training. Non-smoking GPs (who have never smoked) were more numerous to agree on the fact that health personnel should set a good example by not smoking (82.1%) compared to smokers (61.2%) or former smokers (76.5%). More than 56% of non-smoking GPs talk about nicotine addiction compared with 54% of the ex-smokers and 40% of the smokers. Fifty-five percent of the GPs that smoked said they wanted to quit smoking. The members of the Tabac & Liberté association are different from their colleagues as they are more involved, more motivated, and ask more for training and help.

Greece

Following the project's programs, in phase I, 2500 doctors throughout Greece were collected from the Hellenic Cancer Society lists. The questionnaire was sent personally to every sampled GP by mail. Three hundred and sixty three (15%) questionnaires returned. Not any data was available for the non-responders, because the questionnaires were anonymous. The age in one third of the responders ranged between 45 – 55 years. More than 95% concerning the first question (see table 1) had a positive answer but only 69% felt themselves able to help patients to quit smoking. Eight percent of them have received training in smoking cessation, 88% would like to receive further training, and 98% wish to receive appropriate material, in order to treat the patients and/or to help them to quit smoking. Twenty-three percent among the GPs who mailed back the filled questionnaire are smoking every day, 12% (45) smoked occasionally, 22% (79) were ex–smokers, while 43% (155) never smoked. The total number of smoking doctors according to this questionnaire was 129 (35%) of the responders which is equal more or less as in previous studies. The final compliance was very low. A similar attitude was noted in the surveys carried out 3 years before.

Italy

A total of 729 family doctors, 409 in the North and 320 in the South Italy were interviewed by phone in the period July/October 2000 regarding their personal smoking habits and their approach with patients on the topic.

The percentage of current smokers among Italian GPs included in the survey was 28.3 % with a high prevalence in the South (33.3%). The vast majority of GPs thinks that it is their own duty to give information about smoking cessation (96.8%) and considers an important intervention to give information about smoking cessation to their patients (98.5%) but only about 49% GPs thinks their patients will accept their advice. The majority of GPs (87.3%) declared to discuss about tobacco use with their patients during the month preceding the interview and 83.5% GPs would like to be trained on smoking cessation strategies.

Special training for GPs appears necessary, and above all young physicians ask for it.

Moreover, if the attitude and behaviour of doctors regarding smoking cessation with their patients is related to their personal smoking habit, it is also necessary to support personal GPs attitude to quit smoking, given that the smoking prevalence is particularly high among Italian GPs.

Portugal

The results were obtained from 941 questionnaires, out of a total of 3591 mailed ones. The study was representative of the general population of the Portuguese GPs. The sample was fairly even distributed among the different parts of the country, as well as types of practice. It constitutes a reliable source of information for future work in this area. The mean age of the respondents was 44 years (26-

74) – with three quarts belonging to the 40-55 years old group – and 55% were female. The mean time as a practicing GP was 14.5 years, with a majority (69%) reporting being in practice between 10 and 20 years. Forty eight percent had a city practice, 40% a country practice and 12% a mixed one (city and country).

Concerning the questions on the duty and importance of a GP to give information about smoking cessation, on the fact that health personnel should set a good example and on patient acceptance of GPs counselling, 55% responded yes. The second higher pattern of response was related to patient acceptance of GPs counselling: 18% of GPs stated not believing in it.

Out of the 835 respondents, 53% stated they felt prepared in helping patients to stop smoking, discussing this issue 39% in most cases, 37% now and then, 18% routinely and 6% rarely. A great majority (85%) of GPs did not have previous training in smoking cessation, and a full 95% would like to receive it in the future, including materials (in 99% of the cases).

Finally, there was some variability concerning the smoking habits of the GPs: a minority (14%) smoked everyday (12% female, 16% male), 8% smoked now and then (7% female, 10% male), 27% described themselves as ex-smokers (24% female, 32% male) and 51% never smoked (57% female, 42% male). Interestingly, 21% of the responders (18% female, 23% male) stated that they did not want to stop smoking. A further analysis revealed that the heavier smokers were the ones most motivated to stop.

Data on Swedish GPs and other Health Professionals smoking habits

Data on attitude, behaviour and smoking habit of Sweden GPs are also available. Hereby this data are presented more extensively due to the

fact that Sweden did not participate to the first phase of GPs Empowerment project.

The smoking prevalence among Swedish doctors has been the subject of repeated national surveys. The latest survey was conducted by the Swedish Medical Association in 2001 (24). National samples of 10% of all active doctors were sent questionnaires on their tobacco habits and how and when they approached their patients with regard to tobacco.

In 2001 there were 27 400 members (<65 years old) of the Swedish Medical Society. A random sample of 5% (n=1367) were sent a 25 item questionnaire. A response rate of 80% after two reminders was achieved. By 2001 the situation was the same compared to 1996 i.e. 6 % daily smokers, 8 % among males and 5 % among females. In addition, as many as 16 % of the males and 5 % of the females reported use of smokeless tobacco (oral moist snuff, "snus").

In 1999 a tobacco survey aimed at doctors in primary care was conducted in the Nordic countries (25). One thousand questionnaires were sent to Swedish primary care doctors and the response rate was 60 %. The smoking rate was 3.5 %

Ninety percent reported that they ask all or nearly all patients with smoking-related symptoms about tobacco habits but only about 10 % of the doctors routinely ask their patients about tobacco. About 30 % stated that they describe the dangers of smoking to their smoking patients. Sixty percent of all doctors give advice about NRT. Follow-up visits were offered "often" by only 17 %, whereas 50% "seldomly" did so. About 40 % had been engaged in giving advice. Eight out of ten reported having spent less than 2 hours on tobacco counselling during the last month. Four out of ten had had some training or otherwise tried to improve their skills.

Regarding barriers to engage in tobacco prevention, only a few GPs (2 %) still deny that smoking is a big health problem. Four out of ten deny that advice about smoking tend to take too much time. Still, 10 % of all doctors state that it is not their duty to ask about tobacco or

engage in smoking cessation. A surprise finding is that although 60 % say that they have not had any training in smoking cessation, 70 % state that they know enough. As many as 80 % wish that smoking cessation specialists were more readily available.

In conclusion, Swedish GPs have little or no education in smoking cessation but they nevertheless report that they know how to help their patients. There are obviously too few specialists to refer smoking patients to and many doctors find smoking cessation too time-consuming and difficult.

Data are also available on tobacco smoking and attitude among Swedish nurses and dentistry. Nurses serve as role models, coaches and offer support to their patients. A national survey (26) was carried out in 1998 on a random sample of 4 348 out of a total of 79 653 nurses in Sweden. Registered female nurses on active duty working more than halftime, in non-administrative service in 1998 were eligible for the study. The results was based on answers from 3 638 nurses (response rate 84%). The prevalence of daily smoking among registered nurses was 12% in hospital care and 7% ($p<0,05\%$) in primary health care. The prevalence of occasional smoking was 9% in both groups. Nurses in primary health care were most active in tobacco prevention, and non-smoking nurses were particularly active. Large increase of prices for cigarettes and special tax on tobacco were actions nursing staff thought were very positive. Fifty-eight percent of hospitals nurses and 91% ($p<0,05\%$) in primary health care have had the opportunity to talk to patients about tobacco. Thirty-one percent of the nurses in hospitals and 45% ($p<0,05\%$) of nurses in primary health care believed they had enough knowledge to give patients advice about stopping smoking. Tobacco prevention was assigned high priority by fewer nurses in hospital care (42%) compared to primary health care (68%) ($p<0,05\%$). Thirteen percent of nurses in hospital care informed their patients about the health consequences of smoking at least once a week compared to 41% of the primary health

care nurses(p<0,05%). Eighteen percent of hospital care nurses reported that they had initiated active smoking cessation at least once a month and corresponding proportion primary health care nurses was 46% (p<0,05%). More than 20% of the nurses had received training in tobacco-issues during their education. After completion of this training, 13% in hospital care and 58% (p<0,05%) in primary health care have had education in tobacco-issues. Nurses' own smoking has been reduced by half during the 1990´s. This observation and the rest of the results from this first national survey strengthen the belief that nurses have great possibilities to carry out tobacco preventive work. The large difference between hospital and primary care is not justified and should be reduced.

The dentistry has emerged as a very important resource in tobacco prevention. Oral and dental health is important in all age groups and the cosmetic value of healthy teeth cannot be underestimated. Surveys of tobacco use and attitudes have been performed on random national samples in 1991 and 1996 in Sweden (27): the health professionals working in dentistry have by and large stopped smoking and the barriers to tobacco prevention in dentistry seem to be similar to the ones reported in primary care.

AIMS GPs II Phase

The main project aim was to develop European guidelines on how to train doctors to sensitise their awareness against tobacco smoke habits of their patients and to give them evidence based tools to help their patients who want or need to quit smoking.
Intermediate objectives are:

- To reach relevant GP's organizations consensus on European guidelines identified through the project
- To identify, through the GP's updating system in each Country, best strategies to promote the identified guidelines
- To identify proper channels (Universities, training agencies, etc.) and instruments (booklet, video, CD, etc.) through out which distribute/disseminate the guidelines.

Originally the project involved another partner organization from Ireland, the Royal College of Surgeons in Ireland, Dept. of Family Medicine & General Practice Mercer's Medical Centre. This partner had to leave the project because it did not have the proper support from other organizations in Ireland.
In relation to the different national context, each country developed its particular strategy to implement or disseminate clinical guidelines on smoking cessation.
In particular, GPs II phase was devoted:

- **in Denmark,**
    - to develop strategies to inspire the general practitioners to ask all their patients about their smoking habits every time they come to the clinic (the asking will indicate interest in the patient's health and hopefully inspire smokers to quit their smoking);

- **in France**, for Tabac & Liberté,

- to elaborate a guideline for GPs based on the result analysis of phase I taking in consideration that Tabac & Liberté GPs members show significant difference when compared to the other GPs in France.
- to develop actions towards GPs and the general public unquestionably requires to communicate better and even to change the methods that have been using up to now without great success

in Greece,

- to develop Hellenic guidelines on how to train doctors to sensitize awareness against tobacco smoke habits of their patients and to give them evidence based tools for help to chose who want or need to quit smoking.
- to reach relevant GP's organizations consensus on the National level identified through the project
- to discover, through the GP's and /or any other updating system, best strategies so to promote them
- to identify proper channels (Universities, training agencies, etc.) and instruments (booklet, video, CD, etc.) to distribute/disseminate the guidelines.

in Italy,

- to develop, if necessary, guidelines on smoking cessation to be used in general practise or analyse the existing ones;
- to evaluate if the developed guidelines were consistent with the conclusions of the questionnaire survey among the general practitioners made during phase one;
- to reach a consensus on the relevant issue of the Guidelines on smoking cessation to be used in general practise, among all Italian GPs associations;

- to define strategies for the dissemination of the guidelines.

in Portugal,

- to motivate all general practitioners (as well as other health professionals) in smoking cessation techniques with their patients (with or without smoking-related diseases)
- to design (centrally at Instituto da Qualidade em Saude [IQS]) and disseminate among the near 6000 Portuguese GPs (as well as other health professionals) an evidence-based guideline on smoking cessation

in Sweden,

- to further develop existing guidelines and disseminate them as broadly as possible
- to promote the national telephone helpline for smoking cessation to GPs as a tool for helping their patients.

MEANS BY WHICH THE PROJECT WAS IMPLEMENTED

In **Denmark,** clinical guidelines were produced in agreement with the Danish National Board of Health:

- using the documentation from other national smoking cessation guidelines (limited to the guidelines in English, mainly in USA and UK);
- using the Cochrane library report on evidence of smoking cessation;
- searching through Pub Med and other Internet databases (three US guidelines, an English, a Scottish, and one from New Zealand were found).

A questionnaire surveys and group interviews with general practitioners were designed and conducted in order to describe more

precisely the general practitioners experiences with smoking cessation in general practise in Denmark.

In **France**, the research group of Tabac & Liberté decided:

- to use as their main communication subject *Chronic CO intoxication*, which has the advantage of being known by the general public as it refers to death caused by acute CO intoxication;
- to carry out a lobbying action for the general public about "self-managing your health", hoping to obtain the support of public authorities, public and private organizations for this action;
- to elaborate French guideline taking into account the tobacco epidemic, especially among women, the lobbying and communication elements, the training elements for the day-to-day management of patients who wish to quit smoking.

Special attention was put to the facts that the members of Tabac & Liberté showed a significant difference when compared to the other GPs in France, and that in France, just like the other European partners, there were difficulties to mobilize GPs to fight against "tobacco abuse" and global resistance of public opinion following advertisement campaigns with posters.

In **Greece,** since GP's Empowerment phase I project, certain activities regarding doctors attitudes have been raised. Following the formal beginning of this project, a lot of information has been collected again regarding "GP's" smoking habits and needs according to its two main axes.

Communications with individuals, local medical and other doctors associations was activated to exchange information. Contacts were

also developed to find out their anti-smoking activity and especially if there is a relevant directive or guideline.
A new questionnaire was sent with the intention to find out the existing practices, needs and tendency for cooperation. The purpose of this study was to investigate the behaviour and smoking habits of Greek doctors and/or their response rate in completing related questionnaires.
The same questionnaire of the first phase was again sent to 14200 by mail with the quarterly publication of HCS, also in relation of the low compliance of the Phase I survey.
Clinical guidelines on smoking cessation have been developed and a dissemination strategy was planned.

In **Italy**, between the end of phase 1 and the beginning of phase 2 of the GPs Empowerment project, few guidelines and recommendations on smoking cessation to be used in general practise were developed in Italy by different Institutions and Associations.
An evaluation through the scientific literature, on Internet and experts advices was made in order to identify the GPs' Associations more active in the fight against tobacco. All of them were contacted and invited to participate to our the project. On March 28th 2002, a first meeting took place in Florence with a selected number of members of these organizations. It was decided to organize a Consensus Conference on 7th-8th of June in the South of Italy, with the aim:

- to reach consensus among the participants on existing Italian Guidelines
- to draft a consensus document regarding the implementation of these guidelines
- to identify training models for GPs:
  - during the medical curricula
  - during the post-graduation period

In **Portugal**, evidence-based guideline was projected for use by GPs in their everyday work. Its major structure obeyed the general recommendations from the National Guideline Clearinghouse (USA).
The Instituto da Qualidade em Saude (IQS), which has a network of permanent professional relationships with individual GPs (as well as GPs organizations), organized formal meetings. During these meetings the guideline was distributed and discussed, and the practical aspects of the interventions were presented. Most of the suggestions coming from GPs concerning this matter were considered in the final version of the guideline.
The IQS also promoted and sponsored several smoking cessation training courses. These were offered by professional groups, as well as specialty medical societies, and have remained an ongoing activity for several professional groups.
Some clinics on smoking cessation were created at this time, not only in Health Centres but also in hospitals, further supporting the smoking cessation policies.

In Sweden, an extensive review of the evidence for smoking cessation in health care was initiated by SBU – The Swedish Council on Technology Assessment in Health Care. An expert panel worked from 1994 to 1998 and issued an extensive report in 1998 that was revised in 2002 (13). Based on the reviews, a manual, titled "The road to a smokefree life" was produced in co-operation with the NGO "Doctors against tobacco". A dissemination strategy was also planned.
As a shortage of smoking cessation specialists to refer to had been identified, a project aiming at informing GPs on the usefulness of the Telephone Help Line was developed. Recent results indicate that callers who have been advised by their GPs to call the helpline are 3 times as successful in quitting compared to callers with no such support.

RESULTS

In this chapter results obtained in the different countries involved are presented. At the beginning of each section, the national primary care system is described for a better evaluation of the different national strategies.
A brief description on national GPs organization and GPs smoking habits is also presented.
Finally, the results of GPs II phase in each country are described.

Denmark results

Danish Primary Care System

Ministry of Health is the central health authority in Denmark. The Ministry attend to tasks as planning, co-ordination and development of the health service. The National Board of Health is the institution on central level, which is responsible for prevention, information and treatment.
Every citizen in Denmark has a right to receive medical care. The public health insurance makes sure that all medical treatment as basis is free. Parallel with this a big task of the health authority is to inform about health and illnesses.
The public health service is decentralised which means that all specific decisions in practise are taken in the municipalities and counties after directives given by the Ministry of Health.
In every county there is a medical health officer, who on behalf of the National Board of Health supervises authorized health personal. Apart from this the Medical Health Officer advises and guide authorities and institutions on medical, hygienic, environmental and community medical conditions.

Each citizen has a right to choose his or her own General Practitioner as long as the consultation is within a distance of 10 km. Children under the age of 16 years belong to the practitioners and the health insurance of their parents.

In Denmark there are around 3.600 general practitioners with approximately 1.500 patients each. They spend around 10 min. on each patient per consultation and each patient consults his general practitioner 6-7 times per year.

Consultation hours are from Monday to Friday between 8 am – 4 pm either with fixed surgery hours or booking time. Between 8-9 am it is possible to get in contact with the practitioner by telephone. Most of the General Practitioners have moreover one day per week for consultations after 16 pm.

From Monday to Friday in the daily hours the practitioners can come for home-visit if the patient ask for it and the practitioners find it necessary.

Organization of GP's

The Organization of General Practitioners in Denmark (Praktiserende Lægers Organization, P.L.O) is a nationwide organization under the Danish Medical Association, DMA (Den Almindelige Danske Lægeforening, DADL). The specific objectives of the DMA are: to unite Danish doctors in order to protect the interests of the medical profession, and to serve as the body through which the influence of the medical profession may be exercised on general social issues in the best interest of health and the health care system.

The Danish Medical Association was established on 1 September 1857. The first Danish hospital law dates back to 1806, but the doctors were not satisfied with the official effort in the field of a health system. The establishment of a Danish medical association was based on the existing lack of hospitals, poor quality of the hospitals which did exist,

the need for health care to come within the scope of the local authorities in order to support the efforts of the medical profession, the reformation of medical legislation, and the involvement of the medical profession in the development of these matters.
In the years following the establishment of The Danish Medical Association, from 1857 up to 1900, local medical associations were set up throughout the nation as subgroups within The DMA. Today there are three subgroups: The Danish Association of Junior Doctors (FAYL), The Danish Association of Medical Specialists (FAS) and The Organization of General Practitioners in Denmark (P.L.O). P.L.O. was established in 1967.
About 94% of the doctors authorized to practice in Denmark are members of the DMA as well as one of the three craft organization subdivisions. The task of the subdivisions - each within its own area of concern - is to look after the members' professional and financial interests.
With certain exceptions, a DMA member must also enrol in the local DMA branch association in the geographical area within which they carry out their principal occupation. In all, there are 17 such local associations - one for each of the 14 Danish counties, one for Copenhagen, one for the Faroe Islands and one for Greenland.

DMA's smoking policy

DMA's smoking policy asserts that "*doctors don't smoke at work*"

- Hospitals, clinics and other institutions to ban smoking among employees
- All doctors are offered help to smoking cessation

Doctors estimate their patients smoking habits and the possibility of smoking cessation

- Smokers are ensured free counselling, support and help to smoking cessation through the professional system.

- Smokers are not to be condemned or deprived from the right to preventive care or treatment, just because of their smoking status
- Smoking among patients and relatives at hospitals, clinics and other institutions is restricted as much as possible

Doctors are ensured professional competence in all aspects of smoking

- All doctors are educated or in other ways made aware of the latest research within the damaging effect of smoking and smoking cessation methods
- The effect of methods to reduce smoking are documented through research

Doctors support all initiatives in society to reduce smoking, especially:

- Ban against all forms of tobacco commercials
- Ban against addition of dependence-producing substance in tobacco
- A tax policy for tobacco to reduce smoking
- Ban of smoking in all public transportation, buildings and institutions, to allow smoking only in demarcated areas
- Preventive initiatives addressing children and young people to prevent them from starting to smoke
- Ban against sale of tobacco for people under the age of 15 years

Smoking habits of Danish GPs

A questionnaire send to all GP's in Denmark in 2000 showed that only 8% of the GP's smoke every day and 7% smoke now and then. All together 1464 (42%) of GP's returned the questionnaire.

In 1996 a questionnaire made by the former Counsel on Tobacco and Health in Denmark showed that 22 % of the male doctors and dentists were smokers compared with 38 % of the general population and 48 % of the hospital porters.

Among women 19% of the doctors, 10 % of the dentists, 24 % of the nurses and 21 % of the midwife's were smokers in 1996 compared to 35 % of the general population and 40 % of the assistant nurses.

GPs II° Phase: Danish results

a) The questionnaire survey

A survey was undertaken involving 54% of the 42% of the general practitioners who filled in the GPs Phase I questionnaire. They allowed to sent out another and longer questionnaire (the August questionnaire) asking more and thoroughly questions about their attitude towards smoking cessation in general practise, how often and when they talk to their patients about smoking cessation, what kind of materials they use or would like to have to use in general practise, and finally, a description of their own experiences of what works well and what wasn't a success talking smoking cessation in general practise. On August 2000 a questionnaire was sent out to 794 GPs; 530 answered the questionnaire. It means that 67% of GPs answered the questionnaire, corresponding to 15% of all GPs in Denmark. Not any reminders and no data were found on non-responders. The respondents must be expected to be the top motivated part of the general practitioners, which was part of the aims: find out the GPs' good and bad experiences and knowing that these motivated GPs are the first ones being interested in doing something to help their patients stop smoking.

Using the answers from the questionnaire survey and in particular the qualitative comments from the general practitioners on experiences and good ideas, it was made a plan for what new materials, education, and knowledge the general practitioners should be provided with. One clear need sticking out from the survey was the need of an efficient and "easy to use" tool to advice all smoking patients to stop smoking.
The main conclusions of the August questionnaire survey were:

there is no single idea on how to make smoking cessation in general practice, but a quest for many different approaches corresponding to the big variety of general practitioners and smoking patients.
The general practitioners specially asked for:

- Targeted materials to different patient groups
- How to make a personal follow up
- A catalogue of good grips (e.g. illustrations, lung capacity measures…)
- In service training, courses and education on how to do smoking cessation
- Information and documentation of connection between illness, diseases and smoking in GPs medical journals.
- Clinical guidelines

b) Group interviews

With the conclusions from the questionnaire surveys, two groups of general practitioners were selected from the addresses of GPs willing to respond the August questionnaire, and interviewed using the method of the group interviews. These were formed as semi structured qualitative interviews with two small groups of general practitioners. The main aim of the group interviews were to hear more about the GPs experiences with smoking cessation in general practice and to test researchers' ideas to materials, guidelines and education for the general practitioners.

c) The Danish smoking cessation clinical guidelines (Annex 1)

The recommendations and the emphasise in the Cochrane library report *(effectiveness of interventions to help people stop smoking that*

even brief advice from the general practitioner increases the quit rate) makes the fundament of Danish guidelines, together with the results of the questionnaire surveys and group interviews with general practitioners.

A first edition of the guideline was later discussed with a group of general practitioners in order to hear their comments and adjust the guideline to the target group.

The intention of the Danish smoking cessation clinical practice guideline has been to:

- Make it short, clear and concrete
- Put emphasise on the GPs unique role: What can the general practitioner do better or in a different way than others using their medical and health education background
- Distinguish between what every GP should do and a second part containing what the motivated GP can do.

The result was a small booklet and later a poster distributed to all practitioners in Denmark. The title is: Ryger du? - Veje til rygestop i almen praksis (Do you smoke? - Ways to smoking cessation in general practice).

The booklet is meant to inspire practitioners to talk about smoking habits in the clinic, but also to educate about not obvious smoking-related diseases, interview techniques and ways to do smoking cessation in the clinic if the practitioners have the necessary time and willingness.

The booklet consists of 9 parts:

1. The 10 commandments for quitting smoking at the general practitioner's
2. Ask all your patients: Do you smoke?
    - Discuss smoking with your patients
3. Diseases and smoking
    - Smoking-related diseases
    - Other opportunities to discuss smoking

4. About smoking cessation
5. What you can do as a general practitioner
    - Register all patients' smoking habits
    - Ask every time – follow up
    - Recommend everybody to quit smoking
    - Ask if the patient desires to quit – now or later?
    - Refer patients to withdrawal and provide guidance about resources
    - Clarify the nature of the dependence
    - Programmes for treatment at the general practitioner's
    - Support
    - Follow up
    - Maintenance
6. Interview techniques
    - Ask open questions
7. List of literature
8. Materials for use at interviews:
    - The Quit Smoking Process
    - Keys to a Healthy Diet
    - Chart of the Lung Function
    - How would you like to be when you have become an ex-smoker?
9. A CD containing materials:
    - The Quit Smoking Process
    - Keys to a Healthy Diet
    - Chart of the Lung Function
    - How would you like to be when you have become an ex-smoker?

The guideline was sent out with mail to all general practitioners in Denmark in September 2002 together with a letter of instruction

containing an explanation of the aim of the guideline and how it should be used it.

The poster, which will be used as a reminder later this year, show nine different examples of situations where the general practitioners can ask his patients about their smoking behaviour, besides that the text: "Do you smoke?" and "Ask all patients about smoking habits - your question can make a difference" is the main message (enclosed).

d) Future plans

Implementation and evaluation of guidelines

The guideline will be reviewed in local medical journals.
A campaign (*Do you smoke?)* urging the general practitioners to ask all patients about their smoking habits and give all smoking patients advise to quit smoking is published in medical journals.

Support via Internet:

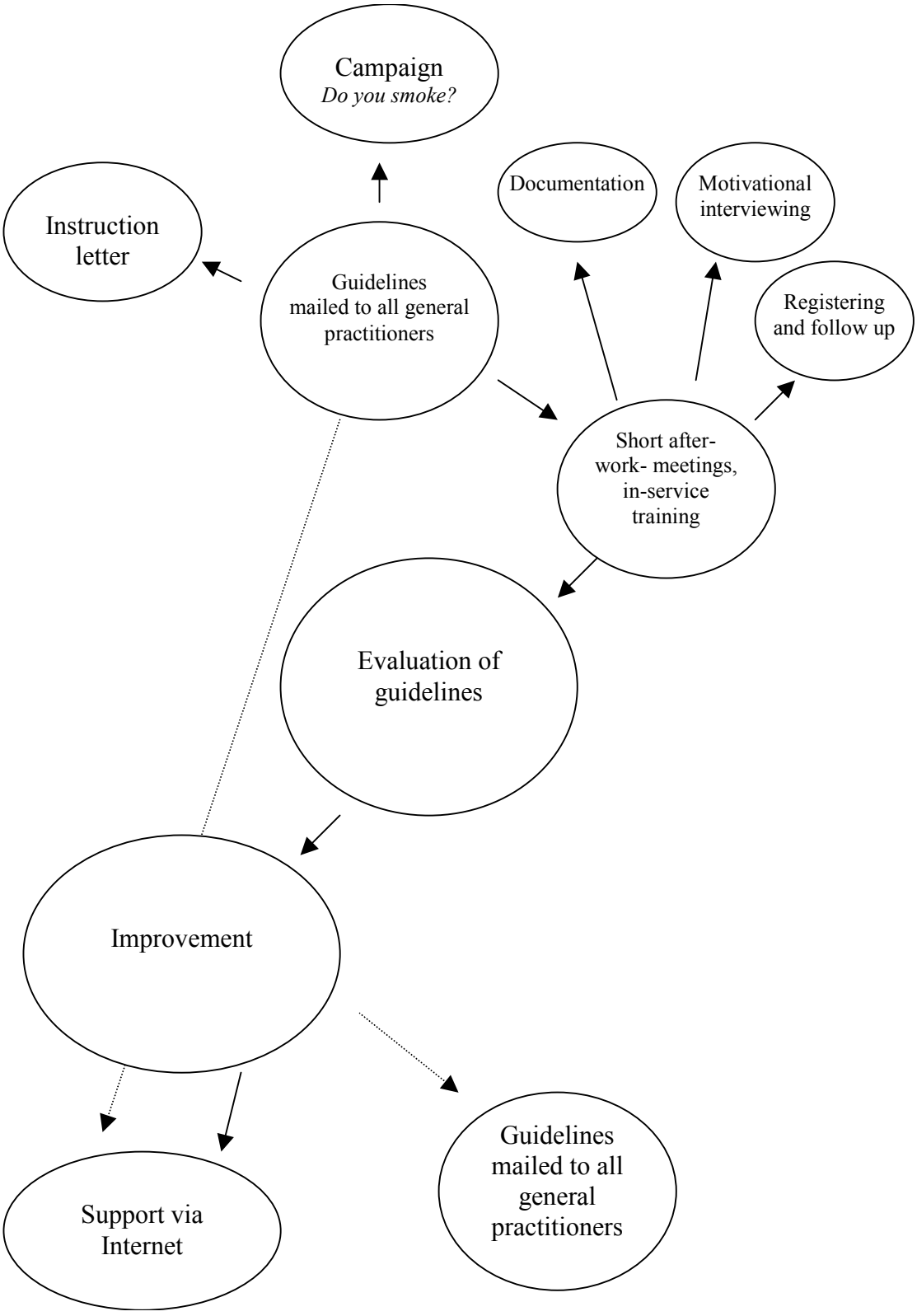
Guideline is to be available on the Internet.

In-service training

In-service training is planned to take part as short (two hours) meetings with general practitioners during spring 2003. The meetings will consist of the presentation of a relevant subject in connection with the guideline, presentation of materials to use in general practice and discussion and exchange of experiences with smoking cessation in general practice. Planning the in-service training as short meetings will hopefully make it possible for as many general practitioners as possible to take part in the meetings even though they have a big working load and a tight schedule. The training will preferably take part of the general practitioners organizations own in-service training program.
Relevant subjects could be:

- Documentation of connection between diseases and tobacco use
- Motivational interviewing
- Registering and follow up on patients smoking behaviour
- Other

The model illustrates the implementation and evaluation plan of the guideline:


Campaign
Do you smoke?
Instruction letter
Guidelines mailed to all general practitioners
Documentation
Motivational interviewing
Registering and follow up
Short after-work- meetings, in-service training
Evaluation of guidelines
Improvement
Support via Internet
Guidelines mailed to all general practitioners

French results

French Primary Care System

In France, up today 95, 000 GPs are in activity, with an average age of 45.4 years old. Sixty percent of them are women. The national mean is 163 GPs for 100,000 inhabitants. There are 23 departments with 135 GPs for less than 100,000 inhabitants in the North of France, with the exception of Paris and Hauts of Seine, and 197 GPs for more than 100,000 inhabitants in 9 departments in the South of France.

Organization of GP's

The organization of the medical profession in France was delegated in the 40s by the government to the National Medical Order (Ordre National des Médecins), which acts as a guarantor for the profession by verifying both the titles, functions and "ethical" practices in exercising doctors. The doctors' governing body manages administrative issues related to the authorities and conflicts either between doctors or doctors and their patients. Ordinal justice, quicker than governmental justice, used to prevent having recourse to court. Doctors members of the Medical Order in one department in France elect departmental bodies (functional) and regional bodies (Law). Departmental bodies then elect the National body that deals with problems doctors may have with the government or the national health system.

Practitioners, traditionally individualistic in France, now seek the help of their medical union to defend their cause. These unions, as other similar unions found in different professions in France, have very few members and are often asked to defend political rather than corporative cases. Because GPs are more numerous, they have had a dominating position during deliberation. This is probably why the small

number -and less unionised - of specialists had to be associate generally with GPs.

The state finances either directly or indirectly training courses and public health actions through several organisms that do not necessarily work synchronically. Unions obtain the funds meant to finance continuous medical training for doctors and use a part of this fund to carry out some of their own training actions. The principal financing organism for doctors' training is the UNAFORMEC in France. At departmental level, there are other associations of Continuous Medical Training (CMT) which are gathered by region and nationally. In order to benefit from these financings locally, doctors often form groups within small local or district associations. These high-quality trainings generally aim at bringing together doctors and are often financed by the pharmaceutical industry. Since the improvement of the national health system and the reduction of health-related costs is less likely to be reached - according to those in power - with the help of medical representative organisations (National Medical Order and/or trade unions), all the governments (whether right- or left-wing) have gotten used to making decisions on national health measures without first consulting health professionals. This resulted in the setting up of a management that has been increasingly administrative and accountant since the 70s with today, a disastrous situation and a clear lack of campaigns, medical players (doctors, nurses, physiotherapists etc.) as well as a strong lack of motivation among the existing medical population. The decrease in medical care is for the moment seen in overburden emergency wards as city doctors no longer visit patients at home in the case of an emergency after 6 p.m.

In this context, and despite the attribution of specific grants - being quite complex administratively to distribute among the state, region, department, districts : CNAM, MILDT, DRASS, DDASS, CPAM, MSA, etc. – and other funds (PRS, PRAPS, FASQSV, FNPEIS, ASS, etc.- even the most motivated have become discouraged. It is thus difficult to ask

doctors to become involved in public health actions that aim to reduce alcohol or nicotine abuse for example.

Smoking policy and associations in France

In France there is an association presided by Professor Tubiana, "L'Alliance pour la Santé –Coalition contre le Tabagisme" (Alliance for Health-Coalition against tobacco abuse), which regroups all the others associations at a national level, and successfully ensures the lobbying in France and Europe of the struggle against tobacco abuse together with European governments and institutions. This association contributed in a large part to both the promulgation of the legislation on the ban for tobacco advertisement in France and the Evin Law.

There is also a reference organization created by people (GPs or other) engaged in the fight against the damaging effects of tobacco: "Office Français de Prévention du tabagisme" (OFT) (French Office for the Prevention of tobacco abuse) which plays an advisory role with the Minister of Health services and the National State Health Insurance Office. This Office carried out a special survey this year in France and reported more than 300 consultations in tobaccology and smoking cessation methods. In the last couple of years, these consultations have tripled partly due to the recognition of Inter-University Degrees of Tobaccology and the action led by local and national associations such as Tabac & Liberté.

At a national level, Tabac & Liberté with 2750 members is by far the largest association of GPs fighting against tobacco abuse. Aims of the association are the research and the implementation of effective means against tabagism and for the smoking cessation of patients followed by their family doctors.

The National League against Cancer (LNCC) and the Minister of Health Services (DGS) also provide some training activities to GPs. Moreover, various local GP associations have an important local role, and

Continuous Medical Training (FMC) includes more and more tobacco abuse in it programs.

Finally, in certain areas (North: ECLAT, Rhône-Alpes: IRAT, Midi-Pyrénées: CAPITOLE/Stop-tabac) multi-disciplinary collaborations are being established to gather all those who work in this field. Just as in the Midi-Pyrénées, on the initiative of Tabac & Liberté, the group CAPITOLE/Stop-tabac regroups regional representatives of national organizations involved in the fight against tobacco abuse:

- National League against Cancer, (LNCC)
- Committee fighting against Respiratory Diseases and Tuberculosis \\ (CMR)
- French Federation of Cardiology, (FFC)
- Regional Committee of Health Education (CRES)
- Tabac & Liberté

As well as other local partners:

- Municipal Health Community,
- CHU Tobacology Centre (University hospital)
- University department of Continuous Medical Training (FMC),
- FMC-31/FMC Midi-Pyrénées

Smoking habits of French GPs

The number of doctors who smoke in France is similar to the one found within the population and it is not their awareness of the danger incurred that motivates these doctors to quit smoking or not. For the past ten years, French GPs have been getting extensive training on smoking cessation methods by both the State (Nicomède program) or various organisms and institutions such as the National League against Cancer, the National Committee of Respiratory Diseases, etc. Since 1994, the Tabac et Liberté association has also been taking on a large part of this training that was later on proposed to pharmacists (after nicotine substitutes

obtained their OTC status) and more recently, to medical or health-related professionals.

GP's trained by Tabac & Liberté were not only pleased with this course but also more motivated to fight against tobacco abuse, as reported by the study carried out within the framework of the GP-1 European survey. Nevertheless, it seems that the recent OTC status of nicotine substitutes has lead to a general lack of interest in the GP's fight against tabagism.

Doctors who smoke (30% on average) do not feel that it is their role to quit smoking in order to set an example for their patients (GP-1 survey). On the contrary, they are often the ones who influence negatively by creating a disparity between their own attitude towards nicotine and the well-known and evident harmful effects of nicotine abuse.

A recent study (2002) provides with more information on this point. It is in fact the medical thesis of Nasila Garrigues-Naserzadech attended at the Faculty of Saint-Etienne and supervised by Pr J.M. Vergnon. The aim of this work was to assess the methods used by doctors in Saint Etienne to manage their patient smokers. In total, 111 doctors participated in this study out of the 148 initially contacted (85%). Two-thirds were men, older (35-55 years old) than their female colleagues (35-45 years old), and had been set up for longer. The reported percentage of smokers was 25% (lower than the percentage generally seen then).

The majority (80%) of doctors said they questioned their patients about their smoking habits. Non-smokers were more often (85%) questioned than smokers (64%). Female doctors proved to detect nicotine addiction more effectively than their male colleagues. Although only few doctors said they used validated Fagerström test (26%), %) HAD (2%) Motivation (8%) and only 3% of doctors performed functional respiratory investigation.

Only half of the practitioners knew the address of the nearest tabacology center where their patients could consult a specialist. This work – even if carried out among only very few doctors – has a certain qualitative value as regards the attitude of GPs in front of patients who smoke (28).

GPs II° Phase: French results

a) First step: establishing relationships

For the Tabac & Liberté association, the first step consisted in developing existing relationships with other associations and institutions in France that worked in the field of tobacco dependence prevention and tobacco cessation.
In particular, relationships have been established at a national level with:

- MILDT Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie (Interminister Mission for the Fight against Drugs and Drug Addiction), chairwomen Mrs Maestracci;
- Alliance pour la Santé (French Alliance for Health) – Coalition contre le Tabagisme (Coalition against Tobacco) – chairman Prof M. Tubiana
- OFT – Office français de Prévention du Tabagisme (French office for the Prevention of Tobacco Dependence), chairman Prof Dautzenberg
- FMC-31, chairman Dr Boissier
- FMC- Midi-Pyrénées, chairman Dr Boissier
- La Fédération Française de Cardiologie (French Federation of Cardiology), chairman Prof D. Thomas
- Le Comité National contre les Maladies Respiratoires (National Committee on Respiratory Diseases), chairman Prof P. Duroux

- Le Réseau Hôpital Sans Tabac (Tobacco-Free Hospital Network), chairman Prof Ruff
- Le Comité Français d'Education à la Santé (CFES) (French Health Education Committee)
- La Fédération Nationale des Sapeurs Pompiers de France (National Federation of French Firefighters)
- The French Army (BSPP: Paris Fire Brigade, Marine Corps and the Army Health Service)
- La Mutuelle Sociale Agricole (Social and Agricultural Mutual/Complementary Health Insurance Fund)
- La Mutuelle Nationale des Sapeurs Pompiers (National Firefighters Mutual/Complementary Health Insurance Fund).

At a local level, Tabac & Liberté association established relationship with regional organizations (ECLAT, IRAT, CAPITOLE/stop-tabac) and "départemental" organizations: Regional Councils of "départements" 31, 38, 63 and URCAM, CRAM, CPAM, DRASS, DASS, CRES, CODES and so on).

Tabac & Liberté is continuing its training actions among regional structures that all fight against tobacco dependence, and hopes to soon set up, after Capitole/Stop-tabac, other regional structures such as Languedoc/Stop-tabac, Aquitaine/Stop-tabac, Bretagne/Stop-tabac, Poitou-Charentes/Stop-tabac, Corse/Stop-tabac and so on.

b) Second step: training

The association developed one training course on smoking cessation for GPs based on the 8 years of experience in this field, with the collaboration of its 60 trainers. Today this training program seems perfectly adapted for GPs. The method proved applicable to certain groups of GPs, such as fire brigade GPs, and healthcare facility GPs, and at continuous medical training. The association Tabac & Libertè

tested it with success at an experimental seminar to fix its limits. This method is reported in the work plan of GPs' Empowerment phase I.
The association is presently evaluating and presenting the results from the Tabac & Liberté smoking cessation methods used for the training of GPs between 1995 and 1999 with more than 5000 GPs trained. During the first 6 months of the year 2000, and this because nicotine patches was sold Over-the-Counter (OTC product) and no longer required a medical prescription, about 6000 GPs and pharmacists received training. In other words, about 10,000 GPs and pharmacists were trained. From this experience, it was decided to propose a training method particularly adapted to the GPs. This method was tested on the occasion of seminars in France.
Tabac & Liberté asked all its trainers to test the concept and methodology (programme, visual documents, role plays, clinical cases) so that these can be similar throughout France.
Furthermore, the members of the association's board of directors have themselves taught the pilot training programs so they can see for themselves how these courses were perceived by GPs [Saint Malo, Paris (GP and Paris Fire Brigade), Montpellier (GP and midwives), Toulouse (GP) and so on.

c) Third step: guidelines (Annex 2)

The third step consisted in organizing a meeting with Tabac & Libertè trainers in order to develop clinical guidelines on smoking cessation for GPs.
GPs also need to be given the precise limits of their sphere of action so that they know at which point in time to advise their patient to consult a specialised center. The basic principle of the work of the trainers of the Tabac & Liberté network is to act as a colleague and to provide just the sufficient amount of information GPs require without giving too much technical information which, although highly interesting, is not easy to apply in daily practice.

GPs should neither be given too much data as they will feel inclined to select which is useful and which is not. Let us keep in mind that the purpose is to share knowledge and not preach.

A working group was set up to work exclusively on the format of the guidelines and not bring any changes. The objective is to have them ready for publication and send them to the 2800 GPs members of the association, with the aid of Pierre Fabre Santé Laboratories, which have already co-operated with Tabac & Libertè during GP- Phase I. Then this guidelines will be sent to all GPs. These guidelines will be the main item of the agenda during the 22 regional meetings that will prepare the association's meeting (3rd and 4th of October 2003).

During this phase II, Tabac & Liberté also finished working on the 2-day training programme about fighting against tobacco dependence in companies. This programme was tested among GPs working in companies and company GPs. The training programme has now been tested and can be discussed with our European colleagues of GP Empowerment program.

d) Validation

Relationships

It is now widely acknowledged by many people and organizations for the management of nicotine addiction in France that Tabac & Liberté is indeed the network of GPs. Efforts to develop regional actions and to gather all the actors in this field goes directly with the government's will and evolution of habits. Tabac & Libertè's policy that has been established for the past 8 years is beginning to produce some results. The quarterly newsletter (n°32 is presently in progress) as well as the Internet site: www.tabac-liberte.com represents the bases of communication towards GPs, smokers and non-smokers.

Training

Training program of Tabac & Libertè association was initially based on experience and knowledge of the trainers and of the scientific committee of the association. For the past 8 years, a group of researchers worked with the aim at enrich, analyze, adapt and modify this program to take into account the evolution of knowledge, the specific expectations of GPs and wish to provide only useful information that can be easily used in the GPs daily practice. This program is now considered operational and validated. It is currently in progress the development of a shorter version of this program that will set out the principal chapters and items so that each trainer has the possibility to adapt and individualize the course according to one's experience.

Guidelines

Ever since the end of phase I, Tabac & Liberté has been working on guidelines which should answer to practical objectives:

- to be the keystone of communication actions towards GPs
- to be the fruit of all the network's experience and the work carried out for the past 8 years
- to be the bearer of the concept developed by Tabac & Liberté: providing only important data that can be used in the GPs' daily practice.
- to be pleasant and easy to read.

Tabac & Liberté is actively working on the improvement of the format in order to have the guideline published. These guidelines will be then sent to thousand of GPs with the aim at convince them to start fighting against nicotine addiction. These guidelines have been validated by the entire network and by the staff director of Tabac & Liberté.

Greek results

Greek Primary Care System

General Practice in Greece is an approved medical speciality but the overall numbers is still limited. The years of practising to gain the GP's title is ranged and it is more or less similar as in other European Countries. Other doctors, such as internists serving in health centres and / or in rural, urban areas and in small villages throughout Greece are working as GP's, on behalf of governmental services, in outpatients premises of insurance companies, or in private practice. There is not a distinct number of patients to serve and they are examining as more as they can in a regular period of time during the week days and/ or as emergencies at home, Health Centres etc

Organization of GP's

In Greece there are three organizations of GPs, the Hellenic Society of General Medicine/Practice, the Hellenic Union of General Medicine Practice and the Panhellenic Federation of General Practitioners. The first one is scientific and the other two represent also a trade union. They are nationwide organisations under the Panhellenic Medical Association (PMA). The specific objectives of the PMA are to unite all Greek doctors through their local societies in order to protect the interests of the medical profession, and to serve as the body through which the influence of the medical profession may be exercised on general social issues in the best interest of health and the health care system.

Smoking policy in Greece

Tobacco Legislation is adequate since several years and well harmonised with EU and/or other International Organisations directives. The role of NGO'S in the implementation of the tobacco

legislation is essential but all related actions must be more comprehensives thus are needed urgent reconsideration (table 2).

Table 2

Revival of the Hellenic Antismoking policy announced by the Minister of Health May 29, 2002 in Athens.

- Activation of the existing laws and ministerial directives
- Prohibition advertising in public as from 1 –1 – 2003, including cinemas, theatres, and direct or indirect ones on TV channels and radio stations.
- Reorganisation and extension of specific antismoking awareness for the general population
- Extension of the existing antismoking programmes in schools
- Prohibition of smoking within all schools premises
- Prohibition of smoking within all public places including airports etc
- Complete prohibition of smoking and sale of tobacco products, within all health premises
- Creation of separated areas for smokers and non –smokers in all restaurants and related places of public entertainments
- Prohibition of smoking in all public transports including taxi
- Establishment of specific medical cessation centres
- Immediate harmonisation of national antismoking policy with the up to date existing EU directives

Smoking habits of Greek GPs

The Greek doctors are smokers to significant high level ranging from 32% - 43,5%. The percentage of the smokers doctors is relevant to that of the general public, revealing that the smoking habit is deeply routed in the Greek society. Considering that no other social group is in position to acquire deeper knowledge of the hazardous

consequences of smoking in both the theoretical and practical levels, it becomes evident that smoking cessation is not dependent to the degree of information of smokers.

GPs 2° Phase : Greek results

The same questionnaire of the first phase was again sent to 14200 by mail with the quarterly publication of the Hellenic Cancer Society. 399 prepaid letters with the questionnaire completed were sent back or 3% out of the total number of doctors. Among them, 82 (21%) were smokers (table 3)

Table 3.

- General practitioners
- Internists
- Gynaecologists
- Cardiologists
- Pneumologists
- Doctors in working place
- General Surgeons
- E.N.T
- Medical Surgical Oncologists
- Rural Doctors
- Health Centres
- Hospitals,
- Others

The majority of the responders wrote that doctors must be good examples for their patients avoiding smoking, and so far are willing to receive further instructions on smoking cessation. They feel also ready to have any further assistance. Moreover, they believe that additional informative material is essential.

Early results of this study showed that the response rate of Greek doctors in filling this questionnaire is exceptional low.

Their knowledge concerning bad health hazards for tobacco products users is adequate, and they are very willing to participate in a well organized antismoking campaign.

The working group of the project agreed on an action plan for the schedule working program to strengthen cooperation with GP's organizations at National Level and is producing the appropriate directives or guidelines for broad national use **(Annex 3)**. All previous preliminary arrangements and actions were further activated with some success.

In Greece there is not any specific directive or program for the GP's or other medical professionals, to be used for the general population smoking prevention. In the context of the project clinical guidelines on smoking prevention for GPs were developed. The working program was carried out with the assistance of the existing Hellenic Cancer Society's throughout the country branches in order to reach to a consensus on the practical aim of the project.

Dissemination strategies have been discussed:

- A booklet, short brochures and posters are more likely to be used
- Guidelines can be transmitted through video, CD disk or can be downloaded from the H.C.S. website which is now under innovation.
- Articles are published regularly in the HCS's official two magazines and in one by the Panhellenic Medical Association and distributed all over Greece. These articles are written mainly by members of the board of the Hellenic Antismoking and Anticancer Society.

The final approval of the proposed guidelines is expected for the end of October 2002.

Italian results

Italian Primary Care System

In Italy, the National Health Service (NHS), reformed in 1978, is constituted by functions, services and activities devoted to promotion, maintenance and rehabilitation of psychical and physical health, addressed to the whole population, without any individual or social restriction. The NHS implementation and coordination is assigned to the Central Government, Regions and Local Health Authorities. Quite recent laws (No.502/1992, No. 517/1993) modified the organization of the general practice in Italy. Aim of these new laws is the quality improvement of medical care and the implementation of local health services. In 1999 a new National Labour Contract for GPs and Paediatricians was signed (D.Lgs. No. 229/1999), according to which the total responsibility for the patient's health is in charge of the family doctor.

GPs' duties are:

- Primary care
- Home assistance
- Health promotion
- Individual preventive intervention

Control of sanitary costs is also responsibility of GPs.
All residents in Italy have the right to receive medical care from GPs. Each citizen can freely choose his/her GP and Paediatrician.
Every GP can accept till 1.500 patients aged over 14 y_s and every Paediatrician can assist a maximum of 800 children aged under 14 y_s. Patients can at any moment change GP or Paediatrician. GP and Paediatrician can also refuse patients on condition that they formally explain the reasons to Health Authorities.

The GP outpatients clinic is open five days per week according with the consulting hours schedule available in the waiting room of the clinic (from Monday to Friday, 8 a.m./ 8 p.m.).
If the patient, because of his/her health conditions, cannot reach the GP's clinic, his/her GP is compelled to visit him/her at home.

Organization of GP's

F.I.M.M.G. (Federazione Italiana Medici di Medicina Generale - www.fimmg.org) is a national professional association of Italian General Practitioners. This association represents also a trade union of the category that represents 90% of Italian GPs. It is organised in different branches, with local sections. It is active in the fight against tabagism with several projects, as the "F.I.M.M.G. Smoke Project", in co-operation with the Italian Association of Pneumologists and Federfarma. The aim is the involvement of a large number of GPs in training courses based on the learning of behavioural therapy and nicotine replacement therapy. More than 1.000 Master Courses have already been performed. In the year 2001, the association distributed to its members two new tools, a training manual and a practical guide on counselling. A free telephone number for patients was also activated.

S.I.M.G. (Società Italiana di Medicina Generale - www.simg.it) is a national scientific association of GPs, with one hundred local sections distributed in the Italian regions. It is member of several Committees of the Ministry of Health and of the European Community. It is also involved in the EU project "Europe against cancer". S.I.M.G.'s activities are particularly focused on GPs training and one of the most important aim is the creation of a Department in the Medical University where GPs are the teachers. Concerning smoke cessation, S.I.M.G. carried out the "A.MI.CO. Project", aiming at implementing

knowledge among GPs on tobacco dependence and at developing their competencies on the clinical use of questionnaires and carbon monoxide measurement in the breath. Furthermore, S.I.M.G., in co-operation with the Italian Association of Pneumologists, is carrying on the definition of Guidelines for GPS about smoking cessation.

SNAMID (Società Nazionale Aggiornamento Medico Interdisciplinare - www.snamid.org) is a scientific society of the general practice, constituted in 1984. It is very active in the field of training for health professionals.

AIMEF (Italian Academy of Family Physicians - www.aimef.org), non-profit scientific association born with the aim at providing a forum for exchange of knowledge and information between general practitioners/family physicians, encouraging educational and research activities.

FIMP (Federazione Italiana Medici Pediatri - www.fimp.org) is the national professional association of paediatricians that represents also the trade union of the category collecting 90% of all paediatricians in Italy. The involvement of paediatricians in the project is crucial, due to the big prevalence of passive smoke exposure in Italian children.

Smoking policy in Italy

The Italian regulation deals with smoking control, in open contradiction with the activity of tobacco production by the State itself (only in 2001 government monopoly on tobacco production will be denationalised).

Since 1942 Italian government's health policy promotes citizens and workers physical and mental health care. Such as rights are guaranteed by means of Civil Law, Constitution, national and regional laws and bills.

Republic protects health as a fundamental right of the individual and as interest of the community, and guarantees free treatments to indigent people (article 32 of Constitution).

Legislation specifically about smoke expresses itself basically regulating smoking prohibition in particular places and smoking advertisement:

- Law 11/11/1975 n. 584

Interdiction to smoke in definite premises and public means of transport.

- Ministerial decree 18/05/1976

It includes regulations about air conditioning and air ventilation system according with the Law 11/11/1975 n. 584.

- Directive of the Prime Minister 14/12/1995

Smoking interdiction is valid in public and private places supplying public services by permission, contract, agreement or credit, as well as in public places. Hence, smoking interdiction extends to all business premises open to public (premises where the generality of administrators and users can enter in settled hours with no formality or permission – besides schools and hospitals)

- Art. 8 Law by decree 10/01/1983 n. 4

It is forbidden to advertise any national or foreign smoking product. Fine: from £ 5.000.000 up to 50.000.000 for the transgressor. The incomes acquired by the State will be used by the Minister of Health to finance health education and information campaigns, researches and surveys aiming to prevent tabagism.

- Law on tobacco monopoly

This law justifies:

- The limit of the free-trade solely in the authorised shops.
- The struggle against illicit trade of foreign tobacco.
- The expensive cost of tobacco products and the possibility of its increasing.

- Law by decree 19/09/1994 n. 626

In enclosed working places, working methods and workers physical efforts must be hold in due consideration, so that workers can have enough healthy air at their disposal. Employers have to make risk assessment for the employees when passive smoking is observed in their working place.

Regional legislation

Tuscany

- Regional law 07/08/1996 n. 65

It is prohibited to smoke in all enclosed spaces used at any title by Region, health body and regional body.
The interdiction is also valid in enclosed places when one of the workers makes request for it.
The incomes of the administrative fines will finance information and education campaigns. The fine is higher when the transgressor is a controller.

Emilia Romagna

- Deliberation of the Regional Council 26/05/1999 n. 785

It includes project against tabagism in order to create a network between Departments for drug addictions and SERT
It provides interventions of primary, secondary and tertiary tabagism prevention and smoke-correlated problems prevention (anti-smoke centres and information campaigns)
It fixes the guide lines for a future regulation to apply anti-smoke rules in every health services.

Smoking habits of Italian GPs and other health professionals

Nowadays in Italy a high proportion of doctors smokes (25-30%), as well as nurses (40%) (29).

Several studies have been carried out in the last two decades regarding smoking habits of health personnel, doctors included. Hereby results obtained in few studies are described in order to give an impression about the smoking habit of doctors and its trend in the last years.

During May 1986 a survey undertaken on the smoking habit of the health personnel of the Magenta hospital, located in the suburbs of Milan, revealed a high prevalence of smokers among doctors (39%). A larger survey carried out by the Lega Italiana per la Lotta contro i Tumori in Italy in the same year showed an higher prevalence in a similar population: 47,6%; (51,2% in males and 47,2 in females).

In Bologna, in the period 1992-1995, the smokers percentage was 43,7% among the hospital personnel, and it was observed a higher attitude to stop smoking in men compared to women.

In 1998 in Florence a survey was made by the Centro Antifumo (data unpublished) on the hospital personnel of the major hospital of the town: 40,5% is current smoker, (37,8% males and 42,6% females). Among doctors, 23,2% smokes, and the percentage is higher among nurses (45,7%). Those who are less than 40 years old smoke more (43.9%) than the others. Most of the smokers (85%) smokes also during working activities in the hospital, even if 58,5% out of smokers would like to stop smoking. Health personnel does not consider smoking habit an important problem; only 43,6% declares to be trained on health effects of smoking and only 38,3% considers that health personnel should set a good example for citizens.

In 1999 a survey was done in the Cancer Institute in Milan: the smoking prevalence rate observed was similar to the one of the Italian

general population (24,55% vs. 25%), with differences among different working groups: 52,38% blue collars; 27,71% nurses; 25,23% clerks; 18,72% technicians; 11,97% doctors. Out of them 10,46% never smokes in the Institute and 63% would like to stop smoking. In the same year a survey (30) has been carried out by Directa, on behalf of AIPO (Italian association of hospital Pneumologists) and FIMMG (Italian federation of GPs), about the smoking habits of hospital personnel: 32% smokes (25% among doctors); 77% smokes in the ward area even if it is prohibited, nevertheless 82% would like to ban smoking behaviour from the wards, and 52% would like to ban it from public places. The prevention activity made by the hospital personnel is considered not sufficiently developed: 23% does nothing about it, and only 26% gives advice to patients but only to those ones with smoking related diseases.

Regarding GPs, in 1996, a survey was undertaken on a sample of 467 GPs representative of the entire GPs population of four Tuscany provinces (Di Rienzo, 1996 – specialisation thesis). The compliance was 86.3%. Among males doctors 27.8% were smokers, and among females smokers were 30.3%. The attitude of doctors to invite their patients to stop smoking was less in smokers doctors compared to ex-smokers or non smokers. In most of the practices there were anti-smoking signals and/or poster on the same issue.

A survey has been carried out in 1999 by Directa, on behalf of AIPO (Italian association of hospital Chest Physicians) and FIMMG (Italian federation of GPs), about the smoking habits of GPs: there are 26% GPs smokers and 1 out of 4 of them smokes in front of the patients. GPs appear not very sensible to smoking prevention activities: 6% does not consider the problem, 54% gives advice to their patients and only 37% declares to gather data on patients' smoking habit.

All the studies on hospital personnel have shown an impressive high percentage of smokers that did not decrease in the last 15 years,

except among doctors. Anyhow the smoking prevalence among GPs is high as shown in other South European countries.

The high smoking rates in health personnel in Italy is probably due to the lack of enough training on the topic. In this respect, the results of a survey undertaken in 1995 on the population of 765 university medical professors, about teaching courses during which smoking cessation methods could be taught, were quite impressive (31). Only 23.1 % was the compliance; among the responders, probably the most sensible to the argument, most of them (83.6 %) teaches something about smoking, mainly on pathogenesis and health risks related to tobacco but only 8 professors teach about smoking cessation strategies.

GPs II° Phase: Italian results

a) Italian Guidelines (Annex 4a)

Validated guidelines were recently developed by the "Osservatorio fumo, alcol e droga" of the Istituto Superiore di Sanità (ISS) (32). The ISS is the technical and scientific Institute of the Italian National Health System. These clinical guidelines on smoking cessation were developed through a multidisciplinary panel of experts who reviewed the guidelines previously produced in other countries. A systematic review of the literature was performed, using the documentation from other national guidelines, randomised controlled trials and systematic reviews. A search in the Internet through Pub Med and Embase was made and the most important web-sites concerning guidelines were analysed.

A quality control on the selected documents was performed, focusing on:

- methods used to find guidelines
- methods used to elaborate and review guidelines

- strength of recommendations and evidence level
- updating level of documents

The minimal clinical intervention proposed in the guidelines is based on a well-documented schedule (the 5A intervention method).

These guidelines have been published on the web site of the "Osservatorio fumo, alcol e droga" (fwww.ossfad.it) and their use has been suggested by the Ministry of Health (www.ministerosalute.it).

Besides the mentioned very detailed guidelines, a brief leaflet on the content of these guidelines was developed in order to facilitate the consultation by health professionals. In the annex 4a, a translation of this leaflet is available. The translation was made by the Italian group of GPs Empowerment project phase II.

The ISS guidelines on smoking cessation have been produced through a critical evaluation of scientific evidence and revised by a panel of experts. For these reasons, no other evaluation has been made in the context of GPs Empowerment project. They can be considered the best one available in Italy.

b) The Consensus Conference on the Guidelines (Annex 4b and Annex 4c)

Several Institutions or Associations, active in the field of smoking prevention in Italy, were involved in the project, and particularly in the Consensus Conference, which took place in Potenza on 7-8 June 2002.

The Institutions and Associations invited to actively participate at the project were:

1. F.I.M.M.G. (Federazione Italiana Medici di Medicina Generale)
2. S.I.M.G. (Società Italiana di Medicina Generale)
3. SNAMID (Società Nazionale Aggiornamento Medico Interdisciplinare)
4. AIMEF (Italian Academy of Family Physicians)
5. FIMP (Federazione Italiana Medici Pediatri)

6. AIPO (Associazione Italiana Pneumologi Ospedalieri - www.pneumologiospedalieri.it) is the scientific association of Italian Chest Physicians. In the association a specific workgroup on smoking prevention is active.
7. Consulta Italiana sul Tabagismo It is a multidisciplinary association that gathers physicians, volunteers, social workers and experts who are active in Italy in smoking prevention. The aims of the Consulta are the development of coordinated strategies for smoking cessation, the promotion of training, the involvement of public health administrators and the constitution of a Scientific Society oriented to research.
8. SITAB (Società Italiana di Tabaccologia - www.tabaccologia.org) is a non profit association which promotes research, documentation delivery, training on primary prevention and treatment of smoking and correlated diseases.

During the consensus conference, the following topics were discussed:

- ISS guidelines
- S.I.M.G. – F.I.M.M.G. – A.I.P.O. guidelines
- S.N.A.M.I.D. Guidelines
- Impact of guidelines on clinical practise of GPs
- Evaluation of patient motivation to quit and medical counselling
- Post-graduate and undergraduate degree training
- Tobacco cessation experiences through the activation of a network of health services

The programme of the conference is shown in Annex 4b.

A consensus document was developed at the conference and revised through e-mail by all participants.

Aim of the document was:

1. to define strategies to implement the use of ISS guidelines in the daily practice of GPs
2. to emphasize the critical role of GPs in helping patients to quit

3. to define suitable strategies to involve GPs in smoking cessation programs carried out by Health Authorities

The consensus document is reported in *annex 4c*.

Portuguese results

Portuguese Primary Care System

In Portugal, the primary care system is organized around Health Centres. These are places where most of the primary care takes place : consultations, admissions, preventive medicine, etc. These centres are spread around the entire country and cover 100% of the territory. They are staffed with GPs and Family Physicians, nurses, social workers, as well as – in some specific cases - other primary care specialties: surgery, paediatrics, obstetric-gynaecology.
The access to this type of care is universal and free of charge (only small co-payments are expected).

Organization of GP's

The Portuguese GPs are organized around a professional association (Associação Portuguesa de Médicos de Clinica Geral - APMCG), responsible for scientific as well as professional/technical issues. Over 80% of the Portuguese GPs belong to this association and can also belong to one of 2 trade unions.
The Portuguese Medical Association (Ordem dos Médicos) is responsible for the professionalization of doctors, issuing professional licenses. Within the OM there is a College of GPs, responsible for post-graduate training programs that leads to the specialty degree.

IQS Smoking policy

The IQS has a network of permanent professional relationships with individual GPs (as well as GPs organizations). It is therefore relatively easy for the IQS to contact these health professionals on a formal (as well as informal) way, to inform of policies or to implement changes.
The IQS also promoted and sponsored several smoking cessation training courses. These were offered by professional groups, as well as

specialty medical societies, and have remained an ongoing activity for several professional groups.

Some clinics on smoking cessation were created at this time, not only in Health Centres but also in hospitals, further supporting the smoking cessation policies.

Smoking habits of Portugal GPs

A questionnaire was sent to all members of the APMCG. From a total of 3591 mailed letters, we got back 855 (23.8%) filled questionnaires as well as 86 (2.4%) returned by the Post Office due to wrong or unknown (not forward) addresses.

Concerning the smoking habits of the Portuguese GPs, authors found some variability: a minority (14%) smoked everyday (12% female, 16% male), 8% smoked now and then (7% female, 10% male), 27% described themselves as ex-smokers (24% female, 32% male) and 51% never smoked (57% female, 42% male). Interestingly, 21% of the responders (18% female, 23% male) stated that they did not want to stop smoking. A further analysis revealed that the heavier smokers were the ones most motivated to stop.

GPs II° Phase: Portuguese results

a) Design of the guideline on smoking cessation (Annex 5)

The guideline was an evidence-based document, projected for use by GPs in their everyday work. Its major structure obeyed the general recommendations from the National Guideline Clearinghouse (USA) – see below. This would be the most efficacious format for practical use, as well as the most updated in terms of scientific validity.

Selection of scientific evidence was made exclusively from secondary sources of information, defined as those which, following a selection of articles, clinical trials and studies from primary databases (Medline, EMBASE, CINAHL, for instance), suffered a critical appraisal based on

their methodological structure, including only the best. Then the major bibliographic databases were seen and the information were updated accordingly. Only the evidence which, on account of its validity, importance and relevance for clinical practice was considered to be the best, was indeed selected (see below). The ground criterion was that the above-mentioned secondary sources of evidence should unequivocally be based on scientific evidence and should be available in print (journals, books) and/or on-line. So the critical appraisal of the scientific evidence from the original articles (carried out according to evidence based medicine criteria) was previously conducted by the authors of the secondary sources themselves. Evidence thus produced has been collected, summarised and presented in the above formats (print and on-line).

Briefly, two main intervention categories recommended were: brief interventions and intensive interventions. Both include various forms of counselling and pharmacotherapy. Brief interventions are of three different types according to the group of patients addressed:

- tobacco users who are willing to make a quit attempt at this time
- tobacco users who are unwilling to make a quit attempt for the time being (motivational intervention)
- recent ex-tobacco users (relapse prevention intervention)

Intensive interventions differ from brief interventions in duration as well as in the intensity of psychological counselling.

b) Preliminary implementation measures of the guideline on smoking cessation

Formal meetings were arranged by IQS and the guideline was distributed and discussed, and the practical aspects of the interventions were presented. Most of the suggestions coming from GPs concerning this matter were considered in the final version of the guideline.

Due to shortage of resources, and also for policy reasons, IQS does not have the responsibility of implementing the guidelines either on a local or on a national level. Therefore, any formal or organized interventions to this end will be develop. However, IQS will support any initiative that may arise on different levels of the Portuguese National Health Service concerning smoking cessation. This will include giving talks, training courses, offering scientific advices, etc.

The entire text from the guideline is put at the IQS web site, so it is available for consultation and clinical use.

c) Validation

The validation of the work from IQS on smoking cessation in Portugal was done in two different steps:

- training of the health professionals (mostly GPs) in smoking cessation techniques
- use of the smoking cessation guideline as a major instrument in smoking cessation actions

The training of health professionals was organized around the needs from these doctors in smoking cessation programs. It was a practical exercise and was done by people with experience in the field. Validation of these teaching/learning experiences was achieved through questionnaires to these professionals, and the results disclosed a good level of satisfaction with the learning experience, as well as the notion of usefulness of the courses.

The guideline was evaluated and highly praised as scientific sound, and considered a useful instrument upon which the practical steps could be based on. It was disseminated at several different levels in the Portuguese National Health System.

Of course the most reliable validation will be done through studies on implementation that are supposed to constitute phase 3 of the GP Empowerment project. Defining the outcomes – in terms of quitting rates – will allow a clear picture of the final results of all these actions.

Swedish results

Swedish Primary Care System

Every person living in Sweden has health insurance. Fees are automatically deducted from salaries. Private health insurance is optional but rare. Hence, most of the health care and dental care is financed via the fiscal system. The health care services are supervised and financed through the regional parliaments – County Councils – which finance more than 95 % of Swedish health care. There are about 4500 GPs in Sweden and they have not a true gatekeeper role in Swedish health care. Most GPs are organised in group practices of typically 4-10 doctors. Since the early 1990´s more and more GPs offices have been privatised. According to the National Board of Health and Welfare the primary care varies considerably throughout the country as regards both organization and content. This can be illustrated by the following examples:

- The percentage of total resources in county council health care and medical budgets devoted to primary care varies between 11.7 and 20.7, according to a study of eight county councils where comparisons are made possible by common definitions.
- The supply of doctors for county council primary care, which a Riksdag (parliamentary) resolution stipulates as one general practitioner per 2,000 inhabitants on average, ranges, per county and expressed in whole-time equivalents, from one per 1,968 to one per 3,103 inhabitants.
- The primary care percentage of medical consultations is on average 42 for the country as a whole but varies from 26 to 55. There appears to be a connection between percentage of resources and percentage of primary care visits.

- The various competencies of primary care, and the knowledge and service which they represent, are integrated with county council organization in such a wide variety of ways that the health centre concept can be said to have lost its meaning. The health centre was intended as a physical concentration of professional specialities to make it easier for residents to seek help and to encourage co-operation between different professionals.
- The cost to the patient of a primary care medical consultation varies a great deal, especially if followed by a visit to another specialist. In cases of this kind, there is a difference of SEK 280 (autumn 1997) between the county councils having, respectively, the highest and lowest patient charges.

Practice, i.e. routines established in everyday work and in this way governing the deployment of resources, varies palpably from one county council to another. The number of visits, for example, varies from 2.3 and 5.4 per child annually in child health care and between 9.7 and 31.4 per expectant mother and year in mother health care.

The shortage of general practitioners has inhibited the development of primary care, and this remains a problem. There is at present a shortfall of between 500 and 700 general practitioners compared with the target set by the Riksdag of one GP per 2,000 inhabitants. The age structure of the profession is uneven, with more than half the practitioners aged over 50 and only 3 percent under 40. The number of training opportunities for prospective GPs has been insufficient during the 1990s. Primary care is faced with a crisis unless initiatives are taken to redress matters.

Co-operation between primary and specialist care needs to be developed so as to optimise resource utilisation and counteract unnecessary waiting list problems. Organizational models and other measures needing to be further developed and evaluated include, for

example, GP consultants in hospital departments, local care agreements, improved referral routines and referral of patients to primary care when they are no longer in need of other specialist competence.

Physician supply in primary care has been a political priority during the 1990s. The follow-up shows that organizational changes have produced good results and that patients are satisfied. But it also shows that availability improvements have been confined to reception work, where as the supply of GPs in medical care for the elderly and in psychiatric care has if anything deteriorated. It is felt that, where older and long-term patients are concerned, continuity is threatened or has deteriorated. One reasonable explanation for the failure of primary care to measure up to good physician availability in all sectors and at the same time to maintain justifiable continuity for groups in special need of it is the shortage of GPs. A clear description of primary care objectives is also needed in order for this aim to be achieved.

The follow-up shows that there are only a few county councils where primary care is in the process of achieving the position as the base of medical care which the Riksdag has repeatedly resolved on for it. If anything one's impression is that well-established hospital care has come to constitute the base and that primary care has been adapted accordingly. The greatest difference is between the big cities and the rest of the country. This may be partly due to the absence of a clear-cut definition of the primary care concept, and also to deficiencies in the analysis and definition of the task of primary care as part of the whole fabric of county council medical care.

The status of preventive care also varies. Maternal and child care is very well developed since half a century. Hypertensive care and treatment of hyperlipidemia is also covered. However, the treatment of lifestyles like smoking, overeating, lack of exercise etc. is poorly developed in Swedish general practice.

Organization of GP's

DLF (Svenska distriktsläkarföreningen) is the professional organisation for general practitioners in Sweden. It is affiliated to the Swedish Medical Association (SMA), founded in 1903, which is the professional association and trade union of physicians in Sweden. DLF has 4400 members which constitutes about 95% of GP's in Sweden. Continuing education is important to DLF. There is also SFAM, which is a professional and scientific association of GPs in Sweden, a non-profit organisation with about 2500 members. SFAM is affiliated with the Swedish Society of Medicine (Svenska Läkaresällskapet) and is a member organisation of Wonca. Main areas of interest for SFAM are continuing professional development, training of future GPs, quality improvement, and research in general practice/family medicine and primary care.

Smoking policy in Sweden

A National Tobacco Act (1993:581) was introduced in June 1993 and further strengthened in July 1994, January 1997, July 2002, and September 2002. Due to EU legislation further revisions will be enacted in January 2003 and January 2005 (SFS2002:586) and from then on Sweden will comply completely with EU law (apart from the exemption from the EU ban on snus). Some important paragraphs are listed below:

1 § Due to risks and inconveniences associated with tobacco smoke this paragraph regulates smoke-free workplaces, public places indoors and outdoors, warning labels, marketing and product control.

2 § Smoking is prohibited in day care centres, schools, health services, public transport, public meetings etc.

4 § Hotels must offer smoke-free rooms and restaurants must provide smoke-free areas.

SLF`s (Swedish GP's association) smoking policy

A policy document was published in 1994 and a revision is under way. In this policy document it was (among other things) stated that:

- Doctors are role models for their patients and should not smoke themselves
- Smoking is a major cause of ill health and premature death and patients should be asked about smoking habits at all times
- A smoking history should be taken and recorded
- Doctors should motivate smokers to quit and offer to help
- Second-hand smoke is also a threat and smoking in hospitals and health care facilities should be restricted

Smoking habits of Swedish GPs

A survey was conducted in 2001 (24). A random sample of 5% (n=1367) were sent a 25 item questionnaire. A response rate of 80% after two reminders was achieved. Six % reported to be daily smokers, 8 % among males and 5 % among females. In addition, as many as 16 % of the males and 5 % of the females reported use of smokeless tobacco (oral moist snuff, "snus").

In the general population 17 % of the males and 21 % of females smoked daily. Snus was used by 20 % of Swedish males and 2-3 % of females.

GPs 2° Phase: Swedish results

1. The questionnaire survey

A comprehensive survey had been performed in 1999 and identified barriers to smoking prevention among GP's. A shortage of smoking

cessation professionals to refer patients to had been identified as a major barrier among GP's and it was therefore of interest to identify how well the existence of a smoking cessation telephone helpline had penetrated the community of general practitioners. A questionnaire was sent to GP's by mail. Three years after the release of the quitline about every second GP knew that a telephone quitline had been established and about one in four had referred patients to it. These are promising results as preliminary data show that callers who have been advised by their GPs to call the helpline are 3 times as successful in quitting compared to callers with no such support. The results of the survey will serve as the basis for further development.

2. Revision of the clinical guidelines

a) Content of guidelines *(Annex 6)*

Assessment Objectives

The main objective has been to assess methods that can be used by the health services to help smokers break the smoking habit. The methods studied include counselling of smokers, nicotine replacement therapy, cognitive behavioural therapy, hypnosis, acupuncture, and therapy based on drugs other than nicotine. The report also evaluates the structural and organizational aspects that can improve the potential of the health services to provide smoking cessation services. The main outcome measures included verification of being smoke free after 6 to 12 months follow-up and an economic analysis. To assure that the results apply in the environments where smoking cessation services are provided, the outcomes were studied separately for primary care centres, maternal health services, and hospitals.

Assessment Strategy

Systematic literature overview, cost-effectiveness analysis.

Primary Data Collection

Systematic literature review of studies found in Medline, Psychlit, and Embase databases, the reference lists from published studies, the "Tobacco Addiction Module" from the Cochrane Collaboration, and a review of reports published by other organizations, eg, AHCPR (now renamed AHCPQ)

Data Criteria; Types of Studies Included

The report is based mainly on randomised controlled studies involving biochemical means to validate smoking cessation after 6 to 12 months. In the absence of such studies, shorter follow-up times and self-reported smoking cessation were accepted in isolated cases to explore important questions. The health economics section includes model analyses.

Review of Publications

Internal review by the project group, the SBU Scientific Advisory Committee, the SBU Board of Directors, and an external review by three Scandinavian experts in the field.

Due to advances in the field since 1998 an update of the scientific material has been made.

3. The Manual

The Manual "The road to a smoke-free life" was produced in co-operation with the NGO "Doctors against tobacco" and was translated to English and attached (see Annex)

1. We must help our patients stop smoking
2. Tobacco dependence
    - Abstinence
    - Nicotine dependence
    - Social dependence

3. Ask every patient about smoking at all times
    - You can make smokers stop
    - To plant a seed
4. The process to quit smoking
    - The motivational ladder for quitting
5. Information and discussion
    - How to approach a smoker
    - Setting a quit date
6. Special considerations
    - Smokers with established disease
7. Pharmaceuticals
8. Follow up
9. Tobacco and your health
10. Snus (Oral moist snuff)
11. References

4. Regional conferences

A series of regional conferences have been staged where the authors of the report presented the evidence-based findings. Doctors and nurses in the region have been invited.

5. The Swedish GPs and the national telephone helpline: Sluta-Röka-Linjen (SRL)

The SRL is a joint initiative of the Centre for Tobacco Prevention (CTP) and the Swedish Cancer Society (SCS). Additional funding on an equal basis was provided by the Heart Lung Foundation, the National Pharmacies and the National Institute of Public Health. was conceived as a 3-year project with an obligation to evaluate outcome. From 2002 to 2004 the Government of Sweden will increase their support for the helpline but the other financiers will prevail.

The Centre for Tobacco Prevention is part of the Stockholm Centre of Public Health, Stockholm County Council.

The aim is to provide high quality tobacco cessation free of charge for all Swedes. The emphasis is rather to provide high quality smoking cessation to motivated callers than to answer all calls. A further aim is to provide an easily accessible referral service for physicians and nurses

Planning for the helpline started in February 1998. A minimal service was in operation from May 1998 to support the international Quit campaign but the official launch of the service with TV and newspaper advertising was not until September 1998. Continuous refinement has been achieved through evaluation and analysis. From November 1999 a ”proactive” service was replacing the ”reactive” service (see below).

The annual budget is 3 million SEK (300 000 USD), 50% each on operations and marketing. CTP provided additional funding up to a total of about 4 million. In view of increasing costs the 50/50 rule was abandoned in 2000 and more money was diverted to operating the help line. Now, about 2/3 goes to the operation of the help line. Funding 2002-2004 will be in the region of 5 million SEK (0.5 million USD).

The staff of SRL:

- Head of the helpline: H Gilljam MD, PhD. General Manager of CTP
- 1 Project leader and counsellor 100%
- 1 Assistant project leader and counsellor 100%
- 3 Counsellors 80%
- About 15 part-time counsellors

Evaluation: 1 researcher 30%, 1 research student 80%

Programmer: 1 programmer 35%

Sweden has no formal training for smoking cessation experts. Primary care nurses with basic training and previous experience in cessation are sought. A few hundred nurses who meet the criteria constitute the main supply for recruiting part-time counsellors. The training program

consists of the basic 3-day training, an eligibility test and individual tutoring for a 6 month period. After further 6 months of experience counsellors are seen as fully trained. Quality criteria are rigorous and there are examples of tentative counsellors being asked to leave after 5 months of training.

Much emphasis has been put on documentation. A computer program allowing for easy entry of patient data has been designed. Vital parts of the patient record are compulsory for the counsellors to fill in. This is done during the course of the counselling which ensures 100% data collection. The database allows for continuous evaluation. With the proactive service an automated record of those wishing to be called back is presented to the counsellors on the chosen date. The service is free for all callers with the exception of mobile phones. Too many crank calls came form mobile owners. The number was used for free testing of phones. Abuse was common and the expenses were rising. However, as more and more subscribers rely on mobile phones it will be possible to open the service for them in the near future.

Callers are free to call on weekdays. The line is open 51 hours a week, weekdays between 9am and 8pm (Fridays 9am to 4pm). The financial situation allows for 2,5 parallel lines but a third line is currently being staffed and next autumn it is planning for 4 lines. When the line is closed a IVR (Interactive Voice Recorder) line with pre-recorded messages is open. This line is also free and has comprehensive information on tobacco, smoking and cessation. Free faxes can be ordered as well.

If the line is busy you are asked to hold, wait in line or leave a message. About 40-50 serious cessation calls per day (2-2,5 lines) has been the rule over the last year but occasional daily bursts with over 250 calls have been processed.

More than 11 000 smoking cessations are recorded in a database (Nov 2001) The present annual capacity is 3-4000 serious cessation attempts. In 2002 the capacity will be 4-5000. Evaluation is an

integral part of the service. Consecutive cohorts are identified and followed for 1 year. Four cohorts from different stages of evolution have been followed. The problem of identifying the database for follow-up has been solved thus: A caller is asked whether he/she would mind taking part in a follow-up. If positive (>90%), a questionnaire is sent home and those who return the questionnaire represent the cohort under study. They are followed up to 12 months by self reports. Those who failed to return the questionnaire are also followed. A 28% abstinence rate according to self report has been registered. With proactive counselling the 12 month abstinence rate is 33% (based on 800 patients). Allowing for some optimism in self-reports it is reasonable to believe that the Swedish helpline is very efficient.

Preliminary results, controlled for confounders, indicate that the cost per life-years-saved is less than 2000 SEK (200 USD) which makes the helpline by far the most cost-effective healthcare service in Sweden. By comparison, the cost of hypertensive treatment in Sweden is calculated to 150000 – 200000 SEK per life-year-saved.

Recent results indicate that callers who have been advised by their GPs to call the helpline are 3 times as successful as others.

6. **The Future**

a) Dissemination

This manual "Doctors against tobacco" will be distributed to every GP in Sweden.

b) Dissemination project

A project involving 100 GPs in the Stockholm region will explore the feasibility of reimbursement of a minimum of 80% recording of patients´ smoking habits.

c) Continuous education

Further training seminars are scheduled for 2003. Following the efforts described above, many contacts have been taken from groups of GP's asking for training. Authors will build upon that demand and disseminate further the knowledge about smoking cessation and our manual.

d) Scientific evaluation of the quitline

Also, scientific evaluation of GP's use of a quitline as a means of improving tobacco prevention will continue. Special emphasis will be put upon how GP's may interact with the service to improve outcome even further.

CONCLUSION

The cornerstone of the smoking cessation strategy should be the routine provision of brief advice and follow up in primary care (1,19,33), anyhow GPs do not exploit many opportunities to discuss smoking with patients but, being keen to preserve good doctor-patient relationship and to avoid negative responses from patients once the topic of smoking had been raised, they prefer to discuss smoking only when patient present smoking-related problems (34,25). Moreover many GPs feel that smoking cessation support is too time consuming and that the time spent is not effective because few patients quit (25). On the other hand there is greater acceptance by GPs in giving care to smokers wanting to stop than in monitoring smoking status and giving opportunistic advice to patient (35). A recent study demonstrated that a comprehensive strategy including a program to improve physicians' counselling practices could be effective in reducing tobacco use (36), while the possibility of a promotion payment at increasing GPs antismoking advice to smokers seems not automatically generate effective health promotion activity (37).

In synthesis, it could be said that there is now a rare confluence of circumstances:

- a highly significant health threat,
- the attitude of clinicians not to intervene in a consistent way,
- existence of effective interventions.

It is hard to think of any other condition presenting such a mix of lethality, prevalence and negligence, in spite of the existence of effective and readily available interventions.

Another aspect worth mentioning is that tobacco cessation treatments are not only clinically effective, but also cost-effective, namely when compared with other disease prevention and medical treatment interventions, such as the treatment of high blood

pressure and hypercholesterolemia, as well as with screening examinations such as periodic mammography or Pap smears. Treatment of tobacco dependence must be considered to be the gold standard of preventive therapies.(35,38).

In countries like the USA, there is a growing recognition that interventions on tobacco use should become part of routine healthcare, being a model of good practice (1). This change in attitudes has been greatly fostered by the appearance in 1996 of a *Smoking Cessation Clinical Practice Guideline* (39), followed by the publication in 2000 of an abridged update - *Treating Tobacco Use and Dependence: A Clinical Practice Guideline* (1). The latter was published as a *United States Public Health Report*, thus reflecting the importance given to this issue in the US.

In this context it was planned the GPs Empowerment project aiming to evaluate, in different European countries, the attitude, behaviour and knowledge of GPs on smoking cessation procedures and to develop clinical guidelines to be apply in the European GPs daily practice.

Five European countries (Denmark, France, Greece, Italy and Portugal) were involved in the first year of the project and data on GPs' attitude, behaviour and knowledge regarding tobacco use and cessation methods have been produced. During the second year of the project clinical guidelines for smoking cessation in GPs' clinical practice in six countries (the previous ones plus Sweden) were developed and validated.

The job made during the second phase of the project was different in the various countries involved, according to the different national level of clinical guidelines development, to the local settings and needs, and according to national opportunities given by the associations and institutions specifically involved in the project.

In **Denmark**, where the Danish Medical Association developed a specific smoking policy, special attention was devoted to the development of a comprehensive strategy on how to make smoking cessation in general practice, evaluating materials, training and information that the general practitioners should be provided with. A survey, made in August, more precisely pointed out this needs, and in particular:

- targeted materials to different patient groups,
- how to make a personal follow up,
- a catalogue of good grips (e.g. illustrations, lung capacity measures…),
- in service training, courses and education on how to do smoking cessation,
- information and documentation of connection between illness, diseases and smoking in GPs medical journals,
- and clinical Guidelines.

A first draft of the Danish smoking cessation clinical guidelines were based on Cochrane library report and discussed with a group of general practitioners in order to:

- make them short, clear and concrete,
- put emphasise on the GPs unique role,
- distinguish between what every GP should do and what a motivated GP may do.

A small booklet on smoking cessation in the clinic was prepared. The August survey has ensured that it is highly probable that the booklet will be read and used, but a formal evaluation is planned to take place in spring 2003, through a combination of telephone interviews and personal interviews with general practitioners..

A poster was also developed and distributed to all general practitioners in Denmark.

In **France**, where tobaccology is a new science and tobacco diseases had not been taught in a classic university *degree course*, although pathologies linked with tobacco lead to more than 60,000 deaths per year, efforts were made and an adapted legislation has been voted for, from the Veil Law (1976) to the Evin Law (1991), which would give society the means to struggle against this scourge. In France, in around fifteen years, if nothing will be done to formally object to the smoking related pandemy, the annual number of deaths attributable to smoking habits will reach the enormous figure of 120,000.

Tabac & Liberté, which is the Association that actively participate to the GPs Empowerment project, established relationships with other French associations and institutions that worked in the field of tobacco dependence prevention and tobacco cessation, and developed, during phase II project, a training program and a clinical guideline on smoking cessation to be used nationally by GPs.

The training program was based on the 8 years of experience in this field of Tabac & Liberté. During these years the program was developed by the same group of Tabac & Liberté trainers: the program was enriched, analyzed, adapted and modified taking into account the evolution of knowledge, the specific expectations of GPs and the wish to provide only useful information that can be easily used in the GPs daily practice.

With the same group of Tabac & Liberté trainers it was organized a meeting in order to develop a guideline that would contain essential information for GPs, menbers od Tabac & Liberté, on how to successfully manage tobacco cessation.

The guidelines were prepared aiming :

- to be the keystone of the communication actions towards GPs,

- to be the fruit of all the network's experience and the work carried out for the past 8 years,
- to be the bearer of the concept developed by Tabac & Liberté : providing only important data that can be used in the GPs' daily practice,
- to be pleasant and easy to read.

At the moment the guidelines meets all the previous requirements but the last one. Further efforts are necessary to solve this problem. Anyhow the guidelines can be considered validated by all of the network and the staff director of Tabac & Liberté, and they will be sent to all GPs who ask for them, either directly from Tabac & Liberté or from others associations linked to Tabac & Liberté. The guidelines are now available in the Internet web site of the association: www.tabac-liberte.com.

In Greece

The same questionnaire of the first phase was again sent to 14200 by mail with the quarterly publication of the Hellenic Cancer Society. Among the 399 responders 82 (21%) were smokers.

Guidelines on smoking cessation to be used in clinical practice for broad national use were produced with the assistance of the existing Hellenic Cancer Society's throughout the country branches. Final approval of this guidelines is expected for the end of October 2002.

Dissemination strategies have been discussed and planned:

- A booklet, short brochures and posters are more likely to be used
- Guidelines can be transmitted through video, CD disk or can be downloaded from the H.C.S. website which is now under innovation.
- Articles are published regularly in the HCS's official two magazines and in one by the Panhellenic Medical Association and distributed all over Greece. These articles

are written mainly by members of the board of the Hellenic Antismoking and Anticancer Society.

In Italy, several Organizations and Associations, also of GPs, are active in the fight against tabagism. A lot of attention there is on this issue at local and national level, within the National Health System: information and educational project were developed and made or are on going by local Health Authorities; in the last years many specialised anti-smoking centres, most of them in hospitals, were set up. Recently, the Minister of Health promoted a strong campaign against smoking and passive smoking. Nevertheless among the health personnel the prevalence of smokers is still very high.

The job made in the context of the second phase of GPs Empowerment project was very useful in Italy because it allowed to many experts of different Italian Organizations and Associations, especially of GPs, to meet for the first time and discuss about:

- the minimal clinical intervention which should be made to effectively reduce smokers among patients;
- what is really feasible in the daily clinical practice for a GP without special training on the topic;
- what is necessary to plan and implement in order to allow the GP applying the evidence based minimal clinical intervention in his/her daily practice.

Also the results obtained with the meeting are of great importance:

1. it was confirmed the fundamental role played by the GP as promoter and expert for their smoking patients; role that should be played in accordance with the local service network on tobacco control;
2. there was unanimous consensus on the use of the Guidelines developed by ISS, due to the consideration that they were based mainly on critical evaluation of scientific evidences;

3. it was stated the necessity to develop appropriate strategies for GPs involvement, according to different GPs' background and practice setting;
4. it was declared the necessity to develop training strategies in relation to intensity of GPs' involvement and to local programs on tobacco control. Particular attention was focused on the necessity to implement educational program on smoking prevention addressed to students during medical curricula.

The consensus document, developed by all the participants at the Consensus Conference held in Potenza, might be used in institutional health planning meetings at different levels, national and local. It is scheduled to officially present it in a press conference, and through the communication channels of the different associations and organizations of the experts who participated at the Conference and contributed to the final consensus document.

In Portugal, there is also a need, as in other European countries, for all healthcare providers to change their attitudes regarding smoking cessation, especially those working in primary care. Based on this conviction, the Institute for Quality in Health Care (Instituto da Qualidade em Saúde – IQS) has decided to take part in smoking cessation campaigns, teaching and research.

The IQS has a network of permanent professional relationships with individual GPs (as well as GPs organizations). It was therefore relatively easy for the IQS to contact these health professionals on a formal (as well as informal) way, to inform of policies or to implement changes.

The guidelines, developed by IQS, was an evidence-based document, projected for use by GPs in their everyday work. Its

major structure obeyed the general recommendations from the National Guideline Clearinghouse (USA), aiming :

- to be the most efficacious format for practical use,
- and to be the most updated in terms of scientific validity.

Formal meetings were arranged by IQS and the guideline was distributed and discussed, and the practical aspects of the interventions were presented. Most of the suggestions coming from GPs concerning this matter were considered in the final version of the guideline.

The guideline was evaluated and highly praised as scientific sound, and considered a useful instrument upon which the practical steps could be based on. It was disseminated at several different levels in the Portuguese National Health System.

Due to shortage of resources, and also for policy reasons, IQS does not have the responsibility of implementing the guidelines either on a local or on a national level. Further efforts will be necessary to implement the guidelines. However, IQS will support any initiative that may arise on different levels of the Portuguese National Health Service concerning smoking cessation. This will include giving talks, training courses, offering scientific advices, etc.

The entire text from the guideline is put at the IQS web site, so it is available for consultation and clinical use.

IQS also promoted and sponsored several smoking cessation courses. The training of health professionals was organized around the needs from the doctors in smoking cessation programs. It was a practical exercise and was done by people with experience in the field. Validation of these teaching/learning experiences was achieved through questionnaires to these professionals, and the results disclosed a good level of satisfaction with the learning experience, as well as the notion of usefulness of the courses.

In **Sweden**, by initiative from SBU – The Swedish Council on Technology Assessment in Health Care – a group of experts convened in 1994 and after making a thorough search of the scientific evidence-based literature and a cost effective analysis of different smoking cessation procedures, a report was written on methods that can be used by the health services to help smokers break the smoking habit.
In co-operation with the NGO "Doctors against tobacco" a manual for primary care doctors has been produced ("The road to a smokefree life") to be distributed to every GP in Sweden.
It was planned a dissemination of the results of the project involving 100 GPs in the Stockholm region with the aim to explore the feasibility of reimbursement of a minimum of 80% recording of patients smoking habits. A series of regional conferences have been also staged where doctors and nurses in the region have been invited.

In conclusion, all the European countries participating in the GPs Empowerment Project - phase II agreed on the necessity to develop, if not yet available, national guidelines on smoking cessation for GPs in order to change: (i) the attitude of clinicians not to intervene on smoking patients suggesting and supporting them in smoking cessation; (ii) the increasing trend of smoking related incidence and mortality.
In all countries there is a low attitude of GPs in applying effective strategies for helping their patients who want or need to quit smoking, despite the GPs' consciousness regarding health risks related to tobacco smoking, and despite the growing information on effectiveness of even brief intervention in smoking cessation.
The guidelines developed and /or discussed in the context of this project, in the different countries involved, aimed at support GPs in their daily practice. The guidelines were developed as scientific

based documents in all countries but France, where they were prepared using the background experience of Tabac & Liberté trainers. In the other countries the guidelines were based mainly on US guidelines and Cochrane revision. In two countries (Italy and Sweden) clinical guidelines were developed out of this project and therefore more attention was devoted to dissemination or consensus strategies. Only a format specific for each country was considered, by all the partners, effective, considering the different national GPs' setting.

There is consensus among all countries involved on the importance and urgency of addressing the smoking problem by GPs in each country involved in the project, from the North to the South of Europe. This underline the necessity to address it in all EU countries.

It is desirable to extend to all European countries the results of this work, so that everybody can profit from it. Presently, the developed national guidelines are all available in the web site of the different organizations involved in the project. All partners planned specific dissemination strategies.

All health personal should also be involved in smoking cessation programs, at every level of the health system, as scientific literature shows to be effective. Guidelines for them should be also provided in the next future.

BIBLIOGRAPHY

1. Fiore MC, Bailey WC, Cohen SJ. Treating tobacco use and dependence clinical practice guidelines. Rockville, MD: U.S. Department of Health and Human Service. Public Health Service. AHRQ Publication N. 00-0032. June 2000. (available on line: http://www.ahrq.gov/clinic)
2. Montesano R, Hall J. Environmental causes of human cancers. Eur J Cancer 37: S67-S87, 2001
3. Centers for Disease Control and Prevention. Perspectives in disease prevention and health promotion. Smoking – attributable mortality and years of potential life lost – United States, 1984. MMWR Morb Mortal Wkly Rep 46: 444-51, 1997
4. US Department of Health and Human Services. The health benefits of smoking cessation: A report of the Surgeon General. Atlanta (GA): US Department of Health and Human Services. Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health. DHHS Publication Nº (CDC) 90-8416, 1990
5. World Health Organization takes on "Tobacco epidemic". JNCI, 94: 644-5, 2002
6. Molarius A, Parsons RW, Dobson AJ, Evans A, Fortmann SP, Jamrozik K, Kuulasmaa K, Moltchanov V, Sans S, Tuomilehto J, Puska P. Trends in cigarette smoking in 36 populations from the early 1980s to the mid-1990s: findings from the WHO MONICA project. Am J Public Health 91: 206-212, 2001
7. Madsen M, Pedersen JT and Nielsen PE. Rygevaner blandt danske læger, sygeplejersker og jordemødre 1989. Ugeskrift for Læger. 152: 3336-40, 1990

8. Monitorering af danskernes rygevaner 1999, PLS consult, December 1999
9. Hill C, Trends in tobacco smoking and consequences on health in France Prev Med 27: 514-519, 1998
10. Pagano R, La Vecchia C, Decarli A. Smoking in Italy, 1994. Tumori, 82: 309-313, 1996
11. Istituto Statistico Nazionale (ISTAT), Annuario Statistico Italiano, Roma. 2000
12. INS do ONSA 1998/99
13. Cohen D, Eliasson M, Eriksson C et al. Smoking cessation methods. SBU Report 138:1998. Stockholm 1998.
14. Jones H, Garrett B, Griffiths R. Subjective and physiological effects of intravenous nicotine and cocaine in cigarette smoking cocaine abusers. J Pharmacol Exp Ther 288: 188 – 97, 1999
15. Prochaska JO, Di Clemente CC. Stages and processes of self-change of smoking : toward an integrative model of change. J Consult Clin Psychol 51: 390-395, 1983
16. Centers for Disease Control and Prevention. Health objectives for the nation cigarette smoking among adults – United States, 1993. MMWR Morb Mortal Wkly Rep 43: 925-30. 1994
17. Centers for Disease Control and Prevention. Cigarette smoking among adults – United States, 1995. MMWR Morb Mortal Wkly Rep 46: 1217– 1220, 1997
18. Ritvo PG, Irvine MJ, Lindsay EA, Kraetschmer N, Blair N, Shnek ZM. A critical review of research related to family physician-assisted smoking cessation interventions. Cancer Prev Control 1(4): 289-303, 1997
19. Raw M, Mc Neill A, West R. Smoking-cessation guidelines for health professionals. Thorax 53 (suppl. 5): S1-S19, 1998

20. Russel M et al Effect of General Practitioners' advice against smoking. BMJ 2: 231-235, 1979
21. Rosso S, Senore C, Ponti A, Segnan N. General practitioners and interventions against smoking: a critical review of interventions Epidemiol Prev. 13:37-44, 1991
22. Fiore MC, Novotny TE, Pierce JP, Giovino GA, Hatziandreu EJ, Newcomb PA, Surawicz TS, Davis RM. Methods used to quit smoking in the United States. Do cessation programs help? JAMA 263:2760-5, 1990
23. Slama A K, Karsenty Y S, Hirsch Tobacco control 4: 162-169, 1995
24. Bolinder G, Himmelmann L, Johansson K. Svenska Läkartidningen 98:3111-7, 2002
25. Helgason AR, Lund KE. General practitioners' perceived barriers to smoking cessation-results from four Nordic countries. Scand J Public Health 30:141-7. 2002
26. Torpenberg I. Tobacco use and attitudes among Swedish nurses. MPH study 2000, University of Linkoping
27. Uhrbom E, Halling A, Bjerner B. Tandvårdspersonalens tobaksvanor och tobaksförebyggande arbete (In Swedish) Tandläkartidningen 1997;89:47-53
28. Garrigues-Naserzadeh N, Sasco A J, Lang F, Vergnon J-M : Le médecin généraliste face à un patient fumeur. Rev Prat Med Gen 16: 600-604, 2002
29. Workshop "Sanità e fumo", Milano 25 February 2000
30. Directa 1999, on behalf of AIPO (Italian association of hospital pneumologists) and FIMMG (Italian federation of GPs) (available on line: http://www.fimmg.org/notizie/fumo.htm)

31. Ciraolo F et al Riflessioni sul ruolo e sulla formazione del medico italiano nell'approccio al paziente fumatore Educazione Sanitaria e promozione della Salute 4:9-17, 1999
32. Osservatorio Fumo, Alcol e Droga. Linee guida cliniche per promuovere la cessazione dell'abitudine al fumo. Istituto Superiore di Sanità, 2002 (available on line: http://www.ossfad.iss.it)
33. Silagy, C Physician advice for smoking cessation. The Cochrane Database of Systematic Reviews, The Cochrane Library, Copyright 2000, The Cochrane Collaboration. Issue 1, 2000
34. Coleman T, Murphy E, Cheater F. Factors influencing discussion of smoking between general practitioners and patients who smoke: a qualitative study. Br J Gen Pract 50: 207-210, 2000.
35. McEwen A, Akotia N, West R. General Practitioners' views on the English national smoking cessation guidelines. Addiction 96(7): 997-1000, 2001
36. Tremblay M, Gervais A, Lacroix C, O'Loughlin J, Makni H, Paradis G. Physicians taking action against smoking: an intervention program to optimize smoking cessation counselling by Montreal general practitioners. CMAJ 165: 601-607, 2001
37. Coleman T, Wynn AT, Stevenson K, Cheater F. Qualitative study of pilot payment aimed at increasing general practitioners' antismoking advice to smokers. BMJ 323: 432-435, 2001
38. Oster G, Huse DM, Delea TE, Colditz GA. Cost – effectiveness of nicotine gum as an adjunct to physician's advice against cigarette smoking. JAMA 256: 1315-8, 1986

39. Fiore MC, Bailey WC, Cohen SJ, et al. Smoking Cessation: Clinical Practice Guideline nº 18. Rockville, MD: US Department of Health and Human Services. Public Health Service, Agency for Health Care Policy and Research; AHCPR publication 96 – 0692, 1996

List of project partners

A.N.P.AS.
Via F. Baracca, 209
50127 Firenze, Italy
Tel. +39/050/46171 Fax: +39/050/506393
www.anpas.org

Instituto de Qualidade em Saúde
Ed. Centro de Saúde de Sete Rios - 4º piso
Largo Prof. Arnaldo Sampaio
1500-498 Lisboa, Portugal
Tel.: 217 220 020 ou fax: 217 220 025
www.iqs.pt

Hellenic Cancer Society/Greece
Tsoha 18-20 street
Gr-115 21 Athens, Greece
tel : +301-6456713-15 fax: + 301-6410011

Community medicine Center for Tobacco Prevention
Wollmar Yxkullsgatan 19
BOX 175 33, Stockholm, Sweden
Ph: (+46 8) 517 78057 Fax: (+46 8) 517 78072

Danish Cancer Society
Strandboulevarden 49
2100 Copenhagen, Denmark
Tel. +45-3525 7500/ 7701 Fax: +45/35257701
www.cancer.dk

Tabac et Liberté/France
36 rue Alsace-Lorraine
31000 Toulouse, France
Tel. +33-0561226155 Fax +33-0561228307
www.tabac-liberte.com

Associated partners

UniTS – Università del Terzo Settore
Via F. Turati, 6
56125 Pisa, Italy
www.uniterzosettore.it

CSPO Centro per lo Studio e la Prevenzione Oncologica
Via A. Volta 171
50131 Firenze

www.cspo.it