PhD thesis
Ann Dorrit Guassora

Balancing smoking cessation advice with trust, morality, and relevance.
The consultation in general practice as a context for a mass strategy of smoking cessation advice: an interactional perspective focusing on trust.

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Ann Dorrit Guassora, MD
Preface

I wish to thank the GPs and the patients who kindly participated in this study. I also wish to thank the supervisors of my Ph.D.-study Dr. Scient. Soc. Dorte Gannik, MA, phil. dr. Thorkil Thorsen and MD, Ph.D., MHPE Charlotte Tulinius for their good help and encouragement. Thank you also to MA, Ph.D. Charlotte Baarts for good advice and to my colleagues general practitioner Anders Beich, and the former general practitioners, MA, Hans Lynge and Ph.D.-student Annette Davidsen with whom I have had helpful discussions of smoking cessation and of trust.

I also want to thank The Research Unit for General Practice in Copenhagen and the leader Hanne Hollnagel for an inspiring environment for research. The study was possible thanks to funding from The Danish Research Foundation for General Practice and from the Fund of Else and Mogens Wedell-Wedellsborg.

I am grateful that Morten, my husband, understood my preoccupation with smoking cessation advice and trust and that he added his perspective of social science to it.

Ann Dorrit Guassora, December 2007
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1. Introduction

This thesis is about Danish general practice consultations as a context for a mass strategy of smoking cessation advice.

The purpose of this study was to generate new knowledge that may contribute to professionalise smoking cessation advice in general practice. This analysis may improve our understanding of the challenges facing a mass strategy of smoking cessation advice in the context of general practice consultations as concerns communication and the social processes in the consultations.

Physicians traditionally give smoking cessation advice to patients with smoking-related illness or with a particular risk related to smoking (Calnan et al. 1986, Thorndike et al. 1998, Wynn et al. 2002, Tulinius and Dencker 2001, Hansen et al. 2004). This approach is termed a high-risk strategy. Such a strategy will target mainly those who are at a high risk and who will therefore benefit the most (Rose 1981). A mass strategy, in contrast, implies advice to all (Rose 1981). For years it has been recommended to implement a mass strategy of smoking cessation advice in general practice (Sundhedsstyrelsen and Nationalt Center for Rygestop 2003, Raw et al. 1999, West et al. 2000, Lancaster and Stead 2004), which implies that such advice should be given to all no matter the health problem in question. Reluctance to adapt such a strategy (McEwen et al. 2001) has been ascribed, among others, to the GP’s failure to recognize the effect that it might have at a population level (Cabana et al. 1999, Lawlor et al. 2000).

Initiating this study, it seemed to me that introduction of intervention at the population level would constitute a major shift in the work of Danish general practice, where GPs are primarily managing the health problems that the patients bring. The patient-physician encounter traditionally concerns a patient seeking help for an illness. Models of the patient-physician relationship are usually based on this case of patients seeking help for an illness (Szasz and Hollender 1956, Parsons 1951, Demak 1987).
In a smoking cessation mass strategy, intervention would be directed at patients at a low risk (Rose 1981) and only few of the patients addressed would benefit (Lancaster and Stead 2004), as brief advice from general practitioners increases the quit rate by 2.5%. The integration of such advice in consultations not addressing issues of smoking-related health problems might shift the scope of the consultations from the benefit of the individual towards the benefit of the population. This may cause patients to speculate about the motives of the intervention and about the purpose of the consultation. I hypothesized that a shift from a high-risk to a mass strategy could jeopardize the patient’s trust in the GP, changing the scope of individual consultations.

The most pertaining element in the conceptualizations of patient’s trust in physicians in the medical literature is that the physicians serve as agents for each single patient, pursuing his/her best interest (Anderson and Dedrick 1990, Mechanic and Meyer 2000, Hupcey et al. 2001, Gilson 2003, McKinstry et al. 2006). This understanding of trust seemed to support my anticipation that a mass strategy could be a problem for trust because it would move the focus away from the individual towards the population.

To general practitioners (GPs) trust is a desired quality of their relationship with their patients (Praktiserende Lægers Organisation 2001, Foged 2003, Pellegrino and Thomasma 1993, Fugelli 2003, Gannik 2004). It is considered a prerequisite for quality work, because it is believed to affect the patient’s willingness to seek care, reveal sensitive information, submit to treatment and stay on the physician’s list (Hall et al. 2001).

GPs take care to protect the patient-physician relationship. Prior research has demonstrated that this is a factor that affects their decision to include preventive services or not (Coleman et al. 2000, Summerskill and Pope 2002, McEwen et al. 2006, Lawlor et al. 2000, Calnan et al. 1986). Some preventive services seem to have been excluded for fear of jeopardizing the patient-physician relationship. It has, however, so far remained unclear in which respects preventive services could damage the patient-physician relationship. The smoking cessation advice practice of GPs is often described by the GPs themselves in terms of “timing” (e.g. Coleman 2004). How “timing” is achieved is, however, not described, and the factors that have to be “timed” have not yet been specified. The present study aims to give some insight in the black box of the connection between smoking cessation advice and the patient-physician relationship.
In this study I pose the question how general practice consultations will work as a context for a mass strategy of smoking cessation advice? The study embraces both the influence that advice has on the patient-GP relationship and the influence that the patient-GP relationship has on advice, providing more detailed insight into aspects of interaction and trust that are affected by smoking cessation advice.

Based on the major themes of the analysis, the study identifies three aspects of interaction in general practice consultations that are challenged by the introduction of a mass strategy of smoking cessation advice in Danish general practice consultations:

- The frames of the interaction order. (Paper 1)
- The meaning that smoking cessation advice achieves in this context. (Paper 2)
- The process of developing and maintaining trust during physician-patient interaction. (Paper 3)
2. Design, materials and methods

The question of how the general practice consultation will work as a context for a mass strategy of smoking cessation advice was investigated in a qualitative study. The study focuses on consultations with patients who brought health problems not smoking related in order to illustrate the principle of adoption of a mass strategy of smoking cessation advice. GP and patient interviews thematized smoking cessation advice or the absence of such advice. Interviews were grounded in observation of consultations to make them reflect the practice of everyday life rather than the attitudes of the participants. Grounding in practice should counteract the bias that might occur in the interviews due to the public expectations known to the GPs as concerns their role in smoking cessation advice.

2.1 Outline of the design
Consultations were observed in six GP surgeries. In each surgery, a number of consultations were singled out for further investigation through interviews with the patients and the GPs. Data consisted of a strategic sample of field-notes and audiotapes from 26 consultations, interviews with 11 patients and interviews with six GPs.

2.2 Selection of GPs
GP selection was geared to recruit GPs with different degrees of activity as far as smoking cessation advice was concerned. A ‘snow balling’ technique (Patton 2002) was used to identify GPs who were considered either more or less ‘active’ by local public administrators working with smoking cessation or by their colleagues. Peers’ selection of participants in this fashion provides maximum variation in terms of the factors that are recognized as important by the group itself (Hammersley and Atkinson 1983, Kuzel 1999). All participating GPs accepted the peers’ description of their strategy as either more or less ‘active’ in terms of smoking cessation advice giving.

Furthermore, the GPs were recruited in a manner that secured variation of sex and duration of practice tenure similar to that known for the group of GPs in general. GPs were from urban and rural settings and belonged to three different districts offering different smoking cessation services. Eighteen GPs were invited to obtain six participants. When the first five GPs had been included, a GP in the category less ‘active’ male with short
practice tenure was still missing. Eight such GPs were approached before one consented. The characteristics of the participating GPs are shown in Table 1.

Table 1: Characteristics of participating GPs. Districts are indicated by numbers.

<table>
<thead>
<tr>
<th>GP</th>
<th>More active</th>
<th>District (no)</th>
<th>Sex (M/F)</th>
<th>Age (yrs)</th>
<th>Tenure in practice (years)</th>
<th>In partnership surgery</th>
<th>Postgraduate training in smoking cessation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Yes</td>
<td>1</td>
<td>M</td>
<td>55</td>
<td>23</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>B</td>
<td>No</td>
<td>1</td>
<td>F</td>
<td>46</td>
<td>4</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>C</td>
<td>Yes</td>
<td>2</td>
<td>F</td>
<td>45</td>
<td>6</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>No</td>
<td>2</td>
<td>M</td>
<td>59</td>
<td>29</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>E</td>
<td>Yes</td>
<td>3</td>
<td>M</td>
<td>50</td>
<td>15</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>F</td>
<td>No</td>
<td>3</td>
<td>M</td>
<td>43</td>
<td>7</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

2.3 Information to participants
Information to participants was kept at a general level to minimize any observer and investigator bias. GPs were informed that the study focused on smoking cessation advice and the doctor-patient relationship. Disclosure of the information that smoking cessation advice was studied could not be avoided in the information to the GPs who were selected according to their activity in this field. Patients were informed only that the study focused on the doctor-patient relationship. Both GPs and patients were informed that data would not appear in public in any form disclosing their identity. It was also explained to the patients that their GP would not have access to the contents of the interview. Information and procedures of consent were approved by the local Ethics Committee.

2.4 Observation
Three days were spent observing each practice. The observation served the purpose of:

1) Overviewing of consultations for the purpose of strategic case selection
2) Adding issues to the interview-guide
3) Grounding the interview in observation of consultations
4) Contextualizing the audio-recording of consultations
5) Developing analytic themes

1) The main purpose of the observation was to identify consultations for detailed analysis. Occurrence of smoking cessation advice given during consultations was registered. So
were the diagnoses of health problems according to the GPs. These parameters along with information of patients’ sex and age were used in patient selection for interviews (see below). Selected consultations were analyzed in detail, primarily to contextualize the interview data.

2) Observations were used for addition of questions to the interview-guide. Some of these additions were relevant only to one particular consultation, while others were relevant in general and were included in the interview guide. An example of such additions stems from the consultation with Mary-Ann who wanted to discuss three issues in the same consultation. After the consultation the GP commented, that he would not raise the extra issue of smoking cessation when so many other issues were already addressed. This observation was included in the interview with the GP and the patient who had participated. The GP also told that the patient had previously declined to discuss smoking cessation. Both the GP and the patient were asked in the interview about the significance of this prior refusal and how and when the issue of smoking cessation advice might be raised again.

3) Interviews were grounded in observation of consultations. The data collection was carried out during 2003-2004 where GPs’ smoking cessation advice received intense attention from political authorities and public health professionals (Appendix 1). Grounding in practice should counteract the bias that might occur in the interviews due to the GPs awareness of expectations to them as concerns their role in smoking cessation advice. During the interview, consultations served as a frame of reference shared by the interviewer and the patient/GP. Observations added to the understanding of the interview and interviews could help explore the meanings of observations. The observation made clear whether advice was given or not, but it did not disclose if the GP already knew if his or her patient was not a smoker, if they had discussed smoking at the last visit or if the patient had another appointment with the GPs soon where the GP felt that a discussion of smoking would more easily fit in. In interviews with GPs, consultations where no smoking cessation advice was given were compared to consultations where advice was given. The GP’s reasons for giving or not giving advice could then be explored and further developed. This triangulation of methods was also performed later during analysis. The combination of interview with observation makes areas of tacit knowledge accessible to interviews to a larger extent than interviews alone.
4) Consultations were documented by audio-recording and by field-notes. Observation contextualized the audio-recordings of the consultations. The investigators presence in the surgeries allowed the conduct of a large number of informal interviews (Kemp and Ellen 1995). The GPs often offered comments to individual patients and individual consultations either as an introduction before the patient entered or when the patient had left. The GPs provided information both from the patient’s file and other information that would give the investigator insight into his/her perceptions of the patient’s situation. Such information could relate specifically to smoking cessation advice, for example if the GP knew that the patient did not smoke or if smoking was not discussed because the issue had been raised recently.

5) Observation contributed to the development of analytic themes. In the theoretical notes themes on the occurrence of smoking cessation advice, the physician-patient relationship and trust were launched on an on-going basis, including both observations that supported and observations that contradicted each other. For example, in GP C’s surgery, it was registered that in some cases the GP gave advice without expecting any answer from the patient. This was different from the practice of advice that I had witnessed in the previous two surgeries. Observation of the consultations of GP C then inspired the theme of "mutuality" which was included in data coding. This code was applied to observation and interviews with all other GPs and patients as well, and it proved to be relevant also to other consultations than those with GP C. Observations thus generated codes that could be confirmed or disregarded after coding of the entire dataset.

On days of observation, the investigator arrived in the morning before the patients and sat in a corner of the consultation room opposite to the GP and the patients, watching them both from their sides. The investigator did not engage in conversation during consultations and did not move from the chair even if the GP and the patient changed their positions. Sitting in the consultation room between consultations, the investigator asked the GPs about the health problem(s) of the consultation. The role as an observer was almost passive, like in the description of the complete observer by Hammersley and Atkinson (1995). Field-notes were divided into observational notes, theoretical notes and methodological notes according to the principles of Schatzman and Strauss (1973).
Observational notes were recordings of utterances that had been heard or they were descriptions of the observer’s perceptions. They focused on questions like who, what, when, where and how? An example of an observational note is that the GP raises the question of smoking cessation advice as he returns to the consultation after fetching a peak-flow metre. While the audio record documented the utterances of the GP and the patient, observation added information, like in this case, where the GP had been out of the consultation room to fetch this instrument for measuring respiratory function.

Theoretical notes were conscious, controlled attempts to interpret the meaning of observations. Theoretical notes also included hypotheses, descriptions of concepts and relations between concepts. As an example, I compared different theoretical frameworks to the ongoing analysis to obtain an impression of their relevance to the data.

Methodological notes addressed research procedures, reminders and critique. As an example, I noticed that GPs were much less eager to convey their ideals of smoking cessation advice and paid much less attention to me as an observer on the second and third day of observation than on the first. Consultations for further investigation were therefore exclusively chosen from the second and third day of observation.

Observation included all consultations with Danish speaking, legally competent adults who had given their consent and who attended with health problems during the last two days in the six practices. This amounted to 124 eligible consultations, when disregarding 44 consultations with patients known to GPs as non-smokers (Figure 1). Table 2 shows the number of these eligible consultations in each surgery.
Figure 1: Flow chart of inclusion of the study sample

324 consultations during 18 days in 6 GP surgeries

108 consultations during day 1 in each of the 6 surgeries

216 consultations during 12 days in six GP surgeries

31 children, 3 not legally competent, 3 not speaking Danish, 2 not observed, 9 who did not wish to participate

124 eligible consultations

Health problem smoking-related (n=44), 11 with advice

Health problem not smoking-related (n=40), 4 with advice

Other health issues (n=13)

Health problem, relation to smoking not evaluated (n=27), 0 with advice

44 non-smokers according to consultation or comments by GPs

124 eligible consultations

Sample of 26 consultations

Interviews with 11 patients

Interviews with 6 GPs

* Strategic selection. See 2.5 for details
Table 2: Number of eligible consultations with possible smokers in each surgery (first column). The second column specifies how many of these consultations contained advice.

<table>
<thead>
<tr>
<th>GP</th>
<th>Number of consultations, total</th>
<th>Number of consultations with advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>B</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>C</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>D</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>E</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>F</td>
<td>31</td>
<td>0</td>
</tr>
</tbody>
</table>

2.5 Selection of consultations for detailed analysis and of patients for interview

A strategic sample of audio-recordings and field-notes on 26 consultations was selected for detailed analysis. Among these, consultations for health problems not related to smoking were given special attention through interviews with patients and GPs. This focus was chosen because, although a mass strategy of smoking cessation advice stipulates that such advice should be given in this kind of consultations, the literature shows that usually it is not.

Additionally, secondary criteria of inclusion were patient sex, age and health problem. Only consultations with patients who were considered smokers or potential smokers by their GP were included. This procedure ensured that the GP would actually consider the patients proper candidates for smoking cessation advice.

Consultations with interviews

Thirteen consultations with health problems not related to smoking were selected for interviews. Four of these contained smoking cessation advice. Nine of the 13 patients consented to interviews. The remaining four consultations were, however, analysed and investigated by interviews with GPs. All four patients consented to that. Another two consultations were included for interviews even though they were about issues that were related to smoking (pregnancy, contraceptive pills). They fitted the strategy of the sample in another sense, since no advice was given even if advice would have been expected,
according to the tradition of advice described. Thus, a total of 11 patients were interviewed. After observation of consultations, patients were contacted by telephone to make an appointment for an interview. The characteristics of the interviewed patients are shown in Table 3. The names of the patients are fictional.

Table 3. Interviewed patients.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Health problem</th>
<th>Advice</th>
<th>Age, years</th>
<th>Time on GP’s list, years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharon</td>
<td>Inflammation of the throat</td>
<td>Yes</td>
<td>34</td>
<td>1</td>
</tr>
<tr>
<td>Gerald</td>
<td>Voiding at night</td>
<td>No</td>
<td>60</td>
<td>10</td>
</tr>
<tr>
<td>Jane</td>
<td>Cystitis or vaginitis</td>
<td>No</td>
<td>48</td>
<td>3</td>
</tr>
<tr>
<td>Sophie</td>
<td>Stress and perfectionism</td>
<td>No</td>
<td>33</td>
<td>6</td>
</tr>
<tr>
<td>Roxanne</td>
<td>Inflammation of the throat</td>
<td>Yes</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>Charles</td>
<td>Wart</td>
<td>No</td>
<td>78</td>
<td>18</td>
</tr>
<tr>
<td>Alice</td>
<td>Neck and back pain</td>
<td>No</td>
<td>61</td>
<td>10</td>
</tr>
<tr>
<td>John</td>
<td>Haemorrhoids</td>
<td>Yes</td>
<td>57</td>
<td>13</td>
</tr>
<tr>
<td>Mary-Ann</td>
<td>Oral contraceptives</td>
<td>No</td>
<td>35</td>
<td>10</td>
</tr>
<tr>
<td>Monica</td>
<td>Pityriasis</td>
<td>No</td>
<td>66</td>
<td>5</td>
</tr>
<tr>
<td>Dave</td>
<td>Possible venereal disease</td>
<td>No</td>
<td>23</td>
<td>½</td>
</tr>
</tbody>
</table>

Among the four patients consenting to observation only, three were in difficult psychosocial circumstances (wife of a man recently severely injured, mother of a child with psychiatric illness, woman with drug problems). The fourth patient not interviewed was a man with a heavy workload at the time.

Consultations without interviews
Eleven consultations containing smoking cessation advice, and occurring in consultations with health problems, were included as a supplement to the consultations with interviews (Figure 1). These consultations were used for contextualization of the interview analysis.
A total of 26 consultations then constituted the strategic sample. Consultations from all surgeries were represented in the sample.

2.6 Definition of the terms smoking-related and smoking cessation advice
Symptoms or illnesses diagnosed by the GPs were defined as *smoking-related* if smoking could have contributed to their development, could shape their future course or if cessation was known to improve the prognosis. Symptoms and illnesses that were brought up during observed consultations were scrutinized by literature search for such relations to smoking. Smoking cessation advice was defined as any discussion of smoking, which went beyond answers to the GP’s anamnestic questions about the patient’s smoking status, the amount of tobacco smoked and the duration of the consumption (SBU 1998).

Two examples of smoking cessation advice that occurred in the consultations are given below. In the transcripts the use of square brackets “[...]” indicates that some information has been added by the author.

Example 1:
A woman, 21 years of age, attended her GP because of allergy and possibly asthma. During the consultations the following advice was given:

GP B: “You’re also a smoker, aren’t you? How much do you smoke?”
Mona: “I think I’ve reduced it to 10 now.”

GP B: “Ten, yes. That can really make… the asthma worse, that you take smoke down there, that makes the body react, you know.”

[Later in the same consultation:]
GP B: “And then we’ll have a look at it again and…then think about that smoking as well, I mean…”
Mona: “Yes.”
GP B: “It really doesn’t make it any better.”
Mona: “Yes, I’ve given it a lot of thought.”
GP B: “You, going to be working in the health services, then…”
Mona: “Yes, well…”
GP B: “…it’s important to be a good [laughs] role model.”
Mona: “The people at the riding school they say that I should stop smoking. So I told them that as soon as I get started at the school, then I’ll stop.”
GP B: “Okay.”
Mona: [Not discernible].
GP B: “That is quite a lot at the same time.”
Mona: “Yes.”
Example 2:

In this consultation with a woman, 69 years of age, attending due to shortness of breath, the GP had left the consultation room to fetch a peak flow metre. As he returns with it, he asks:

A: “How about the tobacco?”
……[steps]…………
Ethel: “Shouldn’t we talk about something else, George.”
GP A: “Shall we?”
Ethel: “Yes.”
GP A: “Why is that?”
Ethel: “How did it work out for you? [laughs] Did you get over it?”
GP A: “What answer would you prefer?”
Ethel: [Laughs].
GP A: “Eh? When you ask me how it worked out for me, what would you like to hear?”
Ethel: “That you didn’t manage.” [Laughs]
GP A: “Yes, then I don’t answer, right.”
Ethel: “Yes. That is how it is.”
GP A: “No, I understand… Do you think that we should talk about it? Or do you know…”
Ethel: “I know, George. I know, I know. And I try, but now I have gone through a lot, so I don’t think that I have been ready for it. I know, yes.”
GP A: “What do you think would make you consider quitting?”
Ethel: “That I would feel better. I think so. I know. I know that, yes.”
GP A: “Do you think… Do you think… Have you thought about what might help you, because there are different possibilities of… of both chewing-gum and other things and…”
Ethel: “No, I have not, really. I have not at all… I have not considered anything at all to stop. Well, I have not, and I… now, I am completely honest and tell you that… that I would say, that my cigarette consumption probably went up last year, regrettably. And then… I have kept it high at those 15-16 cigarettes a day, and that’s too much. I know that, right.”
GP A: “That is too much because… I don’t know how many times you’ve been through all this about lung function and what it means…”
Ethel: “But, I have. Yes, yes, several times I have, right. So I know that. So… Yes, I know that.”
GP A: “And you know that Emma is trained as a smoking cessation instructor?”
Ethel: “No, I didn’t know that.”
GP A: “No, but she is.”
Ethel: [Laughs] “She is?”
GP A: “Yes, then she is trained, you know the same as, ah, The Danish Cancer Society. So, right away if you considered it, you could talk with her about it. Either discuss it with her alone or… she makes groups sometimes, of people who want to stop at the same time and who can then support each other.”
Ethel: “Yes, yes, that is possible, because, unfortunately I have a sister in law who is now going to carry… she is going to be in a respirator all of the time because her lungs do not work. It is not really due to… smoking, but it did, I believe, contribute a little. She has smoked since her early days, right, but it is polio and things like it that made her lungs…”
GP A: “Okay, yes.”
Ethel: “So, now, I think it is getting a little bit difficult to visit her if I’m going to smoke. I’m aware of that. And my children don’t smoke, eh…So they will look forward to the day that mother gets rid of the cigarettes, you know. So, I know. I know it. I am aware of that…So, yes, I’d rather…I think I’ll have to try saying…now you are going to live differently and then get rid of those damned cigarettes.”

GP A: “Okay.”

Ethel: “Yes. That I’ll try.”

GP A: “Yes.”

Ethel: “I must talk with Emma also, and things like that.”

GP A: “You can talk with Emma. You’re also welcome to see us again. One of us.”

Ethel: “Well, I know that. Yes, yes, I know.” [laughs]

2.7 Interviews with patients and GPs

All interviews were made by the author, who invited both the GPs and the patients to listen to the audio record of the consultation before the interview and most accepted this invitation. The interview focused mainly on the observed consultations of the patients selected for interview, but some questions addressed experiences beyond the consultation. In these cases, both GPs, patients and the interviewer related the answers to the consultation observed.

GP and patient interviews thematized smoking cessation advice or the absence of such advice. All GP interviews began with an invitation to the GP to describe the consultation. Questions included the reasons for giving or not giving smoking cessation advice during a particular consultation, how advice was given, the patient’s reaction and if advice had affected their relationship. Another four questions addressed patients’ general reactions to smoking cessation advice, if some consultations could not be used for smoking cessation advice, if the GP regretted not having given smoking cessation advice in particular consultations, and, finally, if particular patient characteristics would make them hesitate to give smoking cessation advice. Questions of trust were not asked unless trust or a synonym ("fidus til", “stole på”) was used by the GP or the patient her-/himsely. This was the case for nine of the 11 patients and four of the six GPs. Informants were encouraged to relate the concept of trust to other concepts utilized by him-/herself, to give examples of consequences of trust or of lack of trust and to make patients and GPs describe factors that they felt were influencing trust. Questions were added to the interview guide during the study inspired by the ongoing analysis and following the principles of Emerson et al. (1995). Added questions raised the issues whether the GPs were considering particular emotions of themselves or of the patients when giving smoking cessation advice and how
they handled advice to people having few resources. The questions if smoking had been discussed previously and if it would be in the future were also added. These additional issues were extracted from GPs’ comments during the observation and from prior interviews. Additional questions addressing specific aspects of the consultation were posed to individual patients and GPs alike.

Questions to patients paralleled the ones posed to GPs. Patients were invited to describe the consultation and asked what had made them contact their GP on this particular occasion. They were also asked about presumed reasons why they were or were not receiving smoking cessation advice, in which form smoking cessation advice was given, what they thought of the advice, whether it would affect future consultations and if they thought that the GP would raise the topic again. Like with the GPs, patients were also asked questions about their prior experience with smoking cessation advice, if there were occasions where they would have preferred not to get such advice, if they had ever felt that such advice was missing, if smoking had been discussed previously and if it would be in the future.

The interviews were inspired by Kvale’s (1996, p. 125) phenomenological approach to learning from the interviewee. Changes of sequence and forms of questions were allowed to follow the answers given by the subject. Attempts to clarify and interpret the descriptions were made together with the subject (ibid. p. 127).

2.8 Analysis

Analysis was carried out along with the data collection. Thus, the interviews and selected consultations from one GP surgery were transcribed and analyzed before inclusion of the next. Analysis of the last two surgeries added no new themes to the ones already identified.

An open coding was used based on the informants’ own categories. The approach was inspired by Giorgi’s (1985) four-step process. These steps are 1) The entire text is read to get a sense of the whole statement; 2) Text units addressing specific issues are coded; 3) The insight provided by the text is expressed in theoretical terms; 4) This insight is captured in consistent statements. In the present study, a local analysis, comparing data within the same surgery, and a final analysis across surgeries were added. Coding and grouping of codes was done using the NVivo software.
2.8.1 The role of theory in the analysis

An inductive approach was applied in the present study. Analytical categories were developed systematically on the basis of the empirical data as described below. The analysis included a comparison of the interaction in consultations and of the perceptions of GPs and patients with different theories (Figure 2: Research process). A theoretical approach was adopted that suited the empirical description of the interaction in the consultations.

![Figure 2: Research process. During analysis, both the observed interaction and the perspectives of GPs and patients were compared with different theoretical perspectives. The figure is inspired by Malterud 2003.](image)

Themes emerging from the present study were comparable to already established concepts and understanding, e.g. ‘presentation of self’, ‘frames’ and ‘rules of conduct’. The
theory that was included in the analysis is presented in detail in section 3, Theoretical perspective.

2.8.2 Transcription and coding
Audio-records of interviews and selected consultations were transcribed verbatim. Individual transcripts were read to get a sense of the whole statement. Text units addressing specific issues were identified and coded. Text units are meaning units that capture a significant element of the whole interview or consultation. Special attention was paid to issues that were relevant to the scope of the study, concerning smoking cessation advice, the GP-patient relationship or trust, but other emerging issues were identified and coded as well. Examples of text units are given in Appendix 2. A specific section of the text could be coded by more than one code. As the analysis of interviews and consultations proceeded, the meaning units of new individual transcripts were compared with codes already established. If any such code fitted the text excerpt at hand, it would be used. If not, a new code would be introduced.

2.8.3 Local analysis
The insights provided by individual transcripts were expressed in general terms and each interview and each consultation was summarized. After patients’ and GPs’ views on consultations had been analyzed separately, they were compared with each other in a local analysis at the level of pairs (Figure 3). Consultations were analysed both from the patient’s and the GP’s perspective. An example of a local analysis is given in Appendix 2.
The local analysis revealed that the patients’ and GPs’ perspectives of consultations were much in line. Most parts of the interviews could be coded with the same codes, as demonstrated in the example of codes in Appendix 2, maybe because patients and GPs were asked the same questions and were referring to the same consultation. Differences of view occurred, but there were no systematic differences between the GPs’ and the patients’ perspectives. The similarity of the perspectives of patients and GPs on the consultations and the absence of systematic differences between perspectives, led to the decision to apply the theoretical framework of interaction order to data. The relationship between theory and themes will be considered in further detail below and in section 3 on the theoretical perspective.

Apart from the local analysis, where consultations were mainly considered in the patients’ and GPs’ perspectives, the analysis of consultations also produced a short description of the phases of the consultations in terms that were more procedural. For example, the code ‘discussion of treatment’ denoted the discussion between the GP and the patient of the possible treatment of a health problem. Other codes described actions taken either by the GPs or the patients. Examples of such codes are ‘introduction of issue by the GP’ and ‘introduction of issue by the patient’. Particular emphasis was placed on how smoking
cession advice was integrated into the consultation and on the process of including such advice.

2.8.4 Analysis across surgeries
Further analysis was carried out across surgeries, including both perspectives of the patients and the GPs (Figure 4).

Figure 4: Sequence of analysis. Outline of the steps of the analytical process.
Issues prevailing across surgeries were captured in common themes based on the aggregation of codes. For example, the code ‘honesty about lifestyle’ was included in the common theme of ‘dialogue’. During the course of this reduction process, individual codes utilized only once or only a few times were excluded.

The common themes were collapsed into main themes. For example, the main theme of ‘mutuality’ was based on the common themes of ‘dialogue’, ‘the GP already said so’, ‘smoking cessation advice in an ongoing relationship’, ‘autonomy’, ‘informed choice’, ‘contract’, ‘respecting a “no” from the patient’ and, finally, the theme of ‘mutual respect’.

2.8.5 Main themes across surgeries

The main themes transcending the surgeries were reported in three different papers:

- Paper 1, “Challenging the relevance criteria in Danish general practice consultations: smoking cessation advice in consultations with health problems not related to smoking”, investigates frames of the interaction order in Danish general practice consultations which are challenged by the introduction of a mass strategy of smoking cessation advice. The paper reports on the main theme ‘criteria of relevance’ and another two main themes: ‘particular risks to particular patients’, and smoking cessation advice surfacing in conversations like “How are you?”. Patients’ and GPs’ accounts of why the GP did or did not discuss smoking cessation, and accounts of why it was discussed, lay at the root of a description of the principles for including issues in a given consultation. Goffman’s (1974) concept of frames was applied to this part of the analysis, as it offered a theoretical perspective describing the mechanisms by which patients and GPs ordered the interaction during consultations. Frames of interpretation could be used to explain when issues were included in individual consultations, or when they were left out. Applying a frame perspective presupposes the existence of an interaction order in consultations that makes up a common ground for a working consensus for GPs and patients. The existence of such an interaction order was verified by comparison of consultations with interviews with patients and GPs. This comparison revealed a shared understanding.

- Paper 2, “Keeping morality out and the GP in. Consultations in Danish general practice as a context for smoking cessation advice”, explores GPs’ and patients’ experience with smoking cessation advice to clarify the meaning that smoking cessation
advice achieves in the context of Danish general practice consultations. The paper reports two main themes of the analysis: That smoking cessation advice may challenge the ideal of moral acceptance of patients, and that mutuality in consultations could not always be upheld during smoking cessation advice giving.

Smoking cessation advice was considered from the GPs’ and the patients’ ideal perception of their relation and was related to their attempts to maintain these ideals in individual consultations. This part of the analysis focused more on what was achieved by the interaction than on how the interaction worked (Holstein and Gubrium 2005). Moral acceptance of patients and mutuality were reported by patients and GPs as reasons for courses of interaction affecting their choice of action in general, and in relation to smoking cessation advice.

- Paper 3, “Developing and maintaining patients’ trust in general practice consultations: the case of smoking cessation advice”, describes the process of developing and maintaining trust during physician-patient interaction in general practice consultations. The paper reports two main themes of the analysis concerning the development and maintenance of trust: That patients should feel that GPs recognize their health problems, and that they should feel that their GP accepts their responsibility to evaluate and possibly resolve their health problem.

This part of the analysis was also based on the presence of an interaction order in the consultations. The concept of rules of conduct (Goffman 1967) helped explain how some interaction like smoking cessation advice could contribute to trust in some cases, while imposing a strain on trust in other cases. Face-to-face interaction could either build or undermine trust. The former would happen if the interaction complied with the rules; the latter would happen if it violated the rules.

Statement were not consider to be related to issues of trust on the basis of theoretical assumptions, but only on the basis of the actual occurrence of the word ‘trust’ or one of its synonyms (‘tillid, ‘stole på’, ‘fidus til’). The connections between trust and the interaction in consultations described in this part of the analysis were made by patients and GPs themselves during the interviews. The understandings of trust revealed in the interviews formed the basis for the analysis of trust during the consultations.
3. Theoretical perspective

The main theoretical perspective used in this study is the sociological theory of ‘interaction order’ as described by Erving Goffman (1959, 1967). According to Goffman, order is negotiated between participants to arrive at a working consensus regarding their meeting (Grbich 1999 p. 41). An interaction order, then, is a rather stable pattern of actions in a particular setting. It is maintained and rebuilt by the people involved. Different elements of interaction order occur in the same setting depending on the situation in question. According to the analysis of trust in Goffman’s theory by Barbara Misztal (2001), interaction order produces normality and trust. This perspective offers an understanding of the relation between interaction order and trust in everyday life.

3.1 Interaction order

The importance of the theoretical work of Erving Goffman to this study of the meeting between patients and GPs lies in its ability to describe the interaction order in the encounters of everyday life (Goffman 1959, Goffman 1967). Goffman offers a view of how order is negotiated within frames of the interaction (Grbich 1999 p. 41). Social frames provide background understanding for events that incorporate the will, the aim and the controlling effort by an agent (Goffman 1974, p. 22). Within social frames, actions are ‘deeds’. Such ‘deeds’ subject the doer to ‘standards’, to social appraisal of his/her actions based on existing norms of e.g. honesty, efficiency and tactfulness. According to Goffman (1983), face-to-face interaction has been shaped through continuing repetition between participants who have to quickly reach a working understanding for their encounter. The interaction can be analysed as a collective contribution to the maintenance of such working consensus (Goffman 1959, p. 92). This process of coordination is facilitated by conventions, as well as by the standardization of physical and verbal actions obtained by socialisation serving specific communicative functions (Goffman 1983, p. 3-5). In some places, interaction order continues very consistently beyond the individual encounters (Goffman 1983, p. 4). This is the case in general practice where numbers of brief encounters between GPs and patients are to some extent shaped by common regulations and expectations. Consultations bear a resemblance that make them recognizable as consultations.
Goffman assumes that the researcher can come to understand the perspective of the people participating by observing them. This is possible as interaction itself gives information as to how an individual sees a situation. An individual demonstrates his/her view of a situation through presentation of self and our actions suggest to others what our immediate intentions are (Goffman 1983, p. 3).

Consultations in general practice can be considered as meetings that have an interaction order. This will be illustrated below by examples, applying Goffman’s concepts of ‘frames’, ‘presentation of self’ and ‘rules of conduct’ to general practice consultations.

3.1.1 Frames
When individuals attend to any current situation, they face the question, "What is going on here?". Frames are an attempt to explain how this understanding is obtained (Goffman 1974 p. 8, Album 1995). We use them for making sense out of events. Definitions of situations are built up in accordance with principles of organization which govern events and our subjective involvement in these events (Goffman 1974, p. 10). According to Goffman, groups of specific frames constitute an important part of a culture (ibid p. 21). Frames affect the content and the form of communication. Usually, we are, however, unaware of these frames and would be unable to describe them exhaustively.

A definition of the situation is ordinarily not created by people in the situation themselves. We negotiate aspects of all the arrangements under which we live, but often once these are negotiated, we continue on mechanically as though the matter had always been settled (ibid, p. 2). When a person recognises an event, he tends to imply in his response one or more frameworks or schemata of interpretation (Goffman 1974, p. 21). When the unmanageable occurs, an occurrence that cannot be ignored and to which the frame cannot be applied, it causes bewilderment and chagrin (Goffman 1974 p. 347).

Frames operate also in general practice consultations. As an example, the interaction order is negotiated within a frame that could be called ‘the health problem(s) in question’ at the opening of consultations. In some consultations, patients present more health problems than the GP can deal with in this one encounter. A negotiation process is then initiated and the patient’s health problems are sorted to arrive at a number of issues that can be addressed in that particular consultation. Further issues can be postponed or disregarded. In some cases, this process of negotiation is addressed openly, as when
patients inform the GP at the beginning of the consultation of how many problems they would like to discuss. In other consultations, the process of negotiation of ‘the health problem in question’ is completely silent and a health problem is established as the subject of the consultation without any discussion at all. In this case the order is an implicit, known order where the implicitness spring from the fact that the patient calls the surgery to make an appointment for consultation regarding one or more specific health problems.

3.1.2 Presentation of self
‘Interaction’ is a central concept in Goffman’s theory. It indicates that behaviour is affected in a reciprocal manner when people are together. Full information on others is not possible and it is to some extent unknown how a situation will evolve. We do not have any direct access to know how other people think or feel, but are left with appearances. Presentation of self is the idea that people show each other who they are (Goffman 1959). Goffman assumes that people will inevitably make an impression. The impression may be made consciously, unconsciously or as a matter of routine. The ability to control the impression that others get of one self is labelled ‘performance’. The concept of performance leads to the concept of ‘audience’. The audience is the people who participate in interaction. The roles as performer and audience are carried out simultaneously.

Both GPs and patients wish to give specific impressions of themselves during consultations. As an example, some patients want to convey the impression of themselves to their GP that they do not attend with trivial questions, but only when they are in real need of the GP. Some GPs want to make the impression that they are striving to give the patient a good experience when they visit the surgery. This can, for instance, be expressed in praise to patients of their own healthcare.

3.1.3 Rules of conduct
Rules of conduct serve as guidelines for suitable and just action (Goffman 1967 p. 48). Engagement in the maintenance of rules of conduct commits a person to a particular image of self (ibid p. 50). Rules of conduct bind the subjects to obligations and at the same time produce justified expectations as to how others should act. Goffman’s examples of rules of conduct are drawn from hospitalized mental patients. One example was the rule that patients should engage in therapy. The patient’s showing up in time was understood
by the staff and other patients as a token of the patient’s appreciation of his/her need for

treatment and as an indication that this particular physician was good at establishing

relationships. The patient’s failure to show was, however, interpreted as a sign that the

patient was too sick to know what was good for him and that his psychiatrist maybe was

not that good at establishing relationships (p. 52). An act that is subject to a rule of

conduct, then, is a communication (p. 51). Rules of conduct transform both action and

inaction into expression.

Intentions are thus are expressed in interaction both by abiding by rules of conduct and by

not abiding to these rules (Goffman 1967 p. 90). Intentions are expressed both in
deferece to others and in demeanor of one self. Deference expresses a promise to others
about how they will be treated (ibid p. 60).

Rules of conduct may not be perceived as long as they work uncompromised, and

subjects who follow them will usually not be aware of any reasons why they are there (ibid
p. 48-49). Practices based on rules of conduct can even be institutionalized (ibid p. 91).
The existence of rules of conduct as well as frames is brought to attention exactly when
they do not work or are compromised in some way.

The examples of actual rules of conduct as described by Goffman in 1967 are not like
today’s rules. Nor does the setting of a mental hospital fit that of general practice
consultations. The concept of rules of conduct, however, can be used for analytic
purposes beyond the actual rules described by Goffman. In general practice consultations,
rules of conduct can describe the aspect that GPs and patients express their intentions to
each other during interaction. For example, the GP may wish to demonstrate to the patient
that he/she intends to help patients, also when trouble is self-afflicted. Demonstration of
this intent would be needed, as the inevitable discussion of how to avoid this kind of
trouble in the future might be conceived of by the patient as a demonstration by the GP
that this particular kind of problem would not be welcomed once again.

3.2 Trust and interaction order

Goffman’s theory of interaction order is used as a theoretical frame for the analysis of
trust. The interaction order theory corresponded well to the interaction observed in the
consultations and to the perceptions of GPs and patients reported in the interviews.
Barbara Misztal (2001) describes how the interaction in everyday life matters to the development and maintenance of trust. Goffman assumes that following rules of interaction reinforces people’s mutual feeling of trust and of relative predictability (ibid. p. 315). Commitment to the maintenance of rules of conduct commits a person to a particular image of self (ibid p. 50). Trust is eventually sustained through the establishment of consistent expectations and presentations of self (Gawley 2007, Luhmann 1979).

Luhmann’s analysis of trust (1979) adds to the analysis by Misztal by connecting trust with the presentation of the self. Luhmann sees personal trust as a generalized expectation that others will handle their freedom in accordance with the self they have presented (ibid p. 39). The freedom of the other has a disruptive potential that can be controlled because the presentation is obligating the person who is presenting himself. This obligation is established as the presentation of self that trust relies on is integrated with a net of norms. This means that together with the possibilities that are enabled by trust, the trusting relation creates a social control. Trust is thus is a kind of capital that opens up new possibilities. This does, however, require a continuing trustworthy presentation of self (ibid p. 64). Trust based on presentation of self can be confined to trust in specific aspects of a person. It is then possible to trust without emotional identification and thorough personal acquaintance (ibid. p. 83).

This particular element of Luhmann’s essay on trust fits well with and adds to the theoretical frame of analysis offered by Goffman. Luhmann’s theory, however, was not used in the analysis in general, as general practice consultations do not fit the idea of a system dealing only with health. Consultations embrace tasks that are very diverse.

3.3 Goffman and phenomenology

Goffman’s work was inspired by the phenomenology of Alfred Schütz (Goffman 1974 p. 4). Schütz (1975 p. 20) describes the extent to which perceptions rely on common sense. He claims that bare facts do not exist. Thinking implies constructions such as abstractions, generalizations and idealizations (ibid p. 21). A principle of typicality helps to group series of experiences. One example could be ‘health problem’ and the related question of which kind of health problem. ‘Health problem’ is a type that can be used for the registration of future health problems. This implies that some aspects of an object are deemed relevant and others are deliberately left out (ibid. p. 25). Commonsense knowledge of everyday life
relies on inter-subjectivity (ibid p. 28), which can be achieved even though the meaning of interaction differs between participants. This is due to a principle of reciprocity of motives that implies the supposition that 1) I would think what he thinks if I were in his place, 2) We understand things in the same way, 3) We understand each others motives.

In a phenomenological perspective, human behaviour is seen from an agent’s own perspective.

### 3.4 The concept of trust in this study

Matching the concept of trust in everyday life in general practice with scientific, theoretical concepts of trust is a challenge. In everyday life, the word trust may have meanings that deviate significantly from the concept of trust utilized in scientific literature. Furthermore, the definition of trust probably should depend on the context (Goudge and Gilson 2005).

One global definition of trust would not grasp the meaning of the concept within different professions, institutions or communities. The context of trust will also imply different consequences of trust. As an example, the citizens trust their taxation authorities and their day-care centres in different respects. They would not trust day-care centres with their money or taxation authorities with their children. In both cases, the statement that we trust these institutions is usually not qualified with any information about what this trust is about. This is implied in a tacit way in the statement itself “that we trust”. The operationalization of trust would differ radically according to the context in question. The question “who is trusting who?” is specifying the meaning of the concept trust, but this is not even specific enough. As suggested by Luhmann (1979), we often trust a person in one respect, but not necessarily in another. This qualification seems particularly relevant to the case of experts, who are trusted as regards their expert knowledge.

The concept of trust has been used by GPs to describe certain desirable qualities of the relation between the GP and the patient. It has been compared to a bank account where savings are deposited during an ongoing relationship (e.g. Foged 2003). Pellegrino and Thomasma (1993) have described trust as a virtue of the medical profession that cannot be substituted by contracts in health care. They stress the importance of a fiduciary responsibility of professionals, who carry out tasks on behalf of their clients as described by Barber (1983). Fugelli (2003) suggests that general practice should brand itself on trust, emphasizing realistic medicine in a personal shape, closeness that endures, and the
sharing of power. Trust has also been considered from a functional perspective (Hall et al. 2001), as concerns the effects of trust on the quality of work in general practice. The most pertaining element in the conceptualizations of patient’s trust in physicians in the medical literature is that the physicians serve as agents for each single patient, pursuing his/her best interest (Anderson and Dedrick 1990, Mechanic and Meyer 2000, Hupcey et al. 2001, Gilson 2003, McKinstry et al. 2006). The present study did not define trust prior to the process of data collection. The understanding of trust was instead based on GPs’ and patients’ own utilization of the word “trust” (“tillid”). As synonyms to trust were accepted “confidence in” (“fidus til”) and “rely on” (“stole på”). Confidence in the sense of safety and security (“tryghed”) was not included, nor was “credence” (“tiltro”). During data collection and analysis, the use of the term “trust” by GPs and patients was related to existing theory.

3.5 Limits of the interactional perspective on trust

By taking an interactional perspective to trust in this study, other aspects of trust are necessarily left out. In his model of trust in health care, David Mechanic (1998) encompasses five important aspects: 1) Expectations about doctors’ competences, 2) the extent to which doctors are concerned with their patients’ welfare, 3) their control over decision-making, 4) their management of confidential information, and 5) their openness in providing and receiving information. This model applies to health care in general and is not specific to general practice. When testing these dimensions in interviews with patients with severe illness, it became clear that some of these dimensions were taken for granted while other dimensions were tested by the patients during the interaction (Mechanic and Meyer 2000). Interaction, including presentation of self, is one mechanism for building trust, but trust is rooted in a number of factors. It may build on guarantees provided by a sovereign. A sovereign is a third party exercising control over the relationship through contracts and agreements (Knudsen 2001). These contracts and agreements are setting the premises for the consultation. The authorization of doctors and accreditation of their institutions are examples of this mechanism for building trust.
A theoretical distinction is usually made between 'system trust' and 'personal trust' (Shapiro 1987, Luhmann 1979). In doctor-patient relations, the former is trust in the medical profession or the health care system, the latter in the actual doctor-patient encounter. Systems trust implies that any doctor will do, whereas personal trust is vested in the individual doctors. Though useful at a theoretical level, this distinction is not productive in everyday life where the two dimensions mingle and incessantly affect one another (Gilbert 1998, Hall et al. 2001). Trust in individual physicians can mediate trust in the health care system (Giddens 1996).

In summary, Goffman’s theory of interaction order was used in the analysis of the interaction in general practice. This theory fitted the context and seems useful in understanding every-day life in general practice. Specific elements of interaction order such as frames and rules of conduct were emphasized in different parts of the analysis. Some amendments and specifications regarding general practice consultations are made in this study. Two major principles of interaction in general practice consultations that were revealed in relation to smoking cessation advice were described. One was relevance criteria which are general principles for deciding what is included in consultations and what is left out. Relevance criteria serve to limit the amount of issues in individual consultations. The other principle was that of rules of conduct. The dynamics of trust in the doctor-patient relationship in general practice can be understood to rely on rules of conduct that apply to the interaction. Interaction following these rules contributes to trust while interaction that does not is likely to undermine trust. The theory of interaction order then applied to and was elaborated for use in the context of general practice consultations.
4. Results

This chapter summarizes the results from the three articles enclosed with this thesis.

4.1 Challenging the relevance criteria (Paper 1)

This paper investigates the frames of the interaction order in Danish general practice consultations that are challenged by the introduction of a mass strategy of smoking cessation advice. The paper examines which principles of interaction in general practice consultations allow smoking cessation advice and which do not. It also explores the function of these frames according to GPs and patients involved in the interaction. The main emphasis was on consultations for health problems not related to smoking. Such visits have been described as ‘missed opportunities’ for smoking cessation advice. Individual in-depth interviews with GPs and their patients were grounded in observation of their consultations. The concept of frames by Goffman was used as an analytic tool. I found that both GPs and patients evaluated potential issues that they wished to include during consultations by criteria of relevance. These criteria constituted frames of interpretation. An issue could be included if the patient or the GP could connect it to something already going on in a consultation. Smoking cessation advice was subject to these criteria of relevance and was primarily discussed if it posed a particular risk to a particular patient. Smoking cessation advice could also occur in a frame of a conversation concerning the patient’s well-being. If smoking cessation advice was given without any other readable frame, it could be perceived by patients as a part of a public campaign. Criteria of relevance served the purpose of limiting the number of issues in individual consultations.

The illness in question could make smoking cessation advice relevant, but patients and GPs saw many other occasions for giving advice. Smoking cessation advice could also be relevant if GPs smelled smoke in the patient’s clothes or saw the patient’s cigarettes. One GP introduced the issues of smoking during an acupuncture treatment by suggesting acupuncture for smoking cessation as well. Advice could also be given as follow up on prior discussions of smoking or when GPs were seeing patients who were new in their practice. Some consultations were used as an opportunity for what some patients termed
'small-talk’. It was, however, considered optional and often occurred in what could be considered the ‘spare time’ of consultations, like when awaiting the effect of acupuncture.

4.2 Keeping morality out and the GP in (Paper 2)
In this paper GPs’ and patients’ experiences with smoking cessation advice were explored to clarify the meaning that smoking cessation advice achieves in the context of Danish general practice consultations. The main focus of the study was on consultations for health problems that were not related to smoking. This part of the analysis focused more on what was achieved with interaction than on how interaction worked.

The results were that patients and GPs agreed that the GP should adopt an attitude of moral acceptance of patients. Moral acceptance of patients, in this study, was an ideal of both GPs and patients that the GP in general should bracket his/her own moral evaluation of the patient’s actions. Ideals of moral acceptance of patients in general practice consultations were challenged by the prevailing negative moral values associated with smoking. Both patients and GPs were aware of a general, public anti-smoking atmosphere and patients felt obliged to show responsibility for their own life-style already before they entered the GP’s surgery.

A general aim of mutuality in the conversation in consultations could not always be achieved in smoking cessation advice. Mutuality in the conversation was defined as the situation where issues of interest to both the patient and the doctor were sought. Achieving mutuality was especially a problem when smoking cessation advice was repeated at short intervals. Almost all patients agreed that GPs should advise patients to stop smoking, but that advice would be annoying if it was repeated at short intervals despite the patient’s lack of interest. Most GPs reported that they were caught in a dilemma as they felt that patients should have the right to refuse smoking cessation advice just as they should have the right to refuse any other treatment. They did, however, also feel that they were obliged to discuss it anyway.
4.3 Maintaining trust (Paper 3)

This paper describes the process of developing and maintaining trust during physician-patient interaction in general practice consultations. It focuses on the relation between this process and smoking cessation advice. The emphasis of the study was on advice in consultations about health problems not related to smoking. In-depth interviews with GPs and patients were grounded in observation of their consultations. The understanding of trust was based on the GPs’ and patients’ own utilization of the word. To study trust as a matter of interaction a theoretical perspective that stems from the work of the sociologist Goffman was applied. According to Goffman, intentions are expressed in interaction by either abiding by or violating ‘rules of conduct’. A rule of conduct is not described like a law, but it indicates how the parties to an encounter are expected to act.

According to the findings of this paper, both GPs and patients expected that the GPs should demonstrate through interaction their intent to evaluate and possibly resolve the patients’ health problems. The demonstration of this intent contributed to patients’ trust in their GPs. The GPs should demonstrate through interaction that they recognized the patients’ health problems, which could strengthen trust.

Smoking cessation advice during consultations may cause patients to think that the GP does not acknowledge his/her responsibility to evaluate and possibly solve the patients’ health problems. It may also convey the impression to the patients that the GPs do not recognize their health problems. These possibilities were recognized by the GPs. However, smoking cessation advice that made the patient feel that the GP showed interest for him/her was regarded as something that supported trust, both by the patients and by the GPs. So was advice that was demonstrating that the GPs were taking responsibility.

Finally, trust was seen by GPs and patients as a resource for smoking cessation advice in general practice. Trust in the patient-physician relationship was reported to make the patient receptive to advice from the practitioner and to counteract the risk of offending the patient.

GPs intended interaction to contribute to trust. Building and maintaining trust is an integral goal of consultations.
5. Discussion

Danish general practice consultations as a context for a mass strategy of smoking cessation advice has not been consistently described before. I anticipated that changing the scope of individual consultations from a high-risk to a mass strategy of smoking cessation advice could jeopardize the patients’ trust in their GPs. This study’s main focus was on consultations with patients without smoking-related illness. This focus was chosen to illustrate the principle of a change from a high-risk to a mass strategy of smoking cessation advice. Smoking cessation advice was defined as any discussion of smoking, which went beyond the GPs’ anamnestic questions regarding patients’ smoking status, kind of tobacco consumed and smoking history.

What does this study add?
- Prior studies have argued that GPs’ smoking cessation advice is a question of ‘timing’. This study adds that ‘timing’ is a matter of relevance, moral acceptance of patients, wish for mutuality in the conversation, display of the GP’s recognition of the patient’s health problem, and the GP’s intention to evaluate and possibly solve the patient’s health problem.
- This study supports the findings of previous surveys of GPs that smoking cessation advice is given in the context of smoking-related illness. This study adds the information that many other occasions can also be used for advice giving and that it can, among others, be provided as a display of the GPs’ interest in patients’ well-being.
- Moral implications of smoking cessation advice have been reported in advice linked to patients’ health problems. This study adds that moral implications are present also when patients’ health problems are not related to smoking.
- Prior studies have described trust as a matter of interaction in general practice consultations. This study adds that GPs intend interaction to contribute to trust and that building and maintaining trust is an integral goal of consultations.
- Very few prior studies have asked the question how preventive services affect trust. This study adds that smoking cessation advice has the potential both to put a strain on trust and to build trust.
- Surveys of patients have concluded that they largely think that physicians should give smoking cessation advice also when it is not linked to smoking related illness. This study adds a number of reservations to these attitudes as far as the practical level of advice implementation is concerned.
5.1 Discussion of results

Prior descriptions of GPs’ traditional strategy of smoking cessation advice have demonstrated that such advice focuses on illnesses related to smoking (Thorndike et al. 1998, Coleman et al. 2004, Wynn et al. 2002, Lawlor et al. 2000). According to a paper by McBride et al. (2003), office visits, notification of abnormal test results, pregnancy, hospitalization and disease diagnosis have been considered as teachable moments for smoking cessation. This study adds the information that GPs see many other occasions for advice giving and that advice can, among others, be taken as a token of the GP’s interest in the patient’s well-being. If advice, however, was not given within a recognizable frame of reference, it was rather perceived by patients as a part of a public campaign and perceived as unimportant to themselves. According to the findings of the present study, patients distinguish between smoking cessation advice due to a particular, personal risk and advice given as in a campaign. Advice in the latter form is perceived as less important by patients than advice given to counter a personal risk. The results of the present study raise the question whether the mixing of mass and high-risk strategies in individual consultations will add to the complexity of interaction. It seems probable that the mixing of mass and high-risk strategies in individual consultations could have the consequence that GPs’ advice may loose some of the impact that they have had until now being a signal of a particular risk.

According to the findings of the present study, both GPs and patients felt that prevailing negative evaluations of smoking were included in consultations along with advice. According to Lupton (1997, p. 25), virtues like self-control, self-discipline and willpower are now pursued in health. This will probably tend to be implied in smoking cessation advice. Smoking cessation advice linked to patients’ health problems has been reported to have moral implications (Pilnick and Coleman 2003). The present study adds that moral implications may also arise when giving smoking cessation advice that is not related to the patient’s health problems. Both GPs and patients felt that advice could conflict with an ideal of moral acceptance of patients in general practice consultations, an ideal shared by patients and GPs. This finding corresponds to the description by Arborelius and Bremberg (1994) of how GPs responded negatively to examples of condemnation and exhortation in their own life-style advice. Giving advice and showing respect could be competing goals in individual consultations.
Issues of interest to both the GP and the patient were sought during interaction. Discussions of smoking were also to the greatest extent possible based on a mutual accept of both parties. This shared aim of mutuality is in accordance with prior studies claiming that life-style advice is an issue that requires inter-subjective justification (Sorjonen et al. 2006) and use of politeness strategies (Aronsson and Sätterlund-Larsson 1987). Frequent repetition of advice was a particular challenge to this aim of mutuality, presumably as it demonstrates to the patient that the GP is not ready to await the patient’s agreement that the issue be raised. GPs are expected to motivate patients for smoking cessation (U.S. Department of Health and Human Services, Public Health Service 2000, Sundhedsstyrelsen og Nationalt Center for Rygestop 2003), but according to the findings of the present study, GPs balance advice to patients who are not motivated to quit smoking against their ideal of establishing mutuality in the encounter. It is difficult to repeat advice in the absence of mutual interest in the subject.

Prior studies have described trust as a matter of interaction in general practice consultations. This study adds that GPs intend interaction to contribute to trust and that building and maintaining trust is an integral goal of consultations. The maintenance of trust during interaction demanded that smoking cessation advice was given in a manner that fitted the rules of conduct, that GPs should recognize patients’ health problems and that GPs should accept the responsibility to evaluate and possibly resolve the patients’ health problems. If not, advice could erode trust. This adds to prior knowledge of the relation between preventive services and trust which has either suggested that preventive services add to trust (e.g. Thompson et al. 2001) or that established trust makes life-style advice more acceptable (e.g. Putnam et al. 2004). No prior studies have specifically addressed the relationship between smoking cessation advice and trust.

Initiating this study one of my preconceptions was that introduction of intervention at the population level would represent a major shift in the work of Danish general practice, where GPs are primarily managing the health problems brought by their patients. The results of this study demonstrated that a smoking-related health problem was not necessarily needed for a GP to give smoking cessation advice. The GP simply needed an occasion to connect smoking cessation advice to what was going on during the consultations already. One such trigger issue could be seeing the patient’s cigarettes.
GPs, however, saw advice as optional in the absence of any health problem related to smoking, whereas lack of such advice in the presence of smoking-related problems was perceived as evidence of professional failure or neglect. A study by Sussman et al. (2006) demonstrated how dynamic factors, resembling the relevance criteria described in this study, could pave the way to a decision to provide preventive counselling for obesity during consultations. These dynamic factors included the patient’s agenda, receptivity to the proposed counselling and the presence of teachable moments. Prior research has demonstrated that GPs’ care to protect the patient-physician relationship is a factor that affects their decision to include preventive services or not (Coleman et al. 2000, Summerskill and Pope 2002, McEwen et al. 2006, Lawlor et al. 2000, Calnan et al. 1986). Some of these services seem to have been excluded for fear of jeopardizing the patient-physician relationship. It has remained unclear, however, how preventive services could damage the patient-physician relationship. Terms like ‘timing’, utilized to describe the terms of smoking cessation advice in consultations (Coleman 2004), probably reflect what is detailed in the present study as criteria of relevance, conversational mutuality, recognition of patients’ circumstances and maintenance of patients’ trust. Surveys abroad and in Denmark have shown that most patients would accept that GPs take an interest in their smoking habits (e.g. Sundhedsstyrelsens 2006, Bremberg and Nilstun 2005). This positive attitude seems to fit poorly with the GPs’ concern for the patient-physician relationship as a barrier to smoking cessation advice. The question is whether the GPs’ and the patients’ perceptions of the GP’s role do not correspond? This study qualifies some of these attitudes, by situating the expectations and attitudes in every-day life of general practice in terms of interaction order and trust. Conflict between GPs’ and patients’ view of the role of smoking cessation advice in consultations were not outspoken. Both groups found that the interaction order could affect the extent to which advice could be given.

I had hypothesized that a shift from a high-risk to a mass strategy could jeopardize trust between the GP and the patient by changing the scope of individual consultations. I thought of trust in the patient-physician relationship as rooted in the expectation that physicians serve as agents for each single patient, pursuing his/her best interest.
(Anderson and Dedrick 1990, Mechanic and Meyer 2000, Hupcey et al. 2001, Gilson 2003, McKinstry et al. 2006). During data collection, I did not introduce any concept of trust to the participants of the study, but trust surfaced in utterances made by the interviewees, usually in contexts of how interaction affected trust. This perspective resembles the theoretical view of Goffman to trust as described by Barbara Misztal (2001). In the present study, two principles of interaction proved relevant to trust: 1) That the GPs should demonstrate through interaction his/her intent to evaluate and possibly resolve the patient’s health problem, and 2) That the GPs should also demonstrate through interaction that he/she recognized the patient’s health problem. One important function of rules of conduct in interaction is that they extend the intentions of the persons involved beyond the consultation in question. They thus support interaction in future consultations. This may be helpful to patients when they have to rely on GPs and have no ideas themselves of what would be the best thing to do. The application of rules of conduct, as those above mentioned, which largely pass unnoticed, project the intentions that have been demonstrated into future interaction.

According to GPs and patients, the relationship between trust and smoking cessation advice then was not a matter of a smoking-related health problem or not. Trust would be negatively affected by smoking cessation advice if the patient perceived of it as a lack of recognition of the health problem by the GP, or if it could be seen as a refuse on the part of the GP to evaluate or solve patients’ health problems. A health problem related to smoking made it easier for GPs to explain advice as a matter of solving the health problem.

According to Misztal’s discussion of Goffman’s theory, trust should also be related to the legibility of a situation. Legibility refers to the ability to apply a frame of interpretation to what is going on, in this case, in the consultation. A lack of capacity to see or to combat incorrect interpretive frameworks makes people attach wrong meanings to occurrences (Misztal 2001, p. 321). Such lack of readability of order results in distrust in the long run. In order to correctly interpret the implications of advice patients in the present study distinguished advice that was directed to them addressing a particular risk from advice that was relevant to all. This issue was, however, not related to trust by patients. This would have been expected since advice given without the context of a relevant trigger issue reduced its legibility and called for alternative frames of interpretation.
Goffman never worked with the consultation in general practice. However, applying his concept of rules of conduct which demonstrate intentions during interaction produced descriptions of rules that are much similar to one of the elements of Mechanics model of patients’ trust in health care (Mechanic 1998): The notions of agency and fiduciary responsibility. The perspective of Goffman adds an understanding to how such communication is carried out and how it interacts with trust. Other dimensions of Mechanics model, such as technical competence, physicians’ access to the means needed and physicians’ disclosure and confidentiality did not occur in the interviews of this study. This was probably so because of the focus of the present study on the level of interaction. It does, however, call into attention that the present study did not cover every aspect of trust in the doctor-patient relationship in general practice.

An important aspect largely ignored here, for example, is the GP’s technical competence. Technical competence, such as knowledge and skill in health matters, has been reported in other studies to be important to patients’ trust (Wright et al. 2004, Hall et al. 2001, Thom and Campbell 1997, Anderson and Dedrick 1990). Although technical competence is important to trust from an overall point of view, the present study focuses on interactional aspects of the patient-physician relationship and, therefore, does not include this dimension. As demonstrated in the study of Mechanic and Meyer (2000), some dimensions of trust are tested during interaction, while others are taken for granted. Some aspects of trust may be managed by the system rather than being controlled in individual encounters between GPs and patient (Knudsen 2001). The GP’s technical competence may be one such aspect.

In the present study, recognition of health problems was related to trust. In a review on how trust can be investigated, Goudge and Gilson (2005) illustrated how the factors contributing to trust and the consequences of trust differ according to the setting. Causes and effects differ with the object in which trust is vested, be it in institutions, interpersonal relationships or in society as a whole. In health care systems, like the Danish one, GPs act as gate-keepers, and therefore decide whether a patient’s health problem is accepted as such by the health care system. Recognition of health problems could be an important element of trust in general practice in health care systems where GPs act as gate-keepers.
What are the consequences of the results of this study for a possible mass strategy? A mass strategy implies that smoking cessation advice moves into new contexts in general practice consultations. According to the findings of this study, making advice acceptable in a specific context requires the presence of a relevant trigger issue and that mutuality can be maintained. It also requires that advice does not convey the impression to the patient that the GP is not recognizing the patient’s health problem or that the GP is not accepting the responsibility to evaluate and possibly alleviate the patient’s health problem. Furthermore, smoking cessation advice would be difficult to reconcile with the ideal of moral acceptance of patients that was demonstrated in this study. The perspectives of these consequences are discussed in section 6, Conclusion and perspectives.

5.2 Discussion of method

5.2.1 Internal validity
Health problems were classified as either related or unrelated to smoking on the basis of the author’s knowledge of the association between smoking and smoking-related morbidity, and the correspondence between this knowledge and that of the participating GPs has not been systematically described. Where any discrepancies in such evaluation were observed, the participating GPs generally adopted a narrower interpretation of smoking-related than the author. The cases chosen that were not related to smoking would therefore tend to be in accordance with the GPs' perception. Discrepancy, however, was seen in cases of sore throats, where GPs tended to emphasize the local irritation by smoke. This did not qualify as related to smoking according to the criteria defined in the present study. No uniform standard exists for how to judge whether health problems are smoking-related or not. Flocke and Stange (2004) used physicians’ diagnoses and evaluated the relation to smoking themselves. Wynn et al. (2002) focused on the patients’ perception, whether a health problem was smoking-related or not. The GPs own opinion would have been the most appropriate definition of smoking-related in this study. However, GPs were not invited to provide such evaluations in order not to invite a possible bias. Asking if the health problems in question were related to smoking might have made the GPs focus on this distinction, which would have compromised the validity of the findings, in
particular of Paper 1. Furthermore the question could have been embarrassing to GPs. My position as a colleague and researcher, knowing more about smoking than they did, made it an awkward question.

Both GPs and patients were surprised by my choice of consultations for interviews. They felt that the consultations were those where they least expected smoking cessation advice. This surprise serves as an indicator that these consultations, in fact, represented a deviation from the tradition of smoking cessation advice in general practice.

New knowledge about the relationship between smoking and health has emerged during the study time, which may have changed the status of an illnesses as being smoking-related or not. Thus, an illness not labelled smoking-related at the beginning of the study in 2003 may appear on the list of smoking-related illnesses at the end of the study period.

Literature searches were therefore continuously performed during the time of the study to ascertain that the investigator’s knowledge base was up to date at the time of observation and interview.

The variation of activity of smoking cessation advice of the GPs included, was based on peers' evaluation and confirmed by the GPs themselves. This provided a sample of three ‘active’ GPs and three GPs who were not particularly active. At the surgeries of the first and second active GPs, GP A and C, a member of the clinic staff had been trained as a smoking cessation counsellor. Counselling on smoking cessation could thus be suggested by the GP and provided within the practice. GP C had been trained as a smoking cessation counsellor herself as well. The third active GP, GP E, had had an extensive training in giving smoking cessation advice. His patients could be referred to the local, public smoking cessation centre.

The shift from a high-risk to a mass strategy was analysed in terms of smoking cessation advice in encounters for health problems not related to smoking. Most of the interviewed patients received no smoking cessation advice. It should be stressed that consultations without smoking cessation advice were just as valuable data as consultations with advice with a view to exploring the consequences of a possible change from a high-risk strategy to a mass strategy. The present study allowed exploration of the logic of the interaction when deciding to include or exclude advice giving in consultations.
5.2.2 The effect of the observer’s presence on the interaction

As an observer, you are part of the situation and will always affect it (Atkinson and Coffesy 2002). My presence as an observer affected the doctor-patient interaction both as regards smoking cessation advice and as regards trust. According to GPs themselves, my presence increased the GPs’ attention to giving smoking cessation advice to some extent and made them provide more advice than they would otherwise have done. This was particularly pertinent during the first day of observation in each practice, where GPs were stating their ideals about smoking cessation advice. Accordingly, the first day of observation was not included in the analysis. All consultations selected for interview were drawn from the second and third day of observation, which were more like usual days in the surgery according to the GPs.

I was also seen as a colleague, which implied the potential to disagree with their practice in some situations. Taboos of professional insufficiency might have affected observation less if the investigator had not belonged to the professional group herself (Coar and Sim 2006). I was not a general practitioner myself, which may have made the GPs focus on the particular working conditions of the GP as opposed to those of other groups of physicians. My status as a physician was also known to the patients, which made my presence in the consultations more acceptable to the patients. It did, however, also make patients treat me as a physician during interviews, sometimes asking for my professional judgement. This may have prevented lay theories of smoking that might be considered controversial to physicians. It may also have contributed to the consensus between the views of GPs and patients in the study.

In addition, both GPs and patients may have made a special effort to present themselves as good GPs and good patients. In some cases patients reported that they thought that GPs had made a special effort to listen to them in the consultation where I was present. Conflicts may have been played down. Both GPs and patients reported that the other could be more difficult to get around than in the situation I had witnessed in the present study. Both patients and GPs also reported that patients in some cases had avoided intimate issues. The playing down of conflicts may also have contributed to consensus of the data sources.

This invites the question whether videotaping as used by Arborelius and Bremberg (1994) and Coleman and Murphy (1999) would have been a better method in this study than
participant observation. The presence of the observer was, however, utilized for open-ended interviews with GPs on an ongoing basis. It also elicited spontaneous comments from GPs. Both on-going interviews and comments could therefore be included to qualify the understanding of the consultations that were observed and to prepare formal interviews. The analysis is thus in closer accordance with the participants’ own understanding than it would possibly have been in a design based on videotaping. Videotaping would also have missed circumstantial knowledge such as if the GP had patients queuing in the waiting room.

5.2.3 Observation of trust

Observation of trust is controversial. It is necessary either to operationalize in advance what will be taken as signs of trust or, as done in the present study, to interview the people observed to gain knowledge of their perception. If it had been anticipated on a theoretical basis that specific actions were producing trust or that specific actions were a product of trust, what actually mattered to trust in this particular context could have been missed (Goudge and Gilson 2005). An example, given by Möllering (2001), is that cooperation is not necessarily a display of trust. It can just as well rely on other social forces, such as power.

In the present study, the understanding of trust was based on interviews with GPs and patients. The understanding of interaction that influenced trust described in the present study was based on the connections made between interaction and trust by the GPs and patients during interviews. An understanding of trust based on interviews may be controversial as well. According to Luhmann (1979), you cannot at all give precise and exhaustive reasons why somebody is trusted or not (ibid. p. 29). He argues that reasons stated for trust are incomplete since trust is needed exactly when information is incomplete. When assuming, as Luhmann, that trust is substituting for information, it is impossible to base trust on knowledge alone.

The aspects of trust revealed in this study belong to the social sphere of expectations. More emotional aspects of trust were less visible in this study. The author’s presence may to some extent have suppressed such intimate issues.
5.2.4 Handling of preconceptions

My preconceptions were founded on a personal experience of difficulty in carrying out a mass strategy of smoking cessation advice as described by Iversen (1998). Performing this program in two different out-patients clinics, I received reactions from physicians and patients that this approach was difficult to fit into every-day work in the clinic. The initiation of the present study was, therefore, initially based on this field knowledge, among others, and the prime concern was with what appeared to be a mismatch between mass strategy and the clinical work of physicians. This much influenced my choice of the subject for this study and the choice of questions that constituted the interview-guide from the beginning of the study. During the data collection and analysis, a conscious attempt was made at challenging my initial preconceptions by searching for data and perspectives that did not conform with these expectations. Elements of this strategy included to accept the perspectives of the GPs and the patients demonstrated in consultations and interviews and to use these concepts of the field itself in open coding.

All the observations, interviews and analyses were done by myself. Being a doctor, some aspects may have been lost because they were taken for granted by both me and the participating GPs. However, the specific focus on the patients’ perspectives minimised the risk that my own field-experience would make me overlook important aspects. Further, different perspectives were invited by sharing parts of the analysis with supervisors with sociological expertise (Dorte Gannik and Thorkil Thorsen).

5.2.5 Generalizability

No matter which research design is chosen, the generalizability of the results will always be limited in some respects. In qualitative research, generalizability does not increase proportionally by the number of individuals or events included in the study. The important question is whether the sample is appropriate for the purpose of the study (Malterud 2003). This determines which questions can be answered. The sample of GPs in this study represents a variation in the activity of smoking cessation advice. Themes that were common in this sample of GPs assumedly are relevant to many more GPs than those included. Likewise, the sample of patients represented different health problems and variation of age and sex and patients receiving advice as well as patients who did not receive advice.
Eighteen GPs had to be invited to get six to participate. Particularly GPs in urban settings who were new in their practice declined participation. Both participating and non-participating GPs expressed uncertainty as to whether their handling of smoking cessation and their handling of the doctor-patient relationship was sufficiently professional. The participating GPs may thus have been those who were comparatively more self-confident professionally and more skilful in handling the doctor-patient interaction. The implications for the finding of this study could be that it does not address the difficulties of the GPs who feel most insecure in this field. By implication, the study may therefore also have underestimated the difficulty in giving smoking cessation advice in general practice, and it should be noted that even skilful GPs found such advice giving to be challenging and a source of potential conflict. The four patients who declined an interview were people in difficult psychosocial circumstances. This selection affects the results in the same way as the selection of GPs. The present findings may, accordingly, be a ‘best case scenario’ for smoking cessation advice.

The interaction described in the present study does, however, belong to the setting of general practice in the Danish community and may be limited to this context.
6. Conclusion and perspectives

6.1 Conclusion

The present study hypothesised that a shift from a high-risk to a mass strategy would constitute a shift in the work of general practice and that a mass strategy may jeopardize patients’ trust in their GPs.

The study reveals that large-scale integration of smoking cessation advice in general practice will upset the principle of relevance; a principle that draws on frames of interpretation shared by the GP and the patient. These frames define which issues can be raised within the time constraints of an individual consultation (Paper 1). The study also demonstrated that a mass strategy of smoking cessation advice would be difficult to reconcile with an ideal of moral acceptance of patients in consultations. Smoking cessation advice was balanced by GPs against the mutual expectation that GPs should demonstrate moral acceptance of patients’ actions. Advice would also be balanced against the wish for mutuality in the consultation in some consultations. Repetition of smoking cessation advice at short intervals was perceived to particularly conflict with the general principle of mutuality in the choice of topics (Paper 2). Finally, it was demonstrated that the development and maintenance of trust could be influenced by a mass strategy of smoking cessation advice. The wish to make interaction support trust may limit the number of consultations actually available for smoking cessation advice. (Paper 3)

6.2 Perspectives

The present study raises at least five perspectives:

6.2.1 Problems in implementation of a mass strategy of smoking cessation advice

A mass strategy of smoking cessation advice has not been implemented during the time of this study. According to UK GPs, 51% of the British GPs are giving smoking cessation advice to patients in all or most of the consultations (McEwen et al. 2005). This may overstate the actual figures because with a response rate of 63% in McEwens study,
selection of more active GPs may have occurred. In 1995, 4.1% of Danish GPs reported that they would always or very often give smoking cessation advice to patients with no smoking-related illness, while 93.2% would do so if the patients had a smoking-related illness (Jensen and Osler 1996). A regional, Danish survey from 2003 reported that 46% of the GPs sometimes raised the issue of smoking cessation in the absence of any symptom related to smoking (Lous and Ollendorf 2004). In a US study by Crabtree et al. (2005), none of the general practices included performed systematic preventive services. This study suggests that relevance criteria limit the amount of issues in individual consultations. Relevance criteria may explain why smoking cessation advice has not yet been implemented in many more consultations. The results of this study indicate that interactional barriers are limiting the extent of smoking cessation advice. These barriers, however, serve a purpose in the interaction order of consultations and cannot be eliminated without side-effects on the interaction as a whole.

The study illustrated conflicts between aims and positions inherent in a mass strategy of smoking cessation advice and aims and positions of the interaction in Danish general practice. Accommodation of smoking cessation advice to local criteria of relevance and rules of conduct may make such advice more likely to be introduced in everyday life. This observation corresponds to the aspect of compatibility in implementation described by Rogers (1995), which takes into account the perspective of the person who is supposed to change behaviour. The implication is, accordingly, that successful implementation requires that a mass strategy is adapted to existing, local values and beliefs and is in conformity with previously introduced ideas of general practice in order to be successfully implemented.

6.2.2 Opportunities for smoking cessation advice

Calculation of the impact of a mass strategy of brief advice from GPs relies on the assumption that all contacts with patients in general practice are opportunities for giving smoking cessation advice (Sundhedsstyrelsen og Nationalt Center for Rygestop 2003, Thorndike et al. 1998, Stott and Davis 1979). The present study, however, makes clear that this is hardly a valid assumption. The hope expressed for the effect of a mass strategy of smoking cessation advice in Danish general practice would therefore seem to be unrealistic.
The present study offers two suggestions for how to increase smoking cessation advice giving in general practice. One is to develop GPs' interaction skills. GPs have a tradition of giving smoking cessation advice, and an improvement of their interaction skills may improve the chances that they will include smoking cessation advice in more consultations. The largest reserve of occasions for inclusion of advice in general practices consultations may be the general conversation of the patient's well-being. An improvement of the interaction skills of GPs could take the form of training in motivational interviewing (Rollnick et al. 1999). Skilful use of motivational interviewing is in accordance with the principle of mutuality in the conversation as described in this study. The other suggestion is to separate smoking cessation advice from routine consultations. The findings suggest that a mass strategy of smoking cessation advice in general practice should be presented frankly as a campaign and should not be introduced in the discussion of the core issues of the consultations. This also applies to preventive services in general as suggested by Crabtree et al. (2005).

6.2.3 Changes in the doctor-patient relationship
Judged from the findings of the study, the introduction of a mass strategy of smoking cessation advice seems to change the relationship between GPs and patients. It should therefore be considered if these changes are, indeed, desirable. Organizational systems can support desirable behaviour of health professionals and should avoid incentives and systems that result in adverse events (Mechanic 2002). Health care systems are part of the social fabric of every country (Gilson 2003). These systems are not only producers of health care, but they are also the purveyors of a wider set of societal values and norms. In a mass strategy of smoking cessation advice, GPs may come to take a position where they are solely responsible for defining the problem and make patients the agents solving the problem (Demak and Becker 1987, Lachmund 1987). Changes in the relation between GPs and patients caused by a mass strategy of smoking cessation advice thus ought to be considered also as a matter of change in the production of societal values and norms.

6.2.4 Handling of patients’ trust in general practice
A social situation lacking trust is very demanding. Absence of trust requires a whole array of other strategies to minimise disappointment or harm (Luhmann 1979). It is also
potentially highly costly and time-consuming. A person who trusts nobody in health matters must have a very large amount of information in order to be able to make the right decisions. Offering a ‘technology’ of trust and continuity, the general practice consultation is both cost-effective and time-effective. It outperforms other parts of the health care system in these respects (Starfield 1998 p. 9). General practitioners are now learning to establish a trusting relationship with the patient in consultations as a part of their training (Sundhedsstyrelsen and Dansk Selskab for Almen Medicin 2004). The findings in this study may help professionalize the handling of patients’ trust in general practice by making GPs more aware of the impact of their actions on trust.

6.2.5 A possible general theoretical perspective for the study of interaction order in general practice

This study has a number of theoretical implications. Goffman’s theoretical concept of interaction order seems to be most useful for investigating issues of implementation and everyday life of general practice work, and it adds another perspective to our knowledge about medical methods. Physicians already know how to evaluate the effect of a method on health and are aware of ethical consequences of interventions. However, Goffman extends the perspective to include how actions are perceived by the patients. GPs are working together with patients and interaction is a central part of this cooperation. The present study suggests how Goffman’s theory may be used in general practice and adds specific principles of interaction of general practice consultations revealed in relation to smoking cessation advice. The specific principles of interaction in general practice added, were the descriptions of relevance criteria and of rules of conduct supporting patients’ trust.

6.3 Future research in this field

The present study leaves some questions unanswered. Adaptation of smoking cessation advice to the context of general practice consultations seems to be a particularly pertinent issue for future research. More health services research is needed to elucidate how smoking cessation advice would best fit the context of general practice. Universal definitions of trust do not capture the meaning of trust in context (Goudge and Gilson 2005). Preconditions and implications of trust differ from one setting to another. This study adds knowledge about some aspects of patients’ trust in GPs as related to
smoking cessation advice. Future research could address trust in the context of other specific interventions in general practice, adding more aspects to an understanding of trust that apply specifically to interaction in general practice consultations.
7. Summary

Introduction:
Physicians traditionally give smoking cessation advice to patients with smoking-related illness or with a particular risk related to smoking. This approach is termed a high-risk strategy. Such a strategy will target mainly those who are at a high risk and who may therefore benefit the most. A mass strategy, in contrast, implies advice to all. Initiating this study, it seemed to me that introduction of intervention at the population level would constitute a major shift in the work of Danish general practice, where GPs primarily are managing the health problems that patients bring. I hypothesized that a shift from a high-risk to a mass strategy could jeopardize the patient’s trust in the GP.

In this study I pose the question how general practice consultations will work as a context for a mass strategy of smoking cessation advice? The study includes both the influence that advice has on the patient-GP relationship and the influence that the patient-GP relationship has on advice, providing more detailed insight into aspects of interaction and trust that are affected by smoking cessation advice.

Design, material and methods:
The question of how the general practice consultation will work as a context for a mass strategy of smoking cessation advice was investigated in a qualitative study. Consultations were observed in six GP surgeries. GPs with different degrees of activity concerning smoking cessation advice were selected. In each surgery, a number of consultations were singled out for further investigation through interviews with the patients and the GPs. Data consisted of a strategic sample of field-notes and audiotapes from 26 consultations, interviews with 11 patients and interviews with six GPs.

Consultations regarding health problems not related to smoking were given special attention through interviews with patients and GPs participating. This focus was chosen since smoking cessation advice is to be included in them according to a mass-strategy of smoking cessation advice, but according to the literature they do not traditionally contain such advice. Smoking cessation advice was defined as any discussion of smoking beyond anamnestic questions from the GP.
GP and patient interviews were grounded in observation of consultations and thematized smoking cessation advice or the absence of such advice. Questions of trust were not asked unless trust or a synonym (“fidus til”, “stole på”) was used by the GP or patient her-/himsel. This was the case for nine of the eleven patients and four of the six GPs. The interviews were inspired by the phenomenological approach of Kvale to learning from the interviewee.

The analysis of the study was inductive. An open coding was based on the informants’ own categories inspired by Giorgi’s four–step process. In the present study, a local analysis, comparing data within the same surgery, and a final analysis across surgeries were added. A theoretical approach was adopted that suited the empirical description of the interaction in the consultations. The main theoretical perspective used in this study is the sociological theory of ‘interaction order’ as described by Erving Goffman. Consultations in general practice can be considered as meetings with an interaction order, applying Goffman’s concepts of ‘frames’, ‘presentation of self’ and ‘rules of conduct’ to general practice consultations. This perspective also offers an understanding of the relationship between interaction order and trust in everyday life.

Results:
The main themes across surgeries are reported in the three papers of the thesis. Both GPs and patients evaluated potential issues that they wished to include during consultations by relevance criteria. An issue could be included if the patient or the GP could connect it to something already going on in a consultation. Smoking cessation advice was subject to these relevance criteria and was primarily discussed if it posed a particular risk to a particular patient. The illness in question could make smoking cessation advice relevant, but GPs saw many other occasions, like if they smelled smoke in the patient’s clothes. Smoking cessation advice could also occur in a frame of a conversation concerning the patient’s general well-being. Relevance criteria served the purpose of limiting the number of issues in individual consultations. If smoking cessation advice was given without any other readable frame, it could be perceived by patients as a part of a public campaign. (Paper 1)

Patients and GPs agreed that the GP should adopt an attitude of moral acceptance of patients. Moral acceptance of patients, in this study, was an ideal of both GPs and patients.
that the GP in general should bracket his/her own moral evaluation of the patient’s actions. Ideals of moral acceptance of patients in general practice consultations were challenged by the prevailing negative moral values associated with smoking. A general aim of mutuality in the conversation in consultations could not always be achieved in smoking cessation advice. Mutuality in the conversation was defined as the situation where issues of interest to both the patient and the doctor were sought. Mutuality was at stake especially when smoking cessation advice was repeated at short intervals. (Paper 2)
Both GPs and patients expected that the GPs should demonstrate the intention to evaluate and possibly resolve the patients’ health problems. The demonstration of this intent contributed to patients’ trust in their GP. The GPs should demonstrate, as well, through interaction that they recognized the patients’ health problems, also adding to trust. Smoking cessation advice during consultations may cause patients to think that the GP is not accepting the responsibility to evaluate and possibly solve the patients’ health problems. It may also convey the impression to the patients, that the GPs do not recognize the patients’ health problems. However, smoking cessation advice that made the patient feel that the GP showed interest for him/her was regarded as supportive to trust by both patients and GPs. So was advice that was demonstrating that the GPs were taking responsibility. Finally, trust was seen by GPs and patients as a resource for smoking cessation advice in general practice. (Paper 3)

Discussion:
The results of this study demonstrated that a smoking related health problem was not necessarily needed for a GP to give smoking cessation advice. What GPs needed was an option to connect smoking cessation advice to what was going on during the consultations already and that it can, among others, occur in the frame of a conversation addressing the patient’s well-being.
Smoking cessation advice linked to patients’ health problems has been reported to have moral implications. The present study adds that moral implications may also arise when giving smoking cessation advice that is not related to the patient’s health problems. Both GPs and patients felt that advice could conflict with an ideal of moral acceptance of patients in general practice consultations, an ideal shared by patients and GPs. This
finding corresponds to a previous description of how GPs responded negatively to examples of condemnation and exhortation in their own life-style advice. The shared aim of mutuality described in the present study is in accordance with prior studies. The present study added the information that frequent repetition of advice was a particular challenge to this aim of mutuality. Prior studies have described trust as a matter of interaction in general practice consultations. This study adds that GPs intend interaction to contribute to trust and that building and maintaining trust is an integral goal of consultations. The maintenance of trust during interaction demanded that smoking cessation advice was given in a manner that fitted the rules of conduct of the consultations. If not, advice could erode trust. This adds to prior knowledge of the relation between preventive services and trust which has suggested that preventive services add to trust. No prior studies have specifically addressed the relationship between smoking cessation advice and trust.

**Conclusion and perspectives:**
The study reveals that large-scale integration of smoking cessation advice in general practice will upset the principle of relevance which draws on common frames of interpretation shared by the GP and the patient of which issues can be raised within the time constraints of an individual consultation. The study also demonstrated that a mass strategy of smoking cessation advice would be difficult to reconcile with an ideal of moral acceptance of patients in consultations. Smoking cessation advice was balanced against the mutual expectation that GPs should demonstrate moral acceptance of patients’ actions. Advice would also be balanced against the wish for mutuality in the consultation in some consultations. Especially the case of repetition of smoking cessation advice at short intervals could be conflicting with a general principle of mutuality in the choice of subjects. Finally, it was demonstrated that the development and maintenance of trust might be influenced by a mass strategy of smoking cessation advice. The wish to make interaction support trust may limit the number of consultations actually available for smoking cessation advice. The implications of this study for a mass-strategy of smoking cessation advice in general practice are that the choice of routine consultations as a frame for this advice may require adaptation of methods of smoking cessation advice. Presenting advice of this kind as a
campaign and separating it from routine consultations would probably ease the presentation. Implementing smoking cessation advice in many more consultations implies a situation where the task of situating smoking cessation advice in an acceptable manner may require considerable interaction skills. To pursue this strategy, GPs’ interaction skills would need to be improved.
8. Dansk resume

Introduktion:


Materiale og metoder:

Resultater:
I den næste artikel blev det beskrevet, hvordan patienter og læger var enige om, at læger skulle udvise moralsk accept overfor deres patienter. Det var et ideal for både læger og patienter, som handlede om, at den praktiserende læge ikke måtte dømme patienten ud fra egne moralske forestillinger. Idealet om en moralsk accept af patienten blev udfordret af de herskende negative moralske værdier, som forbindes med rygning i det omgivende samfund. Det blev også beskrevet, hvordan en generel målsætning om gensidighed i samtalen i konsultationen ikke altid kunne opnås, når det gjaldt råd om rygestop.
Gensidighed i samtalen betegnede det, at der så vidt muligt blev talt om emner, som begge var interesserede i at tale om. Særligt var det vanskeligt at etablere gensidighed, hvis råd om rygestop blev gentaget i konsulationer med korte mellemrum.

I den tredje artikel, blev det beskrevet, at de praktiserende læger igennem samhandlingen skulle vise deres intention om at undersøge og, hvis muligt, afhjælpe patientens problem. Lægerne skulle også vise, at de anerkendte patientens helbredsproblemer. Både patienter og læger oplevede, at det bidrog til patienternes tillid til deres læge, at lægen viste disse intentioner i samhandlingen. Råd om rygestop i konsulationen kunne give patienterne indtryk af, at lægen ikke anerkendte patientens helbredsproblem eller at lægen ikke påtog sig ansvaret for at undersøge og afhjælpe det. Råd om rygestop kunne dog også ses som et tegn på interesse og et ønske fra lægens side om at hjælpe, hvis råd blev givet i den rette sammenhæng. Dertil kom, at tillid blev set som en ressource, som kunne gøre råd om rygestop mere acceptable.

**Diskussion:**
Tidligere beskrivelser af praktiserende lægers råd om rygestop har vist, at de fokuserer på tobaksrelateret sygdom. Denne undersøgelse bidrager med den viden, at de praktiserende læger desuden ser mange andre anledninger for råd om rygestop, og at råd bl.a. kan være en del af lægens interesse for patientens generelle velbefindende. Denne undersøgelse bidrager også med den iagttagelse, at råd uden nogen forståelig forbindelse til konsulationen kan blive identificeret med offentlige kampagner og dermed ses som noget mindre vigtigt for den enkelte patient.

Det er tidligere beskrevet, hvordan det, at den praktiserende læge knytter råd om rygestop til et tobaksrelateret helbredsproblem, har moralske implikationer, og det er blevet antaget, at råd uden relation ville være at foretrække. Resultaterne af denne undersøgelse viser dog, at der også følger moralske implikationer med i konsultationer, som vedrører helbredsproblemer som ikke er tobaksrelaterede. Beskrivelsen af hvordan råd om rygestop og moralsk accept af patienterne, som et ideal for konsultationerne, kan være i konflikt, minder om en tidligere beskrivelse af, hvordan praktiserende læger tager afstand fra fordømmelse og formaning, når de ser det i deres egen livsstilsrådgivning.

Beskrivelsen i denne undersøgelse af stræben efter gensidighed i konsulationen, kan genfindes i andre undersøgelser. Denne undersøgelse bidrager med den iagttagelse, at
især råd om rygestop, som gentages i konsultationer med korte mellemrum, udgør et problem for denne stræben efter gensidighed.

Tillid som et produkt af samhandlingen i konsultationer i almen praksis er beskrevet i tidligere undersøgelser. Denne undersøgelse tilfører til denne viden, at samhandlingens bidrag til tillid overvejes bevidst af praktiserende læger og, at det at opbygge og vedligeholde tillid er integrerede målsætninger for konsultationen. Vedligeholdelsen af tillid fordrer, at råd om rygestop tilpasses de beskrevne 'rules of conduct'. Ellers kan råd skade patientens tillid til lægen. Denne viden er ny i forhold til tidligere undersøgelser, som har foreslået at forebygelse bidrager til tillid. Der er ikke tidligere lavet undersøgelser, som specifikt belyser sammenhængen mellem råd om rygestop og tillid.

**Konklusion og perspektiver:**

Ifølge resultaterne af denne undersøgelse, ville en massestrategi for råd om rygestop i konsultationer i almen praksis gå på tværs af de relevansprincipper, som normalt afgrænser indholdet i den enkelte konsultation. Råd om rygestop, som ikke følger disse principper, er vanskeligere at fortolke for patienten og er tilbøjelige til at blive opfattet som en del af en offentlig kampagne. Resultaterne af denne undersøgelse viser også, at en massestrategi ville være svær at forene med en moralsk accept af patienten, som er et ideal for konsultationerne. Råd om rygestop blev også afvejet over for ønsket om gensidighed i samtalen i konsultationerne. Dette har især betydning, når råd om rygestop bliver gentaget. Endelig kan dannelsen og vedligeholdelsen af tillid have betydning for en massestrategi, idet lægens bestræbelse på at understøtte patientens tillid begrænser antallet af konsultationer som egner sig til råd om rygestop.

De perspektiver som undersøgelsen har for implementering af en massestrategi for råd om rygestop diskuteres, ligesom de ændringer en massestrategi kan indebære i læge-patient forholdet. Også de perspektiver der kan uddrages af undersøgelsen i forhold til vedligeholdelse af tillid, som et led i samhandlingen, diskuteres.
9. References


Tulinius C. and Dencker A. (2001) “Patienterne ville jo tro, at jeg var monoman, hvis jeg tog rygning op hver eneste gang…” En undersøgelse af praktiserende lægers holdninger, arbejde og ønsker til arbejdet som livsstilsrådgiver. [“The patients would consider me monomaniac if I rasied the issue of smoking every time…” An exploration of GPs attitudes, work and wishes for their work with life-style advice.] Københavns Kommune, Copenhagen.


Appendices

Appendix 1: Public context

Appendix 2: Analysis

Paper 1:
Guassora AD, Baarts C. Challenging the relevance criteria in Danish general practice consultations: smoking cessation advice in consultations with health problems not related to smoking.

Paper 2:
Guassora AD, Tulinius AC. Keeping morality out and the GP in. Consultations in Danish general practice as a context for smoking cessation advice.

Paper 3:
Guassora AD, Gannik DE. Developing and maintaining patients’ trust in general practice consultations: the case of smoking cessation advice.
Appendix 1: Public context

The data collection period of this study (2003-2004) was marked by many changes in Denmark as regards smoking:


2002 Health warnings on cigarette packs were enlarged and the contents were changed by law. The prior general warning that smoking was damaging health was substituted by one of two general messages covering at least 30% of one of the most visible sides of a pack containing tobacco products for smoking. Additional messages concerning specific health effects of smoking should cover at least 40% of the other of the most visible surfaces. Both kinds of messages were to be framed by a black line of 3-4 mms width.

2002 Producers and importers of tobacco were demanded by law to supply information on all contents of and additives to their products to the Ministry of the Interior and Health. Lists of contents were to be published by the ministry.

2002 Limits to product names of tobacco were introduced by law to avoid the risk that names could convey the impression that some tobacco products were not very damaging to health. This initiative aimed, in particular, at the expression ‘light’ that had been added to some product names.

2002 Limits to contents of tar, nicotine and carbon monoxide in cigarettes were introduced by law. Prior legislation had considered tar only.

2003 Law prohibiting sale of tobacco to young people under the age of 16.

2003 Recommendations by the National Centre for Smoking cessation concerning the role of health professionals, including GPs.

2005 Recommendations by the National Centre for Smoking cessation advice regarding regional models for smoking cessation services.

Local projects to involve GPs to a higher extent in smoking cessation advice services, e.g. by pharmacies, have been going on during the study period.

During the entire study period, two types of preventive consultations were described in the GPs’ contract: 0104 for assessment of risk for ischaemic heart disease and 0103 for preventive consultations. Both of these consultations should be agreed upon in advance. The contract did not offer any fee for preventive services during routine consultations.
Appendix 2: Analysis

p. 20 in 2.8.2 and 21 in 2.8.3 Analysis, examples of text units:
Text units were identified as expressions of the whole statement. Two examples of text units are given below. They were both coded by the general term “occasion for advice”.

The GP: “Still, I think that he has to come up with something that is related to smoking, present some symptom or maybe it could be if his girl-friend was pregnant or something else, right. There has to be some kind of connection to get to it.”

The patient: “…I don’t think of it as something that I am going to discuss with my GP, even though, of course, it has something to do with my health (…)”
Interviewer: “You don’t expect that they’ll raise the issue, really?”
The patient: “No, not unless it becomes so threatening that if I don’t quit, I’ll have some related illness so and so quickly. Then, I would, of course, expect the GP to say something.”

p. 20 in 2.8.3 Analysis, one example of a local analysis:
The following example displays the summary of the interview with a patient, his consultation and the interview with his GP. Only the parts concerning smoking cessation advice are shown:

Summary of interview with the patient:

Smoking cessation advice:
The patient makes a distinction between the issues he raises himself and other issues such as smoking that are raised by the GP. The GP could talk about smoking like any other issues that may be raised once the GP has addressed the patient’s reason for attending.
The patient would want smoking cessation to be raised on his own initiative. He would feel reproached and uncomfortable if the GP were to predict which problems he might have. The GP should respect a “no” from the patient.
The patient would not expect that GPs raised the topic of smoking, unless it was because he was going to have some related illness in a short time if he did not quit. He would expect that the GP would raise the issue of smoking in relation to a symptom.
The patient has attended two smoking cessation courses: one when his workplace became smoke-free; the other was a local course (Sund By) which he attended at his own initiative.
The patient gave up smoking cessation because of what happened in his personal life. In a short consultation, smoking cessation advice would more easily be perceived as a routine of the GP than if it occurred as a part of a conversation concerning “What are you doing at the moment?” and “How are you?”. The patient is not sure if the GP knows that he smokes. Neither the present nor the previous GP ever mentioned smoking. Smoking cessation advice might negatively affect the relation between GP and patient. The patient has never experienced that a GP has raised an untoward issue.

**Summary of the consultation of the patient:**

Smoking cessation advice:
Smoking cessation advice was not discussed.

**Summary of interview with his GP:**

Smoking cessation advice:
The GP would not discuss smoking with this patient the first time he showed up. He was very sad and badly hurt at the time. It was more important to recognize the patient’s problem. The patient felt very bad at the time. The GP gives advice that ties in with the issue addressed in the consultation to make people understand why he raises the issue and because it is impossible to go over all thinkable preventive services with each patient. It is easier for the GP when there is an admission to raise it in the contents of the consultation. The GP limits the amount of issues addressed in a consultation by only giving the advice that is relevant to an issue addressed during the consultation. He cannot possibly raise an issue of risk if the patient is attending with a wart on the foot. There had been no occasions like for instance a cough, a pack of cigarettes falling out of the pocket, smell of tobacco, a girl-friend who was pregnant or anything else that could lead to a discussion of smoking with this patient. The GP would wait for such an occasion to raise the issue of smoking.

Patients who attend the GP to have confirmed that they are healthy run the risk of leaving the GP with the message that there is an imminent risk that they might die within a short period of time.

The GP feels that it has now become more generally accepted that the individual also carries responsibility for his/her own health. People are less aware of more important effects of renovation, clean drinking water and safe work places.

The GP thinks that if a GP knows his patients, it is easier to avoid giving the impression that advice giving is the GP’s hobbyhorse than if the GP does not know the patient.

Some patients turn down recurring advice from the GP arguing that they do not want to hear about it again.

The GP compares the patients’ wish that the GP takes responsibility for their health with a general tendency of citizens to prefer society to provide services and meet their needs.

**Conflicts between the perspectives of the patient and his GP as far as smoking cessation advice is concerned:**
The GP would raise the issue of smoking if an occasion arose. The patient thinks that the issue of smoking cessation could be raised if he and the GP were discussing some private matters beyond the issue of the consultation.

*Congruence between the perspectives of the patient and the GP:*  
The GP would raise the issue of smoking if an occasion arose. The patient would prefer that a discussion of smoking was raised on his own initiative. He would imagine that the GP would raise the issue of smoking cessation if he would be at risk of having health problems because of it within a short period of time. The GP shows consideration and pays attention to timing when giving smoking cessation advice. The patient never experienced GPs having a bad timing.
Challenging the relevance criteria in Danish general practice consultations: smoking cessation advice in consultations with health problems not related to smoking.

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Charlotte Baarts MA, PhD, Department of Sociology, University of Copenhagen.
Abstract:

Background: Patient visits for health problems not related to smoking have been described as “missed opportunities” for smoking cessation advice, seen from the perspective of a mass strategy. General practitioners (GPs) primarily give smoking cessation advice when patients suffer from smoking-related disease. In general practice consultations, GPs usually provide lifestyle advice either in connection with manifest illness or as a separate part of the consultation.

Aim: To investigate the frames of the interaction order in Danish general practice consultations challenged by the introduction of a mass strategy of smoking cessation advice.

Design: Individual in-depth interviews with GPs and their patients were grounded in observation of their consultations. The consultations of six GPs were observed during three days each. Interviews with 11 patients and all GPs were conducted and primarily addressed the consultations that had been observed. The concept of ‘frames’ described by Goffman was deployed as an analytic tool.

Results: Both GPs and patients evaluated potential issues that they wished to include during consultations by relevance criteria. An issue could be included if the patient or the GP could connect it to something already going on in a consultation. Smoking cessation advice was subject to these relevance criteria and was primarily discussed if it posed a particular risk to a particular patient. Smoking cessation advice could also occur in the frame of a conversation addressing the patient’s well-being. If occurring without any other readable frame, smoking cessation advice was apt to be perceived by patients as a part of a public campaign. Relevance criteria served the purpose of limiting the number of issues in individual consultations.

Discussion: According to the findings of the present study, GPs’ tradition of providing advice covers more strategies than merely giving advice for smoking-related illness. Patients distinguish smoking cessation advice that applies particularly to them, from information on smoking relevant to anybody. Relevance criteria provide a frame of interpretation for smoking cessation advice, explaining when smoking would be brought up and what the GP would aim at in the particular situation.

Implications: The presence of relevance criteria may explain why smoking cessation advice is not implemented in more consultations. Relevance criteria may be seen as interactional barriers to smoking cessation advice. These barriers, however, serve a
purpose in the interaction order of consultations and cannot be eliminated without side effects on the interaction as a whole. Frames of interaction in consultations should be considered when new tasks are introduced into general practice.

Keywords: Smoking cessation, advice, general practice, mass strategy, implementation, qualitative study.
Background
It is recommended to implement a mass strategy of smoking cessation advice in general practice consultations (1-4). A mass strategy implies advice to all patients (5). Seen from this perspective, patient consultations for diagnoses not related to smoking have been described as “missed opportunities” for smoking cessation advice (6). GPs primarily give advice on smoking cessation when patients suffer from smoking-related disease, i.e. diseases that are either due to smoking or may be relieved by smoking cessation (6-10). They prefer to discuss smoking within the context of the problems the patient presents (11). It has been reported that when deciding whether or not to raise the issue of smoking, GPs were careful to determine how appropriate they felt this was in the context of the current consultation (12). In her study of interaction in family practice consultations, Freeman (13) described how lifestyle advice was either connected to a manifest illness by the GP or was introduced in a separate part of the consultation.

As in the study of Freeman (13), the present study uses Goffman’s concepts to describe the interaction order of everyday life and the ‘frames’ surrounding this interaction (14-16). Frames are the shared understandings of what is going on during interaction. Participants of an encounter arrive at a working consensus regarding their meeting by negotiating the meeting within these frames (17, p. 41).

This study investigates the frames of the interaction order in Danish general practice consultations challenged by the introduction of a mass strategy of smoking cessation advice. The study examines which principles of interaction in general practice consultations allow smoking cessation advice and which do not. It also explores the function of these frames according to GPs and patients involved in the interaction.
Materials and methods

In this qualitative study individual interviews with GPs and their patients were grounded in observation of their own consultations. I used both observations and interviews to answer the question of when and how smoking cessation advice did or did not occur in specific consultations, and why the issue was raised or avoided.

Selection of GPs
A sample of six GPs with different levels of activity of smoking cessation advice was included in the study. The selection strategy aimed for maximal variation (18) regarding activity of smoking cessation advice, sex, duration of practice tenure and urban/rural practices (Table 1).

Table 1: Characteristics of participating GPs. Districts are indicated by numbers.

<table>
<thead>
<tr>
<th>GP</th>
<th>More active</th>
<th>District (no)</th>
<th>Sex (M/F)</th>
<th>Age (yrs)</th>
<th>Tenure in practice (years)</th>
<th>In partnership surgery</th>
<th>Postgraduate training in smoking cessation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Yes</td>
<td>1</td>
<td>M</td>
<td>55</td>
<td>23</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>B</td>
<td>No</td>
<td>1</td>
<td>F</td>
<td>46</td>
<td>4</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>C</td>
<td>Yes</td>
<td>2</td>
<td>F</td>
<td>45</td>
<td>6</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>No</td>
<td>2</td>
<td>M</td>
<td>59</td>
<td>29</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>E</td>
<td>Yes</td>
<td>3</td>
<td>M</td>
<td>50</td>
<td>15</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>F</td>
<td>No</td>
<td>3</td>
<td>M</td>
<td>43</td>
<td>7</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

GPs who were considered more or less active by local public administrators responsible for smoking cessation or by colleagues were identified according to the principles of Hammersley and Atkinson (19) and of Kuzel (20). All participating GPs accepted their peers’ description of their strategy as either more or less active.

Eighteen GPs were invited with the aim of arriving at a total of six GPs who wanted to participate. When five GPs had been enrolled, a less active male GP with a short
practice tenure was a combination still missing. Eight GPs fulfilling these criteria were approached before one consented to participate.

**Observation of consultations**
The consultations of six GPs were observed during three days each. Consultations occurring during the last two days in each practice were considered for selection for interviews (Table 2).

**Table 2:** Number of consultations with capable, Danish speaking adults who consented to participation in the study. 44 patients known to GPs as no-smokers have been disregarded.

<table>
<thead>
<tr>
<th>GP</th>
<th>Consultations</th>
<th>Consultations with smoking cessation advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>B</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>C</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>D</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>E</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>F</td>
<td>31</td>
<td>0</td>
</tr>
</tbody>
</table>

Observational, theoretical and methodological notes were taken according to the principles of Schatzman and Strauss (21). After observation, consultations from each practice were chosen for further investigation through interviews conducted with both with the GP and the patient in question (Figure 1).
Selection of consultations and of patients for interview

A strategic sample of audio-recordings and field-notes regarding 26 consultations was selected for analysis in detail. Among these, consultations regarding health problems not related to smoking were given special attention through interviews with patients and GPs participating. This focus was chosen since smoking cessation advice is to be included in them according to a mass-strategy of smoking cessation advice but according to the literature, they do not traditionally contain such advice. Additionally,
secondary criteria of patient sex, age and health problem were applied to choose among them. Only consultations with patients who were considered smokers or potential smokers by their GP were selected; a procedure that ensured that the GP would actually consider the patients proper candidates for smoking cessation advice. Thirteen consultations with health problems not related to smoking were selected for interviews. Four of these contained smoking cessation advice. Nine of the 13 patients consented to interviews. The remaining four consultations were however kept for analysis and for further investigation by interviews with GPs. Patients had consented to that. Another two consultations were included for interviews even though they regarded issues that were related to smoking (pregnancy, contraceptive pills). They fitted the strategy of the sample in another sense, since they did not contain any advice. Advice would have been expected according to the tradition of advice described. Thus, a total of 11 patients were interviewed. All further 11 consultations containing smoking cessation advice, and occurring in consultations concerning health problems, were included as a supplement to the consultations with interviews. They were used for contextualization of interviews.

**Definition of smoking-related symptoms or illnesses**
Symptoms or illnesses diagnosed by the GPs were defined as smoking-related if smoking could have contributed to the development, could shape the future course or if cessation was known to improve the prognosis. Information on the relationship between smoking and symptoms or illnesses was searched for in national and international literature through repeated literature searches during the study.

**Definition of smoking cessation advice**
Smoking cessation advice was defined as any discussion of smoking, which went beyond answers to the GP’s anamnestic questions about the patient’s smoking status, the amount of tobacco smoked and the duration of the consumption (22).
**Interviews**

After observation of consultations, I contacted the patients by telephone to make an appointment for an interview. Characteristics of patients who were interviewed are shown in Table 3.

**Table 3. Interviewed patients.**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Health problem</th>
<th>Advice</th>
<th>Age, years</th>
<th>Time on GP’s list, years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharon</td>
<td>Inflammation of the throat</td>
<td>Yes</td>
<td>34</td>
<td>1</td>
</tr>
<tr>
<td>Gerald</td>
<td>Voiding at night</td>
<td>No</td>
<td>60</td>
<td>10</td>
</tr>
<tr>
<td>Jane</td>
<td>Cystitis or vaginitis</td>
<td>No</td>
<td>48</td>
<td>3</td>
</tr>
<tr>
<td>Sophie</td>
<td>Stress and perfectionism</td>
<td>No</td>
<td>33</td>
<td>6</td>
</tr>
<tr>
<td>Roxanne</td>
<td>Inflammation of the throat</td>
<td>Yes</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>Charles</td>
<td>Wart</td>
<td>No</td>
<td>78</td>
<td>18</td>
</tr>
<tr>
<td>Alice</td>
<td>Neck and back pain</td>
<td>No</td>
<td>61</td>
<td>10</td>
</tr>
<tr>
<td>John</td>
<td>Haemorrhoids</td>
<td>Yes</td>
<td>57</td>
<td>13</td>
</tr>
<tr>
<td>Mary-Ann</td>
<td>Oral contraceptives</td>
<td>No</td>
<td>35</td>
<td>10</td>
</tr>
<tr>
<td>Monica</td>
<td>Pityriasis</td>
<td>No</td>
<td>66</td>
<td>5</td>
</tr>
<tr>
<td>Dave</td>
<td>Possible venereal disease</td>
<td>No</td>
<td>23</td>
<td>½</td>
</tr>
</tbody>
</table>

Individual semi-structured interviews with GPs and patients were conducted as soon as possible after their consultation. At the beginning of the interview, all participants were invited to listen to the audio record of the consultation, and most accepted this invitation. Questions asked during the interviews included why the GP did or did not discuss smoking in this particular consultation, and if smoking had not been discussed, what could have made the GP raise the issue. Further questions explored how smoking cessation advice was given, and if the participants had ever felt smoking cessation advice to be lacking from a consultation. These questions were addressed to both GPs and patients in phrasings appropriate for their different perspectives. It was possible to include consultations during the interview as a shared frame of reference.
between the interviewer and the interviewee. References to other consultations were allowed for comparison.

**Analysis**

The interviews and the corresponding consultations were transcribed verbatim. Coding was based on the informants’ own categories, inspired by Giorgi’s four-step process (23). Individual transcripts were hence read to get a sense of the whole statement, and text units addressing specific issues were coded. The insights thus obtained were expressed in general terms, and they were then summarized in consistent statements. The patients’ and GPs’ views on consultations were analyzed separately and were then compared to each other, as well as to the analysis of their consultations. The analysis focused on the working consensus in the consultations (14-16). Finally, issues that prevailed across cases were captured in common themes. Goffman’s concept of frames was applied because it offered a theoretical perspective of the mechanisms by which GPs and patients ordered the interaction during consultations. The frames of interpretation could be used to explain why issues were included in some consultations and left out in others.

Coding and development of analytic categories were triangulated (24) between the authors and one additional researcher. Analysis was carried out using NVivo software.

**Presentation of quotations**

Quotations represent themes prevailing among GPs and patients. They were chosen because they capture these themes in a short and precise manner. The GPs are named as GPA, -B, -C, -D, -E and –F, while patient names are fictional. In the presentation of the results, the use of parenthesis ‘(...)’ indicates that parts of transcripts have been omitted in order to present a specific point in a short form and the use of square brackets ‘[...]’ indicates that some information has been added by the author in order to clarify the context.

The information given to participants in the study and the procedure concerning consent were approved by the local Ethics Committee.
Results

Relevance criteria
Smoking cessation advice, like all other potential issues that GPs or patients wished to discuss during consultations, was judged by relevance criteria prior to inclusion. The relevance criteria worked as frames of interpretation. They allowed the patient or the GP to include an issue by connecting it to issues already raised in a consultation. Both GPs and patients felt that smoking cessation advice fitted in naturally in the context of illness that could be connected to smoking such as coughs or diabetes. An example of such advice in connection to a health problem was the following consultation with a young woman presenting with allergy. She said that her former GP suspected her of having asthma:

Mona: "Then he gave me some pills to try out..."
GP B: "Some pills?"
Mona: "Yes, and then he asked if it had been of any help, and when I told him that it had, I got some kind of gadget, I had to...to suck."
GP B: "Yes, but it’s been a long time since you have used it."
Mona: "Yes."
GP B: "Yes well, I would like if you had one made here as well to see the...how you...I seem to remember that you’re a smoker, aren’t you? How much do you smoke?"
Mona: "I think I’ve reduced it to ten now."
GP B: "Ten, yes. That’s also something that can really be a part of...making the asthma worse, that you put smoke down there, that makes the body react, you know."
The illness in question made smoking cessation advice relevant in this way, but the GPs saw many other occasions (Figure 2: Relevance criteria).
Pregnancy and visits with children were perceived as good occasions to protect child health, and smoking cessation advice was also part of general preventive health examinations. Smoking cessation advice was seen as relevant if GPs smelled smoke in the patient’s clothes or saw the patient’s cigarettes. Another example of relevance was demonstrated by this GP, who introduced the issue of smoking after she had finished inserting acupuncture needles for the treatment of infiltrations in the patient’s neck:

   GP C: "That one was really tender – is that where you’ve had the most pain?"
   Edith: "A little...I think so."
   GP C: "Are you all-right?"
   Edith: "Yes."
   GP C: "You’re not getting unwell?"
   Edith: "No."
   GP C: "No...Should I stick some in your ears for smoking cessation?"

In this case, smoking cessation advice was introduced through relevance to the acupuncture that was taking place in the consultation. Advice could also be given as follow-up on prior discussions of smoking, or when GPs were seeing patients who were new to their practice, as in the following excerpt:

Relevance criteria for smoking cessation advice:

   Smoking-related illness or symptoms like coughing, shortness of breath, chest pain, hypertension, diabetes, COPD, ischaemic heart disease, asthma, etc.
   Other occasions like pregnancy and visits with children, if the GP sees the patient’s cigarettes or smells smoke on the patient’s clothes; smoking-related illnesses of relatives; a patient attending the GP for the first time; continuation of a prior discussion of smoking; patients talking about smoking; social problems; lifestyle discussions; general preventive health examination; discussion of contraception.
   How are you? A conversation regarding the patient’s well-being.
GP E: “But otherwise you haven’t been ill? Had your appendix removed or anything else?”
Gabrielle: “No.”
GP E: “Do you use any contraception?”
Gabrielle: “Yes, we use condoms.”
GP E: “Have you ever been pregnant? Or had an abortion?”
Gabrielle: “No.”
GP E: “No.”
Gabrielle: “Well, I’ve used the morning-after pill once, but then you don’t know if anything happened, so that…” [laughs]
GP E: “No, what…Do you smoke?”
Gabrielle: “Yes, I do, eh, five a day, approximately.”
GP E: “Yes, how long have you done that for?”
Gabrielle: “Since I was twelve.” [laughs]
GP E: “Is it something that you…like…ever tried to give up?”

Such occasions seem very diverse, but still they were a prerequisite as most patients would be puzzled if their GP raised the subject of smoking if they could not discern the relevance, rooted in the actual consultation.

According to GPs and patients, relevance criteria served a function of limiting the number of issues that could be raised in individual consultations. GPs felt that the number of issues they ought to raise with their patients by far exceeded the number of issues that they actually had time to discuss, and that smoking was part of this array of potential issues:

GP F: “…there are millions of issues that we need to counsel about and smoking is just one of them, and, obviously, there has to be some kind of connection (…) You need some kind of admission to get to it.”

Consultations in Denmark typically last 10 or 15 minutes. As stated by the GP above, smoking cessation advice would primarily be given when GPs found that the contents of the consultations provided an occasion to give it. GPs were also in agreement that many other issues, which could be raised, competed with smoking cessation advice for the scarce time in consultations.
Particular risks to particular patients

As part of the pattern of relevance criteria, GPs usually communicated particular risks to particular patients. When choosing subjects that can be connected to what is already going on in a consultation, most issues will be those of particular interest to the individual patient. The most common example is that of a connection to the illness in question, like in the following excerpt:

GP A: “But that is exactly it: you have good reasons for it, both of you, one must say.”
Jenny: “Yes.”
GP A: “Also, because it is allergic, then...well, then your respiratory tract is more sensible than that of other people.”

In this example, the GP underlines that the patient ought not to compare her smoking to that of other people, because her health is different. It seems that patients distinguish between smoking cessation advice particularly applicable to them, from information on smoking relevant to anybody. The patient below is a woman in her fourties who did not receive smoking cessation advice as she was presenting with vaginitis:

Jane: “If [smoking turned up when I attended with a swollen finger] then I would think (...) that it was probably part of some public campaign that was going on at the time.”

General smoking cessation advice directed at all patients would be perceived by the patient as something different from the other communication in general practice. If the patient did not perceive the smoking cessation advice to be emerging from the contents of the consultation one way or another, it could be perceived merely as a part of a current public campaign. It would then be compared to radio- or TV-spots or to warnings on cigarette packs. Thus, if smoking cessation advice did not fit the relevance criteria in the consultation, the frame of interpretation would change from one regarding particular risks communicated to particular patients to a frame of a current health campaign with information relevant for anybody. It is important to the patient whether advice emerges from an observation regarding an actual health problem, or whether it is general information given to all patients since advice has very different implications in these two situations. This quote from a patient illustrates...
the implications that patients tend to perceive in the GPs’ smoking cessation advice if it is not explicitly stated that the advice is given to all, no matter their personal risk:

Mary-Ann: “Do I look like that? Or do I have any symptoms or signs of disease that make the GP think that something’s wrong? I think I would feel that way if he asked me, without any reason, if I was a smoker. Like “God, does he think that I’ve got a lung cancer?” or, ...I’d be worried.”

“How are you?”

Some consultations were used as an opportunity for what some patients termed “small-talk”. This was a part of the consultation where patients asked health questions of more general nature or told about their everyday life, as in this example:

Cheryl: “...Those are the kind of days where I decide to just relax, just be myself with my dog, right. And I am. I have the answering machine turned on, on the phone. Just in case something should happen to my father or my daughter or something like that. It feels good to just go in and listen to it, now and then, right. But otherwise, yes, that’s what I do.”

GP B: “You once talked about doing something about smoking too?”

This part of the consultation was thought of by the GPs as a part of their professional activity. GPs asked about work, family, well-being and patients’ interests. The GPs explained that they used the knowledge obtained through this kind of conversation to gain a better understanding of the patients’ perception of their own health. It also helped the GPs to better adapt their interventions to the patient’s circumstances. Most GPs agreed that a discussion of smoking could occur as one element in this kind of conversation:

GP C: “Well, it’s also easier to make a well-educated woman who is a mother stop smoking than someone at the lowest social level, who has a man who smokes just as much and maybe drinks too much or whatever. It’s about getting the whole picture concerning the patients…”

GPs and patients agreed that conversations of this kind helped build a good relationship because it demonstrated interest in the patient as a person and made the patient feel safe. It was, however, considered optional and often occurred in what could be considered ‘spare time’ during consultations, as for example when GP C was awaiting the effect of the acupuncture.
Discussion

Frames
Relevance criteria the shape of communication of particular risks to particular patients and in conversation about the patient’s well-being can be seen as examples of the concept of frames, as described by Goffman (16). These frames provide answers to the patient’s internal questions as to what is going on when the GP raises the issue of smoking cessation. They provide a frame of interpretation for smoking cessation advice, explain why smoking was brought up, and what the GP aimed at in the particular situation. The frames shared by GPs and patients are applied to arrive at a working consensus for the discussion of smoking in consultations. Frames are situating individual elements, like smoking cessation advice, in a context that is meaningful to the parties involved.

Particular risks, well-being or public campaign
Prior descriptions of GPs’ traditional strategy of smoking cessation advice have focused on illnesses related to smoking (6-10). In this study, smoking-related illness was the main relevance criterion. GPs were aware whether patients with such illness were smokers to a greater extent than they were when the patients did not have such illness. They also perceived lack of smoking cessation advice to such patients as a failure of their own work. According to the findings of the present study, however, GPs’ tradition of advice giving embraces many more strategies than simply relating advice to smoking-related illness. Many other occasions were found for giving smoking cessation advice in general practice.

Patients distinguish smoking cessation advice that applies particularly to them from information on smoking relevant to anybody. If advice was not given within a recognizable frame of reference, it was likely to be perceived by the patients as part of a public campaign and perceived as less important for themselves. This study supports the findings of previous surveys of GPs that smoking cessation advice is given in the context of smoking-related illness. But this study adds the information that many other occasions are also used for advice giving, and the advice can, among other approaches, be provided as a display of the GPs’ interest in patients’ well-being.
The findings of this study add to the description offered by Sorjonen et al. (25) that lifestyle issues raised in relation to illness tended to be given further attention in the consultations. When raised out of this context, lifestyle issues usually did not achieve a status as an important problem to be dealt with. The interviews of the present study added the function that these actions had, according to GPs and patients. Relevance criteria served the purpose of limiting the number of issues raised in individual consultations.

So, how do the findings of this study match reports from surveys of patients where it is concluded that patients generally think physicians should give smoking cessation advice also when it is not linked to smoking related illness? (26-27). The present study addresses the level of practical implementation of advice. Exploring advice giving, from the perspective of a single consultation, shifts the focus from ‘if’ to ‘how’ smoking cessation advice occurs. Patients and GPs do not answer that smoking cessation advice should not take place, they describe the scene that already exists for advice in consultations.

Relevance criteria and scarcity of time
A general observation springing from the present findings is that any implementation of new tasks will have to face the same relevance criteria as those that apply to all other potential issues raised by GPs or patients during consultations. New topics have to compete with existing health-related issues for the scarce time in consultations and their adoption depends on relevance criteria like all other GP activities. Regulating the amount of topics in a single consultation and the structure of the interaction relies on such principles, and some other type of regulation would be needed if the current one did not function. This is an important aspect to be considered in contemporary implementation activities.

Generalizability
The findings of this study are based on a sample of GPs with different levels of commitment to smoking cessation advice and of their patients. The analysis focused on themes shared by the GPs and patients participating. The themes shared in this sample are probably also shared by GPs and patients beyond the sample in question.
The study was conducted in Danish general practice, and so it is inevitably influenced by the structure of GP surgeries in Denmark. General practice consultations in other countries are of different lengths, either shorter, as in the UK, or longer, as in Sweden. This difference probably affects the notion of scarcity of time that is shown in this study. In most countries, however, access to GPs is still limited and prioritized according to severity, stressing the importance of scarcity of time in general practice.

Limitations
Attitudes to smoking have changed significantly in recent years. This probably affects the way that smoking cessation advice is handled in general practice. The increased attention to smoking may make it easier to find frames for smoking cessation advice during consultations, but it could be at the expense of the gravity that has hitherto been ascribed to GP’s advice, aiming at particular health risks.

Conclusion
Relevance criteria in the shape of communication of particular risks to particular patients and in conversation about the patient’s well-being can be seen as examples of the concept of ‘frames’ as described by Goffman (16). Criteria of relevance are limiting the amount of issues in individual consultations. They apply to smoking cessation advice as well as to any other issue considered for inclusion in a specific consultation.

Implications
This study helps explain why smoking cessation advice has not been implemented in many more consultations. Usually, the success or the failure to implement a new activity is addressed in terms of ‘barriers’ that must be overcome (28-29). It has been suggested that competing demands are barriers to the provision of preventive services (30). Relevance criteria can be seen as interactional barriers to smoking cessation advice. These barriers, however, serve a purpose in the interaction order of consultations and cannot be eliminated without side effects on the interaction as a whole. This implies that frames of interaction in consultations should be considered when new tasks are being introduced. New activities that fit into existing interaction frames will probably be easier to integrate than activities that do not fit well into these
frames. This seems to stress the importance of compatibility in implementation, as described by Rogers (31), which takes into account the perspective of the person who is supposed to change behaviour. The compatibility of a new activity with existing values and beliefs and with previously introduced ideas is important to its implementation (31, pp. 224-25). In the case of smoking cessation advice, attention to existing frames of relevance, beyond the health problem in question, may be a realistic strategy to increase the rate of smoking cessation advice.
References


9. Gallefoss F and Drangsholt K. Smoking cessation intervention and barriers to


Paper 2.

Keeping morality out and the GP in.
Consultations in Danish general practice as a context for smoking cessation advice.

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Keeping morality out and the GP in.
Consultations in Danish general practice as a context for smoking cessation advice.
AD Guassora and AC Tulinius, The Research Unit and Department of General Practice, University of Copenhagen.
Abstract:
Objective: To describe consultations in Danish general practice as a context for a mass strategy of smoking cessation advice.
Materials and methods: The focus of the study was on consultations for health problems that were not related to smoking. Interviews with patients and their GPs were grounded in observation of their own consultations.
Results: Patients and GPs agreed that the GP should adopt an attitude of moral acceptance towards patients. Ideals of moral acceptance of patients in general practice consultations were challenged by the prevailing negative moral values associated with smoking.
A general aim of mutuality in the conversation in consultations could not always be achieved in smoking cessation advice. Achieving mutuality was especially a problem when smoking cessation advice was repeated at short intervals.
Conclusion: Two elements of Danish general practice consultations were challenged by smoking cessation advice to patients without smoking-related illness: the ideal of moral acceptance of patients in general practice consultations held by GPs and patients and the wish for mutuality in the conversation during consultations.
Practice implications: A conversation about smoking based on motivational interviewing would fit in the context of Danish general practice. Relieving the conversation of blocks due to moral implications, however, is still a challenge.
1. Introduction

In a mass strategy of smoking cessation in general practice consultations, advice is directed to all patients no matter which health problem they have. The consultation in Danish general practice as a context for such advice has not yet been thoroughly described.

General practitioners (GPs) traditionally use a high-risk strategy and give smoking cessation advice to patients with smoking-related illness or with a particularly high risk of smoking-related illness (1, 2). In a 1995 survey 93% of Danish GPs reported that they always or very often gave smoking cessation advice to patients with smoking related illness (3). If the patients did not have any smoking related illness, only 4% of the GPs reported giving advice frequently. In recent years, research into the field of smoking cessation advice has mainly adopted a public health perspective (4). This has produced recommendations of a mass strategy (5) of smoking cessation advice in general practice consultations where advice is given to as many patients as possible no matter the health problem in question (6-9). Brief advice from general practitioners increases the quit rate by 2.5% (10). From a public health perspective brief advice is worth while since it has the potential to lead to a large number of ex-smokers in the population (7). This effect depends on a shift from a high risk strategy to a mass-strategy where many more patients are considered as potential recipients of advice.

However, the question of how consultations for health problems that are not related to smoking will work as a context for such advice has not received much attention. Smoking cessation advice delivered in the course of such consultations may achieve new meanings and be shaped by the other activities in the consultation. The findings in some studies indicate that smoking cessation advice does not always conform with the context in general practice consultations: many GPs look for appropriate occasions to discuss smoking with their patients and they are careful when they raise the subject of smoking cessation (11, 12). A qualitative study investigating the process of giving smoking cessation advice revealed that GPs respond carefully to smokers’ reactions (12). Some GPs are concerned that smoking cessation advice to all patients at all visits may harm the patient-physician relationship (13, 14). In an interview study with Danish GPs smoking cessation advice on any occasion was considered
misplaced (11). The context of advice, along with patients’ individual perceptions of the GP’s role and the way that advice is given, has been reported to affect patients’ receptiveness to advice (15). In a study of young women living in disadvantaged circumstances, smoking cessation advice would in general not be perceived as a help (16). Furthermore, opportunistic smoking cessation advice to all patients in general practice has been reported to negatively affect the help-seeking behaviour of some patients who anticipated advice (17). This was due to these patients’ feelings that they would be blamed for smoking when presenting their symptoms.

Most of the knowledge of smoking cessation advice in general practice consultations that is cited above is from the United Kingdom. Although there are many similarities in the way GPs work in the EU, there are also differences influencing attitudes towards smoking and delivering smoking cessation advice that may limit the applicability of primarily British studies to a Danish context. A comparison between GPs in different European countries revealed differences in perceptions of effectiveness of smoking cessation advice and in perceptions of barriers (18). In a recent survey smoking prevalence among Danish general practitioners was 9% for women and 14% for men (19). The smoking prevalence in British GPs in 2007 was one of the lowest in the EU with only 4.2% (20). Additionally British General Practice has moved to a more population based health care agenda with the Quality Outcomes Framework, whilst Danish GPs are still focused on the problems of the individual patient.

In this study GPs’ and patients’ experience with smoking cessation advice is explored to clarify the meaning that smoking cessation advice achieves in the context of Danish general practice consultations. The focus of the study is consultations for health problems that are not related to smoking.
2. Methods

This study used individual in-depth interviews with patients and their GPs about their experiences with the activity of smoking cessation advice. Interviews were grounded in observation of consultations with the patients and GPs interviewed. These perspectives were triangulated.

2.1 Selection of GPs
A sample of six GPs with different levels of activity of smoking cessation advice was included in the study (Table 1).

Table 1: Characteristics of participating GPs. Districts are indicated by numbers.

<table>
<thead>
<tr>
<th>GP</th>
<th>More active</th>
<th>District (no)</th>
<th>Sex (M/F)</th>
<th>Age (yrs)</th>
<th>Tenure in practice (years)</th>
<th>In partnership surgery</th>
<th>Postgraduate training in smoking cessation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Yes</td>
<td>1</td>
<td>M</td>
<td>55</td>
<td>23</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>B</td>
<td>No</td>
<td>1</td>
<td>F</td>
<td>46</td>
<td>4</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>C</td>
<td>Yes</td>
<td>2</td>
<td>F</td>
<td>45</td>
<td>6</td>
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</tr>
<tr>
<td>D</td>
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<td>M</td>
<td>59</td>
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</tr>
<tr>
<td>E</td>
<td>Yes</td>
<td>3</td>
<td>M</td>
<td>50</td>
<td>15</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>F</td>
<td>No</td>
<td>3</td>
<td>M</td>
<td>43</td>
<td>7</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

The selection strategy was maximal variation (21) regarding activity of smoking cessation advice, sex, duration of practice tenure and urban/rural practices. GPs who were considered either more or less active by local public administrators working with smoking cessation or by their colleagues were identified according to the principles of Hammersley and Atkinson (22) and of Kuzel (23). All participating GPs accepted their peers’ description of their strategy as either more or less active in terms of smoking cessation advice giving. GPs were from six different surgeries in both urban and rural settings and belonged to districts with different organisation of smoking cessation services.
Eighteen GPs were invited to obtain a sample of six participants. When five GPs had been included, a less active male GP with short practice tenure was a profile still missing in the sample. Eight such GPs were approached to obtain one consenter.

2.2 Information to participants
Information to participants was kept at a general level to minimize any observer and investigator bias. Patients were informed that the study focused on the doctor-patient relationship whereas the information that smoking cessation advice was studied was added to the information to the GPs. This information was added as GPs were selected according to their activity in this field. Informed consent was obtained prior to observation and interviews. Information and the procedure of consent were approved by the local Ethics Committee.

2.3 Observation of consultations
Consultations were observed and audio-taped during three days in each of the six practices. Observational, theoretical and methodological notes were taken according to the principles of Schatzman and Strauss (24). Observational notes were taken during consultations. Notes added to the audio-record of the consultation filling in the context of the dialogue. Theoretical notes were attempts to interpret the meaning of observations. Methodological notes addressed research procedures, reminders and critique.
After the observation, consultations in each practice were selected for further investigation. Both the GP and the patient in question were asked for interviews.
2.4 Selection of patients for interview and of consultations

Patients and their consultations were selected for interview with the aim to obtain two patient interviews in each practice. Criteria for choosing patients for interview were that they paid the GP a visit due to illness and the health problem they brought was unrelated to smoking. A further criterion was that their GP should consider them smokers or perhaps smokers.
As more than two patients were fulfilling the above criteria in each practice, secondary criteria of patient sex, age and health problem were utilized to choose among them. This inclusion method yielded four patients who received smoking cessation advice as well as nine patients who received no advice. Another two patients attending with smoking-related health issues who received no smoking cessation advice were also interviewed because advice would have been expected. Fifteen patients were invited and 11 of them consented to being interviewed (Table 2).
Table 2. Interviewed patients.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Health problem</th>
<th>Advice</th>
<th>Age, years</th>
<th>Time on GP’s list, years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharon</td>
<td>Inflammation of the throat</td>
<td>Yes</td>
<td>34</td>
<td>1</td>
</tr>
<tr>
<td>Gerald</td>
<td>Voiding at night</td>
<td>No</td>
<td>60</td>
<td>10</td>
</tr>
<tr>
<td>Jane</td>
<td>Cystitis or vaginitis</td>
<td>No</td>
<td>48</td>
<td>3</td>
</tr>
<tr>
<td>Sophie</td>
<td>Stress and perfectionism</td>
<td>No</td>
<td>33</td>
<td>6</td>
</tr>
<tr>
<td>Roxanne</td>
<td>Inflammation of the throat</td>
<td>Yes</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>Charles</td>
<td>Wart</td>
<td>No</td>
<td>78</td>
<td>18</td>
</tr>
<tr>
<td>Alice</td>
<td>Neck and back pain</td>
<td>No</td>
<td>61</td>
<td>10</td>
</tr>
<tr>
<td>John</td>
<td>Haemorrhoids</td>
<td>Yes</td>
<td>57</td>
<td>13</td>
</tr>
<tr>
<td>Mary-Ann</td>
<td>Oral contraceptives</td>
<td>No</td>
<td>35</td>
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<tr>
<td>Monica</td>
<td>Pityriasis</td>
<td>No</td>
<td>66</td>
<td>5</td>
</tr>
<tr>
<td>Dave</td>
<td>Possible veneral disease</td>
<td>No</td>
<td>23</td>
<td>½</td>
</tr>
</tbody>
</table>

The consultations of all 15 patients invited for interview were analyzed along with the 11 remaining consultations with advice in consultations regarding health problems.

2.5 Definition of smoking-related
Symptoms or illnesses diagnosed by the GPs were defined as smoking-related if smoking could have contributed to the development, could shape the future course or if cessation was known to improve the prognosis. Such relations to smoking were scrutinized by literature search for symptoms or illnesses that were brought up during observed consultations.

2.6 Interviews
Individual, semi-structured interviews with GPs and patients were conducted as soon as possible after their consultation. Six patients and five GPs were interviewed within one week after their consultation and further three patients were interviewed within two weeks. Two patients and one GP could not be interviewed until 2 months after. At the beginning of the interview they were all invited to hear the audio-recording of
their own consultation, to refresh their memory. GPs and patients were asked how the patients reacted to smoking cessation advice in this case and in other cases. They were also asked if smoking had been discussed previously and if it would be discussed in future consultations. These questions were all posed to both GPs and patients in phrasings appropriate for the different perspectives. GPs were also asked if smoking cessation advice had been avoided in any consultation, and they were asked to elaborate on spontaneous comments given during observation. Observations that could shed light on any of these questions were included in the interviews. Observations and interviews were performed by the first author (ADG).

2.7 Analysis
Interviews and the twenty-six selected consultations were transcribed verbatim. Coding was based on the informants’ own categories inspired by Giorgi’s four–step process (21, 25). This meant that individual transcripts were read to get a sense of the whole statement and text units addressing specific issues were coded. The insights provided by individual transcripts were expressed in general terms. Patients’ and GPs’ views on consultations were analyzed separately and were then compared with each other and with the observations on the level of pairs. Finally issues prevailing across cases were captured in common themes. Focus on analysis across cases was based on an observed agreement between GPs and patients and the fact that no systematic differences in the perspectives of GPs and patients emerged (26). Coding and development of analytic categories were triangulated (27) between the authors and further one researcher. Analysis was carried out in NVivo software.

Quotations represent themes prevailing among the GPs and patients. The specific quotation has been chosen because it captures a theme or a part of a theme in a short and precise manner. In the presentation of the results below, the use of parenthesis ‘(…)’ indicates that parts of transcripts have been omitted in order to present a specific point in a short form, and the use of square brackets ‘[...]’ indicates that some information has been added by the author in order to clarify the context. GPs are referred to as GP A, -B, -C, -D, -E and -F. Patients’ names are fictional in order not to disclose their identity.
The study was a part of a larger research project on the GP-patient relationship and smoking cessation advice. The results concerning criteria of relevance to smoking cessation advice and the maintenance of trust during interaction will be reported in separate papers.
3. Results

Two elements of interaction in Danish general practice consultations were challenged by smoking cessation advice to patients without smoking-related illness: the ideal of moral acceptance of patients in general practice consultations held by GPs and patients and the wish for mutuality in the conversation during consultations. The situation where the GPs repeated advice in short intervals seemed, in particular, to give problems.

3.1 An ideal of moral acceptance of patients may be challenged by smoking cessation advice

Patients and GPs agreed that the GP should demonstrate openness towards all health issues and should adopt an attitude of moral acceptance towards patients. Moral acceptance of patients, in this study, was an ideal of both GPs and patients that the GP in general should bracket his/her own moral evaluation of the patient’s actions. This would make patients feel that they were safe and could attend with any concern and should not feel ashamed to do so, as explained by this GP:

   GP B: “So being open. To give... she gets the impression that she can attend with anything. That [no matter the subject they bring] I don’t think it sounds awful…”

Smoking cessation advice may contradict this principle of moral acceptance in general practice as explained by this patient, who had received advice from her GP on prior occasions:

   Mary-Ann: "I think... Well, I don’t know exactly where the limit is, but I think there’s a subtle line somewhere, where the GP should take care not to feel superior to the patient, well it’s difficult to explain…”

Advice could convey the impression to the patient that the GP felt superior and that he/she judged the patients actions as wrong. This point was made by both GPs and patients. Both observation and interviews demonstrated that GPs were striving to strike a balance between stressing the patients’ responsibility to stop smoking and showing respect for the patient. This delicate balance was not unique to smoking cessation advice. It was observed also in a situation where a young man came to be tested for venereal disease.

Patients felt obliged to show responsibility for their own life-style already before they entered the GP’s surgery. This was demonstrated in consultations and confirmed by
interviews with patients. Sharon explained why she had raised the subject of smoking herself, even though she had no intentions to stop:

Sharon: "I think that I almost...anticipated that he would ask [about smoking], so I wanted to be ahead of him and to outsmart him, right."

So, the awareness of a general, public anti-smoking atmosphere as well as patients’ prior experiences with GPs attitudes towards smoking affected the interaction in the consultations. One example was this consultation with a woman in her forties who attended because of severe fatigue. The GP noticed that the patient seemed to have a bad conscience regarding her smoking:

GP A: You don’t have any shortness of breath or any...
Linda: No, only the usual smoking ...
GP A: Your body language was quite funny just now when you said that.
Linda: Yes, I do know...
GP A: You looked very much like someone with a bad conscience.
Linda: [laughs] Well, I know you.

Observations as well as interviews demonstrated that some of the GPs were deliberately expressing respect also towards patients’ minor efforts at showing a healthier behaviour, like the GP in the following excerpt of a consultation with a 66 year old woman attending with exacerbation of COPD:

GP D: Still, you should not smoke. It isn’t good for your lungs.
Ellen: No, it is not.
GP D: But four cigarettes a day are...it’s much less than it used to be, I know.

According to the GPs themselves, this was done in order to preserve good relations and to encourage further steps in that direction.

3.2 Mutuality in the conversation could not always be upheld in smoking cessation advice

Both observation and interviews showed that GPs and patients wished for mutuality in the conversation. Mutuality in the conversation was defined as the situation where issues of interest to both the patient and the doctor were sought in the consultation. This aim could, however, not always be achieved in smoking cessation advice. Many patients thought of smoking cessation advice as a duty that fell on the GP; a duty that should be accepted and that accepting to receive such advice was a sufficient
response by the patient. Most GPs reported that they tried to avoid this kind of situation where the patients would just answer the questions and let the GP talk. The example below shows a patient who accepts advice, but does not actually engage in the conversation on smoking cessation. The GP is addressing smoking because he smells smoke in the patient’s clothes:

GP E: “What about the smoking then, is it something that you...”
John: “Want to... want to quit, or...?”
GP E: “Yes, have you ever considered it?”
John: “Ah, well I did, because it is a strain though. But then I’m afraid to... Like everybody else, ...that I would put on 10, 20 or 30 kilos.”

John’s answers were taken as the start of a lengthy discussion of smoking cessation by the GP. During the study interview following the consultation John gave quite another evaluation of smoking than the one presented during consultation:

John: “I have kept on smoking because I like it, I’ve always smoked, I smoked when I was confirmed 40 years ago. (...) To me, smoking is a quality of life, it’s a social matter. When I’ve had supper, I watch TV, the news, with the remote control in one hand and the tobacco in the other. I was a little upset that [GP E] mentioned the tobacco because he kind of put pressure on me, as if I should have thought about it and that I ought to do something about it. Well, yes I thought, now let’s take one thing at a time.”

So, John had private views on smoking that he did not share with the GP and he did not let the GP know that he was not engaging in the conversation.

Almost all patients agreed that GPs should advise patients to stop smoking, but that advice would be annoying if it was repeated at short intervals despite the patient’s lack of interest. Returning to the subject of smoking when patients had recently refused smoking cessation advice was considered a difficult and risky affair by most of the GPs. For some of the observed consultations without smoking cessation advice, both GPs and patients stated that the reason why advice was not given was that they were through with it for the time being like Sophie, who is cited below:

Sophie: “I certainly know what she [GP C] thinks of smoking and she has made it clear many times, so I think we’ve kind of put that behind us. Of course, she would mention it if I attended with some illness. (...) again it’s about equality and mutual respect, right, ‘cause she knows very well that I know that smoking is by God unhealthy and the damage it does. I think she is aware that I understand that...”
Her GP, who was classified as a particularly ‘active’ one in terms of smoking cessation advice, planned to discuss smoking with Sophie again as soon as possible. However, she agreed that the time was not right for such a discussion. It seems that the search for issues of common interest was compromised, in particular in the situation where the patient had rejected smoking cessation advice on a prior occasion. Most GPs reported that they were caught in a dilemma as they felt that patients should have the right to refuse smoking cessation advice just as they should have the right to refuse any other treatment. They did, however, also feel that they were obliged to discuss it anyway. Interviews supported the observation that some GPs would then open a discussion by stating that they were aware that the patient had earlier said “no” and that they just wanted to know if the patient had changed his/her mind. In this way they would openly negotiate whether smoking cessation should be part of the discussion. Stating the permanent possibility of help whenever the patient wanted it was another strategy applied. This kind of strategy helped to avoid imposing further on unwilling patients. In this way patients were told instead that their initiative would be welcomed.
4. Discussion and conclusion

4.1 Discussion
The findings of this study draw attention to moral aspects of smoking cessation advice. Advice may be at odds with the wish to show respect for the patient and with an ideal of moral acceptance of patients in general practice consultations that was demonstrated in this study. This adds to the findings of a Canadian study investigating patients’ perspectives of a physician-delivered smoking cessation intervention where patients looked for a balance in the relationship established with their physician regarding negotiation, respect, mutual understanding, and rapport (28).

Moral implications of smoking cessation advice have also been reported in a British study by Pilnick and Coleman (29) which focused on advice linked to patients’ health problems. While it was suggested in the study by Pilnick and Coleman that advice is maybe better given out of the context of smoking-related illness, the present study demonstrated that this would not itself eliminate patients’ and GPs’ feelings of moral implications. It seems that the public presence of a moral obligation to act responsibly towards one’s own health should be recognized as the point of departure for the discussion in general practice. Reconciling smoking cessation advice with ideals of moral acceptance may demand an active statement of acceptance by the GP. The strategy of some GPs in this study of recognizing patients’ minor efforts at showing healthier behaviour may serve this purpose well.

GPs felt that the aim of mutuality in the conversation could not always be achieved when smoking cessation advice was provided. Patients did not always engage in a discussion of smoking cessation, thereby revealing their own evaluation. In some cases they would prefer to let the GP talk and remain unresponsive. In a study by Sorjonen et al. (30) primary care physicians usually did not give any life-style advice unless the life-style in question had been defined as a problem. The physicians usually accepted the patients’ definition of the status of his behaviour as problematic or un-problematic. This description seems to be in accordance with the findings of mutuality in this study. Aronsson and Sätterlund-Larsson (31) found that patients who disagreed with advice from their physician did not make this clear during consultation.
They found that opposition could be traced in the dialogue as a minimal engagement by the patient. The notion of mutuality may be related to a principle of sameness in Scandinavian culture. An idea of sameness in Norwegian and Danish culture usually leads to a style of interaction where that which the parties have in common is brought to the foreground, and that which separates them is kept tactfully out of the interaction (32, 33).

Smoking cessation advice would especially challenge the wish for mutuality when patients had recently rejected smoking cessation advice. According to a Swedish study, 72% of the GPs would raise the issue of smoking again with a patient who had stated on a prior occasion that she was not interested in stopping smoking (34). While these results were based on survey data, the present study addresses the level of practical implementation. The findings in the present study suggest that frequent repetition of advice is difficult because it is demonstrating to patients that GPs will not await the patient’s agreement. Motivating patients to stop smoking may be balanced by GPs with ideals of mutuality in the conversation.

Strengths and weaknesses of the study
The study may suffer from selection bias as 18 GPs had to be invited to obtain six participants. Both participating and non-participating GPs expressed uncertainty as to whether their handling of smoking cessation and their handling of the GP-patient relationship was sufficiently professional. This uncertainty made some of the GPs decide not to participate. Eight of the 12 non-participating GPs belonged to the group of GPs who were less active as far as smoking cessation advice concerns. The participating GPs may thus have been those who were comparatively more self-confident professionally and more skilful in handling the GP-patient interaction. The implications for the finding of this study could be that it does not adequately address the difficulties of those GPs who feel most insecure in this field. The sample of GPs in this study, however, matches the Danish population of general practitioners with reference to sex, age and surgery partnerships (35).
Comments made by most of the GPs suggest that the knowledge, that the researcher was observing their smoking cessation, made them give advice in more consultations than they would usually have done. This effect was much smaller on the two last days
of observation. Consultations from the first day of observation have thus been disregarded in the analysis.

A qualitative study cannot claim to be representative of the Danish GP population as a whole. The generalizability of the findings relies on the probability, that the themes that are prevailing among GPs and patients in the study are present beyond the study group. There are, however, probably other themes prevailing in the Danish GP and patient population that are not covered in this sample.

4.2 Conclusion
Two elements of Danish general practice consultations were challenged by smoking cessation advice to patients without smoking-related illness: the ideal of moral acceptance of patients in general practice consultations held by GPs and patients, and the wish for mutuality in the conversation during consultations. The situation where the GPs repeat advice at short intervals seemed, in particular, to give problems.

4.3 Practice implications
This paper illustrates some of the challenges in importing of a mass strategy of smoking cessation advice to the every-day life of Danish general practice consultation. The results of this study suggest a need for adaptation of a mass strategy of advice to the cultural context, where it is to be implemented. Moving away from the concept of advice towards a concept of a conversation about smoking based on mutuality is within reach in the form of motivational interviewing (36). However, even within the frame of non-judgemental advice (37) it seems difficult to remove moral implications from the conversation, because patients bring moral perceptions of smokers to the consultations. Specific strategies to address this difficulty may be developed to make advice fit the context of Danish general practice. The findings underline the need for the development of valid processes for cultural translation of guidelines that has been suggested elsewhere (38).

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Information and procedure of consent were approved by the local Ethics Committee.
Conflict of interest: None.

We confirm that all patient and personal identifiers have been removed or disguised so the persons described are not identifiable and cannot be identified through the details of the story.
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Paper 3.

Developing and maintaining patients’ trust in general practice consultations: the case of smoking cessation advice.

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Developing and maintaining patients’ trust in general practice consultations: the case of smoking cessation advice.
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Abstract:

Background: Several studies point to the establishment of personal trust through interaction between GPs and patients. Research into the relationship between lifestyle advice and trust is sparse, and no prior studies have investigated the relationship between trust and smoking cessation advice in general practice consultations.

Purpose: The aim of this paper is to describe the process of developing and maintaining trust during physician-patient interaction in general practice consultations, combining the perspectives of GPs and patients. The study focuses on the relationship between this process and smoking cessation advice.

Methods: The study consisted of interviews with GPs and patients, grounded in observations of their consultations. Consultations in themselves were analysed as well. The study uses the theoretical concept of ‘rules of conduct’ to analyse how interaction affects trust. The emphasis of the study was on smoking cessation advice in consultations with health problems not related to smoking, which could be considered as ‘missed opportunities’ for advice.

Results: According to the findings of this study, the GPs should demonstrate through the interaction the intention to evaluate and possibly resolve the patient’s health problem. The GPs should also demonstrate that they recognized the patient’s health problems. Both GPs and patients felt that these demonstrations contributed to the patients’ trust in their GP. Smoking cessation advice during consultations could convey the impression to the patient that the GP did not recognize the patient’s health problem, or that the GP did not take up the responsibility to evaluate and possibly solve the patient’s health problem. Smoking cessation advice could, however, demonstrate interest and desire to help and so contribute to trust when it was given in the right context.

Conclusions: This study adds to previous research the dimension that GPs intend interaction to contribute to trust. Building and maintaining trust is an integral goal of consultations. Smoking cessation advice both has the potential to put a strain on trust
and to strengthen trust. The outcome depends on the conformity of advice to the specific expectations of the interaction in general practice consultations shared by GPs and patients.

Keywords: trust, family practice, physician-patient relations, smoking cessation, qualitative research.
Introduction

Several studies point to the importance of interaction between physicians and patients for the establishment of personal trust. According to patients, clear and complete communication from the physician is important for trust to develop (1-5), and so is the physicians’ ability to listen (4, 6-7). Furthermore, physicians providing effective treatment and demonstrating competence have been described to engender trust (1, 7-8). According to patients, it also supports trust if the physician displays a thorough evaluation (1) and establishes follow-up (4, 7). Trust in the technical competence based on the interaction between the patient and the GP, however, seems to be less important than the bare fact that the physician is a physician (6-7).

The patient-physician relationship affects trust. The patients’ perceptions of the physician understanding their individual experience (1), showing interest (6) and making him/her feel believed and taken seriously also adds to patients’ trust (5, 9). Patients also associate the development of partnerships and the sharing of power by physicians with trust (4, 7-9). Furthermore, the physician’s expression of care towards the patient is considered an element of trustworthiness by patients as well (3, 6, 8). The above-mentioned studies have all been based on individual in-depth interviews, focus group interview or surveys of patients. The study by Bültzingslöwen (9), however, combined the perspectives of patients and health professionals.

The aim of this paper is to describe the process of developing and maintaining trust during physician-patient interaction in general practice consultations, combining GP and patient perspectives. The study focuses on the relationship between the process of building trust and smoking cessation advice. The emphasis of the study was on smoking cessation advice in consultations for health problems not related to smoking. Patients’ visits without smoking cessation advice have been described as ‘missed opportunities’ for smoking cessation advice (10). Patient visits for diagnoses not related to smoking, in particular, have been reported not to contain smoking cessation advice to any great extent (11-13), and so present an interesting field of inquiry.
No prior studies have reported on the specific relationship between smoking cessation advice and trust in physicians. Research into the relationship between lifestyle advice, in general, and trust in physicians is sparse, even if trust between patient and physician is believed to lie at the root of lifestyle advice, e.g. Putnam et al. (14). The scientific board of the American Medical Association stated that,

“One of the greatest benefits of the patient’s periodic visits to the physician is that both patient and physician have the opportunity to build the mutual trust and knowledge that will stand them in good stead, not only when acute illness may require the physician’s care, but also when the physician attempts to foster those behaviours and activities that contribute to the prolonging of the patient’s healthful and productive life.” American medical association council on scientific affairs (15).

Trust as support for preventive services has been described in several studies. According to a focus-group study of Canadian GPs, patients’ trust facilitates acceptance of new recommendations to patients with ischemic heart disease (14). A connection has been described between trust and the likelihood that elderly patients have mammography, influenza vaccination and eye-examinations for diabetics (16). The connection described between these preventive services and trust was, however, not very strong. In addition, patients’ trust in MMR immunizations may be supported by trust in the GPs or other health care professionals who provide the immunization (17).

Contrariwise, an issue that deserves scrutiny is the effect of the preventive services on the development of trust. In a randomized controlled trial offering group visits to new members of the health plan, including preventive services, such visits improved patients’ trust (18). In the same study, however, individual visits primarily based on preventive services had no effect on trust. Also, a focus-group study of Danish GPs voiced concerns that patients’ trust in the physician may suffer if they are unsuccessful in changing their lifestyle in response to advice they feel obliged to take (19).

Theoretical framework
In order to study trust between physician and patient as a matter of interaction, linking GPs’ and patients’ perceptions of trust to the consultations observed, a
theoretical perspective stemming from the work of the sociologist Goffman is applied, as suggested by Misztal (20). Barbara Misztal (20) describes how, in the theory of Goffman, the interaction in everyday life matters to the development and maintenance of trust. According to Goffman (21, p.90), intentions are expressed in interaction through ‘rules of conduct’. A rule of conduct is not described as a law, but rather as a norm which indicates how to act (21, p.55). Rules of conduct serve as guidelines for suitable and just actions (21, p. 48). They obligate the subjects and at the same time produce justified expectations as to how others should act. Rules of conduct may not be perceived as long as they work uncompromised, and subjects who follow them will usually not be aware of their raison d’être (21, p.48-49). Attention to these rules will, however, arise if they are broken. Commitment to maintaining the rules of conduct commits a person to a particular presentation of self (21, p.50, 22). Following rules of interaction reinforces people’s mutual feeling of trust and predictability. Trust is eventually sustained through the establishment of consistent expectations and presentation of self (23-24).

The examples of contents of rules of conduct as described by Goffman in 1967 have changed, and the setting of a mental hospital, in which they were formulated, does not fit the context of general practice consultation. In this analysis, the concept of rules of conduct, however, is used for analytic purposes beyond the actual/empirical rules described by Goffman. In general practice consultations, rules of conduct can describe the presence of shared expectations regarding the interaction between GPs and patients, and the aspect that GPs and patients express their intentions to each other during interactions. As an example, the GPs and patients in this study agreed, that a lack of recognition of the patient’s health problems could harm trust. GPs’ recognition of patients’ health problems could be observed in consultations. These findings were compared to the theoretical relation between rules of conduct and trust as described by Goffman. Face-to-face interaction could either build or undermine trust, either complying with or contradicting the rules of conduct.
Material and methods

Data were obtained through interviews with both GPs and patients grounded in observation of their consultations. Consultations with and without smoking cessation advice were analysed. The study of trust was part of a larger research project analysing how general practice consultations will work as a context for a mass strategy of smoking cessation advice

Selection of GPs

A sample of six GPs was included in the study (Table 1).

Table 1: Characteristics of participating GPs. Districts are indicated by numbers.

<table>
<thead>
<tr>
<th>GP</th>
<th>More active</th>
<th>District (no)</th>
<th>Sex (M/F)</th>
<th>Age (yrs)</th>
<th>Tenure in practice (years)</th>
<th>In partnership surgery</th>
<th>Postgraduate training in smoking cessation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Yes</td>
<td>1</td>
<td>M</td>
<td>55</td>
<td>23</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>B</td>
<td>No</td>
<td>1</td>
<td>F</td>
<td>46</td>
<td>4</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>C</td>
<td>Yes</td>
<td>2</td>
<td>F</td>
<td>45</td>
<td>6</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>No</td>
<td>2</td>
<td>M</td>
<td>59</td>
<td>29</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>E</td>
<td>Yes</td>
<td>3</td>
<td>M</td>
<td>50</td>
<td>15</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>F</td>
<td>No</td>
<td>3</td>
<td>M</td>
<td>43</td>
<td>7</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

The selection strategy was maximal variation (25, p. 58) regarding activity of smoking cessation advice, sex, duration of practice tenure and urban/rural practices. GPs who were considered either more or less active in providing smoking cessation advice by local public administrators working with smoking cessation or by their colleagues were identified according to the principles of Hammersley and Atkinson (26) and Kuzel (27). All participating GPs accepted their peers’ description of their strategy as either more or less ‘active’ in terms of giving smoking cessation advice. Eighteen GPs had to be invited to obtain acceptance from six GPs. Less active male GPs with short practice tenure accounted for seven of the 12 refusals.
Observation of consultations

The purpose of observation in this study was to provide an overview of consultations for selection for interviews and for use as grounding for interviews. Observations from consultations formed a shared frame of reference between the interviewer and the interviewee and could be drawn upon during the interview. The statements made by the interviewee during the interview could help explore the course of the consultations. The combination of interview with observations made areas of tacit knowledge accessible to interviews, to a higher extent than could have been achieved with interviews alone.

Observation was inspired by the principles of observation described by Hammersley and Atkinson (28). Observational, theoretical and methodological notes were taken during observation according to the principles of Schatzman and Strauss (29). The observational notes added to the record of the consultation, filling in the context of the dialogue. Theoretical notes were attempts to interpret the meaning of observations. Methodological notes addressed research procedures, reminders and critique.

Consultations were observed for three days in each practice. Both the GP and the patients involved in consultations were invited for interviews (Figure 1).
Figure 1: Study design. Consultations with GPs A, B, C, D, E and F were observed. Interviews with the GPs and with the patients were grounded in their own consultations.

Selection of consultations and of patients for interview
A strategic sample of audio-recordings and field-notes regarding 26 consultations was selected for analysis in detail. Among these, consultations regarding health problems not related to smoking were given special attention through interviews with patients and GPs participating. This selection was chosen in order to explore those consultations which have been described as missed opportunities for smoking.
cessation advice (11). Additionally, secondary criteria of patient sex, age and health problem were applied to choose among the eligible patients. Only consultations with patients who were considered smokers or potential smokers by their GP were selected; a procedure that ensured that the GP would actually consider the patients proper candidates for smoking cessation advice.

Thirteen consultations with health problems not related to smoking were selected for interviews. Four of these contained smoking cessation advice. Nine of the 13 patients consented to interviews. The three of them had had advice. The four consultations with non-consenting patients were however kept for analysis and for further investigation by interviews with GPs. Patients had consented to that. Another two consultations were included for interviews even though they regarded issues that were related to smoking (pregnancy, contraceptive pills). They fitted the strategy of the sample in another sense, since they did not contain any advice, contrary to expectation. Advice would have been expected according to the tradition of advice described. Thus, a total of eleven patients were interviewed.

Finally, 11 consultations containing smoking cessation advice, and occurring in consultations with health problems, were included as a supplement to the consultations with interviews. These patients were not interviewed, but consultations were analysed for the purpose of contextualization of interviews. A total of 26 consultations then constituted the strategic sample. Consultations from all surgeries were presented in the sample.

Definition of smoking-related

Symptoms or illnesses diagnosed by the GPs were defined as smoking-related if smoking could have contributed to the development, could shape the future course or if cessation was known to improve the prognosis. Such relations to smoking were scrutinized through literature searches for symptoms or illnesses brought up during observed consultations.

Definition of smoking cessation advice

Smoking cessation advice was defined as any discussion of smoking, which went beyond answers to the GP’s anamnestic questions (30).

Interviews

After observation of consultations, I contacted the patients by telephone to make an appointment for an interview. The interviewed patients comprised seven women and
four men. Their time on the practice lists varied from six months to 18 years. They were 18-78 years old.

Individual interviews with GPs and patients were conducted as soon as possible after their consultation. At the beginning of the interview, all participants were invited to listen to the audio record of the consultation, and most accepted this invitation. The smoking cessation advice or the absence of such advice was the thematic focus in interviews with GPs and patients. Questions concerning trust were not asked unless trust or a synonym ("put stock on" (have “fidus til”) or "rely on" ("stole på")) was used by the GP or patient her-/himself. This was the case for nine of the 11 patients interviewed and four of the six GPs. A definition of trust was not decided upon in advance. Instead the understanding of the concept was based on the GPs’ and patients’ own utilization of the word ‘trust’. Questions were put to induce the informant to relate the concept of trust to other concepts utilized, to get examples of consequences of trust or lack of trust, and to make patients and GPs describe factors that they felt influenced trust. Other aspects of interaction than smoking cessation advice, related to trust, were included when patients pointed them out.

Observations and interviews were performed by the first author (ADG).

**Analysis**

Interviews and the audio record of the 26 consultations were transcribed verbatim. The analysis was inspired by Giorgi’s four–step process (31). This meant that the entire text of the individual interviews and consultations was read to get a sense of the whole statement. Text units addressing specific issues of the whole statement were then coded. Coding was based on the informants’ own categories. The insights provided by the text were then expressed in more general terms and summarized in consistent statements.

The summarized statements from the patients and GPs were then compared to each other and also to the analysis of consultations. This comparison was carried out both for individual consultations with associated interviews and for the material as a whole. The analysis of the consultations also produced a short description of the phases of the consultations, in general terms. One example of a general term was “exploring the history”, signifying the situation when GPs asked questions exploring the health problem presented by the patient.
Analysis of both consultations and interviews focused on the expectations of the interaction in general practice consultations that were shared by GPs and patients and the relationship between their interaction and the fostering of trust (22).

The information given to the participants in the study and the procedure of consent were approved by the local Ethics Committee. Collection of data was carried out during 2003 and 2004.

GPs are referred to as GP A, -B, -C, -D, -E and –F and patients’ names are fictional.
Results

Actions during consultations that demonstrated the intentions of the GPs

Both GPs and patients expected the GPs to demonstrate during the interaction the intent to evaluate and possibly resolve the patients’ health problems. As an example, GP E described the need to demonstrate this intent, when addressing the issue of overweight:

“When people come to see you about their knees, you cannot just tell them that it’s because they weigh too much. You have to listen to what they say and make a proper examination. Afterwards you can talk about the weight”. (GP E)

Pointing directly to the overweight as the obvious cause of the patient’s health problem was avoided by this GP, in order to avoid giving the impression that the GP did not make an effort to evaluate the health problem.

The GPs have to demonstrate that they recognize the patients’ health problems. This patient commented on her own consultation concerning a long-standing health problem that had now worsened:

*I like that he’s managing things undramatically, but still takes them seriously, because... I didn’t feel that he questioned that it was necessary.* (Mary-Ann)

As illustrated by this patient, the GP’s recognition of the patient’s problems made the patient feel that the GPs understood the worry and used it as a starting point for the consultation. In this way, the GPs confirmed to their patients that they had succeeded in delivering their message. Beyond their practical impact, actions during consultations thus also demonstrated the GPs intentions.

Such demonstration of intentions was inherent in the structure of the consultations. In consultations, it was first decided which health problem(s) would be the topic(s) of the consultation. After accepting a certain health problem as the subject of the consultation, the GP sought to obtain sufficient information through questions and clinical investigation. The GP then gave an evaluation of the health problem to the patient and suggested a solution. In most cases, the GP also provided a plan for further control. Through this pattern of interaction, GPs demonstrated to patients that
they had recognized their health problem and accepted the responsibility to evaluate and possibly resolve the health problems.

**GPs’ intentions contributing to patients’ trust**

Both GPs and their patients felt that recognition of the patient’s health problem and the GP’s acceptance of the responsibility to evaluate and possibly resolve the patient’s health problem furthered patients’ trust in their GPs. One of the GPs described the relationship to trust like this:

...that they can get an explanation of the problems that they have... that you evaluate the things they tell you and that they feel that the evaluation you give is reasonable... (GP B)

In the experience of this GP, the process of evaluation contributed in its own right to her patients' trust in her.

Patients said that trust was strengthened when they were taken seriously by the GP, and when they felt that the GP’s work was based on recognition of the problem. Inversely, problems could occur when GPs told their patients that their problems were insignificant or trivial. As an example of why she had trouble trusting her GP, one patient told about an episode when the GP suggested over the telephone that her health problem did not need his attention, while she herself felt that she had serious grounds for concern:

I had had some penicillin. "Well, didn’t it help?” he asked. Well, if it had, then I did not have to go, did I? (Monica)

If patients felt, like the patient in this case, that GPs doubted the reality of their problem, they did not trust the service they were offered.

**Smoking cessation advice that interfered with the GP’s recognition of the patient’s health problem**

Smoking cessation advice during consultations may convey the impression to the patients that the GPs do not recognize their health problems. One patient answered to the question of why smoking cessation advice did not occur during her consultation, which was prompted by stress:

I think that I would have the feeling that I was not heard or seen in what I experienced, and that the stress would only make me smoke even more
(...) so if she wanted to discuss smoking in connection to that, I think that I would lose some of the trust that I had in her. (Sophie)

Her GP responded to the same question of why smoking cessation advice did not occur in this consultation:

*She would feel the trust broken, I think, because she would feel forced into something all different than what she came for (...) Yes, some get upset or angry or loose the thread – the thread is cut to what she actually attended for.* (GP C)

Some patients felt that smoking cessation was not a realistic option due to their difficult psychosocial circumstances. In this case, smoking cessation advice could be perceived as a lack of recognition of these circumstances on the part of the GP. In the following case, the GP demonstrates to the patient that she recognizes the constraints that psychological distress has placed on her ability to reduce her smoking:

Cheryl: ...*Well, what I’ll do is to reduce it because I’ve been able to do that before, and there it was...well, in this period where I’ve felt bad, I’ve smoked more. It...It...*  
GP B: Yes. But of course, it’s obvious that the situation where you’ve been in psychological distress, which you have for a long time, it isn’t the time to try to... and maybe you have still not come to that point yet, where you have the energy, but eh, when you feel like you’ve got it, then you can...  
Cheryl: *Then I will start...Yes...*

Likewise, one GP who was very active in giving smoking cessation advice commented on the case of a patient, a single mother recently divorced and recovering from a depression:

"Actually, I just wanted to show her that I understand that at this point in her life she can’t stop smoking and I wish that I had emphasized it even more". (GP A)

**Smoking cessation advice that interfered with the GP’s responsibility to evaluate and possibly solve the patient’s health problem**

Smoking cessation advice may cause patients to think that the GPs are not taking the responsibility to evaluate and possibly solve the patients’ health problems upon
themselves. One patient offered a mock conversation between a GP and a smoker, illustrating the attitude of one of the GPs whom she had attended:

"Do you smoke?", "Yes", "Then that’s why. Next, please". (Alice)

As is demonstrated in this quote, smoking cessation advice may convey the impression to patients that the GP refuses to help the patient. This possibility was recognized by the GPs. One GP explained why smoking cessation advice should be avoided in the context of conflicts with patients. If the GP advised the patient to stop smoking in such a situation:

"...the patient would say "The GP did not want to help me with what I wanted, and then he mocks me". “ (GP E)

Smoking cessation advice was one of several GP activities that could make the patients feel a lack of recognition of their health problems or that could convey the impression that the GP did not accept the responsibility to evaluate and possibly solve the patients’ health problems. Other examples mentioned by the patients were when the GP did not want to offer any therapy, as when no therapy could be recommended on a scientific basis, or if GPs were reluctant to make referrals or to accept patients for acute visits:

It’s got to be someone you trust. Someone who you feel is doing something. Sometimes, I’ve had the impression that he wanted to postpone it because he didn’t want to initiate too much. (Gerald)

Smoking cessation advice, however, could build trust if the patients felt that it was an expression of interest and help from the GP. One patient felt that the advice she received from her GP confirmed the trust she had in him:

"It was really appropriate that he asked. It shows interest.” (Sharon)

The feeling that smoking cessation advice could build trust was shared by the GPs. Thus, smoking cessation advice that made the patient feel that the GP showed interest in him/her, or advice that demonstrated GPs taking responsibility was regarded as positive for trust.

Trust as a resource for smoking cessation advice

Finally, both GPs and patients saw trust as a resource for smoking cessation advice in general practice. Trust in the patient-physician relationship was reported to make the patient receptive to advice from the practitioner and to counteract the risk of
offending the patient. One patient who did not have a trusting relationship with her GP would resent smoking cessation advice:

“*I might be more interested in discussing smoking if I had another GP. I really wouldn’t like to discuss it with him.*” (Monica)

Another patient described the opposite situation where advice was given by a trusted GP:

“*But if it is someone whom you trust, (...) then you listen.*” (Sharon)

So trust already obtained could be a resource for smoking cessation advice and influenced the way it was perceived by the patients.
Discussion

This paper addresses patients’ trust in their GPs as an element of interaction by including both the perspectives of patients and of GPs. While the vast majority of prior studies described the interaction contributing to trust only from the patient’s perspective, this study describes the common understanding of GPs and patients. According to the findings of this study, the GPs should demonstrate in interaction their intent to evaluate and possibly resolve the patients’ health problem. The GPs should also demonstrate that they recognized the patient’s health problem. Both GPs and patients felt that this would contribute to the patients’ trust in their GPs. Smoking cessation advice during consultations could convey the impression to the patient that the GP did not recognize the patient’s health problem. This could occur when smoking cessation was not felt by the patient to be a realistic option due to difficult psychosocial circumstances. Advice could also cause the patient to think that the GP did not take up the responsibility to evaluate and possibly solve the patient’s health problem. Smoking cessation advice, however, could build trust when the patient felt that it was an expression of interest and desire to help. Finally, GPs and patients saw trust as a resource for smoking cessation advice in general practice.

The findings of this study that GPs should try to demonstrate the intention to evaluate and possibly resolve the patient’s health problem, seem very similar to the findings of Thom and Campbell (1), viz that patients’ trust in their GPs was enhanced when the GPs demonstrate a thorough evaluation. Likewise, the present study described that to gain trust GPs should demonstrate through interaction that (s)he recognized the patient’s health problem. Making the patient feel believed and taken seriously supports trust, as was also described in the study of Bültzingslöwen (9) and that of Berrios-Rivera et al. (5). The present study adds the information that these demonstrations lie in the structure of the consultations. It also adds the information that interaction is consciously managed by GPs to convey these impressions. Building and maintaining trust was an integral goal of consultations. The fact that trust is supported, if the interaction is perceived as an expression of interest or desire to help, was also demonstrated by Mechanic and Meyer (6), reporting the perspective of patients with serious illness. In the present study the
expression of interest and the desire to help was described by both patients and GPs as a successful case of integrating smoking cessation advice in consultations.

This study offers a view on how preventive services affect trust that is different from that of prior studies. Firstly, the particular case of smoking cessation advice has not been related to trust before. Secondly, the results of the study suggest that the relevant question to ask it not whether smoking cessation advice adds to trust, but rather in what way smoking cessation advice can be given to support trust. Adapting smoking cessation advice in general practice consultations according to the rules of conduct laid down in this study should increase the likelihood that smoking cessation advice contributes to trust and does not erode it.

Reliability and validity of findings
Interviews with GPs and patients were grounded in consultations, some of which raised the issue of smoking cessation advice, but most did not. Hence, it follows that in many cases, GPs and patients were explaining during the interview, why smoking cessation advice did not take place. This design, therefore, pointed the focus to aspects of trust in the interaction that may otherwise have passed unnoticed. Focusing on the unexpected, in this case smoking cessation advice in consultations without smoking related illness or symptoms, helps reveal regularities in everyday life that usually go unnoticed, such as those that serve to maintain trust (32). The study does, however, not cover every aspect of trust in the doctor-patient relationship in general practice. An important aspect largely ignored here, for example, is the GP’s technical competence, which is quoted as important for trust in the physician in other studies (1, 33-34). The focus of the study on matters of interaction probably explains, as least partially, why this aspect is not apparent here.
While there are obvious limitations to studying trust under the conditions of this study, the strength of the study is the absence of any priming to discuss trust, i.e., the importance of trust was not suggested to participants in advance. Consequently, this study has not been subject to the idealization of the importance of trust. Not all GPs and patients addressed trust. The two GPs who did not mention trust in their interview were both male and represented the longest practice tenure of the sample, one of them belonging to the group of more active GPs in smoking cessation advice,
the other belonging to the less active group. The two patients who did not mention trust were one young woman and one young man.

The presence of the observer, a doctor herself, may have affected the doctor-patient interaction. Both GPs and patients may have made a special effort to present themselves as good GPs and good patients and introduce an element of idealization into the interaction. To reduce this effect, consultations during the first day of observation, when GPs were explaining their actions and stating their ideals concerning smoking cessation advice, were omitted from the analysis. The analysis was based exclusively on information and observations from the following days of observation where the GPs focused less on the observer’s presence.

The present study may have recruited GP participants whose skills and experience were above the GP average. Both GPs participating and non-participating GPs expressed uncertainty as to whether their handling of smoking cessation and their handling of the doctor-patient relationship was sufficiently professional. This uncertainty made some of the GPs decide not to participate. Thus, the participating GPs may have been those who were comparatively more self-confident professionally and more skilful in handling the doctor-patient interaction. Consequently, the results could represent a perspective of the excellent rather than the average GP, as regards professionalism in interaction with patients.

**Conclusion**

GPs intend interaction to contribute to trust. To GPs, maintaining trust is an integral goal of consultations. Smoking cessation advice has both the potential to put a strain on trust and to add to it. This depends on the conformity of advice to the expectations of the interaction in general practice consultations, shared by GPs and patients.

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