Enhanced CPD DO C

Nisha Bhanu

Ivor G Chestnutt

Exploring Barriers to Tobacco Smoking Cessation in Minority Ethnic Patients in the UK

Abstract: While the role of the dental team in promoting smoking cessation is well described, the nuances of counselling on tobacco use in individuals from ethnic minority backgrounds are less well understood. Beliefs and cultural practices require consideration when discussing the benefits of stopping smoking, an important consideration in a country with the great ethnic diversity prevalent in the UK. This article discusses culturally related barriers to patients stopping smoking. Recommendations for members of the dental team to consider next time they have a conversation with a patient from an ethnic minority background regarding their smoking habits are presented.

CPD/Clinical Relevance: This article provides advice on how the dental team can help patients from ethnic minorities stop smoking.

Dent Update 2022; 49: 920–925

The UK is a multi-ethnic country; however, current research focusing on ethnicity in relation to smoking cessation is not extensive. There are currently no action plans targeting smokers of ethnic minority backgrounds in the Tobacco control plan.[1]

History

The first cases of smoking tobacco in England date back to the 1500s when sailors brought tobacco back from the Americas where it had been used historically as a means of spiritual communication, and a healer of illness.[2] In the course of the twentieth century, the long-term dangers of smoking to health were recognized and accepted. Although the UK has seen a substantial fall in the number of cigarette smokers since the 1970s, tobacco smoking is still the leading cause of preventable death in the UK and imposes a high burden on the healthcare system.[3]

Ethnicity breakdown in England and Wales

Figure 1 illustrates the ethnic breakdown of England and Wales in 2011. These data show a decrease in the White ethnic population from 94.1% in 1991 to 86% in 2011. These figures were further investigated to determine the 10-year population change of ethnic minorities in England and Wales from 2001 to 2011. There was a population increase in all ethnic minority groups (except that of Caribbean, which remained the same).

The prevalence of smoking by ethnicity

A 2020 report[4] on current cigarette smokers aged 18 years and over in the UK found that the highest smoking prevalence was in those describing their ethnicity as Mixed at 19.5%. This compares with 14.4% of those reporting their ethnicity as White. In other groups, smoking prevalence was recorded as: Black (9.7%), Asian (8.3%) and Chinese (6.7%). Marked differences were observed between genders within different ethnic groups, for example, in those describing their ethnicity as Asian: while 13.9% of men smoked, only 2.8% of Asian women said they smoked.

Nisha Bhanu, Final Year Dental Student, Cardiff University School of Dentistry.
Ivor G Chestnutt, BDS, MPH, PhD, FDS(DPH) RCSEd, FDS RCPSGlas, FDS RCSEng, FFPH, FHEA, Professor and Honorary Consultant in Dental Public Health, Cardiff University School of Dentistry.
email: nisha.bhanu@nhs.net

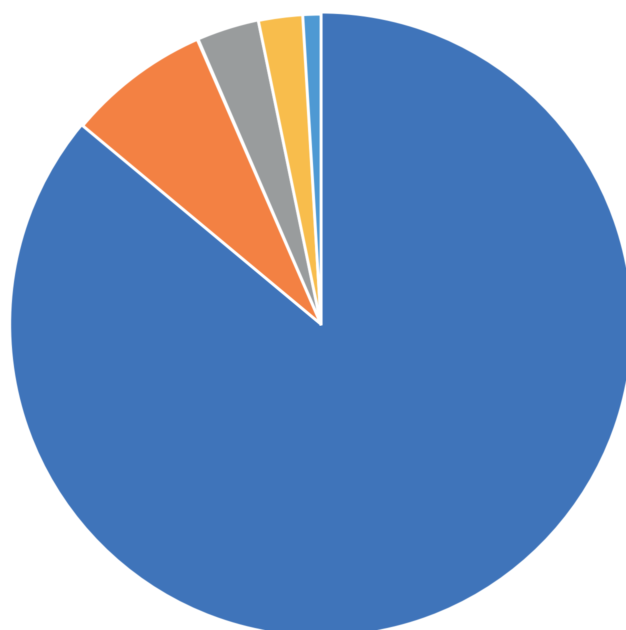

Figure 1. Pie chart illustrating the ethnicity breakdown of England and Wales (adapted from Office for National Statistics[16]).

It should be noted that in this article, the focus is on smoking tobacco cigarettes. Other forms of smoking popular in minority groups, such as waterpipes (hookas) and smokeless tobacco use are not discussed. However, it is important to remember these forms of tobacco are prominent in certain cultures, particularly that of South Asian communities. We have previously reviewed the use of waterpipes.[5,6]

Oral effects of tobacco smoking

The impact of smoking cigarettes on oral health is well recognized and is summarized in Table 1. There are therefore many oral health-related 'hooks' whereby the subject of smoking can be raised with patients.

Smoking cessation

While many smokers have attempted to quit without aids,[7] relying solely on will power and going 'cold-turkey', evidence shows that pharmacological and behavioural interventions increase the chances of stopping smoking successfully. Smoking cessation can be categorized into two forms.

- Pharmacological methods, including:
  –Nicotine replacement therapy (NRT);
  –Varenicline tablets;

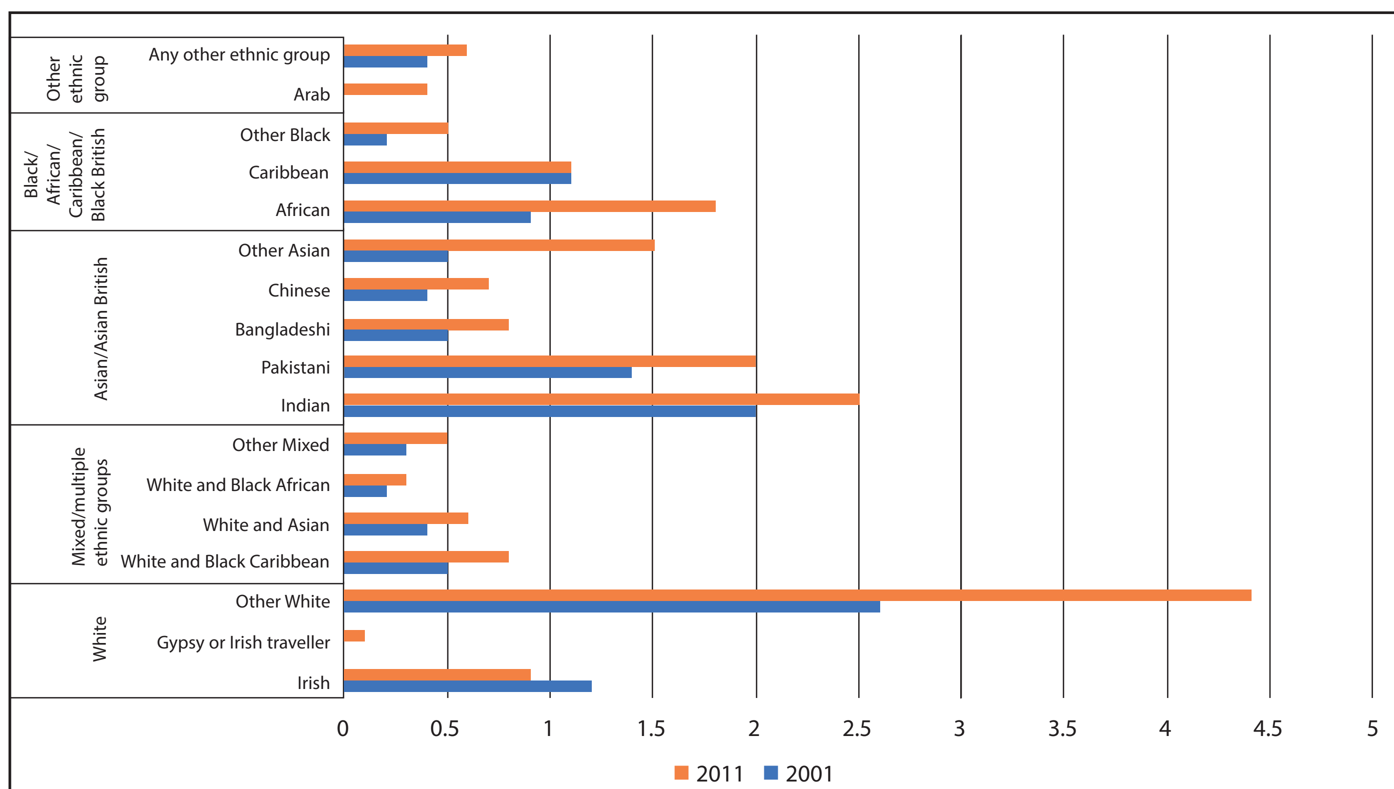

Figure 2. Bar chart illustrating changes in population size with regards to ethnicity (adapted from Office for National Statistics[17]).

Detrimental effect of smoking tobacco	Explanation
Oral cancer	Especially in conjunction with excessive alcohol consumption. This health concern is important to mention when discussing patients' smoking habits
Periodontal disease	Although smokers are less likely to exhibit gingival bleeding and therefore be less likely to be diagnosed with gingivitis, there is a well-established link between smoking and periodontitis
Aesthetic concerns	Short-term smoking can cause yellow discolouration of the teeth and long-term smoking can cause brown staining. This can damage a patient's confidence and is a common reason for smokers to visit a dental professional
Halitosis	Cigarette smoking increases the concentration of volatile sulphur compounds in saliva and causes hyposalivation. This is also a common reason patients seek advice from the dental team

Table 1. Detrimental oral effects of tobacco smoking.

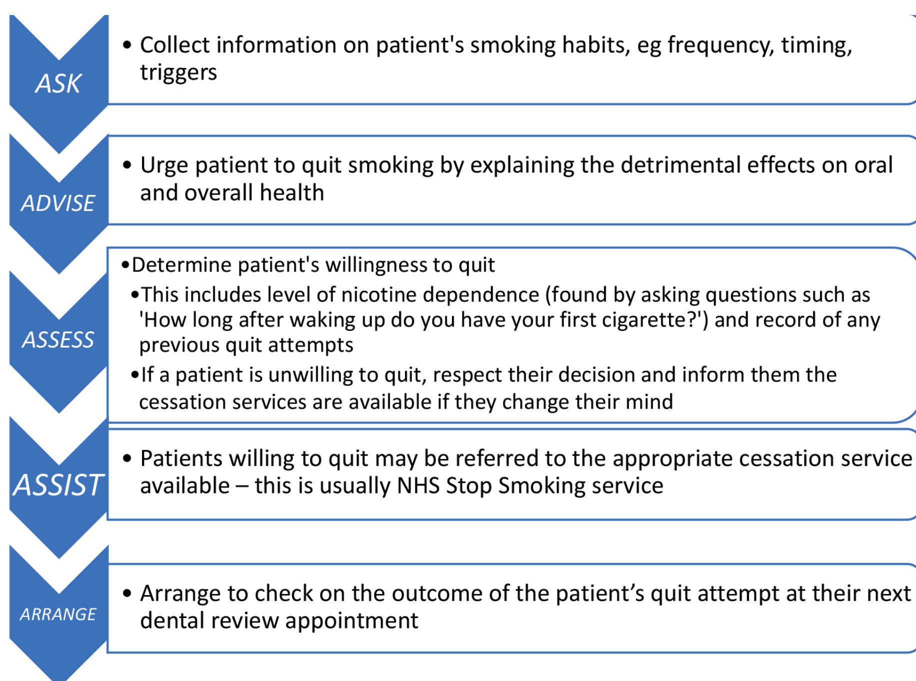

Figure 3. The 5 As of smoking cessation (adapted from Agency for Healthcare Research and Quality[18]).

–Bupropion tablets;
–E-cigarettes;

- Behavioural methods include:
  –Counselling (group, telephone, individual);
  –Exercise;
  –Alternative therapies, such as acupuncture or hypnotherapy.

Evidence for the effectiveness of these different approaches varies markedly. Interventions that involve the use of nicotine replacement during the initial stopping phases is most successful. Current NICE guidelines[8] explain that effective smoking cessation requires 'the 5 As' (Figure 3).

Barriers to smoking cessation in minority ethnic groups

The primary barrier to stopping smoking is of course the addictive properties of nicotine and that is common to all smokers. There are however, other barriers to stopping smoking that require particular consideration when talking to patients from ethnic minority backgrounds. These are illustrated in Figure 4 and discussed below.

The social aspect

The act of exchanging cigarettes 'cements solidarity' and 'positively reinforces existing social networks' among Bangladeshi restaurant workers.[9] Similarly, it was found that young Bangladeshi and Pakistani men were unwilling to quit as they found smoking together fun, even though they were aware of the health risks.[9] The social role that cigarette smoking holds in many ethnic groups should be considered when offering smoking cessation to ethnic minority patients; they may appreciate receiving alternative ideas for socializing among family and friends that do not involve smoking, such as sports.

Lack of knowledge of smoking risks

Many older people of Bangladeshi and Pakistani origin were unaware of the health risks of cigarette smoking.[10] That study also found that many participants were unaware of how nicotine works in helping to stop smoking, and participants reported either never using NRT or, when used, using it inappropriately. This research highlights a greater need for education from dental professionals on the long-term effects of cigarette smoking and how cessation services can help stop tobacco smoking.

Ethnicity-related stress

For many, smoking has become a method of relieving stress caused by issues faced within their ethnic community. It was found that many Bangladeshi and Pakistani participants work in the restaurant business (a common field of work for people of South Asian background), which they found stressful and smoking was a way of coping with this.[11] Employment as taxi/bus drivers, professions that come with unpredictable shift patterns and usually involve working till the late evening,[9] makes it harder for patients to access smoking cessation services if they are run only in standard 9–5 work time. South Asian males often turn to

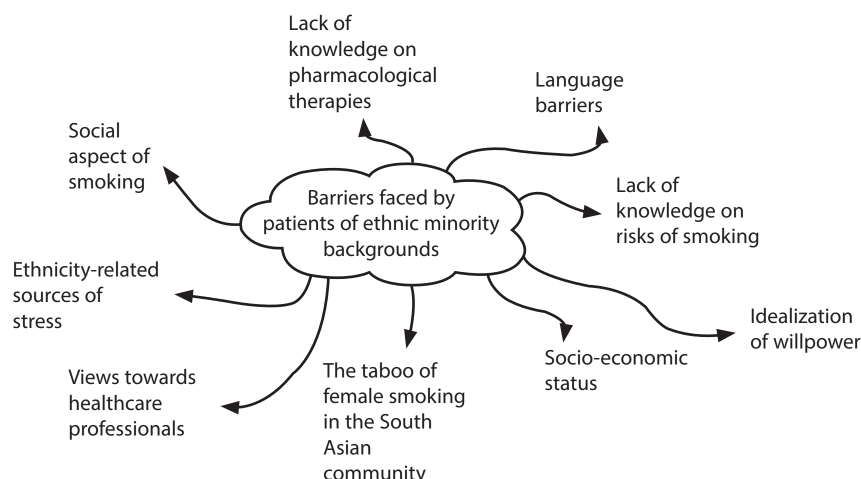

Figure 4. Barriers patients of ethnic minority backgrounds face when considering tobacco smoking cessation.

smoking cigarettes to help ease the stress of migrating and bringing up a family in the UK, as well as supporting an extended family in their mother country.[9] The same study also highlights that younger males felt that smoking cigarettes increased their self-confidence in their hometown where racial attacks and verbal harassment were experienced. These stresses that cause ethnic minority patients to rely on tobacco must be handled sensitively, in a non-judgemental manner and in a setting where patients feel comfortable enough to discuss.

Language barriers

Language barriers are a common issue, for older patients in particular. It was stated that older participants feel as if language barriers mean that 'not everything was understood' and that advertisements of nicotine replacement therapy products were only promoted in English along with inappropriate imagery that could 'lead to confusion about the message of the advertising'. Older participants who have trouble reading English may think it is an advertisement promoting smoking rather than cessation.[9] There is a need for written and verbal cessation advice to be translated into more languages to making it more accessible to patients who cannot fluently speak or read English.

Socio-economic status

In a questionnaire, Bangladeshi and Pakistani participants considered that quitting smoking and staying healthy was pointless due to their limited ability to obtain higher paying jobs, one explaining that 'we are not going to grow up to be like Beckham…we will be McDonald's workers for the rest of our lives.'[9] The role of the dental team to highlight the importance of smoking cessation for everyone in society is crucial, especially as we are in a position to regularly interact with all members of society, regardless of socio-economic and educational status.

Idealization of willpower

Two studies found it common for individuals from South Asian communities to be opposed to asking for professional help and instead rely on willpower to quit smoking.[10,11] Participants who successfully quit smoking without formal interventions were often 'admired and respected' and were seen as 'strong' and 'highly motivated'.[11] When dental professionals engage with patients who do not want professional help to stop smoking, their choice must be respected and the option to come back for help if they feel they need it must be made clear.

The taboo of female smoking in the South Asian community

There is a general taboo towards women smoking in some ethnic communities, making them more likely to hide their smoking habits from healthcare professionals for fear of being judged. A study found that young Bangladeshi girls turn to smoking in order to rebel against cultural gender norms.[12] This secrecy can be harmful for many females as it can prevent them from seeking the guidance they need. In order to overcome this barrier and make female patients more comfortable talking about their smoking habits, a non-judgemental approach should be taken and, if possible, include a non-Asian member of staff to talk to them – this has been found to make patients feel more at ease.

Views towards healthcare professionals

Participants of Bangladeshi and Pakistani backgrounds did not view their general practitioners as appropriate figures to provide smoking cessation.[11] There were a few reasons for this – one participant recalled only receiving verbal encouragement ('good luck') and little guidance, for example no leaflets or advice on how to go about quitting. Another participant highlighted the difficulty of booking appointments with their general practitioner. Two participants discussed the issue of costing for cessation aids such as nicotine when prescribed from a general practicioner, with one participant stating that they would 'rather smoke than spend'. Cessation services in pharmacies were also found to be 'too formal and impersonal'.[13] This is due to the limited amount of time that general practitioners and pharmacists have for appointments, as well as the limited time participants have to visit them. Dental professionals, on the other hand, are seen by patients on a regular basis, which helps build a better rapport and allows more time to delve into sensitive issues such as tobacco smoking. Outreach workers felt that their repeated presence in areas heavily populated by South Asian individuals helped 'develop trust' and encouraged smokers who were initially unwilling to quit, to ask for advice on subsequent occasions.[13]

Reasons for wanting to quit smoking

Clearly the ensuing quality of life and health benefits of stopping smoking cigarettes are common to all, irrespective of background or circumstances. There are, however, in addition, some factors that are of particular relevance to patients with an ethnic minority background when it comes to tobacco cessation (Figure 5).

Faith

Religion was found to play a role in both encouraging and preventing patients from accessing healthcare services. For example, coronary heart disease patients of ethnic minority backgrounds felt that fate influenced many South Asian participants'

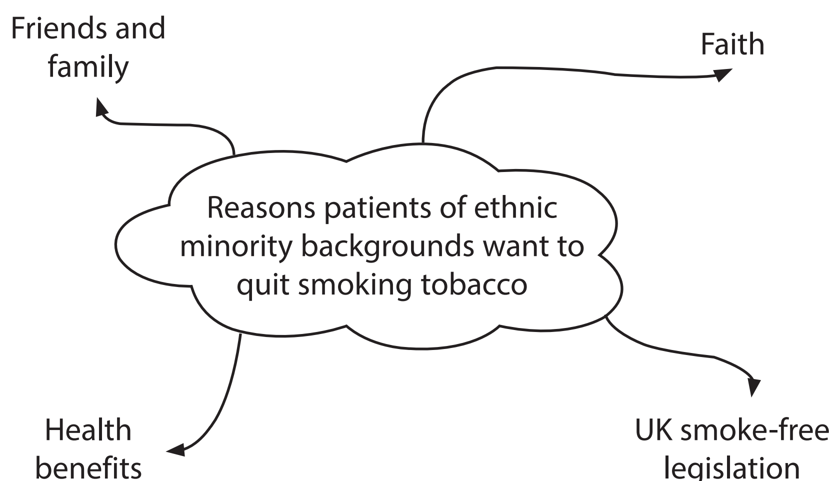

Figure 5. Common reasons patients of ethnic minority backgrounds want to quit smoking tobacco.

attitudes towards their health.[14] This meant that they may be less willing to quit smoking as they have 'no personal control over the onset of their illness'.[14] Many felt that their coronary heart disease was not down to their smoking habits, but instead down to what was 'destined by God'. It can often be difficult to deliver advice to patients who are convinced that their fate is already laid out for them, and respect must be shown towards their religious values if they refuse help. However, it is also important to encourage understanding of how lifestyle changes can reduce patients' chances of tobacco-related illnesses and deaths.

Ramadan is a popular reason for many Muslim patients' decision to quit smoking.[9,11] These studies show that using Ramadan as an incentive to quit is effective, but often leads to short-term results as the religious observance only lasts for 1 month. This highlights the need for successful long-term cessation support for patients. By regularly discussing their tobacco smoking habits after Ramadan, the chances of maintained abstinence are increased.

Health benefits

It is common for ethnic minority patients with comorbidities to act on advice from their doctor. A study focusing on stroke patients for up to 3 years post-stroke[15] found that Black participants were 18.4% more likely to attempt to quit than White participants. They also found that Black and other ethnic minority groups were less likely to be smoking at 3 years post-stroke. Research has established that certain ethnic minorities are predisposed to particular comorbidities, such as heart disease, and the implication smoking has for these conditions can be mentioned by the dental team to help encourage patients to quit and improve their overall health.

Legislation

The Smoke-free legislation introduced in the UK in 2007, which restricts smoking in public places, has been another popular reason to quit. Research tells us that the legislation made many less resistant to requests of maintaining a smoke-free home, showing the legislation for public places is having a positive secondary effect in homes too. However, a review found that South Asian men found the pressure to smoke from peers and family outweighed this legislation and did not affect their smoking habits positively.[16]

Tobacco smoking and COVID-19

The COVID-19 virus still presents with uncertainty. Although research has found that the virus leads to long-term complications in smokers,[17] it is not completely known why this occurs owing to the lack of relevant population-based studies. Regardless, the pandemic has already led to a surge in motivation to quit, whereby many smokers have decided to take the plunge and '#QuitForCovid'. The first UK survey conducted to highlight how coronavirus has impacted smokers' attitudes towards smoking cessation found that 8% of smokers were trying to quit and 2% of ex-smokers had quit completely since the virus outbreak.[18] The pandemic has disproportionately affected people from ethnic minority backgrounds – and not smoking must surely be a positive step in preventing or reducing the severity of the disease should coronavirus be contracted.

How to make tobacco cessation services effective

The following are offered as ways to improve engagement with, and the effectiveness of smoking cessation in, patients from minority ethnic backgrounds:

- Translate written and verbal resources into a language with which the participant is most familiar;
- Research local tobacco cessation services and recommend those that are accessible in the evenings and weekends if better suited;
- Ensure successful abstinence by regularly reviewing and making note of your patient's progress;
- Educate patients on both pharmacological and non-pharmacological forms of smoking cessation;
- Ensure confidentiality is maintained;
- Financial incentives for the dental team to offer cessation advice and referrals have been found to be effective;
- Be mindful of the wording of questions when counselling patients to avoid communication/ language barriers – this may require further training;
- Allow multilingual healthcare professionals of a similar ethnic background to lead smoking cessation discussions to help build trust and make patients feel more comfortable;
- Take care with language and avoid stereotyping or discriminating patients – this may require professionals to partake in regular equality and diversity training;
- Include friends and family in the

participant's cessation journey as motivation, if consent is given;
- Encourage Muslim smoking patients to consider quitting when the month of Ramadan is approaching;
- Be mindful of, and open to, discussing the stress experienced by people of ethnic minority backgrounds, which may make quitting difficult (such as migration, racism and financial difficulties);
- Include more images of people from ethnic minority backgrounds on cessation advertisements and posters to encourage relatability and engagement.

These recommendations have been drawn from a general reading of the available literature. It is difficult to determine fully the strength of evidence supporting these, and in some cases, may only represent good practice.

Conclusions

This article has highlighted that members of the dental team offering patients blanket smoking cessation advice and signposting is not sufficient. An in-depth assessment into their reasons for smoking and reasons for not seeking help must be determined to ensure successful encouragement to quit. While this applies in any cross-cultural discussion, white healthcare professionals in particular must be mindful of race-related issues faced among people from ethnic minority backgrounds, and be open to discussing these issues with patients. This would be appropriate during longer appointments to encourage open discussion. In regard to supporting patients after completing smoking cessation counselling, long-term abstinence is ensured through continuous, regular review of patients – this is a well-suited role for the dental team due to the regularity in which patients visit their dental professional.

Compliance with Ethical Standards

Conflict of Interest: The authors declare that they have no conflict of interest.
Informed Consent: Informed consent was obtained from all individual participants included in the article.

References

1. Department of Health and Social Care. Tobacco control plan: delivery plan 2017 to 2022. Available at: www.gov.uk/government/publications/tobacco-control-plan-delivery-plan-2017-to-2022 (accessed October 2022).
2. Goodman J. *Tobacco in History: The Cultures of Dependence*. London: Routledge, 1994. {OK to change ref to book rather than book review?}
3. Office for Health Improvement and Disparities. Smoking and tobacco: applying All Our Health. 2022. Available at: www.gov.uk/government/publications/smoking-and-tobacco-applying-all-our-health/ (accessed December 2022).
3. Office for National Statistics. Smoking habits in the UK and its constituent countries. 2020. Available at: www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlife expectancies/datasets/smokinghabitsin theukanditsconstituentcountries (accessed October 2022).
4. Shah SB, Chestnutt IG, Lewis MA. 'Hubble-bubble leads to trouble' – waterpipe smoking and oral health. *Dent Update* 2013; **40**: 800–804. https://doi.org/10.12968/denu.2013.40.10.800
5. Noor A, Jahan F, Ahmed B, White D. A pilot study to investigate the dental team's awareness and confidence in advising patients with regards to shisha smoking. *Dent Update* 2019; **46**: 654–661.
6. WebMD. How to Quit Smoking. 2021. Available at: www.webmd.com/smoking-cessation/quit-smoking (accessed October 2022).
7. National Institute for Health and Care Excellence. Smoking cessation. 2022. Available at: https://cks.nice.org.uk/topics/smoking-cessation/ (accessed October 2022).
8. Croucher R, Choudhury SR. Tobacco control policy initiatives and UK resident Bangladeshi male smokers: community-based, qualitative study. *Ethn Health* 2007; **12**: 321–337. https://doi.org/10.1080/13557850701300731
9. Begh RA, Aveyard P, Upton P *et al*. Promoting smoking cessation in Pakistani and Bangladeshi men in the UK: pilot cluster randomised controlled trial of trained community outreach workers. *Trials* 2011; **12**: 197. https://doi.org/10.1186/1745-6215-12-197
10. White M, Bush J, Kai J *et al*. Quitting smoking and experience of smoking cessation interventions among UK Bangladeshi and Pakistani adults: the views of community members and health professionals. J Epidemiol Community Health 2006; **60**: 405–411. https://doi.org/10.1136/jech.2005.040345
11. Markham WA, Featherstone K, Taket A *et al*. Smoking amongst UK Bangladeshi adolescents aged 14–15. *Health Educ Res* 2001; **16**: 143–156. https://doi.org/10.1093/her/16.2.143
12. Begh RA, Aveyard P, Upton P *et al*. Experiences of outreach workers in promoting smoking cessation to Bangladeshi and Pakistani men: longitudinal qualitative evaluation. *BMC Public Health* 2011; **11**: 452. https://doi.org/10.1186/1471-2458-11-452
13. Darr A, Astin F, Atkin K. Causal attributions, lifestyle change, and coronary heart disease: illness beliefs of patients of South Asian and European origin living in the United Kingdom. *Heart Lung* 2008; **37**: 91–104. https://doi.org/10.1016/j.hrtlng.2007.03.004
14. Ives SP, Heuschmann PU, Wolfe CD, Redfern J. Patterns of smoking cessation in the first 3 years after stroke: the South London Stroke Register. *Eur J Cardiovasc Prev Rehabil* 2008; **15**: 329–335. https://doi.org/10.1097/HJR.0b013e3282f37a58
15. Bauld L. The impact of smokefree legislation in England: evidence review. 2011. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216319/dh_124959.pdf (accessed November 2022).
16. World Health Organization. Smoking and COVID-19. 2020. Available at: www.who.int/news-room/commentaries/detail/smoking-and-covid-19 (accessed October 2022).
17. Smokefree Action Coalition. Surge in motivation to quit among smokers as doctors warn of worse complications from COVID-19. 2020. Available at: https://smokefreeaction.org.uk/wp-content/uploads/2020/05/200105-YHSFACFINAL.pdf (accessed October 2022).
18. Office for National Statistics. Ethnicity and National Identity in England and Wales: 2011. 2012. Available at: www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityand nationalidentityinenglandandwales/2012-12-11#ethnicity-in-england-and-wales (accessed October 2022).
19. Office for National Statistics. People identifying as 'other white' has increased by over a million since 2001. 2015. Available at: www.ons.gov.uk/peoplepopulationand community/culturalidentity/ethnicity/articles/peopleidentifyingasother whitehasincreasedbyoveramillionsince 2001/2015-06-26 (accessed October 2022).
20. Agency for Healthcare Research and Quality. Five major steps to intervention (the '5 A's'). 2012. Available at: www.ahrq.gov/prevention/guidelines/tobacco/5steps.html (accessed October 2022).