We won the argument. We have been given the room allocated to the administrative officer for the building. But on looking through the plans of various health centres I see that very few, if any, other groups of doctors have been so lucky, unless (which is quite likely) they too have been allocated a room intended as a store or office for some more privileged person, and which has remained as originally labelled on the plans so as not to displease the Department of Health and Social Security.

Another bad feature of plans such as those in Figs. 1 and 4 and our own unrevised plan (Fig. 5) is that some of the consulting suites are much more desirable than others. The doctor occupying the bottom left consulting room in the plan in Fig. 1, for example, might well have to wait twice as long for his patients as those who occupy the rooms at the top of the passage. This can give rise to bad feeling.

Conclusion

The decision to allow local authorities to plan, build, and own the health centres and then to let out rooms in them to general practitioners was political.[4] It placed general practice in a position of inferiority. General practitioners have to ask the local authority for what they want. If central government built and owned the health centres, as it does the hospitals, the position would be reversed, to the obvious advantage of general practice.

General practice tends to attract to it men whose temperament allows them to work more or less anywhere. They pride themselves on not being fussy, and they tend to take little interest in matters of planning. No doubt this is in many respects a virtue. Nevertheless, a properly thought out building, really suited to the work they do, saves both their time and their tempers. The somewhat unimaginative, expandable design (Fig. 8) suggested in the *Design Guide for Medical Group Practice Centres*,[3] which is a centre only for general practice with no local authority services, has many of the faults that I have found with the health centres. We shall get really good buildings for general practice only if criticism is frank and made available to the designers of the future.

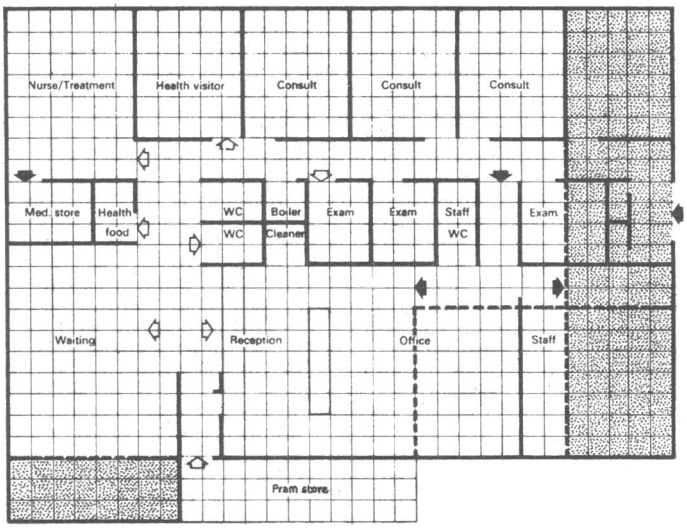

FIG. 8—Unit plan for five to seven doctors. Reproduced by permission of the Royal College of General Practitioners.

References

1 Department of Health and Social Security, *Health Centres—A Design Guide*, 1970. London, H.M.S.O.
2 National Building Agency and College of General Practitioners, *Design Guide for Medical Group Practice Centres*, 1967.
3 The General Practice Advisory Service, *Buildings for General Medical Practice*, 1967. London, H.M.S.O.
4 *National Health Service Act*, 1946. London, H.M.S.O.

Clinical Problems

Cigarette Dependence: II—Doctor's Role in Management*

M. A. H. RUSSELL

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A dependence disorder, once contracted, is as difficult to control in a society as it is to treat in an individual. The fact that cigarette smoking is pursued despite considerable health and financial disincentives points to the strength of the dependence. The Royal College of Physicians has recommended[1] that doctors "should set an example by still greater abstinence from smoking and must take every opportunity to urge their patients not to smoke cigarettes." Many doctors may wish to go further by helping the more dependent smokers among their patients to break the habit, and some may also see a role for themselves in the wider preventive field by assisting in the campaign to curb smoking.

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Natural Discontinuance

Some 18% of smokers become ex-smokers.[2] This so-called natural discontinuance tends to occur after 30 and increases with age, especially after 60. However, the ex-smoker status is unstable. A majority of those who give up smoking do not find it difficult. In 1964 66% of a sample of adult ex-smokers said it was "not difficult at all," 20% found it "fairly difficult," and only 14% found it "very difficult." Surprisingly, as many as 56% of ex-smokers who had relapsed said that stopping had not been difficult at all.[3]

Reasons given for discontinuance fall into six themes.[2] (1) Health is by far the most important motive. Lesser ailments such as cough, sore throat, breathlessness and indigestion influence a smoker more than the more dramatic risk of lung cancer. This is probably because it is usually when the smoker is experiencing one of these ailments that he finally decide to stop. (2) Expense is second only to minor health ailments as a motive for adults to stop smoking. For adolescents it is the prime reason. (3) Social pressure is third in importance. (4) The example of doctors, parents, and teachers who do not wish to lead others into smoking. (5) A wish to master a test of willpower or self-control. (6) A feeling that smoking is nasty and dirty. The last three of these motives are of minor importance.

Value of Medical Advice

The predominance of health as a motive for stopping smoking places the doctor in a favourable position. He is able to advise and influence smokers when they are most susceptible. Furthermore, smokers often stop spontaneously during a brief illness, and all the doctor need do is urge them not to begin again. Of those successful ex-smokers who gave illness as their reason for stopping 54% said they did so on their doctor's advice. But only 20% of smokers report that their doctors have advised them to stop or cut down their smoking.[3] This may be partly because many doctors themselves still smoke, or possibly because they have a feeling of impotence.

An American study[4] showed that firm advice from a physician on a single visit caused a third of the patients to cut down their smoking substantially for at least six months. In one British study[5] 47% of chest clinic patients stopped smoking for at least three months after simple routine advice, while in another British study[6] 23% stopped for six months. These results are as good as those obtained by specialized clinics using all manner of methods over a number of visits.[7 8]

There is therefore reason to expect that simple, firm, unequivocal advice to stop smoking given by a doctor to his patient on a single occasion has as good a chance of being effective as any other currently available antismoking measure.

Case Management

The degree of dependence and the motivation to stop are of key importance in giving up smoking. Both are difficult to assess, yet some attempt to do so is essential if management of the case is to be effective. A smoker of low dependence should require only a moderate amount of motivation to stop in order to succeed, but a highly dependent smoker may be quite unable to stop despite a high degree of motivation. Such a smoker already acknowledges the risks of smoking and further persuasion is superfluous: what he requires is help in overcoming the dependence. Management should therefore begin with an assessment of motivation to stop and the use of persuasion where motivation is lacking. Simple, firm advice is one method of increasing motivation.

Dealing with Motivation

About half of all smokers remain complacent and profess to be happy about their smoking. This they achieve by using face-saving psychological defences such as rationalization and denial. Since health is the first of the reasons for discontinuing smoking doctors are well placed to influence their patients.

To assess the degree of motivation to stop smoking the patient should be questioned to find out at what level his defences are operating, so that persuasion can be focused in that area. The sequence of questions should aim to find out whether the patient (1) is aware of all the health risks and other disadvantages of smoking; (2) accepts the full extent to which these risks apply to himself; (3) accepts (if this be the case) that his health is already affected; (4) accepts the need to stop smoking; (5) accepts that he could stop; and (6) intends to make a firm decision to stop, not merely try to stop.

Support through Withdrawal

Having ensured that motivation is adequate, the doctor's next step is to guide and support the patient through the withdrawal process. There is no really effective drug or psychological treatment that has been shown to have any advantage over simple supportive counselling. But this is no cause for despair, since many smokers have the capacity to stop smoking if they make a determined attempt.

The withdrawal process is basically an exercise in relearning to function efficiently and contentedly without smoking. This entails learning different ways of dealing with many situations as well as adjusting psychologically and in some cases pharmacologically to the loss of a valued object and drug. Yet many smokers, partly because they do not see it as a learning process, lose heart and abandon the attempt in a few days. The aim should be to stop smoking altogether as quickly as possible. Cutting down should never be more than a means to stopping completely. As an end it is useless since it can seldom be maintained. Force of habit, withdrawal symptoms, and stimulus-response sequences (for example, smoking in response to speaking on the telephone or drinking tea) can begin to diminish only when smoking has stopped. Intermittent gratification only strengthens the attachment in dependent cases.

A strategy for giving up smoking should be based on this view of withdrawal as a learning task. It should have two main objectives—firstly to stop smoking completely as soon as possible, so that reinforcement of the old behaviour is removed to allow learning of the new behaviour to proceed; secondly, to persist long enough for the necessary relearning to be achieved. The time required for adequate relearning of a non-smoking mode of living extends well beyond the period of conscious difficulty. The withdrawal process should therefore be regarded as a prolonged task with an early stage that may require considerable conscious effort by the patient and a later stage that is not difficult but which requires vigilance to avoid relapse through carelessness. The essence of good medical support is to seek to maintain motivation and direct it towards these two strategic goals.

There is no space to enumerate the host of tips and aids that are part of the folk-lore of smoking withdrawal clinics. An excellent leaflet on how to give up smoking has been published by the Department of Health and Social Security and should be available for doctors to give to their patients. Advice to think positively of the achievement and rewards of not smoking rather than dwelling on the negative aspects of deprivation, and suggestions to buy specific rewards with the money saved are clearly aimed at maintaining motivation. Gain in weight undermines motivation in many people. They should be reassured that this can be combated later. It may result from metabolic changes as well as increased eating and this too will adjust with time.[9 10] Other recommendations are aimed at helping to overcome the craving and to achieve and maintain cessation. These include reducing the availability of cigarettes, avoiding the company of smokers (which may mean persuading others in the home to stop smoking), avoiding other difficult and tempting situations, the use of oral substitutes, and seeking distraction by keeping occupied. This sort of advice can be more meaningful if some attempt has been made to classify the smoker according to the reinforcers that maintain his smoking. Finally, as with any difficult task, success is more likely if the withdrawal is carefully planned and undertaken when other stresses and distractions are minimal. For most people successful withdrawal requires that it

be given priority over all other activities and interests for two to four weeks, rather than carried on casually alongside more important events.

ANCILLARY MEASURES

In some cases a doctor may wish to employ an additional measure. Three are suggested here.

Tablets.—Proprietary lobeline preparations may be used for their placebo effect, but pharmacologically they are more likely to produce gastric irritation than allay the pangs of withdrawal. An alternative placebo is ascorbic acid.

Stimulus Satiation.—This technique employs the use of forced excessive smoking to satiate the urge to smoke, after which further smoking is unpleasant and eventually aversive. For example, the patient could be instructed to double his smoking four days before and to treble it two days before his withdrawal attempt. The effect should be temporarily to make withdrawal a relief rather than a hardship.[11]

Self Control.—The basis of this method is the elimination of the situational reinforcers of smoking [12 13]. For example, much of the pleasure of smoking while relaxing with a drink after a busy day is from the situation rather than the smoking. The subject is instructed that when he smokes he should leave off what he is doing to sit alone in a cold, unwelcome room, on a hard chair, facing a blank wall. There will then be only a negative contribution from the situation and any pleasure derived must stem from the cigarette alone. A few days of this procedure should greatly diminish the reward of smoking and thereby facilitate withdrawal.

Conclusion

Of all the measures to curb smoking a concerted effort by doctors is one with great but untapped potential. If each of the 20,208 general practitioners in England were to persuade one patient a week to stop smoking the yield would be over one million ex-smokers a year. To equal this it would require 10,000 anti-smoking clinics each having a 33% success rate with 300 subjects a year. It is clearly the minimal duty of doctors firmly to advise their patients to stop cigarette smoking. If more doctors would go further and set an example by stopping themselves so much the better.

References

1 Royal College of Physicians of London, *Smoking and Health Now*, London, Pitman, 1971.
2 Russell, M. A. H., *British Journal of Medical Psychology*, 1971, in press.
3 McKennell, A. C., and Thomas, R. K., *Adults' and Adolescents' Smoking Habits and Attitudes*, Government Social Survey, London, H.M.S.O., 1967.
4 Mausner, J. S., Mausner, B., and Rial, W. Y., *American Journal of Public Health*, 1968, **58**, 46.
5 Burns, B. H., *British Journal of Preventive and Social Medicine*, 1969, **23**, 23.
6 Williams, H. O., *The Practitioner*, 1969, **202**, 672.
7 Berglund, E. L., *A Follow-up Study of Thirteen Norwegian Tobacco Withdrawal Clinics*, Oslo, Norwegian Cancer Society, 1969.
8 Schwartz, J. L., *Public Health Reports*, 1969, **84**, 483.
9 Lincoln, J. E., *Journal of the American Medical Association*, 1969, **210**, 1765.
10 Glauser, S. C., Glauser, E. M., Reidenberg, M. M., Rusy, B. F., and Tallarida, R. J., *Archives of Environmental Health*, 1970, **20**, 377.
11 Resnick, J. H., *Journal of Consulting and Clinical Psychology*, 1968, **32**, 501.
12 Nolan, J. D., *Journal of Consulting and Clinical Psychology*, 1968, **32**, 92.
13 Roberts, A. H., *Psychological Reports*, 1969, **24**, 675.

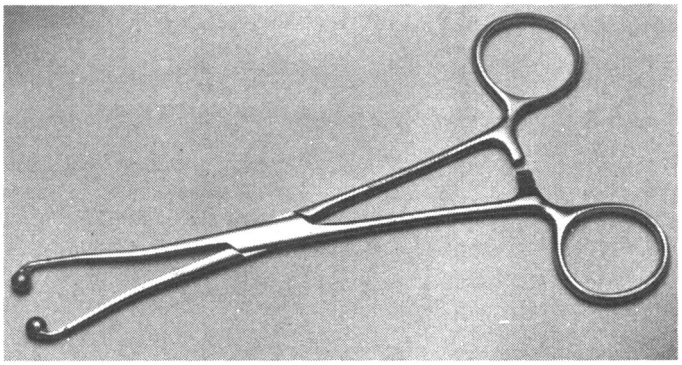
New Appliances

Vasectomy Clamp

Mr. LAURENCE TINCKLER, consultant surgeon, Frenchay Hospital, Bristol, writes: Vasectomy, though not a difficult operation, and regarded as a minor one, may be tedious. The main problem is that it is performed on a very mobile structure, the vas deferens, within another very mobile structure, the scrotum. It is necessary to fix the vas so that it can be cut down on and exposed, identified positively, and divided. The standard manner of achieving this[1] is to palpate the vas through the scrotal coverings, manipulate it into an accessible situation, and hold it at this site between the fingers and thumb while it is exposed. In doing, the vas is apt to slip through the surgeon's fingers and be lost within the scrotum. Another disadvantage of this method of fixing the vas is that the surgeon is left with only one hand free for the rest of the operative manipulations—for incising the scrotal skin, reflecting the coverings of the cord, achieving haemostasis, and locating and picking up the vas. Errors in technique may lead to failure to identify and divide the vas and inadequate haemostasis, with formation of a scrotal haematoma.

The clamp illustrated and described here facilitates vasectomy in that it fixes the vas, thus leaving the surgeon with both hands free to perform the operation with greater ease and accuracy. It is rachet-controlled, with bowed jaws bearing beaded ends (see Fig.).

In carrying out vasectomy with the aid of this clamp the vas is identified by palpation through the scrotal wall and



Vasectomy Clamp

manipulated into a subcutaneous position, where it is secured. It can then readily be cut down on by applying the clamp so that its beads grip the scrotum underneath the vas. The beaded jaws of the clamp grip the scrotum bluntly and are tolerable to a patient undergoing vasectomy under local anaesthesia.

The clamp is available from Down Brothers, Mayer & Phelps Ltd., Church Path, Mitcham, Surrey.

Reference

1 Jackson, P., *et al.*, *British Medical Journal*, 1970, **4**, 295.