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ORIGINAL RESEARCH

How Do Optometrists Approach Directed Questioning on Smoking Status in a Centrally Co-Ordinated, Publicly-Funded National Primary Care Eye Health Service?

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Background: Tobacco use is a leading cause of preventable death worldwide, linked to various health issues, including cancers, cardiovascular diseases, and respiratory illnesses. It also adversely affects ocular health, increasing the risk of conditions like Age-Related Macular Degeneration and cataracts. The socioeconomic burden of smoking in the UK is significant, costing the National Health Service between £2.7 and £5.2 billion annually. Smoking cessation improves health outcomes and reduces healthcare costs. Optometrists are well positioned to identify smoking behaviours and offer cessation advice, yet evidence on current practice in Wales is limited.

Methods: This cross-sectional study used an anonymous online questionnaire to assess smoking-related practice behaviours among optometrists providing National Health Service optometry services in Wales. The survey captured demographic characteristics, training history, current approaches to smoking status identification and cessation advice, confidence levels, and perceived barriers to discussing smoking with patients.

Results: A total of 778 optometrists participated, with 96.3% reporting routine assessment of patients' smoking status. Most respondents felt confident discussing the impact of smoking on health; however, barriers like time constraints and perceived patient reluctance were common. Notably, those with longer professional tenures were more likely to view patient reluctance as a barrier (OR 1.46, 95% CI, 0.026–0.050, $p < 0.001$).

Conclusion: The findings suggest generally positive engagement with smoking cessation among optometrists in Wales, though barriers to patient engagement persist. While training appears to support more proactive practice, further work is needed to understand how optometric interventions influence smoking cessation outcomes and to explore why some practitioners perceive patients as hesitant to discuss health behaviours.

Keywords: smoking, public health, optometry, holistic care, smoking cessation

Introduction

Tobacco use remains a leading cause of preventable death worldwide, contributing to cancers, cardiovascular disease, respiratory illness, impaired immune function, and chronic inflammation.[1–3] The harms extend beyond smokers themselves, with exposure to second-hand smoke producing similar adverse health effects.[2,4,5] Smoking is also a major risk factor for several ocular conditions, including age-related macular degeneration (AMD),[6–9] cataracts,[10,11] and dry eye disease.[3,12]

The socioeconomic burden of smoking is substantial. In the UK, smoking-related illness is estimated to cost the National Health Service (NHS) between £2.7 and £5.2 billion annually, approximately 5% of the NHS budget.[13] Encouragingly, smoking cessation improves health related quality of life,[14,15] and reduces related socioeconomic

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costs.[13] As a result reducing tobacco use through effective cessation support remains a central priority of the global health agenda.[16,17]

Health professionals' input to smoking cessation has been shown to be successful[18–20] they therefore have the potential to play a crucial role in smoking cessation interventions. However, previous research indicates that only a small number of optometrists in the UK have received training in providing smoking cessation support, which results in limited assessment of patients' smoking status and a lack of advice on smoking cessation.[21] This is particularly relevant in Wales, where 3.2 million residents,[22] generate over 800,000 National Health Service (NHS) eye examinations annually.[23] Evidence suggests that patients feel comfortable in having lifestyle conversations, inclusive of smoking status with their optometrist and in fact often expect these conversations to occur.[24] The profession is therefore well placed to identify the smoking status of a patient and provide advice and guidance on smoking cessation.[21]

This role has been formalised through national ophthalmic regulations which came into force in Wales in 2023,[25] which require optometrists to incorporate holistic assessment into NHS eye examinations, including asking all patients aged 16 and over about their smoking status and offering guidance or signposting where appropriate.[25,26] Since the change in ophthalmic regulations, the practice of optometrists in approaching smoking cessation in people accessing NHS eye care in Wales has not been formally evaluated.

The primary aim of this study was to explore optometrist practice in the identification of smoking status and in the provision of subsequent cessation advice. The secondary aim was to explore perceived barriers to asking smoking cessation questions. These findings will further inform training and interventions required to support the optometrists meet their care obligations within the updated regulatory framework.

Methods

This cross-sectional study was administered through an anonymous online questionnaire, which was available for completion from the 21st May 2025 for four weeks. As part of the contractual agreement to perform NHS optometry services, all optometric contractors are required to participate in three "Service Insight" activities a year.[25] This study formed one of the 2024/25 Service Insights.

Inclusion Criteria

All optometrists performing NHS optometry services in Wales were invited to participate in the questionnaire. The exclusion criteria included dispensing opticians and contact lens opticians, as well as optometrists practicing outside of Wales.

Training

This change in service delivery introduced by the ophthalmic regulations in 2023[25] was supported by clinical guidelines[26] and mandatory Making Every Contact Count (MECC) training delivered by Health Education Improvement Wales (HEIW). All optometrists providing WGOS services are required to complete this training.

The training comprised of one online (1 hour) distance learning lecture. The learning objectives are outlined in Figure 1. Comprehension of content was assessed through ten multiple choice questions with a pass mark of 60%.

The online distance learning lecture met the General Optical Council (GOC) UK guidelines on teaching delivery.[27] The content of the training was informed by Public Health Wales Making Every Contact Count learning objectives and was consistent with that provided for other NHS primary care independent contractors, such as dentists and General Practitioners.

The training was delivered free of charge and no monetary incentives or reimbursements for attending were provided. However, successful completion of each aspect of the training programme resulted in the award of Continuing Professional Development (CPD) points, which contribute to professional registration in the UK.

This training is supported by WGOS 1 and 2 clinical manual which outlines the responsibilities of the optometrist in assessing smoking status of patients attending for an eye examination.

1. Recognise your role in supporting people to make healthy choices.
2. Know how to have an effective conversation about healthy lifestyles
3. Understand the key healthy lifestyle messages.
4. Recognise and act on opportunities to have a MECC conversation.

Figure 1 Learning objectives of Making Every Contact Count (MECC) Training.

Development of the Questionnaire

The development of this questionnaire was primarily modelled upon one developed to explore practitioners approaches and behaviours in the identification of depression in people with low vision,[28] and previously used within Wales General Ophthalmic Services.[29] The content of the questionnaire was altered to reflect practice in identification of smoking status and action taken, with the content being informed by similar research in the topic,[21] and through expert input.

The final questionnaire consisted of 6 sections (Part A-G) as outlined in Table 1. Part A captured work demographics, Part B training and resources, Part C a) identification of smoking status b) Action taken, Part D confidence, Part E Barrier and Part G personal demographics. Completion of all sections was mandatory, with the exception of Part G. Parts B, C (b), D and E captured responses on a Likert Scale. Parts A and G captured descriptive data, and Part C (a) was responded to as a binominal Yes/No.

Statistical Analysis

The questionnaire data were analysed using SPSS Version 30 (ibm.com, released 2020). Descriptive statistics were used to describe the background characteristics optometrists (Part A and G) and reported current practice of identification of smoking status (Part B, question 1). Descriptive statistics were used to describe optometrists' views of training and knowledge around smoking cessation (Part B), and action taken (Part C). Categorical variables were summarised as numbers and percentages, continuous variables as medians with interquartile ranges.

A multiple ordinal regression analysis was conducted to ascertain the effects of the following characteristics of optometrists: time since professional registration, primary place of work (Independent practice working with others, Independent practice working on own, Multiple practices working with others, Multiple practices working on own, Hospital, Other), whether additional MECC training had been undergone, and the area in which the optometrist worked

Table 1 Description of the Final Questionnaire Administered

Part A	Work Demographics	8-items
Part B	Smoking cessation training and resources	8-items (Likert scale, strongly disagree, disagree, agree, strongly disagree)
Part C	a. Do you aim to identify whether someone smokes	Yes/No
	a. Action taken with positive smoking status	13-items (Likert scale, never/rarely, sometimes, often)
Part D	Confidence in identification of smoking status	8-items (Likert scale, strongly disagree, disagree, agree, strongly disagree)
Part E	Barriers to identification of smoking status	11-items (Likert scale, strongly disagree, disagree, agree, strongly disagree)
Part G	Personal demographics (Age, gender, ethnicity, area of work	5-items

Notes: The questionnaire consisted of 6 sections (A-G), Part A captured work demographics, Part B training and resources, Part C a) identification of smoking status b) Action taken, Part D confidence, Part E Barrier and Part G personal demographics. Completion of all sections was mandatory, with the exception of Part G. Parts B, C (b), D and E captured responses on a Likert Scale. Parts A and G captured descriptive data, and Part C (a) was responded to as a binominal Yes/No.

(Prefer not to say, Urban, Rural, Mixed) on the perceived likelihood of patients being reluctant to talk about smoking, ("Patients" reluctance to discuss their health behaviors makes it difficult to identify whether they "smoke") as indicated by their responses on a four-point Likert scale (0 = strongly agree, 1 = somewhat agree, 2 = somewhat disagree, 3 = strongly disagree).

PPi

Patients and public were involved in the design of the study via the Wales Vision Forum. The group consists of members who have lived experience of VI. The study concept was explained, and their opinion was sought on the remit, aims and inclusion and exclusion criteria.

Results of the study will be shared with the optometry profession in Wales, the Eye Care Wales Committee, the Wales Vision Forum and Wales Council for the Blind for dissemination to their members.

Ethics

Ethical approval was gained from Health and Care Research Wales IRAS 349825. The study was sponsored by Velindre University NHS Trust ref 2024VCC0038.

Results

Demographics

A total of 778 optometrists responded to the online questionnaire, there are 1086 optometrists listed to provide NHS services in Wales, therefore representing a 72% response rate. Table 2 summarises the professional (Part A) and personal (Part G) background characteristics of the participants.

Table 2 Summary of Professional (Part A) and Personal (Part G) Background Characteristics

PART A Professional background characteristics		
Characteristic/Score		N=778
Primary place of work, n (%)	Independent practice working with others	232 (29.82)
	Independent practice working on own	99 (12.72)
	Multiple practice working with others	355 (45.63)
	Multiple practice working on own	46 (5.91)
	Hospital	10 (1.29)
	Other	36 (4.63)
Type of assessments, n (%)	Practice based	727 (93.44)
	Mobile	26 (3.34)
	A mixture of both	25 (3.21)
Time since professional registration (years) Median (IQR)		16 (20)
Average number of WGOS1 examinations performed each month, Median (IQR)		100 (130)

(*Continued*)

Table 2 (Continued).

Average time spent performing a WGOS1 examination (minutes)	Less than 10	12 (1.54)
	11-20	40 (5.14)
	21-30	426 (54.76)
	31-40	223 (28.66)
	41-50	55 (7.07)
	51-60	13 (1.67)
	More than 60	9 (1.16)
Additional training related to smoking cessation or MECC, n (%)	Yes	184 (23.65)
	No	594 (76.35)
PART B Personal background demographics		
Age (years), n (%)	16-24	52 (6.68)
	25-34	224 (28.79)
	35-44	183 (23.52)
	45-54	165 (21.21)
	55-64	88 (11.31)
	65-74	24 (3.08)
	75+	1 (0.13)
	Missing data	41 (5.27)
Gender, n (%)	Male	271 (24.83)
	Female	442 (56.81)
	Other	1 (0.13)
	Missing data	64 (8.23)
Area worked, n (%)	Urban	246 (31.62)
	Rural	168 (21.59)
	Mixed	290 (37.28)
	Missing data	74 (9.51)

Training and Resources

The majority of respondents (83.1%, n=647) considered themselves to be adequately trained to advise their patients on smoking cessation, to have sufficient knowledge regarding the relationship between smoking and eye disease (97.7%, n=760), and the relationship between smoking and general health (93.7%, n=729). The MECC training was considered to be adequate by 83.2%, (n=647), with 28.9% (n=225), respondents wishing to revisit the training. 72.2% (n=562), felt that adequate resources had been made available to assist in them talking about smoking cessation with patients. (Table 3, Figure 2).

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Table 3 Summary of Responses to Part B of the Questionnaire "Smoking Cessation within WGOS 1 Eye Examination Training and Resources"

	% (n)			
	Strongly Agree	**Agree**	**Disagree**	**Strongly disagree**
I am adequately trained to advise my patients on smoking cessation	15.9 (124)	67.2 (523)	14.9 (116)	1.9 (15)
I have sufficient knowledge about the relationship between smoking and eye disease	41.0 (319)	56.7 (441)	1.30 (10)	1.0 (8)
I have sufficient knowledge about the relationship between smoking and general health	29.7 (231)	64.0 (498)	5.40 (42)	0.9 (7)
Adequate resources have been made available to assist me in talking about smoking cessation with patients	15.6 (121)	56.7 (441)	23.9 (186)	3.8 (30)
The mandatory MECC training was sufficient to enable me to discuss smoking and smoking cessation with my patients	15.7 (122)	67.5 (525)	14.4 (112)	2.4 (19)
I feel I need to revisit the mandatory MECC training	1.93 (15)	27.0 (210)	57.2 (445)	13.9 (108)
I feel more advanced training with regards to smoking and smoking cessation is required	5.14 (40)	35.7 (278)	47.4 (359)	11.7 (91)

Current Practice Around Identifying and Responding to Smoking Status

Overall, 96.3% (n=749) of respondents reported that when performing a WGOS 1 eye examination on someone aged 16 or over, they aimed to identify the smoking status of that patient.

Once a positive smoking status was identified, respondents were most likely to advise on the link between smoking and eye health, assess patient motivation to stop smoking, provide the patient with written or online resources and advise the patient to gradually reduce smoking. Respondents were least likely to advise the patient to convert to an alternative form (eg vape), discuss smoking cessation with family members, refer the patient to the GP, or follow up whether the patient had successfully stopped smoking following the eye examination. (Table 4 and Figure 3).

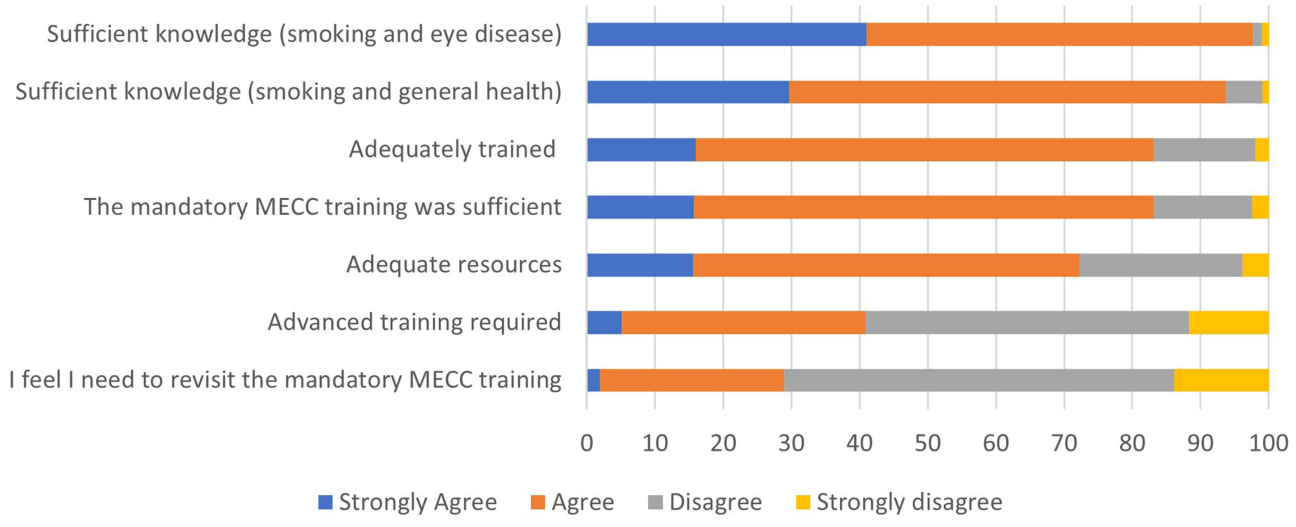

Figure 2 Schematic representation of responses to Part B of the questionnaire "Smoking cessation within WGOS 1 eye examination training and resources".

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Table 4 Summary of Responses to Part C of the Questionnaire "Current Practice"

	% (n)		
	Never/ Rarely	**Sometimes**	**Often**
Assess the patient motivation to stop smoking	7.3 (67)	36.2 (282)	56.4 (439)
Advise of the harmful effects of smoking on general health (eg lung cancer)	17.4 (135)	43.8 (341)	38.8 (302)
Advise of the link between smoking and eye health	1.8 (14)	20.2 (157)	78.0 (607)
Advise patients to completely stop smoking	19.3 (150)	45.4 (353)	35.3 (275)
Advise patients to cut down or gradually reduce smoking	11.3 (88)	45.8 (356)	42.9 (334)
Advise to convert to an alternative eg vaping	65.2 (507)	26.3 (205)	8.5 (66)
Advise patients on the use of stop smoking medications	48.2 (375)	38.6 (300)	13.2 (103)
Provide the patient with written or online resources about smoking cessation support options	14.0 (109)	41.6 (324)	44.3 (345)
Discuss with family members if possible	70.8 (551)	24.3 (189)	4.9 (38)
Provide a referral to a self-help or support group	46.4 (361)	38.7 (301)	14.9 (116)
Refer the patient to their GP	72.4 (563)	23.5 (183)	4.1 (32)
Followed up or assessed whether the patient successfully quit	84.7 (659)	2.2 (17)	13.1 (102)

Confidence in Identification of Whether Patients Smoke as Part of the WGOS1 Eye Examination

Respondents confidence was highest in asking patients whether they smoke, in providing education on the impact of smoking and eye health, and in listening to patients talk about their smoking habits. Respondents confidence was lowest in discussion smoking cessation with the patients family, and providing education around strategies for smoking cessation, and providing educaitnion on smoking and general health. (Table 5, Figure 4).

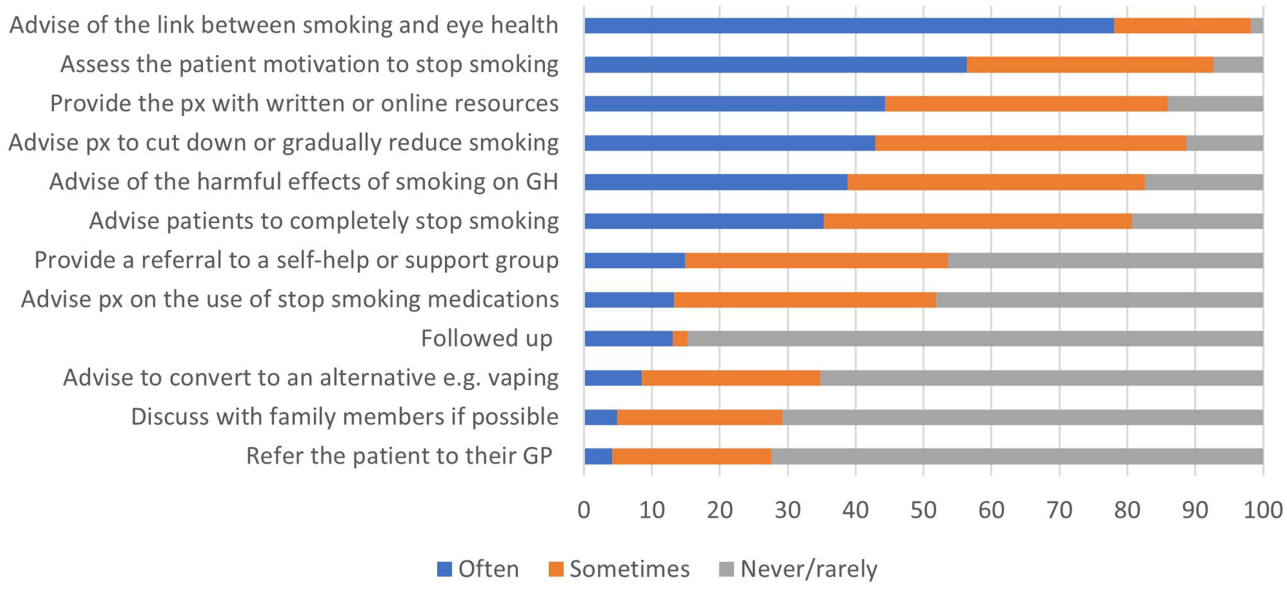

Figure 3 Schematic representation of responses to Part C of the questionnaire "Current practice".

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Table 5 Summary of Responses to Part D of the Questionnaire "Confidence in Identification of Whether Patients Smoke as Part of the WGOS1 Eye Examination"

	% (n)			
	Not confident	**Slightly confident**	**Mostly confident**	**Very confident**
In asking patients whether they smoke I feel	3.6 (28)	14.0 (109)	40.7 (317)	41.6 (324)
In listening to patients talk about their smoking habits I feel….	4.6 (36)	17.6 (137)	52.1 (405)	25.7 (200)
In discussing smoking behaviours and their impact with a patient's family members, I feel …	31.5 (245)	29.0 (226)	31.0 (241)	8.5 (66)
In providing education on the impact of smoking on eye health I feel…	2.7 (21)	18.9 (147)	48.1 (374)	30.3 (236)
In providing education on the impact of smoking on general health I feel…	8.2 (64)	27.4 (213)	47.2 (367)	17.2 (134)
In providing education on possible management strategies for smoking cessation I feel …	18.5 (114)	35.7 (278)	36.4 (283)	9.4 (73)
In directing a patient who smokes to smoking cessation services or agencies, I feel …	7.5 (58)	24.9 (194)	44.1 (343)	23.5 (183)

Over half of respondents (52%, n= 404) felt that optometrists are ideally placed to discuss smoking cessation with patients.

Barriers to Performing Directed Smoking Questions as Part of the WGOS1 Eye Examination

The two main barriers to performing directed smoking questions were a perceived patient reluctance to discuss health beahiours (60%, n=467) and time available (59%, n=459). (Table 6, Figure 5).

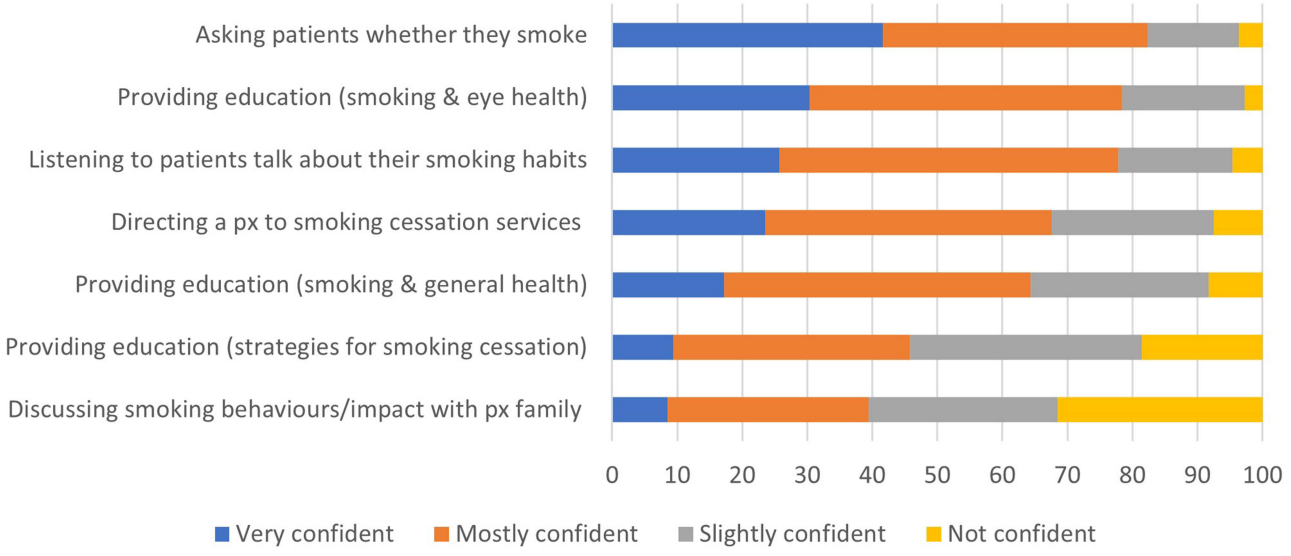

Figure 4 Schematic representation of responses to Part D of the questionnaire "Confidence in identification of whether patients smoke as part of the WGOS1 eye examination".

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Table 6 Summary of Response to Part E of the Questionnaire "Barriers"

	% (n)	
	Agree	**Disagree**
I do not have enough time to talk with patients regarding their smoking behaviours	59.0 (459)	41.0 (319)
My high workload makes it difficult to know if a patient may smoke	27.4 (213)	72.6 (565)
The absence of standard procedures to follow in my workplace when I identify that a patient smokes means they may not always receive the best management	35.1 (273)	64.9 (505)
Smoking is not addressed because the environment in which I work is not suitable for private discussions about well-being.	11.2 (87)	88.8 (691)
Family members attending the consultation means it is difficult to have an open discussion about smoking with the patient.	37.0 (288)	63.0 (490)
Patients' reluctance to discuss their health behaviours makes it difficult to identify whether they smoke.	60.0 (467)	40.0 (311)
Smoking habits are not explored because I need to protect myself from being involved with patients' wider health needs.	15.9 (124)	84.1 (654)
My limited knowledge of smoking means that patients may not always receive the best management for smoking cessation.	26.7 (208)	73.3 (570)
Language and/or cultural barriers make it difficult to discuss smoking with patients.	24.4 (190)	75.6 (588)
My supervisor/team leader/contractor does not believe that identifying whether a patient smoke is part of my role at work.	7.5 (58)	92.5 (720)

Perceived Patient Reluctance to Discuss Health Behaviours

Multiple ordinal regression analysis was conducted to ascertain the effects of time since professional registration, primary place of work, additional MECC training and area of work on the perceived likelihood of patients being reluctant to talk about smoking.

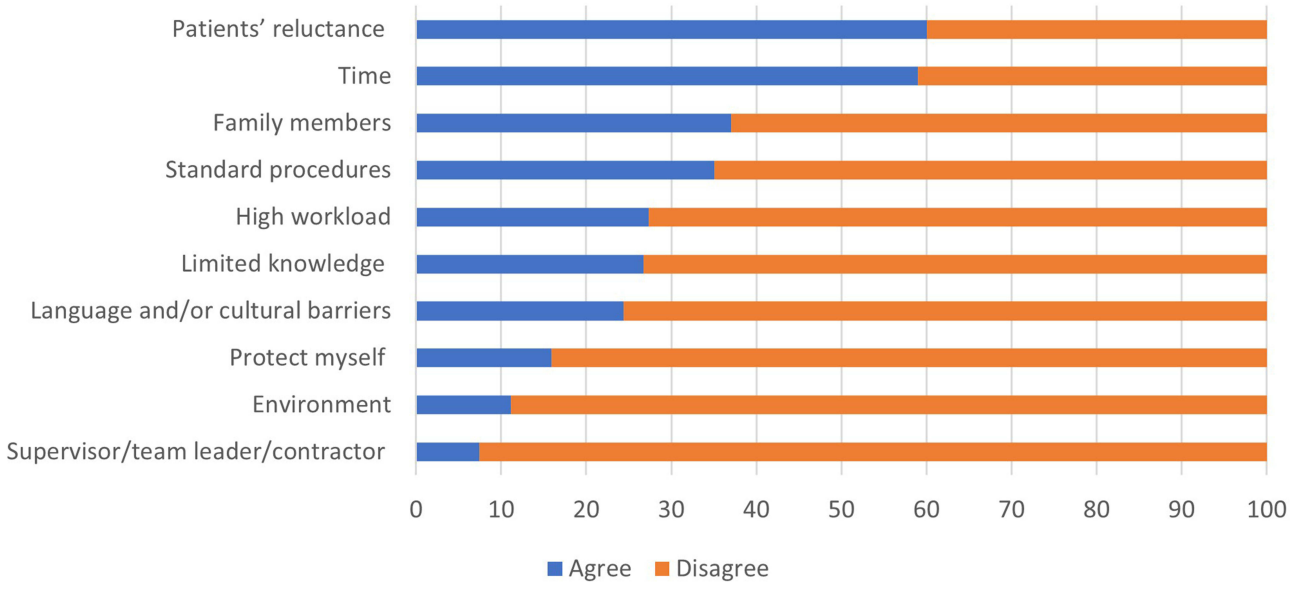

Figure 5 Schematic representation of responses to Part E "Barriers".

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Table 7 Results of Multiple Ordinal Regression Analysis

Variable		Estimate (Co-efficient B)	SE	Wald	*df*	OR	Significance	95% CI (Lower, Upper)
Years since GOC registration		0.038	0.006	39.370	1	1.038	<0.001	(0.026, 0.050)
Additional specific training	Yes	0.049	0.168	0.085	1	1.050	0.771	(−0.280, 0.377)
	No	0[a]			0			
Area worked	Urban	0.611	0.366	2.793	1	1.840	0.095	(−0.106, 1.328)
	Rural	0.296	0.375	0.622	1	1.344	0.430	(−0.440, 1.032)
	Mixed	0.550	0.362	2.311	1	1.733	0.128	(−0.159, 1.259)
Primary place of work	Multiple practice with others	−0.037	0.338	0.012	1	0.964	0.912	(−0.700, 0.626)
	Multiple practice on own	−0.897	0.447	4.021	1	0.406	0.045	(−1.774, −0.020)
	Independent practice with others	−0.132	0.346	0.145	1	0.877	0.703	(−0.809. 0.546)
	Independent practice on own	0.246	0.380	0.421	1	1.279	0.516	(−0.498, 0.990)
	Hospital	−0.111	0.778	0.020	1	0.895	0.886	(−1.635, 1.413)

Notes: Multiple ordinal regression analysis was performed to determine the relationship between years since GOS registration, additional specific training, area worked and primary place of work and "Patients" reluctance to discuss their health behaviours makes it difficult to identify whether they "smoke".
Abbriviations: SE, standard error; dr, degrees of freedom; OR, odds ratio; CI, confidence interval.

The model explained 89% (Nagelkerke R^2) of the variance and results of the test of parallel lines were non-significant x^2 (20) = 13.932, p=0.834, suggesting the assumption of parallel lines was met.

Time since professional registration was a significant predictor of perceiving patient reluctance as a barrier (OR = 1.46, 95% CI for the log-odds coefficient = 0.026–0.050, Wald $\chi^2(1) = 39.370$, p <0.001). This odds ratio indicates that optometrists who have been registered longer have 46% higher odds of perceiving patient reluctance to discuss health behaviours as a barrier to identifying and discussing smoking status. In contrast, working in a multiple-practice setting was associated with lower odds of perceiving patient reluctance as a barrier (OR = 0.406, 95% CI for the log-odds coefficient = –1.774 to –0.020, Wald $\chi^2(1) = 4.02$, p =0.045). This suggests that optometrists working across multiple practices have 59.4% lower odds of viewing patient reluctance as a significant barrier. (Table 7).

Whether optometrists had received additional specific training and area in which they worked was not significantly related to the identification of perceived patient reluctance as a barrier to identification of smoking status.

Discussion

Key Findings

This study examines the practices of optometrists in Wales regarding the identification of patients' smoking status during NHS eye examinations, following the implementation of nationwide mandatory training and updated service delivery guidelines. These guidelines mandate that optometrists ask all patients aged 16 and over about their smoking status and, if a patient is identified as a smoker, provide appropriate advice and referrals for smoking cessation.[26]

Previous UK based research of optometrists[21] revealed that only 35.2% of them routinely asked new patients about their smoking status, and a mere 29% offered cessation advice when a positive smoking status was identified.[21] These low figures are not surprising, given the limited training on smoking cessation available to optometrists and the lack of

profession-specific guidelines on this practice. These findings align with similar studies conducted in other parts of the world regarding optometrists' roles in identifying and managing smoking status.[30–32]

Our findings indicate a significant shift in practice in Wales, with almost all optometrists (96.3%) now routinely assessing smoking status, representing a marked improvement compared with earlier UK data. However, simply identifying smoking status is insufficient for promoting cessation, providing smoking cessation advice has been shown to increase both the likelihood of quit attempts[33] and overall cessation rates.[34] Encouragingly, after identifying a positive smoking status, optometrists took proactive measures, including advising patients on the link between smoking and eye health, assessing their motivation to quit, and supplying written resources or online information. Notably, optometrists expressed confidence in delivering this support, contrasting with previous studies in which optometrists reported limited confidence and knowledge.[35,36]

The analysis of perceived barriers highlighted two main challenges: time constraints and concerns about patient reluctance to discuss health behaviours. Interestingly, optometrists with longer tenure were more likely to perceive patient reluctance as a barrier. Time constraints have previously been identified as a barrier to providing holistic care,[37] but this may diminish as health-behaviour discussions become more embedded in routine practice and as training increasingly emphasises whole-person care.

Although some optometrists perceived patient reluctance as a barrier, existing evidence suggests that patients are generally comfortable discussing lifestyle issues, including smoking, with their optometrist and often expect such conversations.[24] Research in other areas of holistic care, such as depression screening,[37] also shows that perceived patient reluctance tends to decrease as new pathways become normalised within practice.[37]

This evolving dynamic suggests that as optometrists integrate holistic care practices into their routines, both optometrists and patients may benefit from improved communication about health behaviours.

These findings suggest that the introduction of mandatory training and clear service guidance has supported a meaningful shift in optometric practice in Wales. Strengthening ongoing training, embedding structured prompts within clinical systems, and ensuring adequate appointment time may further enhance the consistency and quality of smoking-related discussions. At a service-development level, integrating smoking-cessation pathways more explicitly into routine optometric workflows could help sustain these improvements and reduce variation between optometrists.

Strengths and Limitations

A notable strength of this study is its high response rate, achieved by administering the survey as part of the contractual obligations for primary care optometry, thereby mitigating the self-selection bias typically associated with survey data collection. Nevertheless, research indicates that health professionals may be particularly prone to response bias, wherein they may provide socially desirable answers instead of their genuine opinions or behaviours, potentially distorting the data.[38] It is likely therefore that the results indicate a "best case scenario".

It is essential to acknowledge the limitations inherent in relying solely on quantitative data collection. Although this approach facilitates a broad reach, the data generated often lacks depth. Employing a mixed-methods study design or conducting follow-up qualitative research on optometrists' practices in identifying smoking status and subsequent management would provide a more comprehensive understanding of these practices.

Conclusion

Optometrists are more likely to actively assess a patient's smoking status and provide smoking cessation advice after participating in a brief online training program and when guided by clinical guidelines and protocols. While this practice contributes to addressing smoking as a significant public health concern, future research should evaluate the impact of optometric interventions on the likelihood of patients quitting smoking and explore, from both the optometrist's and the patient's perspectives, the enduring belief that patients are reluctant to discuss health behaviours with their optometrists.

The insights gained from this study can be integrated into standard practice by optometrists and other healthcare professionals in various countries and can be used to inform the implementation of other holistic healthcare practices within the field of optometry.

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