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Smoking Cessation Education Needs as Reported by Current Smokers, Former Smokers, and Nurses

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SMOKING CESSATION EDUCATION NEEDS AS REPORTED BY CURRENT SMOKERS,
FORMER SMOKERS, AND NURSES

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Abstract

Purpose: The purpose of this study was to determine if there is a difference in the importance of selected smoking cessation information to current smokers, former smokers, and nurses in the Appalachian population. There were no instruments found in the literature to assess the perceptions of educational content for smoking cessation, therefore, a Smoking Cessation Education (SCE) survey was developed to measure the perceptions. The conceptual framework for this study was based on the Health Belief Model developed by psychologists Drs. Godfrey M. Hochbaum, S. Stephen Kegeles, Howard Leventhal, and Irwin M. Rosenstock..

Design: The SCE is a ten question survey scored using a five point Likert type scale. Data for the survey was collected within the month of March 2004.

Method: Data was collected from twenty three current smokers, twenty former smokers, and twenty nurses from a major medical center in southern West Virginia. Each subject received the Smoking Cessation Education survey, as well as written instructions on how to complete the instrument, a demographic form, and a consent form.

Findings: The results of this study found the topic of health risks to children with the highest percentage of very important responses among all three groups (91%, n=57). Ninety percent of nurses (n=18) rated risks of smoking and health risks to children of smokers as very important. Ninety five percent of former smokers (n=19) and eighty seven percent of current smokers (n=20) also rated health risks to children of smokers as very important.

Conclusion: This study indicated the topic of health risks to children of smokers as a very important educational topic for nurses and other health care providers to influence smoking cessation. Continuing research is needed to discover and assess other methods for smoking cessation.

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Chapter One

Introduction

One of the most important aspects of nursing is teaching the patients ways to promote a healthy lifestyle. Additionally, tobacco dependence is the leading preventable cause of death in the United States, yet healthcare professionals are not adequately educated on how to help patients break the deadly cycle (Heath, Andrews, Thomas, Kelley, & Friedman, 2002). In fact, “tobacco-related illness cost West Virginia \$656 million every year, and every West Virginian, including those who have never smoked pay \$363 each year for the healthcare costs of tobacco-related illness” (West Virginia Bureau for Public Health, n.d.). As tobacco use continues to cause illness, disability, and death at unprecedented rates, health care professionals will continue to seek ways to help patients break their smoking habit. The purpose of this study will be to determine if there is a difference in the importance of selected smoking cessation information to current smokers, former smokers, and nurses in the Appalachian culture.

Background

There is ample evidence that smoking is linked to ill health, yet many choose to ignore experts’ advice. The heightened attention to smoking and lung cancer has drawn interest among health care providers to seek ways to help patients quit smoking. In fact, the West Virginia State Medical Association (WVSMA), whose main purpose is to promote public health, initiated a number of activities related to reducing tobacco use in the state (Matheny, 2001, p.60).

Traditionally, though, health care providers transmit information about the effects of smoking by saying, “ ‘You should stop smoking because it’s bad for you.’ But that doesn’t really help very many people” (Yoffee, 2002). According to Lancaster, et. Al “The Cochrane review found that brief advice increased the quit rate [and] more intensive advice was slightly more effective.

Nurses providing individual counseling were also effective” (Lancaster, et al, 2000). However, there is very little information available about what current smokers, and what former smokers perceive as important educational topics for smoking cessation. The individual’s perceptions about what are important educational topics may influence a nurse’s ability to assist a person to quit smoking.

Significance

Smoking as an important factor in the production of lung cancer has been confirmed by multiple studies. Smoking has also been linked with heart disease, bronchitis, and other lung diseases. It is estimated that “current cigarette smoking will cause about 450 million deaths worldwide in the next 50 years. Reducing current smoking by 50% would avoid 20-30 million premature deaths in the first quarter of the century and about 150 million in the second quarter (Lancaster, 2000).

It is alarming to know the statistics related to smoking in the Appalachian culture. According to Scaring (2001), “West Virginia is still rated NUMBER ONE in the number of youth using tobacco, the number of adults using smokeless tobacco, and the number of people who wear false teeth, which is a direct result of their tobacco use”

Nurses have many opportunities to implement interventions for smoking cessation. According to the Journal of Advanced Nursing, nurses want to play a key role in smoking cessation programs but are not currently doing so because they need additional support in helping smokers to quit. The journal also states that ninety-nine percent of respiratory nurses responding to [a] survey want to be involved in an organized smoking cessation program however . . . over half [of the surveyed] stated they need more information and training (Journal of Advanced Nursing, 2000). Training and education are key components for a nurse to be an

effective counselor about smoking cessation. Without adequate guidance and knowledge, a nurse can find himself or herself unprepared to deal with the patient's needs. Therefore, nurses need information about what smokers believe they should learn in order to design effective educational interventions. Nurses should also learn about what interventions, which were made by health care providers, helped former smokers decide to stop smoking. Once nurses recognize what smokers and former smokers believe is important to learn, then appropriate actions can be formulated. Understanding and realizing the patient's needs and interest are effective tools for a nurse to utilize to promote behavioral change.

Problem Statement

Smoking is a preventable cause of illness and death, yet many revolt against science or fall under the power of tobacco's addictive properties. Many researchers theorize about what are successful approaches for nurses who want to help patients quit smoking, but little information is known about what patients believe are important educational approaches. The perceptions of current smokers, former smokers, and nurses may affect the effectiveness of the educational content providers teach to influence smoking cessation.

Theoretical Framework

The Health Belief Model (HBM) was introduced in the 1950s by psychologists Drs. Godfrey M. Hochbaum, S. Stephen Kegeles, Howard Leventhal, and Irwin M. Rosenstock. Originally, the HBM was developed to explain human behaviors in regards to health. Its focus was to predict what a person would do about health related issues, and to increase the use of preventive services. Rosenstock states that "the earliest characteristics of the Model . . . were that in order for an individual to take action to avoid a disease he would need to believe (1) that he was personally *susceptible* to it, (2) that the occurrence of the disease would have at least

moderate *severity* on some component of his life, and (3) that taking a particular action would in fact be *beneficial* by reducing his susceptibility to the condition or, if the disease occurred, by reducing its severity, and that it would not entail overcoming important psychological barriers such as cost, convenience, pain, embarrassment” (Rosenstock, 1974, 3). The model’s target seemed to be any individual effected by a health condition.

Concepts of the theory include perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action. Under the perceived susceptibility concept, individuals believed they were susceptible to a health related condition. Rosenstock stated that individuals were believed to vary widely in their acceptance of personal susceptibility to a condition (Rosenstock, 1974,3). At one end, an individual could deny any possibility for contracting a condition. At the other end, an individual could believe that he or she is in danger of the condition. In a neutral position, one believed that he or she has the possibility of developing a condition, but feel that the possibility is not likely to occur.

The perceived severity concept involve a person’s opinion of the degree of seriousness that a health condition poses. Rosenstock states that the degree of seriousness may be judged both by the degree of emotional arousal created by the thought of a disease as well as by the kinds of difficulties the individual believes a given health condition will create for him (Rosenstock, 1974, 3). An individual might be concerned with thoughts of a disease causing death or reducing physical or mental capabilities. Another individual might perceive a condition’s seriousness by looking at how it would effect his or her job, family, lifestyle, or finances.

The perceived benefits and perceived barriers concepts tie in with each other because “an individual may believe that a given action will be effective in reducing the threat of disease, but

at the same time see that action itself as being inconvenient, expensive, unpleasant, painful or upsetting” (Becker, 1974,4). This type of conflict was seen as more difficult to resolve because even though one may be highly motivated to decrease the impact of a perceived health condition, he or she can also fear or be unwilling to go through actions that might be painful or unpleasant.

Rosenstock (1974, 5) described the cues to action concept as “a trigger.” He states that “the combined levels of susceptibility and severity provided the energy or force to act and the perception of benefits (less barriers) provided a preferred path of action” (Becker, 1974, 5). Forms of cues can vary from prevention posters to health screenings. The cues aim to trigger one’s action towards preventive behavior.

Two studies utilized the Health Belief Model (HMB) to assess individual’s perceptions about smoking. One study assessed low socioeconomic adults’ perceptions of lung cancer and smoking (Price, 1994, 361). The other study wanted to identify tobacco use, assess employee’s beliefs on one’s health and family member’s health, and assess the type of smoking policies favored (Mikan, 1999, 439). Both studies addressed the concepts of the HBM.

It will be helpful to utilize the concepts of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action when assessing individuals’ perception about important educational topics for smoking cessation. The focus of the HBM to increase preventive services match the goal for the proposed study. By assessing an individual’s perception about smoking cessation topics, it will guide a health care provider’s approach to discussions about smoking cessation, and hopefully prevent the impending dangers that smoking causes.

Specific Aims

This study will seek to accomplish the following objectives: 1) to determine if there is a difference in the importance of selected smoking cessation information to current smokers, former smokers, and nurses in the Appalachian population, and 2) to use the findings to develop recommendations for topics that nurses and other health care providers can teach to their patients to help them quit smoking.

Operational Definitions

The purpose of this study will be to determine if there is a difference in the importance of selected smoking cessation information to current smokers, former smokers, and nurses. This study will help to measure an individual's perceived severity of smoking, as well as the perceived benefits of smoking cessation, as described by the HBM. The key concept is perception of important educational topics of smoking cessation. The concept is defined by the responses current smokers, former smokers, and nurses have to questions on a questionnaire. A current smoker will be defined as an adult between ages 18 and 60 who currently uses cigarettes. A former smoker will be defined as an adult between ages 18 and 60 who no longer uses cigarettes. Nurses will be defined as registered or licensed nurses employed at least 20 hours per week in a medical department for more than 3 months.

Chapter Two

Literature Review

The purpose of the first study reviewed was to describe the current status of primary care nurse practitioners in the performance of smoking cessation counseling (SCC). This was a descriptive study targeting nurse practitioners practicing adult primary care. Surveys were mailed to a convenience sample of members of the Nurse Practitioner Association of Southwest Pennsylvania (NPASP) (Neely, n.d.). The questionnaire used in this research reflects the recommended interventions for physicians (Neely, n.d.). The questionnaire was five pages and consisted of 37 questions mirroring the NCI guidelines for smoking cessation counseling. The survey asked the NP to respond “yes” or “no” to whether they consistently performed the described practices (Neely, n.d.). Included was a space at the end of each SCC concept section for self reporting of additional questions, practices, and comments (Neely, n.d.). Neely stated that one limitation of the instrument was lack of established reliability and validity. She said that no research was found that established stability, equivalence, or homogeneity of the proposed instrument or similar instruments (Neely, n.d.). Data were analyzed by the researcher (Neely, n.d.). Descriptive statistics were utilized to organize and present the results of the survey (Neely, n.d.). Analysis included calculating the frequency and percentage of the yes and no response to each question (Neely, n.d.).

There were 144 practitioners surveyed, and 29 questionnaires were usable for the study and met the criteria for inclusion of the study. Results were analyzed by evaluating the results of the “yes/no” responses to the questions and their sub-components as they correlated to the SCC concepts ASK, ADVISE, ASSIST, and ARRANGE FOLLOW UP (Neely, n.d.). For the concept ASK, 93% of NPs established smoking status at every contact. Only 86% reported asking if the

individual [was] interested in stopping smoking now (Neely, n.d.). NPs surveyed reported the most frequent performance of SCC interventions in the ADVISE category. Positive responses ranged from 93% -24% with a mean of 75% (Neely, n.d.). The study response indicated a mean of 62% for performance of ASSIST interventions (Neely, n.d.). ARRANGE FOLLOW-UP was the least performed concept with a reported average of 45% overall performance (Neely, n.d.). No p value was indicated in the study. According to Neely, there appeared to be a trend that NPs practicing in primary care settings in southwestern PA are not practicing all the NCI suggested interventions for SCC in sufficient numbers to be approaching the “Health People 2000” goal for the year 2000 (Neely, n.d.).

A limitation of the study [was] the self-reporting without verification format (Neely, n.d.). Neely stated that respondents indicated a factor that increased negative responses in the survey was the “every opportunity” portion of the ask questions. A respondent could practice the behavior 99% of the time yet answer “no” because of a few instances (Neely, n.d.).

Neely stated it would be beneficial to continue study of the smoking cessation counseling practices of nurse practitioners. She also stated that the survey in this study is not recommended for use in its present form for further research. She suggested that changes in the response area would be beneficial because several respondents stated that there was difficulty answering yes/no questions.

This article supported the study of smokers, former smokers, and nurses’ perceptions about topics of smoking cessation because it demonstrates the need for health care providers to have insight about smoking cessation education. Addressing the perceptions that people have about topics for smoking cessation will help a health care provider advise his or her patient about how to quit smoking.

The purpose of the second study was to describe how nurse's education, working experience and their own smoking habits relate to their self-reported competence in advising and supporting clients to cease smoking (Pelkonen & Kankkunen, 2001). A questionnaire was sent to 1000 members of the Finnish Federations of Nurses and to 235 members of the Finish Union of Public Health Nurses at the end of 1998 (Pelkonen & Kankkunen, 2001). Members were selected by random sampling (Pelkonen & Kankkunen, 2001). The questionnaires were sent to nurses' home addresses (Pelkonen & Kankkunen, 2001). The questionnaire included items measuring self-reported competence in giving advice and support to clients in smoking cessation; Likert scales were used for the responses (Pelkonen & Kankkunen, 2001). The variables were: (i) identifying motivation; (ii) encouragement; (iii) own belief in giving advice and support; (iv) ability to create a trustful atmosphere; (v) knowledge of cessation centers; (vi) knowledge of substitutes; and (vii) knowledge of immediate positive consequences after cessation (Pelkonen & Kankkunen, 2001). Age, marital status, educational background, health status and smoking habits were used as background variables (Pelkonen & Kankkunen, 2001). No discussion was noted in the article about the reliability and validity of research instruments.

Pelkonen & Kankkunen stated that the frequencies, means and modes were used to describe the data. The variables measuring competence were reduced by using Varimax-rotated factor analysis (Pelkonen & Kankkunen, 2001). The factors were named as skills factors (variables i-iv) and knowledge factors (variables v-vii) (Pelkonen & Kankkunen, 2001). A t-test was used to compare differences in mean of competence scores (Pelkonen & Kankkunen, 2001). The authors stated that the χ^2 -test was used to compare differences in categorical variables. The significance level was set at $p = <0.05$ (Pelkonen & Kankkunen, 2001).

The authors reported that sixty-seven percent (n=594) of the respondents reported that they always discussed smoking habits with clients who had a smoking-related disease or who initiated a discussion about smoking. They also [found] that nurses who had qualified less than 5 years ago were found to have a better ability to identify clients' motivation to cease smoking, and that knowledge of immediate positive outcomes after smoking cessation was best among nurses with lowest general education levels and among daily smokers (Pelkonen & Kankkunen, 2001).

The authors recommended nurses be provided with more education about assessing clients' nicotine dependency and motivation to cease smoking. They also stated that further research is needed to understand the reality of smoking guidance (Pelkonen & Kankkunen, 2001).

This article supported the proposed study because it demonstrated how nurses were effective smoking cessation counselors. This article was chosen because it discusses the feelings nurses have about their competency and confidence to discuss smoking cessation. Hopefully by showing nurses what their colleagues and other individuals perceive as important to learn, it will help nurses know what they should learn and teach.

The purpose of the third study reviewed was to examine the nurses' attitudes and belief toward their role in assisting patients with smoking cessation. This descriptive study included registered nurses working on medical, surgical, cardiac, oncology, neurology, gynecology, and orthopedic units in hospitals (McCarty et al., 2001). The nurses were randomly selected in two hospitals, and in two other hospitals, the entire population of eligible nurses were sampled (McCarty et al., 2001). A survey was developed by the authors with input from nurse investigators from each hospital. Most survey items were based on statements of nurses

participating in focus groups, and it also included items in accordance with the Theory of Planned Behavior (McCarty et al., 2001). A pilot survey was done to aid in questionnaire development (McCarty et al., 2001). Ten nurses from a single hospital completed the survey and were then interviewed individually regarding item clarity and appropriateness, as well as length of the survey (McCarty et al., 2001). Revisions were made and two nurses from a second hospital completed the survey and were interviewed (McCarty et al., 2001). No further revisions were required (McCarty et al., 2001). No statements about validity and reliability were made in the article.

McCarty et al. stated that envelopes containing a self-administered questionnaire, a stamped envelope addressed to the investigator at the university, a \$5 incentive, and an introductory letter, which included passive consent information, were hand-delivered to the work mailbox of each selected nurse. Four weeks after the delivery of the initial questionnaire, a second questionnaire was hand-delivered to the work mailbox of those not completing the survey after the initial mailing (McCarty et al., 2001). Questionnaires were checked for completeness and coded (McCarty et al., 2001). All data entry was verified and data were subjected to computerized range checks (McCarty et al., 2001).

The authors stated that the resulting survey of nurses was based on constructs from the Theory of Planned Behavior. They stated that this theory has been used to describe similar behavior among pharmacists and physicians, in particular pharmacist provision of medication counseling and physician delivery of preventive services. The theory postulated that behavior and the intention to perform the behavior are a result of a person's attitude toward the behavior (ATB), beliefs about the possible outcomes of the behavior [behavioral beliefs (BB)], the perceived expectation of important others that one will adopt the behavior [subjective norms

(SN)], and one's perception of the ease or difficulty of performing the behavior [perceived behavioral control (PBC)] (McCarty et al., 2001).

Analyses were conducted using the SAS statistical package, version 6.12 (McCarty et al., 2001). Of the nurses surveyed, 397 (68%) returned completed questionnaires (McCarty et al., 2001). Survey response rates varied by hospital and ranged from 63%-73% (McCarty et al., 2001). Nurses had a relatively positive attitude toward helping patients to quit smoking, 63% believed that hospitalization was an ideal time for patients to try to quit smoking, and 59% believed a nurse had an obligation to advise patients to quit smoking (McCarty et al., 2001). In the final multiple linear regression model, self-reported delivery of cessation advice was related to attitudes toward offering cessation advice, perceived ability to offer advice, and unit worked (McCarty et al., 2001).

McCarty et al stated that efforts should be made to educate staff nurses about the efficacy of brief cessation advice and current smoking cessation methods and practices. They stated that information on pharmacotherapy, behavioral intervention, and the effectiveness of these methods should be included.

The article listed limitations of the study. The authors stated that the primary outcome measure relied on self-reported data and nurses might have misreported their level of counseling (McCarty et al., 2001). The likelihood of overreporting of advice may be reduced by the fact that researchers not affiliated with hospitals conducted the survey and the results were confidential (McCarty et al., 2001). Also, nurses not responding to the questionnaire might hold different views or have different cessation delivery practices than respondents (McCarty et al., 2001).

This study was chosen because it is important to know how nurses feel about assisting patients with smoking cessation. Since the study showed that majority of the nurses had a positive attitude towards helping patients quit smoking, this gives reason for the proposed study to examine the perceptions of what should be taught to individuals who wish to quit smoking. By finding out what the perceptions are, nurses may be able to approach the topic of cessation easier.

The aims of the fourth study reviewed were (1) to compare nurses who reported the greatest number of barriers to the performance of tobacco interventions with those who perceived the fewest barriers by (a) personal, professional, and institutional setting characteristics; (b) frequency of clinical encounters and interventions with patients who smoke; and (c) circumstances that limit the delivery of a smoking cessation intervention and (2) to identify predictors of the greatest barriers to tobacco interventions (Sarna et al., 2001). This was a descriptive study where four thousand randomly selected nurse members of the Oncology Nursing Society (ONS) were sent surveys requesting information about their clinical encounters with patients who use tobacco, their practice patterns in assessment and intervention of tobacco use, barriers and facilitators to their interventions with patients, their attitudes about nursing involvement in tobacco control policy, and an assessment of their professional, educational background, institutional work setting, and personal tobacco use (Sarna et al., 2001). A total of 1508 members responded to the survey (Sarna et al., 2001).

The authors stated that the questionnaire “Oncology Nurses and Tobacco Control Survey” was developed by the investigators, and several strategies were used to ensure content validity, including a review of the literature, which contained the AHCPR “Smoking Cessation” guideline recommendations, and a review of the questionnaire by a panel of experts and by 3

focus groups of oncology nurses (Sarna et al., 2001). Reliability was evaluated through test-retest and internal consistency (Cronbach α) (Sarna et al., 2001). The 16-item barrier subscale that was the focus of this article identified factors that prevented nurses from delivering an intervention to assist their patients in stopping tobacco use (Sarna et al., 2001). The 5-part response options ranged from “strongly agree” to “strongly disagree,” and analysis of the instrument’s reliability revealed a Cronbach $\alpha=.82$ (Sarna et al., 2001).

The authors stated that the survey met the requirements for Exemption Status by the Human Subjects Protection Committee at the University of California, Los Angeles. Surveys were mailed in the winter of 1997 to an anonymous random sample of 4000 members of ONS who had noted on their ONS information form that “patient care” was their primary functional area and described their employment status as “full- or part-time” on their membership file as of 1997 (Sarna et al., 2001).

The article stated that analyses were conducted to compare the high and low barrier groups by (1) personal, professional, educational, or clinical characteristics of respondents, (2) frequency of clinical encounters and the 4 most common interventions with patients who smoke, and (3) frequency of types of barriers. Variables associated with having the greatest barriers to tobacco interventions were examined first for their individual relationships and then in a multivariate logistic regression model (Sarna et al., 2001).

The results of the study showed that nurses who perceived the greatest number of barriers were more likely to be current smokers and to be young and were less likely to have an advanced degree, to be a nurse practitioner, or to have administrative responsibilities (Sarna et al., 2001). Also, those with greater barriers were less likely to deliver tobacco cessation interventions (Sarna

et al., 2001). The authors stated that the findings of this study have important implications for research, education, clinical practice, and health policy.

One limitation that was discussed was the fact that some of these findings are “perceived” difficulties to tobacco intervention and may not accurately reflect the frequency of involvement in tobacco control activities (Sarna et al., 2001). Also, selection bias in those who responded to the survey [was] unknown (Sarna et al., 2001). Additionally, this study does not address the critically important and underutilized interventions for the prevention of tobacco use among youth (Sarna et al., 2001).

This study supported the proposed study because it described the barriers that nurses experience when trying to perform tobacco interventions. In the study the nurses in the high barrier group lacked confidence in cessation intervention and were more likely to perceive that cessation interventions would be harmful to patients by increasing their stress or making them feel guilty or that they wouldn't make any difference because of the patient's poor prognosis (Sarna et al., 2001). This study was chosen for review because it helped confirm the idea that nurses need more suggestions about what to teach patients in regards to smoking cessation.

The purpose of the fifth article reviewed was to examine associations between sociodemographic and psychological characteristics of smokers and delivery of five types of smoking cessation counseling interventions by physicians and office staff (Goldstein et al., 1997). This descriptive study included 3037 adults cigarette smokers who saw a physician in the last year. The article stated that “smokers were identified through a random digit dial (RDD) telephone survey administered in 1990 in Rhode Island (Goldstein et al., 1997). Sampling procedures were designed to identify approximately the same number of cigarette smokers in each of 3 designated areas encompassing all 5 counties within the state of Rhode Island

(Goldstein et al., 1997). Individuals were identified by telephone using a variation of the 2-stage Mitofsky-Waksberg RDD method (Goldstein et al., 1997).

Subjects were interviewed over the telephone and were asked questions about demographics, health status, years spent smoking, preparation for quitting smoking, rating the pros and cons of smoking (1, not important to 5, extremely important), where they received health care, and whether during any health care visit in the first 12 months, a physician or health care provider talked with them about their smoking, advised them to stop smoking, offered to help them quit smoking, arranged a follow-up visit to talk about smoking, or prescribed nicotine gum or other medication to help them stop smoking (Goldstein et al., 1997). The authors stated that the reliability of the subscales was good (Cronbach α for pros, .76; for cons, .75).

The authors stated that descriptive statistics were used to document the sociodemographic and behavioral characteristics of smokers who visited a physician within the last year according to each of the 5 types of counseling for smoking cessations (Goldstein et al., 1997). These outcomes were then used as dichotomous-dependent variables in bivariate analyses (χ^2 tests of independence, rank order correlations) and in separate multivariate logistic regression models (Goldstein et al., 1997). Independent variables in these models consisted of patient sociodemographic characteristics, smoking history variables, self-rated health status, setting of the medical visit, patient's stage of readiness to quit smoking, and pros and cons of smoking (Goldstein et al., 1997).

The article reported that fifty-one percent of smokers were talked to about their smoking; 45.5% were advised to quit; 14.9% were offered help; 3% had a follow-up appointment arranged; and 8.5% were prescribed medication. In multivariate analyses, the most consistent predictors of receipt of almost all counseling behaviors were medical setting (private physician's

office only > care in other settings), health status (fair or poor > good, very good, or excellent), more years of education, greater number of cigarettes smoked per day, stage of readiness to quit smoking (preparation > precontemplation), and greater reported benefits of smoking (Goldstein et al., 1997). The authors stated that physicians and other health care providers are not meeting the standards of smoking intervention outlines by the National Cancer Institute and the Agency for Health Care Policy and Research (Goldstein et al., 1997).

In the discussion about limitations, Goldstein et al. (1997) state that recall bias must be considered when interpreting these results. Patients in [this survey] and other surveys may have reported that they did not receive an intervention when it did indeed occur (Goldstein et al., 1997). Smokers may forget that they talked to a health care provider about smoking, especially if they received only a brief intervention, such as simple advice (Goldstein et al., 1997). Even when smokers initially remember an intervention, they may later deny that it occurred (Goldstein et al., 1997).

The purpose of the sixth article reviewed was to describe beliefs about tobacco use and cessation among current and former tobacco users in rural Appalachia using focus groups (Ahijevych et al., 2003). Focus groups conducted in a nonmetropolitan Appalachian county were used to collect data (Ahijevych et al., 2003). Telephone calls to potential focus group participants were used to recruit community members and to provide an overview of the purposes of the focus group (Ahijevych et al., 2003). A total of four focus groups (two former and two current tobacco user groups) were conducted over a 2-day period (Ahijevych et al., 2003). There was a moderator at each focus group session. A semi-structured discussion guide for open-ended questions to encompass the identified purposes was developed, pilot tested with a group of Appalachian cigarette smokers in a different non-metropolitan county, and reviewed by

an expert in focus group methodology (Ahijevych et al., 2003). Questions asked of current tobacco users to determine beliefs about tobacco use and cessation included: What is the role of tobacco in your life? . . . What factors helped or hindered your previous tobacco cessation attempts? and What do you think would be helpful strategies of a program for quitting smoking? (Ahijevych et al., 2003). Among former tobacco users, questions included: What methods were helpful and not helpful in your tobacco cessation experiences? What were your reasons for quitting tobacco? and What are your perception of different types of proposed tobacco cessation intervention strategies? (Ahijevych et al., 2003). The final sample included 27 residents. Thirteen former tobacco users comprised two focus groups, and fourteen current tobacco users formed the remaining two focus groups (Ahijevych et al., 2003).

Data included verbatim transcripts and field notes from each of the four focus group sessions (Ahijevych et al., 2003). These data were content analyzed and coded independently by three health care professionals (Ahijevych et al., 2003). The themes and associated illuminating quotes of the written analyses were reviewed by the coders and discussed until consensus was reached (Ahijevych et al., 2003).

The results for current and former tobacco users were discussed within three dominant themes: Nicotine addiction, pros and cons of tobacco use, and tobacco treatment. The authors included individual quotes to show themes in the richness of the participant's words (Ahijevych et al., 2003). The authors also discussed how the major themes and topics mentioned compare to results from other studies about smoking.

The limitation of the study dealt with the education level of the participants. The authors stated that former tobacco users who participated tended to be more educated than current tobacco users (Ahijevych et al., 2003). This finding was consistent with published literature

citing a negative correlation between education and smoking prevalence in the United States population (Ahijevych et al., 2003).

The authors stated that the themes from the focus group analyses will assist in the development and delivery of tobacco treatment, as well as the training of lay educators to implement a treatment plan in rural Appalachia (Ahijevych et al., 2003). They stressed that effective tobacco cessation interventions are critically needed because the Appalachian population have higher tobacco use and tobacco related morbidity and mortality compared with adults in general (Ahijevych et al., 2003).

This article supported the proposed study because it demonstrated the importance of smoking cessation interventions for the Appalachian culture. Effective strategies for smoking cessation can be developed by understanding the beliefs about tobacco among Appalachian current and former users.

The six articles were selected to help identify the need for more understanding about the perceptions of smoking cessation. A multiple of supporting factors for the study were demonstrated and are as follows: 1) The first study demonstrated the need for health care providers to have insight about smoking cessation education; 2) the second study showed how nurses could be effective smoking cessation counselors; 3) the third study showed that the majority of nurses had a positive attitude towards helping patients quit smoking; 4) the fourth study described the barriers that nurses experience when trying to perform tobacco interventions; 5) the fifth study stated that physicians and other health care providers are not meeting the standards of smoking intervention outlined by the National Cancer Institute and the Agency for Health Care Policy and Research (Goldstein et al., 1997); and 6) the sixth article demonstrated the importance of smoking cessation intervention for the Appalachian culture. Overall, the

studies showed the importance of smoking cessation interventions and the critical role nurses play in providing patient education.

Chapter Three

Methodology

The design of this study was descriptive, and a researcher designed survey was used to collect the descriptive data. The study was conducted at a major medical center in southern West Virginia. Consent for this study was obtained from the thesis committee, IRB at the university and medical center, and attending physicians prior to contacting study participants (See Appendix A & B for IRB approval). The Smoking Cessation Education survey had face validity, was reviewed by a panel of experts for content validity, and was based upon a review of the literature. Potential patient subjects were identified through outpatient records, provider interviews, or patient interviews. Respondents' names were not recorded to ensure confidentiality.

Sample and Setting

The setting for this study was a medical center that housed six different medical departments. The sample of convenience included 63 subjects, composed of 23 patients who are current smokers, 20 patient who are former smokers, and 20 nurses. A current smoker was defined as an adult between ages 18 and 60 who uses cigarettes. Current smokers were eligible for the study if they had been a smoker for more than three months. A former smoker was defined as an adult between ages 18 and 60 who no longer used cigarettes. Former smokers were eligible for the study if they had not been using cigarettes for more than three months. Nurses were defined as registered or licensed nurses employed at least 20 hours per week in a medical department for more than 3 months. Nurse administrators and advanced practice nurses were not eligible for the study.

Procedures

In this study, 23 patients who smoke and 20 patients who previously smoked from the six medical departments were contacted face to face by the investigator during their visit with their attending physician. A letter was given to attending physicians the week of the study to inform them about the research project (See Appendix C). In order to not interfere with the patient visit, permission was obtained from attending physicians prior to interviewing patient study participants. Nurses received a letter the week of the study to inform them about the research project (See Appendix D). They were then contacted face to face by the investigator to participate in the study. Each subject received the Smoking Cessation Education survey, as well as written instructions on how to complete the instrument, a demographic form, and a consent form (See Appendix E-G). The written instructions were the same for the current smokers, former smokers, and nurses. A consent form was signed by each subject (See Appendix B). A consent was also written on the survey and obtained through the completion of the survey.

Instrument

There were no instruments found in the literature to assess the perceptions of educational content for smoking cessation, therefore, a Smoking Cessation Education (SCE) survey was developed to measure the perceptions (See Appendix H). Content on the SCE included the following items: 1) risks of smoking, 2) programs available to help stop smoking, 3) medicines available to help stop smoking, 4) what happens to the body after 24 hours of not smoking, 5) having the doctor or nurse available to help you when you are ready to stop smoking, 6) the costs of smoking, 7) health risks to children of smokers, 8) why smoking habits are hard to change, 9) better breath by not smoking, and 10) how smoking will cause early wrinkles. The subjects responded to each SCE item on a 5 point Likert-type scale from not important to very important.

Also, subjects were asked to add any additional items they believed were important to learn from their health care provider.

Demographic information to describe the sample was collected. Age, gender, smoking status, and educational level were recorded for all subjects. Also, nurse subjects provided information on licensure, employment status, and years of practice at current licensure.

Data Analysis

Mode scores for the total survey were calculated for the current smokers, former smokers, and nurses' responses. The score with the highest frequency represented the item that the subjects rated as a very important topic of smoking cessation education. Mode scores for subjects' age, educational level, and gender were also calculated. The demographic data was analyzed with descriptive statistics. Comparison of frequency scores of the topics was performed between the current smokers, former smokers, and nurse responses to determine if the groups rate the same topic as a very important topic of smoking cessation education.

Expected Outcomes

The results of this study demonstrated what current smokers, former smokers, and nurses believe are important educational topics to encourage smoking cessation.

Limitations

The study findings had limited generalizability because the study was conducted in one medical center in a selected geographic location with a limited number of subjects. The study was further limited by reliability of subject responses, educational level, age, and stage of change.

Chapter Four

Data Analysis

Responses to each question on the demographic questionnaire and to each topic on the Smoking Cessation Education (SCE) survey were entered into a computer database. The responses were analyzed using the SPSS computer program (Statistical Package for the Social Sciences, version 11.0 for Windows). The data were analyzed to accomplish the objectives of the study. A total of sixty three surveys were completed. Of the sixty three surveys, twenty three surveys were from current smokers, twenty were from former smokers, and twenty were from nurses.

Demographic Data

Demographic data were obtained through the use of a four item demographic questionnaire for patients, and a six item demographic questionnaire for nurses. Amongst all three groups, the majority of the respondents were female (78%, n=49). The most common age group was 42-51 (40%, n=25). Within the group of current smokers, high school was the highest level of education among the majority of the respondents. Thirty percent (n=6) of former smokers completed college, and twenty five percent (n=5) completed high school. Among the nurses, ninety five percent (n=19) were RNs, and eighty percent (n=16) never smoked.

Responses to Topics

Frequency distributions were utilized to describe and compare the three groups using the responses from each SCE topic. The respondents (n=23) were asked to rate each of the ten topics, which related to smoking cessation, from very important to not important. The results of this survey provided information about important smoking cessation education topics as reported

by current smokers, former smokers, and nurses. The data were analyzed to accomplish the objectives of the study.

Topic 1: Risks of smoking. Ninety percent of nurses (n=18), eighty five percent of former smokers (n=17), and sixty five percent of current smokers (n=15) rated this topic very important. Four percent of current smokers (n=1) felt this topic was not important, and five percent of nurses (n=1) rated the topic as somewhat important. (Table 1.1)

Topic 2: Programs available to help stop smoking. Fifty two percent (n=12) of current smokers, fifty percent (n=10) of former smokers, and sixty five percent (n=13) of nurses rated this topic as very important. Four percent of current smokers (n=1) rated the topic as not important. Five percent of nurses (n=1) thought it was somewhat important. (Table 1.2)

Topic 3: Medications available to help stop smoking. Fifty percent of former smokers (n=10) rated this topic as very important. Thirty-five percent of current smokers (n=8) also rated it as very important. Twenty-six percent of the group (n=6) thought it was important, but the same percentage was undecided. Forty-five percent (n=9) of nurses rated the topic as very important, and another forty-five percent (n=9) rate it as important. (Table 1.3)

Topic 4: What happens to the body after 24 hours of not smoking. Forty eight percent of current smokers (n=11) rated this as very important. Forty five percent (n=9) of former smokers also rated the topic as very important, and forty percent (n=8) of them rated this important. Sixty percent of nurses (n=12) also found this topic as very important. (Table 1.4)

Topic 5: Having the doctor or nurse available to help you when you are ready to stop smoking.

Forty four percent (n=10) of current smokers, fifty percent (n=10) of former smokers, and sixty percent (n=12) of nurses found this topic as very important. Four percent of current smokers (n=1) thought it was not important. Five percent of former smokers (n=1) thought it was somewhat important, and five percent of nurses (n=1) also thought it was somewhat important. (Table 1.5)

Topic 6: The costs of smoking. Fifty two percent (n=12) of current smokers, forty five percent (n=9) of former smokers, and fifty five percent (n=11) of nurses found this topic very important. Twenty percent of former smokers (n=4) rated this topic as somewhat important. Nine percent (n=2) of current smokers and ten percent (n=2) of nurses also rated this as somewhat important. (Table 1.6)

Topic 7: Health risks to children of smokers. Eighty seven percent (n=20) of current smokers, ninety five percent (n=19) of former smokers, and ninety percent (n=18) of nurses rated this topic as very important. Four percent of current smokers (n=1) thought it was not important, while ten percent of nurses (n=2) rated it as somewhat important. (Table 1.7)

Topic 8: Why smoking habits are hard to change. Sixty one percent (n=14) of current smokers and sixty five percent (n=13) of nurses rated this as very important. Forty five percent (n=9) of former smokers rated it as important. (Table 1.8)

Topic 9: Better breath by not smoking. Forty eight percent (n=11) of current smokers, sixty percent (n=12), and seventy percent (n=14) of nurses rated this topic as very important. Nine percent of current smokers (n=2), as well as five percent (n=1) of nurses, rated it as not important. (Table 1.9)

Topic 10: How smoking will cause early wrinkles. Thirty nine percent of current smokers (n=9), thirty percent of former smokers (n=6), and fifty percent of nurses (n=10) rated the topic as very important. Nine percent of current smokers (n=2), five percent of former smokers (n=1), and five percent of nurses (n=1) rated this as not important. (Table 1.10)

Topic 11: If you feel there are other topics that would be helpful, please write them here. This section requested the respondents to write in topics they felt were important and weren't covered by the rest of the survey. Twelve of 63 subjects completed this section. Eight of the responses dealt with different methods to quit smoking or about personal worries rather than topics. Some of the responses are listed as follows:

1. "First of all you have to want to quit. Nothing will help unless you make up your mind."
2. "Helpful if spouse stops, too"
3. "It not only is very important that a person not smoke for themselves, but also for their family's health and so they will be there for their family."
4. "I was raised in a household with three adult smokers – I feel this had an impact on my life. I am a non smoker – I am worried about secondhand smoke around children and adults."
5. "Some can quit without help. I could only if I wanted to."

The topics that were suggested are as follows:

1. "Second-hand smoke on family members vs. the smoker."
2. "Pictures of tar in lungs – people relate to visual more so than oral/verbal."
3. "Dental hygiene."
4. "Prayer."
5. "Increase risk of impotency especially smoking in the diabetic male."
6. "Effects of smoking on unborn children."

The topic of health risks to children of smokers had the highest percentage of very important responses among all three groups (91%, n=57). All three groups ranked risks of smoking as the next highest very important topic (79%, n=50). The highest very important responses among current and former smokers went to the topic of health risks to children of smokers. Nurses rated the topics risks of smoking and health risks to children of smokers with the highest very important responses. The topic of the costs of smoking had the highest not important responses (10%, n=6). Overall, between 40%-91% of the respondents rated all topics as very important, and there was not a significant difference in the importance of selected smoking cessation information among the three groups. (See Table 1.11)

Limitations

A major limitation of this study was the use of a convenience sample of patients and nurses. Nurse participants were recruited from an internal medicine and surgery department located in a major medical center in southern West Virginia. As a result, the responses may be indicative of the department's practice patterns. The small number of subjects will also limit the generalizability of the study, as the small number will not be a strong representation of the Appalachian population.

Another limitation of the study was the reliability of subject responses. Current and former smokers were approached to participate in the study during a visit with their health care

provider. Although patients were informed the responses would not be revealed to their physician, or have any effect on their visit, patients may have felt encouraged to provide certain responses to make their physician happy.

Results may also be limited by the different levels of the stage of change among current smokers. Those who are more motivated to quit may have viewed the topics differently than those who are not ready to quit.

Implications For Nursing

Nurses have an important role as educators about smoking cessation. Through reviews of studies, Thorgood, Hillsdon, and Summersell (2003) found that "advice from a nurse increased the rate of quitting." Based upon the results of this study, all of the topics would be considered good topics to use as advice to smokers.

Smokers with children may benefit from getting advice about how smoking affects their children's health. Ninety one percent of the respondents of this study felt the health risks to children of smokers was a very important topic. Hospitalization rates in children with asthma in West Virginia are well above average for the United States, and almost 50% of them are exposed to tobacco smoke on a regular basis (Wilson, 2001). Wilson stated that "a person does not need direct exposure to smoke to produce asthma symptoms . . . Therefore, parents need to be educated that not only must they avoid directly exposing their children to tobacco smoke to prevent lung disease, but must avoid smoking in the home altogether" (Wilson, 2001). It is critical to educate the parents about the impact of smoking children's health in order to reduce the development of childhood pulmonary problems.

According to Glover & Glover (2001), "smoking status should be considered the new vital sign and recommendations for cessation should be offered consistently at every visit to

every patient.” The results of this study demonstrated a relatively low percentage of not important responses to the ten given topics. Therefore, addressing any of the topics with the patient can make a difference. Many smokers visit a health care office each year, and it is important for nurses to offer smoking cessation intervention.

The West Virginia Bureau for Public Health is working to address tobacco use in the state (2001). One of the objectives for their tobacco control program is to “reduce cigarette smoking to a prevalence of no more than 15% among West Virginians age 18 and older” (2001). Nurses can help in this area by initiating smoking cessation interventions. Posters with brief statements saying “What happens to the body after 24 hours of not smoking?” can open a discussion about smoking cessation between a nurse and patient. A poster demonstrating the monetary costs of smoking can help the nurse discuss ways to apply the money towards smoking cessation products. Regardless of approach, any effort to begin smoking cessation will help to achieve West Virginia’s goal for tobacco control.

Recommendations for Future Research

In order to more effectively determine important smoking cessation education topics for the Appalachian culture, this study should be replicated on a larger scale. Many different medical department and hospitals should be recruited because this will provide a better understanding about smoking cessation education.

To gain a better understanding of which smoking cessation topic is of most importance, response format of the survey should be changed. For example, the subjects could indicate their preference for the topic by placing a ‘1’ for their first choice, ‘2’ for their second choice, and so on. This type of format could provide more insight into the thoughts subjects have about smoking cessation topics.

Also, the group of nurses should be separated into groups of smokers and former smokers in order to gain a more accurate view of their perceptions.

Conclusion

Results of this study revealed a wide range of topics that current smokers, former smokers, and nurses believe are important smoking cessation topics. As a whole, ninety one percent of the respondents rated the health risks to children of smokers as very important. The rest of the topics ranged from thirty five percent to ninety five percent in very important ratings among the three groups. The highest very important responses among current and former smokers went to the topic of health risks to children of smokers. Nurses rated the topics risks of smoking and health risks to children of smokers with the highest very important responses. In accordance with the Health Belief Model (Rosenstock, 1974), results demonstrated how individuals believed they were susceptible to a health related condition, and it measured the degree of seriousness that smoking poses. The results also explained the perceived benefits of smoking cessation education, and helped form cues to action in order to initiate smoking cessation.

Nurses play a key role in educating patients. In order to reduce the number of problems caused by smoking, nurses need to advise smokers of the dangers of tobacco, and provide support for those motivated to quit.

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Frequency Tables for Topics

Table 1.1

| Topic 1 | Responses | Current | Former | Nurses | All |
|-------------------------|--------------------|----------------------|----------------------|----------------------|----------------------|
| Health risks of smoking | Very important | 65.2% n=15 | 85.0% n=17 | 90.0% n=18 | 79.4% n=50 |
| | Important | 26.1% n=6 | 10.0% n=2 | 5.0% n=1 | 14.3% n=9 |
| | Undecided | 4.3% n=1 | 5.0% n=1 | 0.0% n=0 | 3.2% n=2 |
| | Somewhat Important | 0.0% n=0 | 0.0% n=0 | 5.0% n=1 | 1.6% n=1 |
| | Not Important | 4.3% n=1 | 0.0% n=0 | 0.0% n=0 | 1.6% n=1 |

Table 1.2

| Topic 2 | Responses | Current | Former | Nurses | All |
|---|--------------------|----------------------|--------------------|----------------------|----------------------|
| Programs available to help stop smoking | Very important | 52.2% n=12 | 50% n=10 | 65.0% n=13 | 55.6% n=35 |
| | Important | 34.8% n=8 | 35.0% n=7 | 25.0% n=5 | 31.7% n=20 |
| | Undecided | 8.7% n=2 | 15.0% n=3 | 5.0% n=1 | 9.5% n=6 |
| | Somewhat Important | 0.0% n=0 | 0.0% n=0 | 5.0% n=1 | 1.6% n=1 |
| | Not Important | 4.3% n=1 | 0.0% n=0 | 0.0% n=0 | 1.6% n=1 |

Table 1.3

| Topic 3 | Responses | Current | Former | Nurses | All |
|--|--------------------|---------------------|--------------------|---------------------|----------------------|
| Medicines available to help stop smoking | Very important | 34.8% n=8 | 50% n=10 | 45.0% n=9 | 42.9% n=27 |
| | Important | 26.1% n=6 | 25.0% n=5 | 45.0% n=9 | 31.7% n=20 |
| | Undecided | 26.1% n=6 | 15.0% n=3 | 5.0% n=1 | 15.9% n=10 |
| | Somewhat Important | 0.0% n=0 | 5.0% n=1 | 5.0% n=1 | 3.2% n=2 |
| | Not Important | 4.3% n=1 | 0.0% n=0 | 0.0% n=0 | 1.6% n=1 |
| | No response | 8.7% n=2 | 5.0% n=1 | 0.0% n=0 | 4.8% n=3 |

Table 1.4

| Topic 4 | Responses | Current | Former | Nurses | All |
|--|--------------------|----------------------|---------------------|----------------------|----------------------|
| What happens to the body after 24 hours of not smoking | Very important | 47.8% n=11 | 45.0% n=9 | 60.0% n=12 | 50.8% n=32 |
| | Important | 43.5% n=10 | 40.0% n=8 | 35.0% n=7 | 39.7% n=25 |
| | Undecided | 0.0% n=0 | 10.0% n=2 | 0.0% n=0 | 3.2% n=2 |
| | Somewhat Important | 4.3% n=1 | 5.0% n=1 | 5.0% n=1 | 4.8% n=3 |
| | Not Important | 4.3% n=1 | 0.0% n=0 | 0.0% n=0 | 1.6% n=1 |

Table 1.5

| Topic 5 | Responses | Current | Former | Nurses | All |
|---|--------------------|----------------------|----------------------|----------------------|----------------------|
| Having the doctor or nurse available to help you when you are ready to stop smoking | Very important | 43.5% n=10 | 50.0% n=10 | 60.0% n=12 | 50.8% n=32 |
| | Important | 30.4% n=7 | 20.0% n=4 | 35.0% n=7 | 28.6% n=18 |
| | Undecided | 0.0% n=0 | 25.0% n=5 | 0.0% n=0 | 7.9% n=5 |
| | Somewhat Important | 17.4% n=4 | 5.0% n=1 | 5.0% n=1 | 9.5% n=6 |
| | Not Important | 4.3% n=1 | 0.0% n=0 | 0.0% n=0 | 1.6% n=1 |
| | No response | 4.3% n=1 | 0.0% n=0 | 0.0% n=0 | 1.6% n=1 |

Table 1.6

| Topic 6 | Responses | Current | Former | Nurses | All |
|------------------|--------------------|----------------------|---------------------|----------------------|----------------------|
| Costs of smoking | Very important | 52.2% n=12 | 45.0% n=9 | 55.0% n=11 | 50.8% n=32 |
| | Important | 26.1% n=6 | 10.0% n=2 | 20.0% n=4 | 19.0% n=12 |
| | Undecided | 4.3% n=1 | 15.0% n=3 | 0.0% n=0 | 6.3% n=4 |
| | Somewhat Important | 8.7% n=2 | 20.0% n=4 | 10.0% n=2 | 12.7% n=8 |
| | Not Important | 8.7% n=2 | 5.0% n=1 | 15.0% n=3 | 9.5% n=6 |
| | No response | 0.0% n=0 | 5.0% n=1 | 0.0% n=0 | 1.6% n=1 |

Table 1.7

| Topics 7 | Responses | Current | Former | Nurses | All |
|-------------------------------------|--------------------|----------------------|----------------------|----------------------|----------------------|
| Health risks to children of smokers | Very important | 87.0% n=20 | 95.0% n=19 | 90.0% n=18 | 90.5% n=57 |
| | Important | 8.7% n=2 | 0.0% n=0 | 0.0% n=0 | 3.2% n=2 |
| | Undecided | 0.0% n=0 | 5.0% n=1 | 0.0% n=0 | 1.6% n=1 |
| | Somewhat Important | 0.0% n=0 | 0.0% n=0 | 10.0% n=2 | 3.2% n=2 |
| | Not Important | 4.3% n=1 | 0.0% n=0 | 0.0% n=0 | 1.6% n=1 |

Table 1.8

| Topic 8 | Responses | Current | Former | Nurses | All |
|---------------------------------------|--------------------|----------------------|---------------------|----------------------|----------------------|
| Why smoking habits are hard to change | Very important | 60.9% n=14 | 35% n=7 | 65.0% n=13 | 54.0% n=34 |
| | Important | 26.1% n=6 | 45.0% n=9 | 25.0% n=5 | 31.7% n=20 |
| | Undecided | 4.3% n=1 | 10.0% n=2 | 5.0% n=1 | 6.3% n=4 |
| | Somewhat Important | 4.3% n=1 | 0.0% n=0 | 0.0% n=0 | 1.6% n=1 |
| | Not Important | 4.3% n=1 | 0.0% n=0 | 5.0% n=1 | 3.2% n=2 |
| | No Response | 0.0% n=0 | 10.0% n=2 | 0.0% n=0 | 3.2% n=2 |

Table 1.9

| Topic 9 | Responses | Current | Former | Nurses | All |
|------------------------------|--------------------|----------------------|----------------------|----------------------|----------------------|
| Better breath by not smoking | Very important | 47.8% n=11 | 60.0% n=12 | 70.0% n=14 | 58.7% n=37 |
| | Important | 26.1% n=6 | 10.0% n=2 | 10.0% n=2 | 15.9% n=10 |
| | Undecided | 0.0% n=0 | 15.0% n=3 | 10.0% n=2 | 7.9% n=5 |
| | Somewhat Important | 17.4% n=4 | 10.0% n=2 | 0.0% n=0 | 9.5% n=6 |
| | Not Important | 8.7% n=2 | 5.0% n=1 | 10.0% n=2 | 7.9% n=5 |

Table 1.10

| Topic 10 | Responses | Current | Former | Nurses | All |
|---------------------------------------|--------------------|---------------------|---------------------|----------------------|----------------------|
| How smoking will cause early wrinkles | Very important | 39.1% n=9 | 30.0% n=6 | 50.0% n=10 | 39.7% n=25 |
| | Important | 21.7 % n=5 | 25.0% n=5 | 20.0% n=4 | 22.2% n=14 |
| | Undecided | 4.3% n=1 | 15.0% n=3 | 5.0% n=1 | 7.9% n=5 |
| | Somewhat Important | 26.1% n=6 | 20.0% n=4 | 20.0% n=4 | 22.2% n=14 |
| | Not Important | 8.7% n=2 | 5.0% n=1 | 5.0% n=1 | 6.3% n=4 |
| | No Response | 0.0% n=0 | 5.0% n=1 | 0.0% n=0 | 1.6% n=1 |

Topics Chosen By Groups in Ranking Order
(Based on percentages)

Table 1.11

| Ranking Order | Current Smokers | Former Smokers | Nurses | All |
|---------------|---|--|--|---|
| 1 | <u>Topic 7</u> : Health Risks to Children of Smokers | <u>Topic 7</u> : Health Risks to Children of Smokers | (Tie) <u>Topic 7</u> : Health Risks to Children of Smokers <u>Topic 1</u> : Health Risks of Smoking | <u>Topic 7</u> : Health Risks to Children of Smokers |
| 2 | <u>Topic 1</u> : Health Risks of Smoking | <u>Topic 1</u> : Health Risks of Smoking | See above | <u>Topic 1</u> : Health Risks of Smoking |
| 3 | <u>Topic 8</u> : Why Smoking Habits Are Hard To Change | <u>Topic 9</u> : Better Breath By Not Smoking | <u>Topic 9</u> : Better Breath By Not Smoking | <u>Topic 9</u> : Better Breath By Not Smoking |
| 4 | (Tie) <u>Topic 2</u> : Programs Available To Help Stop Smoking <u>Topic 6</u> : The Costs of Smoking | (Tie) <u>Topic 2</u> : Programs Available To Help Stop Smoking <u>Topic 3</u> : Medicines Available To Help Stop Smoking <u>Topic 5</u> : Having the Doctor or Nurse Available To Help You When You Are Ready To Stop Smoking | (Tie) <u>Topic 2</u> : Programs Available To Help Stop Smoking <u>Topic 8</u> : Why Smoking Habits Are Hard To Change | <u>Topic 2</u> : Programs Available To Help Stop Smoking |
| 5 | See above | See above | See above | <u>Topic 8</u> : Why Smoking Habits Are Hard To Change |
| 6 | (Tie) <u>Topic 4</u> : What Happens To The Body After 24 Hours of Not Smoking <u>Topic 9</u> : Better Breath By Not Smoking | See above | (Tie) <u>Topic 4</u> : What Happens To The Body After 24 Hours of Not Smoking <u>Topic 5</u> : Having the Doctor or Nurse Available To Help You When You Are Ready To Stop Smoking | (Tie) <u>Topic 4</u> : What Happens To The Body After 24 Hours of Not Smoking <u>Topic 5</u> : Having the Doctor or Nurse Available To Help You When You Are Ready To Stop Smoking <u>Topic 6</u> : The Costs of Smoking |
| 7 | See above | (Tie) <u>Topic 4</u> : What Happens To The Body After 24 Hours of Not Smoking <u>Topic 6</u> : The Costs of Smoking | See above | See above |
| 8 | <u>Topic 5</u> : Having the Doctor or Nurse Available To Help You When You Are Ready To Stop Smoking | See above | <u>Topic 6</u> : The Costs of Smoking | See above |
| 9 | <u>Topic 10</u> : How Smoking Will Cause Early Wrinkles | <u>Topic 8</u> : Why Smoking Habits Are Hard To Change | <u>Topic 10</u> : How Smoking Will Cause Early Wrinkles | <u>Topic 3</u> : Medicines Available To Help Stop Smoking |
| 10 | <u>Topic 3</u> : Medicines Available To Help Stop Smoking | <u>Topic 10</u> : How Smoking Will Cause Early Wrinkles | <u>Topic 3</u> : Medicines Available To Help Stop Smoking | <u>Topic 10</u> : How Smoking Will Cause Early Wrinkles |



Smoking Cessation Education 40

Appendix A

Office of Research Integrity
Institutional Review Board

Friday, February 20, 2004

Lynne Welch
Nursing
School of Nursing
One John Marshall Dr.
Huntington, WV. 25755

RE: IRB Study # 3067 At: Marshall IRB 1

Dear Dr. Welch:

Protocol Title:
Smoking Cessation Education Needs As Reported By Smokers, former Smokers, and Nurses

This letter is to acknowledge the receipt of the information identified below.

Expiration Date: 2/19/2005

Our Internal #: 511

Type of Change: (Other)

Expedited

Expedited ?:

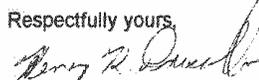
Date of Change: 2/25/2004

Date Received: 2/25/2004

On Meeting Date:

Description: In accordance with 45 CFR 46.110, I am granting expedited approval to the above minimal risk survey study for the period of 1 year. The purpose of the study is to determine if there is a difference in the importance of selected smoking cessation information to current smokers, former smokers, and nurses.

Respectfully yours,


Henry K. Driscoll, M.D.
IRB Chairperson

Appendix B

You are invited to participate in a research project entitled "Smoking Cessation Education Needs As Reported By Current Smokers, Former Smokers, and Nurses." The study is designed to analyze the difference in the importance of selected smoking cessation information to current & former smokers and nurses. The study is being conducted by Lynne Welch, EdD, RN, C-FNP and Ana Grynwald, RN, BSN from Marshall University Graduate School of Nursing. This research is being conducted as part of the thesis requirements for Ana Grynwald.

This survey is comprised of four (4) questions about yourself, and eleven (11) questions regarding smoking cessation which will take a few minutes to complete. Your replies will be completely anonymous, so do not put your name anywhere on the form. You may choose to not answer any question by simply leaving it blank. If you choose to not participate in this survey, you may either return the blank survey or you may discard it. Returning the survey indicates your consent for use of the answers you supply. If you have any questions, you may contact Dr. Lynne Welch at 304-696-2616, Ana Grynwald at 304-690-8606, or the Marshall University Institutional Review Board 304-696-7320.

Patient's signature _____ Date _____



IRB
[Signature]

APPROVED

Appendix C

March 5, 2004

Dear (Doctor's name),

On March 5-12, I will be in the Internal Medicine office conducting a research project titled "Smoking Cessation Education Needs As Reported by Current Smokers, Former Smokers, and Nurses." This research is being conducted as part of my thesis requirements. During the date of March 5-12, I may approach you to find out if you have any patients who qualify to participate in the study. I will be looking for at least 20 current smokers who have smoked for at least 3 months, and 20 former smokers who have quit smoking for at least 3 months. They must also be between the ages of 18-60 years. The study consists of a survey with eleven questions that will take a few minutes to complete. I have enclosed a copy of the survey so you will see what will be given to your patient. I will be on-hand in the office if any questions or concerns need to be addressed.

Thank you for your time. You may also contact me at 304-690-8606 or email at agrn2000@hotmail.com or Dr. Lynne Welch at 304-696-2616 if you have any questions.

Sincerely,

Ana Grynwald, RN, BSN

Appendix D

March 5, 2004

Dear (Nurse's name),

On March 5-12, I will be in the Internal Medicine office conducting a research project titled "Smoking Cessation Education Needs As Reported By Current Smokers, Former Smokers, and Nurses." This research is being conducted as part of my thesis requirements. During the date of March 5-12, I may approach you to invite you to participate in the project, which consists of an eleven question survey that will take a few minutes of your time to complete. At that time, I can address any questions or concerns you may have.

Thank you for your time. You may also contact Dr. Lynne Welch at 304-696-2616 or myself at 304-690-8606 if you have any questions.

Sincerely,

Ana Grynwald, RN, BSN

Appendix E

Smoking Cessation Education Survey

Doctors and nurses try to help their patients quit smoking.
The purpose of this survey will be to help doctors and
nurses help their patients to stop smoking.

Appendix F

Demographic Information

The following questions are for PATIENTS

Instructions: Please circle ONE response for each question.

1. My age is between: 18-25 26-33 34-41 42-51 52-60
2. I am: Male or Female
3. Smoking status: Currently smoke tobacco
 Quit smoking tobacco - If yes, how long have you not smoked? _____
4. Highest level of education achieved:

 Some High School GED High School Some College College

Thank you for your responses. You will find the survey on the next page. The results will be kept confidential. **Your completion of this survey indicates your consent to participate in this study.**

Demographic Information

The following questions are for NURSES only

Instructions: Please circle ONE response to each of the following questions.

1. My age is between: 18-25 26-33 34-41 42-51 52-60
2. I am: Male or Female
3. Smoking status: Currently smoke tobacco
 Quit smoking tobacco - If yes, how long have you not smoked? _____
 Never smoked tobacco
4. Type of licensure (Please circle): ADN LVN RN
5. Employment status (Please circle): Full-time (40+ hours per week) Part-time (20+ hours per week)
6. Years of practice in nursing: _____

Thank you for your responses. You will find the survey on the next page. The results will be kept confidential. **Your completion of this survey indicates your consent to participate in this study.**

Appendix G
Smoking Cessation Education Survey

The following list of topics are items that doctors or nurses may talk about to help their patients to quit smoking. **Please rate each topic based on what you feel would be important for the doctor or nurse to briefly talk about to help a patient to quit smoking.**

Please circle **ONE** response for each topic

| Topics | Responses | | | | |
|--|----------------|-----------|-----------|--------------------|---------------|
| Risks of smoking | Very Important | Important | Undecided | Somewhat Important | Not Important |
| Programs available to help stop smoking | Very Important | Important | Undecided | Somewhat Important | Not Important |
| Medicines available to help stop smoking | Very Important | Important | Undecided | Somewhat Important | Not Important |
| What happens to the body after 24 hours of not smoking | Very Important | Important | Undecided | Somewhat Important | Not Important |
| Having the doctor or nurse available to help you when you are ready to stop smoking | Very Important | Important | Undecided | Somewhat Important | Not Important |
| The costs of smoking | Very Important | Important | Undecided | Somewhat Important | Not Important |
| Health risks to children of smokers | Very Important | Important | Undecided | Somewhat Important | Not Important |
| Why smoking habits are hard to change | Very Important | Important | Undecided | Somewhat Important | Not Important |
| Better breath by not smoking | Very Important | Important | Undecided | Somewhat Important | Not Important |
| How smoking will cause early wrinkles | Very Important | Important | Undecided | Somewhat Important | Not Important |

If you feel there are other topics that would be helpful, please write the topics here:
