

Tobacco: What Is It and Why Do People Continue to Use It?

Paul C. Lewis

In this issue of MEDSURG Nursing, we are fortunate to have an article written by a nursing expert in the areas of tobacco use, addiction, and abstinence. Dr. Lewis provides an overview of the prevalence of tobacco use and the risks of exposure to tobacco and second-hand smoke for both adults and adolescents. He explains the challenges surrounding smoking cessation and encourages abstinence, starting at the grade school level. He concludes by emphasizing that nurses can provide a vital role in addressing this continued public health crisis. Additionally, Web sites that contain valuable information regarding smoking are included. A future article in MEDSURG Nursing will focus on tobacco cessation programs, new national guidelines, and policy implications.

—Linda H. Yoder, PhD, MBA, RN, AOCN®, FAAN

Cigarette smoking among adults has remained at about 20.8% since 2004 (Centers for Disease Control and Prevention [CDC], 2005b). Those most likely to smoke include men, adults less than age 40, and those living below the poverty line. American Indians/Alaskan Natives smoke at a much higher rate (32.4%) than non-Hispanic Blacks (23.0%), non-Hispanic Whites (21.9%), or Hispanics (15.2%). Cigarette smoking among adolescents has stopped declining since 2005 at a level of 23% (CDC, 2005c, 2005d). Adolescent males and females are equally likely to smoke (22.9% vs. 23.0%), with White adolescents smoking more often (25.9%) than Hispanic (22.0%) or non-Hispanic Black (12.9%) adolescents.

While most people recognize the harmful effects of tobacco use, and particularly smoking, few are able to quit easily. Relapse is common among people trying to quit, with up to a 80% relapse rate (U.S. Department of Health and Human

Services [HHS], 2006). Additionally, most people experience a relapse in the first 3 months after the quit attempt (National Institute on Drug Abuse, 2006). Only about 6% of those who try to quit are successful for over a month.

Tobacco use is particularly difficult to address because the addiction produced by nicotine is very strong; the cravings and withdrawal symptoms have been compared to those of cocaine (HHS, 1988). More than 4,000 individual chemicals have been identified in tobacco (see Table 1), including more than 60 that are known carcinogens (cancer-causing agents) (see Table 2). Cigarette smoking accounts for at least 30% of all cancer deaths. It is a major cause of cancers of the lung, larynx, oral cavity, pharynx, esophagus, and bladder, and it contributes to the development of cancers of the kidney, pancreas, cervix, and stomach (HHS, 2004). Smoking also is a major contributor to heart disease, aneurysms, bronchitis, emphysema, male and female repro-

Paul C. Lewis, PhD, FNP-C, RN, is a Nurse Researcher, U.S. Army. He has been on active duty for over 20 years.

Notes: This column is made possible through an educational grant from C-Change, a 501(3)c (not-for-profit) organization. The purpose of the Cancer: Caring and Conquering column is to strengthen the cancer knowledge, skills, and confidence of medical-surgical nurses who care for patients at risk for or living with cancer.

C-Change is a not-for-profit organization whose mission is to eliminate cancer as a public health problem, at the earliest possible time, by leveraging the expertise and resources of our members. C-Change is the *only* organization that assembles cancer leaders from the three sectors - private, public, and not-for-profit - from across the cancer continuum - pre-

vention, early detection, treatment, and quality of life.

C-Change invests in the resolution of problems that cannot be solved by one organization or one sector alone. For more information about C-Change, visit www.c-changetogether.org.

The author and all *MEDSURG Nursing* Editorial Board members reported no actual or potential conflict of interest in relation to this continuing nursing education article.

The opinions or assertion contained herein are the private views of the author and should not be construed as official or as reflecting the views of the U.S. Army Medical Department, Department of the Army or the Department of Defense.

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Table 1.
Partial Listing of Ingredients
in Cigarettes

Acetone
Methane
Arsenic
Nicotine
Vinyl chloride
Stearic acid
Acetic acid
Butane
DDT/Dieldrin
Hexamine
Nitrous oxide phenols
Hydrogen cyanide
Ammonia
Naphthalene
Cadmium
Carbon monoxide
Ethanol
Methanol
Nitrobenzene
Toluene
Formaldehyde

Source: Massachusetts Department of Public Health, 2007.

ductive diseases, and stroke. Smoking will worsen existing pneumonia and asthma significantly. Among pregnant women, smoking has been linked to low-birth-weight infants, miscarriages, and infant deaths (HHS, 2001).

Table 2.
Known Carcinogens
in Tobacco

Nitrosamines
Benzo(a)pyrene
Polycyclic aromatic hydrocarbons
Urethane
Crysenes
Polonium 210
Dibenz acidine
N. Nitrosonornicotine
Cadmium
Nickel
B-Naphthylamine
Toluidine

Source: Massachusetts Department of Public Health, 2007.

Even more problematic is the fact that most tobacco use begins in adolescence, with the risks of negative health consequences unlikely to be a sufficient deterrent during the developmental stage marked by a sense of immortality. Adolescents seem to develop addictive symptoms very quickly and very early in their experimental smoking careers; once addicted, few stop until well into their adult years. An overview of tobacco use, the effects of smoking, theories on why people smoke, and how nursing can affect this public health crisis will be provided.

The Prevalence of Tobacco Use in the United States

Nicotine, in its various delivery forms of cigarettes, cigars, pipes, and chewing tobacco, is one of the most heavily used addictive drugs in the United States (National Institute on Drug Abuse, 2008). An estimated 45.1 million Americans currently smoke, which equates to about 21% of the population or more than one out of five people. Almost 24% of those ages 18 to 44 are current smokers, compared to 10.2% in those age 65 or older (CDC, 2007). Nationwide, 22.3% of high school students and 8.1% of middle school students were smoking in 2004 (CDC, 2005c, 2005d). About an equal number of males and females smoked cigarettes, but more White and Hispanic youth smoked than African-American youth (see Table 3).

Overall, almost an equal percentage of adults smoke compared to adolescents (20.9% vs. 22.5%), which is consistent with the fact that the majority of smokers begin before they are 18 years old (HHS, 1995). There is, however, a slightly smaller percent of females who smoke as adults than smoke as adolescents (18.5% and 22.4 respectively) (see Table 4). When broken down by race/ethnicity, every adolescent category has a higher per-

Table 3.
Percentage of High School (Grades 9-12) Adolescent Tobacco Use by Type, Gender, and Race/Ethnicity – National Youth Tobacco Survey, United States, 2004

Characteristics	Any Tobacco		Cigarettes		Cigars		Smokeless Tobacco	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Gender								
Male	31.5	(±3.0)	22.1	(±2.7)	18.4	(±1.8)	10.8	(±2.2)
Female	24.7	(±3.1)	22.4	(±3.1)	7.5	(±1.4)	1.4	(±0.6)
Race/Ethnicity								
White, non-Hispanic	31.5	(±4.1)	25.4	(±3.8)	13.6	(±2.1)	7.5	(±1.6)
Black, non-Hispanic	17.1	(±3.3)	11.4	(±3.1)	10.5	(±2.1)	1.7	(±1.2)
Hispanic	26.2	(±2.9)	21.6	(±3.1)	13.3	(±1.7)	3.5	(±1.1)
Asian	13.1	(±3.3)	11.2	(±2.6)	5.7	(±2.4)	2.1	(±1.7)
Total	28.0	(±2.9)	22.3	(±2.7)	12.8	(±1.5)	6.0	(±1.2)

CI = confidence interval
Source: CDC, 2005c

Table 4.
Comparison of Adult and Adolescent Current Cigarette Use by Gender and Race/Ethnicity

Characteristics	Adult ¹		Adolescent ²	
	%	(95% CI)	%	(95% CI)
Gender				
Male	23.4	(±0.9)	22.1	(±2.7)
Female	18.5	(±0.7)	22.4	(±3.1)
Race/Ethnicity				
White, non-Hispanic	22.2	(±0.8)	25.4	(±3.8)
Black, non-Hispanic	20.2	(±1.7)	11.4	(±3.1)
Hispanic	15.0	(±1.2)	21.6	(±3.1)
Asian	11.3	(±2.4)	22.3	(±2.7)
Total	20.9	(±0.6)	22.5	(±1.6)

¹ Cigarette Smoking Among Adults (Center for Disease Control and Prevention, 2005b)

² National Youth Tobacco Survey (Center for Disease Control and Prevention, 2005c)

CI = confidence interval

Table 5.
Smokeless Tobacco Usage by Age, Gender, and Race/Ethnicity

	Adolescent ¹	Adult ²
Gender		
Male	13.6	6
Female	2.2	0.4
Race/Ethnicity		
American Indian/Alaskan Native	N/R	9
White	10.2	4
African American	1.7	2
Hispanic	5.1	1
Asian American	N/R	0.6

N/R = not reported in the survey

¹ Youth Risk Behavior Surveillance Survey (Centers for Disease Control and Prevention, 2005d)

² National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2006)

centage of smokers with the exception of Black, non-Hispanic smokers. About 20.2% of adult Black non-Hispanics smoke compared to only 11.4% of adolescent Black non-Hispanics (CDC, 2005b, 2006).

Smoking on average reduces an adult's life expectancy by about 14 years (CDC, 2005a). Tobacco use does not lead quickly to death. Smoking will affect first a person's health by damaging internal organs. The CDC estimated in 2000 that

around 8.6 million people had a chronic illness because they were either current or former smokers (CDC, 2005a). The most common diseases experienced by smokers include chronic bronchitis, emphysema, heart attacks, strokes, and cancer (HHS, 2004).

Smoking is responsible for an estimated 437,000 premature deaths each year, (CDC, 2005a). From 1997 to 2001, smoking-attributable health care expenses and

lost productivity as a result of smoking exceeded \$167 billion a year, while state-based investment in prevention and control programs was 200 times less (CDC, 2005a).

Smokeless Tobacco: A Good Alternative?

Because many of the dangers of tobacco have been linked to the smoke, people who use smokeless tobacco may feel they are at less risk by choosing a safer alternative to smoking. Smokeless tobacco (SLT) includes dip (or snuff), chew, and leaf tobacco. Smokeless tobacco was used commonly on this continent during the 1600s after being introduced by John Rolfe. It was touted to have medicinal value in alleviating toothaches, disinfecting cuts, relieving insect or snake bites, and preserving and whitening teeth (HHS, 1986), all of which subsequently have been proven untrue.

Today an estimated 8% of children in high school (CDC, 2005c, 2005d) and 2.3% of adults (CDC, 2006) are SLT users in the United States. SLT use is most predominant among White males. However, American Indians/Alaskan Natives have a higher usage among adults (9%) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006), while Whites have a higher usage among adolescents (10.2%) (CDC, 2005c, 2005d) (see Table 5).

The nicotine from SLT is absorbed readily through the mucous membranes. Placing tobacco in the mouth introduces about twice the dose of nicotine as a standard 1 mg cigarette. Therefore, a person who uses 8 to 10 dips a day is receiving the equivalent nicotine dose to someone who smokes 30 to 40 cigarettes per day (Massachusetts Department of Public Health, 2007). SLT is a known human carcinogen that contains over 28 cancer-causing agents. While the incidence of lung cancer is lower, SLT users have an increased risk for oral cancer which can form in as little

as 5 years of starting SLT use (Hatukami & Severson, 1999).

Second-Hand Smoke: What Is The Cost of this Hand-Me-Down?

Being exposed to second-hand tobacco smoke (SHS) also poses a serious health risk. Second-hand smoke, which has also been called environmental tobacco smoke, comes from either sidestream smoke (from tobacco left burning) or exhaled mainstream smoke (smoke exhaled by the person smoking). SHS contains 250 toxic chemicals, with at least 50 designated as known human carcinogens. These toxic and carcinogenic chemicals are the same as those found in inhaled tobacco smoke, including formaldehyde, benzene, vinyl chloride, arsenic, ammonia, and hydrogen cyanide. Due to the different temperature at which tobacco burns, sidestream smoke actually contains a higher concentration of certain toxins than the inhaled tobacco smoke (HHS, 2006). Because many toxins are released, no minimum level of SHS has been deemed safe. All sidestream or exhaled mainstream SHS has been designated as a known carcinogen (U.S. Environmental Protection Agency [EPA], 1992).

Nonsmokers are not exempt from the negative health effects of SHS. Within minutes of a nonsmoker's exposure to a smoky environment, the platelets will become stickier and damage to the lining of the blood vessels begins. Decreased coronary blood flow and decreased heart rate variability occur. In people with pre-existing cardiac disease, the risks increase. Those with sensitive airways will begin to experience shortness of breath, phlegm production, and a cough. People with respiratory diseases, such as asthma, are at high risk for rapidly worsening symptoms. Long-term exposure to SHS by nonsmokers has been linked to a significant

increase in heart disease and about a 20% to 30% increased risk of developing lung cancer (HHS, 2006). Children who live in homes with parents who smoke, particularly the mother, are at greater risk for middle ear infections, bronchitis, pneumonia, asthma exacerbations, and even sudden infant death syndrome (Gaffney, 2001; Mannino, Homa, & Redd, 2002). Up to 300,000 annual cases of bronchitis and pneumonia in children less than age 18 months are due to SHS exposure. As many as 1,000,000 children have their asthma worsened annually by exposure to SHS (EPA, 1992).

The greatest exposure for SHS is from the home environment (Martin, Feyerabend, Bryant, Hedges, & Primates, 2001; Okah, Choi, Okuyemi, & Ahluwalia, 2002). However, significant exposures to SHS have been seen even among children in homes where smoking has been banned (Hopper & Craig, 2000). The particles of SHS tend to be smaller, and therefore stay airborne longer than mainstream smoke. This also results in the particles being distributed rapidly and evenly by convection throughout any enclosed space (HHS, 2006; Woodward & Al-Delaimy, 1999). The Surgeon General concluded that fully eliminating all smoking from indoor areas is the only reliable means of protecting nonsmokers from the ill effects of SHS (HHS, 2006).

Learning the Negative Effects Of Tobacco

Tobacco has been a part of the fabric of American life since the time of the first settlers and has been a major cash crop for several hundred years. This public perception has been further supported by very effective marketing campaigns by the tobacco industry (CDC, 2006; Federal Trade Commission, 2007). Only relatively recently did the scientific community start to take a closer look at the impact tobacco has on the

health of its users. The dangers of cigarette smoking first came to public attention in 1962, when the Surgeon General issued a report on the harmful effects of tobacco (HHS, 1964). A second report from the Surgeon General 20 years later identified cigarette smoking as the major single cause of cancer deaths in the United States (Office of the U.S. Surgeon General, 1982), a distinction that continues to be true today. Not until 32 years after the Surgeon General's report did the American Psychiatric Association (1994) include nicotine dependence in its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). The U.S. Food and Drug Administration determined 12 years ago that nicotine was an addictive substance and that most tobacco users continued to use tobacco to satisfy that addiction (Kessler, Barnett, Zeller, Mande, & Schultz, 1997). Continuing research into the many harmful effects of tobacco prompted the Surgeon General to issue a report stating that smoking has now been shown to have a negative health effect on nearly every organ of the body (HHS, 2004).

However, despite research that consistently finds harmful effects from tobacco use or even exposure to tobacco smoke, tobacco use continues to be normalized in the media, which in turn influences adolescent smoking behavior (Pierce, Distefan, Jackson, White, & Gilpin, 2002; Sargent et al., 2000, 2001). Tobacco is an identified addictive and carcinogenic drug but it continues to be so accepted in the United States that over 95% of kindergarten students can correctly identify cigarettes (Hahn et al., 2000). As the science has advanced, the public's perception of the dangers posed by tobacco has not seemed to keep pace.

Why Do People Start Using Tobacco?

With literature showing the harmful, usually irreversible, ef-

fects of tobacco, why do people continue to use it? Unfortunately, the answer is not as simple as could be expected. Almost 80% of all smokers start before age 18 (HHS, 1995) and some begin before age 12 (CDC, 1995). Each day in the United States, approximately 4,400 adolescents ages 12-17 initiate smoking (SAMHSA, 2003). The earlier that adolescents begin to use tobacco, the heavier their usage as adults is likely to be (HHS, 1995); half of all adolescent smokers will still be smoking over 16 years later (Pierce & Gilpin, 1996). The difficulty with preventing adolescents from using tobacco is that often they do not consider the long-term health effects of tobacco use. Adolescents have said they use tobacco for reasons ranging from positive mood enhancement (Blitstein, Robinson, Murray, Klesges, & Zbikowski, 2003) to peer pressure (McFeely, 2001) and weight control (Blitstein et al., 2003). However, some adolescents may be at risk for smoking based solely on other factors, such as low self-esteem (Lewis, Harrell, Bradley, & Shibus, 2001), low socioeconomic status (Gilman, Abrams, & Buka, 2003), or low parental connectedness (Tilson, McBride, Lipkus, & Catalano, 2004), or because of gender or ethnicity (Blitstein et al., 2003).

Why Don't More People Quit? Tobacco Use: Dependence And Addiction

The tobacco companies continually develop new products in an effort to entice new users. They introduce specific products with a specific audience in mind. For instance, women have been targeted with ads proclaiming the social desirability of smoking, independence, and weight control, all delivered in pink cigarette packs (Campaign for Tobacco-Free Kids, 2007; HHS, 2001). Adolescents also have been targeted with pleasing flavors added to cigarettes, cigars, and smokeless tobacco (Cam-

Web Sites With More Information

General Information	
American Lung Association	http://www.lungusa.org/site/pp.asp?c=dvLUK900E&b=22938
American Cancer Society	http://www.cancer.org/docroot/PED/ped_10.asp?sitearea=PED
American Legacy Foundation	http://www.americanlegacy.org/
C-Change (see Publications and Reports, as well as Calls to Action on this site)	http://www.c-changetogether.org
Campaign for Tobacco-Free Kids	http://www.tobaccofreekids.org/
Centers for Disease Control and Prevention	http://www.cdc.gov/tobacco/
National Cancer Institute	http://www.cancer.gov/cancertopics/smoking
Quit Assistance	
Great American Smokeout	http://www.cancer.org/docroot/subsite/greatamericans/Smokeout.asp
American Cancer Society's Guide to Quitting Smoking	http://www.cancer.org/docroot/PED/content/PED_10_13X_Guide_for_Quitting_Smoking.asp
SmokeFree	http://smokefree.gov/
National Cancer Institute	http://www.cancer.gov/cancertopics/tobacco/quittingtips
U.S. Department of Health and Human Services (includes patient handouts)	http://www.surgeongeneral.gov/tobacco/

campaign for Tobacco-Free Kids, 2008). One large tobacco company admitted to targeting media promotions to adolescents while another tobacco company used cartoon characters to lure adolescent interest (HHS, 2000).

Whatever the reason to try tobacco, the outcome remains the same: nicotine is introduced to the body. Nicotine exposure has long been recognized as the primary active and addictive substance in tobacco that leads to physiological addiction (HHS, 1988). Nicotine is known to activate neuronal nicotinic receptors in the mesolimbic dopamine system (Trauth, Seidler, McCook, & Slotkin, 1999). Animal models have shown that once these receptors become sen-

sitized to nicotine, they will remain hypersensitive to the psychomotor activating effects of nicotine for extended periods (Garrett, Dwoskin, Bardo, & Henningfield, 2003; Robinson & Berridge, 2000). Sensitization also has been demonstrated with infrequent nicotine administrations (i.e., once a week) and persisted over 21 days with no additional nicotine exposure (Miller, Bardo, Crooks, & Dwoskin, 2001).

An important distinction should be made with regard to tobacco addiction. When a person is exposed to nicotine a number of times and links to that exposure are made with repetitive behaviors (smoking behaviors), a dual dependence will develop. While

some put both under the heading of *addiction*, the syndrome is clearer if broken out separately. In regard to tobacco use, a difference exists between dependence and addiction. *Dependence* is “cravings of the mind” (Lewis, 2005). This refers to the behavioral consequences of smoking. Dependence is characterized by urges which can be satisfied by the motions and sensations of smoking, a phenomenon called classical conditioning. The act of smoking, for instance, gives a degree of relief even before the nicotine is introduced into the system. Symptoms of dependence may include depression, anxiety, tension, restlessness, and the urge to smoke. Addiction, on the other hand, is “cravings of the body.” This refers to the persistent neurobiological sensitization and the visceral felt need for smoking. It is characterized by cravings that can be alleviated only by nicotine administration in any form. Symptoms of addiction may include irritability, somatic complaints, cognitive deficits, and withdrawal discomfort (Lewis, 2005).

The dopamine system in the human brain is responsible for the sense of reward and pleasure. It is the same system that is activated by cocaine, heroin, and marijuana (National Institute on Drug Abuse, 2008), confirming why abstinence from tobacco is very problematic in the individual addicted to nicotine. When the dopamine system is activated, the person begins to feel relaxed and slightly euphoric. This feeling may become very welcome to youth seeking a cheap “high” or the busy executive who is seeking a stress break from a hectic schedule. Very aware of this phenomenon, the tobacco companies have altered advertising techniques over time to target different groups of regular smokers and potential smokers (Slater, Chaloupka, Wakefield, Johnston, & O’Malley, 2007). The effects of the nicotine will be felt within seconds

of the first inhalation from the cigarette or placement of the dip/chew into the mouth. This quick coupling of the tobacco use behavior and seemingly immediate effect of the nicotine is essential for the classical conditioning to occur, which further guarantees longevity in tobacco use.

Once the brain receptors become sensitized by the introduction of nicotine, they begin to cause the person to seek tobacco. These receptors are linked to the dopamine system; each time they are stimulated by nicotine, a sense of well-being is given to the person. In relatively short order, with only a few nicotine exposures, this up-regulation and repeated stimulation of the nicotinic receptors leads to the physiological addiction. If the nicotine-addicted person does not reintroduce nicotine at regular intervals, he or she may begin to experience withdrawal symptoms. Each of these repeated pairings of smoking and the release of dopamine secondary to the nicotine begins to condition the person to the stimuli of smoking. In Pavlovian fashion, with repeated pairings of the smoking actions and nicotine stimulation of the receptors, the person begins to associate the very act of smoking with the sense of well-being. An established smoker will begin to feel this sense of satisfaction even before lighting the cigarette. In this manner, the action of smoking becomes part of the behavioral addiction. Ironically, this behavioral stimulation of addiction may be more difficult to extinguish in many cases than the actual nicotine addiction itself.

Abstinence, Not Quitting, Is The Key

As knowledge of the dangers of smoking has grown, so has knowledge of the difficulties of cessation attempts. Because nicotine has been recognized as a highly addictive drug, research has led to application of the con-

cept of abstinence. Smokers previously were encouraged to quit and told they would be cured once they stopped smoking. Unfortunately, as many as 80%-90% of those who try to quit return to regular smoking within a year. This quit failure rate increases to around 97% if the person has a smoking lapse (defined as smoking on 3 or more consecutive days) (Shiffman et al., 1996).

Scientists and clinicians alike began to realize that nicotine abstinence was a long-term issue and that former tobacco users needed to stay away from tobacco or risk falling back into the addiction trap. The primary metabolite of nicotine, cotinine, has a half life of 16 to 20 hours; the drug clears the system within 2 days (Moolchan, Ernst, & Henningfield, 2000). However, a person can relapse into tobacco use months or years after quitting, and resume former levels of tobacco use as a result of numerous issues. The person has physiologic changes as a result of formerly smoking and those neuroreceptors are primed and waiting for nicotine. These sensitized receptors remain primed for any future nicotine exposure. The second piece to the late relapse is due partly to the behavioral conditioning, or the dependence described previously, that has accompanied the tobacco habit. The person decides that he or she needs a cigarette to help with a stressful day, remembering either consciously or unconsciously that stress relief was achieved in the past with nicotine. The sense of well-being from the dopamine release also is recalled. The person even may experience the urge to smoke based on the behavioral conditioning. From anecdotal interviews, this urge may take up to a year to lessen and may never extinguish completely. Once nicotine reaches the sensitized receptors, the addiction cycle escalates in a much quicker fashion than it did initially. Whereas the person

may have taken 1-2 years to reach an equilibrium of tobacco intake, he or she will achieve that usage level within days when a relapse occurs.

For these reasons, the traditional approach of smoking cessation is no longer thought to be appropriate. Given the significant addictive aspects of tobacco, lapses in quit attempts are recognized as in other drug treatment programs. Recent programs expect lapses (temporary tobacco use) and differentiate that from a full relapse (regular daily use). This subtle change in paradigm helps the person trying to stop using tobacco understand the long-term ramifications of the decision to quit. Many people seek the quick solution seemingly offered by many new drugs on the market today. However, it generally takes around 12 weeks to get past the nicotine cravings (based on standard medication treatment schedules), and over a year to have a lessening of behavioral urges to use tobacco. Most people attempting abstinence have been smoking for many years and smoking has become part of their daily behavior. It is important to put that into perspective for the individual who wants to stop using tobacco. What has been a reinforced behavior over years is unlikely to disappear rapidly through an intervention such as taking a pill for only 3 months. It also should be noted that any reduction in smoking or days of abstinence reduce health consequences. It is never too late to quit (HHS, 2004).

What Can Nurses Do To Help?

One thing has been shown consistently to help people quit smoking — talking to them. Not everyone is ready to quit smoking when he or she arrives at a hospital or clinic, even after having a heart attack. What seems to be simple to health care providers may be more than the patient can accept along with the stress of a

health problem. The patient has to be ready to quit before he or she is able to quit. However, research indicates that many inpatients may be ready to quit; 22%-30% of inpatients who are offered a method to quit while hospitalized eventually will quit successfully (Chouinard & Robichaud-Ekstrand, 2005). The U.S. Public Health Service Clinical Treatment Guidelines confirm that the more frequently a smoker talks with his or her doctor, nurse, pharmacist, or other health care provider, the greater the chance that he or she will be successful in the attempt to quit smoking (HHS, 2008). Medical-surgical nurses are in an excellent position to approach the patient. A recent health scare or near-miss may create readiness in a patient to consider quitting. Teaching about smoking cessation should be a part of discharge instructions for any smoker, regardless of the reason for admission. Even though a patient currently may not want to stop, providing information may serve as the impetus to get him or her ready to attempt to quit. If a health care facility has a smoking cessation program, the nurse should encourage the patient to participate. The most successful programs incorporate counseling, medications, and a support group activity, dealing with both the addiction and the dependence. Any aspect of such programs is more effective than the person attempting to quit “cold turkey” (Mermelstein, 2003).

A patient often looks to a trusted nurse for advice and assistance. However, that trust may be undermined if the nurse who counsels smoking cessation is continuing to smoke as a personal habit. Smoking rates among nurses may be as high as 22% (Chalmers, Seguire, & Brown, 2002; Patkar, Hill, Batra, Bergare, & Leone, 2003). A nurse will be more effective as a role model by displaying the preferred patient behavior. A nurse is aware of the

harm related to smoking and second-hand smoke, and should lead the campaign for a new paradigm of nonsmoking for everyone. Few things will make a bigger health impact on the population than to encourage smoking cessation, first among nurses, and then across the nation.

Conclusion

Tobacco use remains high in the United States and may even be increasing among adolescents, the highest risk group (CDC, 2005c, 2005d). All forms of tobacco are harmful to the human body, increasing the risk for numerous cancers and other diseases. Nicotine is a highly addictive drug and even limited exposure may “hook” a person for almost 20 years. Nurses should take a stand against this significant national health threat by becoming involved with tobacco cessation classes and participating in events such as the Great American Smoke Out sponsored by the American Cancer Society. Most importantly, nurses can be health advocates for patients. Nurses can educate the public about the dangers of tobacco use, offer them assistance to quit, and be persistent in terms of follow up and encouragement. ■

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Additional Readings

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Hospitals Serving the Uninsured and Underserved Need Help with Public Reporting and Pay-for-Performance Measures

The trend for hospitals to publicly report their data and be paid by insurers for how well they perform is a manageable chore for well-staffed hospitals. But safety-net hospitals, which serve large numbers of impoverished Medicaid clients or are located in rural areas, find that task burdensome. A research team at the University of California at San Francisco conducted interviews with 37 executives from safety-net hospitals to determine their challenges with and solicit recommendations for reporting performance.

The researchers recommend that safety-net hospitals be offered grants to implement electronic records or subsidized training for data collectors, or share data collection personnel. The executives also said financial incentives for reporting did not have the same effect for them as other hospitals. Because their customers do not have a choice of where to get their health care, reporting performance data would not increase their patient volume or profits as it might for other hospitals. Rural hospitals were especially concerned that, because of their small sample sizes, their statistics would appear worse than they were. The researchers recommend letting safety-net hospitals report on special categories that highlight the unique role they play in their communities.

For details, see Goldman et al. (2007). Public reporting and pay-for-performance: Safety-net hospitals executives' concerns and policy suggestions. *Inquiry Journal, 44*, 137-145.



MSN J0809

**Answer/Evaluation Form:
Tobacco: What Is It and Why Do People Continue to Use It?**

COMPLETE THE FOLLOWING

This test may be copied for use by others.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred telephone: (Home) _____ (Work) _____

Registration fee: **Complimentary CNE provided as an educational service by C-Change (www.c-changetogether.org).**

ANSWER FORM

1. If you applied what you have learned from this activity into your practice, what would be different?

OBJECTIVES

This continuing nursing educational (CNE) activity is designed for nurses and other health care professionals who care for and educate patients and their families regarding tobacco use. For those wishing to obtain CNE credit, an evaluation follows. After studying the information presented in this article, the nurse will be able to:

1. Describe the prevalence of tobacco use in the United States.
2. Discuss the effects of smokeless tobacco and second-hand smoke.
3. List reasons for tobacco use and barriers to quitting.
4. Describe how nurses can help their patients quit smoking.

CNE Instructions

1. To receive continuing nursing education credit for individual study after reading the article, complete the answer/evaluation form to the left.
2. Photocopy and send the answer/evaluation form to *MEDSURG Nursing*, CNE Series, East Holly Avenue Box 56, Pitman, NJ 08071-0056.
3. Test returns must be postmarked by June 30, 2010. Upon completion of the answer/evaluation form, a certificate for 1.2 contact hour(s) will be awarded and sent to you.
4. CNE forms can also be completed online at www.medsurnursing.net.

This independent study activity is co-provided by **AMSN** and **Anthony J. Jannetti, Inc. (AJJ)**.

AJJ is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation (ANCC-COA).

Anthony J. Jannetti, Inc. is a provider approved by the California Board of Registered Nursing, Provider Number, CEP 5387.

This article was reviewed and formatted for contact hour credit by Dottie Roberts, MSN, MACI, RN, CMSRN, OCNS-C, *MEDSURG Nursing* Editor; and Sally S. Russell, MN, CMSRN, AMSN Education Director.

Evaluation	Strongly disagree	1	2	3	4	5	Strongly agree
2. By completing this activity, I was able to meet the following objectives:							
a. Describe the prevalence of tobacco use in the United States.	1	2	3	4	5		
b. Discuss the effects of smokeless tobacco and second-hand smoke.	1	2	3	4	5		
c. List reasons for tobacco use and barriers to quitting.	1	2	3	4	5		
d. Describe how nurses can help their patients quit smoking.	1	2	3	4	5		
3. The content was current and relevant.	1	2	3	4	5		
4. The objectives could be achieved using the content provided.	1	2	3	4	5		
5. This was an effective method to learn this content.	1	2	3	4	5		
6. I am more confident in my abilities since completing this material.	1	2	3	4	5		
7. The material was (check one) ___new ___review for me							
8. Time required to complete the reading assignment: _____minutes							

I verify that I have completed this activity: _____

Comments
