

## INTRODUCTION

The causal link between cigarette smoking and a range of cancers is well established (Peterson et al., 2005). Yet interestingly, once a diagnosis of cancer is given the evidence shows that there are still positive benefits from giving up (Nayan et al., 2011). Continuing to smoke reduces survival times, increases the risk of recurrence or development of further primary tumours and reduces treatment efficacy (Schnoll et al., 2003). All cancer patients who smoke will be affected by delay in wound healing, experience a greater risk of wound infection and an increase in tissue and bone necrosis (Nayan et al., 2011). Patients with head, neck and lung cancers are particularly prone to exacerbation of complications associated with surgery and radiotherapy as smoking directly affects these tissues (Nayan et al., 2011). Reducing smoking rates would lower the incidence of smoking-related cancers overall and improve outcomes for smokers treated for cancer. However, there is strong evidence to show that smokers find it very difficult to quit, particularly without assistance and support, even after a cancer diagnosis (Schnoll et al., 2003; Carlebach and Hamilton, 2009). Those who continue to smoke are considered by Schnoll et al. (2003) to be 'hard core'; but John et al. (2006) and Chan et al. (2010) found this pattern to be consistent with other groups suffering from life-limiting, smoking-related diseases such as stroke. Since the 1980s the evidence associated with smoking and ill-health has been strengthening and the effectiveness of certain stop smoking interventions has also been becoming clearer (Schnoll et al., 2003).

Stop Smoking Services (SSS) have been established in primary care settings in the UK for over a decade and more recently such services are becoming available in acute hospital settings. Hospital-based services would seem particularly appropriate because many smokers do not become motivated to take action until they are admitted to hospital with a smoking-related illness, such as cancer (Twardella et al., 2006; Eadie et al., 2008; Department of Health (DH), 2011). Rigotti et al. (2009) refer to this situation, where the patient is more ready than usual to consider a health-related behavioural change, as a 'teachable moment'. However, Gritz et al. (2005) conclude from their systematic review that diagnosis of cancer remains an underused opportunity.

Nurses provide the majority of patient care in hospitals and findings from a Cochrane Review, Nursing Interventions for Smoking Cessation (Rice and Stead, 2008), suggest they have a role in supporting patients to quit smoking. The review highlighted that interventions delivered and supported by nurses, especially in hospital, increased a smoker's success in quitting. There is however some evidence to show that there is reluctance on the part of nurses to introduce the subject of smoking cessation to patients who smoke (Lally et al., 2008). Another Cochrane review, Interventions for smoking cessation in hospitalised patients (Rigotti et al., 2009), concluded that there was insufficient evidence to recommend any one particular hospital-initiated intervention.

What is clear is that smoking behaviour is multi-factoral and therefore multi-method approaches are recommended to support quit attempts (National Institute for Health and Clinical Excellence (NICE), 2007, 2008). A first step in a multi-method approach is a brief intervention (NICE, 2008; DH, 2011). This involves an opportunistic, routine

enquiry to all patients on their smoking status and, if they smoke, their readiness to quit (NICE, 2006; DH, 2011). If they smoke and are open to advice to quit, advice should be clear and tailored to the individual's health and include information on the availability of stop smoking services (Ghodse et al., 2008). Patients have often been given advice to quit by different people, over a long period of time. Research suggests that the hospital admission has the potential to offer the patient the opportunity to act upon this advice. Although the quit attempt can be started in hospital, appropriate community support needs to be available after discharge home to reduce the likelihood of patients returning to smoking (NICE, 2007, 2008). This is supported by evidence from a Cochrane review which showed that smoking cessation counselling delivered in acute hospital settings, combined with follow-up support that lasts at least one month post discharge, increases smoking cessation rates (Rigotti et al., 2009).

Hospitals in the UK are being encouraged to capitalise on the 'teachable moment' by offering smoking cessation support to patients, so they can start a quit attempt when their motivation is high (DH, 2011). As this is a new service in acute hospitals it is important to explore patient experiences so that developments reflect patients' needs and expectations. The purpose of this paper therefore is to report the user experience of such a service and provide information for the development of similar services.

### **The new stop-smoking service**

The new service was based in a 1,000-bed acute hospital in an industrial area in the north of England and targeted four clinical specialties: cardiac, respiratory, Ear, Nose and Throat (ENT) and women's services (including maternity). Any patients referred from outside these target specialities were assessed, as it was important that no patient was refused access. Therefore patients with a variety of diagnoses, including cancers, were referred. The service aimed to provide swift, smoking cessation opportunities for all patients who wished to access them. Many aspects of the service from the initial contact, to the advice and counselling given to patients by smoking cessation staff, were influenced by evidence of best practice (DH, 2009). The service was provided in a range of locations including at the bedside, in the hospital clinics and as a drop-in service in the hospital reception area. The service comprised a team of four part-time smoking cessation facilitators, each of whom worked 15 hours per week, led by a stop smoking specialist working 30 hours per week. All the facilitators had a nursing background, although this was not a specification of the role. The team offered a brief intervention to all smokers on targeted wards. For patients who wanted more, a further assessment with advice and counselling was offered.

## **METHODS**

### **Study design**

A qualitative design was used to collect data via face-to-face structured interviews with service users (n=44) and follow-up telephone interviews with those who could be contacted, approximately 6 weeks later (n=19). A structured interview schedule was developed with questions informed by themes that emerged from the literature

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review. Data were also collected from staff and addressed broader themes including hospital systems and health staff roles that promoted smoking cessation and are reported elsewhere (Jones and Hamilton, 2011).

### **Sample selection and data collection**

Once approval had been secured from the University Ethics Committee and Trust Research and Governance department, the initial approach to patients was made by the smoking cessation team. They used a standard script, prepared by the researchers, to explain the study aims to the 328 patients whom they assessed during the 4 month study period (January 2010 to April 2010 inclusive). The contact details of those wishing to take part were passed to the research team. Recruitment was frustrated by the short length of stay of patients, part-time hours of the smoking cessation team and limited availability of the researcher. Therefore, those who stayed in hospital longer were more likely to be recruited. Also some contextual factors influenced sample selection e.g. only smokers who were made aware of the service, those who chose to access it and those who agreed to be interviewed were invited to participate.

Once the research team had obtained written informed consent from participants, a face-to-face structured interview was conducted at the bedside or in the clinic room. Forty-four participants took part in the interview; 21 women and 23 men, aged from 23 – 73 years. Most were white British (n=42) with one participant classing themselves as 'White Other' and another as 'Asian British'.

INSERT Table 1: Age range of participants

INSERT Table 2: Amount of cigarettes/tobacco smoked by participants

INSERT Table 3: Participants according to hospital specialty

During the interview the researcher documented the participant answers and verbatim quotes. Questions related to: their thoughts about being given stop smoking advice in hospital and having a stop smoking service available, the extent of their tobacco dependency, experiences of previous quit attempts and if any healthcare professional had prompted their quit attempt on this occasion.

INSERT Table 4: Trigger questions for patients

At the end of the interview, participants were asked if a follow-up telephone interview could be undertaken with them 6 weeks later. Nineteen participants were successfully followed-up (male, n=11, female, n=8; age range 29 – 71 years) and undertook a telephone interview. The purpose of the follow-up interviews was to discover the participant's experience of maintaining their quit attempt on returning home and to reflect back on the service they had received.

### **Data analysis**

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A thematic analysis based on the six-stage approach of Braun and Clarke (2006) was undertaken; starting with an in-depth familiarisation with the data that was followed by the generation of initial codes. These codes were applied to the data and collated into potential themes. These themes were then reviewed by a second researcher and a thematic map of the analysis was developed. The next stage was to refine and name the themes. The final stage was to select examples to illustrate the thematic framework.

## **Trustworthiness**

The rigour of a qualitative study is often established through its trustworthiness but strategies for demonstrating this have been subject to much debate (Morse et al., 2002). Four key attributes of trustworthiness have been described: credibility, transferability, dependability and confirmability (Guba, 1981). Credibility refers to how accurately the findings represent what is actually intended, transferability, the extent to which the findings can be applied elsewhere, dependability, the reliability of the findings and confirmability, how well the findings are free from bias in representing the participants' views (Shenton, 2004). In this study credibility was demonstrated by triangulation of participant data leading to identification of common themes; although saturation was not achieved, so the findings must be considered indicative rather than conclusive (DePoy and Gitlin, 2005).

Transparent approaches to data collection and analysis increased transferability and dependability; as did our recruitment method, where efforts were made to select comparative numbers from each gender, a broad age range and a variety of diagnoses. Confirmability was increased by using the same topic questions for each participant and recording their responses immediately. Furthermore, the researcher who undertook the research was a former nurse so had an understanding of health issues. She was aware of the necessity of a reflexive stance, to avoid making assumptions and to minimise bias and so increase confirmability. In combination these methodological attributes provide the reader of this paper with the opportunity to assess trustworthiness for themselves (Miles and Huberman, 1994; DePoy and Gitlin, 2005; Braun and Clarke, 2006).

## **RESULTS**

### **Uptake of the service**

Data routinely collected by the service, comprising service usage and quit rates, are presented here to set the context for our study findings but did not form part of our data collection. The service assessed 783 people in its first twelve months, from April 2009 to March 2010 inclusive; of whom 379 were men (48%) and 404 were women (52%). All these patients set target quit dates and the service measured its impact and effectiveness by the four week quit rate, in the same way as the national stop smoking service. Standard follow-up by the service identified 215 patients (27%) who had quit at four weeks. Further telephone follow-up by service staff identified an overall quit rate of 42% (n=394) in the first year of operation.

### **Analysis framework**

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Lewin's forcefield theory (1963) offered a theoretical framework to inform the data analysis and provided a theoretical context for the key issues arising from the data. Lewin (1963) suggested that there are driving forces (pushes) that promote change and restraining forces (pulls) that mitigate against it; when the balance between the forces shifts it creates a new equilibrium and maintains the change. This has come to be used in managerial contexts to change people's behaviour and is recommended as a resource by the NHS Institute for Innovation and Improvement (NHS Institute for Innovation and Improvement, 2006-2012). However it is also helpful in understanding and promoting change in health behaviours, as in this study.

## **Face-to-face and telephone interviews**

Data from face-to-face and telephone interviews were analysed and are presented together to provide a holistic account of the service user experiences. Pushes towards and pulls away from accessing the hospital smoking cessation service were identified (Figure 1). These were mediated by the battle going on in the smoker's mind over benefits versus mental and physical costs of changing their behaviour and were demonstrated outwardly by how ready they were to quit. Within the main two themes, four sub-themes were identified which outlined how participants expressed the factors that were pushing them towards or pulling them away from engaging with the service and starting a quit in hospital.

INSERT Figure 1: Thematic map of data from interviews

### **'Pushes' towards quitting smoking**

#### *A teachable moment*

Many patients expressed positive views about discovering the service; especially that it was readily available and accessible to them at this time; for example following a diagnosis of cancer or heart attack. For some it was a 'teachable moment' as they were open to changing their behaviour. One participant said, 'I would not have listened before (my heart attacks),' (Participant 118) but now expressed himself as receptive to stop smoking and other health promotion messages. Another said, 'It scared the life out of me being in hospital at 37,' (Participant 212) and yet another described their hospital admission as a 'rude awakening' and 'giving them a fighting spirit to do something now' (Participant 122), others rationalised it as, 'my warning,' (Participant 202) and 'a wake-up call' (Participant 204).

Thirteen participants said health care professionals had advised them to quit over the years and six spoke of hospital staff raising the subject during this admission or clinic visit. One participant said they tended to listen more to health professionals, 'everyone else has recommended quitting, but with my own family I feel they are whingeing' (Participant 203).

#### *Becoming motivated*

Participants found an acute episode of ill-health a powerful motivator in initiating quitting; it focused their thinking. The combination of what they already knew about the effects of smoking and what they had now experienced personally helped to

motivate them. Some had thought about quitting before but the admission to hospital acted as a deciding moment, giving them the motivation to pursue it; although others were less decided, thought they might still fail. Participants also mentioned other motivators relating to family and personal circumstances, such as pregnancy and promises made to family who want them to return to good health. They expressed concerns about returning home and how that would affect their motivation e.g. whether family members, friends and colleagues smoked around them affected how easy or hard they felt it would be to give up.

### *The right environment*

For some, the hospital environment provided an opportunity to think about and possibly pursue a quit. One participant described the hospital environment as, 'like a bubble,' and explained, 'You don't have the same smells, contact with family, friends or workmates or the same routine, you have a false sense of security' (Participant 210 ). Their conclusion was that, 'It's easier to quit here, I am keeping products for when I get home, and when I have other pressures.'

The smoke-free hospital policy provoked a mixed but generally positive response. Some reported it as having a deterrent effect, for example making the environment less conducive to smokers which provoked people into starting to quit. There was general acceptance of the smoke free hospital site in principal, in accordance with a healthy environment and with UK legislation. Choice was an important issue for patients with comments such as, 'you can only suggest someone quits smoking' and the idea that making a hospital smoke-free, 'doesn't necessarily stop it (smoking), it depends on their mind set.'

### *Facilitating choices*

Without exception, participants welcomed the new service. They felt it was wholly appropriate for hospitals to help patients to stop smoking, providing that the choice of patients who did not want to engage with the service was respected. An understanding, non-judgemental approach was important to patients and they felt it improved outcomes. Expressing understanding for the smoker's situation in a personal, friendly manner with advice tailored to the individual, giving a choice of products and discussing the one(s) most appropriate for them was viewed positively and thought to be effective. Once a good relationship was established at the first assessment, participants were more likely to feel supported.

### **'Pulls' away from quitting smoking**

#### *Battling with negative experiences*

Participants came into the hospital often having unresolved issues from previous quit attempts. They may have tried various treatments and services, including national initiatives but still failed to quit or relapsed following a successful quit. They gauged their likelihood of quitting on whether they felt themselves to be more or less determined this time. In some cases this was influenced by their recent circumstances such as: their present health status, a diagnosis of cancer, potential

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requirement for further surgical or medical interventions and support or lack of it from friends and family.

### *Smoking as a way of life*

Smoking was a big part of the life and identity of many of the participants. Many had smoked for a long time and from a young age. Participants talked about how the habits and triggers associated with smoking were entrenched in their lives and extremely difficult to overcome. They expected that on their return home it would be more difficult to sustain the quit because of the presence of triggers and the sense of going it alone; some were deciding how and when to take NRT and preparing their plans for continuing their quit when they were discharged.

Participants provided various rationales for continuing to smoke even though they knew it was bad for their health. One participant expressed the view that, 'Some people can stop just like that, but others like myself, really struggle ... lack the willpower' (Participant 115); others rationalised it by saying they were not being serious or determined enough to quit. Smoking was seen as a good way to deal with stress. Participants cited smoking as a way of coping with life and in particular with hard times.

Two participants perceived smoking as an acceptable risk, 'Smoking is as dangerous as crossing the road; life is risky' (Participant 114) and the other used a similar analogy, 'Cigarettes will kill you but you could get killed going under a bus' (Participant 115). They remained trenchant in their views about continuing to smoke once out of hospital; one (Participant 115) spoke of how he had had a chest pain recently and quit for 7 weeks, thinking it might be smoking-related; but when it was diagnosed as a pulled muscle he went straight back to smoking.

### *Practical barriers to starting a quit attempt*

Some participants experienced delays in being assessed and in getting NRT. One participant said, 'The service wasn't as fast as I expected, I waited for two days to see the adviser. I am still waiting for NRT' (Participant 201). There were problems when NRT inhalator cartridges were mislaid on transfer between wards, leaving the participant without a supply (Participant 116). While another participant said, 'I am still waiting for an inhalator, I'm discharged today, as long as I get NRT before leaving; if I don't it will be hard to quit' (Participant 202).

Smokers can perceive the hospital staff's discouragement of smoking in a negative manner, although this was only in a minority of cases. One said, 'You feel targeted and pressurised as a smoker' (Participant 101). Another said, 'If you say you smoke they look at you as though you are from Mars' but also pointed out the mixed messages from staff when they claimed that, 'When I went for a smoke there was a nurse going out to smoke too' (Participant 117).

### *The continuing attraction of smoking*

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Participants were at risk of resuming smoking once they were discharged from hospital back to their home environment. Nine of the 19 users followed up stated they had maintained their quit, 2 successfully went 'cold turkey', 4 said they had cut down, for 2 it was not clear what had happened and 2 continued to smoke as they had prior to admission. Seven participants had accessed follow-up services in the community and were generally satisfied with their care. Inconvenience or difficulty in obtaining or using NRT tended to be the reason given for failure. Those who successfully found ways to distract themselves from the temptation to smoke were more likely to maintain their quit attempt. This was more difficult for those whose circumstances reduced their opportunities for distraction. Some participants spoke of the comparative lack of support they experienced once they left hospital.

## **DISCUSSION**

The study findings suggested that patients appreciated the opportunity to start a quit attempt during their hospital stay. It was clear that the hospital admission acted as a catalyst for a quit attempt for many patients. A key aspect of the service was that it gave participants the opportunity to start a quit attempt at a moment of readiness prompted by the hospital admission. While acknowledging that for some smokers it would not be the right time to quit, for many patients, they saw it as a good opportunity as they were in a supportive environment with free time, less distraction and a convenient service. These findings supported the concept of the teachable moment which suggests that people, especially those suffering from tobacco-related illnesses, are more receptive to stop smoking messages during hospitalisation as it increases their perception of their own vulnerability (Rigotti et al., 2009). Furthermore, our findings concurred with those of Thomsen et al. (2009) who found that the driving force to change was strengthened for participants by their hospital experience, while some of the restraining forces to continue smoking were reduced.

Many of the findings outlined above and the necessity of incentivising organisations to deliver interventions that address them is being recognised more widely. Commissioning for Quality and Innovation (CQUIN) targets have been identified and adopted in some areas but at present they are not mandatory; however this provides an opportunity to drive this agenda forward in England (NHS London Respiratory Team, 2011). Nevertheless the picture is complex; although the literature supported the finding that for many smokers they may enter a teachable moment during their hospital stay, this study also found that there were a variety of personal factors impacting upon the decision-making process both for and against starting and maintaining the quit.

The restraining forces referred to by Lewin (1963) are complex, may be emotionally based and seem illogical, so for example, John et al. (2006, p48) concluded that 'a substantial portion of individuals smoke despite their disease'. Similarly Lewin (1963) found that an individual's psychological past and the prevailing social atmosphere are likely to influence the strength of the driving and restraining forces when people make their choices. Lewin (1963) argues that lasting change is more likely if the restraining forces are reduced, at the same time as the driving forces are increased. As there is a constant desire to re-establish equilibrium, people try to find a way of



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thinking that rationalises their behaviour and keeps the forces balanced (Lewin, 1963; John et al., 2006).

From a health perspective, the question therefore remains, as to how to assist each smoker to stop during their hospital stay and maintain their quit thereafter. Knowledge alone did not motivate participants in this study to stop smoking. Slark (2010) in her literature review on secondary stroke prevention, including smoking cessation, concluded that, 'improving information and education provision to patients and their families is important but has shown no real significant improvement in adherence' (p284). The findings from this study suggested that success depended on the overall personal cost or benefit participants saw in continuing or quitting.

The strength of motivation varied between participants and previous research suggests many factors affect motivation, for example: lay attributions of illness, mood and stress (Lloyd and Foster, 2006; Townend et al., 2006). Lawrence et al. (2010) suggest that normative family beliefs and the expectations of others might sway people towards certain choices. Although conclusive research investigating the role of family support in smoking cessation following ill health is lacking, family and peer support have been shown to improve success rates in older people (Wagner et al., 2004; Luker et al., 2007). Wagner et al. (2004) suggested that the processes were complex and that the nature of the support and the relationship with the smoker affected the direction of any behaviour change.

Participants in this study identified themselves as being at different points in the process of changing to become a non-smoker (Prochaska and DiClemente, 1983). The follow-up telephone calls identified that some had maintained their quit but others had not, while some had only cut down. The struggle to cut out their main means of coping with stress at a time of high stress was mentioned. This finding concurred with that of Thomsen et al. (2009) who recognised it as a significant barrier to successful smoking cessation. Nevertheless, there were some key factors identified by the participants that made it more likely they would be able to maintain their quit, including the effective use of NRT, perseverance to keep going until it became easier and a supportive family who were prepared to change their own smoking habits.

When these factors, personal strength of motivation and stage of change, are related to stopping smoking in a hospital setting research has found that patients undergoing major surgery were more likely to quit smoking than those having minor surgery (Shi and Warner, 2010) i.e. major surgery is a strong motivator; however other authors argue that teachable opportunities are often missed altogether, for example on diagnosis of cancer, stroke or peripheral vascular disease (Mukherjee et al., 2002; Gritz et al., 2005; Croquelois and Bogouslavsky, 2006). A major health benefit occurs whenever patients stop smoking so there is still value in stopping even after a serious smoking-related disease has been identified (Gritz et al., 2005). This supports the need for stop smoking services in acute hospitals and the importance of identifying all patients who are ready to quit smoking. It suggests that clinical staff should be raising the issue of smoking cessation during the hospital admission process. Indeed this approach has been recommended in UK and US clinical guidelines (Fiore et al., 2008; DH, 2011).

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Our study established that participants supported the notion that hospitals provide a suitable environment to promote stop smoking initiatives however it is still important that smokers are approached in ways that are most likely to support them in successfully becoming a non-smoker. With the increase in disapproval of smoking by UK society as a whole, as demonstrated by the acceptance of the smoking ban introduced in England in 2007, it is not surprising that this study found that some participants felt stigmatised as smokers (DH, 2006). In spite of this sense of stigma they were still smoking, so clinical staff need to be sensitive to the broader contexts in patients' lives that impact on their smoking behaviour and the stage of change a person has reached (Zimmerman et al., 2000; Graham, 2007). As Gritz et al. (2005) explain for example, cancer patients may be psychologically vulnerable at this time and sensitive to any perceived blame for their condition. Indeed, this study found that a non-blaming, non-judgemental approach from the stop smoking staff was important if they wanted their message to be heard and accepted by smokers. Gritz et al. (2005) suggest that advice should focus on the role of addiction, the potential for help by family, friends and healthcare professionals and the negative role of continued smoking on the effectiveness of treatment (Gritz et al., 2005). Their recommendation is for intensive, multimodal intervention (Gritz et al., 2005). Ultimately the smoker has to develop a non-smoking identity if they are to maintain their quit in the long-term (Carlebach and Hamilton, 2009).

This study found that resourcing and raising the profile of the smoking cessation service presented a challenge and the service was not routinely accessed by all target wards by the time data collection had been completed (Jones and Hamilton, 2011). Although nurses, allied healthcare staff and medical staff were encouraged to offer brief interventions and refer patients to the service, in addition to self-promotion by the service team, many barriers to efficacy existed (Jones and Hamilton, 2011). A number of reasons have been suggested for hesitation on the part of oncology nursing staff in addressing the topic of smoking with smokers; ranging from their own personal smoking habits, to feeling ill-equipped to offer stop smoking advice, to a gap between their understanding of the negative impact of smoking on health and acceptance of their responsibility to raise the issue of smoking with a smoker (McCarty et al., 2001; Lally et al., 2008). According to Lally et al. (2008) the nurses own smoking behaviour can act as a deterrent, with smokers less likely to promote smoking cessation to their patients (McKenna et al., 2001). Indeed the nurse referred to as seen smoking by one of the participants sends a potent message of support for smoking. There also appears to be an uncertainty among nurses that makes many of them hesitate to challenge someone's smoking behaviour, possibly because they fear a negative response (McCarty et al., 2001). These issues may hint at some of the reasons why embedding such a service might initially present challenges.

The findings from this study are supported by previous research into stopping smoking and indicate that the new smoking cessation service assisted patients to quit by recognising and working with individual perspectives and experiences. By capitalising on the teachable moment the service was brought to the smoker at a time when they were more likely to be considering a quit attempt. Although participants had positive experiences of the service, smoking had been a well-

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established way of life prior to admission and as such patients were at risk of being pulled back into their smoking behaviours once they returned home.

## **Limitations**

There are two main limitations that might impact on the findings of this study. Firstly, the sample was small and participants were selected from a limited number of wards in one hospital in one geographical location; therefore findings might be specific to this one location and generalisability might be limited. Secondly, less than half of the participants could be followed-up after discharge, which potentially reduced the breadth and robustness of the findings. Furthermore, it could be expected that some of those lost to follow-up returned to smoking after discharge from hospital but their perspectives could not be captured.

## **CONCLUSION**

The strong, causal relationship between smoking and many cancers is well known. As patients entered the hospital environment with a range of diagnoses, some smoking related, it provided a prime opportunity to offer stop smoking advice, assessment and treatment. This study highlighted the broad range of 'pushes' and 'pulls' towards and away from a quit attempt and emphasised the health education role of clinicians in the acute hospital environment. The new stop smoking service was positively received by participants in this study; even so, stopping smoking was a challenge and patients required continuing support once they left the hospital.

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Table 1: Age range of participants

Age Range	No. of patients given initial questionnaires	No. of patients successfully contacted by telephone
Under 18 years	0	0
18 – 29 years	3	1
30 – 39 years	6	3
40 – 49 years	9	2
50 – 59 years	12	6
60 – 69 years	9	6
70 years and over	5	1
Total	44	19

Table 2: Amount of cigarettes/tobacco smoked by participants

No. of cigarettes smoked per day (includes roll ups)	No. of participants	No. of cigars smoked per week	No. of participants	Weight of tobacco smoked in g per 3 months	No. of participants
0 (recently quit)	2	0 (recently quit)		0 (recently quit)	
1-5	3	1-5	1	1-5	1
6-10	6	6-10		6-10	
11-15	7	11-15		11-15	
16-20	5	16-20		16-20	
21-25	5	21-25		21-25	
26-30	5	26-30		26-30	
31+	7	31+		31+	
Missing data	2	Missing data		Missing data	
TOTAL	42		1		1



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Table 3: Participants according to hospital specialty:

Maternity	Cardiology	Respiratory	Vascular	ENT	Women's health	Out of pilot area	Non referred attendance at drop in clinic
4	19	6	5	3	2	2	3

Table 4: Trigger questions for patients:

<ol style="list-style-type: none"> <li>1. Do you think it is a good idea to offer stop smoking advice to people admitted to hospital?</li> <li>2. How did you feel about being given the stop smoking advice as part of your hospital admission/out-patient clinic visit?</li> <li>3. When you think about quitting, are you             <ol style="list-style-type: none"> <li>a) more likely</li> <li>b) less likely or</li> <li>c) about the same likelihood to make a quit attempt at the moment, compared to in the past?</li> </ol> </li> <li>4. Did your doctor/nurse say anything that made you think about stopping smoking on this occasion?</li> </ol>
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Figure 1: Thematic map of data from interviews

Theme 1: Push to access service		Theme 2: Pull not to access service
A teachable moment	Battlefield of the mind	Battling with negative experiences
Becoming motivated	<b>HOSPITAL STOP SMOKING SERVICE</b>	Smoking as a way of life
The right environment		Practical barriers to starting a quit attempt
Facilitating choices	Readiness to quit	The continuing attraction of smoking