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Attitudes and Behaviors Regarding Smoking in Friends and Relatives of Patients in Emergency Room: A New Frontier in the Fight against Tobacco

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Original Article

Abstract

Background: Emergency rooms (ERs) are usually crowded with friends and relatives (F&Rs) of the patients. This experience may result in changes in smoking behaviors and create opportunities for smoking cessation interventions. The study aims to investigate these changes and offers a new frontier in the fight against smoking.

Methods: This cross-sectional study was conducted in the ERs of two universities in different cities. A questionnaire consisting of 18 questions was applied to F&Rs of the emergency patients. Statistical analysis was performed using Jamovi program.

Findings: A total of 603 respondents were included in the study. Of them, 71.3% were first-degree relatives, 51.7% waited 5 or more times in ER before, and 68.6% spent 0-2 hours in a day around the ER. Upon witnessing patients in the ERs, 53.4% of the F&Rs had the idea of quitting smoking and 42.9% wanted to have smoking cessation therapy during their wait in the hospital. While 76.1% of the participants were not using different brands of cigarettes when offered in normal life, this rate was lower around the ERs (64.6%) ($P < 0.001$). Participants smoked 0.82 ± 0.34 cigarette per hour in normal life excluding sleeping time; this number raised almost 6 folds during the wait (4.85 ± 2.11) ($P < 0.001$).

Conclusion: F&Rs smoked more during waiting around ERs. However, they also expressed desire to quit smoking and receive smoking cessation intervention during the wait. Providing smoking cessation counseling to F&Rs in the ER may be a valuable intervention.

Keywords: Tobacco use cessation; Emergency medical services; Friends

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Introduction

There are periods of crisis or situations where people experience more stress than usual and in these situations, they resort to harmful behaviors such as smoking more and care less about their health such as not eating or sleeping well.[1] They can become vulnerable to mental and physical health threats. Such behavioral changes can occur in any situation that cause acute stress: deaths, birth, emergency health problems, fights, sadness, anger, etc. However, some of these periods may also create opportunities for health counseling, because in these periods, people feel a need for a shoulder to lean on and a friendly hand that will reach out to them. For example, a person who had stopped smoking before but was tempted due to the current crisis may be prevented from restarting with a friendly advice.

Smoking can cause a range of chronic health problems, from cardiovascular diseases (CVDs) to cancer, and one in five deaths can be attributed to smoking.[2,3] In addition, smoking is one of the most important preventable causes of death, and campaigns and state policies are being carried out worldwide to change this situation.[4] However, in many societies, the desired results cannot be achieved; therefore, effective combat methods against smoking are constantly being sought.

People with emergency diseases apply to the emergency rooms (ERs) from all segments of the society and their friends and relatives (F&Rs) accompany them. According to the data from 2013, annual ER visits are around 130 million in the United States (US) and this number is around 100 million in Turkey.[5,6] Most patients apply to the ERs with a number of F&Rs accompanying them. Thus, patient and F&R circulation of ERs exceeds the total population of the countries. This is a stressful period and patients' F&Rs waiting here have some stressful but free time with nothing to do. This dangerous combination of stress and free time makes them vulnerable to risky behaviors for health. The fact that so many people with free time come together in a health facility can also be turned into an opportunity for interventions to improve health and treat risky behaviors.

In a study, it was reported that relatives of children who applied to pediatric ERs had a strong motivation to quit smoking and appropriate interventions were needed to help them.[7] Indeed, besides providing much needed emergency care, hospital ERs can also be valuable places to provide tobacco counseling. This service is currently provided elsewhere in health care systems (commonly in primary care settings).[3]

Conducting an academic study on smoking cessation in the stressful environment of the ERs is a challenge to possible negative reactions; therefore, studies conducted in the ERs will fill a large gap in the literature.

In this study, the aims were to investigate the attitudes and behaviors of smoking in the F&Rs of the patients who applied to the ERs, determine their desire to quit with this experience, and explore possibility for smoking cessation counseling in these settings.

Methods

This cross-sectional study was conducted on the F&Rs of patients who applied to the ERs of two universities in different cities between June and December 2018. The universe of this study included F&Rs of 336274 patients (188343 from ERs of School of Medicine of Ahi Evran University, Kirsehir, Turkey and 147931 from ERs of School of Medicine, Giresun University, Giresun, Turkey). At least 541 people with 5% error margin and 98% confidence interval (CI) were needed to reach the recommended sample size.

A total of 6726 people determined by simple random sampling (one in every 50 patients), 5100 people that 18 and older were asked if they smoke and 709 people were affirmative. The purpose and form of the study was clearly explained to them and 603 people agreed to participate in the study.

A questionnaire consisting of 18 questions in Likert formation (3 questions in 2, 8 in 3, 6 in 4 Likert) was prepared in the light of the literature about current and past experiences regarding ERs along with demographic data. Since these questions were asked in an unusual way in a place where the participants would not normally be present, no previous validity or reliability studies were required. It took 15 minutes to complete on average. Participants filled it out themselves, but for those who are unable to read or write, the authors of the study helped.

In summarizing the data, descriptive statistics are given in tables as mean ± standard deviation (SD) or median to quartile width depending on the distribution of variables. Categorical variables

were summarized as numbers and percentages. Normality test of numerical variables was checked by Kolmogorov-Smirnov test. In the comparison of more than two independent groups, one-way analysis of variance (ANOVA) was used in cases where numerical variables were normally distributed, and Kruskal-Wallis test was used in cases where they were not normally distributed. According to the distribution of data, differences between the groups were evaluated by Tukey test when the data was homogeneous and Games-Howell test when it was not homogeneous. Differences between the groups in non-parametric tests were evaluated by Dwass-Steel-Critchlow-Fligner test. Pearson chi-square test was used in 2x2 tables and Fisher's exact test was used in RxC tables. Statistical analysis was performed using Jamovi program (version 0.9.5.12, Jamovi project, 2019), and the level of significance was considered as 0.05 (P-value).

Results

Majority of the patient's F&Rs agreed to participate in the study (2679 out of 3594 individuals: 75%). Among 603 individuals included in the study, 74.1% (n = 447) were men, 25.9% (n = 156) were women, and 59.5% (n = 359) were married. When the relationship with the patient in the ER was investigated, 71.3% (n = 430) were first-degree relatives, 17.4% (n = 105) were acquaintances, and 11.2% (n = 68) were other relatives.

More than half of the participants (51.7%) waited 5 or more times in ER before and 68.6% of them spent 0-2 hours in a day around the ER. It was seen that 53.4% of the individuals had the idea of quitting smoking when they saw the patients in the ER and 42.9% wanted to have smoking cessation therapy during their waiting period in the hospital. When asked whether the disease of their patient was related to smoking, 56.3% thought that there was no relationship, 23.3% thought it was partially related, and 20.2% thought it was related.

Private cars (62.5%) were generally used to and from hospital in this period, 64.6% were not sleeping while waiting in the ER, and 57.7% were eating in the canteen. The participants spent 33.62 ± 35.05 Turkish Liras (TL) per day, excluding hospital expenses and 86.7% of the F&Rs did not think to demand any part of this money back from the patient (Table 1).

While 76.1% of the participants were not using different brands of cigarettes when offered in normal life, this rate was lower in front of the ERs (64.6%) (P < 0.001). When asked why they smoked while waiting, 65.8% of the responses were 'because it reduces my stresses'. While the participants smoked, on average, 0.82 ± 0.34 cigarette per hour in normal daily life (excluding sleeping time), this number raised almost 6 folds in waiting period (4.85 ± 2.11) (P < 0.001).

The smoking rate in men was higher than women during waiting period (11-20 versus 0-10 cigarettes, P = 0.002). Those who thought that their sorrow was reduced or felt themselves better with cigarettes smoked 11-20 cigarettes compared to those who smoked 0-10 cigarettes (P = 0.041, P = 0.007, respectively). The rate of accepting different brands of cigarettes when offered was higher in smokers who consumed 11-20 cigarettes or more compared to those who smoked 0-10 cigarettes (P = 0.009). Participants who found it difficult to observe smoking prohibitions in areas such as closed spaces in normal daily life smoked more than those who did not feel the same (11-20 versus 0-10 cigarettes) (P = 0.005). Participants who thought that their patient's illness was not related to smoking smoked significantly more than those who thought it was (11-20 or more versus 0-10 cigarettes) (P = 0.002). Those who used their private car when traveling to and from the ERs were less likely to smoke more than 1 pack of cigarette than those who were using public transport (P = 0.001).

Those who slept at the hotel while waiting were more likely to smoke more than 20 cigarettes than those who did not sleep at the hotel (P = 0.001) (Table 2). On average, daily median expenditure (excluding hospital expenses) of smokers who smoked 0-10 cigarettes in normal daily life was lower than that of users of 11-20 or more cigarettes during waiting (P < 0.001) (Table 3).

Participants who thought that the illness of the patient in the ER was related to smoking were more interested in having smoking cessation therapy while in the hospital than those who thought it was not related (P = 0.003). Besides, these participants thought to quit smoking more - as they saw the patients in the ER - than those who thought that there was no relationship between their patient's disease and smoking (P <0.001).

Table 1. Emergency room (ER) experience and smoking behaviors

		Value
How many times did you need to wait in ER before?	0-2	122 (20.23)
	3-4	169 (28.03)
	5 or more	312 (51.74)
How long have you waited in the vicinity of the ER today? (hour)	0-2	414 (68.66)
	2-4	107 (17.74)
	More than 4	82 (13.60)
How many cigarettes have you smoked in the vicinity of the ER today?	0-10	492 (81.59)
	11-20	69 (11.44)
	More than 20	42 (6.97)
How many cigarettes a day do you normally smoke?	0-10	173 (28.69)
	11-20	265 (43.95)
	More than 20	165 (27.36)
Do you normally smoke different brand of cigarettes when offered?	Yes. Brands make no difference	144 (23.88)
	No. Unless I have to	281 (46.60)
	No. It makes me cough	90 (14.93)
	Never	88 (14.59)
Do you smoke different brands of cigarettes if offered while waiting in ER?	Yes	213 (35.32)
	No	390 (64.68)
Do you normally find it difficult not to smoke in restricted areas?	Yes	191 (31.67)
	Partially	171 (28.36)
	No	241 (39.97)
Do you find it difficult not to smoke in restricted areas in the ER?	Yes	149 (24.71)
	Partially	174 (28.86)
	No	280 (46.43)
How do you think smoking helps while waiting in the ER?	It reduces my stress	397 (65.84)
	It reduces my sorrow	86 (14.26)
	It makes me feel more fit	41 (6.80)
	Others	126 (20.90)
What else do you do while waiting for your patient?	Praying	189 (31.34)
	Eating and drinking	71 (11.77)
	Passing time with TV or mobile phone	293 (48.59)
	Engaging in conversations	240 (39.80)
Do you think to quit smoking when you see patients in ER?	Yes	322 (53.40)
	No	281 (46.60)
Would you like to receive smoking cessation therapy while in the hospital?	Yes	259 (42.95)
	No	344 (57.05)
Do you think your patient's illness is related to smoking?	Yes	122 (20.23)
	Partially	141 (23.38)
	No	340 (56.38)
What is your transport vehicle to and from ER?	Private car	377 (62.52)
	Public transport	143 (23.71)
	Ambulance	51 (8.46)
	Others	32 (5.31)
Where do you sleep while waiting for your patience?	I do not sleep	390 (64.68)
	I sleep in the hotel	19 (3.15)
	I stay with F&Rs	48 (7.96)
	I stay in the hospital	146 (24.21)
Where do you eat while waiting?	I do not eat	162 (26.87)
	I eat in the canteen	348 (57.71)
	I eat hospital food when delivered	46 (7.63)
	I eat with F&Rs	47 (7.79)
On average, how much TL do you spend daily while waiting (excluding hospital expenses)?		33.62 ± 35.05
Do you demand your spending from the patient or the relatives?	Yes	34 (5.64)
	Partially	46 (7.63)
	No	523 (86.73)

Data are expressed as mean ± standard deviation (SD) or number and percentage
ER: Emergency room; TL: Turkish Lira; F&Rs: Friends and relatives

Table 2. Comparisons of smoking frequencies in emergency room (ER) experiences

		How many cigarettes have you smoked in the vicinity of the ER today?			P
		0-10 (n = 462)	11-20 (n = 69)	More than 20 (n = 42)	
How many times did you need to wait in ER before?	0-2	104 (85.2)	11 (9.0)	7 (5.7)	0.315
	3-4	143 (84.6)	18 (10.7)	8 (4.7)	
	5 or more	245 (78.5)	40 (12.8)	27 (8.7)	
How long have you waited in the vicinity of the ER today? (hour)	0-2	375 (90.6)	30 (7.2)	9 (2.2)	< 0.001*
	2-4	77 (72.0)	19 (17.8)	11 (10.3)	
	More than 4	40 (48.8)	20 (24.4)	22 (26.8)	
How do you think smoking helps while waiting in the ER?					
It reduces my stress		328 (66.7)	39 (56.5)	30 (71.4)	0.183
It reduces my sorrow		62 (12.6)	16 (23.2)	8 (19.0)	0.041*
It makes me feel more fit		29 (5.9)	11 (15.9)	1 (2.4)	0.007**
Others		109 (22.2)	13 (18.8)	4 (9.5)	0.140
What else do you do while waiting for your patient?					
Praying		163 (33.1)	16 (23.2)	10 (23.8)	0.137
Eating and drinking		52 (10.6)	15 (21.7)	4 (9.5)	0.024*
Passing time with TV or mobile phone		240 (48.8)	35 (50.7)	18 (42.9)	0.710
Engaging in conversations		192 (39.0)	29 (42.0)	19 (45.2)	0.675
Do you normally smoke different brands of cigarettes when offered?					
Yes. Brands make no difference		108 (75.0)	20 (13.9)	16 (11.1)	0.053
No. Unless I have to		233 (82.9)	29 (10.3)	19 (6.8)	
No. It makes me cough		71 (78.9)	13 (14.4)	6 (6.7)	
Never		80 (90.9)	7 (8.0)	1 (1.1)	
Do you smoke different brands of cigarettes if offered while waiting in ER?					
Yes		160 (32.5)	32 (46.4)	21 (50.0)	0.009*
No		332 (67.5)	37 (53.6)	21 (50.0)	
Do you normally find it difficult not to smoke in restricted areas?					
Yes		141 (73.8)	34 (17.8)	16 (8.4)	0.005*
Partially		140 (81.9)	19 (11.1)	12 (7.0)	
No		211 (87.6)	16 (6.6)	14 (5.8)	
Do you find it difficult not to smoke in restricted areas in the ER?					
Yes		110 (73.8)	27 (18.1)	12 (8.1)	< 0.001*
Partially		136 (78.2)	29 (16.7)	9 (5.2)	
No		246 (87.9)	13 (4.6)	21 (7.5)	
Do you think to quit smoking when you see patients in ER?					
Yes		269 (54.7)	33 (47.8)	20 (47.6)	0.418
No		223 (45.3)	36 (52.2)	22 (52.4)	
Would you like to receive smoking cessation therapy while in the hospital?					
Yes		206 (41.9)	33 (47.8)	20 (47.6)	0.528
No		286 (58.1)	36 (52.2)	22 (52.4)	
Do you think your patient's illness is related to smoking?					
Yes		96 (19.5)	16 (23.2)	10 (23.8)	0.002*
Partially		101 (20.5)[a]	23 (33.3)	17 (40.5)	
No		295 (60.0)[a]	30 (43.5)	15 (35.7)	
What is your transport vehicle to and from ER?					
Private car		326 (86.5)	32 (8.5)	19 (5.0)	0.001*
Public transport		107 (74.8)	22 (15.4)	14 (9.8)	
Ambulance		39 (76.5)	7 (13.7)	5 (9.8)	
Others		20 (62.5)	8 (25.0)	4 (12.5)	
Where do you sleep while waiting for your patient?					
I do not sleep		331 (84.9)	37 (9.5)	22 (5.6)	0.001*
I sleep in the hotel		10 (52.6)	2 (10.5)	7 (36.8)	
I stay with F&Rs		38 (79.2)	7 (14.6)	3 (6.3)	
I stay in the hospital		113 (77.4)	23 (15.8)	10 (6.8)	

Table 2. Comparisons of smoking frequencies in emergency room (ER) experiences (continue)

	How many cigarettes have you smoked in the vicinity of the ER today?			P
	0-10 (n = 462)	11-20 (n = 69)	More than 20 (n = 42)	
Where do you eat while waiting?				
I do not eat	132 (81.5)	17 (10.5)	13 (8.0)	0.498
I eat in the canteen	289 (83.0)	40 (11.5)	19 (5.5)	
I eat hospital food when delivered	33 (71.7)	7 (15.2)	6 (13.0)	
I eat with F&Rs	38 (80.9)	5 (10.6)	4 (8.5)	
On average, how much TL do you spend daily while waiting (excluding hospital expenses)?				
	32.4 ± 32.2	33.9 ± 29.5	46.9 ± 62.8	0.198
	20 (10-50)	30 (15-50)	30 (15-50)	
Do you demand your expenses from the patient or the relatives?				
Yes	18 (52.9)	10 (29.4)	6 (17.6)	< 0.001*
Partially	25 (54.3)	9 (19.6)	12 (26.1)	
No	449 (85.9)	50 (9.6)	24 (4.6)	

Data are presented as mean ± standard deviation (SD), number and percentage, or median and interquartile range (IQR)
*P < 0.05, Pearson chi-square test is used, descriptive statistics are given as number (%); **P < 0.05, Fisher's exact test is used, descriptive statistics are given as number (%)
ER: Emergency room; TL: Turkish Lira; F&Rs: Friends and relatives

Discussion

This study is one of the rare studies evaluating behaviors and attitudes towards smoking among patients' F&Rs.

Table 3. Comparisons of demographic data, ER experience, and normal daily smoking

	How many cigarettes a day do you normally smoke?			P
	0-10	11-20	More than 20	
Gender[α]				
Men	103 (23.0)	206 (46.1)	138 (30.9)	< 0.001*
Women	70 (44.9)	59 (37.8)	27 (17.3)	
Age (year)	35.2 ± 11.2	34.9 ± 12.4	34.0 ± 11.1	0.606
Marital status[α]				
Married	107 (29.8)	159 (44.3)	93 (25.9)	0.578
Single	66 (27.0)	106 (43.4)	72 (29.5)	
Relationship[α]				
1st degree relative	129 (30.0)	188 (43.7)	113 (26.3)	0.102
Other relatives	17 (25.0)	37 (54.4)	14 (20.6)	
Friends and acquaintances	27 (25.7)	40 (38.1)	38 (36.2)	
What is your transport vehicle to and from the ER?[α]				
Private car	100 (26.5)	172 (45.6)	105 (27.9)	0.053
Public transport	44 (30.8)	63 (44.1)	36 (25.2)	
Ambulance	12 (23.5)	21 (41.2)	18 (35.3)	
Others	17 (53.1)	9 (28.1)	6 (18.8)	
Where do you sleep while waiting for your patience?[α]				
I do not sleep	117 (30.0)	178 (45.6)	95 (24.4)	0.209
I sleep in the hotel	7 (36.8)	7 (36.8)	5 (26.3)	
I stay with F&Rs	10 (20.8)	18 (37.5)	20 (41.7)	
I stay in the hospital	39 (26.7)	62 (42.5)	45 (30.8)	
Where do you eat while waiting?[α]				
I do not eat	49 (30.2)	65 (40.1)	48 (29.6)	0.273
I eat in the canteen	103 (29.6)	159 (45.7)	86 (24.7)	
I eat hospital food when delivered	9 (19.6)	18 (39.1)	19 (41.3)	
I eat with F&Rs	12 (25.5)	23 (48.9)	12 (25.5)	
On average, how much TL do you spend daily while waiting (excluding hospital expenses)?				
	26.2 ± 26.1	35.8 ± 35.5	37.9 ± 41.1	< 0.001**
	20 (10-30)	20 (15-50)	25 (20-50)	
Do you demand your expenses from the patient or the relatives?[α]				
Yes	6 (17.6)	15 (44.1)	13 (38.2)	0.023*
Partially	19 (41.3)	11 (23.9)	16 (34.8)	
No	148 (28.3)	239 (45.7)	136 (26.0)	

*P < 0.05, Pearson chi-square test is used, descriptive statistics are given as number (%); **P < 0.05, Kruskal-Wallis H test is used, descriptive statistics are given as mean ± standard deviation (SD) or median and interquartile range (IQR); [α]Descriptive statistics are given in line
ER: Emergency room; TL: Turkish Lira; F&Rs: Friends and relatives

It is extraordinary for being conducted in the ER and it has a potential to lead a way to develop new health policies.

ERs are the units where the highest number of admittance for diagnosis and treatments takes place in Turkey. These services are being provided constantly (including the nights, weekends, and holidays). Because of this continuous availability and direct accessibility, non-emergency cases are also applied in addition to emergency cases.[8,9]

Although they have been visited by a large number of patients with even larger numbers of accompanying F&Rs, there is no smoking cessation counseling service (or any other health services for the F&Rs) in the ERs. It can be argued that such services are not necessary or needed in emergency areas due to time restrictions and elevated stress factors. But stressful nature of these periods creates formidable risks for smoking and other risky behaviors. While smokers may increase the number of cigarette consumption, non-smokers and ex-smokers may be tempted to smoke. One of the common misconceptions about tobacco is cigarette's stress-reducing image that leads to behaviors such as offering cigarettes to anyone and socializing through it. While this perception or image may be true for some heavy smokers, it is totally unjustified for the larger public. Moreover, it is advised that 'teachable moments' should be created for smoking cessation interventions using techniques of 5As (Ask, Advise, Assess, Assist, Arrange) and 5Rs (Relevance, Risks, Rewards, Roadblocks, Repetition).[10,11] Our study clearly suggests that such interventions are welcomed by majority of the F&Rs in the vicinity of ER despite time restrictions and stressful situations.

Smoking is among the most common behaviors that people resort to avoid stress.[12] All kinds of stress are among the reasons for starting and continuing smoking that lead to addiction.[13] Since the studies in literature are limited regarding smoking behaviors of patients' F&Rs, it may be appropriate to mention other acute stress groups. For example, Prentice et al. thought that there was an increase in smoking during financial strains.[14] Wang et al. found that the probability of starting smoking was higher in newly divorced couples.[15] Emergency health problems cause acute stress for the patient and their F&Rs. The stress level is directly proportional to the severity and urgency of the problem and causes a significant inadequacy in the coping mechanisms.[16] These situations have a negative impact on the work of health planners and smoking cessation units that are trying to wage a war on smoking. The hard-won gains by multiple campaigns and sacrifices (free smoking cessation clinics, free medicines, valuable times of health and care professionals and patients, etc.) can be lost in an instant in front of the ERs.

Smoking cessation therapies in Turkey are mainly provided in smoking cessation clinics and a significant proportion of them are located in primary care facilities (especially in cancer screening centers and in community health centers). This is in line with primary care objective of health promotion and prevention of diseases. Clearly, these efforts are not enough considering the size of the smoking community and the slow progress on reducing smoking rates. Indeed, it may be difficult to give a full counseling session in an emergency setting. Therefore, a modified approach tailored for each individual might be a more suitable option. Questions arise regarding who will provide this service, how to plan follow-ups, and how to finance it. The US Public Health Service suggests that smoking cessation guidelines be recommended, especially by doctors and nurses, to patients who wish to quit smoking, but the best approach to achieve this goal in the ER is unknown.[17] Clear and strong messages should probably be given in the form of short interventions to all F&Rs, and guide them for further intervention. Indeed, such an approach is needed, where appropriate, for everyone who comes in contact with health services for any reasons.

Crisis periods are commonly regarded as periods in which smoking increases, but conversely, smoking behavior decreases in some demanding periods. Examples include periods of hospitalization,[18-20] pregnancy and lactation,[21,22] sacred time zones,[23] and during journeys in public transport.[24] This indicates that 'perception' is among the important factors that determines smoking behavior along with the addictive effects of nicotine. Some social, psychological, and physical patterns (such as smoking immediately after meals, with tea, coffee, or alcohol) are associated with smoking. These associations may be related to social learning and, in time, lead to

misconceptions and behavioral patterns that are hard to break. A good example of a link between perception and smoking is the hospitalized patients. While the perception (and acceptance) of the patients in the hospital is not to smoke which leads to cessation or decrease in smoking behavior, the perception of the F&Rs waiting in front of the hospital is to increase smoking. The challenge here is to reverse this perception, that is, if F&Rs acknowledge that they are in a place where smoking is heavily restricted and they firmly believe that smoking indeed has caused or aggravated present health problems, they also probably will decrease smoking rather than increase, just like the internalized patients. For this purpose, hospital administrators can take some precautions. They may heavily restrict smoking in the vicinity of the ER and designate smoking rooms where verbal and visual simple messages may be placed such as 'if you want to reduce your chances of being a patient in the ER, reduce smoking'. Computers with artificial intelligence and wide interactive screens may be good tools to relegate these messages. In our study, participants were smoking more if they thought the disease was unrelated to smoking. In fact, smoking is more or less involved in many conditions such as cardiac, respiratory, and circulatory diseases and emphasizing this fact may reinforce feelings against.

In the literature, some descriptive studies have been conducted on patients who applied to the ERs for similar purposes.[25,26] In fact, the aim of these studies, just like our own study, is to turn the crisis environment in the ER into an opportunity for smoking cessation. Even simple actions such as just asking patients whether they smoke can turn into a motivation to quit smoking.[27]

Studies conducted on patients presenting to the ERs generally show similar rates for gender distribution[28,29] and this does not produce a significant conclusion[28,30] nor does the occupations.[29,31]

In a study on the prevalence of cigarette smoking in patients admitted to the ERs, 1515 patients were included in the study from the annual turnover of 48000; 21% of the patients were smoking and majority of them (69%) stated that they wanted to quit.[32] In New Zealand, a study conducted in 2010 on the harms and prevalence of smoking found smoking rate of 33.1%.[33]

In terms of our own study group, the participants were mostly men and married. Their desire to smoke regardless of the brands and the noticeable increase in the amount of cigarettes supports the notion that acute stress factors, including health-related acute stress, increase smoking. Accordingly, most of them were thinking that smoking reduced stress while waiting for their patients in the ERs. However, the fact that most of our participants' thoughts on quitting increased as they saw the patients needing emergency care and they wanted to receive treatment to stop smoking while they were in the hospital reminds us of the Turkish proverb 'one bad thing is more effective than a thousand advice'. Although F&Rs increased the number of cigarettes under acute stress, they also showed a willingness to resolve smoking problem. This can be seen as a paradox; however, these dilemmas between logic and addictive impulses in the minds of smokers are commonly encountered by smoking cessation therapists indicating the power of addictions.

According to the guidelines of the design of ERs reported by Australasian College for Emergency Medicine, an ideal ER may be included special rooms such as otorhinolaryngology, ophthalmology, gynecology, and psychiatry.[34] The smoking cessation clinic can also be integrated into a convenient location around the ER, serving patients and F&Rs alike. Bio-psycho-social approach requires the whole assessment of the patients including acute and chronic problems, as smoking is now classed as a chronic disease which causes many chronic diseases.[35-37]

Conclusion

It was understood that the F&Rs who were interviewed in the vicinity of the ER smoked more frequently, but also they said that they would not mind receiving intervention for smoking cessation. This proves that the common belief that the F&Rs in and around ER may not have time or desire to have smoking cessation intervention is wrong. Providing smoking cessation counseling to F&Rs in the ER may be a valuable intervention. New health policies are needed to combat smoking in different settings.

Conflict of Interests

The Authors have no conflict of interest.

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Authors' Contribution

Collecting data: MO; Writing: MU, MYS, IF; data analysis: OO, MAO, GO; collecting data: AV; designing: AA; designing and uploading files: MEG.

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نگرش‌ها و رفتارها در مورد استعمال دخانیات در دوستان و بستگان بیماران در اورژانس: مرزی جدید در مبارزه با دخانیات

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مقاله پژوهشی

چکیده

مقدمه: اتاق‌های اورژانس اغلب مملو از دوستان و اقوام بیماران می‌باشد. این تجربه ممکن است منجر به تغییراتی در رفتار استعمال دخانیات شود و فرصت‌هایی برای مداخلات ترک سیگار ایجاد کند. هدف از انجام پژوهش حاضر، بررسی این تغییرات و ارایه یک مرز جدید در مبارزه با سیگار بود.

روش‌ها: این مطالعه مقطعی در اورژانس دو دانشگاه در شهرهای مختلف انجام شد. پرسش‌نامه‌ای شامل ۱۸ سؤال برای دوستان و اقوام بیماران اورژانسی مورد استفاده قرار گرفت. داده‌ها با استفاده از برنامه Jamovi تجزیه و تحلیل گردید.

یافته‌ها: در مجموع، ۶۰۳ پاسخ دهنده در تحقیق حاضر شرکت کردند. از بین آن‌ها، ۷۱/۳ درصد از بستگان درجه یک بودند، ۵۱/۷ درصد قبل از آن ۵ بار یا بیشتر در اورژانس منتظر مانده بودند و ۶۸/۶ درصد دو ساعت در روز را در اطراف اورژانس سپری کرده بودند. با مشاهده بیماران در اورژانس، ۵۳/۴ درصد از دوستان و اقوام ایده ترک سیگار را داشتند و ۴۲/۹ درصد می‌خواستند در طول مدت انتظار خود در بیمارستان، درمان ترک سیگار را انجام دهند. در حالی که ۷۶/۱ درصد از شرکت‌کنندگان از برندهای مختلف سیگار که در زندگی عادی به آن‌ها پیشنهاد می‌شد، استفاده نمی‌کردند، این میزان در اطراف اتاق‌های اورژانس کمتر بود (۶۴/۶ درصد) ($P < ۰/۰۰۱$). شرکت‌کنندگان در زندگی عادی بدون احتساب زمان خواب، ۰/۳۴ ± ۰/۸۲ در ساعت سیگار می‌کشیدند. این تعداد در طول انتظار حدود ۶ برابر افزایش یافت (۲/۱۱ ± ۴/۸۵) ($P < ۰/۰۰۱$).

نتیجه‌گیری: دوستان و اقوام طی انتظار در اطراف اورژانس بیشتر سیگار کشیدند. با این حال، آن‌ها تمایل خود را برای ترک سیگار و دریافت مداخلات ترک سیگار در طی انتظار ابراز کردند. ارایه مشاوره ترک سیگار به دوستان و اقوام در بخش اورژانس ممکن است یک مداخله ارزشمند باشد.

واژگان کلیدی: ترک مصرف دخانیات؛ خدمات اورژانس پزشکی؛ دوستان

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