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”Responsible smoker” – effect of a good anti-nicotine programme

„Palacz odpowiedzialny” – rezultat skutecznej kampanii antynikotynowej

Passive smoking is hazardous for human health and life. In March 2006 four renowned institutions working in favour of reducing health effects of tobacco smoking, i.e. The European Respiratory Society, The European Heart Network, British Cancer Research Institute and French Institut National du Cancer published a report on the benefits of widespread ban on smoking in public places implemented in many European countries. The report revealed that in the EU countries almost 80,000 people, including 19,000 persons who have never smoked, die of passive smoking every year and that nonsmokers are most exposed to tobacco smoke in their home setting, workplace and other public institutions, e.g. pubs [10]. In Poland almost 2000 people die of passive smoking annually, out of whom a decisive majority, over 1700, due to exposure at home [1, 5, 6, 8]. Passive smoking by babies enforced by pre-natal environment, after birth and during the first years of life is the main health hazard noted among 0–4-year olds [6]. The investigations carried out in 27 countries (including the study in Ciechanów, Poland) found that the exposure to tobacco smoke among children is very high. In Poland in 67% of homes children are exposed to tobacco smoke, in Denmark – in 48%, in Iceland – 46%, in Norway – 32%, in Sweden – 15%, in Finland – 8% [9]. The measurements of nicotine in the air and children’s hair correlated with the results of survey investigations and they suggest a positively proportional relationship between parents’ active smoking and higher parameter values in both measurements [5, 8].

Also, investigations of the contamination of public places by tobacco smoke performed in 36 countries (Poland included, Polish study was coordinated by The Oncological Centre and The Institute of Health Protection PWZS in Ciechanów) confirmed that yearly contamination limits were exceeded many times, especially in pubs and student houses; it was 16 times higher in comparison to Ireland [8].

STRATEGIES

The aims of the present classic anti-nicotine actions include counteracting the beginning of cigarette smoking or help for active smokers to quit the habit of smoking. The history of the third strategy focused on the support for nonsmokers to create defensive abilities against involuntary smoking is rather short, as is the experience and evidence for its effectiveness. Recently a lot of attention has been paid to evident effects of minimum (short) intervention projects within the second

phase prophylaxis. The trend of anti-nicotine actions could have been extended by a widespread implementation of modified schemes of "Minimum Anti-nicotine Intervention" into the primary health care system [3, 4]. The scheme was established by The National Cancer Institute, USA and adopted by Maria Curie-Skłodowska Oncological Centre and The Health Promotion Foundation [3]. It is simple counseling based on four questions initiating specific actions by the primary health care worker, a doctor or nurse, responsible for its implementation: 1) ask each patient if they smoke, 2) advise each smoker to stop smoking, 3) help the smoker give up smoking, 4) prepare a follow-up.

When slightly modified, the scheme facilitates diagnosing the problem of passive smoking by an individual (e.g. during consultation) and starts the intervention in the situation of tobacco problem in the family resulting from overlap between active and passive smoking by the family members (at work and in home setting). Hence, the simplified modified model includes: 1) ask each patient if they are active or passive smokers and if any family members are involuntary smokers, 2) advise each active smoker to give up smoking and inform each passive smoker about the hazards of passive smoking for them and their immediate family members (children), 3) help each active smoker give up smoking or become a "responsible smoker" and help each passive smoker learn defensive strategies against tobacco smoke and protect their immediate family members (children) from tobacco smoke, 4) prepare a follow-up to fix good changes and to overcome crisis (resuming, failure).

Does a "responsible smoker" really exist? We cannot forget that tobacco addiction syndrome is a disease registered at the beginning of the 1990s by The International Disease Classification as "mental and behavioural disorders caused by tobacco smoking (reg. F 17). It is a serious disease which makes 10% smokers never able to quit the habit despite the awareness of its necessity and several trials undertaken.

What are the features of a person who smokes and is responsible? Such a person • will never smoke in the company of nonsmokers • will never ask: "Excuse me, can I smoke?, Do you mind my smoking?" • will never offer/give a cigarette to anybody else • will inform and warn those who do not smoke about the hazards of passive smoking but allow smoking in their company • has enough courage to admit that a cigarette is stronger than they are; that a specific act of courage is very important when the smoker is a teacher, doctor or a parent.

Does the modified scheme of "Minimum Anti-nicotine Intervention" create a chance of establishing responsible behaviours in the group who have received support from competent doctors and nurses and makes them more able to protect their close family and themselves from tobacco smoke? Valid research will certainly answer those questions. The results of such projects implemented are extremely necessary so, undoubtedly, there is a need to undertake the research.

CONCLUSIONS

Can we help people become responsible individuals (in the context of tobacco smoking) when they smoke actively, or when they smoke passively and cannot cope with the problem? Can health care workers provide help? Certainly. It would be great if the help proved effective. The effectiveness of such actions has been relatively low so far. The reasons are complex. Medical staff is poorly prepared to apply "Minimum Anti-nicotine Intervention" schemes. The project has been hardly implemented into the primary health care practice so medical staff are not always perceived by a common recipient of medical services as a group who certainly support nonsmoking, e.g. 15% managements of companies that undertake anti-nicotine actions believe medical staff are a group who support and promote nonsmoking [7]. Primary health care doctors and nurses take the main responsibility for the implementation of Minimum Anti-nicotine Intervention schemes as it is them

who have contact with at least 70% smoking patients. The estimates show that the programme is 4% effective and although this is not a high proportion, it has measurable health, social and economic effects in the populations where active tobacco smoking is widespread and where the network of primary health care is well developed. It can be cautiously presumed that modified Minimum Anti-nicotine Intervention strategy, extended by intervention in the cases of passive smoking, would increase its effectiveness.

REFERENCES

1. Charzyńska-Gula M.: An attempt to determine the scope of allergy among a population of children and adolescents (based on diagnoses carried out by a community nurse for prophylactic and treatment purposes). Nursing Issues, 1/2, 39, 1993.
2. Charzyńska-Gula M.: Health Education of Families. A Handbook for Family Nurses. Association for the Promotion of Health and Prophylactics of the Circulatory System, 47, Lublin 2002.
3. Górecka H.: Treating Nicotine Addiction. Nowa Klinika, 329, 3, 1999.
4. Noskowicz-Bieroniowa H.: Do You Want to Quit Smoking? Methods, Recommendations, Information.... Kraków: Emilia, 3.2001.
5. Polak P., Charzyńska-Gula M., Fetlińska J., Zagroba M.: Changes of behaviour of selected group of parents as a result of anti-tobacco program “Let′s free our children from tobacco smoke.” In: Health Promotion. Theoretical and Practical Aspects, Gozdek, Sygit (ed.) 358, 2005.
6. Przewoźniak K., Zatoński W.: Smoking tobacco in adult population of Poland in the years 1974-1995. In: Smoking Tobacco in Poland. Attitudes, Health Consequences and Prophylactics. Zatoński, Przewoźniak. (ed.) Institute of Oncology, Warsaw, p. 15, 1999.
7. Puchalski K., Korzeniowska E.: Solving Problems Connected With Smoking Tobacco in Work Facilities in Poland. Occupational Medicine, 459, 6, 2001.
8. Source: Smoke Free Partnership (2006) Lifting the smokescreen. European Respiratory Society, Brussels. After: K. Przewoźniak, J. Gumowski, M. Zagroba et al., Contamination of home environment and public space in Ciechanów – study results and practical measures (report from the conference entitled “Addictions – the problem of humanity”). Ciechanów. 17.11.2006
9. Source: data for Scandinavia: Lund et al.1998; data for Poland: GYTS Collaborative Group; Tobacco Control 2002; 11. After: K. Przewoźniak, J. Gumowski, M. Zagroba et al., Contamination of home environment.
10. Website of the Internet campaign “HELP – for a life without tobacco”. Initiative of the European Commission. Polish version. www.ehnheart.org. 29.01.2007

SUMMARY

Passive smoking is often one of the main causes of early death in many countries, Poland including. The present anti-nicotine strategies should also include other solutions that consider the protection of nonsmokers from involuntary smoking and altering the behaviours of active smokers into more responsible forms aside the primary prophylaxis of tobacco addiction and counseling for smokers. The authors suggest a modification of the so called “Minimum Anti-nicotine Intervention” strategy and inclusion of recommendations that would affect reduction of passive smoking.

STRESZCZENIE

Bierne palenie tytoniu to często jedna z głównych przyczyn przedwczesnej umieralności obywateli wielu państw – także Polski. Konieczne jest włączenie do dotychczasowych strategii działań antynikotynowych takich rozwiązań, które poza pierwotną profilaktyką uzależnienia od tytoniu oraz pomocą skierowaną na osoby już palące uwzględniałyby w swoich celach ochronę osób niepalących przed paleniem niedobrowolnym oraz zmianę zachowań palaczy aktywnych na zachowania odpowiedzialne. Autorzy doniesienia proponują modyfikację znanej techniki „minimalnej interwencji antynikotynowej", polegającą na uwzględnieniu w jej przebiegu zaleceń mogących wpłynąć na ograniczenie problemu palenia biernego.