The Abatement of Feigned Knowledge: The Promotion of Smoking Cessation Programs to Nursing Populations Abroad

A Proposal to Export Smoking Cessation Program Structures to Nursing Populations in Asia

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Summary: The issue of unknowns in the smoking prevalence of our nursing populations is a concerning issue especially considering the integral nature of nurses within any effective healthcare infrastructure. Fortunately, the drive to tackle this relative unknown is gaining momentum which necessitates the exploration of cessation program structures that can be applied to the unique population of registered nurses (RNs). In the submission of a proposed program structure, drawing from emergent research in immunology and an intensive refocus on the transtheoretical model (TTM) of behavioral change, to the JNPARR we hope to introduce the foundation of a program that might specifically target the RN population. Within this proposal are the intended features of a targeted cessation program, the accompanying rationales as well as a rudimentary rundown of how we expect a program to operate. By extension, the intent of this submission is also to participating in the robust dialogue of smoking cessation as a context to raise awareness of the importance of evaluating the health status of healthcare professionals.

Introduction: The Smoking Cessation Paradigm

The irony with smoking is that it is confounded by culture and research. Upon this light, smoking represents the interface between scientific research and the sometimes arbitrary or paradoxical nature of societal behaviors. In a different time, cigarette smoking was advised by professionals in a variety of ailments. It is later found that smoking actually causes a host of complications ranging from emphysema, coronary-obstructive-pulmonary disorder to lung cancer and the outcry has been both robust and widespread. As the times and culture changes, it can be said that the societal perspectives on smoking have verily shifted into illustrating smoking antagonistically; as something to fight or defeat. However, this change is neither random nor spontaneous but a rather a process of intense research into the physiology and immunology. In this sense, the research underlies the societal shift and only in light of new or striking information can it be said that research will causally precede societal/behavioral changes.

With this interplay of research and societal change in mind, another shift is that societal attitudes in health are very quick to point out the long term complications or the chronic implications of some behaviors. At the very same time, the man or woman purveying a viewpoint regarding
one’s health could very well not be heeding their own advice. This sense of "feigned knowledge" is most apparent in the healthcare professional population where doctors used to prescribe smoking as a treatment, and in many cases abroad still do, and nurses smoke as a form of stress relief. Then they subsequently turn around and advise a patient who might have had to be hospitalized for smoking. Thus the prevailing question has been how to tackle the problem and reduce the incidence/prevalence of smoking. Additionally, people both professional and layman might further ask whether or not this irony in the healthcare professional field is a result of education, resource accessibility or of direct experience. These questions are embedded in the perception of healthcare professionals as supposedly representative of what it means to be healthy.

The good news is that these points are retrospective in nature as the current environment demonstrates that we have effectively tacked the issue of incidence and prevalence of smoking in the American healthcare industry. However, the unfortunate circumstance is that despite the relative successes in the US we might fail to reexamine how we got to the point where smoking is rightfully the antagonist to human health. From such a reexamination, we might be able to export the same techniques or program structures to other countries facing the same crisis today as we did before. By no means is recreational smoking "conquered" or "finished" because these can only be definitively true in the microcosms of American society instead of comprehensively. Like we started out from the beginning, the answer lies in new research, survey and prospective extrapolation placed upon a well-defined target demographic. In this paper, we target the RN population and shift the focus towards immunology as it relates to the risks in smoking. In these two subjects we find that the RN population helps to propagate smoking cessation or amplification while a focus on immunology allows for prospective considerations to human health.

**RN-Healthcare Professionals: Smoking Trends in the US**

Smoking prevalence in the US has declined significantly in both the general and in the healthcare professional populations. As of the 2010-2011 year, 8.34% of all healthcare professionals are current smokers where 20.51% to 30.08% of this population consists of registered nurses (RN) (17). While these statistics might seem to be a lot of people in reality, it represents a drastic decline from previous levels. At this point, the US has reached neither a complete resolution nor complete attenuation of the issue of smoking in healthcare professionals. Rather it now exhibits a slowing or diminished capacity for professionals to quit. The point of the matter is that at one point in the history of healthcare in the US there was a dramatic decline in the prevalence of smoking where the most significant decline occurred among RNs (17). Taken together, what is most apparent is that the conduct with which the US has addressed the smoking issue has proven to be effective. Whether this efficacy is a result of any one specific methodology of their programs is arguable. What is known is that the knowledge base and resources to quit are all extant in the US. Furthermore, the fact that RNs comprised most of the declines in smoking demonstrates that RNs are generally both willing and able to quit smoking whether or not the habit began before entering the healthcare industry or after joining it. This comparably elevated rate of quitting might also be dependent on the specific reasons for smoking cessation in RNs which may draw from the fact that RNs generally have a better network for healthcare than the general population. Coupled with the better network, RNs are perceived as healthcare.
professionals and thus there is a relative expectation coming from employers or patients for them to be examples of health. These factors might have been working in synergy to get the US to the current level of smoking prevalence today.

**RN-Healthcare Professional: Smoking Trends in the Greater East Asia**

Across the board in Asian nations, boards of health are first observing tobacco-related deaths on epidemic proportions. As per late, the most common and effective way to combat them has been reforms which center on nursing education and elevating it into either baccalaureate-university level (14). For particular nursing populations, the relationship between prevalence in smoking between RN populations and the general population differs. For instance, despite progressive actions and a general declining rate in tobacco-related deaths/disabilities, 24.5% of Japanese RNs smoke and this trend persist even in nursing students (14). Conversely, there is a transcendent uncertainty or disparity in the specific measurements for the RN smoking prevalence. In this respect, Korea and the Philippines are two countries who have been reported to not have concise data on RN smoking prevalence while the data in mainland China is disparate (14). The body of smoking knowledge in Korean and the Filipino healthcare professionals persists in more concise data in physician smoking, with 43% and 63% respectively while RN data remains an unknown (14). In the case of mainland China, studies are reporting that RN smoking prevalence ranges from 2.2-7.3% but these findings are inconsistent with the fact that there reportedly 320 million smokers and a near complete absence of smoking cessation programs (14). In summation, it might be said that there is a nebulous knowledge base on smoking prevalence in RN populations which highlights the assertion that Sarna et al. makes acknowledging that this upcoming generation of RNs is not ready to prepare tobacco users to quit. By extension, this observation is also indicative of the fact that RNs are less equipped to quit smoking themselves. Therefore, the smoking trends in Asia might be hypothesized to be either understated or are increasing. In light of this uncertainty, Sarna et al. indicates that China, Korea, the Philippines and Japan have ratified the WHO Framework Convention on Tobacco Control which demonstrates that there is definitively a political will in tackling the issue of smoking in general.

**The Latent Mechanism I: Immunosuppression as a Function of Alveolar Macrophages (AM)**

Cigarette smoke can be considered like an antigen which is any external substance which induces normal immunological responses in some way, shape or form. In the very same way, cigarettes can be seen as pathogenic insofar as its effect on the human body is a function of the portals of entry. This pseudo-pathogenicity makes the mechanism important and in terms of the immune system, it is necessary to look at the immunological factors that lie at the interfaces of the portals of entry. A recent study specified that, since the portal of entry in cigarettes is the respiratory tract, the immunologic mechanism must incorporate the alveolar macrophages (AM) making their study imperative on how cigarette smoke initially affects immunity. Using inflammatory cytokines and Toll-Like-Receptor (TLR) as a measure of immunological reaction, Chen et al. found that smoker AMs exhibit reduced gene expression and secretion of proinflammatory cytokines and chemokines. Additionally, exposures of AM to tobacco smoke induces a hyporesponsive state which is a similar condition found in endotoxin tolerance (6). This hyporesponsive state is strongly associated with the concept of immunosuppression insofar as it
The Latent Mechanism II: Immunosuppression as a Function of Nicotine

In the presentation of AM we can see the clearer, causal and cellular implications of smoking on the immune system. However, tobacco is not a live pathogen nor virus insofar as it attacks the AM which is illustrated in the sense that it induces hyporesponsiveness. Rather tobacco is toxic in the sense that it is a chemical agent entailing the notion of a singular chemical which is specifically inducing this sense of hyporesponsiveness. In other words, the singular chemical that is the “endotoxin” that AMs might be tolerating is nicotine. The specific mechanism for nicotine immunosuppression tends to be implicit in the AM but is extended onto the T-cell. Not only does nicotine induce a state of hyporesponsiveness in AMs, the agents of innate immunity in the respiratory system, it now compromises the T-cell which implicates detrimental effects on the adaptive immunity which completes the illustration of nicotine as immunosuppressive in a long-term sense (15). To further reinforce the immunological implications, there is an additional characterization of nicotine in calling it immunomodulatory due to emergent research noting that nicotine is not necessarily a free-antigen but rather it binds to create a nicotine-antigenic complex (15). The result of this complexation is the induction of autoimmune response due to the failures of the normal adaptive immune system's T-cells to recognize the somatic cell which might induce their subsequent destruction. Alternatively, it could be that the nicotine-antigenic complex might act to work and suppress the T-cell receptor complex (TCR) which has implications on normal T-cell proliferation. However, it should be noted that there are a host of other chemicals in cigarettes, like derivatives of benzene, which may be working in synergy to produce the net immunosuppressive effects observed (15). Additionally, there is a suspected dose-response relationship in nicotine immunosuppression (15). The introduction of immunosuppressive and now immunomodulatory aspects of nicotine, it becomes more apparent that there are wider implications on the immune system in regards to smoking which now extend beyond the local complications implicit in AMs. In considering the T-cell as a consequence of smoking-induced-immunosuppression, the scope of the issue begins to broaden into something more systemic and holistic which have consequences that can no longer be confined to only respiratory health.

The “Smoking Paradox”: Behavioral Disparities in Smoking Cessations and the Importance of the Latent Mechanism

The irony in the practice of smoking is paradoxical insofar as it is a widely known health risk yet its practice persists. Part of this continuity of smoking behaviors is physiological because of the addictiveness of the nicotine element (15). Once a smoker begins to smoke to relieve symptoms, then we enter the "smoking paradox." Broadly described as “as health risks associated with
smoking become well-known, the less likely any given person is to smoke because of any reason but symptomatic relief” and therefore the paradox lies in the expectation that societal pressures against smoking are associated with increases in disease to smoking (9). While it might seem counterintuitive, especially given the prevalent notion that knowledge of health hazards influences behavior, it makes sense because of some of the physiological properties of smoking already outlined. The body and the mind seem to equilibrate with the continual introduction of the nicotine endotoxin. This has wider implications in terms of smoking cessation and programs whose missions are centered on it. The still unexplored notion of this epidemiological “smoking paradox” informs on why smoking cessation has been observed to slow in the US despite its relative successes in attenuating smoking prevalence in both the general and the nursing populations. It may very well be that even in an era where smoking tobacco has been so heavily stigmatized to protect the greatest amount of people from smoking, the continued population of current smokers is behaviorally distinct from those who have the potential to quit smoking. In other words, it might persist that the previous cessation program structures had been successful in addressing the general majority which leaves us with a behaviorally distinct minority and why the net effectiveness has been observed to slow. In relation to immunological mechanisms and consequences like immunosuppression, it further complicates commonplace products which help smokers quit like Nicotine gum, inhalers, lozenges and patches. As stated before, the immunosuppressive element of smoking is the nicotine and thus introduction into the gastrointestinal system or into the dermal layers might feature a possible systemic complication in those specific organs. For example, the emergence of lung cancer from smokers exhibits a considerable latency period. If this latency period concept is applied onto dermal strata, it could mean that similar immunological complications are imposed on counterparts like the Langerhans Dendritic Cell who conducts a comparable function to that of the Alveolar Macrophage. Thus, even the applications of current cessation products might have long term and unexplored consequences systemically. When equipped with this level of knowledge it becomes clear that in tackling smoking cessation and promoting the unrestricted use of nicotine addictions products, contemporary healthcare might find themselves in a similar position as physicians had in the past; the administration of products whose adverse effects have not yet come to light. In terms of the creation and implementation of smoking cessation programs, the concept of the “Smoking Paradox” is an essential consideration in maintaining as well as understanding the complexity of smoking cessation.

The Advantage of Focusing on Immunology and on the RN Population

In many respects the most important factors in smoking cessation is a structure of professional resources and an in-depth knowledge base. Given that nurses are the largest group of healthcare professionals, the institutional capacity for smoking cessation is largely dependent on nurses. This observation holds true irrespective of whether it is in the US or in the Far East. This manifests in the form of policy changes made in nursing education and a refocus on what underlies public health and prophylaxis (14). Nurses, RNs and NPs, also display the potential to propagate smoking cessation and studies show that programs led by NPs are more effective than programs without NPs (5). This trend is also true for RN in which RN intervention increases the likelihood for quitting (13). Thus if there is a vested interest in attenuating RN smoking prevalence, there is a run-off effect in terms of general smoking cessation. Alternatively, this means that in the targeted intervention of nurses comes a positive externality by concurrently
widening the expertise of the nurse in his or her ability to apply smoking cessation interventions of their incoming patients. In terms of the knowledge base, the acute and chronic health risks of smoking are consistently well defined in terms of cardiovascular or respiratory problems. The CDC has an extensive list of the complications to the cardiovascular and respiratory effect that smoking has. This spans coronary heart disease, amplified stroke risk, emphysema, chronic bronchitis to lung cancer (3). The Surgeon General elucidated all the health risks in an in-depth analysis of smoking risk. What is noticeably absent is a comprehensive review of how smoking impacts the immune system where even the Surgeon General only vaguely explains the oncogenesis or mentions the symptom of leukocytosis (3). However, the CDC and Surgeon General acknowledge that, in light of the slowing of smoking cessation rates, there still exists a repertoire of "underutilized approaches for reducing the use of tobacco products" (16). By focusing on an immunological standpoint the extant advantage is implicit since the CDC and Surgeon General themselves fail to completely explain immunity complications for the public eye. Additionally, RNs have already been previously educated in the fundamentals of immunity and theoretically have the capacity to grasp the more sophisticated points of nicotine/tobacco products as immunosuppressive. In the search for a novel but underutilized approach, a shift towards immunology can prompt RNs to think prospectively as well as incrementally in terms that only they as healthcare experts can fully appreciate.

**Current Solutions: Existing Smoking Cessation Programs and their Motivations**

Current solutions persist as a method named the "5 As" of "ask, advise, assess, assist and arrange" which is a streamlined code of conduct to promote smoking cessation. The "5 As" approach is considered to be the standard care in smoking cessation which draws from the fact that effective treatment options are oriented towards behavioral intervention coupled with pharmacotherapy (14). This importance of behavioral intervention reveals that smoking cessation is best addressed in counseling and skills training methodologies in regards to RN populations. The CDC itself acknowledges that a concept called “academic detailing” which consists of structured visits by trained or educated personnel to assist healthcare providers (4). This emergent interest in assisting professionals by relegating the authority nature of their expertise is a promising method especially in the case of behavioral practices extant in healthcare professional populations. Training disparities in smoking cessation are most apparent between US and Asia insofar as accessibility or the lack of emphasis on smoking cessation. In Asia, there is a great contrast in the general nursing education system in spite of the recent pushes to elevate nursing into university and baccalaureate degree. In the Philippines for example, there is a National Tobacco Control Strategy (10) currently under effect which is focusing on investing, leadership training, surveillance, awareness and advocacy for smoking cessation programs which has also derived from the Department of Health’s passage of Administrative Order No.122 s.2003 (10). Moreover, one of the key actions of the NTCS’s goals are “develop and implement National Clinical Practice Guidelines (CPGs) for smoking cessation” which definitively demonstrates a powerful political will to back smoking cessation for the Philippines. (10). At this current moment, the primary strategy is creation of the CPGs as well as specifically how to integrate and promote it. Not only is there a political will, the Philippines has specifically set up the necessary infrastructure after the Administrative Order to the degree in which it is now a requirement for Department of Health offices to have a sector dedicated to cessation (10). The sectors of the population the NTCS is designed for is the general populace but the directions are
not as targeted nor well defined. Rather it seems to persist in a state where it is more of a national health objective.

Current Solutions: Primer- The Theory and Program Considerations

Smoking cessation programs have two different perspectives on their approaches which range from seeing smoking addiction-cessation as a continuum or in discrete stages. The successful nature of the “5 A’s of Smoking Cessation” are underlined by their basis in the “Transtheoretical Model” [TTM] for behavioral change which incorporates a discrete step-wise perspective on behavior (7). The TTM poses five to six stages which persist as “pre-contemplation, contemplation, preparation, action, maintenance and termination” (12). It is most apparent that the 5 A’s methodology is reflective of the TTM because they both address issues of awareness, action planning, and the persistence of a behavioral change through time. Built within the TTM and its reflection in the 5 A’s are issues which keep a person stuck on a stage since progression through TTM stages is sequential and stages cannot be skipped. Such concerns raised by the TTM are the issue of chronic contemplation – behavioral procrastination and relapse (12).

Typically, the clinical efficacy of TTM applications depends on a concept called “stage matching” which is a rough description of categorizing potential quitters into whatever stage they might be in the TTM. In one study of TTM and smoking cessation, they found modest changes in the propensities to change behavior whenever TTM is applied between stage-matched to non-matched controls (1). While modest for that one study, it is best to consider that TTM is a form of audience targeting because each stage in the TTM is built upon success in the previous stages. Therefore, those who exist in the “preparation stage” are vastly distinct from “contemplation stage” and et cetera. The interesting difference between preparation and contemplation might be seen in terms of committing to a course of action which bears significance when examining smoking cessation for the nursing population. In theory, matching smoking cessation upon RNs and healthcare professionals in general cannot necessarily be “pre-contemplation” given their preexisting knowledge of the health effects of smoking. Thus, a community action proposal geared to this audience must persist with two considerations that might “violate” the discrete nature of TTM structure. On the one hand, RNs have extensive physiological, nursing, healthcare and prevention education thus they are not necessarily subject to lack of awareness of smoking effects. In the context of smoking cessation, we have presented that RN populations abroad are just beginning to have a more widespread awareness of the importance of smoking cessation. On the other hand, many RNs might not be privy to enacting their own change and persist in a personal contemplation stage which is termed as “behavioral procrastination” (12). This behavior contemplation might derive from RNs balancing the reasons for changing versus the costs in the form of time and effort expended to cease smoking. However, it seems easier to impose or advise patients because the time and effort expended is not necessarily personal to the RN. Arguably, a program that attacks the context of smoking cessation from an immunological point of view is incorporating the additional considerations latent within the pre-contemplation to contemplation stages as well as the unique characteristics of the RN population. Using the immunological context addresses pre-contemplation concerns of being “unaware” as well as adding an additional dimension in the “cost and benefit” dynamic that is latent in contemplation stage. Therefore, a new program for smoking cessation must incorporate facets from all stages of TTM contrary to its discrete nature and the proposed need for stage matching. This rudimentary notion of “stage matching” might apply to a general
population but not when the population is both knowledgeable and has unique resource accessibility. By incorporating immunology, we address a new conceptual basis to change behavior and by integrating TTM stages as an overlapping continuum we consider the target populations who are not rigidly “matched” to a specific “stage” like RNs. Additionally, using “academic detailing” allows for an equivalent conveyance of risks of smoking and promoting smoking cessation so that we might be able to change professional smoking as opposed to the general population.

Current Solutions: The Model – Montefiore Smoking Cessation Program

The Montefiore Medical Center’s Department of Oncology has developed a six-session Smoking Cessation Program. This program is bilingual, offered in English and Spanish and is targeted for urban populations. The major result of this program was its specific techniques to culminate in smoking cessation. Some of these measures are “hearing from other group members,” “Learning about substitute behaviors-distraction-delay,” “smoking behavior logs,” “positive affirmation” to “self-talk” (8). Further augmentation of this program takes the form of guest speakers, homework assignments and attendance-based financial incentives and is lead by trained professionals. While it may seem like the target population for Montefiore is not applicable to the RN population, the importance of this model is the specific techniques employed to promote smoking-cessation. For instance, Montefiore measured the helpfulness of the specific techniques on a self-reporting basis with their most successful techniques being the construction of a dialogue (93%), learning substitutive behaviors (78%), and smoking behavior log (72%) which are all methods which encompass the six stages of TTM (8). Interestingly, Montefiore used a physician discussion of nicotine replacement options which itself seems to be an oversight given the immunosuppressive research we have accumulated. Additionally, a very progressive financial policy within the Montefiore Program is the charging of $50 nominal fee to which $5 is reimbursed for every session attended which reduces the net cost to a participant to $20 upon completion of the course (8). In this model, many bases which undermine participation and awareness of smoking cessation are thoroughly addressed from the financial situations to the program mission for cognitive restructuring. The purposes of the techniques used are in line with the TTM model by having participants ascend the stages of TTM through six weeks in the program. The advantages of creating a program by learning from this model lie within its emphasis of participant retention as well as the set of techniques to create both an action plan and amplify awareness. The elements or oversights of this program might be the restrictions of cognitive restructuring insofar as it is passed down from an authority figure or the healthcare professionals. The disadvantage is that the target population has no underlying knowledge and is similar to conditioning in order to avert their attentions away from smoking. While the urban population target of Montefiore Program might be inherently inequivalent to RN-smoking populations, this model highlights the important distinctions that RN populations bear in respect to the general populace. In consideration of these unique aspects of the RN population, the techniques of the Montefiore Program can be superimposed on RN populations for a proposed smoking cessation programs only if we consider the added dimensions raised by academic detailing.
Community Action: Project A.F.K.-S.C.

In our service project I plan to draft a rough outline for a Smoking Cessation Program Plan which I named A.F.K.-S.C. or the “Abatement of Feigned Knowledge-Smoking Cessation.” The first stage of this plan, which will be the service project for our plan, will be a submission of this paper to the Journal of Nursing Practice Applications and Reviews of Research [JNPARR]. Within this journal submission will be the outline for a proposed plan for smoking cessation. Further considerations to the plan in terms of visibility and pitching will also be included in the general outline that will be submitted to the journal. To raise visibility on this plan, I would correspond with the Lung Center of the Philippines [LCP], a non-stock/non-profit corporation, by pitching the need for a comprehensive survey of smoking prevalence in nurses. Part of this pitch would incorporate pointing out the trend of smoking cessation in Greater East Asia, the models extant in America, as well as the relative unknown status of nursing smoking. An additional part of the pitch would nucleate around the mission of LCP to incorporate quality respiratory-lung healthcare-promotion-advocacy and integrate it with financial stability-sustainability. To further visibility of this project, a Twitter-feed would be constructed centered around emergent research into acutely cellular or histopathological topics in lung-health as well as a potential Facebook group if the Twitter-Feed goes well. This is drawn from the high degree of internet penetrance (36% penetrance) and the breadth of social media use in the Philippines (2).

Project A.F.K.-S.C.: Program Structure

Project A.F.K.-S.C. will be structured as an integration of TTM principles, cognitive restructuring and academic detailing. The project’s primary postulation is that the actively smoking nursing population as a whole exists not within one of the traditional stages but rather in between contemplation and preparation. This intermediate existence is a function of both the latent content knowledge about the health risks of smoking as well as the accessibility to professional healthcare. Additionally, the program structure must respect, acknowledge and utilize the entanglement of the RN to the patient population. In addressing this unique status within both the TTM model and the healthcare system, the plan proposal will be divided into subsections.

1. Staffing

The program’s expected professional staff will consist of a resident immunologist M.D., a resident respiratory pulmonologist M.D., a doctoral or a candidate for a PhD in immunology, a resident Nurse Practitioner (NP) and a clerical team of 4 to 6 individuals. AFK-SC will also consider using local volunteers to fill in.

2. Program Operation

The timeframe of this proposed program persists in nine-session gatherings spread through a six-month period. In deference to the findings from TTM and the general literature, the first month will be relatively intensive to better induce contemplation of smoking cessation. Especially given
the temporal nature of smoking cessation and the rigorous occupational demands of nurses, the program will be oriented to emphasize efficient early inclusion into the program. Additionally, the months of the program contain general themes that indicate the goal of that month.

a. First Month – First Half: Abating Feigned Knowledge and Initial Survey
   Goal: Introduction of immunological context of smoking cessation. Introduction of smoking paradox, the program’s mission and conceptualization of “Feigned Knowledge.”
   Techniques: Academic detailing, professional guest lectures, construction of group dialogues (nurse participant to other healthcare professional or other participant nurse).
   Rationale and Expectations: Nurses possess a broadly functional knowledge base of healthcare but lack the focused nature that comes with specialization that PhDs and resident M.D.s possess. Jumping from their general knowledge to that of specialized information is not as greatly disparate for RNs as it would be in a program aimed at the general populace in this context. Academic detailing and lectures allow the program to persist in a balanced discussion of smoking cessation among healthcare professionals. Inducing group dialogue sets the stage for more gradually in-depth or personal discussions that are critical to program success. The combination of these techniques is in ultimate deference to the unique “position” that the RN population exists within the TTM model instead of an informal “stage-matching” that is often attributed in applications of TTM.

b. First Month – Second Half: Dissolution of Responsibility
   Goal: Realization of social significance of nursing to the general population. Realization of the community-population level effects of smoking.
   Rationale and Expectations: While it may be a latent or mutual understanding, the entanglement of nurses to their patients must be overtly addressed. Thus, in the visitation of certain patients in the hospital, the dialogue transforms into a less diagnostic or analytic case study towards a more abstract realization of the public health significance in the function of nursing. This transformation of the conceptualization of smoking cessation introduces a new angle of smoking cessation.

   We expect that participants will understand the immunological foundation of this program by this time and will induce application of this knowledge by helping the participant nurses carry out a small-scale epidemiological study that analyzes risk of acquired infections to those who are continually exposed to nicotine. The purpose is to broaden the knowledge of nurses by exercise their research skills which adds a new dimension to contemplate smoking cessation. Additionally, given the body of research on nicotine immunosuppression, we will see whether the postulation has reproducible data which, if successful, should aid in conveying the conclusion that nicotine supplementation carries its own dangers.

c. Second Month: Affirmation and Commitment
   Goal: To aid the participants in the synthesis of personalized schedules to quit smoking.
   Techniques: Cognitive restructuring via behavioral dissonance and goal-orientation.
   Creation of a smoking log which includes quitting goals.
   Rationale and Expectations: The coupling of medical knowledge and nursing knowledge with the unique focus of Project AFK-SC should culminate in a commitment to quit.
smoking. For the program to help in establishing a personalized calendar or schedule, we expect that a developed will in actualizing a commitment.

d. Third to Fifth Month: Progress reporting
   Goal: Academic detailing to assess cessation retention and progress.
   Rationale and Expectations: The importance of follow-up and conducting a structured retrospective process is emphasized. Additionally, this creates a forum through which participant nurses can share their diverse and varied ways they have tried to quit smoking. This can take the form of sharing their conscious attempts at behavioral or cognitive restructuring to receive feedback. At this point, we can also assess the acute effectiveness of the program itself or its retention mechanisms upon its target population by measuring any internal attrition rates. Additionally, we would expect to see whether or not the concepts and program structure had impacted the propensity to use nicotine-supplementation products.

e. Sixth Month: Patient-RN pairing
   Goal: To induce cognitive restructuring and help RNs "graduate" in their participation to the program via making them apply their lessons on a patient.
   Techniques: Patient-RN pairing in bilateral cognitive restructuring.
   Rationale and Expectations: The idea of "graduating" from a program engenders that a successful participant can apply what they have learned through the program. Thus, the ability to pass on what the program teaches is one way to actualize a commitment, adherence and success in cessation. In acknowledgement of this achievement, our program will administer a ceremonial congratulatory certificate of completion to each successful participant. This program feature is also an extension of the patient significance that nurses have which is meant to help realize the unique position. This feature can be seen as a deviation from the TTM, which is more concerned with personalized stages of change and is made in deference to the unique occupation of RNs.

f. Post-Sixth Month: Follow-Up and Verification of Cessation
   Goal: Verification of cessation in the RNs themselves.
   Techniques: Survey. Final gathering and discussion.
   Rationale and Expectations: The long-term resilience of the program will be culpable and calculable at this time to which the program can pre-plan or fine-tune the program for the next round of participants. At this point, we expect that the program-by-program efficacy and effectiveness can be calculated in terms of behavioral/cognitive restructuring. We also expect to have a full roster of RN completion of the program to which we can compare with the attrition rates of the program through time. This data also allows us to conduct any necessary follow ups to see if and for how long smoking cessation was adhered to by our participants.

3. Participant Retention

Drawing from the Montefiore Program’s innovative reimbursement plan, we will draw the expected cost of the program at $75 per participant. After going through the intensive first month, we will reimburse $20 to all people who complete to this point. Upon completion of the second month, we will reimburse $10 to convey the significance of committing to smoking
cessation. Each subsequent monthly report will result in $3 reimbursements. While we have stressed the importance of doing the RN-patient pairing exercise at the sixth month, this feature of the program brings additional complications in preserving confidentiality and accruing a viable patient population to pair participant RNs up. Thus, it is advantageous to make this feature voluntary with the incentive that $16 will be reimbursed to those who participate and comply with the program follow-up since they will be the data pool for subsequent adjustments made in the program. Should a participant successfully complete the program at the sixth month, they will be reimbursed an extra $10 which is also indicated by a “certificate of graduation” that is largely ceremonial. When compared, a person who participates in the pairing versus a person who does not participate in the pairing feature will have a reimbursement difference $26 to $10 respectively. This progressive reimbursing incentive will encourage participant retention from the onset in addition to promoting the participation in the RN-patient pairing exercise at the sixth month.

4. Ethical and Reactionary Protocols

In consideration of possible detrimental effects of the program, it is most important to preserve and outline the ethics of this program. In deference to the ethical principles of respect, beneficence and justice, it is important to consider the ethical implications in promoting cognitive restructuring especially when it interfaces with the research presented. To preserve a respect for all persons, it is imperative to have a comprehensive debriefing of the program mission with its sets of expectations in addition to accentuating the voluntary nature of this program. This voluntary nature can be preserved by obtaining a consent form in addition to preserving confidentiality especially when using program data to orient the future alterations or adjustments made to the program. In terms of beneficence there is a risk, due to the relatively open-ended nature of Project AFK-SC, that cognitive restructuring entails the possible emergence of pathological behavioral replacements. Thus, given our professional staffing, it must be an ethical standard to note the emergence of such occurrences. Given the research-oriented nature of this program, it should also be said that emergent research, especially those pertaining to risk, in both behavioral and immunological contexts within the field of smoking cessation must be given priority in the consideration of the future of the program. In this light, any emergent risks observed internally through the course of the program or externally in scholarly research must be immediately considered to adhere to this ethical principle. One foreseeable way this might be achieved could be in program surveillance of participants that comes embedded within the concept of academic detailing. In terms of justice, the program is meant to distribute the risks fairly which, given the nature of the program, the risks to an entire participant population will be inherently individualistic. This principle of justice in ethics is more critical in the patient-RN pairing feature of the program to which the patients must go an equal debriefing as well as an acquisition of their consent to participate. Thus the most challenging ethical principle to abide by might be latent within the justice principle should the pairing process be instituted in any application of this program structure.
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Letter to the Editor
Dear Editor,

In JNPARR's third volume, there seems to be an overall theme of self-efficacy and empowering which has resonated in my research on smoking cessation. While the quality and expertise of Philippine nurses is unmatched and has significant bottom-up recognition in the American healthcare system, we simultaneously need to consider how we can possibly bring back the techniques learned into the Philippine context. In this sense, we should ride the momentum of smoking cessation efforts which are currently taking precedence over many public health initiatives across East Asia and bring to light a deeper sense of how smoking affects Philippine nurses. While smoking tobacco health risks are well known and the nursing education extant for it is adequate, many East Asian public health initiatives are capitalizing on the notable absence of effective smoking cessation programs. The absence of such programs might have to do with the inherent structure of nursing education which emphasizes smoking risks but neglects to elucidate a cessation route. The conceptual themes for these emergent programs are similar to concepts of self-empowerment and education which characterized Volume 3 Issue 1's to some degree.

Sources forebodingly indicate the relative lack of knowledge of smoking prevalence in Asians nurses which has bearing on how effectively the general populace can quit smoking. That being said, the comparative data on physician smoking is better known. We can see that general populace programs for smoking cessation in America are most effective when led by an RN. Therefore, it is possible for a runoff effect in addressing the gaps of smoking cessation in RN education as comprehensively educated RNs might amplify the conditions for facilitating smoking cessation in the general populace. Furthermore, the urgency of this lack of knowledge compounds with both the high prevalence of smoking in Asian populations as well as research suggesting that nicotine is immunosuppressive or immunomodulatory. With this newer immunological information, we attain a novel lens through which to further widen and deepen the importance of investigating the long term implications of smoking cessation.

Addressing this fundamental gap and poor public health database in smoking cessation in RNs should be a paramount issue in contemporary nursing research. Using smoking cessation as a type of context to explore the impact of nurses on the behavior of their patients, fellow RNs or even their own selves, we can raise the question of what specifically makes RNs effective in their community. At the same time, my research aligns with JNPARR's call for manuscripts in the Winter 2014 in its overarching theme of "nurses in synergistic collaborations" by drawing upon an international momentum calling for smoking cessation while also adhering to the

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dedicated applicability of such research as a discussion of how engagement of nurses enhance the overall profession itself.

I urge you to review the research I have presented for you in the attachment. In said attachment, I have also drawn up a potential community action plan which is based on certain aspects of current American smoking cessation program features which could be incorporated as a pilot program for use. What seems to be most in need for the health of Philippine communities afflicted with smoking practices is simply not an ostensible or exhaustive listing of the health effects of smoking. Rather, the critical need is for an adaptable institutional infrastructure to quit. If the healthcare institution stands upon the legs of its RNs, the beginning for any effective smoking cessation program must begin with the RN.

Sincerely,
Jeffrey H. David