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Article type : Original Research: Empirical research - qualitative

Title: HEALTH PROFESSIONALS' PERSONAL BEHAVIOURS HINDERING HEALTH PROMOTION: A STUDY OF NURSES WHO SMOKE

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This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/jan.13343

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Conflict of Interest: Roger Watson, Editor-in-Chief of JAN is a Visiting Professor at the University of Navarra.

Funding: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Wordcount

4367 excluding abstract

ABSTRACT

Aim: To explore the views of current and ex–smoker nurses on their role in supporting patients to stop smoking.

Background: Long-term conditions are closely linked to harmful lifestyle behaviours, including smoking and overeating. Health professionals have an important role to play in promoting healthier lifestyles. It has been described that nurses' health behaviours may be a barrier to their health promotion practice. There is a need to gain further understanding on why nurses' health promotion activity is influenced by their own health behaviour.

Design: A secondary analysis of qualitative data gathered in 2010 in the context of a project that aimed to develop a smoking cessation intervention for nurses.

Methods: Eleven transcripts of semi-structured interviews conducted with nurses (current and ex–smokers) working in one university hospital in Spain. Data were analysed using framework analysis.

Findings: Nurses who smoked engaged in social justification in terms of social norms and work stress. Only nurses who had quit smoking were able to identify the negative feelings it generated and the effect that it had on their past health promotion practice. This was expressed by ex-smokers as an internal conflict that prevented them from supporting patients with their own habit.

Conclusion: nurses who smoke may be inhibited as health promoters without being aware of it. Interventions that focus on helping these professionals deal with the challenges associated with these encounters are necessary if health promotion practices are to be enhanced. Targeting this conflict might also work to improve their lifestyle, which would expand the potential impact to professionals' own health.

Key words: cognitive dissonance, health promotion, lifestyle, nurses, nursing, smoking, workplace support.

SUMMARY STATEMENT

Why is this research needed?

- The burden of long-term conditions requires that health professionals engage in the delivery of healthy lifestyle promotion strategies in their routine interactions with patients, such as smoking cessation.
- Nurses' and other health professionals', smoking habit has a negative impact on their professional smoking cessation practice.
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- This study contributes to our understanding of why nurses' personal smoking behaviour influences negatively their professional role in supporting patients regarding smoking.

What are the key findings?

- Psychosocial processes arise among nurses who smoke from the need to reconcile their personal habit and their professional responsibility as health promoters
- As a result of the need to reconcile the negative feelings they had evaded engaging in smoking cessation support with patients.

How should the findings be used to influence policy/practice/research/education?

- Support provided to nurses who hold unhealthy behaviours should encompass strategies to tackle the psychosocial component associated with their health promotion role in addition to the traditional behaviour change support services.
- Nursing education and training should include a focus on developing abilities and strategies so that these professionals strive for the interaction they establish with their patients rather than the specific behaviours only.
- The findings underline the need to consider health promotion practice as a potentially emotional- intense area both on an individual and an organizational level.

INTRODUCTION

The prevalence of tobacco use among nurses has been historically quite high and despite an expansion in knowledge about the hazards of smoking it remains a significant problem (Adriannse *et al.* 1991, Fathallah *et al.* 2012). Nurses, as the largest group of the professional healthcare workforce, are central to health promotion efforts and enabling people to take control over their health (While, 2014). However, the evidence suggests that nurses' engagement in health promotion in their routine clinical practice is sub-optimal (Blake *et al.* 2011). While there are many factors that may contribute to inertia in nurses' health promoting practice, it has been suggested that their own personal health behaviours can be important in determining their engagement in this practice (Fie et al. 2011). There is a need for further understanding of why nurses' personal behaviours influence negatively on their professional role in supporting patients uptake healthy behaviours.

Background

Long-term conditions contribute to 36 million deaths annually, accounting for 63% of all mortality (UN, 2012). The vast majority of the deaths that occur annually are attributable to four diseases: cardiovascular diseases, cancers, diabetes and chronic respiratory diseases (WHO, 2015). The occurrence and severity of those diseases is closely linked to the presence of several unhealthy behaviours such as smoking, unhealthy diets, sedentary life and excessive alcohol consumption. Furthermore, there is some evidence which suggests that those behaviours often coexist and occur concurrently leading to the so-called 'clustering' of health behaviours (Blake *et al.* 2011).

Health promotion strategies at the individual, community and public levels are necessary to support people adopt healthier lifestyles. Health professionals play an important part in delivering these programmes and have a responsibility to ensure that in their routine interactions with patients they

encourage the adoption of healthy life choices. Further, health professionals are viewed as credible health information sources by patients (Fie *et al*. 2011).

Despite this credibility attributed to health professionals, there is evidence from systematic review and meta-analytic studies indicating that: overweight professionals are less likely than their normal weight colleagues to offer advice relating to weight loss to overweight and obese patients (Zhu *et al.* 2011); higher personal activity level is associated with higher physical activity-promoting practices (Fie *et al.* 2011); and smokers are less likely to advise their patients to quit compared with non-smokers (Duaso *et al.* 2014). Very recent evidence coming from a meta-analytic study reinforces the contemporary relevance of the topic suggesting that nurses' smoking status appears to have a negative impact in the delivery of smoking cessation practices (Duaso *et al*. 2017). In addition, studies have found that these professionals also tend to show lower levels of self-efficacy and knowledge about those health behaviours, or even underestimate the associated risks (Zhu *et al.* 2011, Fie *et al.* 2011).

The available evidence suggests that there may be important psychosocial factors relating to the nurses' personal habits and their responsibilities in relation to promoting positive health behaviour (Zhu *et al.* 2013). However, there is a research gap on how this psychosocial component occurs. Smoking is an important area where this conflict between nurses' personal health behaviour and their health promoting role can be observed and, therefore, might serve as example to gain further understanding on the associated psychosocial component.

THE STUDY

Aim

To explore the views of current and ex–smoker nurses on their role in supporting patients to stop smoking.

Design

We conducted a secondary analysis of a qualitative dataset gathered in 2010. Secondary analysis of data involves the re-use of qualitative data derived from pre-existing research studies (Heaton, 2008). Heaton proposes secondary analysis as a tool to investigate new or additional research questions. The data were collected in the context of a research project that aimed to develop a smoking cessation intervention for nurses (Mujika *et al.* 2014). The objective of the primary data collection and analysis was to explore their smoking behaviour and needs to then develop the smoking cessation intervention.

In the light of recent work on nurses' role as health educators and their own health behaviours (Duaso *et al.* 2017, Lopez-Dicastillo *et al.* 2017) we returned to the data to explore the psychosocial component of nurses' smoking behaviour and their health promotion activity.

Data set

The qualitative data set consisted of eleven interview transcripts with nurses, six were smokers and five ex smokers. All nurses worked in one acute regional teaching hospital in Spain and were in contact with patients in their routine practice. Care was taken to maximise diversity on nurses' characteristics on professional and personal characteristics (Miles & Huberman 1994). The nurses worked in a variety of services and specialties in the hospital. All participants were female registered

nurses and their age ranged 27-55 years. Their professional experience ranged between 7-35 years.

Access to the original data was gained through the ward supervisors and information letters sent to the wards. Then, participants were approached individually by the main author to provide details on the study and gain consent. Date, time and location for the interviews were agreed with the nurses. All interviews were conducted either in a private room at the hospital or at the researcher's office, located close to the hospital.

The original dataset was generated through face-to-face individual interviews. This type of interview is usually chosen to collect detailed accounts of the thoughts, attitudes, beliefs and knowledge of the participant regarding a given phenomenon (Sandelowski 2002; Loiselle et al. 2007) The interviewer adopted a conversational, non-judgmental and empathetic approach to establish rapport (DiCicco-Bloom & Crabtree 2006). The interviews started with introductory questions asking participants to describe a regular day in their life and the role that cigarettes played in it. The main topics covered in the interviews were: reasons and triggers for smoking; smoking effects on them; nursing and smoking; and support needed to quit smoking themselves. The interviews were tape-recorded. The average length of the interviews was approximately 35 minutes (range 17-38 min) and the subsequent transcripts were on average fifteen pages.

Ethical considerations

This study was given ethical clearance by a university ethics committee and written informed consent was gained from all participants to conduct the interviews. Participation was voluntary and confidential to the research team. Data were kept securely. It has been suggested that informed consent cannot be presumed in secondary analysis (Heaton 1998). However, a professional judgement may be made about whether the re-use of data violates the contract made between the

participants and the primary researcher (Heaton 1998, Thorne 1998). The main author was the researcher who interviewed the nurses. This helped ensure the goodness of fit between the original data and secondary research question.

Data analysis

Interviews were transcribed verbatim. The starting position adopted for the analysis process was one that sought to identify the psychosocial component around nurses' smoking behaviour and their health promotion role. The analysis was conducted using the framework analysis approach (Ritchie & Spencer 1994). This analytic method allows themes to develop both from the research question and from the narratives of research participants (Rabiee 2004). In this method it is necessary to develop a hierarchical thematic framework that is later used to classify and organise the data according to key themes, concepts and emergent categories. It encompasses five key stages: familiarisation; identifying a thematic framework; indexing; charting; and mapping and interpretation (Ritchie & Spencer 1994). In the first stage, each interview was read by two researchers three times. Then, the thematic framework was identified. It encompassed issues emerging from the data and *a priori* issues considered in the development of the interview guide (Ritchie & Spencer 1994). These were: reasons and triggers for smoking; smoking effects on them; nursing and smoking; and support needed to quit smoking themselves. In the indexing stage, sections of data that corresponded to particular themes were identified. Then pieces of that theme were lifted from the original transcript and placed in the framework's charts so that the key characteristics in the chart were analysed as suggested by Ritchie & Spencer (1994). Table 1 shows an extract from the chart corresponding to the theme "Being 'one of them' and professional identity".

Throughout the analytic stages the thematic framework was revised and further refined. For

instance, 'Smoking and nursing role' was an issue considered a priori and taken as a framework category. However, it was later refined as we found that nurses separated the personal and professional domains by isolating their smoking from the professional self. This led us to including the category 'Isolating the personal self from the professional' so that it provided a better fit with emerging issues in the data. This category fell under the theme that is shown in Table 1.

Data were analysed primarily in Spanish to minimise the risk of altering participants' meanings. After the analysis was completed, the final categories and relevant quotations were translated into English.

Rigour

To ensure trustworthiness Lincoln and Guba's (1985) criteria were used. These include credibility, transferability, confirmability and dependability. The systematic recruitment and data collection procedures used in the origial study to generate the data provided confirmability, as did the discussion of the analysis by the researchers in the secondary analysis presented in this study (Guba & Lincoln 1981). Findings of the primary analysis were presented to participants to ensure study's credibility (Lincoln & Guba 1985). Given that the study presented here is a secondary analysis it was not feasible to check the conclusions with the participants. Furthermore, it has been suggested that member checks should not be seen as a verification strategy to judge accuracy of data analysis (Hadi & Closs 2016). The paper provides detailed description of the study findings, the analysis procedures and interpretation of the data to enhance transferability. An extract from the framework chart reflecting one of the themes is shown in Table 1. Details have also been provided regarding the setting, sample characteristics and data collection and analysis methods so that readers can

judge the extent to which the conclusions are transferable (Lincoln & Guba 1985). Illustrative quotes are included in the presentation of findings to ensure dependability (Patton 2015).

FINDINGS

The analytic process resulted in data being organised into three major thematic areas. Each of them is described below with some quotes for illustration.

BEING 'ONE OF THEM' AND PROFESSIONAL IDENTITY

Being a smoker meant that the nurses had to find strategies and a defensive discourse to resolve their behaviour with their professional responsibility as a health promoter. Some of the nurses did this by separating their personal and professional identities. They argued that their smoking identity was part of their personal identity and quite separate from the professional one. In fact, they isolated their smoking behaviour from anything that had to do with their profession. This line of argument was also evident in the ex-smoker nurses when talking about their past behaviour:

> I think that in terms of patients it (being a nurse who smokes) doesn't have an impact (on the care provided to the patient), I mean... the patient knows, when you are at work you are a nurse, you are not Mary (name changed), me for example. I am a nurse and it is my nursing role, I am not Mary, the Mary in the street, I'm another one. [...] The patient knows that when you come to work you leave your personal life outside. (Nurse 10, smoker).

However, in contradiction to this defence they held an underlying anxiety that patients may notice their smoking status. This anxiety inhibited their ability to tackle the issue of smoking with their patients. They also felt that they were not morally allowed to recommend the patient to quit smoking while they were not able to do so themselves. It was only after becoming ex-smokers, that these nurses recognised the experience of this internal conflict. The combination of two facts, awareness of their professional duties and their own personal habit, resulted in a conflict that made them feel uncomfortable. As a consequence they tended to avoid bringing up the issue of smoking cessation among their patients:

> I think it does have an impact. I think it does. […] For example, if a patient is trying to quit and has a lung cancer and a smoker nurse who smells of tobacco approaches him advocating for something that she's doing wrong…, that has to provoke some kind of reaction in the patient. So I think yes, it does have an effect on the educational role (Nurse 6, ex - smoker)

> Let's see, in principle a health promoter, or educator or health agent, isn't it? Then, what is she doing? It (smoking) goes against your professional practice (Nurse 3, ex - smoker)

There was also a perception that their smoking somehow undermined their professional and moral authority to counsel patients on smoking when they cannot manage their own habit. In essence they believed that nurses should 'practice what they preached':

> … "he/she tells me to quit smoking... how easy! And he/she smokes" [...]. If there is no coherence in the person who is urging you to that (quit smoking), with what authority is that nurse going to tell the patient that he/she has to quit? (Nurse 6, ex - smoker)

The internal conflict in their personal behaviour and professional role resulted in them developing strategies to manage this conflict. One strategy was to absent themselves from their health promotion responsibility:

> Someone who smokes... perhaps he or she is more permissive in that sense... you are more permissive in that patient education (Nurse 1, smoker)

Another strategy was just to go through the motions of playing the role of health promoter without an underlying belief in the importance of the message they were giving. In this case the nurses repeated the message without any reflection or meaningful follow through with the patient:

> It depends on how conscious you are of what you're saying because if you keep repeating words like a parrot... what a problem... none at all! (Nurse 11, smoker)

DUALITY IN THE PSYCHOLOGICAL EFFECT OF SMOKING

Smoking had a dual impact on how nurses perceived their psychological state. First, it produced positive feelings, in association with calming and relaxing effects. The act of smoking provided nurses with an escape 'experience' from their work lives, which was viewed as positive. Therefore, there

was a perception that their smoking benefited them both in terms of the pleasurable effect of the nicotine and in escaping the stress of their work environment. These factors were mutually reinforcing:

> Mmmh... it relaxes me, helps me take a break, I mean, yeah, if I'm nervous, it's mainly... yes, it relaxes me. (Nurse 1, smoker)

> There are moments when you need to have a break, to leave the ward. Be on your own and nothing else. A moment for you and the cigarette. I think it's the disconnection what provides some rest. Not sure if it's the cigarette in itself. (Nurse 6, ex - smoker)

However, these positive feelings were often short lived and were modulated soon after by negative feelings of guilt, in relation to the shame and stigma they experienced. The nurses felt guilty for what they had done, which resulted in a negative psychological affect. This negative feeling was partly related to concerns about the impact of smoking on their personal health:

> [after smoking] I used to feel terrible. You say "I have smoked despite [all I know about tobacco]..." [It is] Horrible. Horrible in the sense that... absolutely. (Nurse 4, ex - smoker)

It was also partly related to them reflecting on the social image of nursing that they might be projecting. As such, terms such as 'sad', 'horrible', 'wrong', 'silliness', 'absurd', 'unconsciousness' and 'shame' were frequent in the interviews. The next quote illustrates this:

> It is absurd, totally. Yeah, it's complete unconsciousness because we, nurses, that are seeing the effects of tobacco directly... the basis I have to say "I have to quit smoking"... Because we supposedly try to take care of health... and all of a sudden you do that [smoking]. I think it's absurd. I mean... I feel ashamed. (Nurse 11, smoker)

NURSES ENGAGING IN SOCIAL JUSTIFICATION

Nurses tried to rationalise their smoking behaviour socially in response to the perceived impact that their behaviour had. Nurses adopted the long-known socially acceptable association between stress and smoking and alluded to the nature of nursing work as an explanatory factor. They argued that smoking was a strategy deployed to deal with the stress associated with: shift work, high workload, as well as dealing with difficult human circumstances and complex situations. Working shifts, especially night shifts, were commonly identified as a source of stress and a trigger for their smoking behaviour:

> ... the shifts also play a role, because with them you have a messy life, you eat at certain times, sleep at others, sometimes you don't sleep, plus if you have kids... I mean, stress derives from the personal life and from the shifts as well. (Nurse 4, ex - smoker)

Workload was also regarded as compounding factor in their stress experience and rationalisation of their smoking:

> ... [Smoking] in days in which you have a tough shift, that you don't have a minute to stop due to a very heavy workload. And you end up just exhausted and stressed!. (Nurse 10, smoker)

In addition, they believed nursing was a profession with great responsibility, as it dealt with human circumstances. They attributed their perceived stress to situations they encountered in their practice in terms of patients' and families' needs, which they were not always able to fulfil. The emotional overload did not only come from the inability to fulfil their needs but also from the fact that nursing is a profession where nurses were often involved in relationships and situations highly charged with emotions:

> I have experienced situations like when you are taking care of a patient who is very ill, grasping for breath, with a lung cancer, the family very uptight, with... very bad... and I have got out and said "I'm going to smoke". I mean situations that overwhelm you, that you can't control with medication, that you can't control.... that affect your human nature, you know? (Nurse 9, smoker).

Concrete situations that could be regarded as stressful, such as dealing with situations where a patient's life could be at risk, sometimes triggered a so-called smoking break:

> ... a moment of tension, a moment of ... well, of... there are... inappropriate performances, bad responses, mmm... things don't work as they should... and those can also create tension and in a concrete situation say – I'm... I need to get out for a sec [to smoke]. (Nurse 11, smoker)

Cigarettes also had a function in offering time for oneself in situations of high workload. Smoking a cigarette was a time that offered a chance for disconnection and getting some space from what they were doing:

> ... a bit of tranquility... and... you clear from work that little while and you focus on... you let your mind go blank (...) disconnect and say "I'm getting out of... of my workplace to another completely different place" you know? That it has to be the street and... then you can have a breath of fresh air and let your mind go blank.... (Nurse 5, smoker).

DISCUSSION

The major findings of this study are presented under three themes. These include: being 'one of them' and professional identity; duality in the psychological effect of smoking; and nurses engaging in social justification. Nurses often tried to isolate their smoking in their personal life in face of the need to reconcile it with the role expectations attributed to their profession. Previous studies have identified the discomfort that nurses who smoke experience and that often results in them denying the health consequences of smoking (McKenna *et al.,* 2001); having feelings of shame and guilt (Sarna et al. 2005, Gonzalez et al. 2009); and avoiding addressing the issue of smoking with their patients (Heath et al. 2004, McCann *et al.,* 2005). Recent evidence reinforces this evidence and points out the impact that nurses' smoking behaviour may be having on how they deal with patients who smoke (Duaso et al. 2017), compromising their role as agents of health promotion among their patients (While 2014, Cummings 2015). This would be concordant with the Theory of Cognitive Dissonance (Festinger 1957), which posits that individuals strive to keep some coherence between their cognitions and behaviours. According to this theory, when a controversy occurs between the

two, it results in an internal conflict, which in turn, creates discomfort, as in the accounts of nurses in the present study. Other recent studies also point out that nurses who smoke struggle with the ambivalence they experience (Radsma & Bottorf 2009). This could also explain the shame and guilt that nurses who smoked felt and the fact that they had no problem in dealing with anti-smoking health promotion after quitting smoking, but not before.

The inclusion of ex-smoker nurses was a novel aspect in this study in comparison with previous studies, which only focused on nurses who smoked (Gonzalez *et al* 2009). Their accounts helped to understand why their health promotion role was compromised when being smokers, as their reflections were more candid. They remembered how when confronted with situations where they had to engage in health promotion they either evaded it or delivered bland messages that lacked conviction. They had felt conflicted and sought to skip any chance of getting involved in conversations around smoking and healthy decision-making with their patients. The negative feelings they experienced had to be inhibited and this prevented them from supporting patients with their smoking behaviour.

Abandoning the smoking behaviour enabled them to engage in that health promoting activity. This would be concordant with the Theory of Cognitive Dissonance, as quitting smoking would resolve the inconcistency. However, there might be other mechanisms through which nurses might also be able to handle their health promotion role despite holding an unhealthy behaviour. Nurses with unhealthy lifestyles could be supported in addressing the negative feelings and cognitions that might arise when confronted with their health promotion responsibility. In part this must also include a recognition that maladaptive behaviours, such as smoking, might be a product of work placed stress. In general, these stresses are often under-considered except in more emotionally intense areas such as palliative care (Shimoinaba *et al.* 2009). Therefore, nurses should be provided with formal support

to modulate the psychosocial processes that might arise also accompanying the health promotion role. Following on the International Council of Nurses' (ICN) call for nurses to make 'a personal commitment to eat healthily, exercise appropriately, drink sensibly and avoid the use of tobacco' (ICN 2010, p.37), Kelly et al (2017) advocate the need to incorporate strategies by employers to support nurses so that they can fulfill this expectation and improve their health promotion practice.

Nurses might benefit from training in abilities and strategies such as motivational interviewing that would help them focus on the interactions they establish with their patients rather than on specific behaviours. Previous studies suggest that the opportunity to talk openly about a negative health behaviour with a recipient that listens, without being told off, makes people believe they are capable of achieving their goals (Mujika *et al.* 2014). Developing this kind of skills among nurses, so that they care for their patient focusing on the person rather than on the behaviour itself, could contribute to enhance their engagement in health promotion. In accordance with this, Kelly et al (2017) reported that it was crucial that nurses felt supported rather than punished or blamed.

It could be argued that what has been found in relation to the smoking behaviour in this study could be extended to other behaviours such as unhealthy eating and lack of exercise. Nurses who hold unhealthy habits might be undergoing similar psychosocial processes in relation to other areas where conflict between those behaviours and their health promoting role exist. Where nurses have unhealthy personal behaviours, appropriate interventions that focus on supporting them to modulate the psychosocial processes arisen about their health promotion role or on developing motivational abilities to use with patients, may have dividends both for their health promoting role with their patients and potentially for nurses' own health. The perception of being able to help others and the related positive outcomes might encourage to modify theirs.

Limitations

The nurses who took part in the original project were self-selected in one hospital and thus may not be representative of all the nurses in that hospital or other places in terms of socio-demographics, knowledge, awareness or other values. However, they provided a useful insight that would need to be further investigated about the process of why nurses' health promotion activity was influenced by their own health behaviour. In the future, research should include nurses from different cultural backgrounds and gender and with different types of training in health promotion or in smoking cessation to gain a better insight.

CONCLUSION

Nurses with an unhealthy behaviour such as smoking, experience internal processes that might have a negative impact when engaging in health promotion practice. Smoking nurses may be inhibited as health promoters without noticing it and they may need help to address the conflict that they experience between their professional responsibility and their smoking behaviour. If health promotion practices are to be enhanced, interventions that help these health professionals are necessary. In addition to traditional approaches such as smoking cessation support, nurses who smoke and more generally those with unhealthy behaviours, should be provided with formal support to modulate the psychosocial processes that might arise in their health promotion role. Also, training on motivational skills is necessary to facilitate that nurses develop the abilities that will allow them to focus on their patients rather than on a specific behaviour. The inclusion of this kind of help in the agenda of workforce management would have a positive clinical impact in terms of facilitating a patient-centered health promotion that would foster healthy choices. Should these interventions work to improve health professionals' interactions with patients and the outcomes achieved their impact might extend to also include improving professionals' personal health behaviours. Future studies on nurses or other health professionals' unhealthy behaviours should move on from descriptive into experimental designs.

Author Contributions:

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE*):

1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;

2) drafting the article or revising it critically for important intellectual content.

* http://www.icmje.org/recommendations/

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Table 1.
Theme 1. BEING ONE OF THEM AND PROFESSIONAL IDENTITY

Isolating the personal self from the professional		**Difficulty in concealing smoking**		**Feeling that they are doing wrong**		**Strategies to manage conflict between personal and professional aspects**	
I think that in terms of patients it (being a nurse who smokes) doesn't have an impact (on the care provided to the patient), I mean... the patient knows, **when you are at work you are a nurse,** you are not Mary (name changed), me for example. **I am a nurse and it is my nursing role,** I am not Mary**, the Mary in the street,** I'm another one. [...] The **patient knows that when you come to work you leave your personal life outside**. *Nurse 10*	Being a nurse at work Patients awareness Personal self outside work	I think it does have an impact. I think it does. […] For example, if a patient is trying to quit and has a lung cancer, and a **smoker nurse who smells of tobacco approaches him advocating for something** that she's doing wrong…, that has to **provoke some kind of reaction in the patient**. So I think yes, it does have an effect on the educational role *Nurse 6*	Doing health education while smelling (of tobacco) Effect on the patient	Let's see, in principle **a health promoter, or educator or health agent, isn't it**? Then, what is she doing? **It (smoking) goes against your professional practice** *Nurse 3* … "he/she tells me to quit smoking... how easy! And he/she smokes" [...]. If there is **no coherence in the person who is urging you** to that (quit smoking), **with what authority is that nurse going to tell the patient** that he/she has to quit? *Nurse 6*	Health education role awareness Professional authority undermine Need for coherence Professional authority undermine	Someone who smokes... perhaps he or she is more permissive in that sense... you are **more permissive in that patient education** *Nurse 1* It depends on how conscious you are of what you're saying because if you keep **repeating words like a parrot**... what a problem... none at all! *Nurse 11*	Permissiveness Play the role