RESEARCH PAPER

An ethnographic study of tobacco control in hospital settings

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Background: Tobacco control in hospital settings is characterised by a focus on protection strategies and an increasing expectation that health practitioners provide cessation support to patients. While practitioners claim to have positive attitudes toward supporting patient cessation efforts, missed opportunities are the practice norm.

Objective: To study hospital workplace culture relevant to tobacco use and control as part of a mixed-methods research project that investigated hospital-based registered nurses' integration of cessation interventions.

Design: The study was conducted at two hospitals situated in British Columbia, Canada. Data collection included 135 hours of field work including observations of ward activities and designated smoking areas, 85 unstructured conversations with nurses, and the collection of patient-care documents on 16 adult in-patient wards.

Results: The findings demonstrate that protection strategies (for example, smoking restrictions) were relatively well integrated into organisational culture and practice activities but the same was not true for cessation strategies. An analysis of resources and documentation relevant to tobacco revealed an absence of support for addressing tobacco use and cessation. Nurses framed patients' tobacco use as a relational issue, a risk to patient safety, and a burden. Furthermore, conversations revealed that nurses tended to possess only a vague awareness of nicotine dependence.

Conclusion: Overcoming challenges to extending tobacco control within hospitals could be enhanced by emphasising the value of addressing patients' tobacco use, raising awareness of nicotine dependence, and improving the availability of resources to address addiction issues.

Over the latter part of the 20th century hospitals began to implement tobacco control strategies. Early steps included banning the sale of tobacco products and restricting smoking to indoor designated areas, and eventual banning of smoking throughout hospital buildings.[1] Currently, policies declaring hospital buildings and grounds as smoke-free zones (smoking prohibited everywhere on hospital property) are under consideration in many jurisdictions.[1 2] Since smoke-free zones further inhibit tobacco use, this strategy heightens an interest in practitioners supporting patient cessation.[2] This issue is of particular relevance to nurses working in direct patient care since they are the largest health practitioner group in these settings and have the most amount of contact with patients.[3–7] While health practitioners claim to have positive attitudes towards providing cessation support[8–11] and agree tobacco use is an important health issue,[9–12] missed opportunities to provide this support have been the reported practice norm.[9 11 13–15] The World Health Organization's Framework Convention on Tobacco Control recommends that tobacco reduction interventions be available in hospitals.[16 17] Given the potential for extending tobacco control in hospitals and associated demands on health practitioners, we undertook an ethnographic study of hospital workplace culture in hopes of enhancing our understanding of issues relevant to clinical practice related to tobacco.[18 19]

Workplace culture, conceptualised as an amalgamation of the values, assumptions and beliefs embedded in an institution and clinical practice,[20] can be investigated by reviewing institutional documents, noting administrative support of practice, observing clinician practice activities, and listening to employees.[21] Thus, a cultural perspective moves inquiry beyond the knowledge, attitudes and beliefs of employees, to provide a broader view of contextual factors effecting practice. The purpose of this ethnographic study was to investigate nurses' workplace culture[22] as it relates to tobacco use and control.

BACKGROUND LITERATURE: HOSPITALS AND TOBACCO CONTROL

Evidence related to hospital-based smoking restrictions provides insight into compliance issues, staff attitudes, and effects on staff smoking rates. Despite high compliance by hospitals legislated to implement such policies,[23] evidence suggests that staff and visitors continue to smoke in non-designated areas.[1 24 25] For example, nurses report that the hectic pace at work prohibits having sufficient time to go outside to smoke during breaks and use inside rooms as unofficial places to smoke.[26] With regards to nurses' attitudes, they tend to demonstrate more sympathy for smokers and are less supportive of smoking bans than doctors.[24 26–28] In part this may be related to reports that smoking restrictions create unique challenges for nurses because they regularly deal with patients' requests to smoke and are the main enforcers of policy restrictions.[24 27 28] A perceived lack of administrative support for cessation has led some nurses to question the reasonableness of hospital-wide smoking bans.[26] Finally, there has been evidence suggesting that staff smoking rates decrease in response to smoking bans.[1 23] Recently reported findings suggest employees faced with restrictions demonstrated higher quit rates and had less time to smoke, but relapse rates were similar to employees at other hospitals with no restrictions.[29] Although nurses suggest smoking bans could be an incentive to stop smoking, the lack of organisational support for cessation has been reported to be a deterrent.[26]

Meta-analysis of clinical trial studies has suggested that cessation interventions delivered in hospitals can effectively influence tobacco use.[30–32] Hospitalisation provides an ideal opportunity to address tobacco use: patients are faced with

physical health issues (likely tobacco-related) and regular patterns of tobacco use are altered because of restrictions.[30 33 34] Clinical practice guidelines recommend that accessibility to resources (that is, nicotine replacement therapies, practice guidelines, education sessions, in-hospital cessation expertise, and community cessation programmes) supports practitioners in providing cessation interventions.[33 35 36] Moreover, evidence suggests that perceived availability of such resources can influence practitioner engagement in cessation support.[37–39]

Fiore and colleagues[33] contend an additional essential component for implementing a cessation strategy is an institution-wide documentation system related to patients' tobacco use status. Efficacy studies of systemic documentation regarding tobacco in health care settings have reported diverse results. Two studies reported that the use of a documented reminder influenced the rate of assessment of smoking status, patient referral (to a programme available through the study), and provision of tobacco-related counselling.[40 41] In a recent study, the use of a ''fifth vital sign stamp'' increased the rate of asking about smoking status, but did not influence the provision of advice about tobacco reduction, assistance with cessation, or arrangement for follow-up.[42]

In summary, there is an emerging body of evidence concerning protection and cessation strategies in hospital settings. While previous research reveals some outcomes associated with smoking bans and possible factors influencing the use of cessation interventions, a better understanding of the way tobacco use is addressed and managed in these contexts could provide directions for enhancing the integration of tobacco control measures in hospital settings.[20]

METHOD

This ethnographic study was part of a mixed-methods research project that investigated registered nurses' integration of tobacco-related activities in their practice. Ethical approval for the research project was obtained from the University of British Columbia Behavioral Research Ethics Board and from each of the study hospital ethical review boards.

Study sites

Two hospitals in the Canadian province of British Columbia (BC) were chosen for this study because of their potential to demonstrate differences in workplace culture specific to tobacco. They were of similar size but situated in two regions with the largest difference in population tobacco use rates: a 260 bed hospital that served a region with a population smoking rate of 31.2%, and a 294 bed hospital servicing a region with a population smoking rate of 19.6%.[43] All adult in-patient wards at the two study sites were included in the study: 2 psychiatric, 4 surgery, 1 intensive care, 1 cardiac care, 1 orthopaedic, 1 neurology, 2 rehabilitation medicine, and 4 medical wards.

Data collection

The first author (AS) completed approximately 135 hours in the field observing ward activities, conducting 85 unstructured conversations with nurses, and collecting documents on the 16 wards. Field work observations included paying attention to conversations (among various clinicians, and those between nurses and patients at the nursing station), observing signs on the ward related to tobacco use and smoking restrictions, and noting evidence of cessation resources. Documents collected include: admission forms, various patient-care forms (for example, care maps), referral forms, and various patient reference materials. Designated smoking areas and main entrances to the hospital were observed and photographed. Unstructured conversations with nurses (lasting 10–30 minutes) were conducted on the ward in a location chosen by the participant. Each conversation began with the researcher posing a question like, ''Think of everything you would do for a patient during a shift (pause) and now when I say tobacco what do you think of?'' Conversation notes were hand recorded and later typed into an electronic file. Informed consent was obtained from all participants that talked with the researcher.

Analysis

Ethnographic analysis, a non-linear inductive process that includes coding, sorting, theorising, and reflecting upon the analytic process, was used.[22] In this study the dataset included field notes, documents, hand-recorded conversations, and photographs of designated smoking areas. Initial stages of analysis included several reviews of the entire dataset to identify key concepts profiling tobacco in the two workplaces. The data were then coded using these key concepts to facilitate retrieval and comparisons between the two sites. Additional review of the coded data and reflection on the initial conceptualisation led to refinement of the concepts used to describe the presence of tobacco in these workplace cultures.

RESULTS

The findings from this study illuminate complexities associated with managing tobacco use in hospital settings. To contextualise the findings, background information relevant to the study sites is described. The findings are then presented focusing on two main topics that reveal the ways tobacco use was addressed and managed in these hospital workplace cultures. The first section addresses the duality of how tobacco control was shaped by organisational structures. The second section describes insights gained by examining the ways nurses theorise about patients' tobacco use and their practice.

The study scene

The study hospitals were situated in regions with established tobacco control strategies,[44] and where anti-tobacco messages were publicly advertised (for example, cigarette package labelling, billboard and television advertisements relaying information about the health effects of tobacco use and cessation tips). Youth prevention, cessation, and public space protection were primary strategies supported by regional government authorities.[45] Additionally, at the time of the study there was interest by the provincial government to pursue legal action against the tobacco industry in an attempt to recover costs for treating tobacco-related health conditions.[46] In the study regions, hospital policies demonstrated a prohibition for selling tobacco products on site, the establishment of indoor smoking restriction policies, and a dearth of available in-service education, policies, or protocols concerning cessation.

During any given shift worked by the nurses, the probability of encountering patients who were long-time smokers was high. Findings from surveys completed by nurses participating in the larger research project demonstrated that most nurses reported ''frequently'' to ''almost always'' caring for smokers during every shift worked (response rate 58%; n = 213).[11] Field observations revealed that the majority of the patients on the study wards appeared to be middle-aged and older, which would be typical of adult inpatient wards (for example, surgery, medicine, intensive care, and psychiatry). Since people generally begin smoking in their teens, most patients who smoked could be expected to have a smoking history that spanned decades and to be nicotine dependent.

There were two key health care system characteristics described by the nurses that held relevance for their involvement in cessation; high workload demands and deteriorated relations with administration. The nurses spoke about the increasingly busy pace of work, which they attributed to patient acuity, shorter patient hospital stays, and inadequate staffing patterns. These descriptions of heavy workloads led to reflections about how the increased pace had changed their work patterns; current practice was focused on assessments, physical treatments, and medications. Thus, there was diminished time to spend with patients and families to teach or address anything but physical needs. Nurses also spoke about changes in administration within the hospital and the larger health care system, which had led to a perception of decreased support from and loss of open communication with management.

The dual nature of tobacco control in the hospital setting

A close examination of various efforts to integrate tobacco control revealed an interesting binary in these hospital settings. While there were conspicuous indicators of efforts to implement tobacco protection strategies at the study sites with varying degrees of success, there was, on the other hand, a noticeable lack of evidence demonstrating support for cessation strategies.

Conspicuous signs of tobacco control: protection in the hospital setting

Tobacco use by staff, patients and visitors was shaped by protection strategies, which were identifiable through hospital policies, no-smoking signs and, occasionally, ward information pamphlets. Despite efforts to locate smoking in designated outside areas away from hospital entrances, there was visible evidence of the contrary; at one hospital entrance there was a pail that was used as an ashtray by people who frequently gathered to smoke there. Outside designated smoking areas, equipped with containers for cigarette butts, provided shelter from weather (to varying degrees) along with places to sit. These outside areas evolved over time and tended to depart from hospital policies; yet remained uncontested spaces for smoking. For example, at one site patients' designated smoking areas were on specific outdoor patios on each hospital floor (an equal number of patios were designated non-smoking). Nurses explained the patios became designated smoking areas because of complaints to hospital administration about sick people smoking and, at times, vomiting in front of hospital entrances in full public view. While patients were provided a less public space on the patios, there was no change in hospital administration policy to reflect the new designated smoking areas. Alternatively, at the other study site a designated indoor patient smoking room had been recently closed to inhibit the spread of a virus between wards. Patients were then required to go outside to smoke and were exposed to harsh weather. Eventually, patients began to use a staff designated sheltered smoking area (accessed from outside of the building). Nurses revealed, with some animosity, that this area was now shared by staff, visitors, and patients—an unauthorised change that was not openly addressed with administration. While protection strategies were clearly implemented, related compliance issues point to the complexity of issues that tobacco use brings to hospital settings.

Inconspicuous signs of tobacco control: cessation in the hospital setting

In both of the study sites, there was little evidence of implemented cessation strategies. The availability of resources at the one study site was the most tangible evidence of an attempt to integrate cessation interventions. The hospital servicing the community with a higher smoking rate was the site with significantly better access to tobacco-related resources (for example, nicotine replacement therapy (NRT) (patch and gum), in-hospital cessation expertise, and a community cessation programme that included in-hospital visits). Yet, without documented hospital policies and protocols regarding cessation there was limited legitimised support to integrate cessation into clinical practice. In addition, the absence of available in-service education concerning brief tobacco interventions also echoed a lack of legitimised support for providing cessation interventions.

Despite admission nursing history forms (in both hospital sites) including a question about smoking status, a review of patient-care records revealed a notable absence concerning tobacco. For example, on recorded timelines of expected care and health outcomes for patients with respiratory conditions there were no references made to tobacco use. Nurses explained that smoking status assessed on admission was very rarely transcribed onto other patient-care documentation. Furthermore, patient referral forms for specific health services (for example, cardiac home follow-up care, diabetic clinic, chemical dependence, rehabilitation care, geriatric follow-up and home oxygen) did not consistently include information on smoking status. For example, while cardiac home follow-up forms included a question about tobacco use, the home oxygen forms did not. Efforts to locate patient education materials revealed limited availability of cessation resources and an inadequacy of information that addressed tobacco. For example, of the 16 wards studied, one ward had a single copy of the provincial smokers-helpline pamphlet. Although wards that admitted patients with cardiac, cerebrovascular, and respiratory health conditions tended to have patient education materials that mentioned tobacco use, the information was limited to associated health risks of smoking and the suggestion that ''now would be a good time to stop smoking''. Rarely were strategies about how to stop smoking included in these materials.

The few nurse–patient interactions related to tobacco that were observed involved nurses negotiating times for nursing care based on when the patient would ''be out for a smoke'' or activities related to patients' need for NRT. While requesting an order for NRT was one activity observed, in discussion nurses frequently revealed a lack of familiarity with the use of NRT and withdrawal symptoms. For example, on one occasion, the researcher's presence appeared to cue the use of a nicotine patch for an agitated patient and in another the nurse decided a patient ''did not really want'' to have a nicotine patch because he fell asleep before she could administer one (over an hour later).

In summary, the inconspicuous presence of evidence concerning cessation strategies appears to reveal a workplace culture that systemically devalues the importance of addressing patients' tobacco use and cessation efforts.

Nurses' theorising about patients' tobacco use and their practice

As nurses talked about tobacco in the hospital setting they struggled to justify their actions and perceptions. Implicit in the discussions were a number of theories and assumptions related to the relevance of tobacco use in their workplace culture.

Tobacco: not a front-line issue

Nurses commonly alleged that tobacco use was not a ''front-line issue'' in their everyday practice, justifying this with references to ''more important'' health priorities for acute care patients. Additionally, due to brief hospitalisation periods, addressing lifestyle issues was not viewed as a

realistic goal but as something to be addressed once the patient was stabilised and at home. This framing of tobacco use as an unimportant issue during acute illness is reflected in a comment by a psychiatric nurse: ''Tobacco is not talked about on this ward, patients are offered the patch and if they refuse, then they simply go out to smoke.'' Another nurse working on a surgical ward stated: ''Tobacco use is a secondary issue…the effects are long term and people are not willing to talk about it.''

There were times, however, when nurses admitted that tobacco use became an issue that they had to address—for example, when dealing with irritated patients who wanted to go out for a smoke but were unable to leave the ward. One nurse said that tobacco use only became a ''priority'' for nurses ''if the patient is in our face'' about wanting to smoke. This statement reflects the way some nurses constructed patients' need to smoke as a relational problem concerning the management of irritable or stressed patients.

Other nurses constructed patients' tobacco use as an issue when it posed clinical and safety risks for patients associated with ''going out for a smoke''. For example, on the one hand nurses admitted, somewhat jokingly, that they ''liked'' smokers because they ''get up and move''; yet, they also worried that leaving the ward to have a cigarette might place new postoperative patients at risk because of light headedness, possible vomiting or ''passing out'' after smoking a cigarette. Cardiac nurses were particularly concerned that smoking would affect their patient's fragile cardiac condition. If unsuccessful at convincing patients to abstain from smoking, then the nurses prepared nitroglycerine (glyceryl trinitrate) for the patient upon their return to the ward from having a cigarette. The nurses lamented with colleagues about the risks associated with patients leaving the ward to smoke, but not with administrators who were perceived to be disinterested in these issues.

In summary, nurses' constructions of smoking as a low priority issue, and at best a relationship or patient safety issue, appeared to reflect a lack of preparedness to support patients in dealing with nicotine dependence and withdrawal beyond allowing patients (when possible) to go outside for a cigarette.

The burden of tobacco

Tobacco use imbued a sense of burden in these hospital settings. The nurses shared ethical dilemmas they experienced that were associated with their patients' tobacco use, their discomfort with being enforcers of smoking restrictions, concerns about the blurring of their professional boundaries, and being aware of their patients' deteriorating health in the face of continued smoking. While these could invoke a sense of compassion for smokers, they also heightened nurses' worry and strained their relationships with patients who smoked.

The first burden involved ethical dilemmas associated with patients having to leave the ward to smoke. Many of the nurses considered the previously mentioned risks associated with leaving the ward to have a cigarette along with several benefits: ''If having a smoke will calm the person down, then I would rather the patient have a smoke'', ''Smoking might be the one pleasurable event in the patient's life'', and ''Smoking might be the one avenue a patient can exercise control during their hospital stay''. Balancing the risks and benefits of patients leaving the ward for a cigarette was not easy. On most wards there was a lack of consensus on whether nurses should accompany patients outside for a smoke, which created tensions among the nurses, and between patients and nurses. Some nurses were willing to accommodate patients' need to smoke (time permitting), others stated there was no way they would assist a patient in this way, and a third group of nurses were ambivalent. For the latter group there was an added dilemma. These nurses' firmly believed that smoking was harmful to the health of their patients; yet, they questioned their professional obligation to meet their patient's need to smoke.

A second burden involved the nurses' role as an enforcer of tobacco restrictions. The nurses relayed several stories of patients smoking in undesignated areas, which at the extreme resulted in small fires (two during data collection). Nurses responded to policy infractions by confiscating and locking-up the patient's cigarettes at the nursing desk. They justified this action on the basis that the patient exposed others to environmental tobacco smoke, and created a substantial risk of fire, as well as the added risk of smoking near oxygen outlets. Once cigarettes were confiscated, patients were required to request cigarettes from the nurses and would be given only one at a time. Moreover, on wards secured at night (for example, psychiatric wards), nurses searched patients and their rooms to ensure there were no cigarettes or lighters available to the patient. Enforcement of smoking restrictions created additional work for nurses and an uncomfortable policing role.

A third burden was related to situations where professional boundaries were challenged. For example, a nurse who smoked recounted that, at the beginning of a 12-hour night shift, a patient began asking for a cigarette at which time the nurse flatly said no. By the end of the shift the nurse relented and gave the patient one of his cigarettes. He regretted the action because a professional boundary had been crossed and his relationship with the patient had changed. Nurses also felt uncomfortable about sharing their common smoking areas with patients. As one nurse explained, ''When people smoke together there is a different level of conversation that can occur and this puts both the nurses and patients in an awkward position.'' Others mentioned that since going for a coffee or meal break with a patient is ''inappropriate'' professional behaviour, they should not be expected to share smoking breaks with their patients.

A fourth burden was reflected in nurses' voiced frustrations about caring for patients with deteriorating physical health conditions associated with continued tobacco use. Despite recognising the need to support smoking cessation, they saw themselves as unable to intervene. For example, one nurse noted that her patient with early signs of chronic pulmonary obstructive disease was administered salbutamol to ease breathing difficulties while no one offered support for cessation. Another nurse said:

> Tobacco is a leading cause of cancer. We see people when they have received a recent diagnosis and it is a crying shame that we do nothing. But how can we? I mean if doctors are not addressing this; what are we to do? This really needs to be addressed.

Addiction and tobacco use: uncultivated terrain

In these hospital settings the physical health risks associated with tobacco use was clearly evident in nurses' reflections and various documents; however, there were few specific references to the addictive dimension of tobacco use. Most nurses did not explicitly describe patients who smoked as addicted. Furthermore, there was minimal awareness of withdrawal symptoms or how the stress associated with illness and hospitalisation might influence the need to smoke. Nurses' attempts to rationalise how and why people continue to smoke when faced with deteriorating physical health also revealed a lack of awareness about the addictive nature of nicotine. Several nurses, for example, admitted they

''do not get'' why people continue to smoke, with all that is known about various associated physical health risks. Some nurses framed smoking as a habit and then attempted to explain smoking by comparing it with other habits. For example, some nurses compared smoking to eating chocolate, or considered the habit of smoking as a stress reliever and wondered why people did not simply use other techniques to relieve stress. More importantly, the framing of tobacco use as a habit was commonly linked to the notion that smoking was a personal choice along with the conclusion that adults ''should take responsibility'' for their health. Accordingly, these nurses thought smokers should make the decision to ''break their habit'' to enhance their health and decrease their use of health care resources.

DISCUSSION

These findings portray how tobacco use was addressed and managed in the study sites, which reveals important insights into both nurses' practice related to tobacco use management and the implementation of tobacco control strategies. While novel, the results must be reviewed in light of study limitations. Data collection was limited to the two hospital study sites. Since hospital workplace cultures can differ significantly, further study in other settings is warranted. Still, insights from this qualitative study are helpful in stimulating new ways of thinking about tobacco control in hospital settings.[47] The number of hours in the field and the number of conversations with nurses created a rich dataset for analysis. However, in-depth probing with nurses may have provided additional insights into the issues addressed.

Although nurses in this study clearly demonstrated knowledge of health consequences related to tobacco use, parallel knowledge about addiction or nicotine dependence was surprisingly limited. Previous research suggests that nurses are aware that tobacco use is a physical health priority.[1 11 26] While it is possible that if probed these nurses might have acknowledged that irritated patients might be experiencing nicotine withdrawal symptoms, it is poignant that when left to their own reflections they did not talk directly about nicotine dependence. In tobacco control communities, it is readily acknowledged that tobacco is a highly addictive substance and for the majority of smokers tobacco use is not a matter of choice.[48] Additionally, it is generally accepted that stopping smoking at any point will result in immediate and long-term physical health benefits, tobacco users should receive support with cessation, and many will experience several failed attempts at stopping before eventually overcoming their addiction.[48] Education is one avenue available to shift nurses' awareness of these points and enhance their views of tobacco use; however, addressing the apparent systemic devaluing of addressing tobacco use and cessation in hospital settings will also be required to support sustained changes in practice.

The findings related to nurses' framing of tobacco use as a relational problem, risk to safety, and primarily a habit or choice provides important new insights into nurses' practice related to tobacco use. In addition, findings from this study suggest that these framings of tobacco use were influenced by a workplace culture that devalues the importance of addressing tobacco use as a health priority and overlooks its addictive dimension. Reframing tobacco use as a health issue that includes addiction (nicotine dependence) will require shifts in organisational structures and resources such as: changes to patient-care documentation systems and reference material so that patients' tobacco use and management are consistently present,[40–42] inclusion of appropriate resources for practitioners to support nicotine withdrawal,[33] and protocols for supporting patients experiencing withdrawal symptoms.[33] This broader approach to tobacco use would enhance practitioners' knowledge and ability to appropriately diagnose and treat nicotine withdrawal symptoms (rather than simply identifying the patient as irritable and demanding). Moreover, incorporating a regard for nicotine dependence into the everyday management of tobacco use might alleviate confusion about patients' counterintuitive behaviour of continued smoking, mitigate related nurse-patient relationship strain, and evoke compassion for patients who continue to smoke when faced with deteriorating physical health.

The findings of this study extend previous evidence that nurses are the enforcers of smoking bans and their apparent negative attitudes towards bans,[24 27 28] by describing the ethical dilemmas that this work creates in their practice. The presence of ethical dilemmas in nurses' workplaces has been previously noted[49–52] and that the ambiguity related to practice decisions or outcomes creates moral distress for many nurses. Findings from this study demonstrate that this level of complexity and ambiguity is also represented in nurses' efforts to manage patient tobacco use. Although nurses are responsible for enforcing smoking bans, they are also accountable for promoting health, respecting patient choice, and promoting autonomy.[53] Nurses' responses to this dilemma should not be ignored. Administrators need to pay attention to the everyday practices that evolve from tobacco control measures in hospitals, and find ways to respond to the concerns that tobacco use among patients raises for nurses and for other health providers. In addition, providing adequate resources for addressing nicotine dependence and supporting cessation may not only be effective in decreasing moral distress for nurses, but may also increase the possibility that patients receive assistance in dealing with nicotine withdrawal and cessation efforts.

What this paper adds

Tobacco control measures within hospital settings have tended to focus on protection strategies and researchers have described compliance issues regarding designated smoking areas, varied staff attitudes towards smoking bans, and diverse effects on staff smoking rates. There is a paucity of research examining workplace culture and the integration of tobacco control strategies, such as cessation support.

This ethnographic study sheds light on the often taken for granted practices and attitudes that affect the organised delivery of cessation support in hospital settings. Nurses who felt mandated to enforce smoking bans believed this activity disrupted their relationships with patients and viewed tobacco control as a burden. Tobacco use was not seen as a ''front-line issue'' in nurses' everyday practices. Of particular concern was the systemic devaluing of cessation support, which inhibited practitioners' integration of cessation support in encounters with patients who smoked. Without clear policies and protocols regarding cessation there is limited legitimised support to integrate cessation into clinical practice.

Conclusion

This examination of the ways tobacco use is framed and managed in hospital settings provides direction for future research and new ways to enhance the integration of cessation interventions. Findings related to how nurses constructed tobacco use as an issue and the management of patients' tobacco use could be used to refine survey measures used to investigate nurses' practice related to tobacco control. In addition, further exploration of nurses' perceptions could be beneficial—for example, how nurses

view smoking as a form of self-medication for stress and anxiety, or about their comfort in talking to patients about smoking and smoking cessation along with how these conversations are perceived to influence other areas of care.

More importantly, the findings suggest that if we desire to strengthen tobacco control measures in hospitals, then efforts need to be directed towards finding ways to support a shift in workplace culture that positions tobacco use as a health priority that encompasses both physical health risks and addiction issues. Emphasising the value of treating nicotine dependence, and providing staff with appropriate resources to address patients' addiction issues, will be essential.

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