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MEANINGS OF THE USE OF ALCOHOL AND TOBACCO FOR HEALTH PROFESSIONALS

Emilene REISDORFER[a], Edilaine Cristina da Silva GHERARDI-DONATO[b], Rodrigo Otávio MORETTI-PIRES[c]

ABSTRACT

In order to improve the quality of health care in the Brazilian public Family Health Strategy (FHS), it is important that health care professionals consider the meaning they attribute to the use of alcohol and tobacco in their self-knowledge process. The aim of this study was to understand the meaning attributed to the use of alcohol and tobacco by health care professionals working in the FHS. A qualitative study was performed in five small towns in southern Brazil between March and May of 2012. Direct observations and in-depth interviews were performed with 39 subjects. From the content analysis, two central categories were identified: "Do what I say but not what I do," and "I am a role model." It was possible to identify that the health professionals experience an interactive process of reframing concepts about their own use of psychoactive substances, which causes them to respond to the social expectation of being a role model of behavior.

Descriptors: Primary health care. Alcohol drinking. Smoking. Health personnel.

RESUMO

No processo de autoconhecimento do profissional de saúde para a melhoria da qualidade da assistência na Estratégia de Saúde da Família (ESF), torna-se importante a abordagem do significado atribuído ao uso de álcool e tabaco. Este estudo pretendeu compreender o significado atribuído ao próprio uso de álcool e tabaco por profissionais da ESF. Foi realizado um estudo qualitativo em cinco cidades de pequeno porte da Região Sul do Brasil entre março e maio de 2012. Foram realizadas observações diretas e entrevistas em profundidade com 39 sujeitos. A partir da análise de conteúdo, foram encontradas duas categorias centrais: "Faça o que eu digo mas não faça o que eu faço" e "Eu sou um exemplo de comportamento". Foi possível identificar que o profissional vivencia um processo interativo de ressignificação dos conceitos a respeito do próprio uso de substâncias psicoativas, que o levam a responder à expectativa social de ser modelo de comportamento.

Descritores: *Atenção Primária à Saúde. Consumo de bebidas alcoólicas. Hábito de fumar. Pessoal de saúde.*
Título: *Significados atribuídos ao uso de álcool e tabaco por profissionais de saúde.*

RESUMEN

En el proceso de autoconocimiento de los profesionales de la salud para mejorar la calidad de la atención, es importante abordar el significado de su uso del alcohol y el tabaco. Este estudio tuvo como objetivo comprender el significado atribuido al propio consumo de alcohol y tabaco por parte de profesionales de la salud de la Atención Primaria de Salud. Se realizó un estudio cualitativo en cinco ciudades del sur de Brasil entre marzo y mayo de 2012. Se realizaron observaciones y entrevistas con 39 personas. A partir del análisis de contenido, encontramos dos categorías centrales "Haz lo que yo digo pero no lo que hago" y "Yo soy un ejemplo de comportamiento." Fue posible identificar al profesional de la salud experimenta un proceso interactivo de reformular sus propios conceptos sobre el uso de sustancias psicoactivas, que causan a responder a una expectativa social de ser un modelo de conducta.

Descriptores: *Atención Primaria de Salud. Consumo de bebidas alcohólicas. Hábito de fumar. Personal de salud.*
Título: *Significados atribuidos al uso de alcohol y tabaco por parte de profesionales de la salud.*

a Ph.D. in Psychiatric Nursing, University of São Paulo at Ribeirão Preto College of Nursing. Post-doctoral fellow, Faculty of Nursing of the University of Alberta. Edmonton, Alberta, Canada.
b Post-doctoral fellow, Nursing, University of Alberta. Ph.D. in Psychiatric Nursing and Professor at University of São Paulo at Ribeirão Preto College of Nursing. Ribeirão Preto, São Paulo, Brazil.
c Post-doctoral fellow, Organization of American States (through the program of the National Secretary of Drug Policy and the University of São Paulo at Ribeirão Preto College of Nursing). Ph.D. in Psychiatric Nursing, University of São Paulo at Ribeirão Preto College of Nursing. Coordinator, Graduate Program in Collective Health, Federal University of Santa Catarina. Instructor, Department of Public Health, Federal University of Santa Catarina. Florianópolis, Santa Catarina, Brazil.

INTRODUCTION

In 1994, the Family Health Strategy (FHS) was adopted as a guiding principle of Primary Health Care (PHC) in the Unified Health System (SUS, as per its acronym in Portuguese), the Brazilian public health system, as a strategy for redirecting the technical assistance model. The operation of the FHS was enabled through the implementation of multidisciplinary teams in basic health care units.

Since then, a change has been observed in the health care offered in the SUS, in the search for greater rationality in the use of other care levels, and improvement in key health indicators of populations served by the family health care teams. Within the proposal for operationalization of the FHS, one of the key differentials is its interdisciplinary composition and method of working in teams.[1]

In addition, proximity with the community is important to address health problems in general, yet attention should be paid to related situations of psychological distress, which are extremely frequent and poorly treated at this level of care.[2]

Among the disorders related to mental health, the use of licit psychoactive substances such as alcohol and tobacco has been gaining attention on public health policy agendas, as these are currently the main drugs being abused.[3]

With regard to tobacco, the World Health Organization estimates that one-third of the adult population are smokers, being 47% of the male population and 12% of the female population.[4] Data from one study developed with the adult population in the 27 Brazilian state capitals and the Federal District show a mean prevalence of active smokers of 16.1%. The prevalence was higher among male respondents (20.5%) compared to females (12.4%), and particularly high among those with eight years of education or less.[5]

Despite recognition of the FHS as an important space for care of users of tobacco and alcohol, some obstacles still exist to its full structuring, such as the tendency to medicate symptoms, and not perceiving the different patterns of alcohol and tobacco use as a health problem, which is strongly related to the subjective unpreparedness of the professionals to deal with content related to psychological distress and subjective needs in everyday care.[6]

In the process of training of health care professionals to improve the quality of care provided, it is important to look at the meanings of their own use of alcohol and tobacco. From the moment in which the professional sees him or herself as a user or non-user of these substances, their perception of the needs of patients who are users can be adjusted.

Treating people with problems related to the use of alcohol and tobacco is a very complex task, as it involves, in addition to technical knowledge, a personal attachment that is directly related to personal beliefs and perceptions that the health care professionals have regarding the use of these substances.[7]

Some studies suggest the important role of health care professionals as role models for those they treat.[8-9] In the perspective of alcohol and tobacco use, this role seems even more relevant, as some people may have difficulty accepting treatment from a person who is a user of these substances.[10]

The importance of the self-knowledge of health care professionals in the search to identify their own beliefs, values and biases in relation to alcohol and tobacco, and to users, gains increased importance, because these aspects may not be obvious, but may manifest through behavior or approaches at the time of care, as well as in guidance for drug users and their families.[11]

Reflection on the characteristics of consumption of these substances by health care professionals is similar to that of their patients, as both are human beings potentially influenced by the same conditions.

Few studies have addressed the significance of the use of alcohol and tobacco among professionals working in Primary Health Care (PHC) of the SUS,[8,10,12] and those that exist are mainly related to tobacco use. Furthermore, no studies were found that broaden knowledge on the significance of the use of these substances in this population.

Studying the significance of psychoactive substance use, specifically by professionals working in the FHS, can contribute to broaden knowledge on the factors that influence the care in this model. It may also provide support for possible actions that can contribute to improve the care provided to people who use alcohol and tobacco.

Thus, the aim of this study was to understand the meaning attributed to alcohol and tobacco use

by PHC professionals, and to answer the following question: What are the meanings attributed to the use of alcohol and tobacco by PHC professionals?

METHOD

A qualitative study using content analysis[13] was developed so as to broaden understanding of the phenomenon studied.

The qualitative method is based on the constructivist paradigm. Ontologically, there are multiple realities, multiple truths and individual constructions of reality, which is socially constructed and constantly changing. The researcher and subject are in an interactive relationship, so the findings of the research are created in the context of the situation that permeates the collection of data.[11,14]

The study was conducted in five small towns in the state of Santa Catarina, in southern Brazil, during the first half of 2012. The municipalities participating in the study were defined from the patterns of alcohol and tobacco use by health care professionals, which were identified in the study *Análise da articulação entre os Núcleos de Apoio à Saúde da Família e a Estratégia de Saúde da Família na* 6ª *Secretaria de Desenvolvimento Regional do Estado de Santa Catarina - dos desafios* às *potencialidades para a efetivação do Sistema* Único *de Saúde* (Analysis of the relationship between the Centers for Family Health Support and the Family Health Strategy in the 6th Department of Regional Development of the State of Santa Catarina – from the challenges to the potentials for realization of the Unified Health System), carried out the previous year with a quantitative methodology. In this study, all of the professionals in the FHS were interviewed with the aim to investigate their health conditions, and the articulations of the health care network.

In each municipality included in the sample, the greatest possible variability was sought, in an attempt to include the different patterns of substance use. The site chosen to undertake this research was adequate, as all municipalities have full coverage of the FHS and follow the institutionally-advocated precepts.

A total of 39 professionals were interviewed in the following categories: community health workers, nursing technicians, nurses, physicians, dentists, nutritionists, pharmacists, psychologists and social workers.

Participants were selected by seeking key informants and professionals who had greater length of service in the municipality. Those who had participated in the quantitative phase performed in the previous year were included. Thus, working time in the municipality and prior assessment of the pattern of alcohol and tobacco use were guaranteed. Professionals who did not participate in the quantitative stage were not invited to participate.

The concept of theoretical sampling was used to define the number of interviews, as its purpose is to identify people, events and places that maximize opportunities to discover variations among concepts, consolidating the categories, their properties and dimensions.[15]

Data were collected between March and May of 2012. Semi-structured, in-depth interviews were conducted and sought responses based on the subjective experience of the individuals, in order to objectify the understanding of a problem or situation.[14] Direct observation was also performed by the researcher during the interviews.

The interviews were semi-structured with a script constructed by the researcher, and held in a location chosen by the participant, provided that it offered the privacy needed to guarantee quality of the responses. Some of the guiding questions of the interview were: “How do you feel in face of a PHC user seeking treatment?,” “Does drinking and/or smoking interfere with the way you treat people who seek care here?,” and “What is the role of these substances in your daily life?”

The interviews were recorded and transcribed by the researcher, then read thoroughly and subjected to content analysis.[13] Using a qualitative descriptive approach, the content analysis offered a practical approach to understanding the perspectives.[14] The analysis was performed interactively, with the text being divided into words, sentences and paragraphs. The process of generating subcategories was performed until the core categories were identified in the interviews. The Atlas.ti 5.5 software was used for organization and better visualization of the analysis process.

The health care professionals invited to participate in the study were informed of their non-obligation to participate, and signed the Free and Informed Consent Form. They were also guaranteed, along with the Municipal Administration, that there would be no penalties or losses for those

who did not wish to participate. The project was approved by the Research Ethics Committee of the Federal University of Santa Catarina, under case number 1043, on December 13, 2010.

RESULTS AND DISCUSSION

As observed, the majority of participants were women (74.4%) and married (64.1%). As well, the majority were community health workers (35.8%), a fact that is consistent with the reality of Primary Health Care, where most workers are found in this category. Most had worked in the profession and in the city for over three years (82.0%), a situation that favored expanded knowledge of the local reality. Regarding the use of tobacco and the abuse of alcohol, the prevalence was 5.1% and 12.8% respectively, lower than the general population.[16-17] Further information can be found in Table 1.

Meanings attributed to the use of alcohol and tobacco by health professionals

The meaning of the use of psychoactive substances by health care professionals is socially constructed, in their interaction with their family, friends, coworkers, and the community where they live and/or work.[18] This construction presents some singularities regarding the use or nonuse of alcohol and/or tobacco. The use of psychoactive substances is determined by a variety of factors related to life history and genetic and physiological issues. It is no different with individual health care professionals, as before assuming this social position, they are members of a society and suffer the same influences as other people who do not work in health care.[19]

The factors that led individuals to consume psychoactive substances are varied, as are the factors that led them to abstain. The overall prevalence of consumption was lower among caregivers than among the population as a whole, which can be explained by the fact that these people have greater technical knowledge on the subject, including the consequences of use on their health.[16-18]

In the analysis of the interviews, two main categories were found related to the meaning of alcohol and tobacco use. These two central categories were: "Do what I say but not what I do," and "I am a role model of behavior."

To understand the meanings attributed to alcohol and tobacco use, and to the care provided, the perception of these by the study participants was sought. Some differences between groups of people were perceived, especially among the health care professionals who use the substances and those who do not, as shown in Figure 1.

No differences were observed specifically related to alcohol or tobacco use, as the reports were very similar, regardless of the substance used.

Some differences were observed in the meanings attributed to alcohol and tobacco by profes-

Table 1 – Socio-demographic characteristics of the research subjects – 2012.

Variables	N	%
Municipality of work		
Arabutã	8	20.5
Alto Bela Vista	8	20.5
Seara	5	12.8
Peritiba	10	25.7
Presidente Castello Branco	8	20.5
Age range (years)		
≤ 30	22	56.4
31-40	9	23.1
≥ 41	8	20.5
Level of education		
Incomplete primary	3	7.7
Complete high school	13	33.3
Incomplete higher education	1	2.6
Complete higher education	22	56.4
Profession		
Community health worker	14	35.8
Nursing technician	3	7.7
Nurse	5	12.8
Physician	4	10.3
Dentist	4	10.3
Nutritionist	3	7.7
Psychologist	2	5.1
Pharmacist	2	5.1
Social worker	1	2.6
Physiotherapist	1	2.6

Source: Data from the authors.

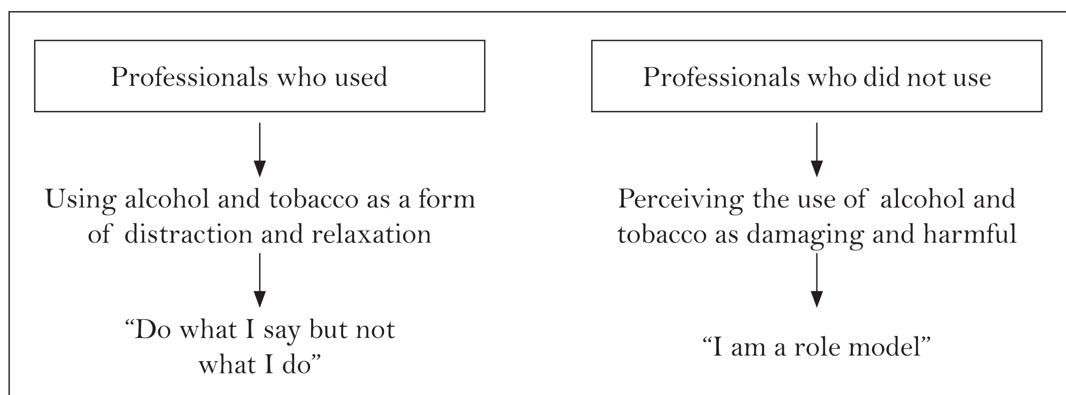

Figure 1 – Construction of meanings attributed to alcohol and tobacco use.

sionals who used and those who did not. The professionals who used these substances reported that they helped them to relax and unwind, but they believed that the population of the community where they worked should not know of their use. The nonusers reported they perceived the substances as harmful and damaging to their health, and believed that their behavior could be a model for the community.

"Do what I say but not what I do"

For professionals who used alcohol and tobacco, the meaning associated with use was related to leisure time, as a way to "let go" and relax from the stress of work.

> *[...]alcohol is like, more at parties, to unwind, loosen up, not because I have to drink [...], I have it at home too, but I don't drink, only when somebody comes over. (E21)*

> *(E17) for me it is calming (cigarette), even if only psychologically, not that I am aware that this is psychological...so I know it's bad, it's just that [...] it is calming, it helps me. (E17)*

The statements also pointed to use when accompanied by other people, as unaccompanied use was pointed to as being non-pleasurable.

> *I think it's like, it's more for relaxation, if you have to drink alone, if you are dependent, it's not enjoyable. (E14)*

In addition, health care professionals regarded their use as normal or social. In general, they did not identify problems related to their use.

> *So I drink beer when I go, I don't know, to a party, when I'm with friends, but it's from time to time. I'm fine that way, I don't know, I don't worry. (E3)*

Smoking health care professionals tended to attribute meanings to the recreational aspect of substance use, i.e., tobacco is calming, used after stressful situations, as well as for company or a pastime.

> *I live alone, you know, so the cigarette makes me company, but it's like I have nothing to do at home, I smoke a cigarette, time goes by, something like that. (E21)*

Thus, it can be said that among the professionals who used the substances, the meaning attributed to use was related to relaxation, constituting part of the subjects' everyday experiences.

The pattern of alcohol use similar to SUS users was reported as an opening to broach the subject in a more empathetic manner, facilitating understanding of the problem.

> *I am a person who likes to use alcohol as a way of enjoying a drink. And I also understand, because I'm not an addict, that I can have this control. (E29)*

The health care professionals who used alcohol and/or tobacco preferred not to admit their use to the community, also in order to be considered examples of behavior. This fact demonstrated that the professionals assumed a paternalistic role, which is socially imposed on them.

> *I don't smoke at the health clinic, I try to hide my addiction as much as possible, I smoke at home. I think it's difficult to tell someone not to smoke, if you smell like*

cigarettes or if he saw you smoking. I try to avoid this as much as possible, it's like 'do what I say but not what I do,' right? (E21)

Among the professionals who used alcohol and/or tobacco, a trend was noticed of denial of use in order to be able to "request" abstinence from patients, without being questioned about their own use.

I think it's like, we also work in the health care sector, they care a lot about this, they say that if we are drinking, how can we go to their house and say that they can't drink. (E22)

[...] In the community we avoid placing example questions. Then how will I make demands from people? (E30)

Even among the professionals who used substances, the significance associated with being a "role model of behavior" was perceived, demonstrating the need to hide and deny their use in order to maintain the appearance of a healthy person, and be able to offer guidance without being hypocritical.[12]1

"I'm a role model"

Among the health care professionals who did not use any substances, it was perceived that the meaning was more related to the damage caused by the use of substances, or stressful family situations associated with the consumption of alcohol and tobacco.

[...] For me alcohol, the worst drug that exists is alcohol. Of course there's crack, which isn't used so much here, but here in our region alcohol is the worst drug. (E17)

Two ways in which the meanings attributed to alcohol and/or tobacco use by health care professionals interfere in the care they provide could be identified. The first could be summarized by the phrase, "*Follow my example*": the professionals who did not use alcohol or tobacco placed their behavior as an example to be followed.

Since I graduated, I have this habit and never let it go, I can control myself, and if I can, why can't the other guy [...] this is what I emphasize. (E4)

Nevertheless, it was perceived that, both for the professionals who used substances and those who did not, what mattered was to be an example of social conduct for SUS patients. This finding is consistent with international literature on the subject, which shows that health care professionals seek to model their behavior to the expectations of health service patients.[18]

Among this group of professionals, it was perceived that they felt as if they could orient the patients not to use, then they could also not use, because if the patients could abstain then they should be able to abstain from use as well.

[...] So I think it is something really harmful [...] I think that I don't smoke because of this, that I think it's harmful, I think others could also stop, right, you know, do something that even I don't do. (E16)

For this group of professionals, the meanings were part of the construction of the professional identity related to caring for the substance user. The meanings were influenced by the families and communities into which they were inserted, beyond the context in which they acted professionally, as well as related to academic training obtained, either undergraduate or trainings conducted in the workplace. The achievement of specific training influenced the confidence they felt to address the issue with users and their families.

Based on this, the professionals chose work strategies consistent with their training and confidence, and thus defined the type of care they could provide.

It was through symbolic interaction with other people and communities that the health care professionals constructed the meaning of their alcohol and tobacco use, and developed concepts that guided their actions.[20] In each new interaction with other users, the meanings related to the use of substances changed, being reinforced by the assertion that their use is really harmful, and that people expected nonuse and exemplary behavior from the professionals.

When an individual is socially identified as a health care professional, this can be thought of as the emergence of a new identity. Assuming this role requires a new attitude that socially befits the health care professional.[19]

The context in which professional and personal action develops, the influences of family,

friends and the community, as well as the training received by health care professionals, allowed the establishment of meanings associated with the use of alcohol and tobacco, and the care provided in this area. These meanings led the professionals to adopt a model of behavior that they judged to be socially expected, and thus to establish strategies of compatible care.

FINAL CONSIDERATIONS

It was possible to identify that the health care professionals experienced an interactive process of constant redefinition of their concepts regarding the use of psychoactive substances, which led them to respond to a social expectation of being a role model of behavior for the community, avoiding alcohol consumption and tobacco.

It may be asserted that health care professionals are individuals inserted in the same society as the patients of health services to whom they provide care, thereby being exposed to very similar information and influences. The fact of having attended a course which gave them specific training to work in health care changed the way they perceived the process of health and disease, but not enough to change deep-seated cultural issues such as the use of alcohol, tobacco and eating habits.

Further studies are needed on this relationship between being a health care professional and also an individual in the community, addressing the ways and strategies used to deal with these issues.

One limitation of this study is the fact that it only included one rural region of one state, with its individual historical and cultural characteristics, which prevents generalization on the subject for Brazilian reality overall.

Furthermore, it is concluded that the context in which the health professional lives and acts directly influences the construction of meanings attributed to psychoactive substance use itself. Thus, it also interferes in the way the professional constructs care, based on the expectations of the people with whom they live and interact.

The contributions made by this study reflect the need to consider the meanings attributed to the use of alcohol and tobacco by health care professionals when setting public policy for this field. A more comprehensive approach enables performance focused on situations brought by service users and a redefinition on the part of health care professionals.

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Author's address / *Endereço do autor / Dirección del autor*
Emilene Reisdorfer
9919 87 Avenue, T6E2N8
Edmonton, Alberta, Canadá
E-mail: mireisdorfer@gmail.com

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