

Original Article

A Qualitative Study on the Difficulties Faced by Healthcare Professionals Working in Smoking Cessation Clinics

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ABSTRACT

OBJECTIVE: Smoking cessation clinics are an essential component of tobacco control policies, providing integrated pharmacological and behavioral interventions to support individuals in overcoming tobacco dependence. The quality and effectiveness of these services are closely associated with healthcare professionals' experiences and the organizational context in which care is delivered. This study aimed to explore healthcare professionals' experiences, perceived barriers, coping strategies, and recommendations regarding smoking cessation services in Türkiye.

MATERIAL AND METHODS: A qualitative phenomenological design was employed. Purposive sampling was used to recruit 13 healthcare professionals working in smoking cessation clinics, addiction units, and Healthy Life Centers. The study was conducted between November 2025 and April 2026. Data were collected through face-to-face semi-structured interviews and analyzed using thematic analysis.

RESULTS: Participants perceived smoking cessation clinics as valuable and effective services but identified several barriers that limited service delivery. Major challenges included low patient motivation, inadequate adherence to follow-up visits, normalization of smoking in social life, heavy workload, limited consultation time, insufficient multidisciplinary support, and medication access problems. Healthcare professionals reported using individualized counseling, motivational interviewing, evidence-based treatment algorithms, and digital follow-up systems to improve treatment adherence and cessation success. Professional motivation was primarily sustained by observing successful patient outcomes and contributing to improved quality of life, despite existing structural constraints.

CONCLUSION: Smoking cessation services are influenced by the interaction of individual, organizational, and systemic factors. Strengthening multidisciplinary teamwork, improving institutional resources, expanding behavioral support, enhancing digital follow-up systems, and increasing public awareness may improve the effectiveness and sustainability of tobacco dependence treatment. Incorporating healthcare professionals' experiences into tobacco control policies may contribute to higher-quality services and better long-term cessation outcomes.

KEYWORDS: Smoking cessation, tobacco dependence, healthcare professionals, qualitative research, phenomenology, tobacco control

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INTRODUCTION

Smoking remains a leading cause of preventable disease and mortality, posing a significant public health challenge at both global and national levels.¹ International policies directed toward tobacco control have established a systematic framework through the MPOWER strategy package developed by the World Health Organization.² This package encompasses six core components: monitoring tobacco use (Monitor), protecting individuals from tobacco smoke (Protect), offering cessation services (Offer), warning about the dangers of tobacco (Warn), enforcing bans on advertising and sponsorship (Enforce), and raising taxes on tobacco products (Raise).^{2,3}

Türkiye is among the countries that have adopted and implemented MPOWER strategies, and is particularly notable for its smoke-free zones, warning policies on tobacco products, and advertising bans. Furthermore, within the "provision of

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cessation services" component of MPOWER, the expansion and increased accessibility of smoking cessation clinics constitute a significant part of national tobacco control policies. These clinics adopt a holistic approach, offering both pharmacological treatment and behavioral counseling to individuals in their process of overcoming tobacco addiction.^{4,5} Recognizing tobacco addiction as a chronic disease characterized by relapses necessitates that clinical interventions be planned not merely as immediate advice but as chronic disease management.

The quality of services offered in smoking cessation clinics is closely related not only to current health policies but also to the experiences, approaches, and structural conditions faced by the healthcare workers providing these services. Therefore, evaluating service delivery processes from a healthcare worker's perspective is critical for identifying strengths and areas for improvement in practice. Qualitative research methods allow for a better understanding of this complex process by deeply examining the experiences and perceptions of healthcare professionals.⁶

This study aims to examine, from a qualitative perspective, the experiences and approaches of healthcare workers in smoking cessation clinics regarding the services they provide. Accordingly, the goal is to gain a more comprehensive understanding of the relationship between tobacco control policies and clinical practices in Türkiye by analyzing healthcare workers' views on service delivery processes, the difficulties they encounter, and the strategies they develop.

Main Points

- **Multifaceted Barriers in Smoking Cessation:** Healthcare professionals experience systemic challenges in service delivery, primarily attributable to heavy workloads, brief consultation times (5–10 minutes), and recurring disruptions in medication and nicotine replacement therapy supply chains.
- **The Need for Multidisciplinary Teams:** Delivering effective tobacco dependence treatment is constrained by insufficient human resources; integrating dedicated psychologists and nurses into clinics is vital to alleviating administrative burdens on physicians and enhancing behavioral counseling.
- **Sociocultural Normalization of Smoking:** Tobacco addiction is heavily normalized and highly visible in social environments, creating significant social pressure that undermines patients' motivation and lowers long-term treatment adherence.
- **Cognitive and Behavioral Resistance is a Key Clinical Obstacle:** The public perceives smoking as a mere "habit" rather than a chronic disease, which frequently results in low patient motivation, poor follow-up attendance, and premature discontinuation of treatment.
- **The findings of the current study suggest that structuring smoking cessation clinics under the umbrella of a more comprehensive, holistic "Addiction Treatment Center" could address the logistical and administrative challenges encountered in the field.**

MATERIAL AND METHODS

This research involved healthcare professionals working in units providing smoking cessation services in Türkiye. Participants were selected through purposive sampling. Ethical approval for the research was obtained from the Scientific Research and Publication Ethics Committee of Erzurum Technical University Rectorate with decision number: 2025-ETÜ-0052, date: 13.11.2025. Inclusion criteria for employees were as follows: having worked for at least 6 months in a smoking cessation clinic in Türkiye, being a healthcare professional, and being a volunteer. A Personal Information Form and a Semi-Structured Interview Form, each consisting of 7 questions, were used in this study. The Personal Information Form, collected by the researchers, consisted of demographic information such as age, gender, and seniority. The Semi-Structured Interview Form consisted of open-ended questions designed to assess problems encountered in smoking cessation clinics in Türkiye. The study was conducted between November 2025 and April 2026. This research was conducted using face-to-face interviews, in accordance with the phenomenological approach, a qualitative research method. The "bracketing" method was applied during the interviews and the analysis process to prevent researchers' own assumptions and clinical experiences from influencing the findings. Throughout the analysis, data were coded independently of personal interpretations, adhering solely to the participants' statements. Before data collection, participants were informed about the purpose of the study, and their consent was obtained. The demographic information form was completed first, followed by the Semi-Structured Interview Form. Interviews lasted an average of 50 minutes. The discussions were terminated when data saturation was reached (after the 13th participant) and no new themes or codes emerged. The researcher recorded the interviews. Data analysis was conducted on the day of the interviews. Demographic data were analyzed using descriptive statistics expressed as numbers and percentages. Qualitative data were analyzed using thematic analysis. The data were coded by two independent researchers, and themes were clarified through consensus. Since our analysis used thematic analysis, no mathematical coefficient (such as Cohen's Kappa) was calculated; instead, a "consensus process" was employed to ensure reliability in qualitative research. After independently coding the data, the two researchers met, compared the code lists, and debated codes on which they disagreed, returning to the raw data (participant citations) until 100% consensus was reached.

Although the study group has a multidisciplinary structure, physicians' experiences are emphasized at certain points in the Introduction and Discussion sections because of their primary responsibilities for diagnosis, initiation of pharmacotherapy, and clinical management. However, to reflect the common experience of all participants, the term "healthcare workers" is used throughout the text.

RESULTS

As part of the study, in-depth interviews were conducted with 13 healthcare personnel working in smoking cessation clinics. Regarding the participants' sociodemographic characteristics, 9 were women, 9 were married, and 7 were physicians. According to the distribution of the institutions where they work, 7 of the

participants work in tertiary hospitals, 1 works within the Green Crescent (Yeşilay), and the others work in smoking cessation clinics under the umbrella of Healthy Life Centers (Table 1).

As a result of the thematic analysis of the data obtained from the interviews, the functioning of smoking cessation services, operational obstacles encountered, patient-centered barriers, sociocultural factors, and solution-oriented strategies were organized into 5 main themes and 13 sub-themes (Table 2).

Theme 1: Polyclinic Operation within an Institutional and Systemic Framework

Participants stated that smoking cessation polyclinics generally operate systematically and successfully within the framework of the legislation, regulations, and algorithms determined by the Ministry of Health. One participant, stating that the system is well-established, expressed the situation as follows:

“Activities are progressing smoothly within the framework established by the Ministry of Health; the system is well-established” (P5).

However, the functionality of polyclinics varies according to institutional history. While it was emphasized that the system is better established in existing institutions, it was stated that there is a lack of standardization and uniformity in application in some newly opened polyclinics (P3, P6). One participant summarized this situation with the words, “In some places, the standard of application is not fully established” (P3). Although appointment and registration systems are actively used as part of the digital infrastructure, momentary freezes and internet interruptions experienced in the TUBATIS and e-Nabız automation systems are systemic factors that slow down the service (P1, P5, P9, P10). Despite these technical difficulties, patients’ success in smoking cessation and their positive feedback constitute the primary source of professional satisfaction, moral fulfillment, and intrinsic motivation among employees (P2, P4, P10, P13). One participant described this situation as follows: “Seeing a patient quit smoking makes me forget all my tiredness” (P2).

Theme 2: Structural and Operational Limitations in Service Delivery

Under this theme, operational, logistical, and administrative obstacles faced by healthcare professionals in providing services were addressed. The problem most widely agreed upon by participants was the lack of a multidisciplinary team structure and of human resources. Due to insufficient staffing of psychologists and nurses, bureaucratic procedures, preliminary interviews, and form-filling processes, which could be carried out by non-physician personnel fall on physicians, increasing their workload and making it difficult to focus on clinical care (P1, P6, P7, P9, P12, P13). Participants described this deficiency as follows:

“This work cannot be carried out by a single physician; team support is essential. Without support from psychologists and nurses, the entire burden falls on the physician” (P6, P10).

Another important structural limitation concerns time management. Participants stated that a quality motivational interview for tobacco addiction should last at least 20–30 minutes, but the current system’s 5–10-minute examination times are insufficient (P9, P10, P11, P12, P13). Furthermore, it was noted that the current performance (incentive) system does not adequately reward the time devoted to providing high-quality care (P13). One participant explained the time constraint as follows:

“Actually, we need to dedicate more time to the patient, but it’s very difficult to do this within a 5–10 minute timeframe” (P9).

At the logistical and spatial level, it was stated that the inability to perform blood tests and pulmonary function tests in primary care facilities leads to patients being referred to different institutions and prolongs the treatment process (P5, P11). In addition, periodic logistical disruptions in the provision of free medications (nicotine patches and gum) (P1, P10, P13), outpatient clinics located in remote corners of hospitals (P13), and the lack of isolated, private waiting areas where patients do not negatively affect one another (P6, P10, P12) constitute operational obstacles.

Table 1. Sociodemographic characteristics of the participants

No	Age	Marital status	Education degree	Job	Workplace	Total working time (year)
1	25–29	Married	PhD and above	Doctor	Smoking cessation clinic	6–10
2	40–44	Single	Master’s degree	Doctor	Smoking cessation clinic	16–20
3	30–34	Single	Master’s degree	Doctor	Smoking cessation clinic	6–10
4	55–59	Married	Master’s degree	Doctor	Smoking cessation clinic	>26
5	35–39	Married	Bachelor’s degree	Nurse	Smoking cessation clinic	16–20
6	50–54	Married	PhD and above	Doctor	Tertiary hospital	>26
7	50–54	Married	Bachelor’s degree	Psychologist	Tertiary hospital	11–15
8	25–29	Single	Master’s degree	Doctor	Tertiary hospital	0–5
9	45–49	Married	Bachelor’s degree	Nurse	Tertiary hospital	16–20
10	35–39	Married	Bachelor’s degree	Psychologist	Tertiary hospital	16–20
11	25–29	Single	Bachelor’s degree	Nurse	Tertiary hospital	11–15
12	35–39	Married	Bachelor’s degree	Psychologist	Yeşilay*	11–15
13	50–54	Married	PhD and above	Doctor	Tertiary hospital	>26

*Yeşilay is a non-governmental organization

Table 2. According to data analysis, main themes, sub-themes, codes, and citations

Main themes	Sub-themes	Codes and contributor citations
Theme 1: Polyclinic operations within an institutional and systemic framework	1.1. Standard procedures and digital infrastructure	• Compliance with Ministry of Health legislation/regulations (P3, P5, P8) • Scheduled patient admission via appointment system (P1, P9, P13) • Preliminary interview, form completion and registration processes (P1, P9, P13) • Slowdown/freezing issues in TUBATIS and e-Nabız automation systems (P1, P5, P9, P10)
	1.2. Degree of institutionalization and standardization	• Polyclinics becoming more systematic over time (P2) • The system being well-established in long-standing institutions (P5, P6, P8, P11) • Lack of uniformity in practice in newly opened units (P3, P6)
	1.3. Service satisfaction and job satisfaction	• Positive feedback from patients who are satisfied with the process (P2, P4) • Emotional satisfaction from patients quitting smoking (P2, P10, P13) • Responsibility to impact human life and health (P2)
Theme 2: Structural and operational limitations in service delivery	2.1. Lack of human resources and multidisciplinary team	• Concentration of workload on a single physician (P1, P6, P7, P9, P12, P13) • Need for psychologists, nurses, and support staff (P3, P6, P8, P9, P10, P11) • Need for psychiatric or other consultations for advanced addictions (P1, P9, P10)
	2.2. Time and logistics constraints	• Insufficient examination times (5–10 min) for motivational talks (20–30 min) (P9, P10, P11, P12, P13) • The performance/incentive system does not reward the dedication of quality time (P13) • Periodic interruptions in the provision of free medication and NRT (nicotine patches/gum) (P1, P10, P13)
	2.3. Spatial and infrastructural limitations	• Referrals due to lack of blood tests and spirometry in primary care (P5, P11) • Location of outpatient clinics in remote corners of hospitals (P13) • Insufficient isolated waiting areas where patients will not be negatively affected (P6, P10, P12)
Theme 3: Patient-centered barriers and adherence problems	3.1. Resistance to behavioral change and non-compliance	• Patients' lack of mental readiness/indecisiveness to quit (P1, P2, P4, P11) • Individuals' irregular attendance at follow-up appointments (P5) • Lack of belief in recovery and early drug discontinuation (P1, P9, P12)
	3.2. Cognitive barriers and communication difficulties	• Difficulty understanding due to advanced age or illiteracy (P1) • Burden of repetitive information regarding form completion and medication regimens (P1) • Unwarranted fears of medication side effects (P1) • Difficulty communicating with younger groups due to the decreasing age of addiction (P4) • Negative perception or tendency towards verbal abuse towards healthcare professionals (P2, P3, P6, P7)
	3.3. Patient's perception and expectations regarding service	• Viewing the polyclinic solely as a means of obtaining "free medication" (P5, P10) • Expecting excessively high levels of tests and analyses from the service unit (P2, P3, P13)
Theme 4: Sociocultural context and perception of addiction	4.1. Social normalization and visibility of tobacco addiction	• Integration of smoking with social life (cafes, social gatherings, etc.) (P1, P13) • High visibility of smoking in public spaces (P4) • Lack of social/family support; negative peer pressure (P1, P3, P6, P7, P9)
	4.2. Misconceptions about health and lack of clinical perception	• Society views tobacco as a simple "habit" rather than an "addiction" (P1, P6, P11, P12, P13) • Smoking is perceived as a means of coping with stress or preventing loneliness (P11, P12, P13)
Theme 5: Clinical strategies and policy recommendations	5.1. Evidence-based methods and individualized approaches	• 5A methods for those ready to quit, 5R methods for those not ready (P9, P10) • Individualized treatment based on the patient's addiction history and demographics (P1) • Offering alternative objects (gum, distraction) for behavioral dimensions (P1)
	5.2. Macro policies and the comprehensive struggle	• Making addiction education a mandatory subject in schools (P6) • Mass campaigns to revive the spirit of "Smoke-Free Zones" (P3, P4, P5, P6, P7, P8, P9, P10, P12) • Increasing clinic recognition through social media and advertising (P3, P5, P9, P10)
	5.3. Empowering healthcare professionals	• Mandatory certification and continuing education before starting work (P5, P11) • Transformation of polyclinics into "Addiction Treatment Centers" (P6) • Automated reminder systems to facilitate follow-up processes (P1, P3, P10, P13)
NRT: nicotine replacement therapy		

Theme 3: Patient-centered Barriers and Adherence Problems

Patient-related factors constitute one of the most important dimensions limiting the effectiveness of service delivery. Healthcare professionals reported experiencing difficulties in clinical practice, especially when working with patients who are unmotivated, hesitant, or mentally unprepared to quit smoking (P1, P2, P4, P11).

“We may encounter problems with difficult patients from a health perspective. We encounter problems persuading difficult patients, explaining to them that their situation is serious, and encouraging them to take medication. The primary problem for patients is their indecision and unwillingness to quit” (P4).

Patients’ failure to attend follow-up appointments regularly negatively affects the continuity and effectiveness of the treatment process (P5). In addition, individuals’ lack of confidence in their ability to overcome addiction and their tendency to discontinue medication prematurely reduce treatment adherence (P1, P9, P12).

At the cognitive level, difficulties in understanding due to advanced age or illiteracy place a constant informational burden on healthcare personnel during form completion and the explanation of medication regimens (P1). Unwarranted fears of medication side effects (P1) and difficulty establishing healthy communication with the younger patients, attributable to the decreasing age of addiction (P4), are additional barriers. Some patients’ perceptions of the outpatient clinic as merely a “free medication point” rather than a professional counseling and treatment center (P5, P10) and their lack of adherence to treatment undermine the quality of the process. Finally, negative perceptions or tendencies toward verbal violence against healthcare workers have also been reported occasionally (P2, P3, P6, P7).

Theme 4: Sociocultural Context and Perception of Addiction

One of the most striking findings of the study is the normalization and high visibility of tobacco addiction in social life. Participants emphasized that smoking, unlike other types of addiction, is highly visible and culturally accepted in the public sphere, which directly complicates clinical success.

“As a physician, I welcome the provision of such a polyclinic service for smoking cessation, which is the most common and visible of addictions, and I have personally witnessed its positive results and received favorable feedback from patients” (P4).

The perception of tobacco use in society as a simple “habit” rather than a “disease/addiction,” and the framing of smoking as a means of coping with stress or preventing loneliness were identified as incorrect health beliefs (P1, P6, P11, P12, P13). One participant expressed this perception in the words: “Many patients don’t see it as a disease, they just consider it a habit” (P11). This normalization leads patients not to receive the support they need from their social environment and even to experience negative social pressure from their friends, because smoking has become so commonplace in daily life (P1, P3, P6, P7, P9, P11).

Theme 5: Clinical Strategies and Policy Recommendations

Healthcare professionals actively use both evidence-based clinical protocols and individualized approaches to cope with these multifaceted challenges and increase treatment adherence (P1). In clinical practice, the “5A” (ask, advise, assess, assist, arrange) algorithm is followed for patients ready to quit, and the motivational “5R” (relevance, risks, rewards, roadblocks, repetition) algorithm is followed for those who are not ready (P9, P10). Treatment processes are individualized according to the patients’ demographic information, smoking history, and level of addiction; for behavioral dimensions such as mouth and hand habits, practical suggestions are offered: chewing gum, engaging in alternative activities, or increasing daily activity. Macro-level policy recommendations argue that the fight against tobacco should be transformed into a comprehensive social campaign and education strategy:

“The individual, social, and societal harms of smoking should be taught in compulsory basic education, and a comprehensive campaign encompassing all segments of society should be organized as part of health-promotion efforts to provide accurate information and raise awareness. Türkiye had previously achieved significant successes with the Smoke-Free Air Campaign. We need to recapture this atmosphere. Only in this way can those who want to quit smoking receive support from those around them” (P6).

Stating that leaving a smoke-free, healthy airspace for future generations is the shared responsibility of all stakeholders, the participants suggested the following concrete steps to increase the effectiveness of polyclinics:

- Ensuring that personnel undergo a mandatory and rigorous certification process before starting their duties and providing continuous professional training (P5, P11).
- Ensuring the continuity of free medication, patches, and nicotine replacement therapy (NRT) supply at the institutional level (P13).
- Transforming and integrating polyclinics into broader “Addiction Treatment Centers” (P6).
- Establishing advanced digital monitoring systems integrated with TUBATIS that will automatically manage long-term follow-up appointments, phone calls, and message reminders for patients at 3 months, 6 months, and 1 year (P1, P3, P10, P13).

DISCUSSION

The findings of this study reveal that the services offered in smoking cessation clinics are conducted within a structured framework in accordance with Ministry of Health regulations, but the framework is constrained by operational, patient-centered, and sociocultural limitations. The participants’ positive evaluations of the necessity and functioning of the services show that tobacco control policies have elicited an institutional response. However, the lack of standardization and uniformity in application, especially in newly established units, indicates that time and monitoring mechanisms are needed to achieve a homogeneous level of service quality

across the country. The findings show that the difficulties encountered in tobacco addiction treatment largely stem from the interaction of individual and structural factors. Low motivation, indecisiveness, and a tendency among patients to view the process as a simple “habit” rather than a “disease,” as emphasized by participants, directly undermine clinical success. It is well established in the literature that the failure to perceive tobacco addiction as a chronic, relapsing brain disease is one of the most fundamental cognitive barriers that reduce treatment adherence.⁷⁻⁹

One of the most striking aspects of the study is the high visibility of smoking in public spaces and the sociocultural normalization of smoking. This situation, which participants described as “the most visual of addictions,” transforms quitting smoking from a matter of individual willpower into a social phenomenon. Environmental triggers and negative peer pressure cause the individual to lose the motivation gained in the clinical setting when in the social sphere. This finding is consistent with studies arguing that clinical interventions targeting individuals alone are insufficient for tobacco control, and that macro-level environmental and legal regulations that reduce the social appeal and acceptance of tobacco are vital.^{1,10}

Institutional limitations regarding service delivery are concentrated particularly with respect to time constraints and insufficient human resources. This outpatient service, which requires intensive communication, in-depth motivational interviewing, and a behavior-change-focused approach, is squeezed into routine 5–10-minute examination slots. This constraint makes it difficult for physicians to thoroughly apply evidence-based “5A” and “5R” algorithms, and the fact that the incentive/performance system does not reward this valuable time exacerbates the problem. Furthermore, a limited multidisciplinary team structure (insufficient staffing of psychologists and nurses) causes administrative tasks, such as secretarial duties and preliminary interviews, to fall on physicians. The challenges encountered in smoking cessation services are reported not only at the national level but also in the international literature. A study of 15 European countries found that staff in smoking cessation clinics experienced significant role conflict and time pressure while providing routine healthcare services and treating tobacco addiction. This situation parallels the administrative challenges and the need for structural transformation of clinics, as expressed by the participants in the study, such as the suggestion to establish Addiction Centers. Therefore, fighting tobacco addiction in a more integrated, multidisciplinary manner within independent units with logistical support is a global necessity.^{11,12} The literature shows that combining behavioral therapy with pharmacotherapy significantly increases the success rate of tobacco addiction treatment.¹³⁻¹⁵ In this context, the lack of a psychosocial support component (psychologist) in outpatient clinics, or the reduction of the process to merely a “free medication” mode, constitutes the most fragile operational link in the system.

The development of individualized clinical approaches and alternative behavioral interventions (occupational activities, chewing gum, etc.) by healthcare professionals to cope with these challenges is an indicator of their professional

competence. However, the success of these strategies is limited by technical and logistical factors, such as periodic interruptions in drug/NRT supply and slowdowns in automation (TUBATIS/e-Nabız). This situation reveals that the knowledge and skills of healthcare workers alone are not sufficient; logistical continuity and suitable working conditions are at least as crucial as clinical knowledge.^{16,17}

From the perspective of professional motivation, the greatest sources of satisfaction for healthcare workers are patients’ quitting smoking and spiritual fulfillment. Qualitative research indicates that one of the strongest protective factors against burnout among healthcare personnel with heavy workloads is the feeling of “touching human lives and seeing tangible success”. However, structural limitations and non-compliant patients who do not attend follow-up appointments can undermine this motivation. Therefore, institutional recognition and support mechanisms are needed to sustain employee motivation.^{18,19}

Study Limitations

Although this study provides important data by revealing, in depth, the service delivery and challenges encountered in smoking cessation clinics from the perspective of healthcare professionals, it has some limitations.

Sample and Generalizability Limitation: The most fundamental limitation of the study is that due to its qualitative research design, it is limited to 13 healthcare professionals selected by purposive sampling. This situation restricts the generalizability of the findings to all smoking cessation clinics nationwide and to healthcare personnel with different socioeconomic or regional dynamics.

One-Sided Perspective (Stakeholder Limitation): The research addressed the service process solely from the perspective of service providers (healthcare professionals). The experiences and perceptions of service recipients (patients), administrative managers, and policymakers regarding the process were excluded from the scope of this study. The inability to conduct a multi-stakeholder evaluation may limit a holistic analysis of structural problems.

Limitations in Institutional Diversity: Participants were predominantly employed in tertiary hospitals and Healthy Life Centers, which may have limited representation of diverse institutional operational models and logistical challenges in primary care or in private foundations/non-governmental organizations; only a single participant represented the latter (Yeşilay). Despite these limitations, the research provides a strong micro-level understanding of operational bottlenecks in the field. Future studies should prioritize mixed-methods designs combining quantitative and qualitative methods and include simultaneous patient- and employee-focused monitoring to expand the literature.

CONCLUSION

This study has revealed that smoking cessation clinics, as currently structured, play a critical role in the fight against tobacco, but that multidimensional improvements at the

individual, institutional, and societal levels are needed to maximize service effectiveness. Clinical success is directly related not only to the medication prescribed by the physicians but also to the institutional infrastructure and sociocultural perceptions surrounding the patient. The concrete proposals developed in this direction are listed below:

1. Institutional and Operational Recommendations

Making a Multidisciplinary Team Structure Mandatory: The employment of psychologists and nurses, in addition to physicians, in polyclinics should be standardized. Having bureaucratic processes and preliminary assessments carried out by auxiliary personnel will allow the physician to focus on the main clinical and motivational services.

Revision of Examination Times and Performance System: The time allocated per patient in smoking cessation polyclinics should be 20–30 minutes to allow for behavioral change counseling. The performance (incentive) system should be structured based on qualitative interview time and clinical success rates rather than quantitative patient numbers.

Strengthening Logistics and Digital Infrastructure: Periodic interruptions in the supply chain of treatment materials, such as free medication, nicotine patches, and gum, should be prevented. The integration of TUBATIS and e-Nabız systems should be optimized, and automated digital systems providing SMS or call reminders should be implemented for long-term patient follow-up at 3 months, 6 months, and 1 year.

Standardization and Training: To ensure uniform application, particularly in newly opened units, mandatory certification and continuous professional development training for personnel commencing their duties should be systematized.

2. Social- and Policy-level Recommendations

Transforming Social Perception: To counter the widespread normalization of tobacco use in the social sphere, mass awareness campaigns and public service announcements (reviving the spirit of “Smoke-Free Air Zones”) should be implemented, emphasizing that tobacco is not a “habit” but a chronic “health problem/addiction”.

Education-Based Interventions: The fundamentals of addiction prevention should be integrated into the formal school curriculum as mandatory courses or modules to raise awareness among future generations early in life.

Accessibility and Promotion: Polyclinics should be relocated from remote corners of hospitals to more visible, accessible locations, and the free and professional nature of these services should be more effectively promoted to the public via social media and mass communication channels.

Ethics

Ethics Committee Approval: Ethical approval for the research was obtained from the Scientific Research and Publication Ethics Committee of Erzurum Technical University Rectorate with decision number: 2025-ETÜ-0052, date: 13.11.2025.

Informed Consent: Before data collection, participants were informed about the purpose of the study, and their consent was obtained.

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Footnotes

Authorship Contributions

Concept: E.D., C.D., Design: E.D., Data Collection or Processing: E.D., C.D., Analysis or Interpretation: E.D., Literature Search: E.D., C.D., Writing: E.D., C.D.

Conflict of Interest: No conflict of interest was declared by the authors.

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