

## IMPLEMENTATION OF PATERNALISM PHILOSOPHY AND SMOKING CESSATION GUIDELINES TO MOTIVATE JORDANIAN PATIENTS WITH CARDIOVASCULAR DISEASE TO QUIT SMOKING

Rami Azmi Elshatarat<sup>1,2,\*</sup>, Majed Sa'ad Al-Za'areer<sup>2</sup>, Natheer Mahmoud Albdour<sup>2</sup>,  
Mustafa Y. Yahya<sup>1,3</sup>, Zyad T. Saleh<sup>4</sup>, Mohammed A. Albalawi<sup>5</sup>, Roqia S. Maabreh<sup>6</sup>



<sup>1</sup>Department of Physiological Nursing, School of Nursing, University of California, San Francisco, California, USA

<sup>2</sup>College of Nursing Science, Al-Ghad International Colleges for Applied Medical Sciences, Al-Madinah Al-Munawarah, Kingdom of Saudi Arabia

<sup>3</sup>Cardiac Arrhythmia Service and Cardiac Electrophysiology Clinic, Stanford University Medical Center, Stanford, California, USA

<sup>4</sup>Faculty of Nursing, The University of Jordan, Amman, Jordan

<sup>5</sup>Colleges of Medicine and College of Nursing Science, Taibah University, Al-Madinah Al-Munawarah, Kingdom of Saudi Arabia

<sup>6</sup>College of Nursing Science, Al-Ghad International Colleges for Applied Medical Sciences, Dammam, Kingdom of Saudi Arabia.

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#### Corresponding Author:

Rami Azmi Elshatarat,  
RN, CNS, MSc, PhD.  
College of Nursing Science  
Al-Ghad International Colleges for  
Applied Medical Sciences  
Al-Madinah Al-Munawarah  
Kingdom of Saudi Arabia  
elshatarat@hotmail.com

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### ABSTRACT

The prevalence of smoking and cardiovascular disease (CVD) is high among Jordanian population. Despite Jordanian government establishment of tobacco control regulations, Jordanians still smoke in public areas and indoor work places. Implementation of paternalistic laws through prohibiting of smoking in public places and indoor areas, selling tobacco to minors and increasing taxes on tobacco products have been recognized as effective strategies to control smoking and limit its' harm. Government should take firm actions to enforce these regulations to protect Jordanians from the hazards of second-hand smoking. Tobacco use has strong addictive properties. Smoking cessation interventions are necessary to reduce health hazards of tobacco use. According to tobacco cessation guidelines, clinicians should assess smoking behavior at each patient visit and assist patients to quit smoking. Also, clinicians should provide counseling and pharmacological treatment to patients who are willing to quit smoking. On the other hand, patients who are unwilling to quit smoking, motivational intervention and improve patients' self efficacy to quit smoking are highly recommended to help those patients to make attempts to quit smoking in the future.

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**Abbreviations:** CVD: Cardiovascular Disease; CHD: coronary heart disease; JD: Jordanian dinar; NRTs: nicotine replacement therapies

### INTRODUCTION

Cardiovascular disease (CVD) is a leading cause of death for both men and women worldwide [1, 2]. In 2008, about 17 million died from CVD of all deaths in the world [2]. The mortality rate from CVD is gradually increasing to reach 23.3 million people by 2030 [2, 3]. More than 80% of all deaths results from CVD disproportionately take place in the low and middle income countries [2].

In the Middle East, 54% of deaths from non-communicable diseases are due to CVD [4]. In Jordan, CVD is the first leading cause of death, which is responsible for about 35% of all deaths [5]. In Jordan, tobacco use, diabetes mellitus, hypertension and hyperlipidemia are the most common risk factors for coronary heart disease (CHD) [6]. The majority of Jordanian patients with CHD had at least one of the previous risk factors [6].

Tobacco use is a significant preventable risk factor for cardiovascular disease, including coronary syndromes,

congestive heart failure and cerebrovascular accident [1, 2, 7]. Tobacco users are more likely to have higher serum levels of cholesterol and platelet aggregation, arteriosclerosis and atherosclerosis [7, 8]. Smoking cessation programs are necessary to prevent cardiac events and sudden death [7].

Despite many patients made attempts to quit smoking, they were unsuccessful [7, 9-12]. Benowitz and his colleagues reported that 80% of American smokers who attempted to quit smoking independently, were relapsed within the first month of abstinence; and only 3% of them remained abstinent for 6 months after they quitting [10]. In a previous Jordanian study, Elshatarat and his colleagues [13] reported that 40% of cigarette smokers with CVD who made attempts to quit smoking within 12 months of hospitalization, were unsuccessful to quit smoking [13]. Generally, the failure of smoking cessation may be due to

addictive properties of tobacco, lack of patients' self-efficacy, using unsuccessful smoking cessation strategies and intolerance of nicotine withdrawal symptoms [7, 9-12].

Smoking cessation programs and smoking control regulations are necessary to reduce health hazards of tobacco use, prevent CVD and reduce the morbidity and mortality rate caused by tobacco use, providing on overall improve communities' health status [7, 9-12]. To achieve tobacco use reduction, government policy makers and health professions should collaborate to establish smoking cessation programs, educate the public about the health hazards of tobacco and enforce smoking control regulations. In the Arab countries including Jordan; tobacco control policies have been established to protect smokers from harming themselves, and prevent others from the hazards of second-hand smoking [14].

According to a literature review, two main arguments were discussed to treat tobacco use [15-17]. The first is utilization of enforcing tobacco control regulations to protect smokers from harming themselves and others with disregards to the smokers' autonomy [18]. This approach is consistent with paternalism philosophy, whereby a policy or practice of treating and governing people in a fatherly manner is used [19]. Dworkin [20] defined the paternalism as the interference with a person's liberty of action, justified by improving welfare, happiness, and interest or values of the person being coerced [21]. Also, paternalism is defined as overriding a individual's behaviors, wishes or actions with the goal of protect the clients from harming themselves of their unhealthy behavior, to achieve the best benefit for individuals and welfare of entire community [20, 21].

Goodin [18] is one of the scientists who supporting smoking reduction by regulations and paternalistic laws based on two reasons: 1) tobacco users falsely and irrationally underestimate the personal health hazards; and 2) smokers have nicotine dependence and the withdrawal effects make smoking cessation extremely challenging. Goodin [18] concluded that paternalistic laws are needed to prevent or strongly discourage tobacco use, restrict the accessibility of tobacco use, protect smokers from harming themselves and support the smokers in their efforts to quit smoking.

The second argument disagreed with paternalistic philosophy and supported the idea of providing education to the smokers about the hazards of smoking through cigarette packet labeling, smoking cessation advice and programs. Therefore, it is the choice of the tobacco users to continue or quit smoking [15, 22]. In 2008, the United States Public Health Service released an updated guideline for treating tobacco use and dependence, and it is an example of the second approach to smoking cessation. This updated clinical practice guideline was synthesized from more than 8,700 articles, and contains recommendations for tobacco users, clinicians, health care providers and policy makers on successfully strategies for treating tobacco and nicotine dependence [11]. This guideline provides health care providers clinical pathways to assist tobacco users in their efforts to stop smoking. This clinical pathway is dependent on the willingness of tobacco user to quit.

The aim of this paper is to describe the implementation of smoking cessation strategies among Jordanian population, particularly patients with CVD. The specific objectives of this paper are to: 1) describe

paternalism philosophy, 2) provide a brief summary about existing knowledge and behavior related to tobacco use among Jordanian population, 3) describe smoking control regulations in Jordan, and 4) summarize the implementation of paternalism philosophy and treating tobacco use guideline to quit smoking among patients with CVD.

### **Background of Paternalism Philosophy**

Paternalism was derived from Latin word "pater", the meaning parent. Fathers are responsible for regulating their children's life, and they make all or at least some of decision related to goodness and the welfare of their children even these decisions are in opposition to that of the child [23].

Paternalism is defined as "the intentional overriding of one person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose will is overridden" [23]. In Greek philosophy and political philosophy, the family is considered as a model for the state. In a patriarchal family, the subjects obeying the king as children obey their father for example of story of Abraham and his son [23].

Paternalism is used to guide interventions that lead to person benefit [23]. Enforcing smoking control regulations and establishing smoking cessation programs are the most important implication of paternalism philosophy in term of treatment of nicotine dependence and tobacco use. These smoking control regulations are proposed to protect tobacco users from harm themselves, prevent second hand smoking and prevent manufacturers of causing harm to others [24, 25].

### **Paternalism and Common-Morality Theories**

Common morality based on the concept that all people share by virtue of communal life, and it concerned with the social practices of right or wrong. The greatest obligation in any given circumstance must be found based on the greatest balance of right over wrong in that particular context [23, 26].

Beauchamp and Childress [23] described four principles of common morality theory: 1) Respect for autonomy - respect people's decisions. Freedom is made decisions about ones own body without the coercion or interference of others. Autonomy is a freedom of choice or a self-determination that is a basic human right; 2) Beneficence - be helpful to people: The concept of doing well and preventing harm to people. The principle of beneficence presupposes that harm and benefits are balanced, leading to positive outcome; 3) Non maleficence - do not inflict harm or pain: Which dictates that one prevents harm and correct harmful situation. These examples of rules of non maleficence: "Do not kill", "Do not cause pain or suffering to other", "Do not incapacitate", "Do not cause offense to others" and "Do not deprive other of goods of life"; and 4) Justice- equal distribution of benefits and burdens [23].

### **PATERNALISM: CONFLICTS BETWEEN BENEFICENCE AND AUTONOMY**

Principle of beneficence achievement is the obligation of health care providers when they treat the patients. Hippocras said "as to disease, make a habit of two things - to help, or at least to do no harm" [23]. Traditionally, health professionals are more knowledgeable than patients themselves and more able to judge what can harm the patients. Therefore, they have obligations to treat

and prevent patients from harm. Henderson said that "best physicians" use these guidelines: "So far as possible, do no harm." You can do harm by the process that is quaintly called telling the truth. You can do harm by lying... Try to do as little harm as possible, not only with treatment with drugs or with knife, but also in treatment with words." [23]. Despite paternalism intervention involves lack of patients' autonomy, health care professionals have to respect patients' right of autonomy to decide what they want [26].

One question arises when doing critical evaluation of principles of common morality theory: Do principles, when specified for behavior, enable us to reach practical judgments, or are they either too indeterminate or too determinate to eventuate in judgments? We might think that the normative options seem to be just two. Either do good intervention to achieve efficiencies with regardless to smoker wishes and liberty or never do against their wishes but this may do harm for others [23].

The prima facie principles often conflict and the underlying account is too indeterminate to provide a decision procedure to adjudicate those conflicts. The greatest obligation in any given circumstance must be found based on the greatest balance of right over wrong in that particular context [23, 26].

#### **Smoking control and paternalism**

Tobacco use has been universally recognized as a major cause of serious disease and death globally [5]. The smoking health hazards are dependent on several factors such as age at which tobacco use is began, form of tobacco, tobacco consumption per day and duration of tobacco use [14, 27]

Health professionals are working towards tobacco control to reduce its health hazards [5]. Tobacco control regulations including prohibiting smoking in public places and indoor areas, prohibiting the sale of tobacco to minors, increasing tobacco prices and taxes on tobacco have been recognized as effective approaches to smoking cessation [5, 28]. Therefore, health professions and government policy makers should collaborate together to control tobacco use.

For example, in 2007, Belmont city, California, prohibited smoking inside most apartments, outdoor workplaces, parks, stadiums, sports fields, trails and outdoor shopping areas. But it is still allowed in single-family homes and their yards, and on city's streets and sidewalks, except in city-sponsored events locations or within 20 feet [29]. According to the paternalism principles, establishing government laws to protect the community from the hazards of smoking on smokers themselves, hazards of second-hand smoking, and to reach optimum health status for all community [24].

From the view of scientist who supported implementation of paternalism laws, the following population groups are involved in tobacco use regulation policies: Smokers who still want use tobacco, adult nonsmokers who don't want to expose to smoking, children who exposed to smoking from smokers, fetuses who exposed to maternal smoking, the state which set taxes and pay for health care, and health care professionals who trying to reduce smoking [14, 30].

#### **Smoking Knowledge and Behavior Among Jordanian Population**

Tobacco use in Jordan is relatively high among Middle East countries. Approximately, 47% of Jordanian men and 6% of Jordanian women are smokers [31]. Although cigarette smoking is the most popular form of

tobacco use in the Middle East, water pipe smoking is also becoming a very popular practice especially among adolescents and university students [32]. Water pipe is a common social activity and it is associated with Arab culture tradition like weddings, and funerals [33-35].

Researches on the knowledge and behavior of smoking in Jordan were conducted on university students [36-39]. Most of students in Jordan lack knowledge about the hazards of smoking, hazards of second-hand smoking and nicotine dependence, particularly about water pipe smoking [36-38]. The majority of university students began smoking in their teen for pleasure, peer pressure, and to relieve stress. Even though there are tobacco policies established in Jordan against smoking in public places and around children, universities students still smoke in the cafeteria, at home, and inside college buildings [36-39]. Moreover, Shishni and her colleagues reported that Jordanian nurses and physicians were unaware about addictive properties of smoking, particularly water pipe smoking [40, 41]. Despite Jordanian nurses and physicians were aware of the importance of screening smoking status of their patients and assisting their patient to quit smoking, they did not usually do so in their clinical practice [40, 41].

Few studies have been conducted in Jordan to assess tobacco use among patients with cardiovascular diseases [13, 42, 43]. Elshatarat and his colleagues reported that there was a knowledge deficit among Jordanian hospitalized men with CVD related to the hazards of smoking, the addictive properties of cigarette and water pipe smoking, and the successful methods for smoking cessation. Also, the subjects said that they made attempt to quit smoking, but they failed [42, 43]. Most of the cigarette smokers (82.9%) used unsuccessful methods to quit smoking such as dependent on themselves without help from others and the majority of the cigarette smokers (95.2) were still planning to use the same methods in the future attempts to quit smoking [42, 43]. For example, only about 14% of the cigarette smokers used pharmacological treatment (NRTs) to quit smoking [42]. The subjects said that there is policy restricting smoking in any indoor areas at work (19.4%), they yet smoked in indoor work places (76.6%) and the smoking is allowed in their homes with presence of children (64%) [13, 43].

#### **Tobacco Use Control in Jordan**

In Jordan, more than half (59%) of Jordanian males who 15 years and older were smokers [44]. In addition, smoking is highly prevalent among adolescents. In 1999, Jordan's Global Youth Tobacco Survey (GYTS) was conducted to assess the students between the ages of 13 and 15 years. The researchers reported that 25% of male students and 14.5 % of female students are smokers [45]. This high smoking prevalence may due to many reasons, including their imitating adults, loving to show off their self as "real man", peer pressure, presence of smokers among their household members and easy access to cigarettes [36, 46, 47].

Researches on tobacco knowledge, attitudes and practices are neglected in Jordan, particularly among patients with life threatening diseases. However, the Jordanian government and health organizations were aware of great health problem and epidemic problem of high prevalence of tobacco use and its health harm on Jordanian population. Therefore, Jordan was one of the first countries in the Middle East to establish smoking restriction regulations [45, 46]. In 1977, Jordanian

government prohibited smoking in public places, indoor work places, and on public transport as well as it banned tobacco advertising. The person who violates these regulations will pay a fine ranging from JD25 (Jordanian dinar) to JD500 (1 JD = 1.4 USD), or a jail penalty (< 4 months) if the violation to these regulations are repeated. This legislation aims to protect Jordanian population from being exposed to second-hand smoke and promote tobacco free environment [45, 46]. Juvenile Monitoring Legislation by the Jordanian government in 2001 imposed restrictions on tobacco the sales to minors (< 18 years old). Penalties would be JD 20 fine for a first-time violation of this law, and the vendor would face a JD100 fine and a jail sentence of up to one year if the violation of this law is repeated [45, 46]. In addition, the Ministry of Health in Jordan started three months smoking cessation programs through media campaign (e.g. ads on television, radio, official newspapers, billboards and distributed brochures) to fight tobacco use, and enhance public health awareness of the hazards of smoking, harms of second-hand smoking and tobacco addiction [45, 46]. Unfortunately, most of tobacco control regulations in Jordan were not enforced and no follow up researchers was done to assess the efficiency of these tobacco regulations and smoking cessation programs [43, 46].

#### **Implementation of Paternalism Philosophy and Treating Tobacco Use Guideline**

Breathing air that is free of unhealthy components or carcinogenic materials is one of the most essential rights for humankind. Governments have the right and the authority to enforce bans on smoking in public places, and health care institutions [14, 15, 24]. Despite it is very important to keep smoke free hospital environment; some researchers believed that prohibiting the smoker patients inside the hospital are against patients' rights and provoke an aggressive reaction from patients' autonomy [48]. On the other hand, other researchers believed that the right to breath clean air and keep hospitals free of smoke is more important, and the smokers patients have the opportunity to smoke in designed place of smoking outside the hospital and away from non-smokers [49-51]

Individuals who are exposing to second-hand smoke are more likely to develop serious diseases such as CVD, respiratory disease and cancer [7, 8]. Smoke free policies can protect people from the hazards of second-hand smoke, reduce how much they passively smoke each day, prevent children from starting to smoke, help smokers to quit smoking, increase in smoking cessation attempts and reduce relapse rate of former smokers [7, 52].

Based on the facts of benefits of implying smoke free policies in health care institution, bans on smoking should be enforced in hospitals' and clinics' rooms, corridors, and other facilities [7, 11, 49]. Also, smoke detecting alarm should be implanted in hospitals' rooms and facilities to prevent smoking in the hospitals. Health care providers should support and advocate to enforce these policies in hospitals, clinics and other health care institutions [7, 11, 53]. Patients, visitors, and workers should be informed about the hazards of second-hand and the prohibition of smoking inside the hospitals and other health care institutions by distributing hand out educational material, putting warning signs about prohibition of smoking inside the hospitals and other health care institutions [52]. To prevent overriding the smokers' autonomy and freedom, each hospital should

establish outdoor smoking places to allow smoking in these areas without harm of non smokers [49, 52].

Health care providers have a major role in helping individuals in treating diseases such as CVD and preventing its related risk factors [7]. Health care providers should act as role model for others in practice of healthy lifestyle and they can affect positively to change individuals' unhealthy habits such as smoking. They can use the opportunity of hospitalization to educate the patients about the hazards of second-hand smoking, benefits of smoking cessation, and the role of enforcing tobacco control regulations in preventing non smokers from harm of smoking [7, 49].

According to tobacco treatment guidelines [11, 12], tobacco use has addictive properties and considered as a chronic disease that requires systematic interventions [11, 12]. Fiore and his colleagues [11] concluded the "5 A's" model for treating tobacco use and dependence. The health care providers must the following this 5 A's model to treat their smoker patients from nicotine dependence. The 5 A's model includes (Ask all patients about tobacco use through systematic screening, Advice to quit smoking, Assess willingness to make attempt to quit smoking, Assist to quit smoking and Arrange follow up) [11].

In Addition, Fiore and his colleagues [11]reported that if the patient is willing to quit, the clinician must assist their smoker patients to quit smoking by offering pharmacological treatment and enhance motivation for behavior change through such providing counseling. Clinicians should encourage all patients, particularly those with threaten disease, to make a quit attempt and use both medication and counseling interventions. Also, they should arrange for follow up contacts to prevent relapse [11].

Seven first line pharmacological treatments are strongly recommended for treating nicotine dependence. These medications are classified to 5 nicotine replacement therapies (NRTs) (nicotine gum, nasal sprays, inhalers, lozenges, and patches) and 2 non NRTs (bupropion SR, and varenicline). Combination of medication and providing counseling are more effective in treating nicotine dependence and prevent smoking cessation relapse [11, 54]. NRTs must be taken with caution among patients with CVD and under supervision from their clinicians, particularly in patients within 2 weeks period post myocardial infarction, those who with unstable angina pectoris, and patients with serious arrhythmias [11]. The nicotine patch has been demonstrated as safe for patients with CVD. Non NRTs (bupropion SR, and varenicline) are not contraindicated for patients with CVD. Bupropion SR has been reported that generally well-tolerated for patients with CVD, but occasional may causes hypertension [11].

On the other side, if a patient who currently uses tobacco is unwilling to quit smoking, clinicians should provide a brief clinical approaches such as motivational intervention to motivate the patient to make a quit smoking attempt in the future [11].

Fiore and his colleagues recommended four general strategies to provide motivational intervention for tobacco users who unwilling to quit smoking [11]. These motivational intervention strategies included: 1) express empathy: listen to patient and explore the importance of addressing the hazards of tobacco use and the benefits of quitting tobacco use, and respect the patient's autonomy and right to choose or reject quit smoking; 2) develop discrepancy: remind the patient of the discrepancy between his present behavior and his priorities and goals.

Then support him to quit smoking and explain the options of smoking cessation for the patient (counseling and medication); 3) roll with resistance: use reflection technique when the patient expresses resistance to treatment, and assist the patient to quit smoking through providing the patient information about hazards of smoking, and provide counseling; and 4) support patient's self-efficacy through remind the patient of previous successes of quitting smoking, offer options for achievable strategies to stop tobacco use such as call the quitline, read about the benefits of quit smoking and the successful methods to quit smoking, and inform the patient to share his/her ideas about smoking cessation plan with his/her health care providers [11].

Motivational intervention is an effective strategy to promote patient's motivation to make a future attempt to stop tobacco use [11]. Therefore, clinicians should use the recommended motivational strategies for patients who are unwilling to stop tobacco use in the future [11].

Hospitalized patients, particularly patients with chronic and threaten diseases such as CVD patients, are more likely to be motivated to make smoking cessation attempt for two reasons. First, the illness related to tobacco use resulting in hospitalization may motivate the patient to quit smoking to prevent recurrent admission and prevent disease complications. Also, the hospitalization period is considered as a "teachable moment" [11]. Second, smoking in the hospital setting is prohibited by the regulations of hospitals that accredited by The Joint Commission on Hospital Accreditation [49] to achieve smoke-free environment. As a result of enforcing regulations for smoke-free in the hospitals, the majority of the hospitals extended smoking space from indoor facilities to outdoor environments. Therefore, smoking in extended smoking spaces is a barrier for the hospitalized patients, particularly those with threatens CVD and connected to cardiac monitor [11]. According to previous reasons, clinicians should use hospitalization as an opportunity to motivate the patients to make a quit attempt after discharge from hospital.

Based on finding of the previous Jordanian studies [13, 42] that have been conducted on Jordanian smokers who hospitalized with CVD, the authors reported that public education as well as patients with CVD in Jordan is essential to correct wrong knowledge about nicotine dependence, beliefs about the health hazards of tobacco use, health harms of second-hand smoking and benefits of quit smoking [13, 42]. Since most of the patients with CVD in previous studies [13, 42] as well as Jordanian smokers [36, 38, 39, 47] initiated tobacco use before 18 years old, community health education will be most beneficial at an earlier age through school curriculum, as a part of education during each health care visit by their health care providers (nurses or physicians). In addition, providing the patients with self-help educational materials such as brochures, audio-visual materials, and computer assistant programs, are effective methods to help the hospitalized patients to quit smoking [11, 42]. Putting labels about the harm of smoking on the cigarette packages, and discuss topics about the health hazards of smoking in the media such as television, the radio, in newspapers, or social network will be helpful for improving knowledge about smoking hazards in the communities [11, 42].

## CONCLUSION

Lack of knowledge of the effects of tobacco use and nicotine dependence results in smokers' failure to quit

smoking and increases the risk for CVD. A national stop smoking campaign, and establishing smoking cessation programs are needed. Also, community health education should start with school aged children to improve their knowledge about the addictive properties of smoking, and the hazards of second-hand smoke.

Paternalism is a philosophical idea that helps health care providers in understanding more about tobacco use control. Implementation of paternalistic laws and regulation polices on smoking aim to achievement of beneficence and non-maleficence even overriding of clients autonomy to prevent the harm of smoking. Therefore, Existing smoking laws need to be enforced to enhance the health of the Jordanian population.

Patients' smoking behavior must be assessed at each health care visit in every health care setting to identify smokers and treat them to reduce tobacco use and nicotine dependence. Health care providers must counsel and provide smoking cessation strategies for patients who use tobacco to enable them to quit smoking [11]. Health care providers need appropriate training to improve their knowledge of smoking cessation strategies [40, 41].

Little is known about patients' perspective of smoking and how could paternalism attribute in smoking cessation among Jordanian population. Further experimental researches are needed to examine the effect of tobacco control regulations, and pharmacological treatment and counseling on Jordanian patients with CVD to treat tobacco use.

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