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The gap between stated importance of and clinical work in promoting healthy lifestyle habits by healthcare professionals in a Swedish hospital setting: A cross-sectional survey

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Abstract
The objective of this study was to explore the stated importance of promoting healthy lifestyle habits (alcohol, eating habits, physical activity and tobacco) by healthcare professionals, and to what extent these attitudes were translated into clinical work.

In 2014, healthcare professionals (n = 251) from cardiology departments in two hospitals in Stockholm, Sweden, participated in a cross-sectional descriptive questionnaire-based survey. The questionnaire included topics regarding stated importance and clinical work undertaken to promote healthy lifestyle habits. Personal and organisational factors of potential importance, expectations and future work were also explored. To analyse differences in stated importance and clinical work within and between lifestyle factors, comparisons of proportions were performed with 99% confidence intervals (CI). Relationships between stated importance and clinical work were investigated using logistic regression. The majority of healthcare professionals stated that it was ‘very important’ to promote healthy lifestyle habits among patients in general (69%–94%) and in their own clinical work (63%–80%). Despite this, always asking questions (18%–41%) or providing counselling (11%–23%) regarding lifestyle habits was reported to be rare. Overall, tobacco cessation was considered the most important behavioural change and was more often included in clinical work compared to promoting physical activity, healthy eating habits and limiting alcohol use.

Clinical work was mainly influenced by to what extent the healthcare professional perceived clear organisational routines and objectives. In conclusion, we observed a gap between stated importance and clinical work in the promotion of healthy lifestyle habits among healthcare professionals. There were differences between lifestyle factors, indicating that work with tobacco cessation is the most established.

Our results suggest that in order to promote patients’ lifestyle habits in line with evidence-based guidelines, healthcare management should focus on and improve organisational routines and objectives.
1 | INTRODUCTION

Healthcare professionals are considered to be a credible source of health information (Lobelo, Duperly, & Frank, 2009). Thus, the healthcare sector has an important role in improving health in society by distributing correct information on healthy lifestyle habits (Cavill, Kahlmeier, & Racioppo, 2006; The Swedish Government, 2018). Healthy lifestyle habits (moderate use of alcohol, healthy eating habits, regular physical activity and tobacco cessation) are important in primary and secondary prevention of cardiovascular disease (CVD) and premature mortality (Carlsson et al., 2013; Chow et al., 2010; Ek et al., 2018; Ekblom, Ek, Cider, Hambraeus, & Borjesson, 2018; Minges et al., 2016). To stress the importance of healthy lifestyle habits and provide measurable objectives, guidelines have been developed for each lifestyle habit (Piepoli et al., 2016; The National Board of Health & Welfare, 2011, 2018). The objectives are tobacco cessation and aerobic physical activity of moderate intensity 5 days a week (≥30 min/day) in combination with muscle strength training 2 days/week. Furthermore, the recommendations include a high intake of fruits, vegetables, legumes, wholegrain products, fish and unsaturated fatty acids and moderate consumption of alcohol (Piepoli et al., 2016). However, only a minority of patients achieve the recommended level of lifestyle behavioural change as part of secondary prevention (Chow et al., 2010; Kotseva et al., 2016). Therefore, there is room for improvement in clinical work.

Studies within primary care indicate that healthcare professionals consider health promotion and disease prevention to be important (Brotons et al., 2005; Luquis & Paz, 2014; Weinhehall et al., 2014). There are, to our knowledge, only a few studies focusing on stated importance of health promotion and disease prevention among healthcare professionals within hospital care. Johansson et al concluded that health promotion was considered less important among healthcare professionals working in hospitals compared to those working in primary care (Johansson, Stenlund, Lundstrom, & Weinhehall, 2010). There are few studies exploring clinical work with lifestyle habits. Haynes explored patients’ views on the advice they received from UK hospitals on changing lifestyle habits. The study demonstrated that the majority of patients were asked about tobacco use and fewer patients were asked about alcohol use, physical activity and eating habits (Haynes, 2008). Similar pattern was seen in another study using medical records to report lifestyle habits (Haynes & Cook, 2008).

The above-mentioned guidelines state the importance of healthcare professionals offering support for healthy lifestyle habits at every consultation for individuals with CVD, both within primary and hospital care. While primary care has the largest role in lifestyle behavioural change, hospital care do have a unique role, early in the acute process, i.e., postmyocardial infarction, to establish the importance of lifestyle behavioural change, which will help the primary care colleagues at a later stage (Piepoli et al., 2016). There is, however, a need to further investigate healthcare professionals’ stated importance and clinical work with different lifestyle habits within hospital care since hospital healthcare professionals have been shown to rate health promotion as less important compared to primary care professionals (Johansson et al., 2010). This study aims to explore stated importance among healthcare professionals towards promoting healthy lifestyle habits (alcohol, eating habits, physical activity and tobacco) at two cardiology departments in hospital care, and to what extent these attitudes are translated into clinical work.

2 | METHODS

This was a cross-sectional descriptive study performed on healthcare professionals working in cardiology departments at two major hospitals in Stockholm, Sweden. The departments consisted of two wards and one accompanying outpatient clinic treating patients with cardiovascular diseases.

2.1 | Data collection

Data were collected using self-completion questionnaires in March 2014. The first author (AE), or occasionally key staff members in the cardiology departments, handed out the questionnaires. One reminder was sent out.
The questionnaire was developed from existing questionnaires (The National Board of Health & Welfare, 2011; Weinehall et al., 2014) and concerned three areas (Table 1):

- Stated importance and clinical work to improve patients’ lifestyle habits (alcohol, eating habits, physical activity and tobacco use).
- Personal and organisational factors of potential importance.
- Expectations and future work.

In order to assess questionnaire face validity, pilot testing was performed on various healthcare professionals. The results led to no questions being changed.

Stated importance and clinical work to improve patients’ lifestyle habits.

Four questions were identified as core questions, focusing on stated importance (of the healthcare sector in general and own clinical work) and clinical work to promote patients’ lifestyle habits (asking and providing counselling) (Table 1). The core questions were analysed for each of the investigated lifestyle habits (alcohol, eating habits, physical activity and tobacco use). Prior to data analyses, the response categories of the four core questions were dichotomised into the highest category at the scale (very important, always and to a great extent, respectively) versus all other categories. Number of response categories varied between four and six for the four core questions (Table 1). Dichotomisation was done in line with previous studies and evidence-based guidelines (Piepoli et al., 2016; The National Board of Health & Welfare, 2011, 2018; Weinehall et al., 2014).

### 2.2 Personal and organisational factors of potential importance

Further eight questions focused on personal (age, gender, profession, years in the profession and workplace) and organisational factors (perceived clear routines, clear objectives and strong management support). When analysing responses, profession was divided into physicians versus all other healthcare professionals; workplace was divided into inpatient and outpatient care; age was divided into under and over 40 years, and years in profession was divided into under and over 9 years. The response categories for questions regarding organisational factors were, on analysis, divided into ‘agree to a great extent’ or ‘totally agree’, versus all others.

**Table 1** Questions used in the survey (translated by the authors)

<table>
<thead>
<tr>
<th>Question</th>
<th>Response options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core questions</strong></td>
<td></td>
</tr>
<tr>
<td>In general, how important do you think it is to provide counselling to patients on the following lifestyle habits?</td>
<td>Four-graded ordinal scale&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>In your own clinical work, how important do you think it is to provide counselling to patients on the following lifestyle habits?</td>
<td>Four-graded ordinal scale&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>I ask patients about their lifestyle habits in my clinical work</td>
<td>Six-graded ordinal scale&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>To what extent are you counselling patients about the following lifestyle habits in your clinical work?</td>
<td>Four-graded ordinal scale&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Organisational structure</strong></td>
<td></td>
</tr>
<tr>
<td>Are there clear routines for counselling of lifestyle habits in your workplace?</td>
<td>Four-graded ordinal scale&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>There are clear objectives for the work to promote patients’ lifestyle habits</td>
<td>Six-graded ordinal scale&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td>The top management has clearly stated that the work to promote patients’ lifestyle habits is a priority</td>
<td>Six-graded ordinal scale&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Healthcare professionals beliefs and requests</strong></td>
<td></td>
</tr>
<tr>
<td>I think it has a positive effect on the patients’ health if they change the following lifestyle habits</td>
<td>Six-graded ordinal scale&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>I think patients expect to be asked about the following lifestyle habits</td>
<td>Six-graded ordinal scale&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>As compared with your current practice, how would you like to change the extent to which you discuss the following lifestyle habits with patients?</td>
<td>Five predetermined response options&lt;sup&gt;†&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>†</sup>Alcohol, eating habits, physical activity and tobacco.

<sup>a</sup>1. Very important, 2. Partly important, 3. Not very important, 4. Not important at all.


<sup>c</sup>1. To a great extent, 2. To some extent, 3. To a minor extent, 4. Very little/not at all.

<sup>d</sup>1. Totally agree 1. 2. 3. 4. 5. 6. Do not agree at all.

<sup>e</sup>1. A lot less, 2. A little bit less, 3. To the same extent, 4. A little bit more, 5. A lot more.
other categories (Table 1). This was done in order to explore to what extent participants perceived these organisational factors as important. Further investigating details about routines, objectives and management support was outside the scope of the present study.

2.3 | Expectations and future work

We further explored healthcare professionals’ expectations and future work, using three questions. The first question aimed to investigate to what extent healthcare professionals perceived that lifestyle habits were important to health outcomes. The second question investigated how healthcare professionals perceived patient expectations of being asked about lifestyle habits. For those questions, the responses were categorised as ‘Always’ versus all other categories (Table 1). The third question asked to what extent the healthcare professionals wanted to discuss lifestyle habits in the future. The responses were categorised as two groups: ‘a lot more’ and ‘a little bit more’ versus ‘to the same extent’, ‘a little bit less’ and ‘a lot less’. (Table 1).

2.4 | Study cohort

All healthcare professionals, e.g. physicians, nurses, assistant nurses, physiotherapists, dieticians, occupational therapists, social workers, psychologists and biomedical analysts (n = 287), were invited to participate. Healthcare professional who did not have patient contact or did not provide full information for all four core questions were excluded from the data analysis.

The Regional Ethical Review Board in Stockholm, Sweden, approved the study (reference number: 2015/580-31/5). The healthcare professionals received oral and written information about the study and signed written consent was obtained prior to them receiving the questionnaire.

2.5 | Statistics

Statistical analysis was performed using SPSS 24.0 software (IBM Corp.). All nominal and ordinal data were presented as frequencies and relative frequencies. To analyse differences in gender and profession between the included and non-included (those who dropped out did not have patient contact, or did not answer the core questions) participants, a Chi-square test was used. The level of significance in these analyses was set to \( p < .05 \).

To analyse differences in responses for the four core questions within and between the four lifestyle habits of alcohol, eating habits, physical activity and tobacco use, differences in paired proportions and their 99% confidence intervals (CI) were calculated (Newcombe, 1998). CIs including zero were interpreted as having no difference. Additionally, to assess relationships between the core questions for stated importance and clinical work, Spearman's rho was used.

Unadjusted logistic regression was used to calculate odds ratios (OR) for whether personal or organisational factors related to stated importance or clinical work. To correct for multiple testing bias, the confidence interval (CI) was set to 99%.

To analyse whether current counselling practice related to the extent to which participants wanted to change to their future clinical work (‘greater extent’ vs. ‘to the same extent or less’), a Chi-square test was used. The level of significance in these analyses was set to \( p < .05 \).

3 | RESULTS

The study population consisted of 251 healthcare professionals, giving a response rate of 87% (Figure 1). No significant differences regarding gender or profession were found between the non-included (dropouts, did not have patient contact, or did not answer the core questions) and the included study responders (Figure 1). Among the included participants, the majority were women working in inpatient care. One third were physicians, six of ten were 30–49 years old and more than 40% had worked less than 10 years (Table 2). One fifth perceived that the cardiology department had clear routines for promoting healthy eating habits, tobacco cessation and physical activity. However, less than one tenth reported that they perceived clear routines for promoting a healthy lifestyle in terms of alcohol consumption. A minority reported perceiving clear objectives and management support, most frequently for tobacco cessation, followed by the promotion of physical activity levels, eating habits and less for the reduction in hazardous alcohol consumption (Table 2).

3.1 | Stated importance and clinical work to improve patients’ lifestyle habits

The majority of participants emphasised the importance of providing counselling to patients with unhealthy lifestyle habits within the healthcare sector in general. Importantly, there were significant differences between lifestyle habits. Proportion of participants stating ‘high importance’ varied between 69% and 94% (Figure 2). More participants stated that they regarded counselling on tobacco cessation to be important compared to alcohol counselling (difference 12%, CI: 4%–19%), physical activity counselling (13%, CI: 5%–20%) or counselling on healthy eating habits (25%, CI: 16%–34%) (Figure 2).

Furthermore, the majority of participants emphasised the importance of providing counselling to patients with unhealthy lifestyle habits within their own clinical work. Proportions of participants rating ‘high importance’ varied between lifestyle habits, from 63% to 80% (Figure 2). Counselling on tobacco cessation was more often rated as ‘very important’ compared to counselling on both alcohol consumption (13%, CI: 3%–23%) and healthy eating habits (17%, CI: 7%–27%). Providing counselling on physical activity was considered to be more important than counselling on healthy eating habits in their own clinical work (13%, CI: 3%–24%) (Figure 2).
A minority of participants reported that they *always asked* their patients about lifestyle habits, with differences between the lifestyle habits ranging from 18% to 41% (Figure 2). A larger proportion of participants always asked patients about tobacco use in comparison to alcohol use (difference 21%, CI: 11%–31%), eating habits (23% CI: 14%–34%) and physical activity (12%, CI: 2%–23%). Furthermore, a larger proportion always asked about physical activity in comparison to healthy eating habits (11%, CI: 1%–21%) (Figure 2).

Finally, less than one fourth of the participants actually *provided counselling* ‘to a great extent’ to individuals with unhealthy lifestyle habits. Counselling varied with lifestyle habits ranging between 11% and 23% (Figure 2). Counselling tobacco cessation was more commonly provided than counselling alcohol use (difference 12%, CI: 3% to 20%) or eating habits (9%, CI: 0.3% to 18%). In addition, participants provided physical activity counselling more often than alcohol counselling (10%, CI: 1% to 18%) (Figure 2).

### 3.2 Differences between stated importance and clinical work for lifestyle behavioural change

Figure 2 shows that for all lifestyle habits, there was a wide gap between the stated importance of the healthcare professionals’ own clinical work and to what degree they actually asked their patients about these habits (alcohol 47%, CI: 37%–57%; eating habits 45%, CI: 35%–55%; physical activity 47%, CI: 37%–57% and tobacco 39%, CI: 8%–29%). Moreover, for alcohol and tobacco, there were differences between all four core questions.

The correlation between stated importance in general and clinical work (asking and counselling) was poor ($r < 0.3$) for all lifestyle habits. Regarding stated importance within own clinical work, and to what degree participants asked and counselled about the four lifestyle habits, the correlation was fair ($r: 0.3–0.5$) (Supplementary 1).

### 3.3 Personal and organisational factors of potential importance

Table 4 describes the relationship between personal and organisational factors, and stated importance and clinical work. Gender, profession and to what extent participants perceived clear routines and objectives were related with stated importance, but with differences between lifestyle habits. For clinical work, several factors affected to what degree healthcare professionals asked and counselled about the four lifestyle habits. These were mainly organisational factors (e.g. perceive clear routines, objectives and strong management support). Overall, it was more prevalent for physicians, individuals with more than 9 years in the profession and individuals working within outpatient care to ask about and provide counselling (Table 3).

### 3.4 Expectations and future work

In general, the participants had a positive attitude towards lifestyle habits being an important part of patient health, and stated they would like to increase their work in promoting healthy lifestyle
The major finding of this study was that at hospital Cardiology departments, counselling on major lifestyle habits (alcohol, eating habits, physical activity and tobacco use) varies greatly in terms of its perceived importance by healthcare professionals, compared to the extent it is used in clinical work.

Although participants rated clinical work with lifestyle counselling as important 'to a large degree', only a minority asked about lifestyle habits or provided lifestyle counselling. This was in line with a study by Weinehall et al finding a difference between stated importance and clinical work among 266 healthcare professionals in primary care from Sweden and the US (Weinehall et al., 2014).

There are a few other studies focusing on stated importance among healthcare professionals in primary care (Brotons et al., 2005; Luquis & Paz, 2014) supporting our results of a high stated importance. However, there is lack of knowledge of to what degree this is a part of the clinical work. One small Swedish study among representatives (n = 78) of cardiac rehabilitation centres declared that the centres offered counselling of the different lifestyle habits to a great extent 83%-99% (Ogmundsdottir Michelsen et al., 2019). This is in contrast to our study where this was stated among 11%-23%. The large difference between those studies is notable and may be due to different questions being asked that our study asked all healthcare professionals regarding their clinical work while Ogmundsdottir Michelsen et al asked a selected group possibly answered about what the clinic should offer.

The gap between stated importance and clinical practice is striking since individuals with established CVD constitute a high-risk population with an increased risk of new cardiovascular events and mortality (Chow et al., 2010). All four lifestyle habits investigated have a cumulative impact on preventing new cardiovascular events (Chow et al., 2010). This highlights the importance of healthcare professionals regularly asking individuals about all lifestyle habits.

In our study, tobacco cessation was rated as being most important and had a more prominent role in clinical work. This may be an effect of higher knowledge in this area. The negative effects of tobacco on health have been known for a long time (Critchley & Capewell, 2004). However, the importance of regular physical activity, healthy eating habits and moderate use of alcohol has become more evident during the last few decades (Carlsson et al., 2013; Chow et al., 2010; Ek et al., 2018; Ekblohm et al., 2018; Kotseva et al., 2016; Minges et al., 2016; Yusuf et al., 2004).

Our study demonstrated that a large number of participants perceived a lack of clear routine, a lack of clear objectives and lack of strong management support as reasons why they did not work with behavioural changes in everyday clinical work. This is in line with a Swedish study exploring perceived barriers among healthcare professionals within primary and hospital care (Johansson et al., 2010). These results showed that more effort needs to be invested in the structural support of behavioural changes for it to be a regular part of clinical work.

Personal factors affecting stated importance and clinical work were mainly gender, profession and years in profession. A previous study show that women have reported greater perceived importance for the healthcare sector to promote healthy
The present study was in agreement with this, with women to a greater extent compared to men stated that eating habits were of a 'high importance' in their practice. In a previous study, physicians were more negative to health promotion and preventive aspects of clinical work than other healthcare professionals (Johansson et al., 2010). The present study differs in this regard, showing that physicians attach greater importance to counselling on physical activity in their own clinical work compared with other healthcare professionals. Physicians also asked about tobacco and provided counselling on alcohol intake and tobacco cessation more often than the other professionals. Douglas et al. showed that physicians more frequently ask patients about physical activity when it is associated with their disease, than talk about physical activity in general (Douglas, Torrance, van Teijlingen, Meloni, & Kerr, 2006). The clear association between the four lifestyle habits explored in the present study and CVD may be a possible explanation why physicians in cardiac care are more positive towards improving their patients’ lifestyle habits. In agreement with earlier studies, more years in the profession had a positive impact on clinical work (asking about eating habits and physical activity) (Luquis & Paz, 2014; Weinehall et al., 2014).

In the present study, the majority of healthcare professionals stated that they would like to increase and improve their work with promoting healthy lifestyle habits among patients. The results of the present study may aid this effort, showing that asking about and counselling lifestyle habits in clinical work, and having clear objectives, clear routines and strong management support are important. Furthermore, it is important to focus at less experienced healthcare professionals, non-doctors within inpatient care.

In order to be able to support individuals to achieve secondary prevention objectives, it is crucial to identify individuals at risk by routinely asking about lifestyle habits and thereby supporting what is called self-management (Lorig & Holman, 2003). Previous studies emphasise that patients self-management is important to achieve objectives for lifestyle change, which requires that the healthcare system is imbued in supporting self-management (Lorig & Holman, 2003). This is not explored in this study. Interestingly, only a minority of the participants stated that patients always expected questions regarding their lifestyle habits. This is in contrast to a large national survey (n = 1,800) where a majority (97%) of the population stated that they would like to be asked about their lifestyle habits (The National Board of Health & Welfare, 2016). A study performed on patients acutely admitted to hospital, reported that the patients

**FIGURE 2** Percentage of healthcare professionals (n = 251) considering lifestyle habits very important in general and in own clinical work and to what extent healthcare professionals always asked and offered counselling for different lifestyle habits. Note: *denotes statistical detected difference at the 1% level. Differences between lifestyle factors within the same statement/question are indicated by 1–4: 1>alcohol, eating habits and physical activity; 2>eating habits; 3>alcohol and eating habits; 4>alcohol.
wanted to have questions about their physical activity as long as it was associated with hospital admission (Murphy & Le Jeune, 2018). It is important to provide individually tailored counselling and explain how lifestyle habits can be associated with the individuals’ health and outcome of the treatment (Murphy & Le Jeune, 2018; The National Board of Health & Welfare, 2016). To be able to provide such individually tailored support, it is fundamental to ask all patients of their lifestyle habits.

### 4.1 Strengths and limitations

There are several limitations to this study. The study population may be considered small and data were collected from two different major hospitals in Stockholm, Sweden. On the other hand, response rate was high, with a small internal dropout. Included individuals were similar to non-included with regard to gender and profession. This suggests that our sample may have been representative of
healthcare professionals working at cardiac departments in major hospitals. In order to test the stability of our results, the analyses have been repeated using bootstrap-based confidence intervals and bootstrap logistic regressions. These results were similar and did not affect the significant results. A strength of this study is its setting within a hospital department. Previous studies on clinical work regarding lifestyle habits have been performed within primary care (Brotons et al., 2005; Luquis & Paz, 2014; Weinehall et al., 2014). In the present study, all healthcare professionals at cardiac departments with patient contact were included, ensuring a broader perspective. All data were self-reported, which is associated with risk of own interpretation, as well as risk of social desirability, i.e. individuals may rate importance and own clinical work higher because they know what the expectations are. In order to make results comparable to the literature, the majority of questions were taken from previous studies and the questionnaires face validity was tested before the study was initiated (The National Board of Health & Welfare, 2011; Weinehall et al., 2014).

In future studies, it would be of value to examine medical records to determine how often healthcare professionals record their patients’ lifestyle habits and, when needed, offer support to improve these habits. Finally, it would be of interest to explore barriers and facilitating factors further in order to implement an intervention to improve clinical work through the promotion of healthy lifestyle habits (Piepoli et al., 2016; The National Board of Health & Welfare, 2011; Weinehall et al., 2014).

The novelty of this study is that it includes all healthcare professionals working in cardiology departments. This provides a wider perspective on the healthcare sector’s attitudes and current practice in terms of promoting healthy patient lifestyle habits. Previously, studies have only focused on primary care settings. Finally, it describes the current work with lifestyle habits, showing possible targets for improvement in order to prevent cardiovascular morbidity and mortality.

there is a gap to their clinical work and only a minority offer this support. Stated importance and clinical work differed for the four studied lifestyle habits (alcohol use, eating habits, physical activity and tobacco use). In order to improve the clinical work with lifestyle habits among patients, clear organisational routines and objectives within the cardiac departments have to be established.

CONFLICT OF INTEREST
The authors have no conflict of interest to declare.

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REFERENCES

**TABLE 4** Healthcare professionals’ (n = 251) beliefs of lifestyle habits (whether it is important for patients health, whether they think patients expect questions) and to what extent they would like to work with lifestyle habits in the future

<table>
<thead>
<tr>
<th>Always important for patients’ health</th>
<th>Patients always expect questions</th>
<th>Increased work in the future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol use</td>
<td>Eating habits</td>
<td>Physical activity</td>
</tr>
<tr>
<td>204 (81)</td>
<td>162 (65)</td>
<td>193 (77)</td>
</tr>
<tr>
<td>217 (87)</td>
<td></td>
<td>217 (87)</td>
</tr>
</tbody>
</table>

Note: There was an internal dropout in some questions, as not all participants answered all questions.

**5 | CONCLUSIONS**

Although healthcare professionals employed in cardiology departments generally have a positive attitude to lifestyle counselling,


SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

Appendix 1. Correlation between stated importance and actual clinical work