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Punish the smoking industry, not the smoking individual

Clifford E Douglas

When he was US Surgeon General, Dr C Everett Koop said, "One of the things that keeps me motivated is that the tobacco industry does such sleazy things". Dr Mark Jameson, by contrast, is motivated by his feeling that individual smokers are doing the wrong thing. The distinction is more than superficial; one viewpoint blames the tobacco industry, the other, the industry's victims.

Dr Jameson's decision to refuse to care for patients who smoke prompted this constructive point-counterpoint. He believes that people who use tobacco are making a "free choice" and do not deserve his care because of the added burden their "choice" places on their health and on society. Unfortunately, his policy is counterproductive.

• First, Dr Jameson's blame-the-victim approach only helps the tobacco industry. Tobacco peddlers must be delighted whenever tobacco control advocates focus their limited resources and attention on individual smokers, rather than on the implementation of broad public policies that far more effectively counteract the industry's highly successful marketing efforts and reduce overall consumption rates.

Before the 1980s, the medical and voluntary health communities focused almost exclusively on the need for smokers to stop smoking, and did not engage in public policy advocacy. Thus, the tobacco industry was virtually unhindered by policies designed to control tobacco, and did not lose a single legislative battle in the US Congress until 1983, when the federal excise tax on cigarettes was raised from 8 to 16 cents a pack, causing the most significant drop in consumption seen in many years.

If the individual approach, rather than broad public policy activism, were most effective at reducing tobacco use, the tobacco companies would be peddling and promoting cigarettes door-to-door to individual consumers. But the industry knows that targeting individuals is not nearly as productive as influencing the overall social environment through widespread advertising and promotion, aggressive media advocacy, and public policy intervention. By influencing the environment, the industry maintains the legitimacy of its products, entices children into addiction, and ultimately sells more tobacco products.

Taking a tip from the industry, health advocates, including the Advocacy Institute's Smoking Control Advocacy Resource Center (SCARC) in Washington, DC, are supporting broad policy changes, such as tobacco tax increases, advertising and promotional bans, smoke-free policies, and effective enforcement of laws prohibiting the sale of tobacco products to young people. Such measures have the greatest impact on reducing tobacco use, protecting children and focusing society's attention on the true adversary: the tobacco industry.

• Another flaw in Dr Jameson's policy is the fact that it is premised on the assumption that those who use tobacco are merely exercising bad judgment, even if the user is only 12 years old. Dr Jameson rejects the characterisation of tobacco user as "victim", but there is ample evidence that many people who use tobacco are precisely that. Dr Jameson's policy disregards the powerfully addictive nature of tobacco products. It is beyond dispute that nicotine is pharmacologically addictive in the same manner as heroin and cocaine. The vast majority of those who smoke want to stop, but most have an extraordinarily difficult time doing so. Defending the policy by reference to individual "choice" and "personal responsibility" may sound appealing, but it plays directly into the hands of the tobacco industry, which argues that tobacco use is simply an "adult choice". The industry still pretends that nicotine is not addictive.

Tobacco addiction is a childhood disease that continues in adulthood. The nicotine industry aggressively recruits new adolescent customers with marketing themes of sexual attractiveness, weight loss and maintenance, athletic prowess, and social success. It is no surprise that most tobacco users become addicted before they are old enough to make rational decisions about whether or not to use tobacco. Portraying tobacco use as a simple voluntary act, as though it were like gum chewing or bicycle riding, ignores the dependency-forming nature of the activity and its onset during childhood.

• Dr Jameson's policy cannot be applied fairly and consistently. For example, the policy prescribes that Dr Jameson will care for a smoker in the event of an emergency, even if the crisis is precipitated by the patient's tobacco use. He would also care for patients in cases of hospitalisation or institutionalisation. One wonders what differentiates the emergency situation from the more mundane case

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in which a smoker not facing imminent death asks Dr Jameson to be his or her primary care physician. Since approximately one out of every three smokers dies directly as a result of his or her tobacco addiction, the only difference between the two types of cases appears to be one of degree – that is, the immediacy of the crisis caused by the individual's tobacco use. The emergency patient faces premature death now; the would-be regular patient faces a high probability of dying prematurely later (perhaps next week or only a few months from now).

• By refusing to accept patients who use tobacco, Dr Jameson also loses one of the best opportunities to promote cessation. One of the greatest influences affecting whether or not an individual continues to use tobacco is the intervention of his or her physician. When a doctor tells a patient, "You must quit smoking, and here are some ways I can help you to do it," studies show that the patient is far more likely to be motivated to become a former user. Bill Godshall shares this view, and argues that more physicians should encourage their patients to accept greater responsibility for their health. Unfortunately, a physician who closes the door in a prospective patient's face loses any opportunity to do so.

• An additional, unintended consequence may be the harm inflicted on the would-be patient's children by secondhand smoke in the home. Many smokers have small children, who are both endangered by their parents' tobacco use and helpless to do anything about it. A child's best hope to avoid the harm caused by involuntary smoking in the household might be for the family doctor to intervene by helping the smoking parent to quit. Dr Jameson argues that physicians should decline to care for smokers because their behaviour harms the public. Ironically, his policy may result in the smoker's children being exposed to that very same harm.

• This raises a related question. If a potential patient uses tobacco, will Dr Jameson refuse to care not only for that person but also for that person's family? If so, is this policy fair to that person's children? Or will Dr Jameson care only for the non-smoking members of the family, leaving the smoking parent to his or her addiction, thereby endangering the children who are forced to inhale that parent's secondhand smoke?

• Dr Jameson's policy is premised on the belief that physicians have an almost absolute right to decline to care for patients they wish to avoid, a view generally supported by the American Medical Association's (AMA) Principles of Medical Ethics. Even the AMA tempers this laissez faire approach to the practice of medicine with certain caveats. For example, the AMA's 1992 Code of Medical Ethics: Current Opinions, in a section concerning HIV-infected patients and physicians, states that "A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV". It does not matter if the physician is afraid of, or prejudiced against, those with HIV, according to the section: the physician must render care.

Ironically, arguments similar to those which Dr Jameson makes regarding smokers could be made regarding those suffering from HIV. Illness results from the exercise of "personal choice". The activities which cause the illness too often harm others. The illness costs society billions of dollars and considerable social angst. Yet Dr Jameson apparently does not (to his credit) turn away individuals engaged in risky sexual practices or illicit drug use.

Given his emphasis on "personal responsibility", why doesn't Dr Jameson also turn away alcoholics, motorcyclists who ride without helmets, high-wire circus performers, boxers, and overweight people who eat at fast-food restaurants. All engage in risky lifestyles. All cause a potentially greater burden on their own health and on society. What is the difference between these activities and tobacco use? With the exception of the drinking of alcohol by the alcoholic, the other activities are not addictive (or, of course, as harmful as tobacco use). Nor are most of these activities foisted on adolescents and children by a wily multi-billion dollar industry. Yet Dr Jameson's policy punishes nicotine addicts – yes, many of them victims – while letting others off the hook.

Another AMA ethical principle holds that "A physician shall recognize a responsibility to participate in activities contributing to an improved society". Does Dr Jameson's policy satisfy this standard? Consider that the tobacco industry successfully targets children, poor people, the less-educated, and other vulnerable groups. Consider the highly addictive nature of tobacco products. Consider the greater impact that effective public policy advocacy has in comparison to the individual-by-individual approach. In the light of these factors, it is questionable whether Dr Jameson's narrow and prejudicial policy will truly contribute to an "improved society".

Physicians should not be required to care for tobacco users, and this column does not argue otherwise. No, physicians should consider all of the factors discussed here and choose to render such care of their own free will. Should a physician have the right to sever a relationship with a patient if the patient utterly fails to act on the physician's advice? In most cases, yes. However, severance of a relationship does not even enter into the picture in Dr Jameson's case, for his policy demands that he decline to begin such a relationship in the first place.

• Dr Jameson's policy is, at best, of symbolic value. Denied care at his office, most potential patients will simply find other doctors. On the positive side, his policy sends the constructive message that there is something wrong with tobacco use, that it is harmful, that people should not engage in it. Yet what if all doctors adopted this policy and refused to treat tobacco users? One billion people (or one-fifth of the Earth's population), including 50 million

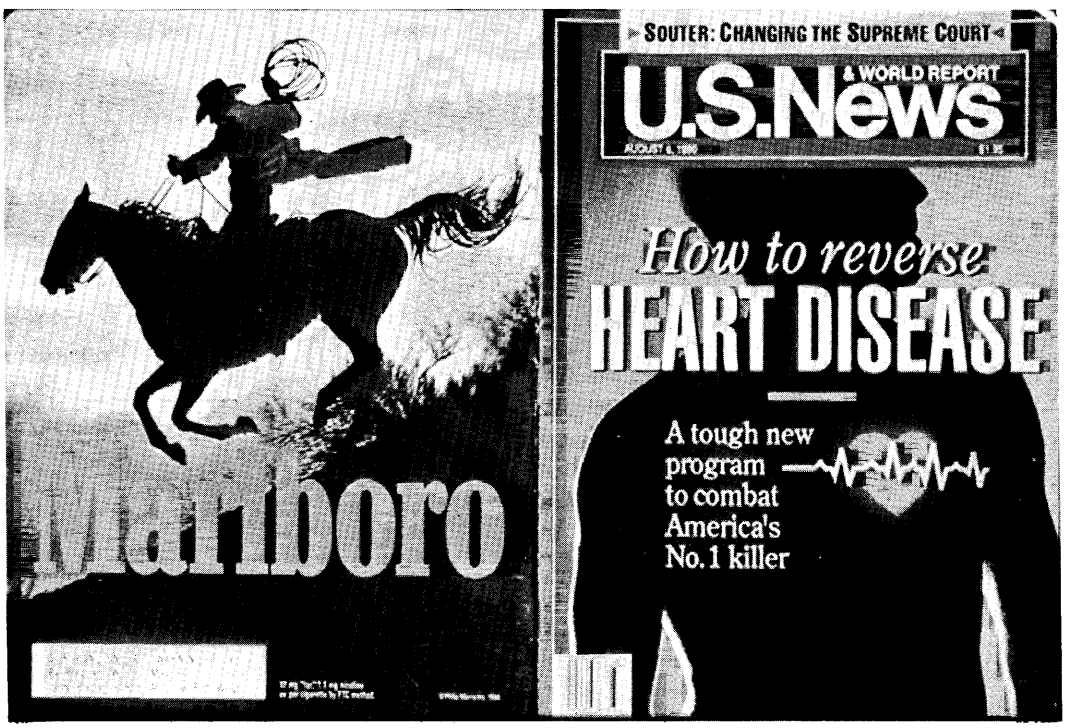
people in the US, would be denied health care. The enormous consequences of that scenario are hard to fathom, but certainly would be devastating. While it is easy to respond that such an outcome is hypothetical, one might ask whether Dr Jameson's policy should be measured against a different standard merely because it is the policy of one and not of all physicians? Is Dr Jameson willing to carry out this policy because he knows most others will not? Is the issue here merely a "practical" one, or is it one that raises more fundamental questions about access to health care, the nature of addiction, and the targeting of children by legal drug pushers?

Dr Jameson believes that tobacco use is uniquely destructive and deserves special treatment. This is true, but the dilemma is that his policy ineffectively targets tobacco addicts and not the root causes of the problem: the activities of the tobacco industry and inadequate public policy responses to the tobacco epidemic.

The bottom line is that, if Dr Jameson, by engaging in public policy advocacy efforts, were to succeed (for example) in helping to persuade the legislature in his home state of Maryland to raise that state's tobacco taxes substantially, he would contribute to the prevention of many more deaths from tobacco use with that action than he ever could by denying health care to tobacco users. Well-intentioned as his policy might be, "just saying no" to smoking patients is the wrong way to go.

Dr Jameson, and other physicians, should seek to punish the smoking industry – not the smoking individual.

See also pp 236 and 237–8 – ED



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