COMMENTARIES

The most compelling smoking cessation incentive a doctor can offer

William Godshall

Considering that many doctors still don't urge smokers to stop smoking, tobacco control advocates are justified in criticising doctors who engage in this irresponsible medical practice, which can even be considered malpractice. In contrast, insisting upon smoking cessation is arguably the most appropriate medical regimen that doctors can prescribe to smokers since stopping smoking is always more effective in preserving health than is receiving smoking-related medical treatments.

So when doctors such as Mark Jameson establish a policy that, except for emergencies, requires smokers to stop smoking as a prerequisite for receiving medical services, which is the most compelling smoking cessation incentive a doctor can offer, it is ironic and disturbing that the sharpest criticism of this policy comes from within the tobacco control movement.

To argue that doctors should be required to provide services against their will to smokers or any other population group (except those having legally protected civil rights) is to argue that doctors should not be protected by laws that prohibit involuntary servitude. A similar example of this gross injustice would be to require doctors to perform abortions against their will.

Simply put, if doctors were forbidden to freely enter into and sever relationships with patients, they would be relegated to being nothing more than servants attending to the whims and demands of patients and politicians, with most of the ever-increasing bills being paid with other people's money.

The American Medical Association goes even further in the defence of physicians' rights in its Principles of Medical Ethics. Principle VI states that "A physician shall, in the provision of appropriate patient care, except in emergences, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services."

The patient/physician relationship is in essence a freely negotiable and severable contract based upon mutual goals and trust. Few people would question the right of a person to hire or fire a doctor of their choice, even when an insurance company, health maintenance organisation, employer, or government entitlement programme pays the bill. The reasons why people choose or change doctors vary widely, but many of these reasons are related to the perceived quality of care or competence of the doctor.

Similar respect for the rights of physicians should also prevail. There are circumstances that might obligate a doctor who begins a specific treatment for a patient to continue that treatment, but other than these exceptions and emergency situations, doctors should continue to be free to sever patient relationships with or without cause. Perhaps of even greater importance, doctors should continue to be free to enter into professional relationships with patients of their choice.

A similar example involves lawyers' right to freely choose or release clients. Would anyone argue that a lawyer should be required to continue to represent a client who lies to the lawyer and refuses to follow the lawyer's advice? Besides, the threat of being dismissed as a client provides an incentive for clients to be honest with their lawyers and follow their advice.

The view that doctors should be required to treat smokers appears to be based upon the simplistic rhetoric of both the "right to health care" social idealism and the outrageous "right to smoke" propaganda of the tobacco industry. Ironically, these two perceived rights are philosophically incompatible with each other, and both reject individual responsibility as well as the right to negotiate contracts freely.

Respect for the protected rights of both doctors and patients also enhances the quality of medical care. If a patient refuses prescribed regimens, medications, or other treatments

This commentary and the one that follows are in response to the "Speaking Personally" *column by Dr Mark Jameson on page 236. The author of each of these commentaries was given the opportunity to review Dr Jameson's article and a draft of the opposing commentary before finalising the version printed here.*

Readers are invited to offer their own views in letters to the editor. We also invite suggestions for other topics that would be appropriate for future "point-counterpoint" commentaries. The first "point-counterpoint" commentaries in Tobacco Control *were published in the December 1992 issue, on the topic of criminalising the purchase and possession of tobacco by minors.* – ED

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needed to preserve his or her health or life, it is quite likely that a doctor's threat to sever their relationship will provide the necessary incentive to achieve patient compliance. Even if the patient refuses to comply and the relationship is severed, that patient is likely to find that another doctor will reinforce the directions of the previous doctor, thus resulting in patient compliance.

But what about the truly stubborn patient who goes to a half-dozen doctors, all of whom prescribe similar regimens and sever the relationships due to noncompliance? Surely, nobody would argue that the best interests of that patient or any of those doctors would have been to require each and every doctor to continue tolerating the no-win situation? Besides, after many concurring opinions, the patient is far more likely ultimately to comply.

Clearly, a doctor's ultimatum to sever a patient relationship requires an intention to follow through accordingly, but these ultimata can be very effective and should be utilised more often by more doctors. If a smoker went to several doctors who all required smoking cessation as a prerequisite to becoming a patient, that smoker would have a much greater incentive to stop smoking than would a smoker who was continually treated for other conditions by a doctor who never urged smoking cessation.

Nearly 90% of people who overcome nicotine addiction do so of their own volition, which is entirely dependent upon a very strong desire to stop smoking. Knowing this, it seems imperative that doctors, like tobacco control activists, identify and implement the incentives that truly encourage smokers to stop smoking.

A doctor's policy requiring potential patients to quit smoking recognises that it is the smoker, and not the doctor, who is the most influential variable in smoking cessation. Most medical procedures are not emergencies, and weeks or months may pass from the time a doctor recommends treatment for a chronic disease to the time the procedure takes place. A doctor's insistence on stopping smoking on these occasions, when patients are most health conscious, may be very effective.

Although modern medicine can cure diseases, save lives, and add to life expectancy, all of the health benefits attributable to America's entire multi-billion dollar health care industry do not counterbalance the morbidity, mortality, and years of potential life lost attributable to tobacco smoking.

Attaching ventilators, by-passing clogged arteries, and cutting out or irradiating cancers rarely benefit patients who continue to smoke. Even if these patients stop smoking before these procedures, their prognosis is rarely better than if they had stopped smoking five years previously. In addition to diseases caused by smoking, such as lung cancer, emphysema, and heart disease, from which very few patients fully recover, the chances of successful treatment and recovery from virtually every other disease are diminished if the patient is a smoker, and especially if the patient continues to smoke.

Few doctors, nurses, or allied health professionals receive adequate training about nicotine addiction, which is inexcusable as smoking has been the leading cause of disease and death in the US for decades. Furthermore, the health care industry has placed far greater importance on and has spent far more money treating the symptoms than treating the underlying problem.

This is probably due to the absence of effective nicotine addiction treatments as well as the lack of a payment system for physician counselling of patients. This latter reason also helps explain why most doctors spend little time talking to smokers about stopping smoking. Recently available nicotine gum and skin patches have encouraged more physicians to attempt to treat nicotine addiction, but even these medications have limited successes as they are not usually included as part of a more comprehensive smoking cessation programme.

A promising development in the medical treatment of nicotine addiction is the addiction medicine specialty. If more doctors required potential smokers to stop smoking and subsequently referred them to addiction specialists, who are much better trained and more interested in treating drug addictions, the addiction specialty field would further thrive, especially if adequate insurance payment mechanisms were established.

Many pack-a-day smokers consider their health status to be excellent, in part because their doctors haven't informed them otherwise. This attitude exemplifies the myths that health is the absence of symptomatic disease and that all people have similar chances of contracting diseases. These myths also reinforce nicotine addiction and other irresponsible high-risk behaviours. More physicians should strive to empower their patients to accept greater responsibilities for their own health, as the patients will be the ultimate beneficiaries.

If adopted by more doctors and other health care providers, using thoughtful guidelines, policies that require prospective patients to stop smoking as a condition for receiving various medical treatments can not only help achieve the goals of the tobacco control movement, but can also improve the quality and cost-effectiveness of the health care delivery system.